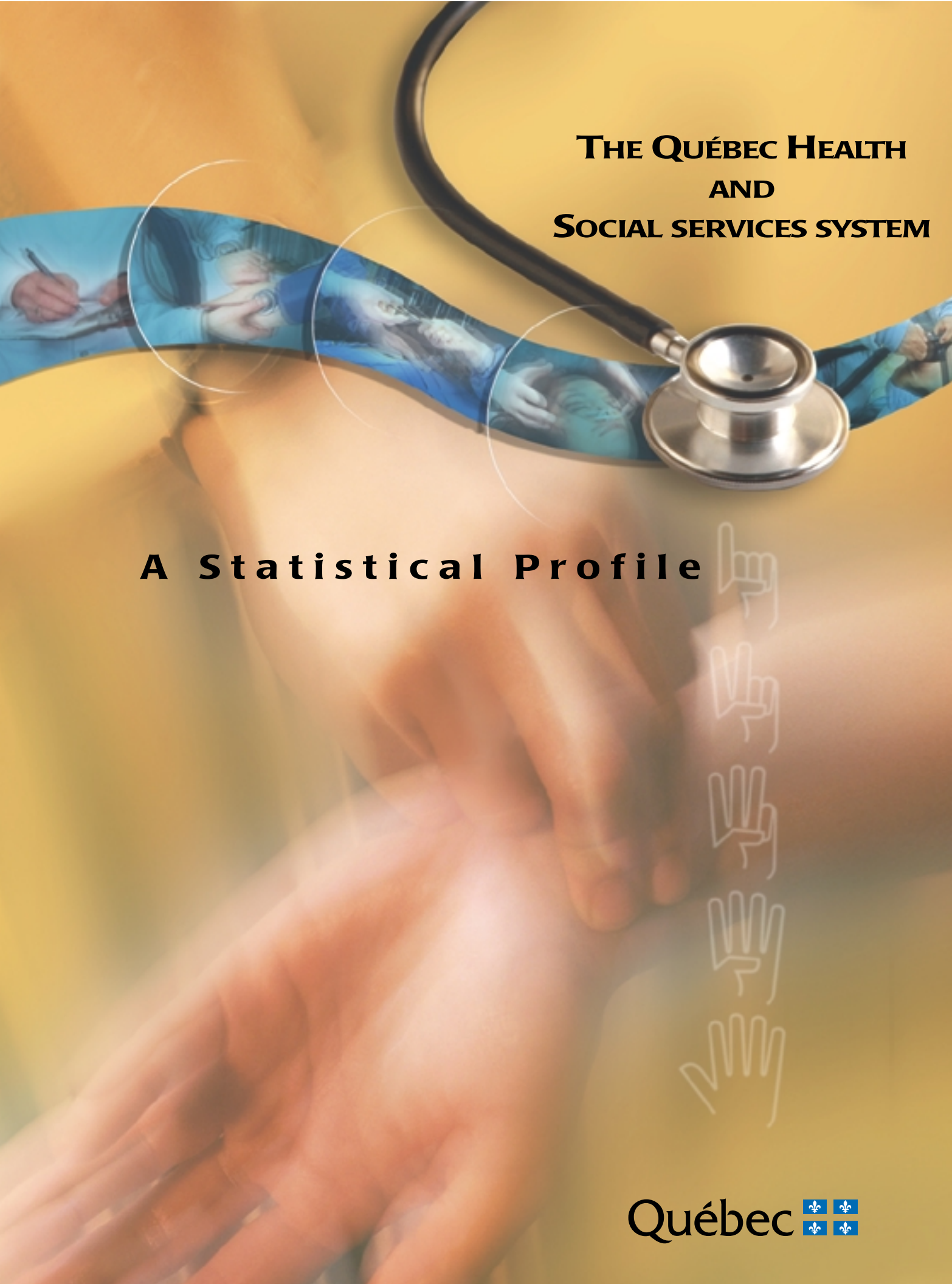
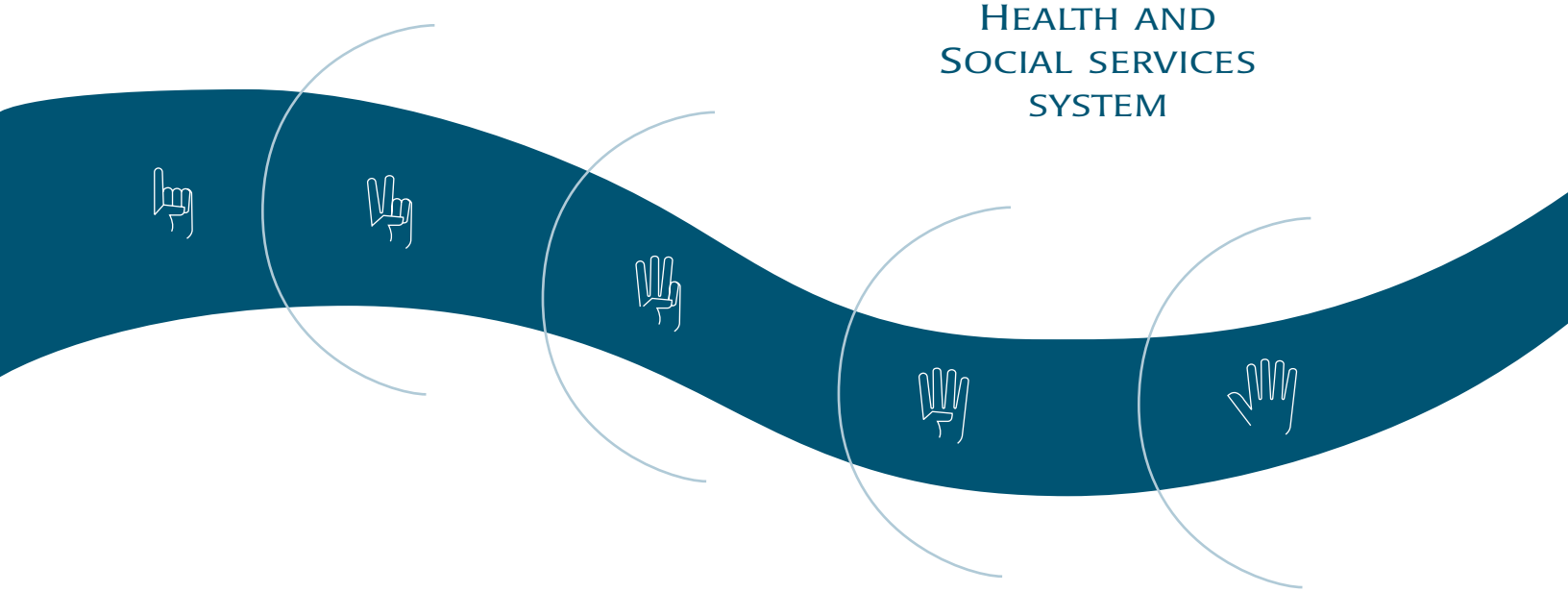


The Québec Health and Social services system

A Statistical Profile

Québec

The Québec Health and Social services system



A Statistical Profile

October 2001

COLLABORATORS

We would like to express our deep appreciation to the people whose kind assistance, on questions of both form and content, helped to bring this publication to a successful conclusion. We have not dared to try to name them all, because so many people generously lent their knowledge to the study that we are afraid of forgetting someone. They will certainly recognize themselves and will also know how profoundly grateful we are for their participation.

In particular, we would like to offer special thanks to Mr. Jean Mercier, who initiated the project when he was at the helm of the Direction des indicateurs de résultats et de l'information statistique. Lastly, it should be stressed that this publication was done under the authority of Ms. Mireille Fillion, Assistant Deputy Minister, Direction générale de la planification stratégique, de l'évaluation et de la gestion de l'information, and of Mr. Jean Houde, Director, Direction de la gestion de l'information.

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In the following text, the masculine form applies to women as well as men, except in the case of nursing staff, where due to the overwhelming number of women in the profession, the feminine form is used and applies to men as well.

PREFACE

That Québec's system of health services and social services often serves as a model within North America, that the ministère de la Santé et des Services sociaux (MSSS) receives visitors and interns from other countries, and that the Ministère is frequently asked to send representatives abroad – all this is testimony to the fact that Québec has much to say on the subject. Others are, of course, very interested in the general principles 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 that describes its structure and functioning.

Although all of this information is available, it often sits in immense data bases, or is consigned to voluminous reports that are not disseminated very widely. We therefore need a more accessible instrument in order to respond to the need for information.

It therefore gives me great pleasure to offer you the document entitled "The Québec Health and Social Services System: A Statistical Profile."

This publication of 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 in its presentation, in a synthesized manner, of an overview of the way the system is currently organized, the resources that it requires, the use that is made of it, and 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 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 and social services to the attention of a significant proportion of Québeckers.

That the current government allowed the transformation of the organization of services in order to better adapt to new realities and new needs, that it made a special effort to encourage the provision of services to beneficiaries in their home environment, that it continues to search for better ways to finance and manage the services – all this demonstrates our steadfast concern to find the most effective solutions to the problems that our society is facing.

I would like to thank all of those who have contributed to the production of this publication. They will be repaid by the interest that you take in the publication.

Minister of State for 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 system of health and social services and a description of its major components, these documents contain a range of statistics illustrating the fundamental aspects of the system. *The Québec Health and Social Services System: A Statistical Profile* is thus an update of the information presented in previous similar publications, including:

Les affaires sociales au Québec, published in August 1980;
Québec's system of health and social services, published in 1985;
Québec's system of health and social services, published in 1989;
Québec's health and social services system, published in 1992;
Health and well-being: the Québec perspective, published in 1993;
The cost and effectiveness of health services and social services, published in 1996.

This publication is meant to serve as a practical reference tool which, we hope, will respond to readers' expectations. Our goal is not to study all aspects of the system in depth, or to determine the factors that explain the phenomena that the study highlights, or to specify the actions that might involve changes in the observed trends, but only to describe them enough that readers can come to 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 Documentation Centre of the ministère de la Santé et des Services sociaux, located at the following address:

1075, chemin Sainte-Foy,
5e étage
Québec (Québec)
G1S 2M1
Tel. : 1 (418) 266-7007
Fax : 1 (418) 266-7024

There is also a wealth of relevant information on the Ministère's Web site at **www.msss.gouv.qc.ca**

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS AND ACRONYMS

A.V.	Annual variation
A.A.V	Average annual variation
a/c	Activity centre
ACDQ	Association des chirurgiens dentistes du Québec
AIDS	Acquired immunodeficiency syndrome
ALS	Average length of stay
AQPP	Association québécoise des pharmaciens-propriétaires
ASCBMFQ	Association des spécialistes en chirurgie buccale et maxillo-faciale du Québec
Att-days	Attendance days
AS	Average stay
$B	Billion of dollars
Ben.	Benefits
BMI	Body Mass Index
BSQ	Bureau de la statistique du Québec (now ISQ)
CAP	Canada Assistance Plan
CCP	Conseil consultatif de pharmacologie
CEGEP	General and vocational college
CH	Hospital centre
CHQ	Corporation d'hébergement du Québec
CHST	Canada Health and Social Transfer
CST	Canada Social Transfer
CHSGS	General and specialized care hospital centre
CHSLD	Residential and long-term care centre
CHSP	Psychiatric hospital centre
CJ	Youth centre
CLSC	Local community service centre
CMQ	Conseil médical du Québec
COA	Regional steering committee – admission (residential centre)
CPEJ	Child and youth protection centre
CQRS	Conseil québécois de la recherche sociale
CR	Rehabilitation centre
CRCS	Canadian Red Cross Society (now Héma-Québec for Québec)
CR JDA	Rehabilitation centre for young persons with adjustment problems
CR MDA	Rehabilitation centre for mothers with adjustment problems
CR PAT	Rehabilitation centre for persons who suffer from alcoholism or other problems of addiction
CR PDI	Rehabilitation centre for mentally impaired persons
CR PDP	Rehabilitation centre for physically impaired persons
CR PDP A	Rehabilitation centre for persons with hearing impairment
CR PDP M	Rehabilitation centre for persons with motricity impairment
CR PDP V	Rehabilitation centre for persons with visual impairment
CSST	Commission de la santé et de la sécurité du travail
DGI	Direction de la gestion de l'information
DGPSE	Direction générale de la planification stratégique et de l'évaluation
Dir.	Direction
EAR	Employment-Assistance Recipient
ENAP	École nationale d'administration publique
EPF	Established Programs Financing
Exp.	Expenditures
FG	Group home
FIIQ	Fédération des infirmières et infirmiers du Québec
FMOQ	Fédération des médecins omnipraticiens du Québec
FMRQ	Fédération des médecins résidents du Québec
FMSQ	Fédération des médecins spécialistes du Québec
FRSQ	Fonds de la recherche en santé du Québec
FSA	Forward sortation area
FTE	Full-time equivalent
Gov.	Government or governmental
GDP	Gross domestic product

GNP	Gross national product
GSC	General and specialized care
HC	Health care centre
HIV	Human immunodeficiency virus
Hosp.	Hospitalization
Hours pd.	Hours paid
Hours wkd.	Hours worked
HSS	Health and social services
IA	Induced abortion
ICD-9	International Classification of Diseases – Ninth Revision
ICT	Information and communications technologies
IPI	Implicit price index
ISQ	Institut de la statistique du Québec
ISR	Income Security Recipient (now EAR)
LDU	Local distribution unit (mail)
LRH	Low-rental housing
$M	Million of dollars
MCT	Structure Mission-Class-Type
MED-ÉCHO	Data storing and processing for research on hospital clientele
MEQ	Ministère de l'Éducation du Québec
MIP	Mentally impaired persons
MSSS	Ministère de la Santé et des Services sociaux
NSTC	New situations of children taken in charge
OECD	Organisation for Economic Co-operation and Development
OIIQ	Ordre des infirmières et infirmiers du Québec
OPHQ	Office des personnes handicapées du Québec
OSGE	Office des services de garde à l'enfance
PAA	Persons suffering from alcoholism and other addiction problems
PAV	Residential centre
PC	Psychiatric care
PIP	Physically impaired persons
% dist.	Percentage distribution
Pers.	Persons
Pop.	Population
PPP	Purchasing-power parity
PYLL	Potential years of life lost
QHA	Québec Hospital Association
RAMQ	Régie de l'assurance maladie du Québec
RCM	Regional County Municipality
RFT	Regular full time
RLTC	Residential and long-term care
RP	Reports processed (youth)
RREGOP	Pension plan for government and public agencies employees
RRF	Régime de retraite des fonctionnaires (public servant pension plan)
R.S.Q.	Revised Statutes of Québec
RRSSS	Regional Board of Health and Social Services
RSS	Health and Social Services Region
SAAQ	Société de l'assurance automobile du Québec
Sal.	Salary
SDD	Security or development in danger (of children aged 0 to 17)
SDI	Service du développement de l'information (Information development service)
SERHUM	Statistics on changes in human and material resources of the Québec health and social services system
SIC-CLSC	Client Information System-CLSC
SIFO	Financial and operational system
STATEVO	Statistics on changes in service utilization in the network
STD	Sexually transmitted disease
Tot.	Total
TSS	Health and social services territory
Var.	Variation
WHO	World Health Organisation
WHLS	Work habits learning service

INTRODUCTION

The Québec Health and Social Services System: A Statistical Profile paints an overall portrait of the main features of health services and social services in Québec.

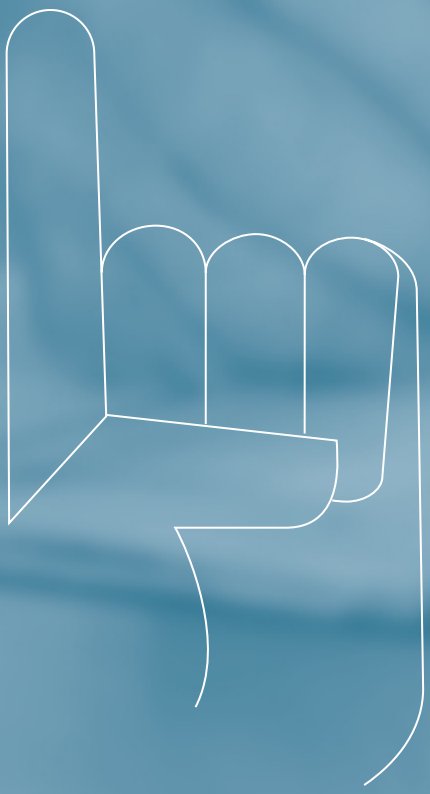
This descriptive synthesis has two main objectives. On the one hand, it conveys basic statistical information which will be very useful to decision-making bodies within the MSSS, where it can be put to use as needed to complement the various operating reports related to specific objectives. On the other 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.

The document is divided into five chapters. Chapter 1 presents a portrait of Québec, its territory, population and society. Chapter 2 describes the health and social services system, focusing on its history, laws and the various components that make it up, as well as the human and institutional resources it requires. Chapter 3 outlines the main services offered to the population, while Chapter 4 illustrates the costs incurred by the health and social services system as a whole. Chapter 5, using relevant indicators, sums up the state of health and welfare of the population of Québec.

The document concludes by looking at several prospective elements which will help the reader understand the underlying direction of our health and social services system at the beginning of this third millennium.

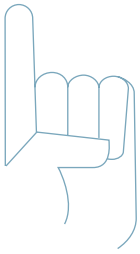
As well as an outline of the main elements discussed, each chapter includes a statistical section, under the heading, "SOME FIGURES," with a descriptive analysis of the content of the tables and figures presenting the basic statistical information, in synthesized format, for the most recent years. The 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 allow readers to benefit as fully as possible from the information provided in this document, several sections contain specific information on the types of data considered, as well as some definitions that are necessary in order to fully understand the figures presented here.

Québec



- Territory
- Population
- Society

QUÉBEC



Québec is situated in north-eastern North America, between the 45th and 60th parallels.

Having been the birthplace of New 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, in the face of the centralizing aims of the federal government, Québec closely guards its own claims in all areas under its jurisdiction including health and social services, while doing its best to use every available means to offer its population the best possible services, at the lowest cost possible, with the best possible results.

TERRITORY

Québec's territory is immense. It covers 1,667,926 square kilometres in surface area, and is delimited by a boundary that is 10,867 kilometres long. 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.

Close to 45% of Québec's territory is covered by forest, while its urban and agricultural areas represent barely 2%, or 33,530 square kilometres. The rest of the territory is made up of tundra,[1] taiga[2] and water. Moreover, Québec boasts a number of lakes and rivers that few countries or states can rival. Its inland waters cover approximately 166,426 square kilometres. The St. Laurence River, one of the largest rivers in the world, is by far its most important watercourse. Flowing through southern Québec from west to east over a distance of 1,140 kilometres, the St. Laurence ranks third in the world in terms of navigable distance.

Figure **1**

Québec
in North America,
2000

MSSS, SDI, January 2000.

1. A vast, discontinuous, treeless plain which supports a growth of mosses, lichens, and numerous low shrubs.
2. A coniferous evergreen forest which forms an almost unbroken belt along the southern edge of the arctic tundra.

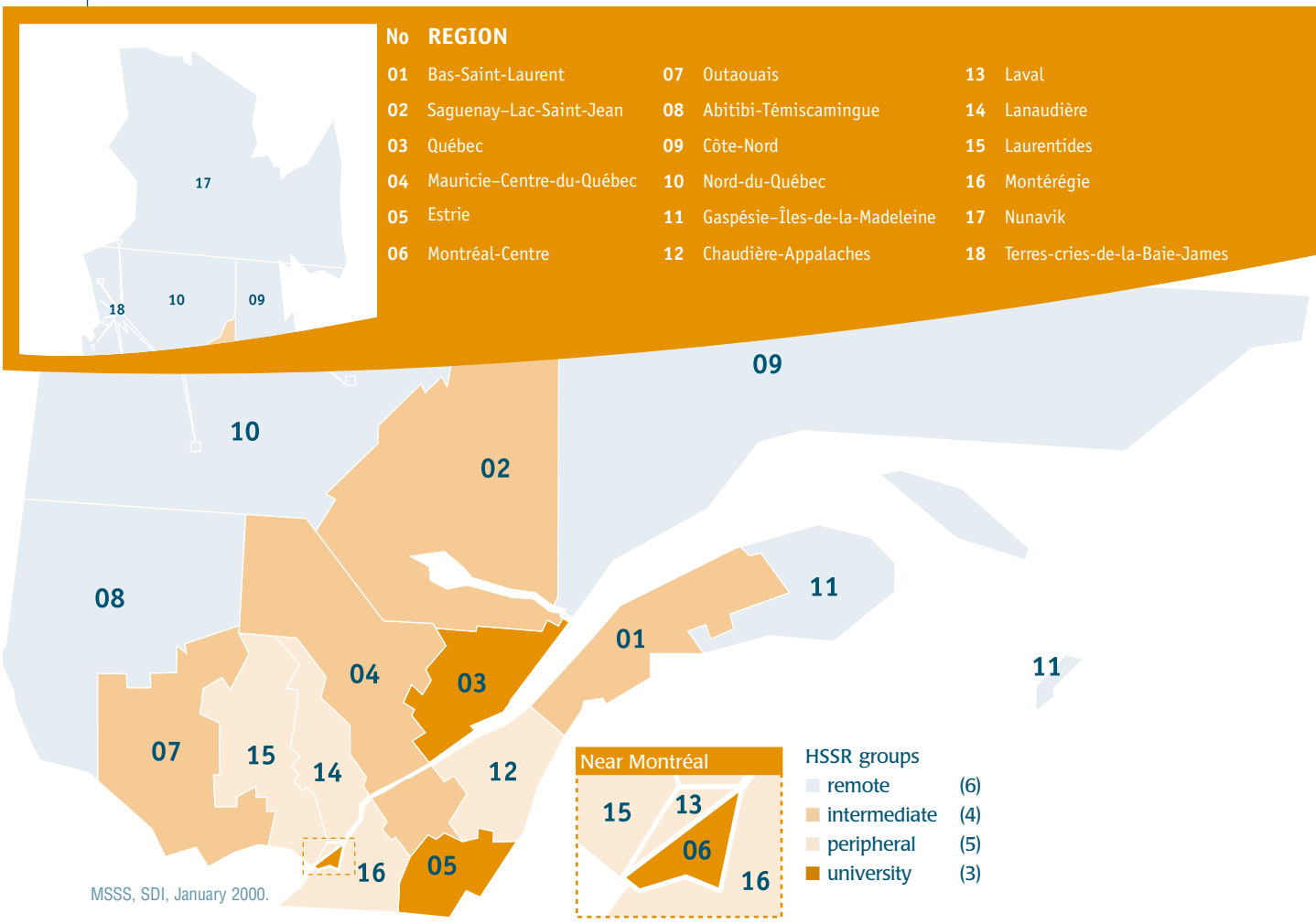
Québec is divided into 18 health and social services regions (or régions sociosanitaires (RSS)). These can be grouped together into four major categories: the university regions, the peripheral regions, the intermediary regions, and the remote regions. Historically, Québec was divided into health and 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 13 health and social services regions in Québec. Subsequently, the number rose to 17, and then rose again in 1991 to the present number of 18 health and social services regions (RSS). The number of administrative regions, on the other hand, settled at 17. 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 health and social services regions 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) health and social services regions. In 1994, the Kativik health and social services region (17) was renamed, becoming the Nunavik health and social services region (17). Then, in 1997, the Mauricie-Bois-Francs administrative region (04) was divided into two administrative regions: the Mauricie (04) and the 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) health and social services region.

Each health and social services region is subdivided into local community service centre (CLSC) territories or districts, making up 168 districts in total.

Sixteen (16) Regional Health and Social Services Boards (RRSSS), along with the Bay James Regional Centre for Health and Social Services (Nord-du-Québec) and the Cree Board of Health and Social Services of James Bay (Terres-Cries-de-la-Baie-James), ensure the planning and organization of health and social services in their respective regions.

Figure 2

Québec's **Health and Social Services Regions,** *2000*



POPULATION

In 2001, Québec's population was close to 7,400,000 people, or 24% of the total population of Canada. Contrary to the other provinces and territories in Canada, the official language of Québec is French. Altogether, the English community represents 11% of the population of Québec, while allophones make up 10%. In 1997, there were also some 75,000 First Nations and Inuit people belonging to eleven (11) different nations.

Close to 80% of Québec residents live in urban areas, mainly in metropolitan Montreal and its surrounding area, which alone account for more than half (59%) 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 societies, the Québec population is characterized by rapid aging, with all the repercussions that this entails in terms of health and social services needs. On the other hand, 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 and over) – a period that should last another ten years. However, starting in 2010, the babyboomer generation will reach retirement age, and this will bring about a rapid increase in the "dependent" part of the population. This unfavourable period should last until 2040.

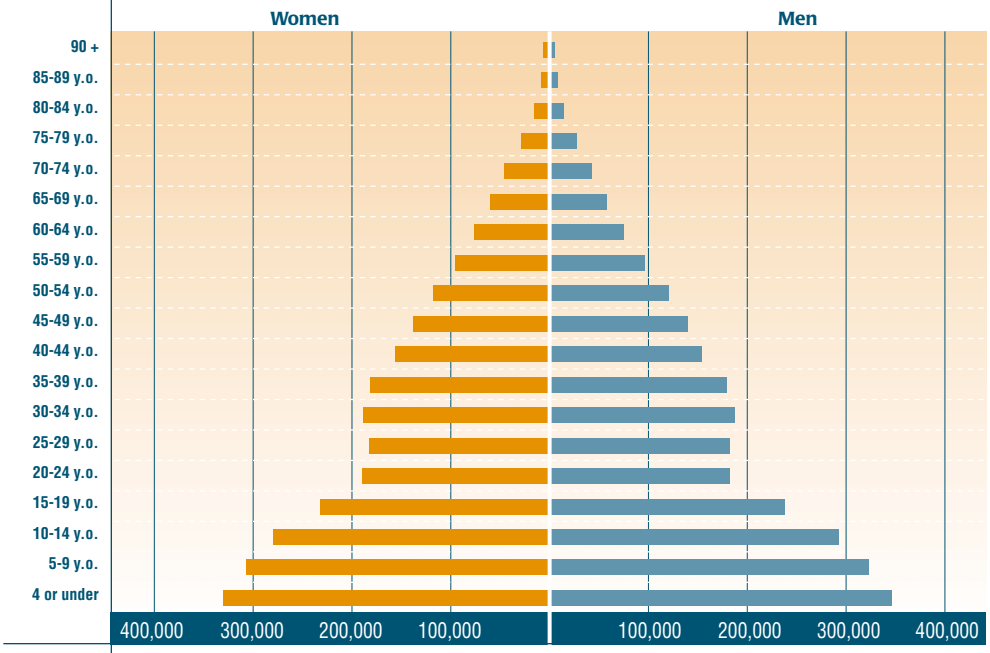
SOME FIGURES

The data presented in the following tables and figures 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 and 1996). The corresponding data for the years between two censuses are the result of intercensal estimates while those pertaining to the years 1997 and later were obtained through postcensal projections.

In Québec, as in several industrialized countries, the age structure of the population is changing at an accelerated pace. The population is aging due partly to a sharply declining birth rate, especially during the 1960s and in recent years, and to low net migration. In 1961, just as the last baby boomers were being 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 7.4 million people

Figure **3-A**

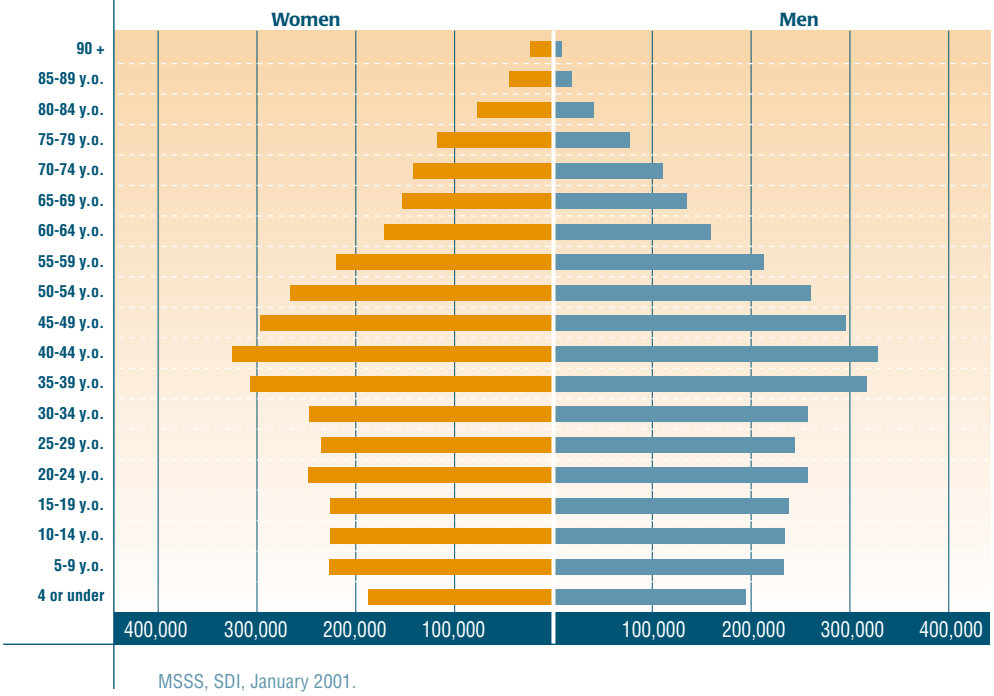
Population of Québec,
Age Pyramid,
1961



MSSS, SDI, January 2001.

Figure 3-B

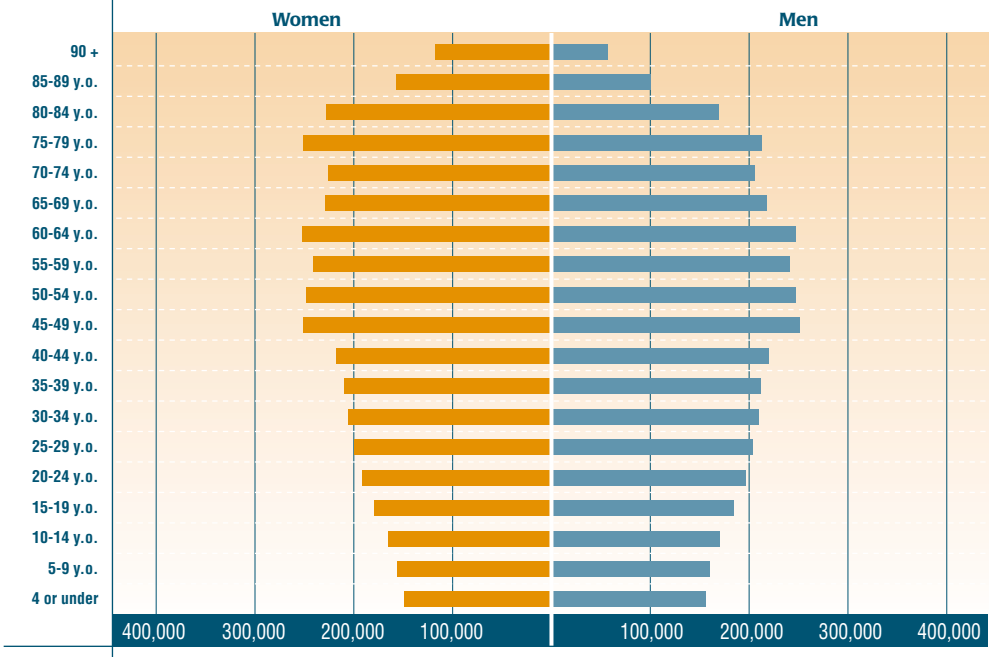
Population of Québec,
Age Pyramid,
2001



MSSS, SDI, January 2001.

Figure 3-C

Population of Québec,
Age Pyramid,
2041



MSSS, SDI, January 2001.

currently living in Québec. What will be observed in 40 years will look a lot more like a wasp's nest than a pyramid; perhaps the term "age nest" will be used to describe the 7.6 million people living in Québec in 2041.

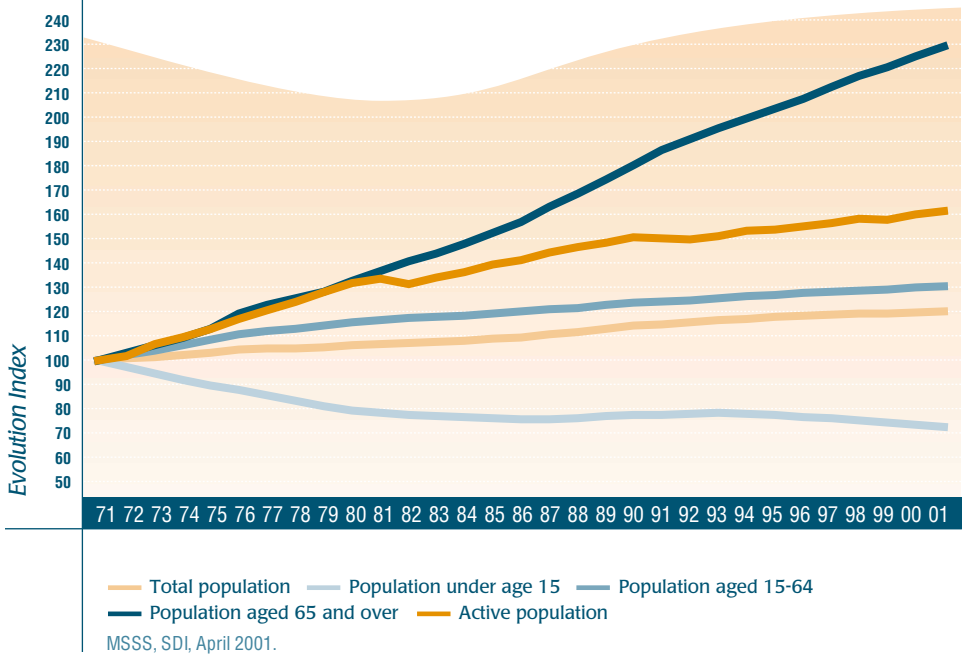
During the 1970s, the growth in the economically active population, that is, the population aged 15 to 64 who are employable, was similar to that observed in the population aged 65 and over. However, from 1980 onwards, the growth of the first group slowed down, while the growth of the second group accelerated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

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 index of a population can be defined as the ratio of the total population aged 0 to 14 and 65 and over, 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.

Figure **4**

Population Development in Québec,
by Selected Age Groups,
1971 to 2001

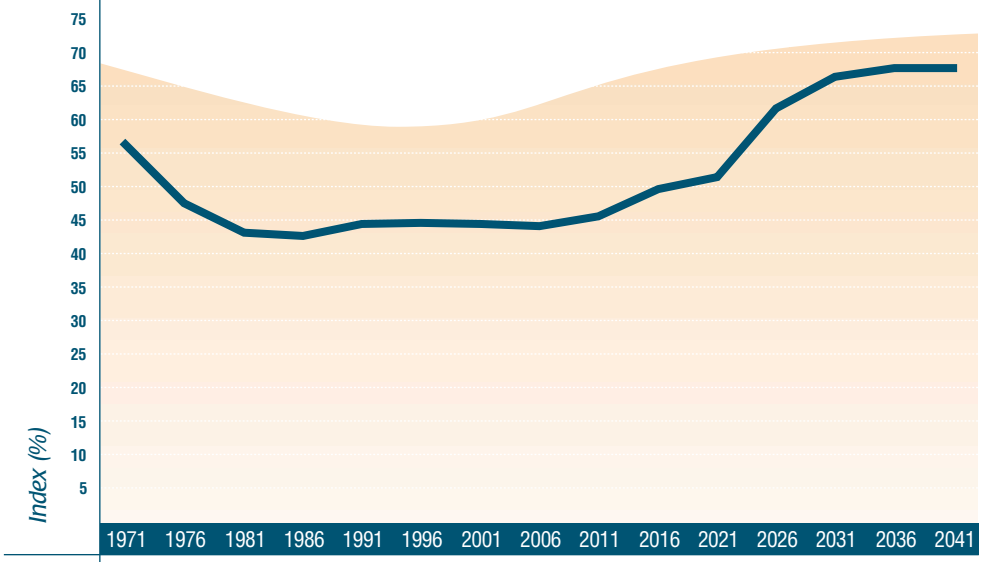


MSSS, SDI, April 2001.

For Québec, the period from 1980 to 2010 appears to be “favourable”. In fact, the dependency index remains firmly under the 45% mark during this 30-year period, given that the population aged 15 to 64 includes the babyboomer group. On the other hand, starting in 2010, the baby boomers will become part of the group of people aged 65 and over, and this will translate into a dramatic increase in the dependency index. The higher index period should last into the 2040s.

Figure **5**

Dependency Index
for the Québec Population, 1971 to 2041



MSSS, SDI, July 2000.

Table 1

Québec's Population by Selected Age Groups,

on July 1,
1971 to 2021

Year	Total population	Population under age 15	Population aged 15 - 64	Population aged 65 and over	Active population[1]
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	2,798.0
1977	6,455.1	1,542.3	4,407.2	505.9	2,879.0
1978	6,463.4	1,497.0	4,443.7	520.6	2,945.0
1979	6,488.8	1,458.7	4,491.8	538.2	3,003.0
1980	6,528.2	1,429.0	4,543.8	555.4	3,087.0
1981	6,567.8	1,410.4	4,583.7	573.7	3,130.0
1982	6,600.7	1,397.8	4,613.2	589.7	3,084.0
1983	6,623.8	1,386.5	4,633.5	603.8	3,141.0
1984	6,654.8	1,377.5	4,657.6	619.7	3,201.0
1985	6,689.8	1,368.2	4,683.3	638.4	3,269.0
1986	6,734.3	1,360.4	4,715.1	658.7	3,313.0
1987	6,806.7	1,366.4	4,756.1	684.1	3,384.0
1988	6,860.9	1,372.1	4,782.8	706.0	3,445.0
1989	6,949.2	1,384.1	4,834.4	730.7	3,481.0
1990	7,022.3	1,394.6	4,871.7	756.0	3,531.0
1991	7,066.9	1,397.6	4,886.9	782.6	3,522.0
1992	7,114.5	1,405.0	4,907.9	801.4	3,518.0
1993	7,166.4	1,408.7	4,937.9	819.8	3,546.0
1994	7,208.2	1,404.6	4,967.4	836.1	3,595.0
1995	7,241.9	1,392.4	4,995.7	853.6	3,612.0
1996	7,274.0	1,382.7	5,021.2	870.1	3,642.5
1997	7,302.6	1,368.6	5,043.1	890.9	3,677.1
1998	7,323.0	1,352.7	5,060.6	909.7	3,712.1
1999	7,345.4	1,336.2	5,083.2	926.1	3,701.6
2000	7,371.8	1,321.1	5,107.4	943.3	3,753.2
2001	7,399.9	1,308.4	5,131.2	960.3	3,790.7
2002	7,428.0	1,297.7	5,154.3	976.0	N/A
2003	7,456.1	1,286.9	5,175.8	993.4	N/A
2004	7,483.3	1,272.2	5,198.4	1,012.8	N/A
2005	7,509.7	1,251.4	5,225.0	1,033.3	N/A
2006	7,535.0	1,227.9	5,249.7	1,057.4	N/A
2007	7,559.3	1,205.7	5,270.1	1,083.5	N/A
2008	7,582.5	1,186.5	5,282.5	1,113.6	N/A
2009	7,604.6	1,170.1	5,289.1	1,145.4	N/A
2010	7,625.5	1,155.2	5,290.7	1,179.6	N/A
2011	7,645.1	1,140.8	5,287.1	1,217.2	N/A
2012	7,663.6	1,131.0	5,273.0	1,259.7	N/A
2013	7,680.9	1,126.1	5,253.1	1,301.6	N/A
2014	7,696.9	1,124.2	5,228.6	1,344.1	N/A
2015	7,711.9	1,122.8	5,202.9	1,386.2	N/A
2016	7,725.8	1,120.6	5,175.7	1,429.5	N/A
2017	7,738.6	1,118.4	5,147.2	1,472.9	N/A
2018	7,750.2	1,116.1	5,116.4	1,517.6	N/A
2019	7,760.5	1,113.5	5,080.8	1,566.2	N/A
2020	7,769.4	1,110.5	5,041.7	1,617.2	N/A
2021	7,776.9	1,107.0	5,003.2	1,666.6	N/A

1. Monthly average.

MSSS. SDI, April 2001.

Table 2

Proportion of People Aged 65 and Over
in the Québec Population,
1971 to 2041

Year	Total population	Persons aged 65 and over	Proportion (%)
1971	6,155.6	419.3	6.8
1981	6,567.8	573.7	8.7
1991	7,066.9	782.6	11.1
2001	7,399.9	960.3	13.0
2011	7,645.1	1,217.2	15.9
2021	7,776.9	1,666.6	21.4
2031	7,751.9	2,122.6	27.4
2041	7,550.8	2,182.4	28.9

MSSS, SDI, October 2000.

SOCIETY

Over the course of the last 30 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 this period, Québec's economy experienced a rate of annual growth of more than 5%.

Other significant phenomena also changed society. In education, for example, Québec achieved immense progress and soon closed the gap which 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 the fertility rate and the rapid increase in the number of divorces and commonlaw relationships.

With the arrival of the 1980s, economic growth slowed down and the labour market changed. The demands of productivity led to 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. Currently, one in five children lives in a single-parent family.

At the end of the 1990s, the government of Québec, however, like several other governments, succeeded in balancing its budget and putting its finances in order through a series of sometimes difficult, but necessary choices, thus creating better prospects for future generations. Furthermore, through early retirement programs implemented in the public and parapublic sectors, new job opportunities were offered to those wishing to enter the work force.

Today, Québec ranks among the world's elite in several spheres of activity, including high technology – suffice it to mention aerospace technology, aeronautics, biotechnology, telecommunications, multimedia and data technologies. Economic growth has regained a rate nearing 2.5% per year, while the unemployment rate has dropped to its lowest level in more than a quarter of a century, or 8% at the beginning of 2001. At the same time, there has never been as much concerted action, on the part of all actors in Québec society, with the goal of improving the quality of life of every citizen.

Lastly, due to sustained efforts, with the consent of all its players, the health and social services system is changing in order to adapt to new realities and meet new needs more effectively.

The education system, as well, will not be left behind. It too is seeking to adapt to the realities of the new millennium, marked by globalization and large-scale competition. In particular, a considerable effort has been made, both on the part of firms and by those who work in the education sector, to bring these two complementary worlds closer together, this being the very essence of a strong and growing economy.

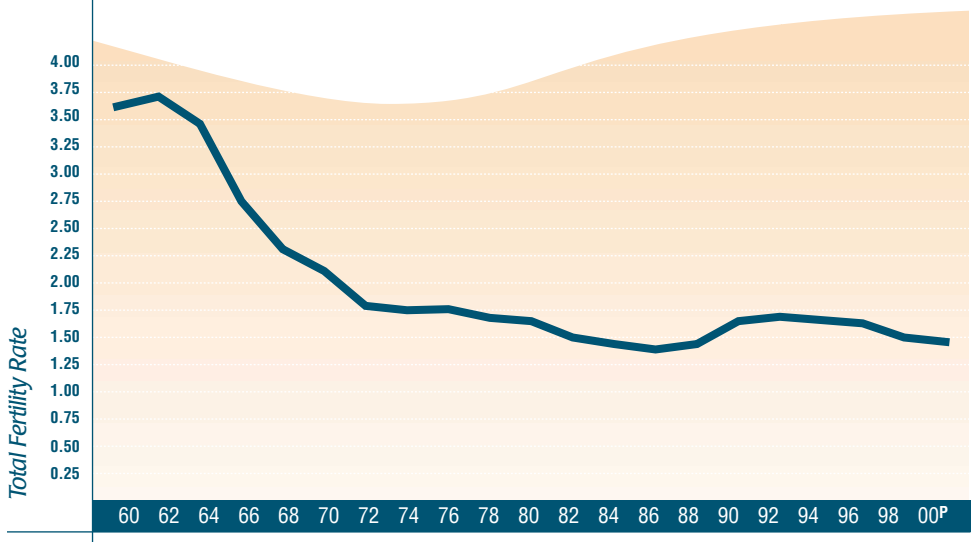
For Québec, the new millennium is therefore opening onto a future that is full of promise. The organization of health services and social services must therefore keep in step with this new era.

SOME FIGURES

From 1971 to 1986, the marriage rate decreased by half, while the divorce rate doubled. The annual number of births also dropped dramatically, from around 144,500 to 72,000 in barely four decades. This was conveyed by a sharp drop in the total fertility rate.[3] From 3.6 in 1960, it has dropped to 1.44 children per woman of childbearing age in 2000. It dropped as low as 1.37 in the mid-1980s. Moreover, during the period from 1971 to 1986, net annual migration was usually negative.

Figure 6

Total Fertility Rate
for the Québec Population,
1960 to 2000



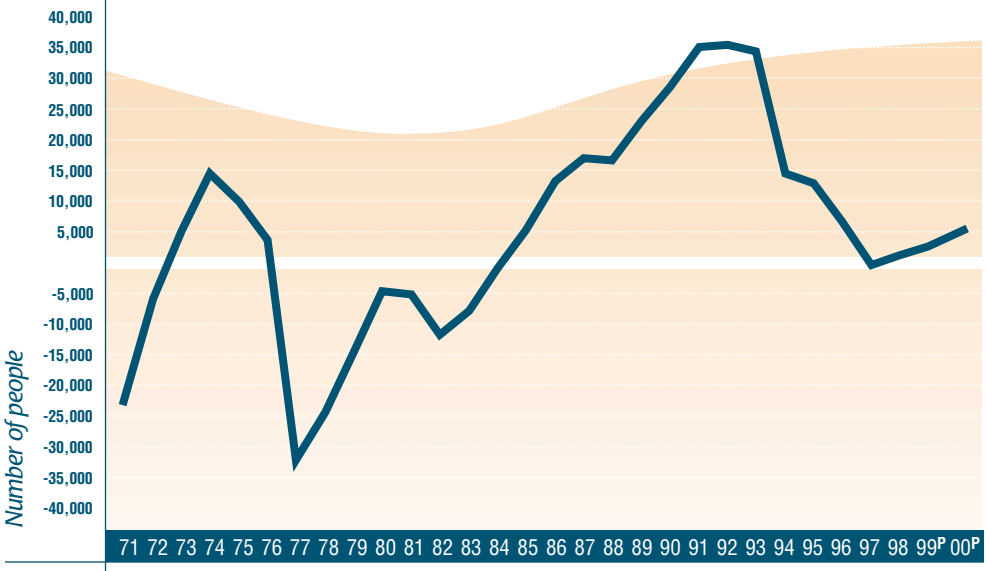
P = Preliminary
MSSS, SDI, February 2001.

3. The total fertility rate is the average number of children born to a generation of women whose fertility rates have been observed, by age, during any given year.

Figure 7

Development of Net Migration

for the Québec Population,
1971 to 2000



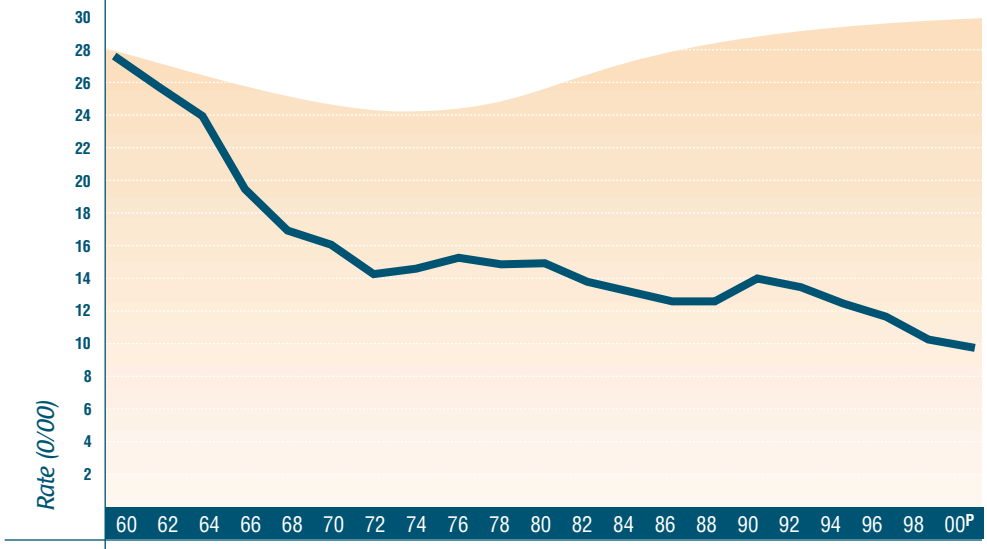
P = Projection

MSSS, SDI, April 2001.

The direct consequence of the drop in the birth rate, or the number of live births per 1,000 persons, is that the population is aging. Those aged 65 and over formed about 11% of the population in 1991, putting Québec among the youngest societies in the Western world. However, the population has already begun to age at a faster pace. In 2001, the proportion of those aged 65 and over reached 13%. In 2021, more than one in five persons will be 65 years of age or older, and in 2041, close to 29% of the population will have turned 65.

Figure 8

Birth Rate
for the Québec Population,
1960 to 2000

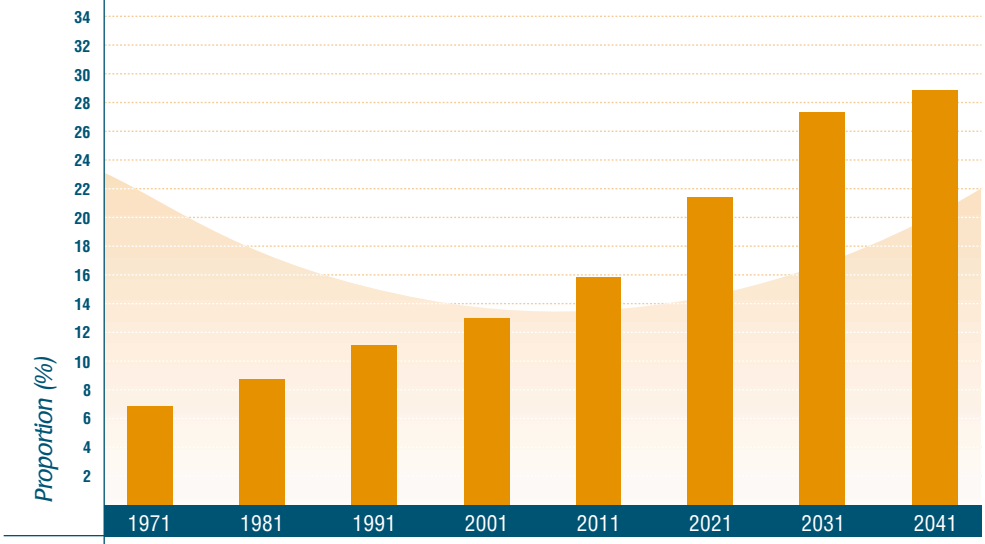


P = Preliminary

MSSS, SDI, February 2001.

Figure 9

Proportion of People Aged 65 and Over
in the Québec Population,
1971 to 2041



MSSS, SDI, July 2000.

An Integrated System of Services

- History and Laws
- Main Components
- Human Resources
- Institutional Resources

AN INTEGRATED SYSTEM OF SERVICES

In Québec, questions regarding health and well-being are looked at as one entity. This is a major thrust of Québec's social policy, and one which is the envy of many countries around the world. Specifically, this policy was 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 system is the only health care system in Canada to boast this distinctive characteristic.

Health services and social services are provincial fields of jurisdiction within the Canadian confederation[4]. They are or form the subject of cost-sharing programs with the federal government, originally through the Canada Assistance Plan (CAP) and through Established Programs Financing (EPF), until April 1, 1996, and then, after this date, through the Canada Social Transfer (CST) program, now called the Canada Health and Social Transfer (CHST). The federal government's participation under these programs remains conditional to the provinces' respecting national standards set out in chapter 3 of the Canada Health Act.

The values and principles that guide the organization of health services and social services have not changed since 1970. These same principles have been the true pillars of the public health and social services system. In today's terms, these principles are:

- **universality** of services, that is, making the services accessible to everyone without discrimination;
- **equity** of services, that is, equitably sharing the costs while correcting inequalities, considering needs and disparities in wealth;
- the **public nature** of services, that is, offering services which are administered and financed by the state;
- the **continuous adaptation** of services, that is, ensuring that the system remains adaptable and flexible.

Health services and social services are essentially financed by the state, directly from Québec's general revenues. Today, public funding in fact accounts for almost three-quarters of the overall costs of the system.

Following the Rochon Commission, which was set up in the mid-1980s, many significant changes took place within the health and social services system in the 1990s. Starting in the mid-1990s, the MSSS and its partners embarked upon a major policy shift in favour of services that were better adapted to new realities, that is, more oriented towards ambulatory care and closer to the home environment of users. The idea was to take advantage of new technologies and innovative practices in order to take some of the pressure off hospital resources, putting more emphasis on home support services and day care.

These changes brought about a transformation of the network of services. Thus, while there was no reduction in the number of actual sites providing services (facilities), there was a reduction in the number of institutions, with facilities fulfilling various missions being grouped together, some facilities undergoing a change in vocation.

Moreover, this wave of change in services was accompanied by a financial management which was based on Québec's objective of achieving a balanced budget. Thus, several early retirement programs, including advantageous conditions, were offered to employees, and many workers took advantage of them.

Nevertheless, the third millennium brings with it new challenges, urging us to look collectively once again at the question of how the system is organized and run, as well as how it is financed. There is a need to find a new balance in this regard.

4. See Appendix 1: Federal Government Participation.

HISTORY AND LAWS[5]

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 that various actors played 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 new realities and new needs.

A Policy Emerges

Under the French regime and during the 19th century, hospital maintenance and funding, as well as care of the poor and destitute, fell to the municipalities, parishes and religious communities, with the help of government grants, charity fund-raising 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 Hôpital de la Marine, the first hospital founded and run by the state. Subsequently, the 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.

The Department of Health, created in 1936, was entrusted with the responsibility of supervising "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.

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. The same year, an act was passed authorizing the provincial government to set up a family allowance system and make payments to families with children. Then, 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.

5. See Appendix 2: List of Laws in Force in the Field of Health and Social Services.

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 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. 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 a 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 system for the delivery of health and social services that would entirely shape the organization of health services and social services in Québec. For example, moving away from the idea of public hygiene and adopting that of community health is a good illustration of the new dynamic and innovative philosophy that was proposed for service delivery.

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 financial accessibility by ensuring that medical care, oral surgery services and optometric services would be provided free of charge. The latter broadened this concept, as it was 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. A family allowance plan was also set up by the government of Québec, following the example of the federal government. The Act respecting child day care and the Act respecting occupational health and safety should also be mentioned here.

In 1974, the Department'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 our 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 decentralization.

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).

In the mid-1980s, the 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 that should be based on three main orientations, these being the adoption of a government policy on health and welfare, the regionalization of the health and social services 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. 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 network of services being adapted and reorganized, and 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 that would facilitate slowing down the rate at which public expenses tied to health and social services were increasing, and make the system perform better. This new health and welfare strategy was structured around these three main complementary results.

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 organization and operation of the system – for the obligation to obtain results with regard to the health and welfare of the population. Lastly, the Policy aimed to establish greater equity among persons and among social groups, from the standpoint of health and welfare, and not simply 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, Québec undertook the immense task of transforming the health and social services network, in order to adapt it to the changing needs of the population, to the development of new practices, and to 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 on a local level, meaning the CLSC territories, and on the introduction of simple access mechanisms to specialized services on a regional level, as well as to highly specialized services on a 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 on a 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 objectives and national targets 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), or 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.

The New Millennium: Striking a Balance

Despite all of the actions that have been taken, there are still problems which 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 set 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 January 2001, 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.

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.

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 paralysing the system and preventing it from evolving towards the balance being sought. This is the condition to which Québec's health and social services system can resolutely commit itself in the third millennium, provided with the necessary means to take up its future challenges with optimism.

MAIN COMPONENTS

Québec's health and social services system is based on a three-tiered structure. The first corresponds to the institutions, the second to the regional boards and third to the MSSS. Community organizations also play a key role in several areas of activity. Like the institutions, these organizations have representatives in the regional decision-making bodies. Lastly, the private practices of Québec's physicians complete the list of the system's main components.

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.

The regional health and social services boards are in charge of planning and organizing services within their territories. 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 boards are accountable for their administration to both the population in their territories and to those in authority at the MSSS.

MISSION AND NETWORK

The network of health and social services institutions fulfil five main ministerial missions.

- The mission of a **child and youth protection centre** (CPEJ) is to offer psychosocial services in the regions, including social emergency services, as are required by the situation of a young person pursuant to the Youth Protection Act and the Act respecting young offenders (Revised Statutes of Canada, 1985, chapter Y-1), 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 **local community service centre** (CLSC) is to offer, at the primary level of care, basic health and social services, of a preventive or curative nature and, rehabilitation or reintegration services to the population of the territories it covers;
- The mission of a **hospital centre** (CH) is to offer diagnostic services and general and specialized medical care, in the physical and mental health sectors;
- 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 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.

Following the transformation of the network, several institutions have taken on more than one mission. In fact, more than one-third of institutions fulfil multiple missions, taking up more than three-quarters of the budget for the entire network. Among the most numerous institution groups, are the CH-CHLSDs (69 on March 31, 2001), the CLSC-CHSLDs (47 on March 31, 2001) and the CLSC-CHSLD-CHs (22 on March 31, 2001). Moreover, there remains only one institution fulfilling the CPEJ mission alone. These institutions have, in most cases, been grouped together with rehabilitation centres for young persons with adjustment problems (CR JDAs) and rehabilitation centres for mothers with adjustment problems (CR MDAs) to form the new **youth centres** (15 on March 31, 2001).

Working alongside this network of institutions is a network of some 5,000 community organizations (in 1999-2000) of which 2,750 are subsidized by the MSSS, and approximately 660 are subsidized by the regional boards. This network includes four types of organizations addressing the needs of specific groups of users. First of all, there are organizations that work in prevention, health promotion and community service. Among the issues they address, these organizations handle adoption and work with people affected by alcoholism or drug addiction, the disabled, and the elderly. Secondly, there are those organizations which provide services to women victims of violence, such as shelters, sexual assault centres, and women's centres. There are also those organizations devoted to youth services and those providing home support services.

In addition to community organizations, there are special organizations which are called upon to play a support role for individuals afflicted with mental health problems and their families. These are alternative mental health resources which offer respite and crisis relief services, among others.

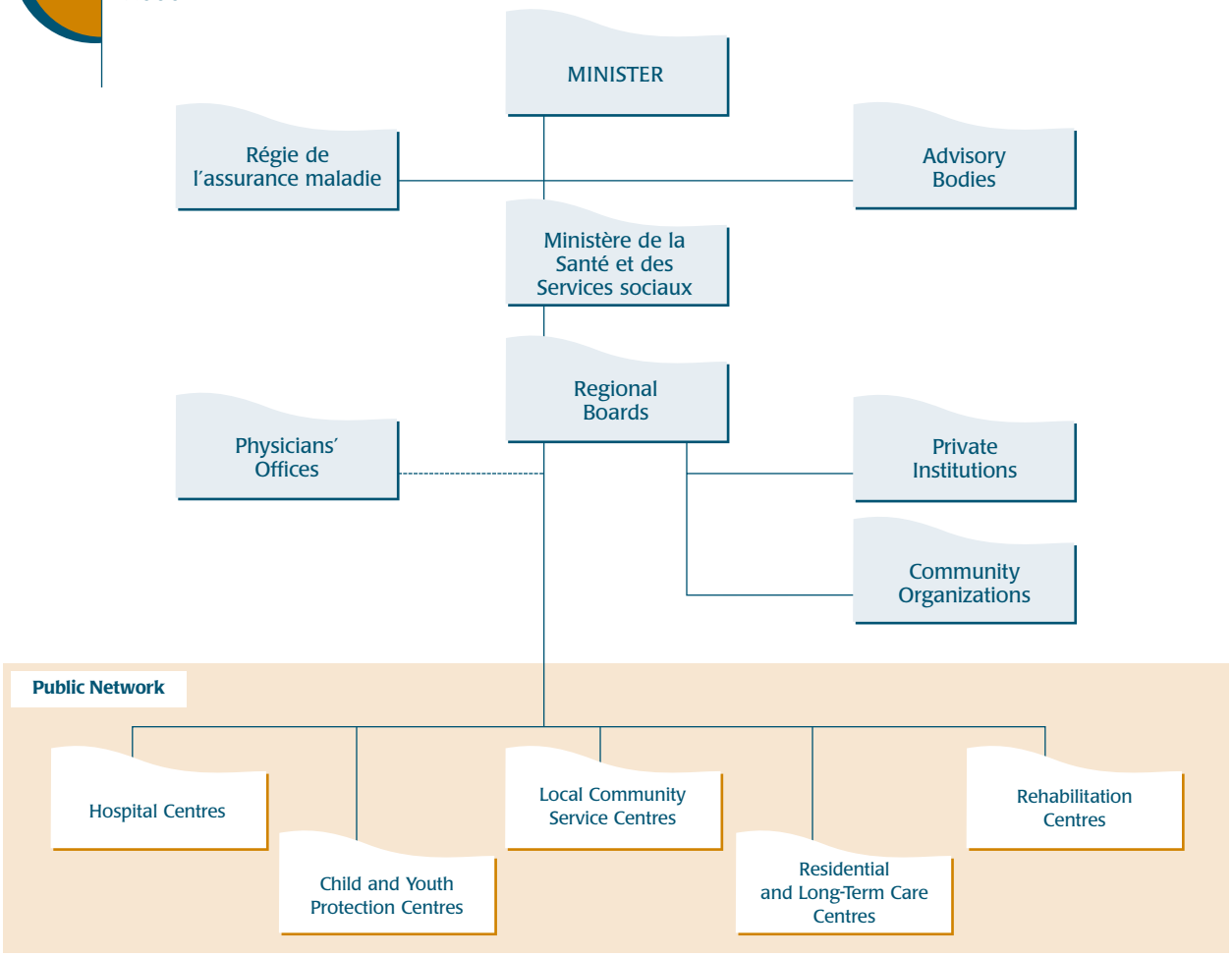
In addition to all of these resources, are private health facilities as well as some types of outpatient services, such as day centres, work habits learning centres, group homes and supervised apartments.

Lastly, there is the Régie de l'assurance maladie du Québec (RAMQ). The role of this organization 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 the 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. The RAMQ is also one of the main health and social services data warehouses in Québec and must manage several information systmes at the MSSS in addition to its own..

Figure 10 illustrates the relationships between the various elements of this structure.

Figure 10

Québec's
Health and Social Services System,
2000



MSSS, SDI, January 2000.

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 1999-2000, Québec's public system of health and social services employed some 250,000 people, or a little less than 7% of the Québec labour force. Of this number, there are approximately 20,250 professionals who receive fees reimbursed by the RAMQ, including almost 14,300 physicians, and some 228,000 managers and unionized employees in the network of institutions. This latter figure includes just over 99,600 nurses, nursing assistants and attendants, as well as almost 2,000 managers, unionized employees, and casual and contractual employees in the MSSS and the RAMQ.

In 1999, there were 1.94 physicians per 1,000 persons in Québec, or one physician for every 515 people. In the mid-1990s, the ratio was over 2 per 1,000. The great majority of these physicians are paid according to the "fee-for-service and by unit" method. However, whereas salary-based compensation is declining, the "flat rate fees" method has been growing rapidly since the beginning of the decade. In 1999, a new compensation system emerged, known as "blended compensation" (a blend of fee-for-service compensation and per diem compensation). Slightly more than 1,000 physicians were paid according to this method at one time or another during the year, totalling $30 million, or 1.3% of the total compensation paid to physicians.

Among the other professionals paid by the RAMQ (whether dentists, optometrists or proprietary pharmacists), there has been an improvement in the "professionals to population" ratio.

In 1999-2000, there was a ratio of 18.2 unionized employees to every manager in the Québec network of health and social services institutions. This represented a marked increase in comparison to the ratio that prevailed at the beginning of the decade (12.3 employees per manager). However, the number of managers dropped much more dramatically than did the number of unionized employees (-33% vs. -1.5%).

In 1999-2000, the total compensation costs for managers and unionized employees reached $5.9 billion. The annual average salary of managers was $63,139, whereas the average salary of unionized employees was $35,028 ($26,600 for office employees and $50,300 for professionals). Since the mid-1990s, there has been a significant increase in overtime ($120 million in 1999-2000). In addition, although their numbers climbed back up in 1998-1999 and 1999-2000, there has been an overall decline in the number of regular, full-time unionized employees since the mid-1990s. In fact, the decline in the number of regular, full-time employees occurred essentially in the job categories requiring shorter training. Moreover, the increase in average salaries was greater in the job categories in which more advanced training is required, particularly for graduate nurses (an increase of 21%).

Among nursing staff, the proportion of nurses with degrees (either from university or CEGEP) increased, whereas the opposite trend occurred among nursing assistants.

Lastly, between 1990-1991 and 1999-2000, there was a 40% decrease in the number of employees of the MSSS, particularly among managers and public servants. However, there was a 7% increase in 2000-2001. During the same period, the number of personnel employed by the RAMQ was more or less stable, although there was a slight decrease in the number of public servants and managers. Despite the fact that the public servant group remains by far largest, there has been a continuous increase in the relative size of the professional group.

SOME FIGURES

Physicians and Other Professionals Paid by the RAMQ

The number of physicians in Québec is normally calculated from two sources. The first is the files of the RAMQ, which contain all of the physicians registered with the Régie and subject to an agreement, whether they practise in Québec or elsewhere, and who submit at least one request for payment to the Régie during the year. These are called "active" physicians. The figure that appears in many of the RAMQ's statistical reports is the number of "active" physicians practising in Québec, or around one physician per 515 persons.

However, 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 the Southam Medical Data Base managed by the company Southam Communications Limited, of Scarborough, Ontario. This data base 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 data base 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 RAMQ statistics, because in the Southam Medical Data Base the term "specialist" is not always the same as the definition used in the provincial medical insurance plans.

In this publication, we have adopted the definition used in the *Annual Statistics of the RAMQ,* that is, the number of "active" physicians.

In 1999, some 20,250 health care professionals, paid by the RAMQ, delivered services to Québeckers, for a ratio of 363 persons per professional. Of this number, 14,268 were physicians (7,114 general practitioners and 7,154 specialists). At the beginning of the decade, there were more general practitioners than specialists (7,093 vs. 6,772); since 1993, the situation is reversed. In 1999, there was one physician for every 515 persons, whereas in 1990 this ratio was one for every 506 persons. The "number of persons per professional" ratio for dentists went from 2,541 to 2,211, i.e., a 13% improvement. For optometrists and proprietary pharmacists, the ratio also improved between 1990 and 1999, by 8.1% and 15.1% respectively.

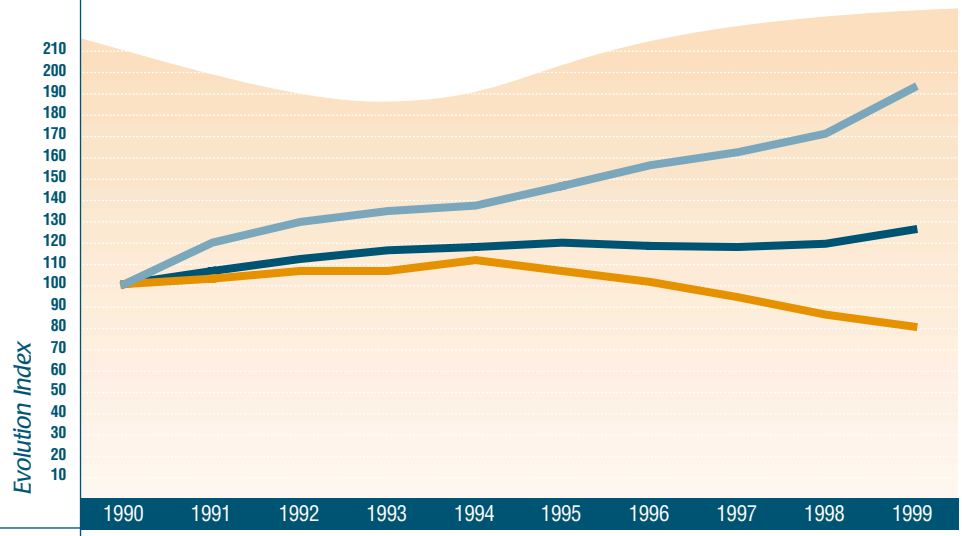
From 1990 to 1996, the "number of physicians per 1,000 persons" ratio rose from 1.97 to 2.02. However, in 1997 the ratio dropped to 1.96, and then to 1.93 in 1998, reflecting early retirements. In 1999, there was a slight upward movement (to 1.94), though only among general practitioners.

Overall, in 1999, 86.4% of physicians' compensation was paid according to the "fee-for-service and by unit" method, with the rest divided between the other three compensation methods: salary (3.0%), blended compensation (1.3%) and flat rate fees (9.3%). Whereas flat-rate-fees compensation (sessional payments) has increased sharply since 1990 (by 92%), salary-based compensation, after peaking in 1994, has been declining, so that for the period as a whole this method has declined by 20%. Fee-for-service and by unit compensation, after increasing steadily up to 1995 (by 19.5% from 1990 to 1995), held steady for several years and then increased markedly in 1999.

If we take into account the fact that some physicians can be paid through more than one method, then in 1999 two-thirds were paid by fee for service and by unit, 28.3% by flat rate fees or through blended compensation and 5.3% by salary. In 1990, these proportions were 73.5%, 18.3% and 8.2% respectively.

Figure 11

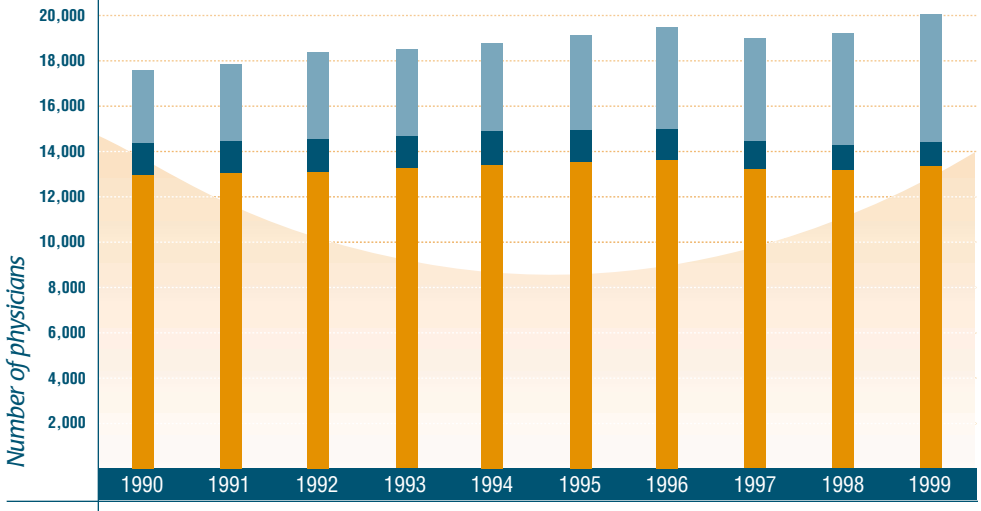
Change in **Amounts Reimbursed to Active Physicians,** by Compensation Method, Québec, *1990 to 1999*



MSSS, SDI, November 2000.

Figure 12

Number of **Active Physicians,** by Compensation Method, *Québec, 1990 to 1999*



MSSS, SDI, November 2000.

Table 3

Number of Health Care Professionals[1]

Paid by the Régie de l'assurance maladie du Québec and "Number of Persons/Professional" Ratio, by Professional Category,
1990 to 1999

Category of professionals	Unit	90	91	92	93	94	95	96	97	98	99
Total professionals	**Number**	**18,857**	**19,162**	**19,338**	**19,655**	**19,945**	**20,239**	**20,482**	**20,108**	**19,999**	**20,244**
	Ratio	**372**	**369**	**368**	**365**	**361**	**358**	**355**	**363**	**367**	**363**
General practitioners (and residents)	Number	7,093	7,085	7,131	7,099	7,153	7,243	7,346	7,063	6,953	7,114
	Ratio	990	997	998	1,009	1,008	1,000	990	1,035	1,055	1,033
Specialists	Number	6,772	6,883	6,941	7,131	7,256	7,301	7,354	7,228	7,159	7,154
	Ratio	1,037	1,027	1,025	1,005	993	992	989	1,011	1,024	1,027
Dentists (and oral surg.)	Number	2,763	2,874	2,902	2,979	3,054	3,140	3,196	3,213	3,262	3,323
	Ratio	2,541	2,459	2,452	2,406	2,360	2,306	2,276	2,274	2,248	2,211
Optometrists	Number	1,004	1,021	1,050	1,069	1,088	1,102	1,114	1,113	1,130	1,143
	Ratio	6,993	6,922	6,776	6,704	6,625	6,572	6,530	6,566	6,490	6,426
Proprietary pharmacists	Number	1,225	1,299	1,314	1,377	1,394	1,453	1,472	1,491	1,495	1,510
	Ratio	5,731	5,440	5,414	5,204	5,171	4,984	4,942	4,901	4,905	4,865

1. Professionals who are "active" in Québec, that is, subject to an agreement with the RAMQ, practising in Québec, and having submitted at least one request for payment during the year; these figures appear in the RAMQ's Annual Statistics.

MSSS, SDI, November 2000.

Table 4

Number of Physicians[1] per 1,000 Persons,

by Category of Physician, Québec,
1990 to 1999

Category of physicians	Unit	90	91	92	93	94	95	96	97	98	99
Total physicians	**Number**	**13,865**	**13,968**	**14,072**	**14,230**	**14,409**	**14,544**	**14,700**	**14,291**	**14,112**	**14,268**
	/1,000 pers.	**1.97**	**1.98**	**1.98**	**1.99**	**2.00**	**2.01**	**2.02**	**1.96**	**1.93**	**1.94**
General practitioners	Number	7,093	7,085	7,131	7,099	7,153	7,243	7,346	7,063	6,953	7,114
	/1,000 pers.	1.01	1.00	1.00	0.99	0.99	1.00	1.01	0.97	0.95	0.97
Specialists	Number	6,772	6,883	6,941	7,131	7,256	7,301	7,354	7,228	7,159	7,154
	/1,000 pers.	0.96	0.97	0.98	1.00	1.01	1.01	1.01	0.99	0.98	0.97

1. Physicians "active" in Québec, that is, subject to an agreement with the RAMQ, practising in Québec, and having submitted at least one request for payment during the year; these figures appear in the RAMQ's Annual Statistics.

MSSS, SDI, November 2000.

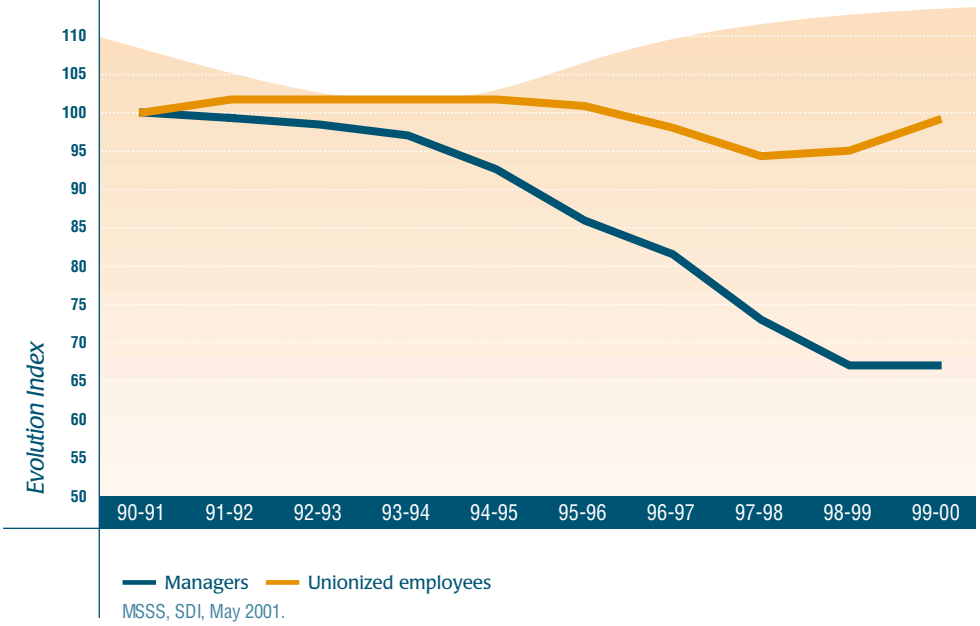
The Network Staff

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.

As of March 31, 1991, 62.3% of the network staff (managers and unionized workers), expressed in terms of FTEs, had regular, full-time jobs (RFT); by March 31, 2000, this proportion was only 58.6%. Among managers, the proportion of RTF went from 89.8% to 91.0%, whereas among unionized employees the trend was reverse, that is, from 60.1% to 56.8%. In 1990-1991, there was a ratio of 12.3 unionized employee for each manager in the network; in 1999-2000, the ratio was 18.2. Thus, during this period the number of managers dropped by 33%, whereas the number of unionized employees declined by 1.5%.

Figure **13**

Change in Managerial and Unionized Staff
of the Québec Network of Health and Social Services Institutions, Calculated in Full-time Equivalents, by Job Category,
1990-1991 to 1999-2000



MSSS, SDI, May 2001.

In 1990-1991, the total compensation costs of managers and unionized employees in the network was a little less than $5.2 billion. These costs peaked at more than $5.9 billion in 1994-1995, and then dropped to $5.6 billion in 1997-1998. In 1999-2000, total compensation costs were close to $5.9 billion.

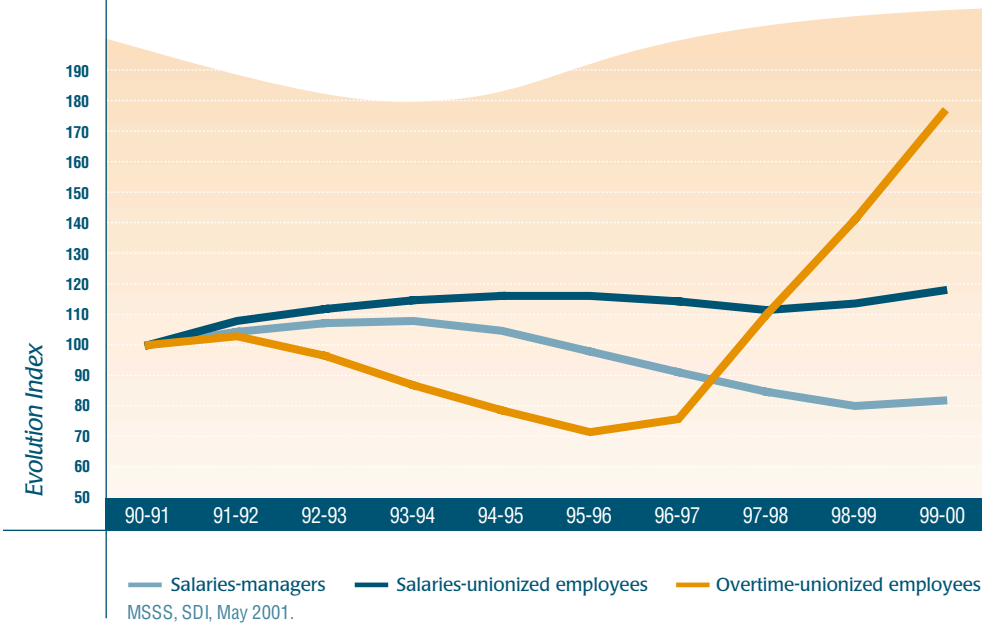
During this ten-year period, the average managerial salary grew from $51,400 to $63,139 representing an increase of 22.8% or slightly more than an average annual increase of 2%. As for unionized employees, the average salary went from $30,470 in 1990-1991 to $35,028 in 1999-2000, which works out to an increase of 14.9%, or an average annual increase of 1.6%.

For the unionized staff, compensation for overtime decreased up to 1995-1996, declining from $68 million to $48.5 million. Since then, however, there has been a considerable increase, with overtime compensation reaching nearly $120 million in 1999-2000.

Figure 14

Change in Total Compensation Costs

of the Personnel of the Québec Health and Social Services Network, by Job Category,
1990-1991 to 1999-2000



MSSS, SDI, May 2001.

From 1994-1995 to 1997-1998, the number of regular, full-time unionized employees shrank continuously. In FTE terms, they numbered close to 97,000 in 1994-1995, and less than 83,600 in 1997-1998. However, in 1998-1999 and 1999-2000, their numbers have been rising, reaching 88,000. On the other hand, the number of employees without full-time, regular jobs (i.e., casual, part-time, etc.), grew significantly in 1997-1998, i.e., by 6.7% in one year. In 1998-1999, their numbers remained stable, but in 1999-2000 there was a further increase of 3.6%. While the end of the period is seeing an increase in the total number of staff in the "professional," "technician" and "nurse" categories, the opposite trend is occurring for assistant technicians, office employees and blue-collar workers, except for 1999-2000.

Among unionized employees, the average annual salary ranged from $26,600 for office employees to $50,300 for the professional category in 1999-2000. For the period between 1990-1991 and 1999-2000, graduate nurses benefited from the highest average salary increase (21%), followed by professionals (16%), nursing assistants (12%), technicians (11%), and blue-collar workers with a total increase of 7%.

However, if we eliminate the effect of inflation and look at salary increases in constant 1992 dollars (1992 = 100), we can see that the "nursing assistants," "technicians," "assistant technicians," "office employees" and "auxiliary staff" categories experienced a decline in real average salaries. As for the other job categories, managers received real increases of 6.5%, graduate nurses 6.2% and professionals 2.2%.

Table 5

Managerial and Unionized Staff

of the Québec Network of Health and Social Services Institutions, Calculated in Full-time Equivalents, by Job Category, *1990-1991 to 1999-2000*

Job category	90-91	91-92	92-93	93-94	94-95	95-96	96-97	97-98	98-99	99-00
Total staff	**169,978**	**172,464**	**172,286**	**172,045**	**171,592**	**169,368**	**164,435**	**157,498**	**157,815**	**163,372**
% of RFT[1]	**62.3**	**62.4**	**62.7**	**62.7**	**62.7**	**63.0**	**62.7**	**58.5**	**58.6**	**58.6**
Managers	12,774	12,672	12,570	12,385	11,820	10,969	10,407	9,317	8,537	8,519
% of RFT[1]	89.8	89.8	89.7	89.9	90.4	91.7	92.0	91.9	91.5	91.0
Unionized employees	157,204	159,792	159,716	159,660	159,772	158,399	154,028	148,181	149,278	154,853
% of RFT[1]	60.1	60.2	60.6	60.6	60.7	61.0	60.7	56.4	56.8	56.8
Number of unionized employees per manager	12.3	12.6	12.7	12.9	13.5	14.4	14.8	15.9	17.5	18.2

1. Regular full-time.

MSSS, SDI, May 2001.

Table 6

Unionized Staff

of the Québec Network of Health and Social Services Institutions, Calculated in Full-time Equivalents, by Job Category, *1990-1991 to 1999-2000*

Job category	Occ. Status	90-91	91-92	92-93	93-94	94-95	95-96	96-97	97-98	98-99	99-00
Unionized staff	**Total**	**157,204**	**159,792**	**159,716**	**159,660**	**159,772**	**158,399**	**154,028**	**148,181**	**149,278**	**154,853**
	RFT[1]	**94,445**	**96,157**	**96,765**	**96,712**	**96,904**	**96,620**	**93,454**	**83,562**	**84,743**	**88,009**
	Other	**62,759**	**63,635**	**62,951**	**62,948**	**62,868**	**61,779**	**60,574**	**64,619**	**64,535**	**66,844**
Professionals	Total	11,161	11,672	12,285	12,612	13,223	13,561	13,908	14,113	14,941	15,984
	RFT[1]	8,210	8,533	8,927	9,089	9,481	9,636	9,892	9,737	10,307	10,919
	Other	2,951	3,139	3,358	3,523	3,742	3,925	4,016	4,376	4,634	5,065
Technicians	Total	21,457	22,042	22,327	22,630	23,137	23,257	22,921	22,472	22,944	23,785
	RFT[1]	14,119	14,598	14,892	15,124	15,625	15,843	15,753	14,761	15,036	15,467
	Other	7,338	7,444	7,435	7,506	7,512	7,414	7,168	7,711	7,908	8,318
Nurses	Total	34,811	35,557	35,902	36,392	36,665	36,838	35,923	35,501	36,578	38,052
	RFT[1]	18,811	19,443	19,701	19,890	19,971	20,353	19,560	18,126	19,259	20,470
	Other	16,000	16,114	16,201	16,502	16,694	16,485	16,363	17,375	17,319	17,582
Assistant-technicians	Total	41,694	42,039	41,391	41,265	40,922	40,334	39,065	37,220	37,057	38,492
	RFT[1]	21,592	21,685	21,559	21,352	21,184	20,946	19,887	17,243	17,152	17,602
	Other	20,102	20,354	19,832	19,913	19,738	19,388	19,178	19,977	19,905	20,890
Trainees and students	Total	625	735	706	402	550	454	406	322	384	480
	RFT[1]	64	75	72	59	68	55	40	39	42	50
	Other	561	660	634	343	482	399	366	283	342	430
Office workers	Total	21,066	21,346	21,270	21,083	20,804	20,391	19,673	18,696	18,525	19,000
	RFT[1]	14,384	14,531	14,642	14,619	14,509	14,289	13,812	11,938	11,821	12,107
	Other	6,682	6,815	6,628	6,464	6,295	6,102	5,861	6,758	6,704	6,893
Auxiliary staff	Total	26,390	26,401	25,835	25,276	24,471	23,564	22,132	19,857	18,849	19,060
	RFT[1]	17,265	17,292	16,972	16,579	16,066	15,498	14,510	11,718	11,126	11,394
	Other	9,125	9,109	8,863	8,697	8,405	8,066	7,622	8,139	7,723	7,666

1. Regular full-time.

MSSS, SDI, May 2001.

Table 7

General Statistics on Managerial and Unionized Staff

of the Québec Network of Health and Social Services Institutions,
1990-1991 to 1999-2000

Job category	Indicator	90-91	91-92	92-93	93-94	94-95	95-96	96-97	97-98	98-99[1]	99-00[1]
Total staff	Nbr working	240,461	242,360	239,231	241,445	239,448	235,371	228,923	216,312	222,882	228,634
	Nbr FTEs[2]	169,978	172,463	172,287	172,308	171,586	169,359	164,426	157,496	157,815	163,370
	Sal. paid ($)	5,176,440,044	5,573,565,270	5,757,263,476	5,896,247,301	5,947,585,795	5,894,187,107	5,770,364,625	5,605,939,297	5,665,454,901	5,865,061,505
	Overtime ($)	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	119,918,269
Managers	**Nbr working**	**14,874**	**14,686**	**14,455**	**14,254**	**13,472**	**12,263**	**11,371**	**9,878**	**9,593**	**9,525**
	Nbr FTEs[2]	**12,774**	**12,672**	**12,570**	**12,385**	**11,821**	**10,974**	**10,400**	**9,316**	**8,538**	**8,519**
	Average sal. ($)	**51,400**	**53,418**	**55,611**	**56,711**	**57,630**	**58,060**	**58,404**	**60,364**	**62,330**	**63,139**
	Sal. paid ($)	**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**	**539,444,161**
Unionized staff	**Nbr working**	**225,587**	**227,674**	**224,776**	**227,191**	**225,976**	**223,108**	**217,552**	**206,434**	**213,289**	**219,109**
	Nbr FTEs[2]	**157,204**	**159,791**	**159,717**	**159,923**	**159,765**	**158,385**	**154,026**	**148,180**	**149,277**	**154,851**
	Average sal. ($)	**30,470**	**31,017**	**32,367**	**32,957**	**33,348**	**33,712**	**34,405**	**34,926**	**35,000**	**35,028**
	Sal. paid ($)	**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**	**5,325,617,344**
	Overtime ($)	**68,006,062**	**70,021,423**	**65,575,925**	**59,197,201**	**53,536,238**	**48,497,769**	**51,604,984**	**74,967,093**	**96,194,838**	**119,918,269**
Professionals	Nbr working	14,972	15,588	15,318	17,004	17,780	18,293	18,742	19,217	20,768	21,780
	Nbr FTEs[2]	11,161	11,672	12,286	12,611	13,225	13,560	13,914	14,113	14,940	15,983
	Average sal. ($)	43,288	43,692	47,026	47,989	48,623	49,198	50,125	50,625	50,389	50,270
	Sal. paid ($)	459,664,233	501,718,837	551,119,662	589,193,337	649,141,613	652,948,907	677,147,066	692,781,972	736,513,672	786,543,284
	Overtime ($)	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	14,098,336
Graduate nurses	Nbr working	3,859	4,454	5,009	5,405	5,935	6,527	7,058	7,322	8,046	8,845
	Nbr FTEs[2]	2,779	3,228	3,658	4,010	4,416	4,920	5,271	5,588	6,099	6,798
	Average sal. ($)	40,222	41,633	43,878	45,183	46,216	47,032	48,050	48,702	48,634	48,492
	Sal. paid ($)	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	321,334,701
	Overtime ($)	1,473,069	1,569,351	1,801,557	1,609,272	1,443,783	1,416,750	1,582,846	3,128,369	4,569,880	6,810,378
Nurses	Nbr working	47,714	47,998	47,602	47,934	47,585	47,019	45,753	43,482	44,501	44,552
	Nbr FTEs[2]	32,032	32,329	32,243	32,381	32,249	31,910	30,652	29,913	30,478	31,253
	Average sal. ($)	36,700	37,620	38,987	39,660	40,000	40,327	41,096	41,316	41,009	40,931
	Sal. paid ($)	1,088,291,236	1,194,362,986	1,224,845,416	1,258,749,349	1,263,493,111	1,260,723,649	1,226,555,225	1,204,651,446	1,227,614,203	1,253,068,083
	Overtime ($)	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	46,002,892
Technicians	Nbr working	29,968	30,529	30,589	31,425	32,037	32,101	31,782	30,972	31,983	32,794
	Nbr FTEs[2]	21,457	22,042	22,327	22,630	23,135	23,260	22,915	22,472	22,944	23,785
	Average sal. ($)	33,850	34,293	35,575	36,173	36,452	36,772	37,447	37,819	37,698	37,602
	Sal. paid($)	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	880,791,591
	Overtime ($)	13,198,895	13,981,282	13,516,190	12,849,571	11,794,952	11,244,547	11,115,949	14,922,233	19,060,763	22,081,139
Assistant-technicians	Nbr working	62,764	62,998	61,608	61,581	60,639	59,457	57,840	54,187	55,798	57,802
	Nbr FTEs[2]	41,694	42,038	41,391	41,265	40,918	40,329	39,065	37,221	37,058	38,492
	Average sal. ($)	25,839	26,356	27,226	27,534	27,584	27,635	27,948	28,070	27,903	27,824
	Sal. paid ($)	1,014,127,065	1,085,293,096	1,105,244,034	1,119,054,532	1,110,885,523	1,096,765,511	1,064,913,477	1,017,190,737	1,015,582,341	1,049,869,661
	Overtime ($)	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	16,681,331
Office workers	Nbr working	28,237	28,402	27,975	27,790	27,243	26,540	25,431	23,729	24,460	25,160
	Nbr FTEs[2]	21,066	21,345	21,271	21,083	20,802	20,385	19,670	18,695	18,525	19,000
	Average sal. ($)	24,565	24,827	25,644	25,920	26,035	26,110	26,434	26,650	26,602	26,595
	Sal. paid($)	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	498,538,687
	Overtime ($)	3,731,418	3,876,013	3,486,096	3,187,514	2,861,650	2,641,246	2,959,171	4,636,712	5,705,444	6,905,128
Auxiliary staff	Nbr working	37,193	36,710	35,766	35,226	34,067	32,558	30,451	27,051	27,178	27,408
	Nbr FTEs[2]	26,391	26,400	25,835	25,276	24,468	23,559	22,127	19,857	18,849	19,060
	Average sal. ($)	26,098	26,120	26,922	27,206	27,296	27,340	27,646	27,896	27,898	27,912
	Sal. paid ($)	661,726,054	690,289,507	687,533,100	683,918,274	662,318,839	638,978,985	602,803,243	546,653,477	521,959,853	526,361,443
	Overtime ($)	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	7,288,624
Trainees and students	Nbr,working	880	995	909	826	690	613	495	474	555	768
	Nbr FTEs[2]	624	737	706	667	552	462	412	321	384	480
	Average sal. ($)	15,461	16,777	16,951	16,592	16,769	17,249	17,651	18,977	20,153	18,877
	Sal. paid ($)	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	9,109,894
	Overtime ($)	26,830	47,910	52,196	55,914	36,761	22,341	28,013	29,080	35,229	50,441

1. Average salaries of 1998-1999 and 1999-2000 do not take retroactivity into account; it was 1.5% for 1998-1999 and 2.5% for 1999-2000.
2. Full-time equivalents.

MSSS, SDI, May 2001.

Nursing Staff

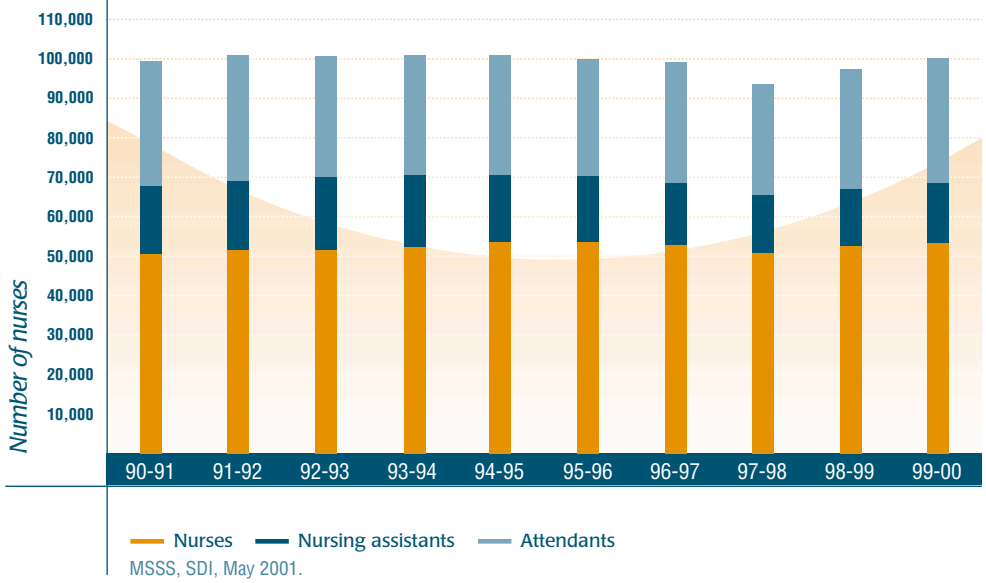
In this section, we take a closer look at the data relating to nursing staff, broadly defined. Using educational attainment, three groups can be distinguished: nurses who have obtained a college or university degree; nursing assistants, who hold a diploma in nursing care at the Secondary V level; and health care attendants, who have received ad hoc training in a recognized educational institution.

Adding together the three groups in 1999-2000, there were 99,630 persons employed, or 68,312 FTEs, giving a ratio of 0.69 FTEs for each person employed. In 1990-1991, there were 99,642 persons employed, representing 66,806 FTEs, giving a ratio of 0.67. At the beginning of the period, the "nurse" group made up almost 51% of the total nursing staff, with nursing assistants accounting for 18% and health care attendants for 31%. In 1999-2000, these proportions were, respectively, 54%, 14% and 32%. The decline in staffing has therefore been concentrated among nursing assistants.

Although the number of health care attendants and nursing assistants peaked at the beginning of the period (1991-1992 for the former, 1990-1991 for the latter), the number of nurses peaked in 1995-1996. Note, however, the increase in the number of health care attendants (5.9%) and of nurses (3.4%) in 1998-1999 over the previous year, and the increases of 5.2% and 1.6% respectively in 1999-2000.

Figure **15**

Working Nursing Staff
in the Québec Network of Health and Social Services Institutions, by Job Category,
1990-1991 to 1999-2000



MSSS, SDI, May 2001.

Table 8

Working Nursing Staff and Full-time Equivalents

in the Québec Network of Health and Social Services Institutions, by Job Category, *1990-1991 to 1999-2000*

Year	Unit	Nurses	Nursing assistants	Attendants	Total staff
1990-1991	Working	50,647	17,682	31,313	**99,642**
	In FTE[1]	34,813	11,729	20,264	**66,806**
1991-1992	Working	51,832	17,590	31,575	**100,997**
	In FTE[1]	35,555	11,794	20,581	**67,930**
1992-1993	Working	52,611	17,411	31,021	**101,043**
	In FTE[1]	35,902	11,627	20,189	**67,718**
1993-1994	Working	53,339	17,385	30,957	**101,681**
	In FTE[1]	36,388	11,548	20,128	**68,064**
1994-1995	Working	53,520	17,053	30,519	**101,092**
	In FTE[1]	36,666	11,316	20,082	**68,064**
1995-1996	Working	53,546	16,899	29,873	**100,318**
	In FTE[1]	36,830	11,210	19,857	**67,897**
1996-1997	Working	52,811	16,121	29,715	**98,647**
	In FTE[1]	35,924	10,682	19,522	**66,128**
1997-1998	Working	50,804	14,137	28,962	**93,903**
	In FTE[1]	35,500	9,775	19,185	**64,460**
1998-1999	Working	52,547	14,012	30,677	**97,236**
	In FTE[1]	36,576	9,227	19,952	**65,755**
1999-2000	Working	53,397	13,952	32,281	**99,630**
	In FTE[1]	38,052	9,296	20,964	**68,312**

1. Full-time equivalent.

MSSS, SDI, May 2001.

Administrative Personnel of the MSSS and the RAMQ

At the beginning of the 1990s, there were almost 1,100 staffed positions (excluding contractual and personnel "on loan") in the MSSS. On March 31, 2000, there were only 660, which works out to a decrease of 40%. However, in March 2001, there were 706 staffed positions in the MSSS, representing an increase of 7% over the previous year.

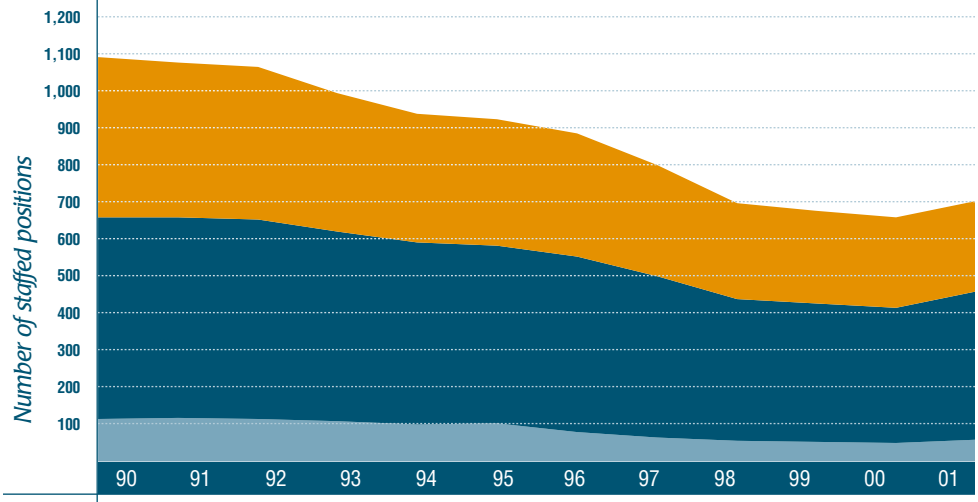
Among public servants, the decline was steady between 1990 and 2000, whereas among professionals and managers the decline began in 1993. Although the trend was similar for these two latter groups up to 1995, since then the managerial category has seen a sharp drop in staffing, going from 102 to 49 staffed positions in five years. However, it should be noted that managerial positions are increasingly filled by contractual employees who are not counted in the "staffed" positions. From 1995 to 2000, the number of positions staffed by professionals went from 481 to 366, whereas the number of positions staffed by public servants fell from 343 to 245. However, by March 2001, the downward trend had not only halted, but the number of staffed positions had increased for all three job categories.

In 1990, the distribution of total staffed positions among the three groups were 11% for managers, 50% for professionals and 40% for public servants. In 2001, these proportions are 8%, 57% and 35% respectively.

Figure 16

Number of Staffed Positions in the MSSS,

by Job Category, as of March 31,
1990 to 2001



MSSS, SDI, May 2001.

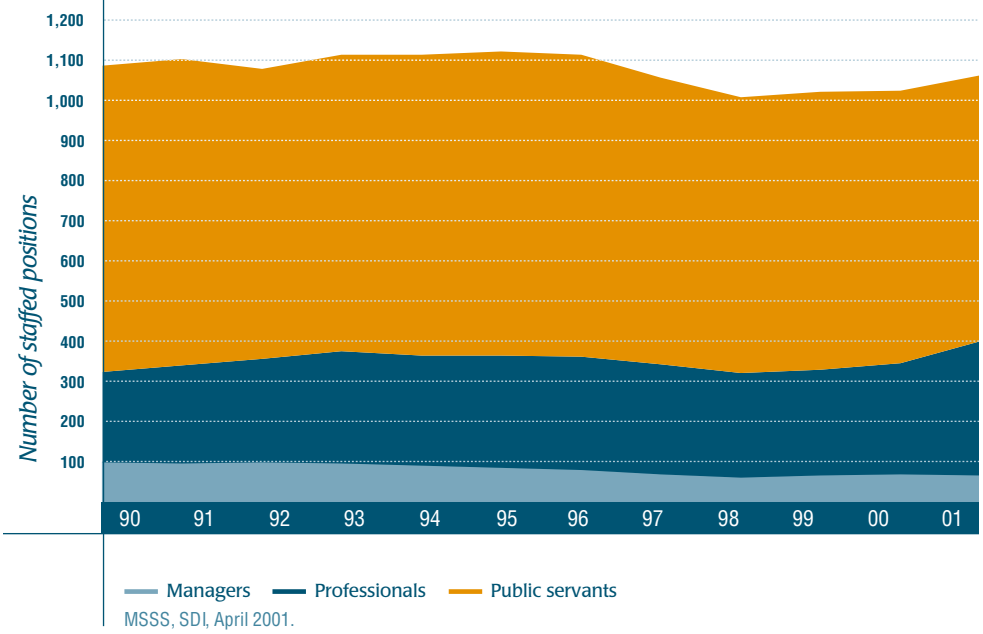
The trends were different at the Régie de l'assurance maladie du Québec. In fact, the number of positions staffed by professionals increased by 23% from 1990 to 2000, with a further increase of 20% in 2001 due essentially to the fact that many technicians acquired the status of computer analyst. During the period, the number of positions staffed by public servants remained relatively constant until 1996, followed by a decline. As regards positions filled by managers, the number began to decrease in 1994 and then stabilized around 65 beginning in 1997.

In 1990, managers filled 9% of the positions, professionals filled 21% and public servants filled 70%. Eleven years later, the proportions are 6%, 31% and 63% respectively. As a result, even though the absolute number of staff remained more or less the same, at a little more than 1,000 staffed positions, professional positions have, however, become increasingly numerous while public servant positions remain by far the most numerous.

Figure 17

Number of Staffed Positions

at the Régie de l'assurance maladie du Québec, by Job Category,
as of March 31, 1990 to 2001



MSSS, SDI, April 2001.

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.

In March 2001, the Québec health and social services network has 349 so-called "public" institutions. In addition, there are 129 so-called "private" institutions managed by single owners. These 478 institutions oversee 2,023 facilities (1,863 public and 160 private), that is, 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.

Since 1990, the number of institutions that have one single mission has fallen by 60%. Currently, 37% of institutions operate more than one mission, that is twice more than in 1990. Within the network, there are 27% private institutions, most of which operate a CHSLD. Close to 40% of private institutions are self-financed, that is, they are financed through the "not-under-agreement" method.

The number of facilities remained relatively stable throughout the decade. Approximately 8% of them have a private status. Since 1990, the number of public facilities has increased by approximately 2% while the number of private facilities has fallen considerably (by 34%), and the number of private not-under-agreement facilities dropped even more, by 44%. Since several facilities have been brought under the authority of one institution, the "number of facilities to institution" ratio doubled from 2.7 to 5.3 in the case of public facilities and remained quite stable (around 1.1) in the case of private facilities.

Since 1996, the number of approved beds for general and specialized care has been reduced by 26%. Moreover, since 1990, as a result of de-institutionalization, the number of approved beds in psychiatric hospital centres for short-term psychiatric care has been cut by half. In the meantime, approved beds for residential and long-term care were reduced by 7%; in fact, this percentage is the result of a reduction in the number of beds reserved for patients who require less than 2 1/2 hours of care per day, which is in part made up by the addition of beds for patients requiring more than 2 1/2 hours of care perday. Currently, there are 2.8 approved beds for general and specialized care per 1,000 people as well as 6.6 approved beds for residential and long-term care. It should be noted that 20% of all approved beds for residential and long-term care are private, that is, the great majority (90%) of all private, approved beds. From March 31, 1991 to March 31, 2000, the number of set-up beds for general and specialized care, with public and private under-agreement status, was reduced by more than 30%. In March 2000, approximately 95% of the remaining beds were devoted to short-term physical care, that is, a ratio of slightly less than 2.1 set-up beds for 1,000 people.

SOME FIGURES

The Québec health and social servics network is made up of several multi-dimensional components. Institutions, facilities, approved beds with permit or set-up beds, internal or external places, status, method of financing, and unit of services, are all elements that have a highly complex reality and overlap with each other, making it difficult to present a simple statistical portrait of this network of institutions.

To sum up, institutions and the facilities that they oversee have either a public or private status. All public institutions, that is, non-profit institutions, are financed according to a “budget” method, that is, through the Consolidated Revenue Fund. On the other hand, partially for-profit private institutions must sign a financing agreement with the MSSS, pursuant to section 475 of the Act respecting health services and social services (Revised Statutes of Québec, R.S.Q., chapter S-4.2). However, private, totally for-profit institutions must self-finance and are thus “not under agreement.” Lastly, all public and private institutions must hold an operating permit issued by the MSSS.

Approved beds are those which appear on the institution’s operating permit. Some beds may have been approved without being actually included in the operating permit; this situation is, however, very rare. Lastly, among the approved beds, set-up beds are those which are staffed and ready for use.

Table 9

Categorization of Institutional Resources

of the Québec Health and Social Servics Network, *2001*

Institution			Facility	Unit of services
Mission	**Class**	**Type**		**SGS SP HSLD PAV CJ FG PDI PDP PAT**
CH	CHSGS		CHSGS	Institutions and the facilities that are attached to them have a: PUBLIC, that is, non-profit STATUS; PRIVATE, for-profit STATUS. They receive a budget according to the FINANCING METHOD: BUDGET-BASED, for public ones; UNDER AGREEMENT, for private, partially for profit (support activities); NOT UNDER AGREEMENT, for private, totally for profit (all activities). An institution can take on one or several (up to 5) MISSIONS. In March 2001, one-third of institutions have more than one mission. The same is true of a facility. In March 2001, around 13% of facilities have more than one mission. Thus, an institution or a facility can have beds or places in several UNITS OF SERVICES. These beds or places are APPROVED with an operating PERMIT issued to the institution by the MSSS for a three-year period. The majority of these beds or places are SET UP, that is, they are staffed and ready for use.
	CHSP		CHSP	
CLSC			CLSC	
CHSLD			CHSLD	
			PAV	
CPEJ			CJ = (CPEJ +	
CR	JDA		CR JDA +	
	MDA		CR MDA)	
	PAT		CR PAT	
	PDI		CR PDI	
	PDP	Hearing	CR PDP	
		Visual		
		Motor		
			FG	

MSSS, SDI, March 2001.

Institutions

On March 31, 1990, the Québec health and social services network had 917 institutions, 758 of which (or over 82% of the total) had one single mission. On March 31, 2001, the number of institutions was reduced to 478, 37% of which had more than one mission. The number of institutions with one single mission dropped to 303, that is, by 60%.

Since 1990, only CPEJs, one of the five major categories of institution, saw its number of institutions increase. However, since 1993, this number has remained stable at 19 or 20. The number of institutions in the other four categories have been reduced as follows: by 48% for CHSLDs, 39% for CRs, 23% for CHs and 6% for CLSCs.

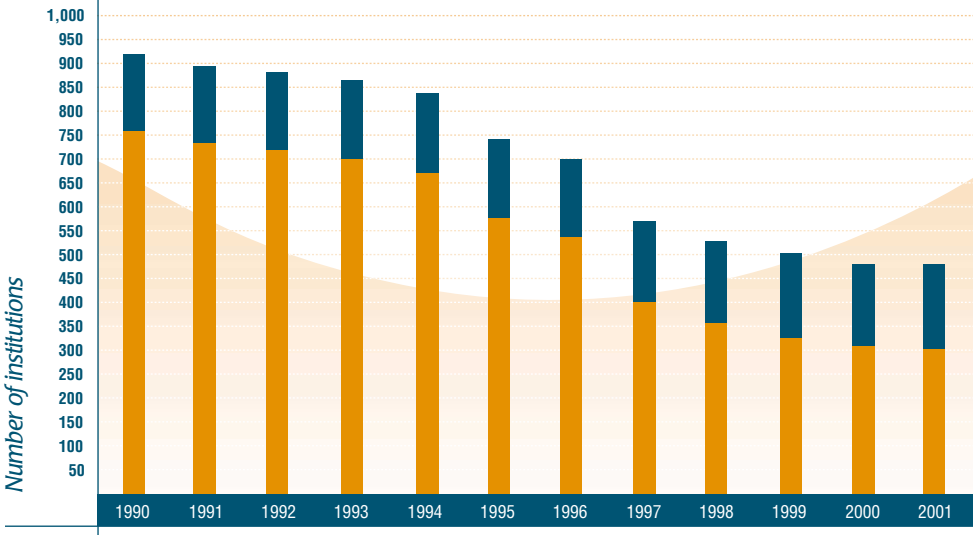
Of the network's 917 institutions in 1990, 233 or slightly more than one quarter were private. In 2001, 129 (or 27%) of the network's 478 institutions were private. In 1995, this proportion was lower than 21%. Since then, the proportion of private institutions has increased, stabilizing at around 27% from 1998 onwards. However, in absolute terms, their number is falling, representing a decrease of 45% since 1990. Moreover, the overwhelming majority of private institutions have a CHSLD mission.

In the early 1990s, close to half of the private institutions (45% in 1990 and 48% in 1992) were self-financed, that is, financed according to the "not-under-agreement" method. By the end of the period, over one-third of private institutions (38% in 1999, 40% in 2000 and 2001) were not under agreement.

Figure 18

Number of Institutions

in the Québec Health and Social Services Network,
by Number of Missions taken On,
Situation Observed on March 3, 1990 to 2001

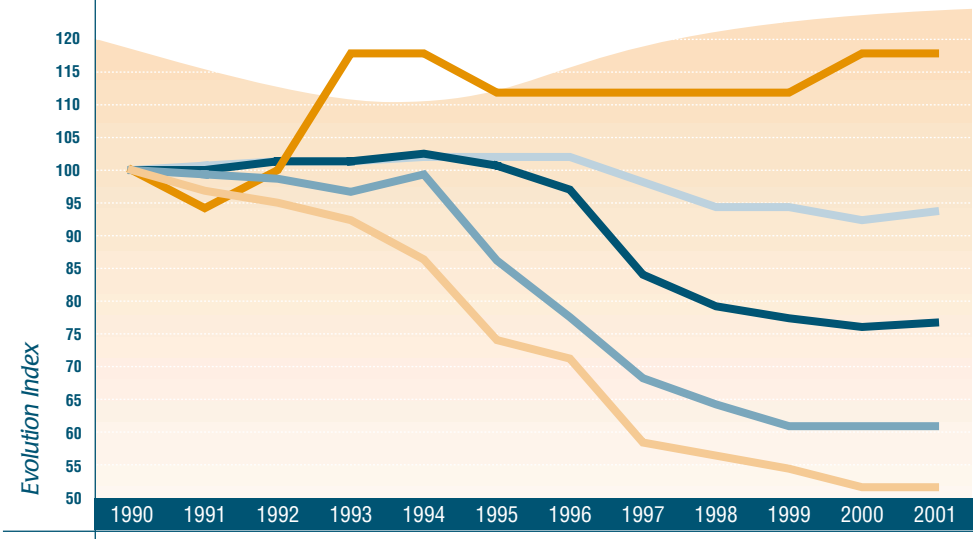


MSSS, SDI, April 2001.

Figure 19

Change in Number of Institutions

in the Québec Health and Social Services Network,
by Number of Missions Taken On,
Situation Observed on March 31, 1990 to 2001

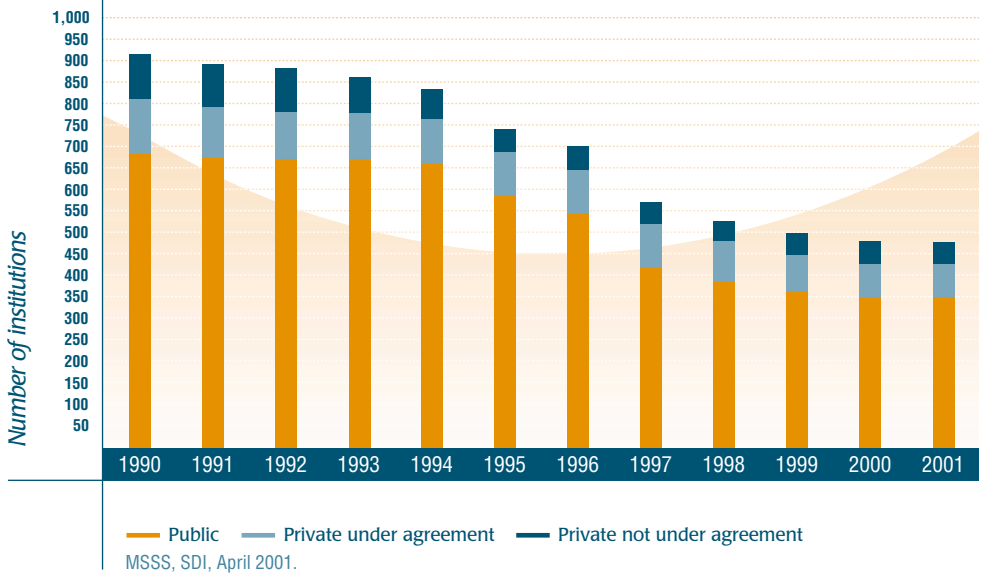


MSSS, SDI, April 2001.

Figure 20

Number of Institutions

in the Québec Health and Social Services Network,
by Status and Financing Method,
Situation Observed on March 31, 1990 to 2001



MSSS, SDI, April 2001.

Table 10

Number of Public and Private Institutions

in the Québec Health and Social Services Network,
by Grouping of Missions Taken On,
Situation Observed on March 31, 1990 to 2001

Grouping of missions	90	91	92	93	94	95	96	97	98	99	00	01
All groups	**917**	**894**	**882**	**864**	**835**	**740**	**700**	**570**	**529**	**501**	**479**	**478**
CLSC	131	128	128	128	127	128	128	100	82	72	67	67
CH	27	27	27	26	28	28	26	22	18	18	19	19
CPEJ	14	13	13	16	14	12	5	1	1	1	1	1
CHSLD	462	441	428	410	378	307	294	214	193	178	163	160
CR	124	124	122	119	122	102	82	65	62	57	57	56
CLSC-CH	5	6	6	5	7	7	7	4	1	1	1	1
CLSC-CPEJ					1							
CLSC-CHSLD	13	15	15	15	14	14	14	29	40	45	46	47
CLSC-CR	2	2	2	2	3	3	3	4	3	3	2	2
CH-CHSLD	108	107	110	111	110	108	104	83	79	72	68	69
CH-CR					1	1	1					
CPEJ-CHSLD		1										
CPEJ-CR[1]			1	1	2	4	11	15	15	15	15	15
CHSLD-CR	8	7	8	8	7	6	5	5	4	3	3	4
CLSC-CH-CHSLD	5	5	5	6	5	5	5	14	18	22	22	22
CLSC-CHSLD-CR										1	1	1
CH-CPEJ-CHSLD	1	1										
CH-CHSLD-CR	15	15	14	14	13	12	12	11	9	9	8	7
CLSC-CH-CPEJ-CHSLD			1	1	1	1						
CLSC-CH-CHSLD-CR									1	1	2	3
CH-CPEJ-CHSLD-CR	1											
CLSC-CH-CPEJ-CHSLD-CR	1	2	2	2	2	2	3	3	3	3	4	4

1. CPEJ-CRs are new CJs.

MSSS, SDI, April 2001.

Facilities

From 1990 to 2001, the number of facilities has on the whole remained relatively stable, varying between 2,000 and 2,100. However, examination by mission reveals different trends in each of these categories of facilities.

Whereas the number of CHSLD facilities and residential pavilions decreased by 17% during the past ten years, the number of CJ, CH, CR and CLSC facilities increased by 20%, 15%, 19% and 8% respectively.

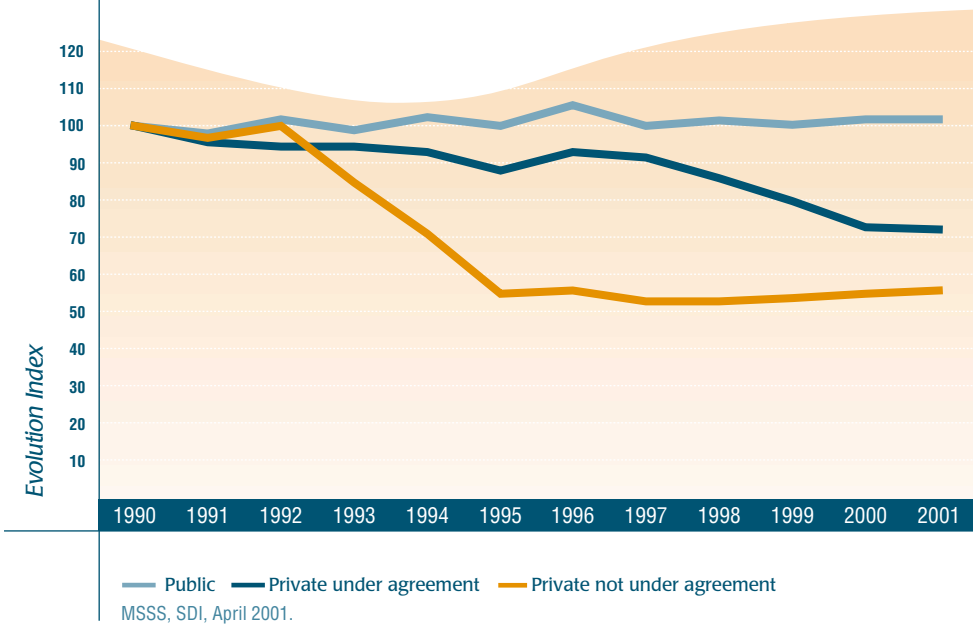
While the number of public facilities increased slightly (by 2%) during the period examined, the number of private facilities decreased by close to 34%. The number of private not-under-agreement facilities decreased most dramatically, that is, 44% whereas the number of private under-agreement facilities decreased by 28%.

In 1990, close to 12% of facilities were private, that is, less than 7% were financed according to the under-agreement method and slightly more than 5% were not under agreement; 11 years later, the proportion of private facilities is around 8%, that is, 2.8% are not under agreement and 5.1% are under agreement.

The number of facilities per institution doubled among public health and social services institutions (2.7 to 5.3) and remained relatively stable among private ones (varying from 1.1 to 1.3 for under-agreement facilities; from 1.0 to 1.1 for not-under-agreement facilities).

Figure **21**

Change in number of Facilities
in the Québec Health and Social Services Network,
by Status and Financing Method,
Situation Observed on March 31, 1990 to 2001

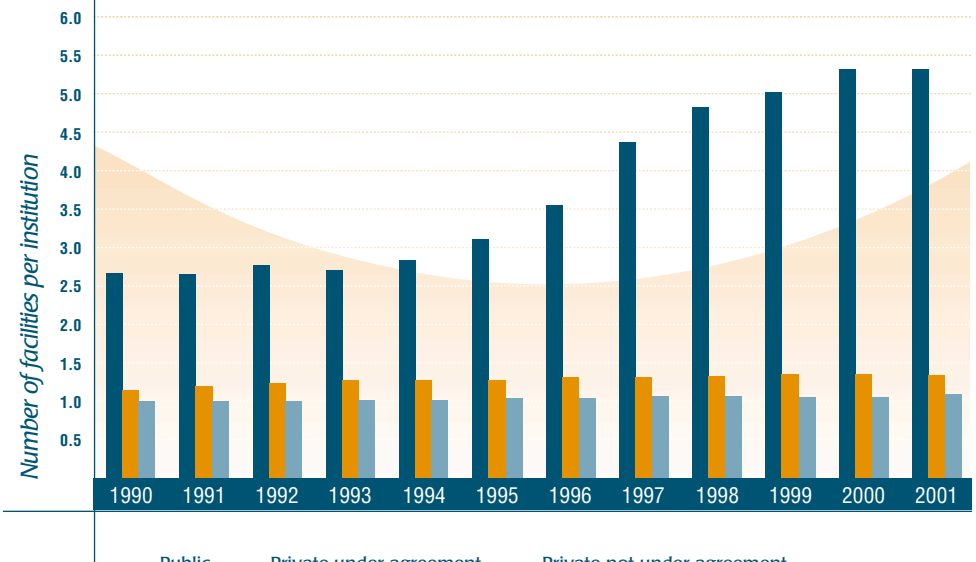


MSSS, SDI, April 2001.

Figure 22

Number of Facilities per Institution

in the Québec Health and Social Services Network,
by Status and Financing Method,
Situation Observed on March 31, 1990 to 2001



MSSS, SDI, April 2001.

Table 11

Change in Number of Public and Private Institutions

of the Québec Health and Social Services Network,
by Number of Missions of the Facility,
Situation Observed on March 31, 1990 to 2001

Mission	Unit	90	91	92	93	94	95	96	97	98	99	00	01
Total[1]	**Number**	**2,075**	**2,029**	**2,102**	**2,033**	**2,080**	**2,013**	**2,122**	**2,017**	**2,036**	**2,007**	**2,023**	**2,023**
	Index	**100**	**98**	**101**	**98**	**100**	**97**	**102**	**97**	**98**	**97**	**97**	**97**
CLSC	Number	363	360	355	353	368	372	381	371	378	380	392	393
	Index	100	99	98	97	101	102	105	102	104	105	108	108
CJ	Number	279	265	356	362	392	376	400	368	338	319	322	334
	Index	100	95	128	130	141	135	143	132	121	114	115	120
CH[2]	Number	180	169	172	172	176	176	175	162	206	206	206	207
	Index	100	94	96	96	98	98	97	90	114	114	114	115
CHSLD	Number	667	659	658	641	620	598	616	594	584	572	559	554
	Index	100	99	99	96	93	90	92	89	88	86	84	83
PAV	Number	236	237	234	232	236	232	232	222	206	202	197	195
	Index	100	100	99	98	100	98	98	94	87	86	83	83
FG	Number	199	188	158	149	159	147	142	142	118	125	109	111
	Index	100	94	79	75	80	74	71	71	59	63	55	56
CR PDI	Number	231	221	242	234	265	236	287	275	298	298	322	321
	Index	100	96	105	101	115	102	124	119	129	129	139	139
CR PDP	Number	33	33	36	43	44	46	54	58	70	75	80	83
	Index	100	100	109	130	133	139	164	176	212	227	242	252
CR PAT	Number	42	43	45	44	51	50	54	47	61	64	85	85
	Index	100	102	107	105	121	119	129	112	145	152	202	202

1. The total does not correspond to the sum of the missions because several facilities have more than one mission.
2. Sum of CHSGSs and CHSPs.

MSSS, SDI, April 2001.

Approved Beds with Permit

Although the number of facilities has, on the whole, remained more or less the same, the ambulatory shift and rationalization have resulted in a reduction in the number of beds and places, especially after 1996.

Thus, the number of beds devoted to general and specialized care decreased from more than 28,800 in 1990 to less than 20,500 in 2001, or a decrease of close to 29% during this period, 26% of which occurred since 1996. The number of beds for short-term psychiatric care in CHSPs was reduced by more than half, from 2,730 to 1,280. Even the number of beds for residential and long-term care decreased slightly (less than 7%), essentially affecting those reserved for patients requiring less than 2 1/2 hours of care. Thus, of the 52,500 beds noted in 1990, in 2001, there are slightly less than 48,600 beds devoted to residential and long-term care and some 3,700 places in residential pavilions had to be added.

In the early 1990s, Québec had ratios of more than 4 beds for 1,000 people in general and specialized care, and 7.5 beds for 1,000 people in residential and long-term care; in 2001, these ratios are 2.8 and 6.6 respectively.

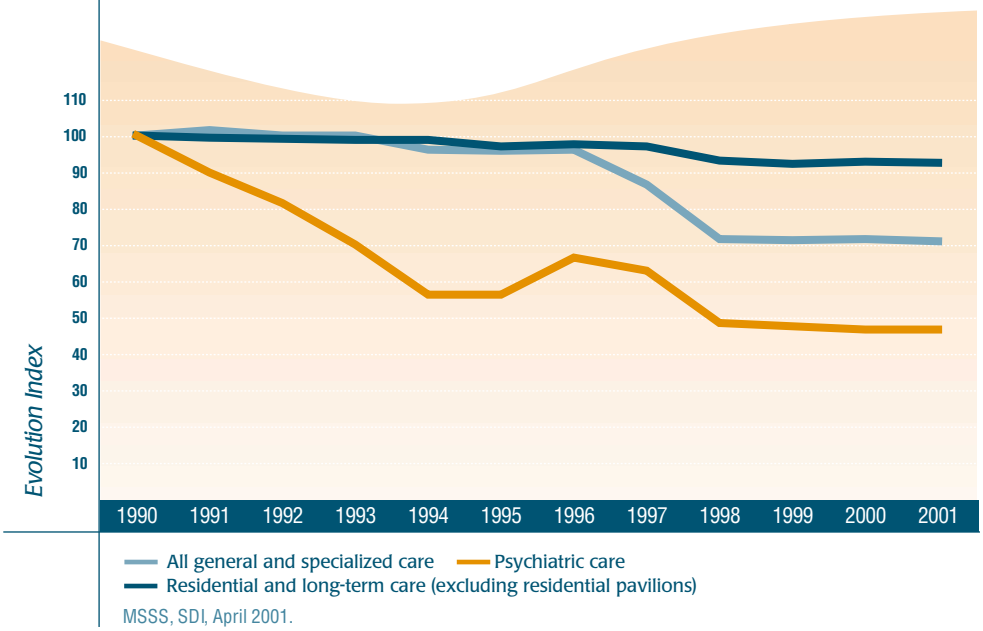
Depending on the year, between 90% (in 1990) and 87% (in 2001) of private institutions operate the CHSLD mission, which means that the great majority of private beds are devoted to residential and long-term care.

In 1990, close to 22% of beds devoted to residential and long-term care were private, that is, more than 11,500 beds; in 2001, some 9,900 private beds make up 20% of all beds devoted to residential and long-term care.

In this unit of services, although the number of public beds followed a similar trend to that of private under-agreement beds, with a slight reduction (6% for public beds and 3% for under-agreement beds), the number of private, not-under-agreement beds decreased by 34% since 1990. It reached the lowest point in 1997 with less than 2,400 beds.

Figure **23**

Change in Number of Approved Beds with an Operating Permit
from Institutions of the Québec Health and Social Services Network,
by Unit of Services,
Situation Observed on March 31, 1990 to 2001

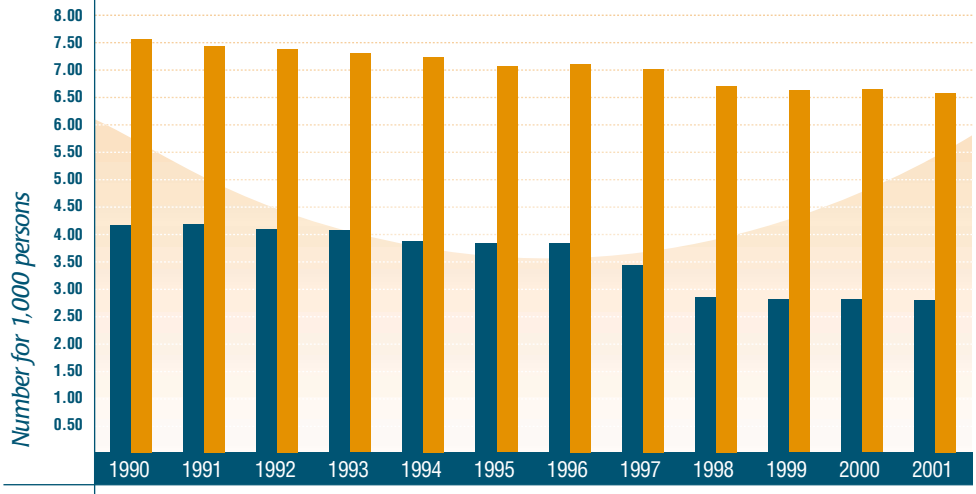


MSSS, SDI, April 2001.

Figure 24

Number of Approved Beds per 1,000 People with an Operating Permit

from Institutions of the Québec Health and Social Services Network, by Unit of Services,
Situation Observed on March 31, 1990 to 2001



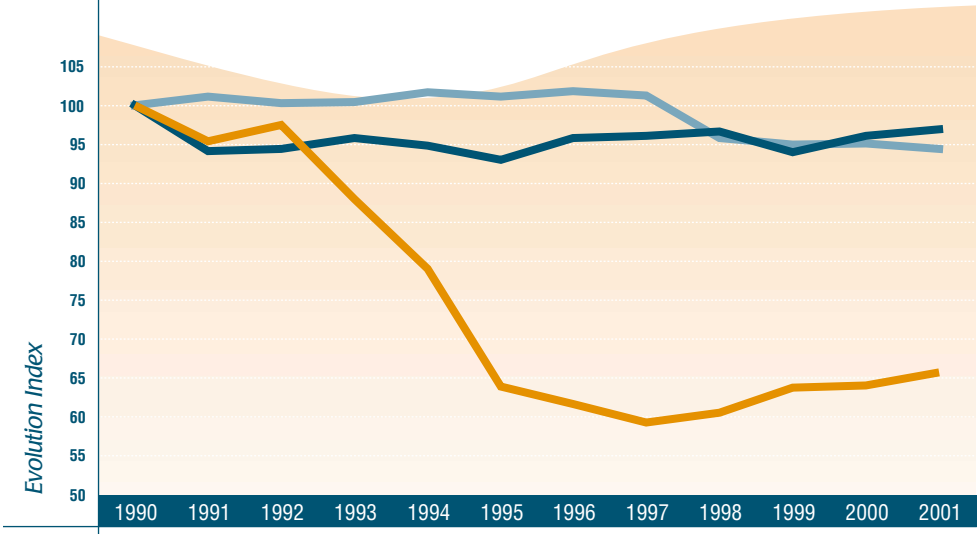
General and specialized care
Residential and long-term care (excluding residential pavilions)

MSSS, SDI, April 2001.

Figure 25

Change in Number of Approved Beds

for Residential and Long-Term Care with a Permit from Institutions of the Québec Health and Social Services Network, by Status and Financing Method,
Situation Observed on March 31, 1990 to 2001



Public
Private under agreement
Private not under agreement

MSSS, SDI, April 2001.

Table 12

Number of Approved Public and Private Beds and Places per 1,000 people

with an Operating Permit from Institutions of the Québec Health and Social Services Network, by Unit of Services,

Situation Observed on March 31, 1990 to 2001

Unit of services	Unit	90	91	92	93	94	95	96	97	98	99	00	01
GSC[1]	Number	28,835	29,286	28,832	28,896	27,738	27,675	27,706	24,970	20,680	20,575	20,640	20,524
	/1,000 pers.	4.15	4.17	4.08	4.06	3.87	3.84	3.83	3.43	2.83	2.81	2.81	2.78
PC[2]	Number	2,730	2,451	2,229	1,913	1,538	1,538	1,813	1,716	1,328	1,299	1,280	1,280
	/1,000 pers.	0.39	0.35	0.32	0.27	0.21	0.21	0.25	0.24	0.18	0.18	0.17	0.17
RLTC[3]	Number	52,521	52,308	52,094	51,881	51,942	50,976	51,374	51,065	48,936	48,526	48,748	48,569
	/1,000 pers.	7.56	7.45	7.37	7.29	7.25	7.07	7.09	7.02	6.70	6.63	6.64	6.59
PAV[4]	Number	4,314	4,387	4,329	4,227	4,297	4,280	4,259	4,102	3,885	3,828	3,751	3,707
	/1,000 pers.	0.62	0.62	0.61	0.59	0.60	0.59	0.59	0.56	0.53	0.52	0.51	0.50
CJ[5]	Number	3,757	3,683	3,912	3,920	3,933	3,716	3,974	3,767	3,173	3,208	3,009	3,317
	/1,000 pers.	0.54	0.52	0.55	0.55	0.55	0.52	0.55	0.52	0.43	0.44	0.41	0.45
FG[6]	Number	1,460	1,396	1,150	1,089	1,149	1,089	1,051	1,121	939	1,004	892	896
	/1,000 pers.	0.21	0.20	0.16	0.15	0.16	0.15	0.15	0.15	0.13	0.14	0.12	0.12
MIP[7]	Number	9,349	9,390	9,125	8,882	8,533	7,709	8,134	7,773	8,085	7,919	7,989	7,481
	/1,000 pers.	1.35	1.34	1.29	1.25	1.19	1.07	1.12	1.07	1.11	1.08	1.09	1.01
PIP[8]	Number	434	434	469	584	596	585	602	560	506	511	557	558
	/1,000 pers.	0.06	0.06	0.07	0.08	0.08	0.08	0.08	0.08	0.07	0.07	0.08	0.08
PAA[9]	Number	442	442	482	468	421	451	460	309	399	439	447	444
	/1,000 pers.	0.06	0.06	0.07	0.07	0.06	0.06	0.06	0.04	0.05	0.06	0.06	0.06

1. Beds for general and specialized care, including for psychiatric care (except those in CHSPs), hostel and neonatalogy.
2. Beds for short-term psychiatric care in CHSPs; 1990 to 1994, estimated data.
3. Beds for physical and psychiatric, permanent and temporary, residential and long-term care; 1990 to 1994, estimated data.
4. Places offered in residential pavilions.
5. Places offered in youth centres.
6. Places offered in rehabilitation facilities (9 places or less).
7. Places offered in rehabilitation facilities for mentally impaired persons.
8. Places offered in rehabilitation facilities for physically impaired persons.
9. Places offered in rehabilitation facilities for persons suffering from alcoholism or other addiction problems.

MSSS, SDI, April 2001.

Set-Up Beds

The change in the number of beds can also be examined in relation to set-up beds. However, this type of information could only be obtained through public and private under agreement institutions. It should be noted that this is a description of the situation at a precise moment in time, that is, on March 31 of each year.

For our purposes, the period of March 31, 1991 to March 31, 2000 was covered. Since the mid-1990s, the number of set-up beds for general and specialized care has dropped by 31%, whereas that of set-up beds for residential and long-term care and places in residential pavilions decreased by 8% and 25% respectively.

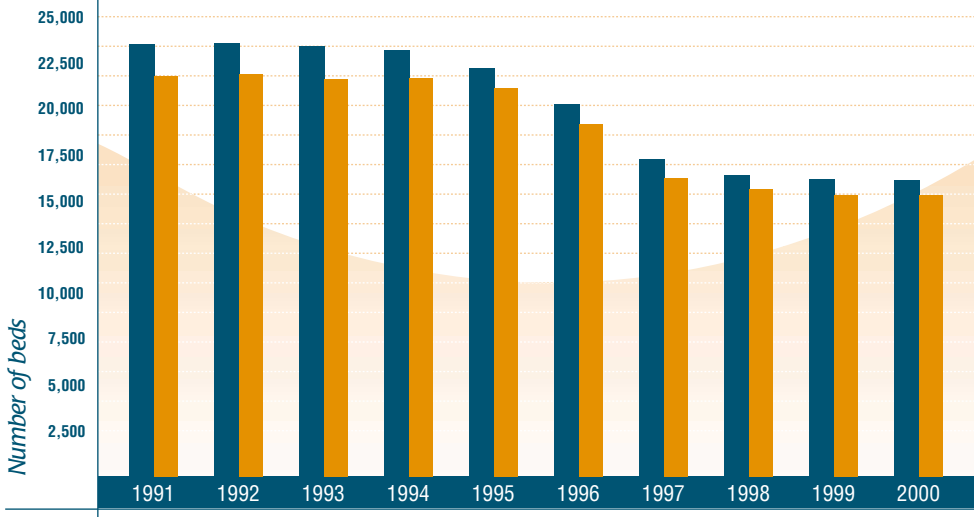
On March 31, 2000, Québec had 2.1 set-up beds per 1,000 people in short-term physical care; in 1991, this ratio was 3.4 beds per 1,000 people. For short-term psychiatric care, the ratio decreased from 1.1 beds per 1,000 people in 1991 to 0.6 beds in 2000.

At the beginning of the period, 92% of beds for general and specialized care were devoted to short-term physical care; on March 31, 2000, this proportion rose to 95%.

Figure 26

Number of Set-Up Beds in Institutions

of the Québec Health and Social Services Network, by Unit of Services,
Situation Observed on March 31, 1991 to 2000

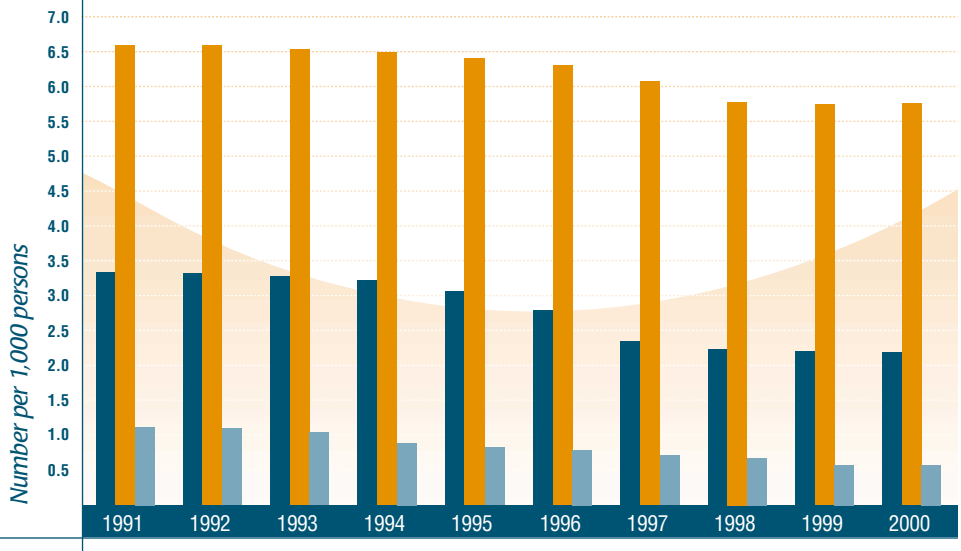


MSSS, SDI, January 2001.

Figure 27

Number of Set-Up Beds per 1,000 People in Institutions

of the Québec Health and Social Services Network, by Unit of Services,
Situation Observed on March 31, 1991 to 2000



MSSS, SDI, January 2001.

Table 13

Change in Number of Set-Up Beds

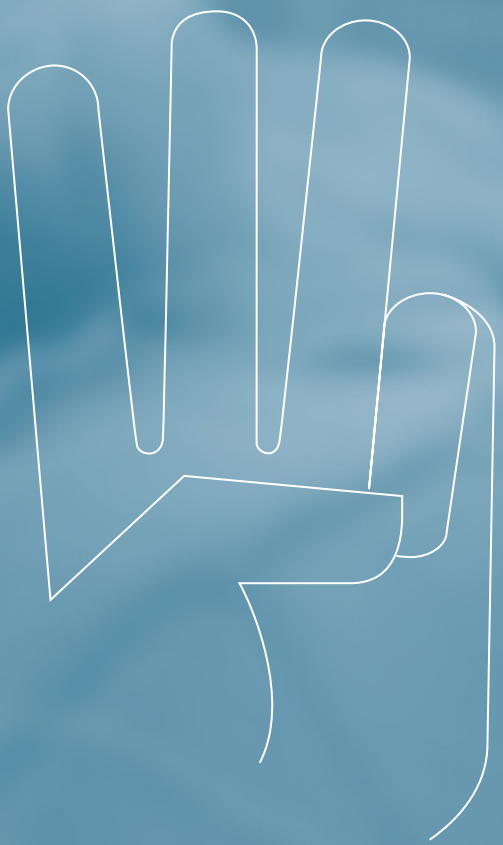
in the Québec Network of Health and Social Services Institutions,
by Unit of Services,
Situation Observed on March 31, 1991 to 2000

Unit of services	Unit	91	92	93	94	95	96	97	98	99	00
General and specialized care[2]	Number	23,543	23,565	23,417	23,148	22,193	20,277	17,224	16,389	16,169	16,129
	Evolution index	100	100	99	98	94	86	73	70	69	69
	/1,000 pers.	3.35	3.33	3.29	3.23	3.08	2.80	2.37	2.24	2.21	2.20
Short-term physical care[3]	Number	21,755	21,872	21,625	21,680	21,066	19,164	16,251	15,632	15,282	15,257
	Evolution index	100	101	99	100	97	88	75	72	70	70
	/1,000 pers.	3.10	3.09	3.04	3.03	2.92	2.65	2.23	2.14	2.09	2.08
Residential and long-term care[4]	Number	46,410	46,719	46,604	46,663	46,300	45,807	44,325	42,336	42,207	42,482
	Evolution index	100	101	100	101	100	99	96	91	91	92
	/1,000 pers.	6.61	6.61	6.55	6.51	6.42	6.33	6.09	5.80	5.76	5.78
Residential pavilions[5].	Number	4,371	4,356	4,610	4,462	4,078	4,110	4,155	3,896	3,414	3,260
	Evolution index	100	100	105	102	93	94	95	89	78	75
	/1,000 pers.	0.62	0.62	0.65	0.62	0.57	0.57	0.57	0.53	0.47	0.44

1. Refer to only public and private under agreement institutions that produced an annual statistical report.
2. Beds for short-term physical health and geriatric care; excluding short-term care beds used for residential care and long-term care.
3. Among institutions having reported beds for general and specialized care, only those which recorded 15 or more departures per bed and per year were retained; this corresponds to "active care" as defined in "Statistiques MED-ÉCHO".
4. Beds for permanent and temporary, residential and long-term care for persons with decreasing autonomy, with or without a psychiatric diagnosis, including short-term care beds used for residential and long-term care.
5. Places in residential pavilions, whether used for a physical or psychiatric problem.

MSSS, SDI, January 2001.

Services



- Home Services
- Ambulatory Services
- Pre-hospital Emergency Services
- Short-term Care Services
- Services Covered by the Health Insurance Plan
- Youth Protection Services
- Rehabilitation Services
- Residential and Long-term Care Services

SERVICES

This chapter provides a broad portrait of the health and social services used by the Québec population. Because it would be impossible to cover all of the available services in an exhaustive way, the discussion is limited to those services that seem to us to be the most important (in terms of volume or cost), those that are the "entry points" to the system, or those that are related to the new realities confronting the population.

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 which are provided to users who must travel to obtain them. Here we are referring to users registered for these services which are called "ambulatory services." In fact, the treatments are ambulatory because they allow users to travel to the services that they need while continuing to lead an active life. Lastly, the third category of services include those which 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.

It should be noted that these types of services are not mutually exclusive. Each has to be considered separately as a whole in itself and adding them together creates a significant distortion since some services will be counted twice. It should also be noted that, in some cases, much more data are provided on the cost of services than on clienteles or utilization of services. This is due to the availability of data. Indeed, there is sometimes considerable bias in favour of data on cost, especially when it comes to chronological series that are sufficiently comparable.

HOME SERVICES

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 services to those already in place, and the injection of additional public funds underscored this commitment.

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

If we use a definition that includes expenditures related to the remuneration of doctors for house calls, then in 1999-2000, in gross terms, Québec spent $491 million on home services, or more than twice as much as it spent at the beginning of the decade, compared to an overall increase in health and social services expenditures of 33%. At present, home services represent 3% of Québec's total gross expenditures on health and social services. It should be noted that this amount excludes overhead costs, that is, the costs related to the general administration and operation of the institutions that provide these services.

During the 1990s, expenditures on home care increased twice as much as did expenditures on home assistance (132% versus 71%). Home care obviously includes nursing care, but it also includes rehabilitation services (physiotherapy, occupational therapy, inhalation therapy and speech therapy), psychosocial services and specialized care (total parenteral nutrition, hemodialysis and peritoneal dialysis). For its part, home assistance includes custodial care, domestic assistance and support to families and relatives.

However, the definition can be adjusted to better isolate "home support" services. For example, remuneration to doctors for house calls can be subtracted in order to obtain a set of services that can be more validly compared with the situation in the rest of Canada, particularly in Ontario. In this case, it is preferable to use the term "home care" instead of the term "home support," because we now want to focus on the services that are freely chosen by individuals who are in need of support, and not on the services that reflect a social objective of maintenance and assistance to compensate for the functional limitations that confine people to their homes.

Defined in this way, expenditures on home support in 1999-2000 (excluding medical services provided at home that are paid by the RAMQ, but including administrative and operational costs, which represent 26% of the total), reached some $480 million, that is, $65 per capita or 3.4% of total net expenditures on health and social services.

SOME FIGURES

In order to translate home services in Québec into numbers, we therefore need to consult a range of information sources – including "Intégration-CLSC" for the clientele, the "système M30" for expenses, "Gestion SBF-R" for grants to community organizations, and "statistiques RAMQ" for house calls made by physicians – in order to paint a picture, which, although it is clearly incomplete, will be refined over the coming years.

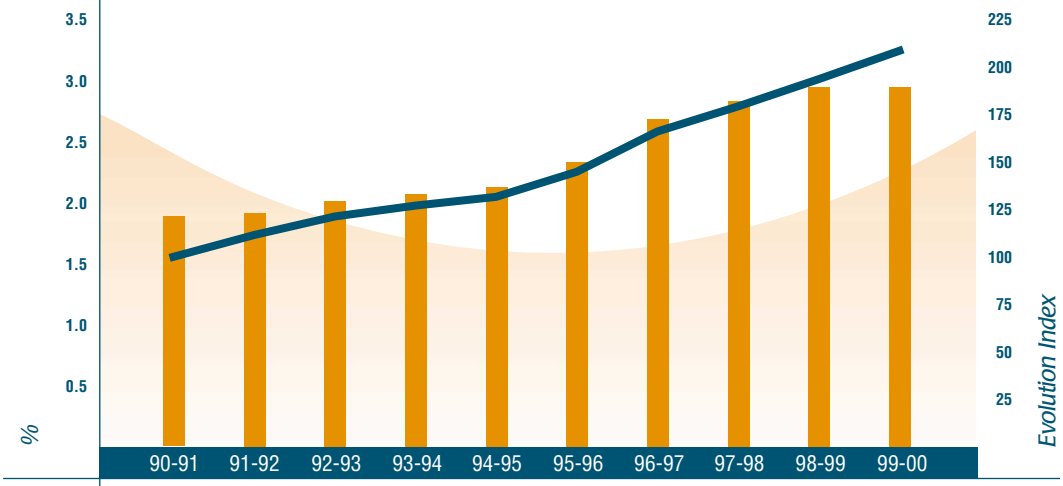
The SIFO derived data base (Système d'information financière et opérationnelle – Financial and Operational Information System) provides us with a good approximation of the trends in costs related to these services.

Adding up the gross expenditures on home services delivered by physicians (RAMQ), by the Office des personnes handicapées du Québec (OPHQ), and by community organizations, results in a total of $235 million in 1990-1991 and more than $491 million in 1999-2000, which represents an increase of 109%. Over the same period, gross expenditures for all health and social services increased by 33%. Moreover, in 1999-2000, 3% of gross expenditures on health and social services in Québec were devoted to home services.

Figure 28

Expenditures on Home Services as a Proportion

of Total Gross Expenditures and Evolution Index for these Expenditures, Québec, *1990-1991 to 1999-2000*

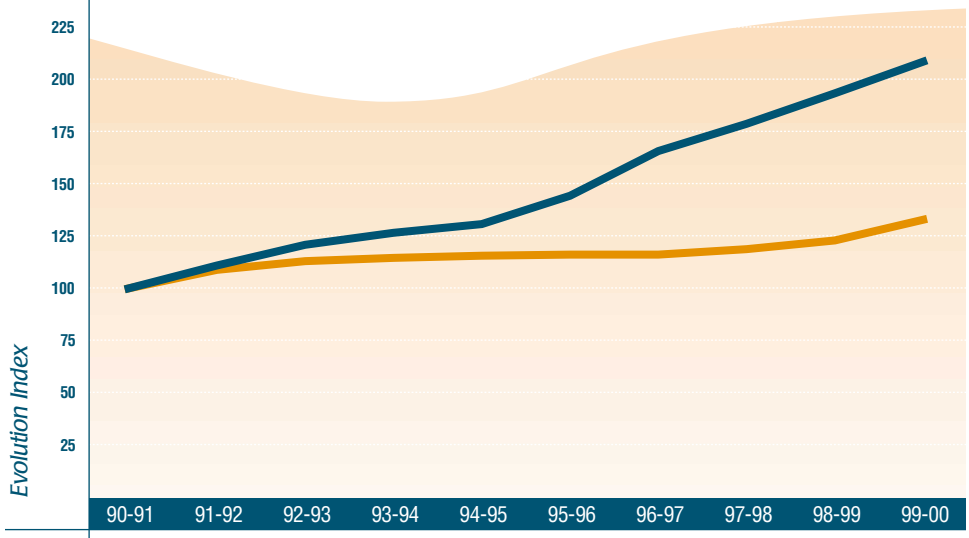


MSSS, SDI, January 2001.

Figure 29

Change in Total Gross Expenditures and in Expenditures

on Home Services, Québec, *1990-1991 to 1999-2000*



MSSS, SDI, January 2001.

AMBULATORY SERVICES

One of the major 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 truly describes the real situation of this set of services.

For the purposes of this document, we use a quite realistic operational definition of ambulatory services, though we do not claim that this definition is better than the others or makes them obsolete. Thus, we define ambulatory services as the sum of three large groups: medical services dispensed to ambulatory users; hospital services provided to registered users as opposed to users admitted to a hospital; and day services provided to users who remain in their own environment.

In 1999-2000, Québec spent close to $1.5 billion on ambulatory services; the sum represented 9% of total gross expenditures on health and social services. This was a 33% increase over 1990-1991. Medical ambulatory services generated 51% of these expenditures, whereas hospital ambulatory services amounted to 42%. Day services amounted to 7%.

Besides the 31 million outpatient visits to doctors in 1999, in 1999-2000 there were nearly 278,000 day surgeries, nearly 3.7 million visits to emergency, some 350,000 day hospital visits and nearly 1.6 million visits to day centres.

In 1990-1991, expenditures on home services broke down as follows: 42% on home care; 49% on home assistance; and 9% on community services provided by voluntary agencies. By 1999-2000, this breakdown had changed to 47%, 40% and 13% respectively, therefore indicating a shift towards home care and community services.

Indeed, over the period analyzed, expenditures related to home care increased twice as fast as did expenditures on home assistance (132% versus 71%), whereas expenditures on community services tripled.

At the time of writing, the MSSS was developing an officially recognized operational definition of home care, that is, a precise and exhaustive list of all of the measurable elements that are included in this category of services. To date, no information system was able to provide all of the data needed to measure precisely the utilization of these services and the costs that result. However, the MSSS is in the process of introducing an information system (Intégration-CLSC) that should start to produce results for 2000-2001 in a few months. Until then, only a very partial picture of the situation can be obtained, based on data in the old clientele information system CLSC (SIC-CLSC) data bank.

Nevertheless, we can identify a significant increase (almost 12%) in the number of individualized interventions in the home care field of activity and a 14% increase in the number of users (different individuals) between 1997-1998 and 1998-1999. In addition, there was an increase of more than 9% in the number of hours worked by employees assigned to these services during the same period. This is clearly a filed of activity that is growing rapidly.

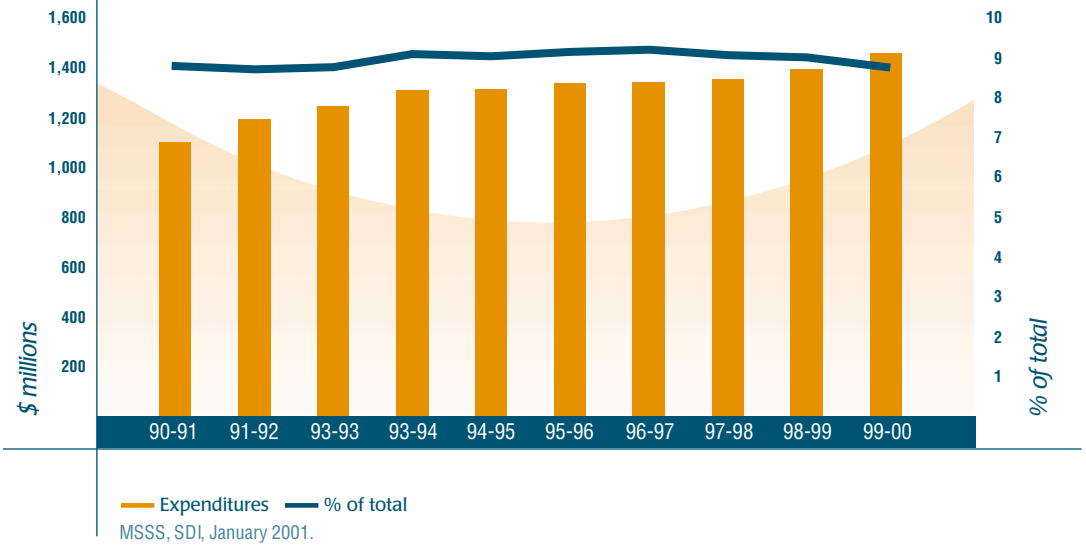
SOME FIGURES

We have retained three main groups making up the ambulatory services: medical services dispensed to outpatients, that is, examinations in doctors' offices and in institutions; hospital services provided to registered users (as opposed to users admitted to a hospital), that is, day surgeries, outpatient services, emergency, and day services, that is, services in day hospitals and in day centres.

In 1990-1991, Québec spent $1.097 billion on ambulatory services. Ten years later, these expenditures reached $1.458 billion, an increase of 33% over the amount at the beginning of the decade. Nine per cent of total gross expenditures therefore go to ambulatory services, not counting the administrative and general operating costs of the institutions that provide these services, a proportion that has been quite stable for ten years.

Figure 30

Expenditures on Ambulatory Services as a Proportion
of Total Health and Social Services Expenditures, Québec,
1990-1991 to 1999-2000



MSSS, SDI, January 2001.

In 1999-2000, 51% of expenditures on ambulatory services covered medical services, 42% were for hospital services and 7% for day services. There were 31 million outpatient medical visits, which was 1 million more than at the beginning of the decade. Today, the average visit costs $24, or $4 more than in 1990. In addition, close to 278,000 day surgeries were performed, a practice that has been growing steadily since the early 1990s, even though this growth has slowed and even stabilized over the last two years. In 1999-2000, the records show almost 3.7 million hospital emergency visits, more than 6.2 million visits for outpatient consultations for problems of physical health, and close to 150,000 outpatient consultations for mental health problems. Lastly, almost 232,000 patients were seen by health professionals in day medicine, for a total of some 450,000 care-days.

As regards day services, there were nearly 350,000 day hospital visits, including 237,000 for the treatment of acute phases of mental illnesses. In addition, there were nearly 1.6 million attendances in day centres, including more than 842,000 cases of persons suffering from a mental impairment.

PRE-HOSPITAL EMERGENCY SERVICES

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. The fundamental objective of the system is to minimize mortality and morbidity of users by seeking to achieve a maximum performance level at each step in the intervention chain. This goal involves reducing as much as possible the "response time," that is, the length of time between the telephone call and the arrival of ambulance services at the scene; the "response interval," that is, the length of time between the intervention at the scene and transportation to the emergency room; and the "out-of-service delay," that is, the time elapsed between the arrival at the treatment centre and the moment when the ambulance team can respond to another call.

Each link in the chain of interventions is part of a chain of events involving several people. The first link consists of the "first actors," that is, the first persons to arrive on the scene who call the pre-hospital emergency services. Next in line is the "emergency calls coordination centre" which then takes over. Its basic functions are as follows: to answer and handle emergency calls, to distribute and allocate available resources, and to monitor and manage these resources. The third link consists of the "first respondents," who begin resuscitation or essential stabilization actions while waiting for the arrival of specialists. They are particularly important in compressing intervention time delays and in the continuity of care. "Ambulance services" are the next to come into play, stabilizing the condition of the victim and transporting him or her quickly to a hospital capable of providing the necessary care. Ambulances are also used to transfer patients from one institution to another. The last link in the chain are "emergency room" staff who are distributed around Québec.

In terms of pre-hospital services, ambulance transportation is at the heart of the intervention chain and is, beyond any shadow of a doubt, the most important link.

In Québec, in 1998-1999, the cost of an ambulance ride was $125, plus $1.75 per kilometre covered. The cost is the responsibility of a third-party payer in the following cases:

- persons injured in a road accident;
- recipients of last-resort assistance;
- persons injured at work;
- veterans;
- users transported between two institutions (CHs and CHSLDs);
- seniors (or: persons 65 years of age and older);
- members of the Canadian Armed Forces;
- inmates of detention centres;
- First Nations or Inuit on a reserve;
- members of the Royal Canadian Mounted Police.

Each vehicle is staffed by two ambulance technicians who have received training recognized by the MSSS and the MEQ. All technicians have to hold a card attesting to their basic training, to adhere to standards of skills maintenance, and to obtain a work permit from the hospital responsible for the pre-hospital services. This training requires 840 hours of courses taught in two vocational training colleges.

In 1998-1999, there were approximately 3,100 ambulance technicians in Québec, or one for every 2,380 persons. Eight hundred of these technicians work for Urgences-santé, an agency that covers the regions of Montréal-Centre (06) and Laval (13). In the other regions, the regional boards are responsible for the organization of services.

Financing of pre-hospital emergency services comes from three sources. The MSSS funds around half, whereas the other half is relatively equally divided between the Société de l'assurance automobile du Québec (SAAQ) and users of ambulance services.

SOME FIGURES

For the 1998-1999 financial year, the budget devoted to pre-hospital emergency services was about $206 million, $136 million of which was through the regional boards and $70 million through Urgences-santé. In 1994-1995, the budget was $193.5 million, $97.5 million of which was assumed by the MSSS, $43 million by the SAAQ and $53 million by users (paying agents). Added to these amounts was $8 million for the air ambulance, a cost that has been relatively stable since the mid-1990s.

In 1998-1999, there were 542 ambulances in Québec, or 7.4 ambulances for every 100,000 persons. Four years earlier, there were 8 ambulances for every 100,000 persons, or 578 in total.

In 1994-1995, 440,000 ambulance trips were made, or 61 trips for every 1,000 persons. In 1998-1999, 471,400 trips were made, for a ratio of 64 trips for every 1,000 persons.

From 1994-1995 to 1998-1999, the budget for pre-hospital ambulance services rose from $26.84 per capita to $28.08 per capita. The average cost per trip, on the other hand, showed a slight decline of $3.55.

Table 14

Various Statistics on Pre-hospital Emergency Services, Québec, *1994-1995 and 1998-1999.*

Indicator	94-95	98-99
Population	7,208,170	7,322,994
Number of ambulances	578	542
Number per 100,000 persons	8.02	7.40
Number of transports	440,096	471,419
Number per 1,000 persons	61	64
Expenditures[1] ($ million)	193.5	205.6
Amount per person ($)	26.84	28.08
Average amount per transport ($)	439.68	436.13

1. $8M per year for air ambulance must be added to these amounts.

MSSS, SDI, February 2001.

SHORT-TERM CARE SERVICES

The observations presented in this section only related 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, have also been excluded.

The observed trend in hospitalization for short-term active care is largely the result of two phenomena. First, the development of medical technologies, by gradually reducing the use of what are called "invasive" methods, leads to a decrease in the length of hospital stays. Second, the increased use of day surgery is 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 at the end of the 1990s. Indeed, its increased use has resulted in a decline in the number of hospitalizations requiring short stays in institutions, thereby leaving more place for long stays, even though their length is shorter than what it used to be.

In 1999-2000, some 736,000 hospitalizations for short-term care generated 5.3 million hospitalization days. These two figures represented a significant decline as compared to data recorded in the mid-1990s. The average stay also declined, dropping from 8.8 days in the mid-1980s to a little more than 7 days at the end of the 1990s, although it seems to have stabilized since.

The number of hospitalizations has declined among users of all age groups, except for those between 50 and 59 years of age and those 70 years or older. As for the number of hospitalization days, the only exception to the downward trend is persons aged 85 years and older. In terms of the average stay, only those aged 15 to 19 years are outside the general trend, with an average stay of 5.1 days.

The diagnostic categories that generate the longest average stays are "Mental disorders" and "Neoplasms," whereas the shortest stays are in the categories related to births.

In six diagnostic categories including diseases of the circulatory system and mental disorders, there was an increase in the number of hospitalizations between 1992-1993 and 1999-2000.

SOME FIGURES

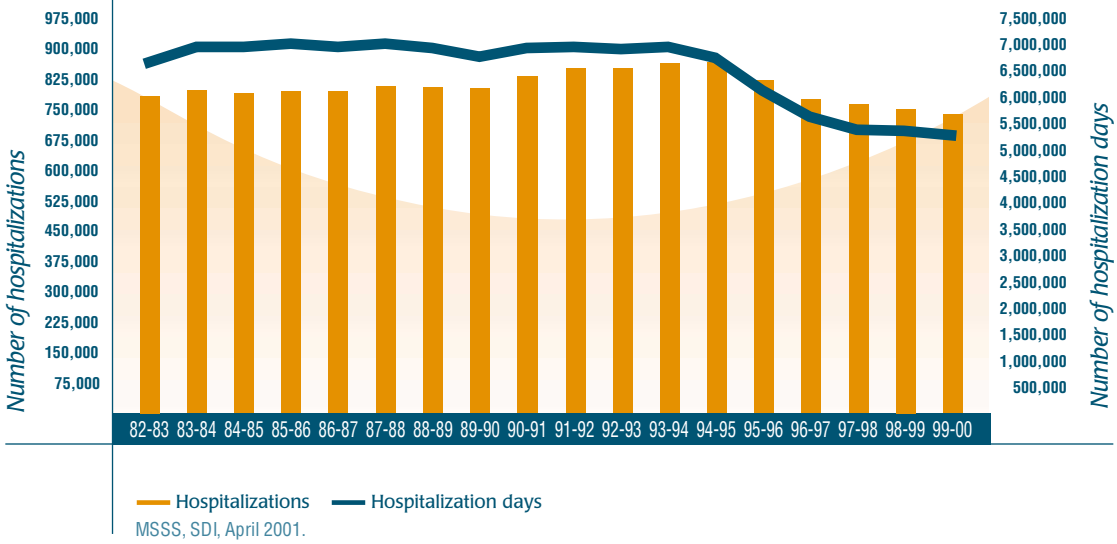
Over the 1980s, the number of hospitalizations for short-term care remained relatively stable at around 800,000. However, in the first half of the 1990s, there was a significant growth, that is, 8.2%. But since 1994-1995, the number of hospitalizations for short-term care has been declining each year. From slightly more than 865,500 in 1994-1995, the number was less than 740,000 in 1999-2000, or a decline of more than 15%.

As for the hospitalization days related to these admissions – and leaving aside the years 1982-1983 and 1989-1990, when their number declined as compared to other years – these also remained relatively stable, just under the 7 million mark until the mid-1990s. Since then, the number has been continually declining. In 1999-2000, there were some 5.3 million patient days, representing a decline of 24% since 1993-1994.

Figure 31

Number of Hospitalizations and Hospitalization Days

for General and Specialized Short-term Care, Québec,
1982-1983 to 1999-2000

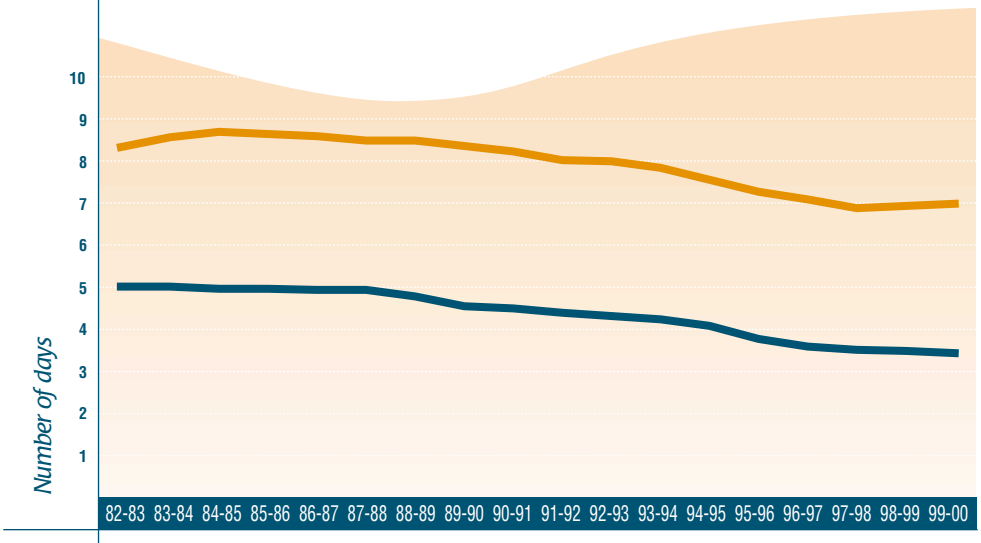


MSSS, SDI, April 2001.

Figure 32

Average Stay for General and Specialized Short-Term Care,

by Category of Care, Québec,
1982-1983 to 1999-2000



MSSS, SDI, April 2001.

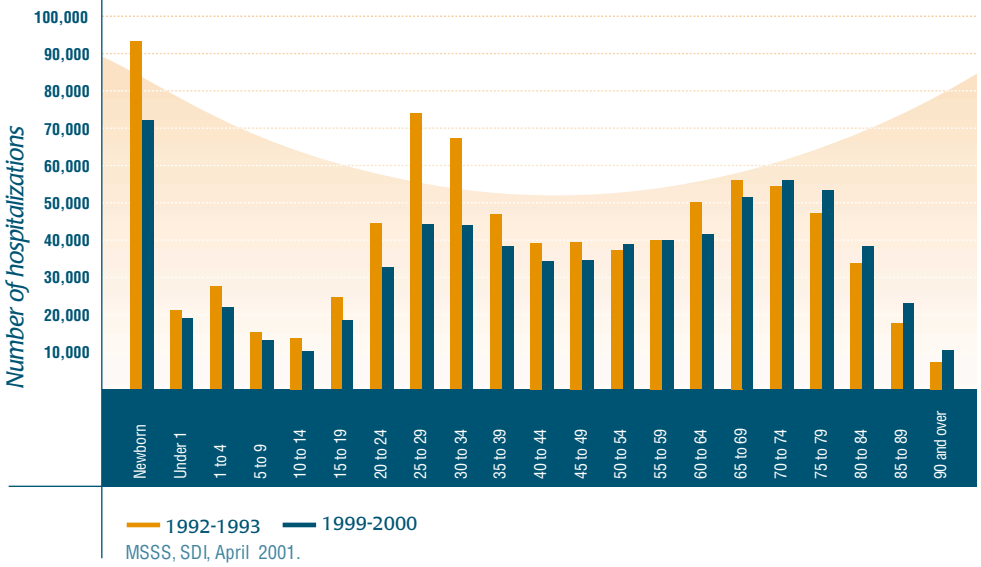
The figures reveal that the average stay is declining, especially since the mid-1980s, even though by the end of the decade the situation appeared to be stabilizing at slightly more than 7 days per hospitalization. In this respect, the impact of neonatal care is important, since the average stay for such care declined by more than 31% from 1982-1983 to 1999-2000, representing an average annual decline of more than 2%.

From 1992-1993 to 1999-2000, the number of hospitalizations decreased for all age groups, except for persons aged 50-59 years and those aged 70 years or older. The decline was particularly marked for newborns, as well as for people aged between 20 and 35, that is, the period in which women generally give birth. This trend reflects the drop in Québec's birthrate since the middle of the 1990s.

During the same period, the number of hospitalization days declined for all age groups, except for persons aged 85 years and older. The rapid increase in the number of people in this age group has outweighed the impact of the development of new medical technologies and practices.

Figure 33

Number of Hospitalizations for General and Specialized Short-term Care,
by User Age Group, Québec,
1992-1993 and 1999-2000

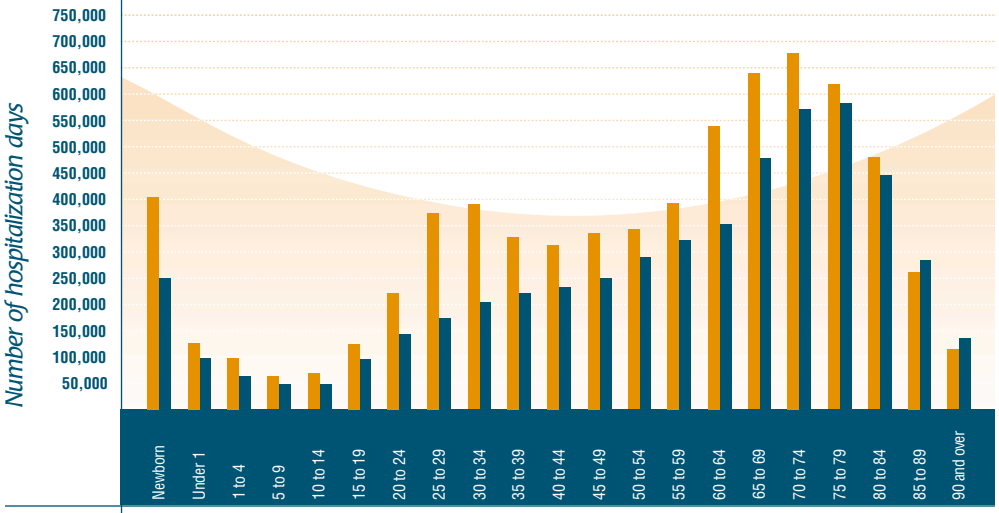


MSSS, SDI, April 2001.

Figure 34

Number of Hospitalization Days for General and Specialized Short-term Care,

by User Age Group, Québec,
1992-1993 and 1999-2000

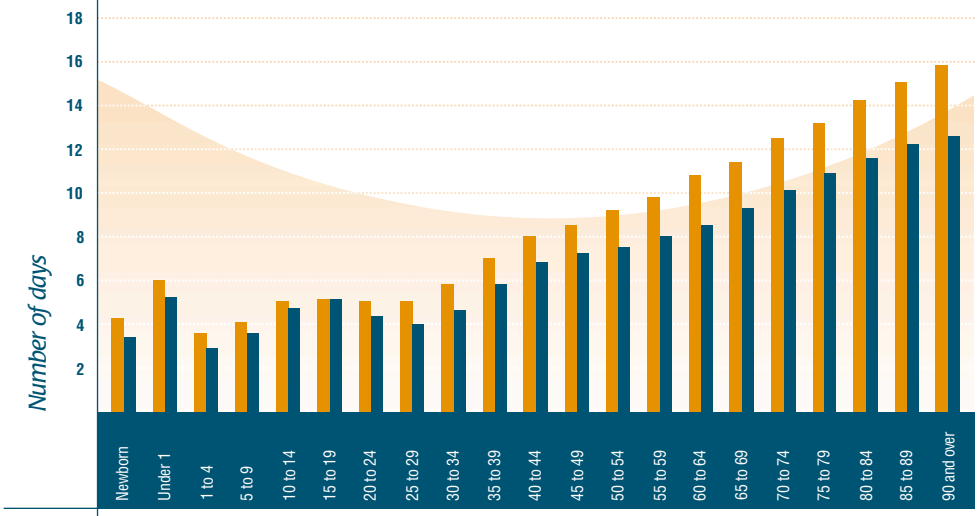


MSSS, SDI, April 2001.

Figure 35

Average Stay for General and Specialized Short-term Care,

by User Age Group, Québec,
1992-1993 and 1999-2000



MSSS, SDI, April 2001.

Lastly, between 1992-1993 and 1999-2000, the only age group for which the average stay was unchanged was the 15-19 year-olds. For all other age groups, the average stay decreased significantly. The particular situation of the 15-19 age group is no doubt the result of a considerable decline in pregnancies among young women of this age (1,671 fewer hospitalizations, or 26% fewer in 1999-2000 as compared to 1992-1993) and shorter stays for childbirths (2.8 days on average in 1999-2000), combined with an increase in the number of hospitalizations for mental disorders (785 more hospitalizations, representing a 66% increase over 1992-1993), which require longer stays (16.2 days on average in 1999-2000). Overall, the significant decline in the number of births (and hence short stays) during the past 3 or 4 years is increasing the proportion of longer stays, leading in turn to a lengthening of the overall average stay, especially in recent years.

The International Statistical Classification of Diseases, 9th revision (ICD-9) provides us with two levels of diagnostic groupings: the grouping in 19 general categories and the grouping in 119 more precise categories. Here, we restrict our observations to the "19-category grouping".

Although the total number of hospitalizations declined markedly (by more than 110,000 or 13%) between 1992-1993 and 1999-2000, six diagnostic categories moved in the other direction, particularly "Mental disorders" (an increase of 16.3%) and "diseases of the circulatory system" (an increase of 5.6%). The two categories that experienced the greatest decline were, without question, those linked directly to births, that is, "Complications of pregnancy, childbirth and puerperium" (with 28%) and "Live-born children in good health" (with 22.5%).

Between 1992-1993 and 1999-2000, the number of patient days declined in all diagnostic categories except in the category "Symptoms signs and ill-defined conditions." The decline was particularly marked in the category "Complications of pregnancy, birth and the puerperium" (45%).

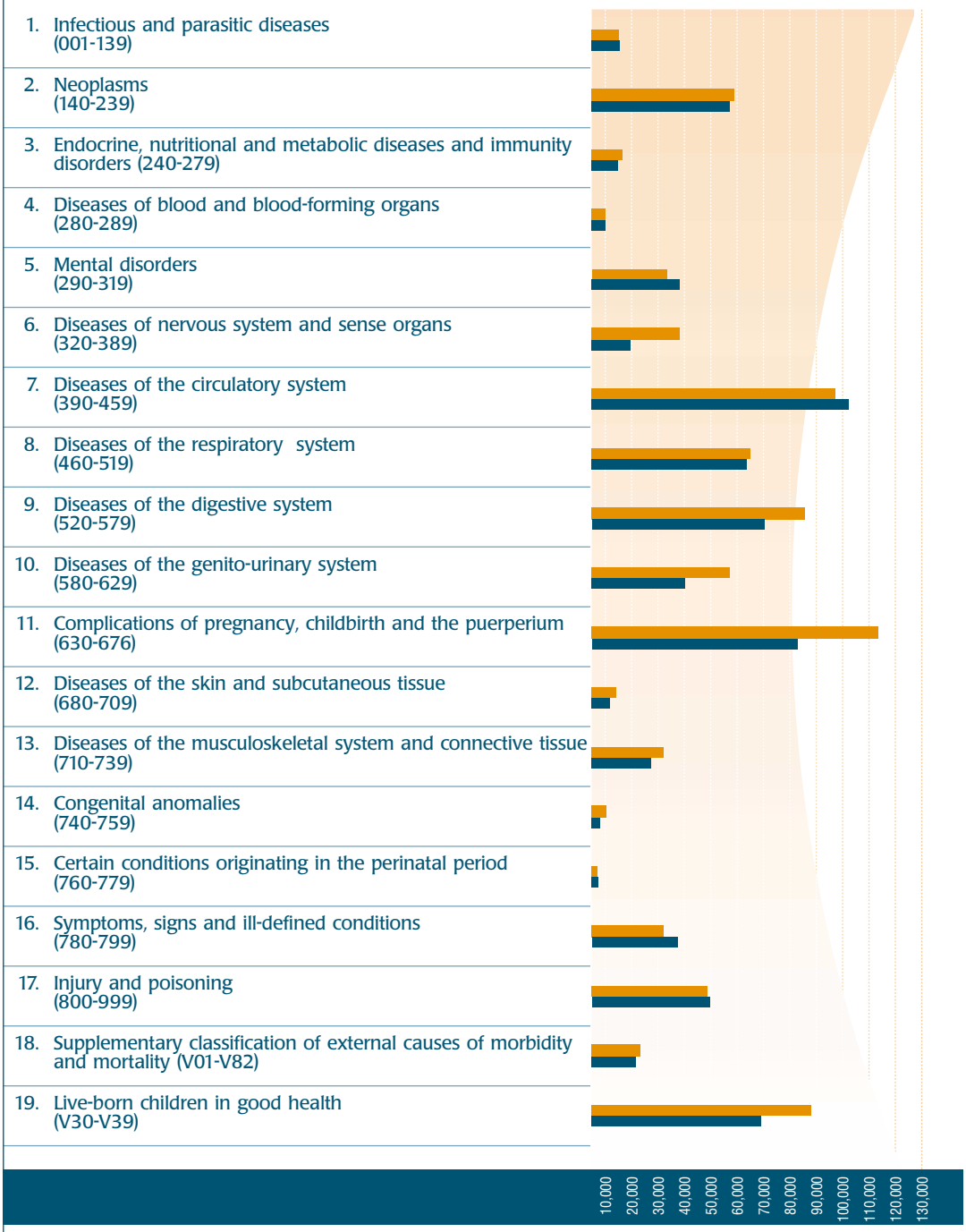
As regards average stay by category, there were decreases everywhere, except for the category "Diseases of nervous system and sense organs." This phenomenon is essentially due to the transfer to day surgery of a significant proportion of hospitalizations for short-term care, thereby giving more weight to longer stays. For example, in the sub-category "Diseases of the eye and Adnexa," hospitalizations declined from 20,453 in 1992-1993 to 3,964 in 1999-2000. In addition, the average stay for this sub-category was just 2.8 days in 1999-2000.

Whereas the diagnostic groups related to births give rise to the shortest stays (on average), the categories "Mental disorders" (22.2 days, on average, in 1992-1993 and 17.3 days in 1999-2000) and "Neoplasms" (13.1 days in 1992-1992 and 10.8 days in 1999-2000) are those with the longest stays.

Figure 36

Number of Hospitalizations for General and Specialized Short-term Care,

By 19-category Diagnostic Grouping, Québec,
1992-1993 and 1999-2000

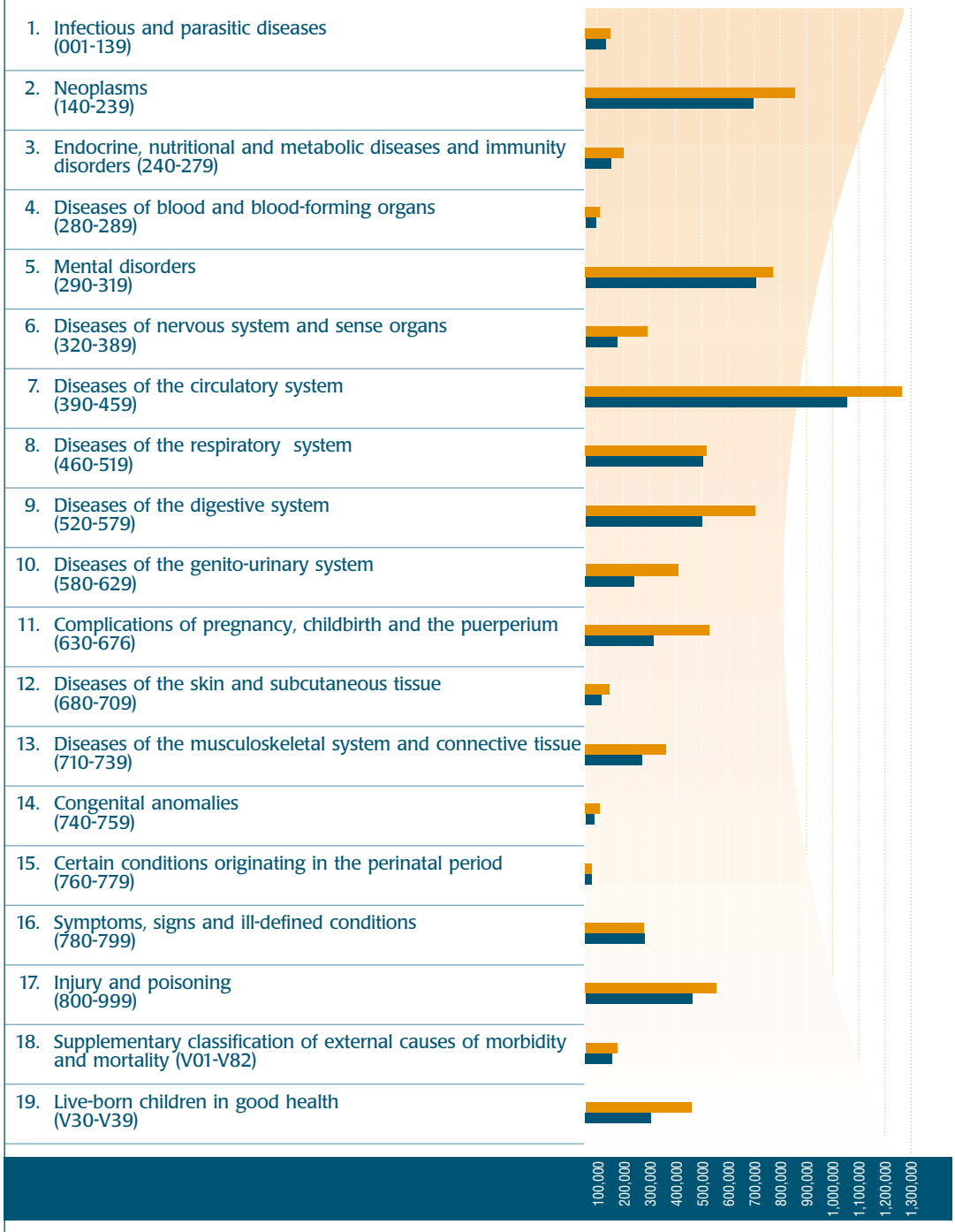


MSSS, SDI, April 2001.

Figure 37

Number of Hospitalization Days for General and Specialized Short-term Care,

By 19-category Diagnostic Grouping, Québec,
1992-1993 and 1999-2000

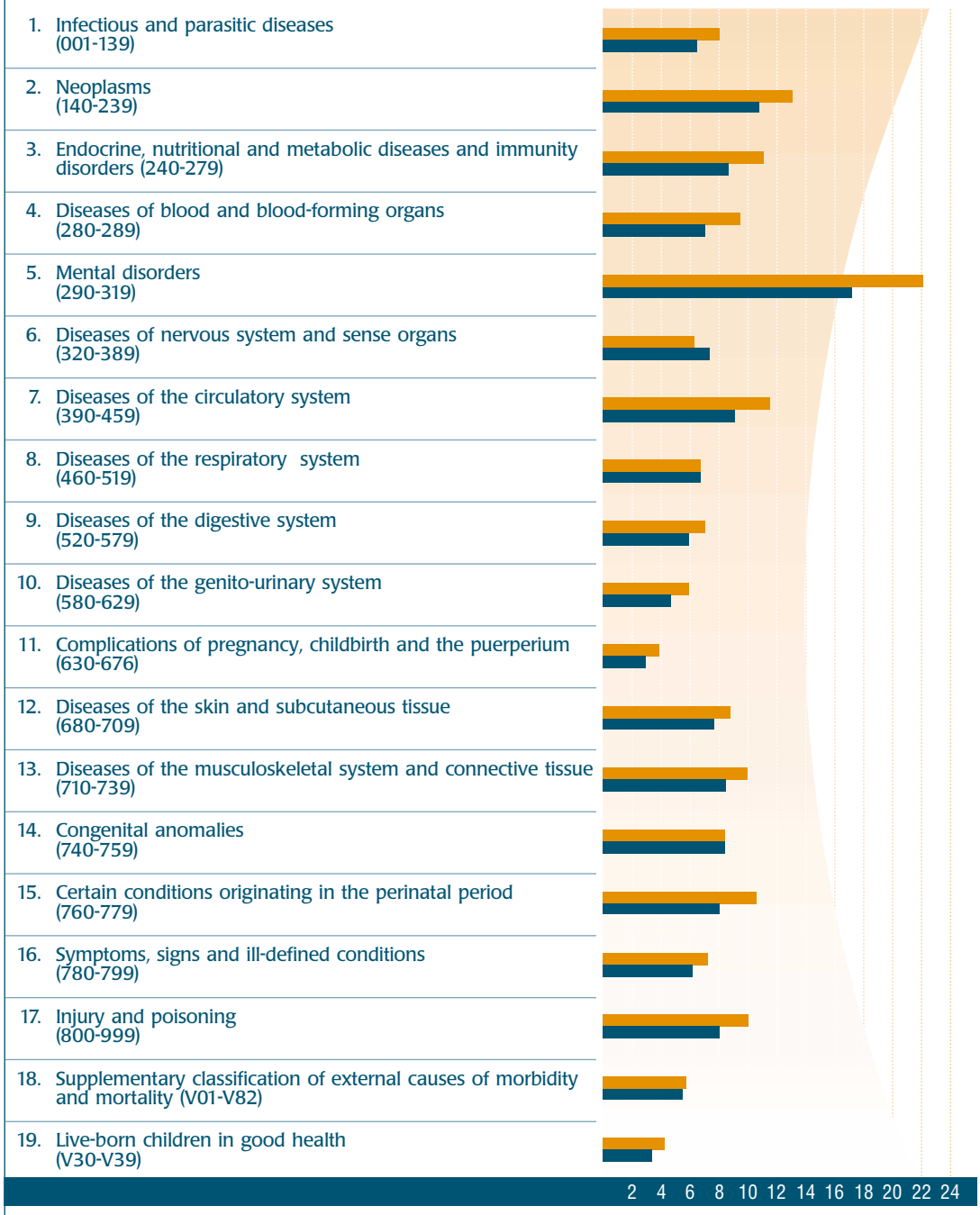


MSSS, SDI, April 2001.

Figure 38

Average Stay for General and Specialized Short-term Care,

by 19-category Diagnostic Grouping, Québec,
1992-1993 and 1999-2000



MSSS, SDI, April 2001.

Table 15

Hospitalizations for Short-term Care[1]

in General and Specialized Facilities[2] Participating in the Med-Écho System, Québec, *1982-1983 to 1999-2000*

Year	Hospitalizations		Attend-days		Average stay	
	Number	% an. var.	Number	% an. var.	Days	% an. var.
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	0.7
V.A.V.[3]%		-0.2		-1.3		-1.0

1. Refers to physical, psychiatric and neonatal care.
2. Only "active" general and specialized care facilities, that is, excluding those that mainly provide long-term rehabilitation, convalescent, or psychiatric care. In addition, long-term care provided in the facilities retained, whether in beds assigned for short or long-term care, was eliminated.
3. Average annual variation.

MSSS, SDI, April 2001.

Table 16

Hospitalizations for Short-term Care[1]

in General and Specialized Facilities[2] Participating in the Med-Écho System, by User Age Group, Québec,
1992-1993 and 1999-2000

Age group	1992-1993				1999-2000				% var of hosp. 1999-2000/ 1992-1993
	Hosp.	% Dist.	Att-days	% Dist.	Hosp.	% Dist.	Att-days	% Dist.	
All ages	848,921	100.0	6,897,984	100.0	736,481	100.0	5,277,738	100.0	-13.2
Newborn	93,408	11.0	403,240	5.8	72,345	9.8	248,607	4.7	-22.5
Under 1	20,949	2.5	125,360	1.8	18,932	2.6	97,581	1.8	-9.6
1 to 4	27,427	3.2	97,640	1.4	21,923	3.0	62,864	1.2	-20.1
5 to 9	15,168	1.8	61,567	0.9	13,094	1.8	47,402	0.9	-13.7
10 to 14	13,882	1.6	68,850	1.0	10,372	1.4	48,338	0.9	-25.3
15 to 19	24,434	2.9	124,549	1.8	18,434	2.5	94,388	1.8	-24.6
20 to 24	44,561	5.2	220,896	3.2	32,675	4.4	143,878	2.7	-26.7
25 to 29	74,016	8.7	373,712	5.4	44,089	6.0	174,379	3.3	-40.4
30 to 34	67,145	7.9	389,920	5.7	43,848	6.0	203,306	3.9	-34.7
35 to 39	46,659	5.5	326,633	4.7	38,303	5.2	222,547	4.2	-17.9
40 to 44	39,107	4.6	311,963	4.5	34,340	4.7	232,164	4.4	-12.2
45 to 49	39,337	4.6	335,666	4.9	34,608	4.7	247,615	4.7	-12.0
50 to 54	37,267	4.4	341,501	5.0	38,790	5.3	290,317	5.5	4.1
55 to 59	40,076	4.7	391,117	5.7	40,172	5.5	320,413	6.1	0.2
60 to 64	50,021	5.9	538,548	7.8	41,381	5.6	351,920	6.7	-17.3
65 to 69	56,043	6.6	637,626	9.2	51,541	7.0	477,419	9.0	-8.0
70 to 74	54,248	6.4	677,657	9.8	56,120	7.6	568,887	10.8	3.5
75 to 79	46,969	5.5	618,269	9.0	53,172	7.2	581,225	11.0	13.2
80 to 84	33,573	4.0	477,781	6.9	38,449	5.2	445,273	8.4	14.5
85 to 89	17,408	2.1	261,589	3.8	23,222	3.2	284,306	5.4	33.4
90 and over	7,223	0.9	113,900	1.7	10,671	1.4	134,909	2.6	47.7

1. Refers to physical, psychiatric and neonatal care.

2. Only "active" general and specialized care facilities, that is, excluding those that mainly provide long-term, rehabilitation, convalescent or psychiatric care. In addition, the long-term care given in the facilities retained, whether in beds assigned to short-term or long-term care, was eliminated.

MSSS, SDI, April 2001.

Table 17

Hospitalizations for Short-term Care[1]

in General and Specialized Facilities[2] Participating in the Med-Écho System, By 19-category Diagnostic Grouping, Québec, *1992-1993 and 1999-2000*

19-category diagnostic grouping (ICD-9)	1992-1993				1999-2000			
	Hosp.	Attend-days	% Distrib.	Av. stay	Hosp.	Attend - days	% Distrib.	Av. stay.
Total (001 - V39)	**848,894**	**6,897,582**	**100.0**	**8.1**	**736,481**	**5,277,738**	**100.0**	**7.2**
1 Infectious and parasitic diseases (001-139)	11,708	94,965	1.4	8.1	12,059	77,858	1.5	6.5
2 Neoplasms (140-239)	60,781	796,612	11.5	13.1	58,801	637,019	12.1	10.8
3 Endocrine, nutritional and metabolic diseases and immunity disorders (240-279)	13,151	146,512	2.1	11.1	11,412	98,927	1.9	8.7
4 Diseases of blood and blood-forming organs (280-289)	5 875	55 725	0.8	9.5	5 692	40 188	0.8	7.1
5 Mental disorders (290-319)	32,152	712,927	10.3	22.2	37,406	648,329	12.3	17.3
6 Diseases of nervous system and sense organs (320-389)	37,180	234,929	3.4	6.3	16,519	121,965	2.3	7.4
7 Diseases of the circulatory system (390-459)	103,982	1,203,186	17.4	11.6	109,759	995,987	18.9	9.1
8 Diseases of the respiratory system (460-519)	67,760	461,344	6.7	6.8	66,100	447,639	8.5	6.8
9 Diseases of the digestive system (520-579)	91,165	643,413	9.3	7.1	73,457	441,841	8.4	6.0
10 Diseases of the genito-urinary system (580-629)	58,842	350,830	5.1	6.0	39,732	188,109	3.6	4.7
11 Complications of pregnancy, childbirth and the puerperium (630-676)	121,911	473,014	6.9	3.9	87,803	261,662	5.0	3.0
12 Diseases of the skin and subcutaneous tissue (680-709)	10,234	90,179	1.3	8.8	7,974	61,320	1.2	7.7
13 Diseases of the musculoskeletal system and connective tissue (710-739)	30,738	307,811	4.5	10.0	25,246	215,015	4.1	8.5
14 Congenital anomalies (740-759)	6,385	53,616	0.8	8.4	3,751	31,443	0.6	8.4
15 Certain conditions originating in the perinatal period (760-779)	2,544	27,051	0.4	10.6	3,009	24,331	0.5	8.1
16 Symptoms, signs and ill-defined conditions (780-799)	30,900	223,815	3.2	7.2	36,540	226,530	4.3	6.2
17 Injury and poisoning (800-999)	49,444	497,980	7.2	10.1	50,074	407,730	7.7	8.1
18 Supplementary classification of external causes of morbidity and mortality (V01-V82)	20,734	120,433	1.7	5.8	18,802	103,238	2.0	5.5
19 Live-born children in good health (V30-V39)	93,408	403,240	5.8	4.3	72,345	248,607	4.7	3.4

1. Refers to physical, psychiatric and neonatal care.

2. Only "active" general and specialized care facilities, that is, excluding those that mainly provide long-term rehabilitation, convalescent and psychiatric care. In addition, long-term care provided in the facilities retained, whether in beds assigned to short- or long-term care, was also eliminated.

MSSS, SDI, April 2001.

SERVICES COVERED BY THE HEALTH INSURANCE PLAN

The Régie de l'assurance maladie du Québec administers a number of programs in compliance with the laws and regulations in force and in accordance with the agreements concluded between the 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 which 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).

The number of medical services has been decreasing since 1993; in 1999, there were 81.1 million, each at an average cost of $27.38.

Medical services include "physician-patient" contacts, that is all of the examinations, consultations, surgery, and psychiatric treatments. These services are provided by physicians in medicine and surgery who are remunerated on a fee-for-service basis.

Every year, each physician has an average of between 3,500 and 3,700 "physician-patient" contacts. In 1999, over a quarter of these uniquely involved persons aged 65 and over.

Since it was introduced, coverage under the "Dental Services" program has undergone several changes in relation to its different clienteles. In 1999, dentists and oral specialists provided 2.6 million dental services, at an average cost of $31.75 per service.

Coverage under the "Optometric Services" program has decreased markedly since it came into force. Thus, in 1999, 1.7 million insured services were provided, a decrease of more than half as compared with 1990. In 1999, the average cost of each optometric service was $16.11.

Since the prescription drug insurance plan was introduced in 1997, a new clientele – "plan members" – has been added to the clienteles already covered by the "Medications and Pharmaceutical Services" program. Theses are clients who are not covered by a private group insurance contract.

In 1999, 54.8 million drug prescriptions were submitted to the RAMQ in accordance with the "Medications and Pharmaceutical Services" program. This represented a significant increase (91%) over 1990, that is, an average annual increase of 6.7%. In 1999, the average cost per prescription was $27.33.

Fewer than 20% of these prescriptions were submitted by employment insurance recipients (social assistance), nearly 58% by seniors aged 65 and older, and slightly more than 23% by prescription drug insurance plan members.

In 1999, some 280,000 persons benefited from one of the six technical aid programs, at an average cost per beneficiary of $241.61. In 1990, slightly less than 250,000 beneficiaries received services of this type at an average cost per service of $167.27.

SOME FIGURES

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 and who hold a valid health insurance card have the right to insured 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, a blended remuneration (fee-for-service and fixed sums). Fee-for-service is the most prevalent remuneration method, accounting for nearly 80% of cases.

Until April 1995, tariff objectives were established on the basis of an average gross annual income, adjustable at each of the negotiations with the professional federations. From April 1, 1995 to March 31, 1998, the Fédération des médecins spécialistes du Québec (FMSQ) and the Fédération des médecins omnipraticiens du Québec (FMOQ) concluded agreements with the MSSS, thus replacing the mechanism of a tariff objective by a predetermined global budget envelope for each of the two federations of physicians. The MSSS has also reached an agreement with the FMRQ. In 1999, when amendments were made to the agreement linking the MSSS and the FMSQ, the agreement linking the MSSS and the FMOQ was amended. The agreement with the FMSQ was renewed until March 31, 2001.

In addition, for general practitioners, dentists and optometrists, there is a quarterly or semi-annual individual income ceiling beyond which fees are reduced. Finally, fees paid to physicians are increased or reduced for a given period depending on the territory or place of practice in which services are provided. Thus, general practitioners who dispense services in territories that are understaffed receive 115% of the basic remuneration provided for in the agreements while specialists in these territories receive 120%. Conversely, in the university regions (Montréal-Centre, Québec, Estrie), general practitioners receive 70% of the basic remuneration in the first three years of practice while new specialists received 70% of the basic remuneration for the first two years and 80% for the following two years.

From 1990 to 1993, the number of medical services increased from 80.6 million to 86.7 million, that is, an average annual increase of 8%. However, during the five following years, it decreased, dropping to 81.1 million in 1999.

The cost of services per user was $243.84 in 1990; in 1999, it was $299.21, that is, an average annual increase of 2.1%. The average cost per service increased from $21.30 to $27.38 during the same period, or an increase of 28.5%.

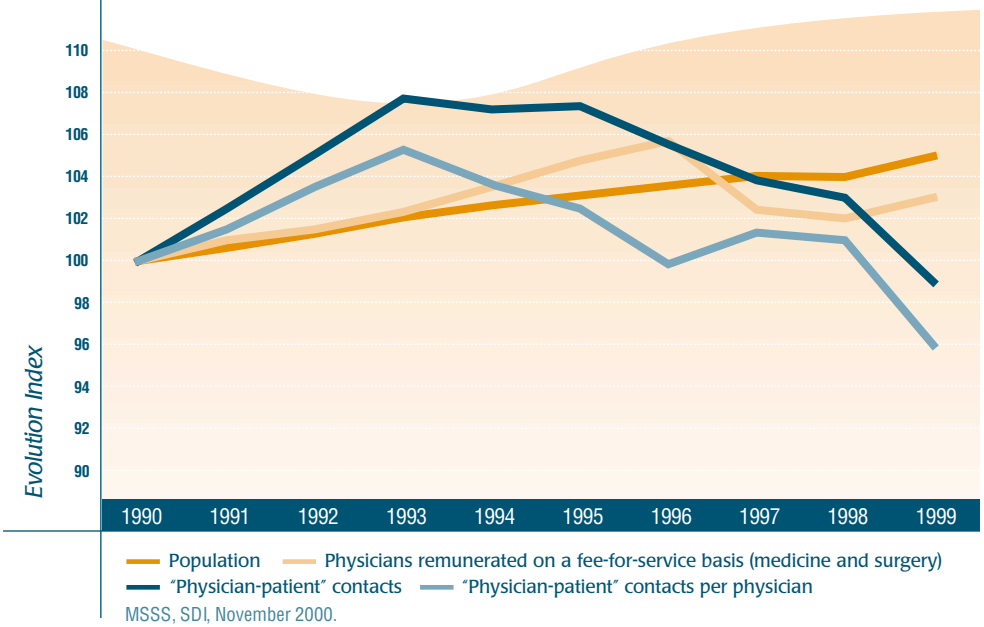
En 1990, there were 46.4 million “physician-patient” contacts for the entire population. Three years later, this figure had surpassed the threshold of 50 million contacts. However, it then decreased and by 1999, the number of contacts had fallen to 46 million, largely due to the elimination of a significant number of consultations.

In fact, before 1997, the growth curve of the number of “physician-patient” contacts was higher than the population growth curve, as was that of the number of physicians remunerated on a fee-for-service basis in medicine and surgery. Since then, the situation has reversed itself. The “number of contacts per physician” ratio has tended to decrease since 1993 and, as of 1995, it has remained well below the population growth curve.

Figure 39

Comparative Change in the Number

of "Physician-Patient" Contacts, for the Entire Québec Population, *1990 to 1999*

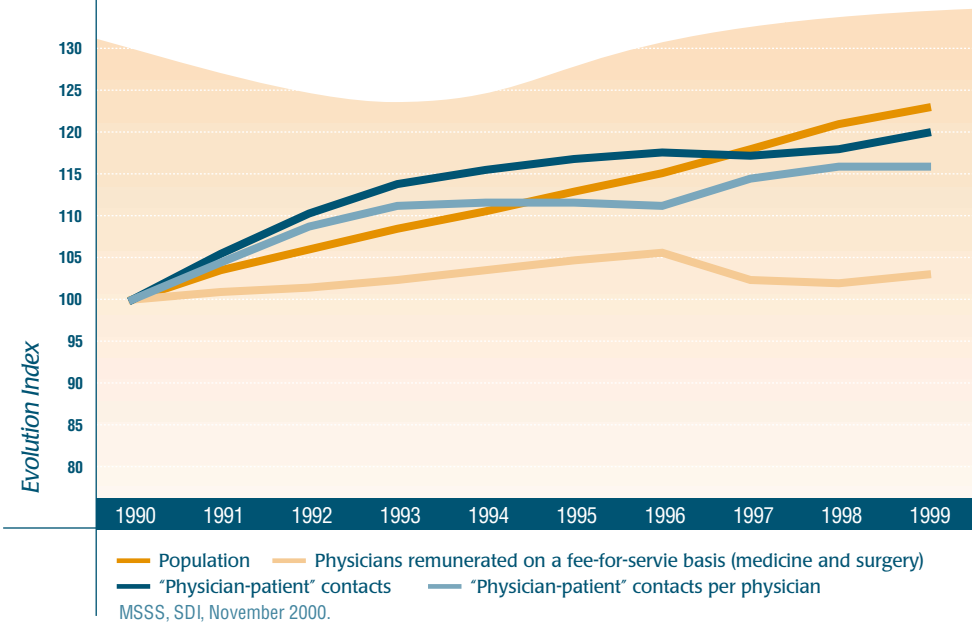


MSSS, SDI, November 2000.

Figure 40

Comparative Change in the Number

of "Physician-Patient" Contacts, for the Population Aged 65 and Over, Québec, *1990 to 1999*



MSSS, SDI, November 2000.

Examination of the same data for only the category of users aged 65 and older reveals a growth in the number of "physician-patient" contacts until 1997, that is, an increase of 18% since 1990, followed by stagnation in 1998 and a slight resurge in 1999, when the number of contacts was slightly less than 12.3 million. In 1990, 22% of all "physician-patient" contacts involved persons aged 65 and over; in 1999, the proportion had almost reached 27%.

Although the number of "physician-patient" contacts per physician, at around 3,600, has hardly changed for the population as a whole, the situation is different for the category of persons aged 65 and older. For this population segment, the number of "physician-patient" contacts per physician increased from 803 in 1990 to 932 in 1999, an increase of 16%.

Table 18

Number, Cost and Average Cost of Medical Services Covered

by Québec Health Insurance, All Methods of Remuneration Combined, *1990 to 1999*

Indicator	90	91	92	93	94	95	96	97	98	99
Number of services										
	80,625,182	82,381,538	84,840,843	86,681,156	82,654,116	83,018,559	81,964,765	81,108,695	81,276,106	81,135,289
Evolution index	100	102	105	108	103	103	102	101	101	101
Annual variation (%)		2.2	3.0	2.2	-4.6	0.4	-1.3	-1.0	0.2	-0.2
Number per participant	10.5	10.5	10.8	10.8	10.2	10.1	10.1	9.9	9.8	9.6
Cost of services										
($)	1,717,621,824	1,841,232,561	1,934,091,547	2,027,674,369	2,072,858,872	2,110,894,451	2,102,639,544	2,096,794,798	2,100,843,313	2,221,871,492
Evolution index	100	107	113	118	121	123	122	122	122	129
Annual variation (%)		7.2	5.0	4.8	2.2	1.8	-0.4	-0.3	0.2	5.8
Cost per participant	243.84	257.04	268.76	278.26	284.86	287.27	287.30	287.55	287.59	299.21
Average cost of services										
($)	21.30	22.35	22.80	23.39	25.08	25.43	25.65	25.85	25.85	27.38
Evolution index	100	105	107	110	118	119	120	121	121	129
Annual variation (%)		4.9	2.0	2.6	7.2	1.4	0.9	0.8	0.0	5.9

MSSS, SDI, November 2000.

Dental services

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

The Oral Surgery Program, introduced on November 1, 1970, was the first and oldest of these programs to be established. It is intended for all Québec residents. The services insured include examinations, consultations, X-rays, anesthesia, emergency opening of the pulp chamber and oral surgery procedures (except teeth or 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 aged under 8. 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 aged under 10. 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: 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, which were 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, 4.6 million insured dental services were provided by professionals paid by the RAMQ; in 1999, there were 2.6 million, or 43% less. This figure decreased significantly at three points – by 15% in 1992, by 12% in 1993 and, most recently, by 30% in 1997. These decreases were due to measures aimed at limiting the program's coverage.

At the beginning of the period observed, the average cost per service was $24.10; at the end of the period, it had reached $31.75, an increase of 32%.

If the figures are broken down according to category of eligible persons, an increase of 44% in the average cost per service for children can be observed, from $22.03 in 1990 to $31.63 in 1999, while the average cost per participating child fluctuated from $81.53 in 1990, to $102.18 in 1993, and then dropped back to $88.16 in 1999.

As regards oral surgery, the average cost per service for eligible persons as a whole increased from $66.01 in 1990 to $83.01 in 1999, an increase of 26%. During the same period, the average cost per participating person increased by 17%, reaching $132.90 in 1999.

Finally, the average cost per dental service provided to employment assistance recipients has fluctuated a number of times since 1990. It was $31.48 at the beginning of the period, grew to $32.98 in 1992, then decreased to $31.29 in 1995 and to $29.84 in 1999. The average cost per EAR participant increased to 12% between 1990 and 1993, that is, from $209.13 to $235.16. It subsequently decreased to $186.04 in 1999.

Table 19

Number, Cost and Average Cost of Dental Services Covered

by Québec Health Insurance, All Programs Combined,
1990 to 1999

Indicator	90	91	92	93	94	95	96	97	98	99
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
Evolution index	100	104	89	78	82	84	85	60	60	57
Annual variation (%)		4.3	-14.7	-12.0	4.3	3.3	0.4	-29.7	0.1	-4.3
Cost of services										
($)	110,393,087	115,267,206	114,109,777	117,184,579	120,056,790	123,876,529	125,314,698	84,769,069	86,174,832	82,962,394
Evolution index	100	104	103	106	109	112	114	77	78	75
Annual variation (%)		4.4	-1.0	2.7	2.5	3.2	1.2	-32.4	1.7	-3.7
Average cost of services										
($)	24.10	24.14	28.02	32.68	32.09	32.07	32.30	31.08	31.56	31.75
Evolution index	100	100	116	136	133	133	134	129	131	132
Annual variation (%)		0.1	16.1	16.7	-1.8	-0.1	0.7	-3.8	1.5	0.6

MSSS, SDI, November 2000.

Optometric services

The Optometric Services Program was also introduced on November 1, 1970. Prior to May 15, 1992 all Québec residents were eligible. Now, only persons under 18 years of age or 65 years of age and over are eligible. There have 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.

In 1990, 3.6 million insured optometric services were recorded; in 1999, this figure was 1.7 million, or 54% less. Due to the reduction in the program's coverage, the number of optometric services decreased by 13% in 1992, 54% in 1993 and 22% in 1994.

From 1990 to 1999, the average cost per service increased from $14.74 to $16.11, an increase of 11%. On the other hand, the average cost per participant, following 5% growth in the first two years, decreased over the entire period observed, from $34.23 in 1990 to $31.64 in 1999.

Table 20

Number, Cost and Average Cost of Optometric Services Covered

by Québec Health Insurance, All Programs Combined,
1990 to 1999

Indicator	90	91	92	93	94	95	96	97	98	99
Number of services										
	3,628,702	3,770,477	3,267,343	2,005,836	1,571,674	1,596,715	1,637,732	1,585,543	1,610,955	1,666,250
Evolution index	100	104	90	55	43	44	45	44	44	46
Annual variation (%)		3.9	-13.3	-38.6	-21.6	1.6	2.6	-3.2	1.6	3.4
Cost of services										
($)	53,499,766	57,396,121	48,790,933	30,943,869	24,640,785	25,047,402	25,784,417	25,563,812	26,077,011	26,851,140
Evolution index	100	107	91	58	46	47	48	48	49	50
Annual variation (%)		7.3	-15.0	-36.6	-20.4	1.7	2.9	-0.9	2.0	3.0
Average cost of services										
($)	14.74	15.22	14.93	15.43	15.68	15.69	15.74	16.12	16.19	16.11
Evolution index	100	103	101	105	106	106	107	109	110	109
Annual variation (%)		3.2	-1.9	3.3	1.6	0.1	0.4	2.4	0.4	-0.4
Average cost per participant										
($)	34.23	35.78	35.77	34.14	33.43	33.51	33.63	32.43	31.62	31.64
Evolution index	100	105	104	100	98	98	98	95	92	92
Annual variation (%)		4.5	0.0	-4.6	-2.1	0.2	0.4	-3.6	-2.5	0.1

MSSS, SDI, November 2000.

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 and over.

On January 1, 1997, the prescription drug insurance plan came into force in conformity with the Act respecting prescription drug insurance, which was adopted on June 20, 1996. Certain provisions of the Act had nevertheless been implemented on August 1, 1996.

The purpose of the 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 may consist of a deductible amount and a coinsurance payment and has a maximum, which varies according to the clientele insured.

In concrete terms, the RAMQ insures persons who are not members of a group insurance contract, employment assistance recipients and certain other holders of a valid claim booklet, as well as persons aged 65 and over. Children aged 0 to 17 as well persons aged 18 to 25 who are spouseless and who attend an educational institution on a full-time basis are also insured.

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, since September 1999, a midwife.

In 1990, the program covered 28.7 drug prescriptions; in 1999, this figure reached 54.8 million, that is, an exponential growth of 91%.

The average cost of a prescription was $17.46 in 1990 and $27.33 in 1999, which represented an increase of 57%.

When each of the three clienteles are examined separately, it can be seen that during the period of observation, the number of prescriptions for employment assistance recipients increased by 50%. During this time, the average cost of these prescriptions increased from $17.59 to $29.09, that is an increase of 65%. In 1990, 75% of the eligible persons participated in the program. This participation rate increased to over 80% by 1995. Since then, there has been a net decrease, and by 1999 the participation rate was slightly more than two-thirds. However, the source of this downward trend is largely due to the fact that since 1997, the number of participants are counted in terms of "full-time equivalents" (FTEs). The average net cost (excluding deductibles and coinsurance) per participant increased from $292.02 in 1990 to $633.39 in 1999, an increase of 136%. On the other hand, it should be noted that the bulk of this increase occurred in the last three years of the period observed, that is, 13.5% in 1997, 26% in 1998 and 27% in 1999.

The number of prescriptions for persons aged 65 and over increased from 21.7 million in 1990 to 31.6 million in 1999, an increase of 46%. The average cost per prescription grew by 47% during the same period, from $17.85 to $26.26. There was an upward trend in participation in the program until 1996, that is, from 86.7% in 1990 to 89.4% in 1996. On the other hand, during the last three years, the participation rates have barely been above 80%. Intergroup transfers of clientele and methodological changes, such as the use of FTE to count participants, largely explain the breaks in the trends observed. Finally, the average net cost per participant increased from $592.93 in 1990 to $832.19 in 1999, an increase of 40%.

Members of the new prescription drug insurance plan obtained 9.5 million prescriptions in 1997, and 12.7 million in 1999, an increase of 33%. The average cost per prescription increased from $25.12 to $28.57, a 14% increase. A slight increase in the rate of participation in the program was also noted. It went from 59.3% in 1997 to 60.2% in 1999. On the other hand, the average net cost per participant increased from $199.51 to $274.07, that is, an increase of 37% in three years. The latter increase, like the one observed for EARs, was essentially due to changes made in the financial contribution maximums for each program.

Table 21

Number, Cost and Average Cost of Pharmaceutical Services Covered

by Québec Prescription Drug Insurance, All Programs Combined, *1990 to 1999.*

Indicator	90	91	92	93	94	95	96	97	98	99
Number of prescriptions										
	28,664,833	31,174,942	31,288,044	31,254,906	33,032,486	35,163,799	36,482,816	45,318,802	49,730,814	54,816,791
Evolution index	100	109	109	109	115	123	127	158	173	191
Annual variation (%)		8.8	0.4	-0.1	5.7	6.5	3.8	24.2	9.7	10.2
Gross cost of prescriptions										
($)	500,419,190	579,583,509	639,534,242	689,530,169	768,200,026	841,024,660	864,941,339	1,119,414,244	1,291,827,580	1,498,363,380
Evolution index	100	116	128	138	154	168	173	224	258	299
Annual variation (%)		15.8	10.3	7.8	11.4	9.5	2.8	29.4	15.4	16.0
Average cost of prescriptions[1]										
($)	17.46	18.59	20.44	22.06	23.26	23.92	23.71	24.70	25.98	27.33
Evolution index	100	106	117	126	133	137	136	141	149	157
Annual variation (%)		6.5	9.9	7.9	5.4	2.8	-0.9	4.2	5.2	5.2
Net cost of prescriptions[2]										
($)	509,824,809	597,179,516	648,861,586	690,102,334	732,513,213	803,365,525	769,148,347	832,497,348	989,471,823	1,170,743,227
Evolution index	100	117	127	135	144	158	151	163	194	230
Annual variation (%)		17.1	8.7	6.4	6.1	9.7	-4.3	8.2	18.9	18.3

1. Gross cost divided by number of prescriptions.

2. Gross cost less the deductible, coinsurance and $2 contribution.

MSSS, SDI, November 2000.

Table 22

Volume and Cost of Medications and Pharmaceutical Services Covered

by Québec Prescription Drug Insurance, by Group of Insured Persons,
1990 to 1999

Indicator	90	91	92	93	94	95	96	97	98	99
Group of insured persons										
Employment insurance 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	10,458,139
Evolution index	100	109	120	125	133	141	139	132	140	150
Gross cost of prescriptions ($)	122,355,138	143,801,392	172,655,242	188,242,484	198,758,437	217,551,982	217,036,015	231,287,646	264,572,406	304,264,636
Evolution index	100	118	141	154	162	178	177	189	216	249
Average gross cost per prescription ($)	17.59	18.94	20.66	21.60	21.47	22.20	22.38	25.13	27.20	29.09
Deductible and coinsurance							10,932,094	34,321,168	31,537,525	27,575,706
Net cost of prescriptions ($)	122,355,138	143,801,392	172,655,242	188,242,484	198,758,437	217,551,982	206,103,921	196,966,478	233,034,881	276,688,930
Number of participants	418,994	463,233	505,454	551,195	582,652	606,735	591,917	498,328	467,292	436,837
Evolution index	100	111	121	132	139	145	141	119	112	104
Net average cost per participant ($)	292.02	310.43	341.58	341.52	341.13	358.56	348.20	395.25	498.69	633.39
Evolution index	100	106	117	117	117	123	119	135	171	217
Persons aged 65 and over										
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	31,646,098
Evolution index	100	109	106	104	110	117	123	122	132	146
Gross cost of prescriptions ($)	387,469,671	453,378,124	476,206,344	501,859,850	569,247,003	623,308,515	647,758,630	648,247,693	724,239,232	830,890,866
Evolution index	100	117	123	130	147	161	167	167	187	214
Average gross cost per prescription ($)	17.85	19.22	20.77	22.27	23.94	24.58	24.18	24.40	25.20	26.26
Deductible, $2 contribution and coinsurance					35,492,227	37,494,972	84,714,204	177,264,836	185,609,166	202,456,763
Net cost of prescriptions ($)	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	628,434,103
Number of participants	653,481	673,953	685,564	710,250	734,684	757,526	777,940	728,960	739,221	755,159
Evolution index	100	103	105	109	112	116	119	112	113	116
Net average cost per participant ($)	592.93	672.71	694.62	706.60	726.51	773.32	723.76	646.10	728.65	832.19
Evolution index	100	113	117	119	123	130	122	109	123	140
Prescription drug insurance plan members										
Number of prescriptions								9,548,024	11,266,119	12,712,554
Gross cost of prescriptions ($)								239,878,905	303,015,942	363,207,878
Average gross cost per prescription ($)								25.12	26.90	28.57
Deductible and coinsurance ($)								75,330,892	85,209,066	97,587,684
Net cost of prescriptions ($)								164,548,013	217,806,876	265,620,194
Number of plan members								1,391,941	1,510,485	1,609,848
Number of participants								824,743	907,325	969,182
Average net cost per participant ($)								199.51	240.05	274.07

MSSS, SDI, November 2000.

Technical aids

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

- Devices that Compensate for Physical Disabilities Program (prosthesis, orthopedic equipment, locomotor assist, posture assist, and other equipment);
- External Breastforms Program;
- Hearing Devices Program;
- Ostomy Appliances Program;
- Visual Devices Program;
- Ocular Prostheses Program.

The Devices that Compensate for Physical Disabilities Program was introduced on July 1, 1975. It is intended for all Québec residents who have a motor disability. The program has undergone some changes, for example the introduction of the notion of negligence and the withdrawal of the preventive adjustment service as well as the amount allocated for this purpose. In addition, since November 12, 1998, the RAMQ has been given responsibility for certain appliances and the payment of certain services that were previously the responsibility of the OPHQ.

In 1999, 53,656 people took advantage of this program, or 21% more than in 1990. The cost per beneficiary increased by 20%, from $773.04 in 1990 to $930.85 in 1994, and then decreased to $ 849.52 in 1999.

The External Breastforms Program was introduced on January 1, 1978. It is intended for women who have undergone a total or radical mastectomy. Since November 1, 1991, women 14 years of age and over who have a total absence of breast formation (aplasia) are also eligible for the program. Since March 1, 1993, employment assistance recipients who are eligible for a last resort program have been entitled to a supplement for costs in excess of the established fixed amount. And finally, as of October 9, 1996, the $200 annual payment per breast to cover the costs related to the purchase of an external breastform was reduced to a $200 bi-annual payment.

All these changes, to both the coverage and terms of the program, are reflected in the change in the number of beneficiaries and the cost per beneficiary. Thus, the number of beneficiaries increased from 2,280 in 1990 to 4,192 in 1999, but along the way, this figure jumped by 4,577 in 1993, fell by 4,734 in 1997, increased again by 5,835 in 1998 and then fell again by 4,653 in 1999. The cost per beneficiary went from $53.18 in 1990 to a high of $364.02 in 1993, finally falling to $211.05 in 1999.

The hearing devices program is intended for all persons who have a degree of hearing impairment. It was introduced on August 22, 1979 and, since then, has undergone significant changes. On July 29, 1993, it was transferred from the OPHQ to the RAMQ. In addition, on May 22, 1997, the eligibility criteria were made more restrictive. For example, the repair of devices is no longer covered for adults.

In 1990, there were 8,790 beneficiaries of this program. This number grew until 1996 and even tripled between 1992 and 1993. Following changes to the program, this figure decreased by 38% in 1997 and by 60% in 1998, when there were 18,858 beneficiaries. In 1999, there were 23,143 beneficiaries.

The average cost per beneficiary was $386.85 in 1990. It reached $475.17 in 1992 and then decreased to $254.31 in 1997. On the other hand, it doubled in 1998, reaching $502.24, and in 1999, it reached $532.96.

The Ostomy Appliances Program was introduced on April 1, 1981. All Québec residents who have undergone a permanent colostomy, ileostomy or urostomy are eligible for the program.

There were 9,000 beneficiaries of the program in 1999, a 34% increase over 1990. The average cost per beneficiary doubled from $324.08 to $637.24.

The Visual Devices Program was introduced on November 30, 1977. Since December 12, 1996, it has also included the OPHQ and MEQ visual devices programs. The program is intended for all Québec residents who have a visual impairment and are thus unable to read, write or move about in unfamiliar surroundings.

The number of beneficiaries of this program has increased considerably during the period observed, from 2,674 in 1990 to 6,631 in 1999. On the other hand, the average cost per beneficiary reached a high of $916.58 in 1993 and subsequently decreased. By 1999, it had dropped to $462.99.

The Ocular Prostheses Program was introduced on April 1, 1981. At the time, it was intended for persons who had undergone enucleation or evisceration or who had a conjunctival flap. Since November 1, 1991, persons who have an atrophied eye without useful vision or who have congenital anophthalmia or microphthalmia or who require an eyeball for a maxillofacial prosthesis after exenteration are also eligible.

During the period observed, the number of beneficiaries of this program remained relatively stable, increasing from 1,893 beneficiaries in 1990 to 1,963 in 1999, a very small increase of slightly less than 4%. On the other hand, the average cost per beneficiary more than doubled in 1993 following the addition of new beneficiaries requiring very expensive services. Thus, in 1993, the average cost per beneficiary was $208.72, compared with $62.17 in 1990. In 1999, it was $181.56.

Overall, in 1999, the six technical aid programs examined included more than 280,000 beneficiaries at an average cost per beneficiary of $241.61. In 1990, there were slightly less than 249,000 beneficiaries and the average cost per beneficiary was $167.27.

Table 23

Number, Cost and Average Cost of Technical Aid Services Covered by Québec Health Insurance, All Programs Combined, *1990 to 1999*

Indicator	90	91	92	93	94	95	96	97	98	99
Number of services										
	248,882	270,793	304,903	442,637	568,879	581,515	433,769	297,654	253,647	281,384
Evolution index	100	109	123	178	229	234	174	120	102	113
Annual variation (%)		8.8	12.6	45.2	28.5	2.2	-25.4	-31.4	-14.8	10.9
Cost of services										
($)	41,629,258	44,509,621	54,797,434	72,942,970	78,627,897	76,429,499	76,667,829	63,472,324	66,315,803	67,986,156
Evolution index	100	107	132	175	189	184	184	152	159	163
Annual variation (%)		6.9	23.1	33.1	7.8	-2.8	0.3	-17.2	4.5	2.5
Average cost of services										
($)	167.27	164.37	179.72	164.79	138.22	131.43	176.75	213.24	261.45	241.61
Evolution index	100	98	107	99	83	79	106	127	156	144
Annual variation (%)		-1.7	9.3	-8.3	-16.1	-4.9	34.5	20.6	22.6	-7.6

MSSS, SDI, November 2000.

Table 24

Average Cost Per Beneficiary of Technical Aid Services Covered

by Québec Health Insurance, by Program,
1990 to 1999

Program / Indicator	90	91	92	93	94	95	96	97	98	99
Prosthesis, orthopedic equipment, locomotor assist, posture assist, and other equipment										
Number of beneficiaries	44,198	47,436	51,179	52,651	46,625	47,726	49,618	50,858	53,476	53,656
Cost of program ($)	34,167,027	35,856,810	41,562,714	46,048,282	43,400,771	43,205,764	45,848,157	43,126,531	46,008,793	45,581,821
Average cost per beneficiary ($)	773.04	755.90	812.10	874.59	930.85	905.29	924.02	847.98	860.36	849.52
External breastforms										
Number of beneficiaries	2,280	2,069	2,834	7,411	8,579	9,647	7,744	3,010	8,845	4,192
Cost of program ($)	121,242	123,455	637,185	2,697,765	2,297,298	2,585,209	1,862,845	688,974	1,895,186	884,723
Average cost per beneficiary ($)	53.18	59.67	224.84	364.02	267.78	267.98	240.55	228.90	214.27	211.05
Hearing devices										
Number of beneficiaries	8,790	9,680	10,184	34,128	58,164	66,279	71,982	44,705	18,058	23,143
Cost of program ($)	3,400,442	4,036,679	4,839,157	14,579,663	22,673,083	19,650,032	19,317,056	11,368,790	9,069,510	12,334,377
Average cost per beneficiary ($)	386.85	417.01	475.17	427.21	389.81	296.47	268.36	254.31	502.24	532.96
Ostomy appliances										
Number of beneficiaries	6,727	6,798	7,376	8,138	8,202	8,436	7,922	8,639	8,927	9,037
Cost of program ($)	2,180,055	2,418,663	4,756,517	5,454,368	5,239,182	5,756,593	5,036,972	5,505,199	6,058,442	5,758,724
Average cost per beneficiary ($)	324.08	355.79	644.86	670.23	638.77	682.38	635.82	637.25	678.66	637.24
Visual devices										
Number of beneficiaries	2,674	3,053	3,293	4,136	5,098	5,721	6,062	5,833	6,241	6,631
Cost of program ($)	1,642,807	1,922,024	2,611,338	3,790,987	4,621,043	4,845,601	4,230,894	2,446,826	2,943,362	3,070,104
Average cost per beneficiary ($)	614.36	629.55	793.00	916.58	906.44	846.98	697.94	419.48	471.62	462.99
Ocular prostheses										
Number of beneficiaries	1,893	1,790	1,871	1,919	1,957	1,999	2,019	1,980	1,931	1,963
Cost of program ($)	117,685	151,990	390,523	371,905	396,520	386,300	371,905	336,004	340,510	356,406
Average cost per beneficiary ($)	62.17	84.91	208.72	193.80	202.62	193.25	184.20	169.70	176.34	181.56

MSSS, SDI, November 2000.

YOUTH PROTECTION SERVICES

Within the framework of the Youth Protection Act, youth centres (centres jeunesse, or the amalgamation of CPEJs, CR JDAs and 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 which 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 security or development of the child is in danger. If this, in fact, is the case, a decision must finally be made to apply the appropriate protection measures.

In 1999-2000, approximately half of the reports received by youth centres, within the framework of the Youth Protection Act, were acted on. Among these, nearly 91% were assessed. In more than 46% of the cases, it was concluded that the security or development of the child was in danger, that is, an average of one case out of five reports processed.

During the same year, the average waiting period for an assessment was 17.5 days, or 32.8 days, if only waiting periods of more than four days are considered. Following the assessment, some 8,800 new situations were taken in charge, that is, an average of one per 5.8 reports processed. Among these, more than 48% were directed to the courts. The average length of time that a situation remained taken in charge was 24.6 months.

In total, it is estimated that approximately 16,000 children between the ages of 0 and 17 years were taken in charge at one time or another during the year within the framework of the Youth Protection Act. This is equivalent to 1% of all children aged from 0 to 17 years in Québec. Considering the turnover in clientele, the total number of children taken in charge during a given year can be estimated at 24,000.

SOME FIGURES

The youth centres receive approximately 50,000 reports annually, that is a rate of 30 cases per 1,000 children aged from 0 to 17 years. This rate has barely changed since 1993-1994.

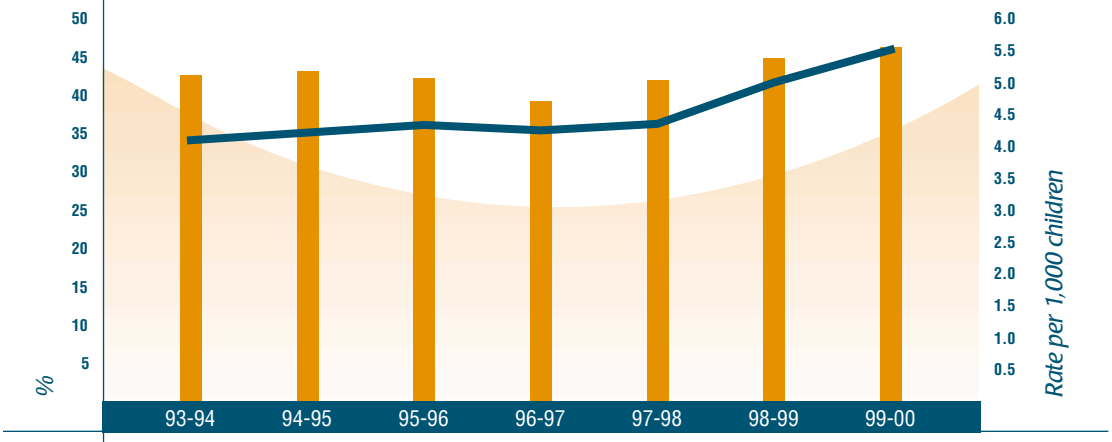
In 1999-2000, the youth centres acted on slightly less than 25,500 situations that were brought to their attention, that is, on 50% of reports processed. In 1993-1994, 46.5% were acted on, that is, slightly less than 24,000. Of this number, 20,800 reported cases were assessed in 1993-1994, that is, 87.5% of the reports acted on. In 1999-2000, 23,000 assessments were carried out, or nearly 91% of the reports acted on.

At the beginning of the period observed, 42.6% of the assessments concluded that the security or development of the young person was in danger; by the end of the period, the proportion had reached more than 46%. Thus, in 1993-1994, for every six reports acted on, there was one case in which the security or development of the young person was in danger (SDD). In 1999-2000, the ratio was one one to five.

Figure 41

Proportion of Total Assessments Carried Out

in Which the Security or Development of the Child is in Danger, and the Number of New Situations Taken in Charge per 1,000 Young Persons Aged 0 to 17, Québec, *1993-1994 to 1999-2000*



MSSS, SDI, January 2001.

On average, the waiting period for an assessment varies between 18 and 21 days, depending on the year. In 1999-2000, it was 17.5 days. In 1993-1994, 55% of the waiting periods were longer than four days; in 1999-2000, the proportion was 53%. If only the waiting periods longer than four days are considered, the average waiting period varies between 33 and 38 days, depending on the year; in 1999-2000, it was 32.8 days.

In 1993-1994, there were 7,000 new situations taken in charge, or an incidence rate of four cases per 1,000 children aged from 0 to 17. Seven years later, there were more than 8,800, or an incidence rate of 5.5 per 1,000. This means that in 1993-1994, there was one new situation taken in charge for every 7.4 reports processed, compared with one new situation taken in charge for every 5.8 reports processed in 1999-2000.

Certain directions are taken in the context of taking a situation in charge. Among these, judicial directions (that is, those that end up before a judge) accounted for 32% of all directions in 1993-94; in 1999-2000, this proportion reached more than 48%. It should be noted that during the time that a child's situation is taken in charge, the direction is reviewed at least once a year, so that by the end fo teh process, the rate of court referrals may easily be even higher.

In total, the average length of time that a child's situation remains taken in charge varies from 23 to 26 months, depending on the year. In 1999-2000, it was 24.6 months.

Table 25

Indicators Related to Reports on Children

Aged 0 to 17 in Need of Protection, Québec,
1993-1994 to 1999-2000

Indicator	93-94	94-95	95-96	96-97	97-98	98-99	99-00
Reports processed							
Number	51,071	51,045	49,388	47,620	49,500	49,191	51,310
Rate per 1,000 children aged 0 to 17	30.2	30.2	29.3	28.4	29.8	30.0	31.8
Reports acted on							
Number	23,765	24,901	24,553	23,786	24,249	24,948	25,451
% of reports processed	46.5	48.8	49.7	49.9	49.0	50.7	49.6
Assessments carried out							
Number	20,798	21,179	21,500	20,155	21,114	22,661	23,047
% SDD	42.6	43.0	42.1	39.2	41.9	44.8	46.1
% SDND	54.6	53.0	54.3	57.4	55.5	52.6	51.5
Waiting period for assessment							
Average waiting period (days)	21.1	18.6	18.1	18.8	20.1	20.1	17.5
Court referrals							
% of total directions	32.0	35.5	40.7	42.7	46.1	47.7	48.2
New situations taken in charge							
Number	6,921	7,123	7,266	7,110	7,219	8,244	8,822
Rate per 1,000 children aged 0 to 17	4.1	4.2	4.3	4.2	4.4	5.0	5.5
% placement	38.6	35.9	34.1	35.4	36.0	33.9	32.5
RPS/NSTC ratio	7.4	7.2	6.8	6.7	6.9	6.0	5.8
Situations no longer taken in charge (terminated)							
Average length (months)	23.6	24.2	25.1	25.8	25.6	24.3	24.6

SDD = Security and development in danger

SDND = Security and development not in danger

RPS = Reports processed

NSTC = New situations taken in charge

MSSS, SDI, January 2001.

REHABILITATION SERVICES

Rehabilitation services are intended for the following groups of persons: persons suffering from alcoholism or other problems of addiction, persons with a physical impairment and persons with a mental impairment.

Two variables are illustrated for each of the groups: the volume of users admitted and registered and their distribution by age group, and the staff – clinical and support staff assigned to care for them.

While the number of users who were admitted has been decreasing since 1996-1997, the number of non-resident outpatient users of services for persons suffering from alcoholism and other problems of addiction has increased constantly since 1990-1991. In 1999-2000, there were 5,000 users admitted to rehabilitation centres and 31,300 registered for outpatient services. The average length of stay for users admitted to services centres was 22 days.

Users are most concentrated in the 25 to 39 year age group, even though their number as a proportion of all users is in decline. Moreover, the highest growth has been observed among those under 18; their number grew by five times between 1990-1991 and 1998-1999, but decreased by 10% in 1999-2000.

The number of staff assigned to these users grew until the mid-1990s and then remained relatively stable at approximately 700 employees until 1998-1999. In 1999-2000, there was an increase in staff of nearly 9%. In 1990-1991, 64% of staff were made up of clinical staff while in 1998-1999, this proportion was 81%. In 1999-2000, the proportion of staff assigned to clinical services is 77%.

Each and every year, some 2,000 users are admitted to rehabilitation centres for persons with a physical impairment. On the other hand, the registrations for outpatient services are increasing dramatically. In 1999-2000 there were 57,000 registrations, as compared with slightly more than 33,000 in 1990-1991. The average length of stay of users admitted to services centres was 48 days.

In 1999-2000, seven out of ten users were aged over 21 and by the mid-1990s, this proportion had increased to more than 78%.

In 1999-2000, some 2,300 employees devoted their work time to this clientele, 68% of whom were clinical staff. While the number of employees assigned to clinical services has increased, support staff experienced the reverse situation, as their numbers have decreased constantly since 1992-1993. However, the situation had stabilized by the end of the period observed.

Currently, there are some 25,200 users of services for persons with a mental impairment. These persons, whose number has been growing since 1990-1991, are being admitted less and less to a centre of services and, instead, being increasingly directed towards outpatient services. Nearly 70% of these persons are aged over 21, and approximately 7% are aged between 18 and 21.

The number of staff who work with this group had decreased since 1993-1994, but increased in both 1998-1999 and 1999-2000. Nearly 80% of this staff work in clinical services. Moreover, there were three times fewer support staff in 1999-2000 than at the beginning of the period observed.

SOME FIGURES

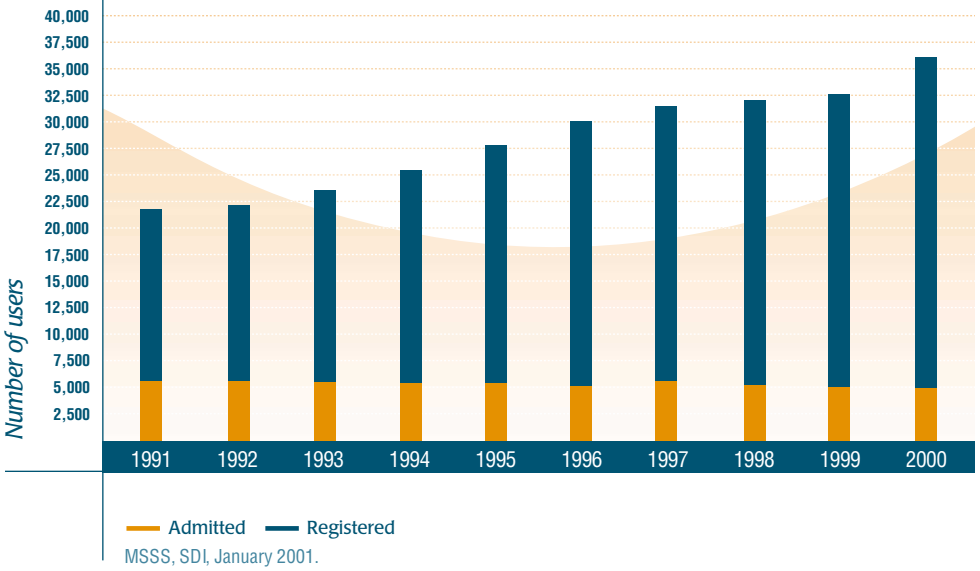
Persons suffering from alcoholism or other addiction problems

In total, the number of users of services intended for persons suffering from alcoholism or other addiction problems is increasing, but this growth is solely due to registered users considering the volume of users who are admitted has decreased (13%) since 1990-1991. Thus, between 1990-1991 and 1999-2000, the number of users who were registered increased from 16,160 to 31,280, or an increase of 94%. During this time, the number of users who were admitted decreased from 5,700 to approximately 4,900.

Figure 42

Total Number of Users Admitted and Registered

in Québec Rehabilitation Centres for Persons Suffering From Alcoholism or Other Addiction Problems,
Situation Observed on March 31, 1991 to 2000

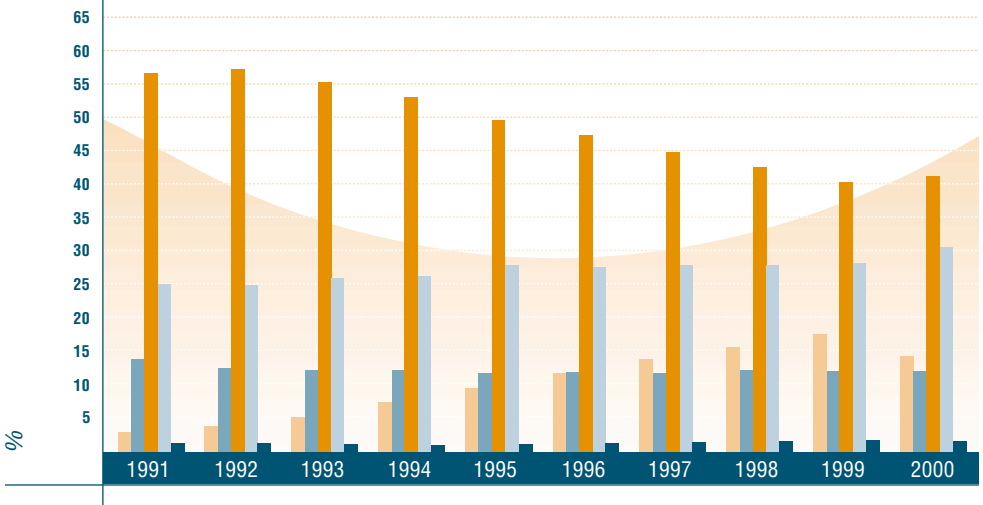


MSSS, SDI, January 2001.

Figure 43

Percentage Distribution of Users Admitted and Registered

in Rehabilitation Centres for Persons Suffering From Alcoholism and Other Addiction Problems, by age group,
situation observed on March 31, 1991 to 2000



MSSS, SDI, January 2001.

On March 31, 1991, there were 444 residential places (residences and group homes) intended for this clientele; in 1999-2000, the number of places had decreased to less than 400. The 4,900 users admitted in 1999-2000 generated slightly more than 90,000 attendance days, for an average stay of slightly more than 18 days.

When the number of admitted and registered users are added together, and distributed according to age group, a decrease in the number of users aged 25 to 39 years can be observed, even though they are still the largest group. They represented more than 57% of the total in 1991-1992, compared with slightly more than 41% of the total in 1999-2000. During the same period, users aged 0 to 17 increased from 3% to 17.6% of the total, that is, six times more than at the beginning of the period. The relative volume for users aged 40 to 64 increased slightly (5 percentage points) while the relative position of users aged 18 to 24 decreased somewhat, and that of users aged 65 and over increased slightly.

The staff assigned to this clientele increased between 1990-1991 and 1994-1995 and, after remaining relatively stable at approximately 700 employees, it increased at the end of the period observed.

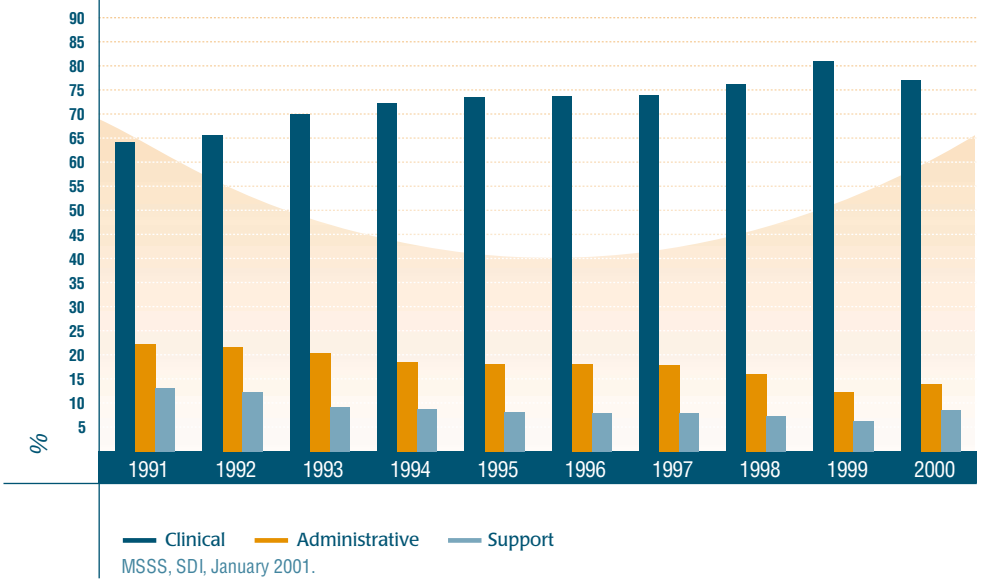
In 1990-1991, 65% of the staff were assigned to clinical services, 22% to administrative services and 13% to support services. In 1999-2000, these proportions were 77.3%, 14.1% and 8.6% respectively.

Figure 44

Percentage Distribution of Staff in Québec Rehabilitation Centres

for Persons Suffering From Alcoholism and Other Addiction Problems, by Category of Staff,

Situation Observed on March 31, 1991 to 2000



MSSS, SDI, January 2001.

Table 26

Indicators Related to Services Provided to Persons Suffering From Alcoholism and Other Addiction Problems, Within Québec's Network of Health and Social Services Institutions,

Situation Observed on March 31, 1991 to 2000

Indicator	91	92	93	94	95	96	97	98	99	00
Residential places										
Number[1]	444	426	450	427	427	457	506	434	459	389
Evolution index	100	96	101	96	96	103	114	98	103	88
Occupancy rate (%)	77.1	79.1	74.9	77.5	75.9	72.6	72.6	72.0	63.5	62.7
Users admitted[2]										
Number[3]	5,667	5,632	5,517	5,441	5,423	5,169	5,696	5,287	5,023	4,916
Evolution index	100	99	97	96	96	91	101	93	89	87
Number per 1,000 persons[4]	0.81	0.80	0.78	0.76	0.75	0.71	0.78	0.72	0.68	0.67
Users registered[5]										
Number[3]	16,160	16,574	18,084	20,031	22,459	25,000	25,896	26,792	27,688	31,281
Evolution index	100	103	112	124	139	155	160	166	171	194
Number per 1,000 persons[4]	2.30	2.35	2.54	2.80	3.12	3.44	3.55	3.67	3.78	4.26
Attendance days of admitted users[2]										
Number	124,973	122,987	123,061	120,760	118,269	121,133	134,070	114,096	106,457	89,090
Evolution index	100	98	98	97	95	97	107	91	85	71
Average stay (days)	22.1	21.8	22.3	22.2	21.8	23.4	23.5	21.6	21.2	18.1
All staff										
Clinical	290	324	407	475	521	507	521	504	582	604
Administrative	101	107	118	121	129	124	126	106	90	110
Support	59	61	54	58	58	54	55	49	46	67
Total	450	492	579	654	708	685	702	659	718	781

1. Including residences (10 places or more) and group homes (9 places or less).
2. Users admitted for one or more days; they stay overnight at the institution.
3. Total number of users who received care during the year.
4. Total number of users who received care during the year as a proportion of the total population.
5. Users registered for less than one day; they do not stay overnight at the institution.

MSSS, SDI, January 2001.

Persons with a physical impairment

On March 31, 1991, there were some 500 inpatient places for persons with a physical impairment; on March 31, 2000, this figure had decreased by 12% to 444.

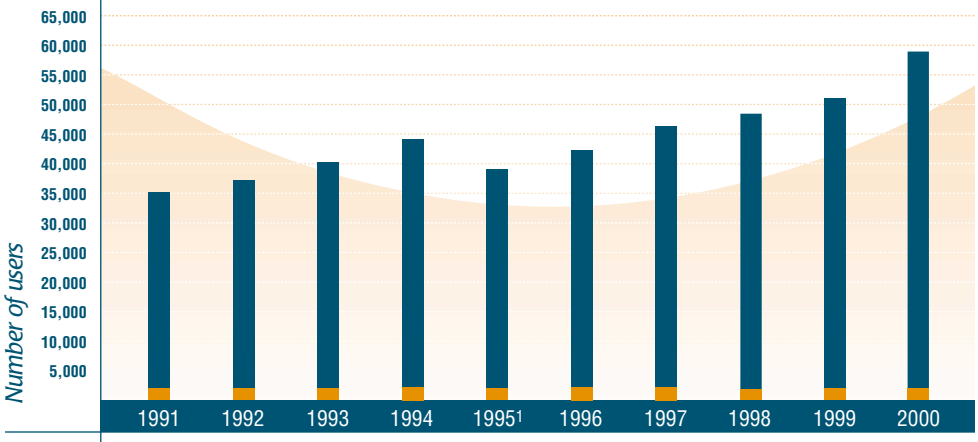
Although until 1995, the number of users admitted, at around 2,000, more or less remained the same, it has since come close to 2,700. The number of registered users has increased considerably since the very beginning of the 1990s, from 33,300 to more than 57,000, or an increase of 71%. In 1990-1991, the users who were admitted generated more than 103,200 attendance days, for an average stay of slightly more than 52 days. In 1999-2000, they generated 120,000 attendance days, for an average stay of approximately 45 days.

In 1999-2000, more than 70% of users were aged over 21; the proportion reached over 78% by the mid-1990s. At the beginning of the period observed, the group of users aged 0 to 4 represented 5.6% of the total, while those aged between 5 to 17 made up 14.8% of the total, while the proportion of users aged 18 to 21 was 3.6%. In 1999-2000, these proportions were 9.2%, 13% and 6.5% respectively. Thus, there was a decrease in the relative proportion of the group of users aged 5 to 17 and an increase in the relative proportion of the two other age groups.

Figure 45

Total Users Admitted and Registered in Québec Rehabilitation Centres

for Persons With a Physical Impairment,
Situation Observed on March 31, 1991 to 2000



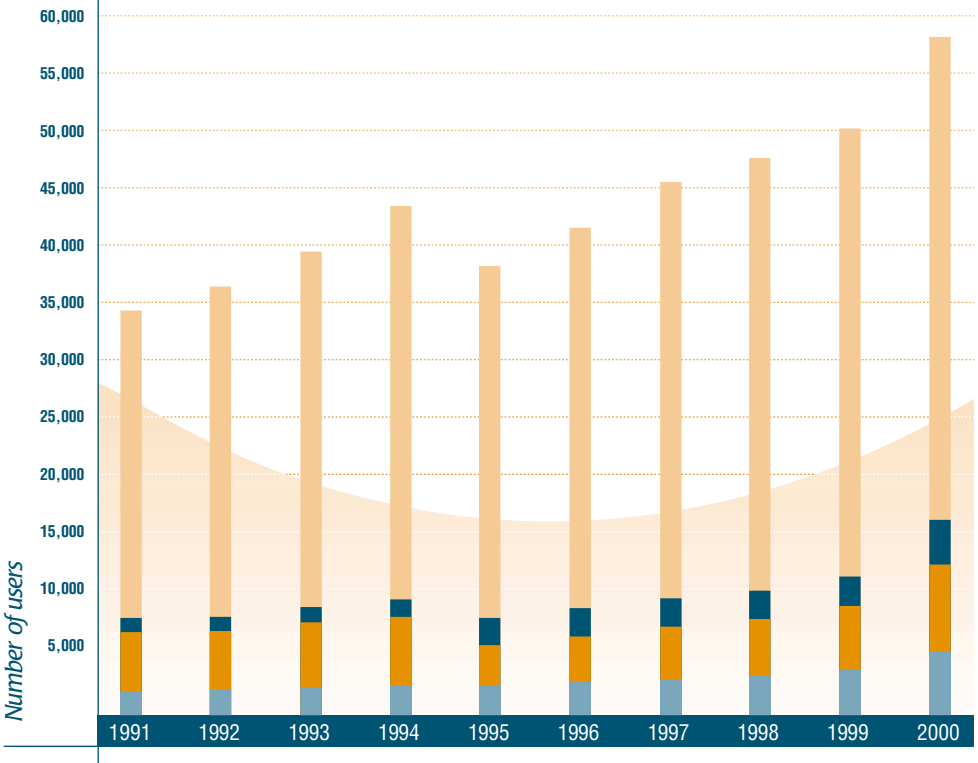
1. Difference due to change in method used to compile data on users.

MSSS, SDI, January 2001.

Figure 46

Distribution of the Number of Users Admitted and Registered

in Québec Rehabilitation Centres for Persons with a Physical Impairment,
by Age Group,
Situation Observed on March 31, 1991 to 2000



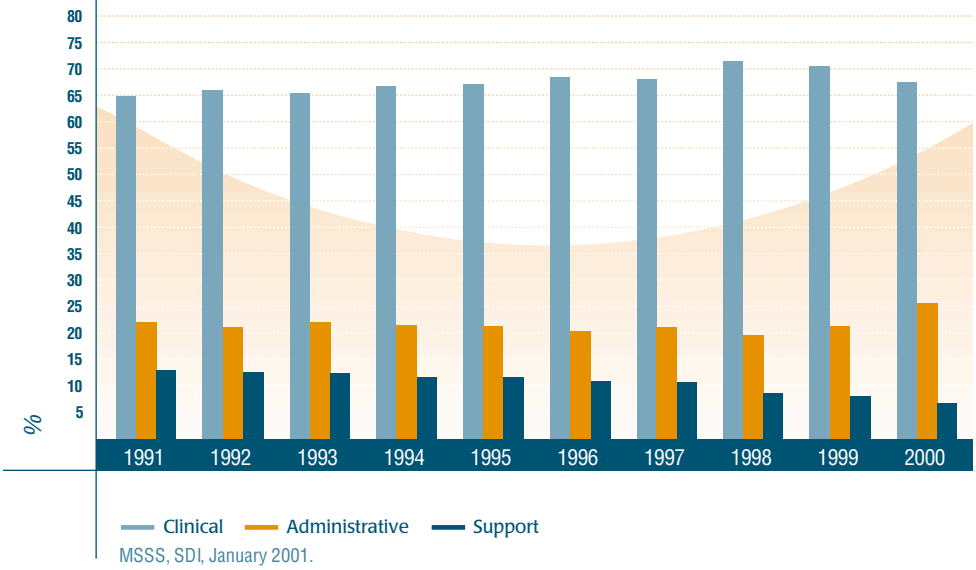
MSSS, SDI, January 2001.

The volume of staff assigned to persons with a physical impairment varied little during the period observed, remaining at around 1,800 or 1,900 employees, except for the last year when it reached nearly 2,300. On the other hand, while there was an upward trend in the volume of clinical and administrative staff, the volume of support staff decreased constantly from 1993 onwards and then stabilized in 1999-2000. In 1990-1991, clinical staff accounted for 65% of total staff, administrative staff made up 22% and support staff accounted for 13%; in 1999-2000, these proportions were 68%, 25% and 7% respectively.

Figure 47

Percentage Distribution of Staff of Rehabilitation Centres

for Persons With a Physical Impairment by Category of Staff,
Situation Observed on March 31, 1991 to 2000



MSSS, SDI, January 2001.

Table 27

Indicators Related to Services Provided to Persons with a Physical Impairment,

Within Québec's Network of Health and Social Services Institutions,

Situation Observed on March 31, 1991 to 2000

Indicator	91	92	93	94	95	96	97	98	99	00
Set-up beds										
Number[1]	504	532	511	453	432	507	540	481	432	444
Evolution index	100	106	101	90	86	101	107	95	86	88
Occupancy rate (%)	56.1	64.6	65.7	64.6	57.5	52.2	45.1	59.6	72.3	74.0
Users admitted[2]										
Number[3]	1,971	2,093	2,022	2,171	2,076	2,697	2,606	2,395	2,588	2,686
Evolution index	100	106	103	110	105	137	132	122	131	136
Number per 1,000 pers.[4]	0.28	0.30	0.28	0.30	0.29	0.37	0.36	0.33	0.35	0.37
Users registered[5]										
Number[3]	33,328	35,291	38,362	42,230	37,114	40,247	44,249	46,662	49,179	57,077
Evolution index	100	106	115	127	111	121	133	140	148	171
Number per 1,000 pers.[4]	4.75	4.99	5.39	5.89	5.15	5.53	6.06	6.37	6.70	7.77
Attendance days of admitted users[2]										
Number	103,233	125,359	122,539	106,848	90,650	96,622	88,983	104,715	113,961	119,945
Evolution index	100	121	119	104	88	94	86	101	110	116
Average stay (days)	52.4	59.9	60.6	49.2	43.7	35.8	34.1	43.7	44.0	44.7
All staff										
Clinical	1,168	1,221	1,290	1,311	1,230	1,262	1,173	1,354	1,338	1,531
Administrative	397	390	433	423	389	376	361	373	403	578
Support	234	234	243	227	211	200	183	166	153	154
Total	1,799	1,845	1,966	1,961	1,830	1,838	1,717	1,893	1,894	2,263

1. Including residences (10 places or more) and group homes (9 places or less).
2. Users admitted for one or more days; they spend the night in the institution.
3. Total number of users who received care during the year.
4. Total number of users who received care during the year as a proportion of total population.
5. Users registered for less than one day; they do not spend the night in the institution.

MSSS, SDI, January 2001.

Persons with a mental impairment

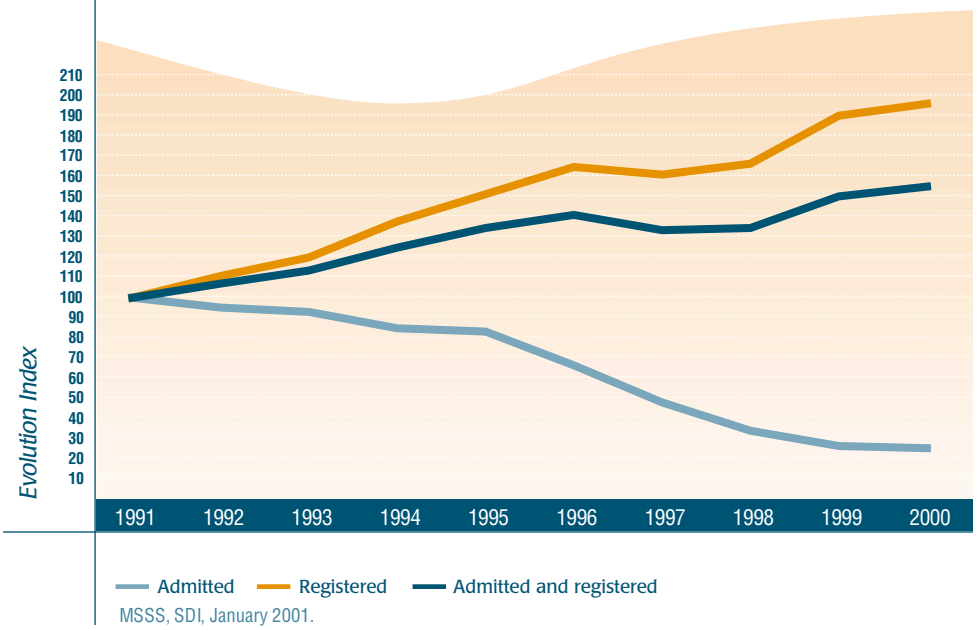
Since 1990-1991, the total number of persons with a mental impairment who receive services has grown steadily, reaching 25,200 in 1999-2000. On the other hand, this increase has been solely generated by registered users whose number almost doubled during the period observed, while the number of users admitted was four times lower.

In fact, in 1990-1991, there were nearly 3,500 inpatient places for every 4,000 users; the latter generated more than 1 million attendance days. In 1999-2000, there were slightly more than 900 inpatient places for slightly less than 1,000 admitted users, generating fewer than 245,000 attendance days. The average stay was slightly less than 250 days.

In 1999-2000, 68% of all users were over 21 years old, while 5.6% were aged from 0 to 4 and 6.7% from 18 to 21. Those aged from 5 to 17 accounted for slightly less than 20% of the total. The distribution according by age group varied little during the period observed.

Figure 48

Change in the Number of Users Admitted and Registered
in Québec Rehabilitation Centres for Persons With a Mental Impairment,
Situation Observed on March 31, 1991 to 2000



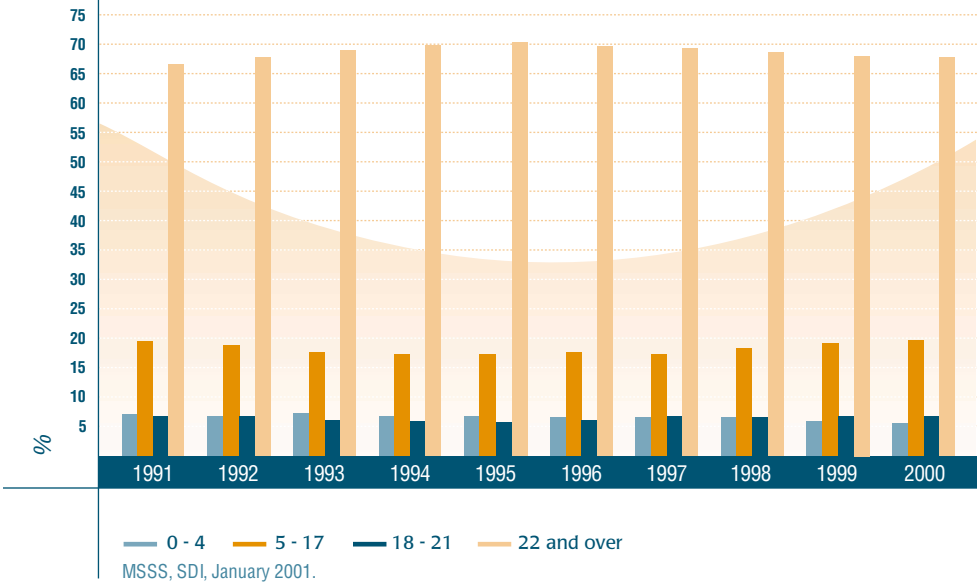
MSSS, SDI, January 2001.

Figure 49

Percentage Distribution of Users Admitted and Registered

in Québec Rehabilitation Centres for Persons With a Mental Impairment, by Age Group,

Situation Observed on March 31, 1991 to 2000

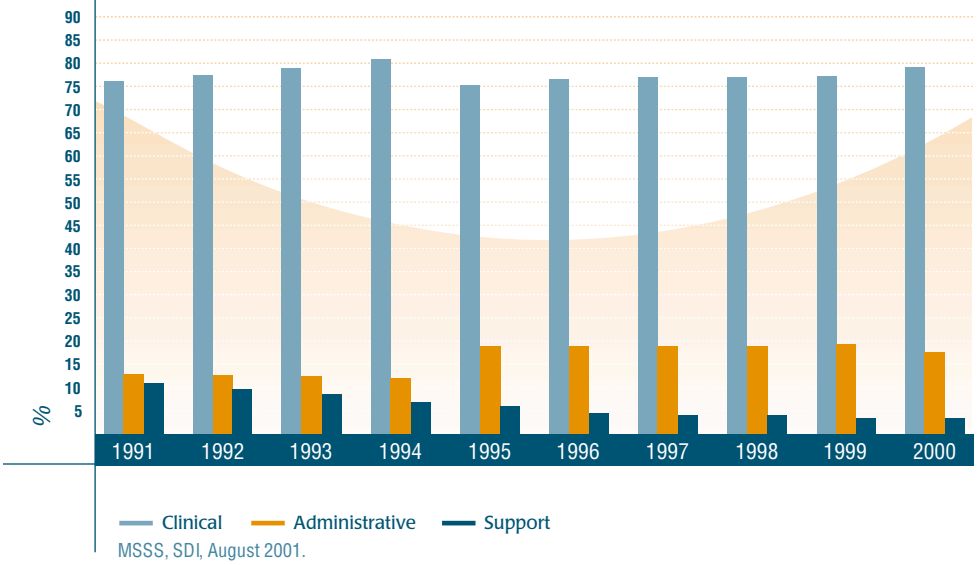


MSSS, SDI, January 2001.

Figure 50

Percentage Distribution of Staff of Québec Rehabilitation Centres

for Persons With a Mental Impairment, by Staff Category,
Situation Observed on March 31, 1991 to 2000



MSSS, SDI, August 2001.

From 1990-1991 to 1993-1994, there was an increase in the staff assigned to persons with a mental impairment, followed by a decrease until 1997-1998. However, during the last two years, there has been a net increase. On the other hand, the number of support staff decreased constantly throughout the period, then stabilized in 1999-2000.

Clinical staff made up three-quarters of total staff each year of the period observed, while administrative staff remained at a constant level of around 19%. However, there were four times fewer support staff at the end of the period compared to the beginning, its relative weight having decreased from 11% to 3%.

Table 28

Indicators Related to Services Provided to Persons With a Mental Impairment,

Within Québec's Network of Health and Social Services Institutions,

Situation Observed on March 31, 1991 to 2000

Indicator	91	92	93	94	95	96	97	98	99	00
Set-up beds										
Number[1]	3,476	3,369	3,220	2,924	2,864	2,062	1,690	1,131	1,010	902
Evolution index	100	97	93	84	82	59	49	33	29	26
Occupancy rate (%)	84.4	86.5	83.1	81.0	71.4	81.1	72.3	80.5	78.0	74.1
Users admitted[2]										
Number[3]	3,952	3,755	3,679	3,339	3,275	2,629	1,889	1,348	958	984
Evolution index	100	95	93	84	83	67	48	34	24	25
Number per 1,000 pers.[4]	0.56	0.53	0.52	0.47	0.45	0.36	0.26	0.18	0.14	0.14
Users registered[5]										
Number[3]	12,330	13,658	14,752	16,985	18,638	20,305	19,804	20,509	23,410	24,195
Evolution index	100	111	120	138	151	165	161	166	190	196
Number per 1,000 pers.[4]	1.76	1.93	2.07	2.37	2.59	2.79	2.71	2.80	3.19	3.29
Attendance days of admitted users[2]										
Number	1,071,181	1,063,157	976,982	864,209	745,994	610,453	445,979	332,282	287,391	243,801
Evolution index	100	99	91	81	70	57	42	31	27	23
Average stay (days)	271.0	283.1	265.6	258.8	227.8	232.2	236.1	246.5	300.0	247.8
All staff										
Clinical	4,456	4,664	5,035	5,501	4,694	4,675	4,438	3,731	4,232	4,555
Administrative	758	768	798	819	1,170	1,158	1,087	917	1,061	1,020
Support	634	580	538	461	361	279	236	191	180	187
Total	5,848	6,012	6,371	6,781	6,225	6,112	5,761	4,839	5,473	5,762

1. Including residences (10 places or more) and group homes (9 places or less).
2. Users admitted for one or more days; they spend the night in the institution.
3. Total number of users who receive care during the year.
4. Total number of users who receive care during the year as proportion of total population.
5. Users registered for less than one day; they do not spend the night in the institution.

MSSS, SDI, January 2001.

RESIDENTIAL AND LONG-TERM CARE SERVICES

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

The context of the 1990s – budget constraints, downsizing, the need to provide services closer to people's living environment – has 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 even though the number of attendance days has decreased, reflecting a significant decrease in average stay.

Even though the distribution by age group of persons accommodated has more or less remained the same, the clientele has become significantly "heavier" since alternative services have drained the "light" clientele. Thus, within the network, those persons who are accommodated require more care and deaths are increasingly frequent, especially among persons aged 75 to 84.

Despite a slight increase in 2000, since 1995 the waiting periods have been decreasing for persons in need of accommodation, resulting in a decrease in the "number of persons waiting to be accommodated/number of persons accommodated" ratio, which suggests that the situation for this clientele is improving.

SOME FIGURES

In June 2000, 14% of persons admitted to residential and long-term care centres were aged 64 or under. Persons aged 75 to 84 formed the largest group (35%), followed by persons aged 85 or over (33%). Persons aged 65 to 74 made up 18% of the total. Since 1995, the distribution of users by age group has been relatively stable.

In March 2000, there were more than 45,700 places listed (including those in residential centres) for residential and long-term care, including 43,300 in June 2000 managed by regional steering committees - admission (COAs), which was a decrease of 9% and 2%, respectively, from 1995. During this time, the number of new persons admitted increased by 22%, and the volume of persons accommodated (those accommodated plus new admissions) increased by 10%. The average waiting period for persons in need of accommodation went from 80 days to less than 58 days, or a reduction of 38%. On the other hand, this waiting period has increased since 1998 when it was 47 days. Since 1995, the average length of stay has decreased constantly, going from 260 to 218 days.

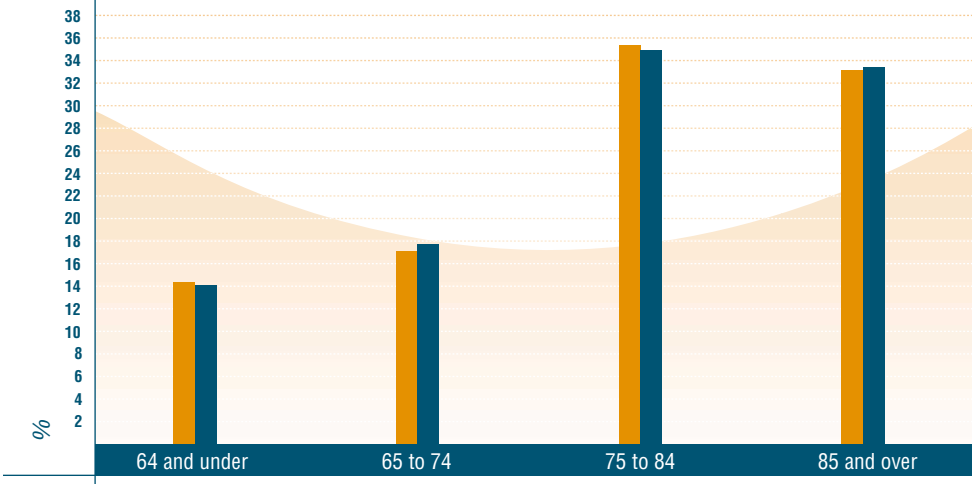
Between 1995 and 1997, the number of persons waiting for accommodation fell by 27% but this figure has since increased slightly. Following an increase between 1996 and 1998, the waiting periods for persons in need of accommodation is now decreasing sharply. It should be noted, however, that this result does not include the waiting periods for those accommodated during the last twelve months of the period observed; the latter were obviously priority cases requiring accommodation with a significant provision of care and within short waiting periods.

On the whole, between 1995 and 1999, the "number of persons waiting to be accommodated/number of new persons accommodated" ratio clearly decreased, suggesting an improvement in the situation for this clientele, despite some decrease in the number of places available in the network of institutions. However, in 2000, the ratio increased slightly.

Figure 51

Percentage Distribution of Persons Benefiting from Residential and Long-term Care Services in Québec's Network

of Health and Social Services Institutions, by Age Group,
1995 and 2000

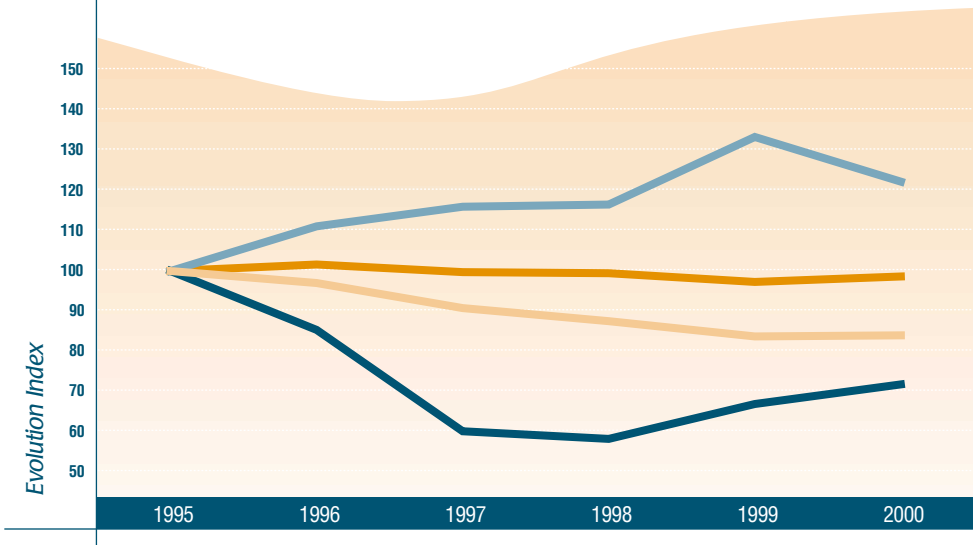


MSSS, SDI, February 2001.

Figure 52

Change in Certain Indicators Related to the Accommodation

of Seniors in Québec,
Situation Observed in September, 1995 to 1999, and in June 2000



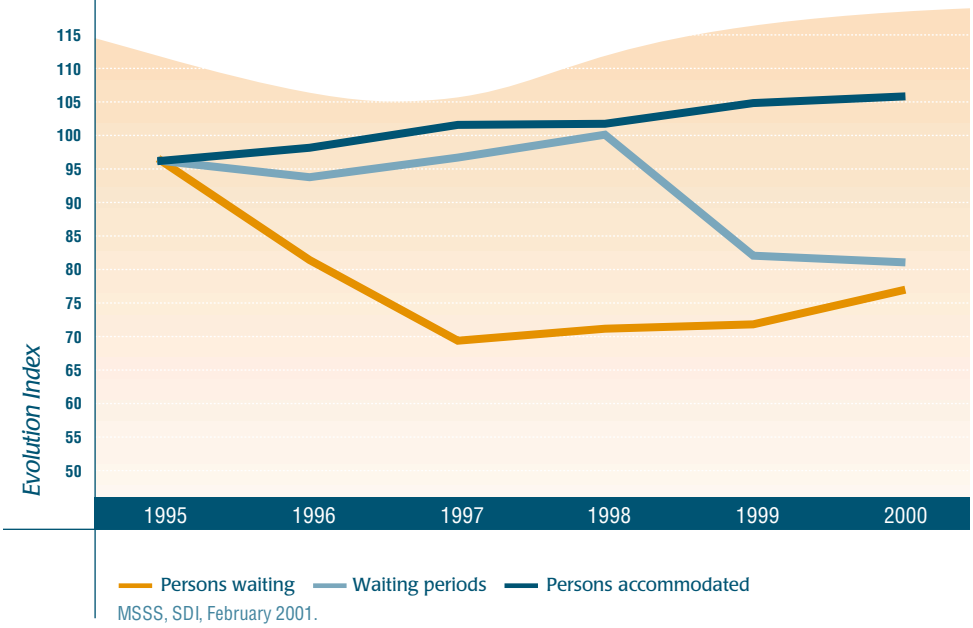
1. Direction-admission committees.
2. During last twelve months.

MSSS., SDI, February 2001.

Figure 53

Change in the Number of Persons Accommodated, Persons

Waiting for Accommodation and Waiting Periods, Québec,
Situation Observed in September, 1995 to 1999, and in June 2000

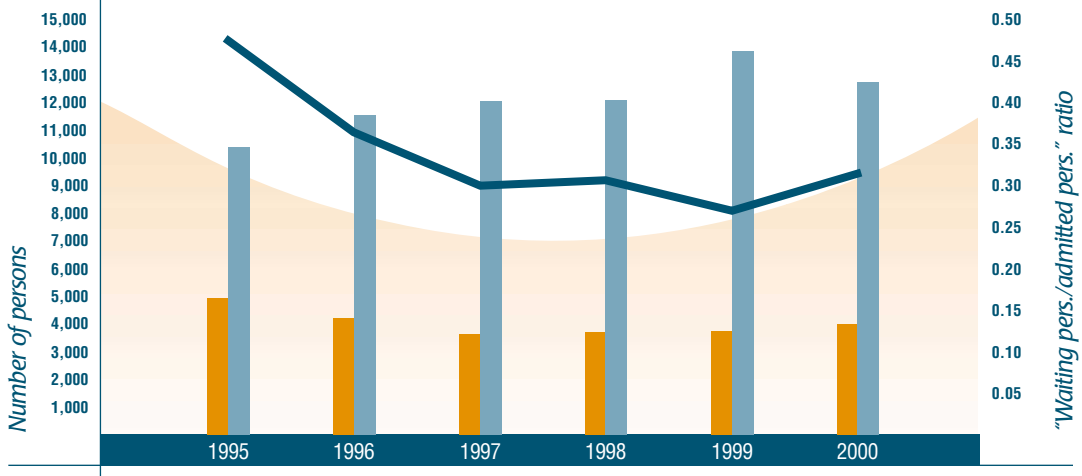


MSSS, SDI, February 2001.

Figure 54

Number of Persons Admitted to a Residential Centre

During the Last Twelve Months, Compared With Number of Persons Waiting for Accommodation, Québec,
Situation Observed in September, 1995 to 1999, and in June 2000



1. During last twelve months.

MSSS, SDI, February 2001.

Table 29

Use of Residential and Long-term Care Services,

Within Québec's Network of Health and Social Services Institutions,

Situation Observed on March 31, 1991 to 2000

Indicator	91	92	93	94	95	96	97	98	99	00
Set-up beds										
Number[1]	50,781	51,075	51,214	51,125	50,378	49,917	48,480	46,232	45,621	45,748
Evolution index	100	101	101	101	99	98	95	91	90	90
Number per 1,000 persons	7.2	7.2	7.2	7.1	7.0	6.9	6.6	6.3	6.2	6.2
Occupation rate (%)	94.7	94.7	94.1	93.3	94.7	94.4	94.0	95.4	95.1	94.8
Users										
Number[2]	67,177	67,290	68,644	70,321	67,031	68,354	70,642	70,818	72,846	73,536
Evolution index	100	100	102	105	100	102	105	105	108	109
Number per 1,000 persons[3]	9.57	9.52	9.65	9.81	9.30	9.40	9.67	9.67	9.92	10.00
Attendance days										
Number	17,560,365	17,657,697	17,583,276	17,413,567	17,414,061	17,196,912	16,642,193	16,098,420	15,829,540	15,836,829
Evolution index	100	101	100	99	99	98	95	92	90	90
Average stay (days)	261.4	262.4	256.2	247.6	259.8	251.6	235.6	227.3	217.3	215.4

1. Including residential pavilions.
2. Total number of users accommodated during the year.
3. Total number of users accommodated during the year as a proportion of the population.

MSSS, SDI, February 2001.

Table 30

Indicators Related to Residential and Long-term Care Services,

Québec,

Situation Observed in September, 1995 to 1999, and in June 2000

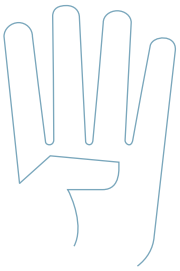
Indicator	95	96	97	98	99	00
Number of beds managed by the COA[1]	44,006	44,690	43,814	43,651	42,698	43,301
Evolution index	100	102	100	99	97	98
Number of persons admitted[2]	10,403	11,548	12,061	12,101	13,852	12,701
Evolution index	100	111	116	116	133	122
Waiting period[3] (days)	80.7	68.8	48.5	47.0	53.9	57.9
Evolution index	100	85	60	58	67	72
Average length of stay	259.8	251.6	235.6	227.3	217.3	217.6
Evolution index	100	97	91	87	84	84
Number of persons accommodated	67,031	68,354	70,642	70,818	72,846	73,472
Evolution index	100	102	105	106	109	110
Number of persons waiting for accommodation	4,924	4,200	3,608	3,696	3,728	3,976
Evolution index	100	85	73	75	76	81
Waiting periods[4] (days)	205	200	206	213	176	174
Evolution index	100	98	100	104	86	85

1. Direction-admission committees.
2. During the last 12 months.
3. Persons admitted during the last 12 months.
4. Persons waiting for accommodation.

MSSS, SDI, February 2001.

The cost of services

- Sources of Funding
- Québec's Financial Situation
- The Health and Social Services Mission



THE COST OF SERVICES

In the field of health and social services, the notion of "cost" applied to a range of terms covering different realities and concepts. For example, the expression "total health expenditures" is defined as all expenditures, both public (including federal, provincial and municipal) and private, 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 different concepts. First, we can consider "government expenditures for the Health and Social Services Mission" via Québec's Public Accounts and Credit Book. These are net provincial public expenditures, that is, after deducting the revenues of the network's institutions (for private and semi-private rooms, ancillary activities, sale of services, etc.). In this way, changes in 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.

Second, we can study "real gross expenditures." These are gross provincial public expenditures, that is, before deducting the revenues received by the network institutions. These expenditures are obtained in the annual financial reports of the institutions (the AS-471 forms), to which are added the expenditures related to the programs administered by the RAMQ, as well as the grants provided to community organizations, the OPHQ and other health and social services agencies. In this way, the whole health and social service system is included, making it possible to measure its size in terms of gross dollars, both on the provincial and regional levels, and, as a result, to undertake comparisons between the various regions of Québec.

Lastly, if we only consider the institutions' financial reports, we can speak of "net direct costs," that is, the costs related to the principal activities of the network institutions after deducting revenues received by activity centre. This allows comparisons to be made between the costs directly related to clinical services and those related to overhead expenses for those services, that is, administration, maintenance, and general operations. In addition, by adding in grants to community organizations, we can determine the financial outline of the eight client programs that cut across the field of health and social services in Québec.

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 total spending. In addition, other sources of funding include revenue 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 includes essentially three sources of revenue: federal transfers and the contributions paid by employers and individuals to the Health Services Fund; contributions to the Drug Insurance Fund; and other sources of revenue that go into the Québec Consolidated Revenue Fund, such as consumer tax and corporate and individual income tax.

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

Until March 31, 1996, federal transfers for health and social services came under the Canada Assistance Plan (CAP) and particularly under the Established Programs Financing (EPF) arrangements. Since then, these transfers have been made under the Canada Social Transfer (CST) program, recently renamed the Canada Health and Social Transfer (CHSP).

SOME FIGURES

In 1991-1992, 6.7% of the funding of health and social services came from autonomous revenues. Employer contributions were 22.2%, federal transfers were 33.1%, and the remaining 38% was drawn from the other sources (income and sales taxes, etc.) of the Québec Consolidated Revenue Fund.

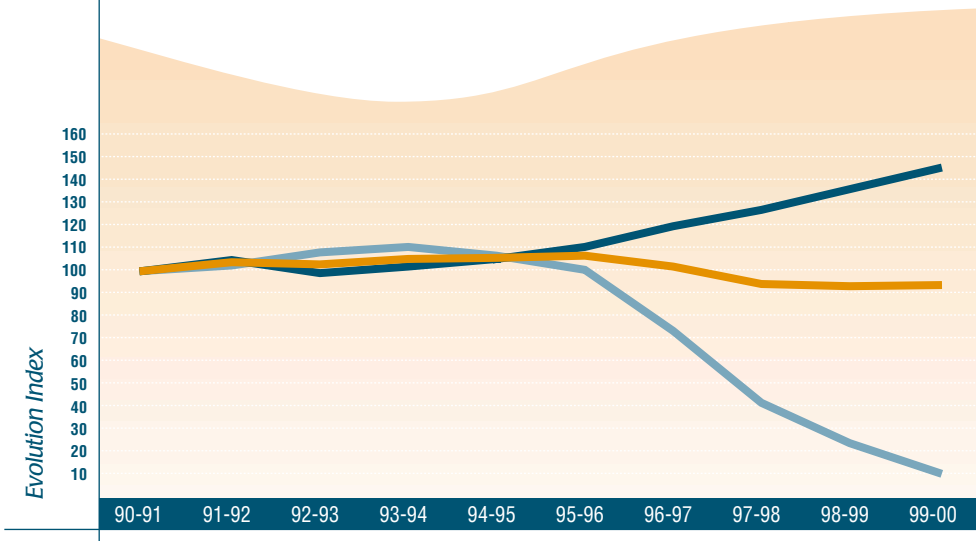
In 1994-1995, autonomous financing reached 7.5% of the total, whereas the 92.5% paid from the Québec Consolidated Revenue Fund were split between federal transfers (32.3%), contributions by employers and individuals (23.9%), and, for the balance, the other revenues of the Québec Consolidated Revenue Fund (36.3%).

In 1999-2000, it is estimated that 6.9% of the financing of health and social services is derived from the autonomous revenues earned in the sector itself, with the rest, or 93.1%, being taken from the Québec Consolidated Revenue Fund, of which 26.2% represents premiums paid to the Health Services Fund.

Figure **55**

Change in Federal Transfers

for Health and Social Services, by Type of Transfer, for Québec,
1990-1991 to 1999-2000



1. From 1990-1991 to 1995-1996: includes the Established Programs Financing (EPF), health component, and certain MSSS expenditures in welfare that are shared under the Canada Assistance Plan (CAP). Beginning 1996-1997: includes part of the Canada Health and Social Transfer (CHST) established on the basis of EPF and CAP of 1995-1996; this part represents 54.3%.

MSSS, SDI, October 2000.

QUÉBEC'S FINANCIAL SITUATION

After a number of decades during which Québec incurred annual deficits, the government finally achieved a balanced budget at the end of the 1990s, thanks to, on the one hand, a determined effort to rationalize finances and, on the other, a favourable period of economic growth.

In 2000-2001, Québec's budgeted revenues totalled $51 billion. Total federal transfers represented 16.1% of this amount, i.e., $8.2 billion. In 2001-2002, total revenue should be $51.1 billion, of which $9.5 billion (18.5%) will be federal transfers.

SOME FIGURES

The 1998-1999 budget showed a small surplus of $126 million, the 2000-2001 budget shows a surplus of $500 million, plus a reserve of $950 million to respond to certain needs in the fields of health and education. In 2001-2002, budgeted operating expenditures should hit $43.2 billion, whereas debt servicing charges should be about $7.9 billion, or 15.5% of the $51.1 billion total budgeted expenditures. In 1997-1998, the budgetary deficit was just under $2.2 billion.

In 2001-2002, the total debt of the Québec government will have reached $102 billion, that is, $65 billion of direct debt and $37 billion pension plan liability. However, the size of the debt has decreased in relation to gross domestic product (GDP), falling from 52.2% in 1997-1998 to 45.9% in 2001-2002.

Table 31

Budget Situation[1] of the Québec Government,

1997-1998 to 2001-2002

$ in million	97-98	98-99	99-00	00-01	01-02[2]
Total budget revenues	41,831	46,695	47,399	50,903	51,136
Independent revenues	35,842	38,605	41,047	42,729	41,652
Federal transfers	5,989	8,090	6,352	8,174	9,484
Total budget expenditures	43,988	46,569	47,369	49,453	51,136
Operations expenditures	36,645	39,382	39,997	41,789	43,226
Debt servicing	7,343	7,187	7,372	7,664	7,910
Reserve				950	
Surplus (Deficit)	(2,157)	126	30	500	
GDP	187,235	193,281	202,425	213,316	221,751
Total debt	97,728	99,568	100,546	102,780	101,691
Direct debt	57,294	59,144	61,209	63,708	64,731
Pension plan liability	40,434	40,424	39,337	39,072	36,960
Total debt as % of GDP	52.2	51.5	49.7	48.2	45.9
Debt servicing as % of budget expenditures	16.7	15.4	15.6	15.5	15.5
Federal transfers as % of budg et revenues	14.3	17.3	13.4	16.1	18.5

1. Québec government 2001-2002 Budget, produced by the ministère des Finances.

2. Forecasts.

MSSS, SDI, April 2001.

THE HEALTH AND SOCIAL SERVICES MISSION

The budgeting structure set out in the government of Québec 's Public Accounts and Credit Book is made up of three principal 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 departments. In the case of the Health and Social Services mission, the portfolio and the mission are the same, since there is only one department, the MSSS, involved.

For the Health and Social Services mission, the third level is currently (2001-2002) comprised of the following four programs:

- Québec-wide functions;
- Regional functions;
- the OPHQ;
- the RAMQ.

Since the beginning of the 1990s, the Québec GDP has grown by an average of 3% per year. After an increase of 7% in 1991-1992, average annual growth in government spending grew by barely 1.9%, so that in 2000-2001, it represented 22% of GDP. Ten years ago, this ratio was almost 24%. In 2001-2002, it is predicted that government spending will reach 22.2% of GDP.

More than one-third of this spending is devoted to the Health and Social Services mission, which represents 7.5% of GDP in 2000-2001. The "Regional Functions" budget program (i.e., the sums required for operating the network of institutions and boards, as well as the grants given to community organizations, related activities and debt servicing) accounts for two-thirds of the expenditures of the mission in 2000-2001. The "RAMQ" program (i.e., all of the programs and the administration of the board) absorbs a little more than 24% of the total. In 2001-2002, expenditures related to the Health and Social Services mission will hit $16.7 billion, representing 34% of all government spending.

The examination of health and social services expenditures through the lens of the MSSS's client programs reveals that, in 1999-2000, the $10 billion of net expenditures for all eight programs represents an increase of 8.4% over 1997-1998. The "Physical Health" program accounts for 46% of these expenditures, whereas the "Older Persons with Decreasing Autonomy" program generated a little less than 25% of the expenditures.

The distribution of gross direct costs related to the principal activities of institutions, according to the ministerial mission, indicates that only the CR, CJ, and CLSC missions saw their costs rise between 1997-1998 and 1998-1999. For the latter, the increase was almost entirely due to the injection of funds into home care. On the other hand, for 1999-2000, there is a growth in gross expenditures for each of the five ministerial missions.

Since the early 1990s, the proportion of expenditures related to the principal activities of institutions that is spent on clinical services has grown steadily; in 1999-2000, these expenditures represented 68% of the total. Between 1993-1994 and 1998-1999, expenditures on overhead (administration, operations, and so on) have fallen by almost 10%. However, in 1999-2000, there was a 4.6% increase over the previous year.

In 1999-2000, the principal activities of institutions required some 337.6 millions paid hours (including salaries and benefits), of which 77% were worked (including salaries only). Salaries and benefits amounted to nearly 74% of gross direct costs.

The cost of the programs administered by the RAMQ reached almost $4.4 billion in 1999-2000. This represented an average annual increase of 4.3% since 1990-1991. The "Medical Services" program accounted for 62% of the RAMQ's costs and more than 93% of this expenditure was for doctors' compensation. Almost 86% of compensation is paid according to the "fee for service and by unit" method. The "salary-based" method has been declining, whereas the "flat-rate fees" method is increasing strongly.

On average, in 1999, a general practitioner earned $129,086 a year, while a specialist earned $184,489.

Between 1990-1991 and 1999-2000, the costs of the "Drugs and Pharmaceutical Services" program more than doubled. The creation of the Pharmacare Plan in 1997, obviously played a large part in this increase. In 1999-2000, the costs of this program were over $1.3 billion. It should be noted that the regime is partly financed through the financial contributions of participants in the Drug Insurance Fund.

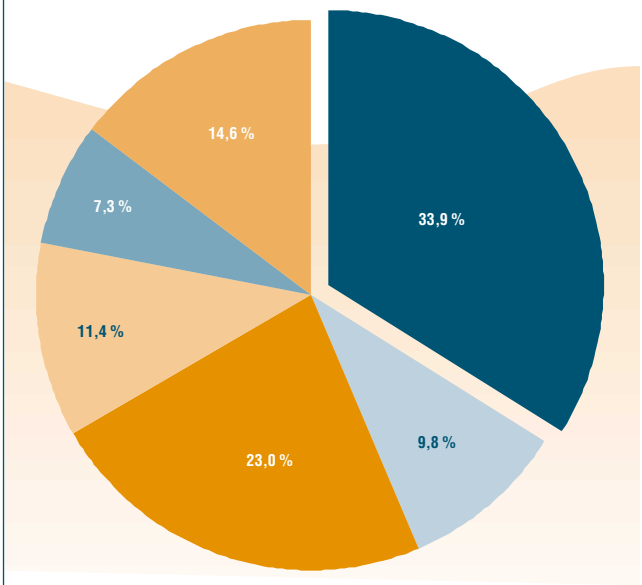
Lastly, whereas the costs of the "Dental Services" and "Optometric Services" have been declining markedly as a result of stricter eligibility criteria, the annual costs of the "Technical Aids" program have been growing by an average of more than 5%.

SOME FIGURES

For 2001-2002, the budgeted expenditures of the Québec government are more than $49 billion, of which $16.7 billion, or more than one-third of the total, are devoted to the Health and Social Services mission.

Figure **56**

Percentage Breakdown
of the Québec Government's Budgeted Expenditures, by Major Mission,
for the 2001-2002 Fiscal Year



- Health and Social Services Mission = $16.7 B
- Support for Individuals and Families Mission = $4.8 B
- Education and Culture Mission = $11.3 B
- Economy and Environment Mission = $5.6 B
- Governance and Justice Mission = $3,6 B
- Debt Servicing Mission = $7,2 B

MSSS, SDI, April 2001.

Expenditures in Relation to Collective Wealth

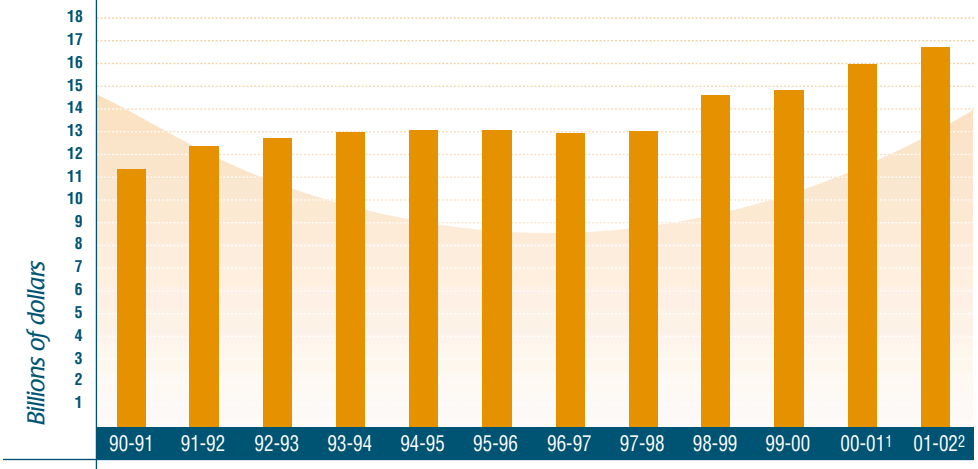
From 1990-1991 to 2000-2001, the collective wealth of Québec, as measured by its GDP, increased by more than 38%, or an annual average increase of 3%. Even when the effect of inflation is removed, the increase was still almost 15%, or an average annual GDP increase of 1.3%. In 2001-2002, the GDP is expected to increase by 4%, or almost $222 billion.

After increasing by 7% in 1991-1992, government expenditures grew by a total of slightly less than 21% over the period covering the other ten years, representing an annual increase of barely 1.9%. In real terms (eliminating the effect of inflation), government expenditures went from $39.6 billion in 1990-1991 to $42.8 billion in 2000-2001. In 1990-1991, government expenditures represented 23.8% of GDP; in 2000-2001, this proportion was 22.4%. In 2000-2001, it should also be over 22%.

Expenditures related to the Health and Social Services mission accounted for 33.5% of total government expenditures in 2000-2001. This proportion was 30.8% in 1990-1991 and 32.6% in 1999-2000. In 2001-2002, it should reach 34%. In 2000-2001, health and social services expenditures were $16 billion, or 41% higher than in 1990-1991, a figure that represents $2,169 per capita. In 2001-2002, these expenditures will rise to more than $16.7 billion, or $2,259 per capita.

Figure **57**

Québec Government Budget Expenditures
on the Health and Social Services Mission,
1990-1991 to 2001-2002



1. Propable expenditures
2. Expenditure budget

MSSS, SDI, April 2001.

In real terms, expenditures related to the Health and Social Services mission hardly increased at all between 1990-1991 and 1997-1998. Beginning in 1998-1999, however, there was a significant catching-up due to the injection of supplementary credits. Thus, on a per capita basis, expenditures declined by a total of 7% between 1991-1992 and 1997-1998. However, the increase was significant – 19% between 1997-1998 and 2001-2002.

Table 32

Gross Domestic Product, Government Expenditures and Spending

on the Health and Social Services Mission, Current $ and Constant 1992 $ (1992 = 100), Québec, *1990-1991 to 2001-2002*

Universe	Indicator	90-91	91-92	92-93	93-94
GDP[3]	$ current ($,000,000)	154,359	156,257	157,794	162,447
	$ per capita	21,986	22,111	22,179	22,668
	$ constant ($,000,000)	166,335	160,924	157,794	159,732
	$ per capita	23,692	22,772	22,179	22,289
Government expenditures	$ current ($,000,000)	36,777	39,354	41,010	41,558
	$ per capita	5,238	5,569	5,764	5,799
	% GDP	23.8	25.2	26.0	25.6
	$ constant ($,000,000)	39,630	40,529	41,010	40,863
	$ par personne	5,645	5,735	5,764	5,702
HSS Mission[4]	$ current ($,000,000)	11,312	12,342	12,698	12,943
	$ per capita	1,611	1,746	1,785	1,806
	% GDP	7.3	7.9	8.0	8.0
	% Total exp.	30.8	31.4	31.0	31.1
	$ constant ($,000,000)	12,190	12,711	12,698	12,727
	$ per capita	1,736	1,799	1,785	1,776
Population on July 1		7,020,720	7,066,891	7,114,467	7,166,405
Implicit index of health care costs in Canada[5]		92.8	97.1	100.0	101.7

1. Probable expenditures.
2. Expenditure budget.
3. Estimated GDP at market price; in 2000-2001 and 2001-2002.
4. Amounts based on 2001-2002 budgeting structure, in order to keep the annual comparability.
5. Forecast in the cases of 2000-2001 and 2001-2002

MSSS, SDI, April 2001.

In 1990-1991, expenditures on the Health and Social Services mission amounted to 7.3% of Québec's GDP; and in 1992-1993 and 1993-1994 they even reached 8%. From then until 1997-1998, the ratio fell back to 6.9%; in 2000-2001 and 2001-2002, it was 7.5%.

94-95	95-96	96-97	97-98	98-99	99-00	00-01[1]	01-02[2]
171,049	178,580	180,559	187,235	193,281	202,425	213,316	221,751
23,730	24,659	24,823	25,640	26,394	27,558	28,937	29,967
165,585	171,382	171,797	175,973	179,362	185,726	191,286	196,043
22,972	23,665	23,618	24,097	24,493	25,285	25,949	26,493
42,830	42,781	41,152	42,317	44,588	45,455	47,687	49,172
5,942	5,907	5,657	5,795	6,089	6,188	6,469	6,645
25.0	24.0	22.8	22.6	23.1	22.5	22.4	22.2
41,462	41,057	39,155	39,772	41,377	41,705	42,762	43,471
5,752	5,669	5,383	5,446	5,650	5,678	5,801	5,875
13,070	13,045	12,922	12,990	14,596	14,829	15,989	16,715
1,813	1,801	1,776	1,779	1,993	2,019	2,169	2,259
7.6	7.3	7.2	6.9	7.6	7.3	7.5	7.5
30.5	30.5	31.4	30.7	32.7	32.6	33.5	34.0
12,652	12,519	12,295	12,209	13,545	13,606	14,338	14,777
1,755	1,729	1,690	1,672	1,850	1,852	1,945	1,997
7,208,163	7,241,867	7,273,993	7,302,550	7,322,994	7,345,395	7,371,765	7,399,931
103.3	104.2	105.1	106.4	107.8	109.0	111.5	113.1

Table 33

Amounts Spent on the Health and Social Services Mission,

by Component of 2001-2002 Budgeting Structure, Québec,
1990-1991 to 2001-2002

Budgetary program		90-91	91-92	92-93	93-94	94-95
1- Québec-wide functions	In thousands of $	**192,903**	**218,157**	**212,643**	**208,562**	**207,665**
	% annual variation		**13.09**	**-2.53**	**-1.92**	**-0.43**
1.1 - Directorate and department management						
	In thousands of $	85,712	82,490	83,512	79,409	78,585
	% annual variation		-3.76	1.24	-4.91	-1.04
1.2 - Advisory bodies	In thousands of $	1,857	1,831	1,938	2,020	2,212
	% annual variation		-1.40	5.84	4.23	9.50
1.3 - National activities	In thousands of $	105,334	133,836	127,193	127,133	126,868
	% annual variation		27.06	-4.96	-0.05	-0.21
2- Regional functions	In thousands of $	**8,459,722**	**9,186,485**	**9,464,682**	**9,601,253**	**9,617,048**
	% annual variation		**8.59**	**3.03**	**1.44**	**0.16**
2.1 - Operation of regional boards	In thousands of $	53,527	54,812	71,300	83,734	83,565
	% annual variation		2.40	30.08	17.44	-0.20
2.2 - Fonctionnement des établissements						
	In thousands of $	7,531,186	8,121,451	8,434,524	8,504,692	8,491,270
	% annual variation		7.84	3.85	0.83	-0.16
2.3 - Support for community organizations						
	In thousands of $	49,470	56,301	64,524	85,461	92,645
	% annual variation		13.81	14.61	32.45	8.41
2.4 - Related activities	In thousands of $	609,412	710,645	641,266	638,056	647,715
	% annual variation		16.61	-9.76	-0.50	1.51
2.5 - Debt servicing	In thousands of $	216,127	243,276	253,068	289,310	301,853
	% annual variation		12.56	4.03	14.32	4.34
2.6 - Consolidation and development of health and social services						
	In thousands of $					
3- OPHQ	In thousands of $	**40,753**	**38,301**	**40,216**	**38,449**	**39,636**
	% annual variation		**-6.02**	**5.00**	**-4.39**	**3.09**
3.1 - Services for handicapped persons						
	In thousands of $	30,317	27,573	29,115	27,602	29,297
	% annual variation		-9.05	5.59	-5.20	6.14
3.2 - Directorate and administration	In thousands of $	10,436	10,728	11,101	10,847	10,339
	% annual variation		2.80	3.48	-2.29	-4.68
4- Régie de l'assurance maladie du Québec						
	In thousands of $	**2,618,866**	**2,899,348**	**2,980,152**	**3,094,573**	**3,205,851**
	% annual variation		**10.71**	**2.79**	**3.84**	**3.60**
4.1 - Medical services	In thousands of $	1,796,312	1,925,391	1,990,904	2,066,628	2,118,002
	% annual variation		7.19	3.40	3.80	2.49
4.2 - Optometric services	In thousands of $	52,872	60,186	43,415	27,014	25,340
	% annual variation		13.83	-27.87	-37.78	-6.20
4.3 - Dental services	In thousands of $	106,843	130,134	109,280	115,131	115,598
	% annual variation		21.80	-16.03	5.35	0.41
4.4 - Pharmaceutical and drug services[3]						
	In thousands of $	517,714	629,025	652,871	692,618	753,652
	% annual variation		21.50	3.79	6.09	8.81
4.5 - Other services	In thousands of $	80,478	87,711	104,187	121,197	124,531
	% annual variation		8.99	18.78	16.33	2.75
4.6 - Administration	In thousands of $	64,647	66,901	79,495	71,985	68,728
	% annual variation		3.49	18.82	-9.45	-4.52
All programs	In thousands of $	**11,312,244**	**12,342,291**	**12,697,693**	**12,942,837**	**13,070,200**
	% annual variation		**9.11**	**2.88**	**1.93**	**0.98**

1. Probable expenditures. 2. Expenditure budget.
3. Only amounts related to drugs and pharmaceutical services provided to older persons and Employment-Assistance recipients.

MSSS, SDI, April 2001.

95-96	96-97	97-98	98-99	99-00[1]	00-01[1]	01-02[2]	V.A.M.(%)
202,781	**166,433**	**160,429**	**160,350**	**162,366**	**205,795**	**231,294**	
-2.35	**-17.92**	**-3.61**	**-0.05**	**1.26**	**26.75**	**12.39**	**1.52**
75,244	64,431	58,317	61,712	63,480	74,226	76,785	
-4.25	-14.37	-9.49	5.82	2.86	16.93	3.45	-0.91
2,792	2,427	2,775	2,653	3,137	3,888	3,989	
26.22	-13.07	14.34	-4.40	18.24	23.94	2.60	6.58
124,745	99,575	99,337	95,985	95,749	127,681	150,520	
-1.67	-20.18	-0.24	-3.37	-0.25	33.35	17.89	3.02
9,512,513	**9,493,030**	**9,651,060**	**11,027,712**	**11,125,085**	**11,848,996**	**12,351,140**	
-1.09	**-0.20**	**1.66**	**14.26**	**0.88**	**6.51**	**4.24**	**3.20**
82,312	87,607	90,790	88,153	87,121	89,474	93,994	
-1.50	6.43	3.63	-2.90	-1.17	2.70	5.05	4.80
8,346,439	8,203,043	8,026,571	8,132,077	8,894,005	9,828,408	10,105,266	
-1.71	-1.72	-2.15	1.31	9.37	10.51	2.82	2.48
100,670	145,431	177,968	197,151	198,219	216,358	236,077	
8.66	44.46	22.37	10.78	0.54	9.15	9.11	13.91
648,131	706,490	953,266	1,001,842	1,096,691	1,235,127	1,399,306	
0.06	9.00	34.93	5.10	9.47	12.62	13.29	7.17
334,961	350,459	402,465	401,289	433,367	479,629	516,497	
10.97	4.63	14.84	-0.29	7.99	10.67	7.69	7.53
			1,207,200	415,682			
47,553	**44,612**	**43,716**	**42,795**	**34,115**	**44,891**	**47,256**	
19.97	**-6.18**	**-2.01**	**-2.11**	**-20.28**	**31.59**	**5.27**	**1.24**
37,140	34,701	34,644	33,834	25,092	35,443	37,519	
26.77	-6.57	-0.16	-2.34	-25.84	41.25	5.86	1.79
10,413	9,911	9,072	8,961	9,023	9,448	9,737	
0.72	-4.82	-8.47	-1.22	0.69	4.71	3.06	-0.58
3,282,429	**3,217,827**	**3,134,511**	**3,365,483**	**3,507,924**	**3,889,805**	**4,085,722**	
2.39	**-1.97**	**-2.59**	**7.37**	**4.23**	**10.89**	**5.04**	**3.78**
2,121,833	2,219,622	2,158,743	2,293,162	2,281,230	2,560,096	2,586,700	
0.18	4.61	-2.74	6.23	-0.52	12.22	1.04	3.09
26,000	24,675	24,243	23,870	24,285	24,206	24,706	
2.60	-5.10	-1.75	-1.54	1.74	-0.33	2.07	-6.14
119,299	104,721	107,213	93,062	101,505	100,648	99,829	
3.20	-12.22	2.38	-13.20	9.07	-0.84	-0.81	-0.56
819,336	703,346	695,313	801,524	951,472	1,058,098	1,212,140	
8.72	-14.16	-1.14	15.28	18.71	11.21	14.56	7.35
129,121	97,315	78,473	82,112	87,125	86,147	97,563	
3.69	-24.63	-19.36	4.64	6.10	-1.12	13.25	1.62
66,840	68,148	70,526	71,753	62,307	60,610	64,784	
-2.75	1.96	3.49	1.74	-13.16	-2.72	6.89	0.02
13,045,276	**12,921,902**	**12,989,716**	**14,596,340**	**14,829,490**	**15,989,487**	**16,715,412**	
-0.19	**-0.95**	**0.52**	**12.37**	**1.60**	**7.82**	**4.54**	**3.31**

Expenditures by Program

The word "program" is a term that has a variety of different meanings within the Health and Social Services mission.

It can refer to, at one and the same time, the budgetary programs set out in Québec's Public Accounts and Credit Book, the eight client programs of the MSSS, the programs administered by the RAMQ, or even programs related to particular problems and issues (e.g., the breast cancer screening program).

BUDGETARY PROGRAMS

During the 1990s, expenditures on the "Québec-wide Functions" program underwent a decline of 16%, or an average annual decrease of 1.7%. However, in 2000-2001, there was an increase of almost 27% in comparison to the previous year, and it is expected that there will be a further increase of 12% in 2001-2002. Of the three components of this program, the largest decrease was experienced by Direction et gestion ministérielle, where expenditures dropped from $85.7 million in 1990-1991 to $63.5 million in 1999-2000, or an average annual decrease of nearly 3%. It should be noted, however, that after having reached a low of $58.3 million in 1997-1998, the amount accounted for by this component of the program then began to rise – by 5.8% in 1998-1999, 2.9%, in 1999-2000, and 16.9% in 2000-2001. An increase of 3.5% is expected for 2001-2002.

As for the "Regional Functions" program, expenditures rose by 40% between 1990-1991 and 2000-2001, which works out to an average annual increase of 3%. Among the components of the program, expenditures related to the operations of the regional boards increased by 67% (for an average annual increase of almost 4.8%), whereas expenditures related to the operation of institutions rose by slightly more than 30%. During the same period, there was an explosion of amounts allocated to community organizations (an increase of more than 337%), i.e., an average annual growth rate of 14%. Over the decade, the amounts allocated to debt servicing more than doubled, going from $216 million to $480 million, or an average annual increase of 7.5%.

Expenditures for the "OPHQ" program grew from $40.8 million to $44.9 million over the period, or by 10.2%, representing an annual average increase of less than 1%. Whereas the amounts granted to the "Services to Handicapped Persons" component went up by 17% (an average of 1.4% per year), those related to the "Management and Administration" component declined by 9.5% (or an average of 0.9% per year).

Expenditures for the "RAMQ" program[6] went from $2.6 billion in 1990-1991 to $3.9 billion in 2000-2001, representing an average annual increase of 3.7%. The two major components of the program, "Medical Services" and "Pharmaceutical Services and Drugs," absorb around 93% of all of the expenditures of the "RAMQ" program. In 2001-2002, the RAMQ's expenditures will top $4 billion, representing 24.4% of the total expenditures of the Health and Social Services mission.

THE CLIENT PROGRAMS

Since the mid-1990s, health and social services have been divided into five fields of activities, each of which is sub-divided into eight client programs. This structure was devised to facilitate the establishment of financial outlines in the context of budget allocation and to bring them in line with the concepts put forward in the Health and Welfare Policy.

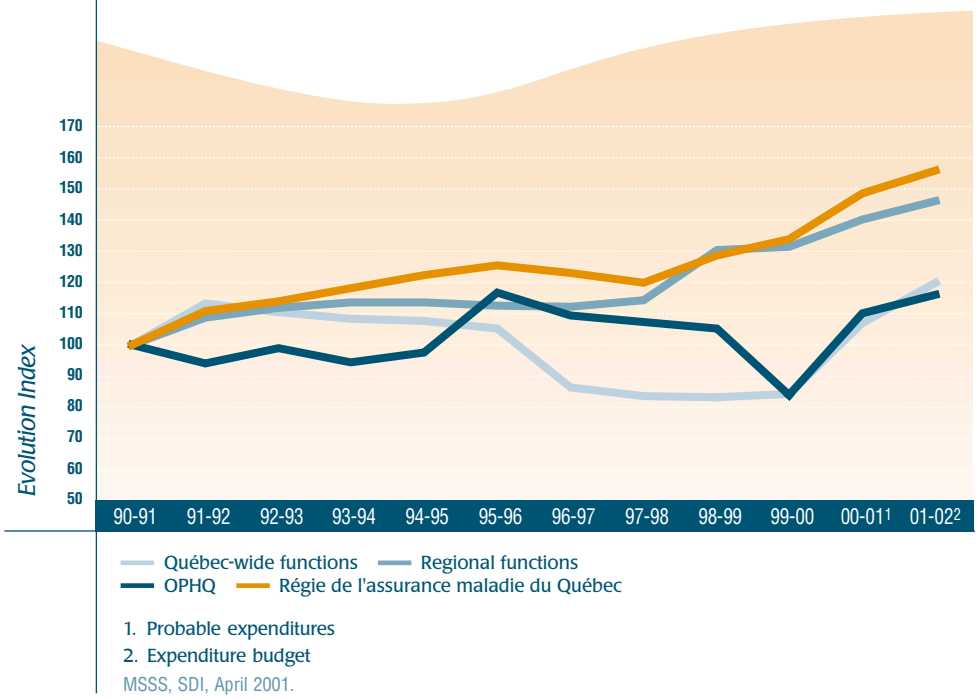
The five fields of activities are as follows: Physical Health, Mental Health, Public Health, Social Adjustment and Social Integration. The "Social Adjustment" field of activities embraces the "Youth and Their Families" and "Alcoholism and Drug Addiction" client programs, whereas the "Social Integration" field covers the "Older Persons with Decreasing Autonomy", "Intellectual Deficiency", and "Physical Deficiency" client programs. For the other three fields of activity, there is no subdivision, and so the program and the field are one and the same.

Net expenditures related to the principal activities of the network institutions (excluding the RAMQ), along with the grants given to community organizations, amounted to almost $10 billion in 1999-2000, or 6% higher than in 1993-1994 and 5.6% higher than in 1998-1999.

6. Some amounts are not counted in the RAMQ budgetary program of the MSSS resource envelope, even though they are related to programs administered by the RAMQ. These amounts nevertheless appear in the Annual Report and in the Annual Statistics of the RAMQ.

Figure 58

Change in Government Expenditures Spent on the Québec Health and Social Services Mission, by Budgetary Program, *1990-1991 to 2001-2002*



1. Probable expenditures
2. Expenditure budget

MSSS, SDI, April 2001.

After having suffered a decrease of 3% between 1993-1994 and 1998-1999, the "Physical Health" program (which, with 46% of all expenditures, is the most important program), underwent an increase of 6.7% in 1999-2000. The "Older Persons with Decreasing Autonomy" program (the second most important, with 24% of total expenditures), declined by 2.4% between 1993-1994 and 1998-1999, but then increased by 4% in 1999-2000.

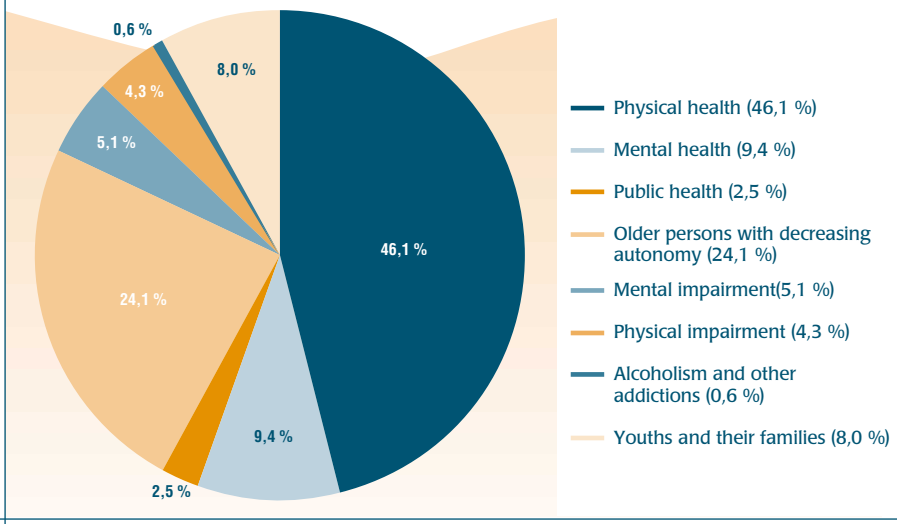
In 1998-1999, the "Mental Impairment" and "Youth and their Families" programs saw their expenditures return close to the level at which they had been at the beginning of the period analysed, but in 1999-2000 they experienced increases of 4.3% and 6% respectively. It should be noted that, beginning in 1997-98, expenditures for the "School Education" activity centre, representing up to $50 million depending on the year, are excluded from the financial outline of the "Youth and Their Families" program.

For the period from 1993-1994 to 1999-2000, there were increases in expenditures for the four other programs, i.e., "Mental Health" (14%), "Physical Deficiency" (34%), "Alcoholism and Drug Addiction" (36%) and "Public Health" (30%). On the other hand, these four programs account for less than 17% of all expenditures. The percentage distribution of expenditures by client program has remained virtually unchanged over the course of the period analysed.

Figure 59

Percentage Distribution

of Net Health and Social Services Expenditures, by Client Program, Québec, *1999-2000*



MSSS, SDI, April 2001.

Table 34

Net Real Health and Social Services Expenditures,

by Client Program, Québec, *1993-1994 to 1999-2000*

Client-Program	93-94		94-95		95-96		96-97		97-98		98-99		99-00	
	In thousands $	% of total	In thousands $	% of total	In thousands $	% of total	In thousands $	% of total	In thousands $	% of total	In thousands $	% of total	In thousands $	% of total
Physical health	4,416,377	46.94	4,434,659	46.87	4,400,022	46.72	4,141,671	44.55	4,095,930	44.61	4,281,721	45.43	4,567,504	45.88
Mental health	817,021	8.68	853,491	9.02	846,736	8.99	874,182	9.40	906,824	9.88	890,017	9.44	928,623	9.33
Public health	187,913	2.00	181,950	1.92	188,874	2.01	219,976	2.37	238,327	2.60	238,451	2.53	244,678	2.46
Older persons,with, decreasing autonomy	2,355,053	25.03	2,285,725	24.16	2,283,167	24.24	2,356,816	25.35	2,318,535	25.25	2,297,760	24.38	2,388,027	23.99
Mental impairment	488,864	5.20	503,979	5.33	491,033	5.21	479,347	5.16	466,818	5.08	488,906	5.19	509,800	5.12
Physical impairment	317,853	3.38	340,424	3.60	341,349	3.62	358,331	3.85	361,477	3.94	385,495	4.09	425,495	4.27
Alcoholism and other addictions	45,773	0.49	46,824	0.49	50,934	0.54	54,117	0.58	53,852	0.59	57,259	0.61	62,159	0.62
Youth and their families	751,660	7.99	785,527	8.30	784,926	8.33	778,216	8.37	705,910	7.69	747,172	7.93	791,774	7.95
Services for women and partners in trouble[1]	27,514	0.29	29,712	0.31	30,975	0.33	33,270	0.36	34,839	0.38	37,233	0.40	37,535	0.38
All programs	**9,408,028**	**100**	**9,462,291**	**100**	**9,418,016**	**100**	**9,295,926**	**100**	**9,182,512**	**100**	**9,424,014**	**100**	**9,955,595**	**100**

1. Expenditures of community organizations in "Services for women and partners in trouble" pertain to the "Social Adjustment" activity field, but cannot be distributed by the client-programs currently in force at the MSSS; these expenditures are thus excluded from the calculations of distribution by program, but are counted in the total.

MSSS, SDI, April 2001.

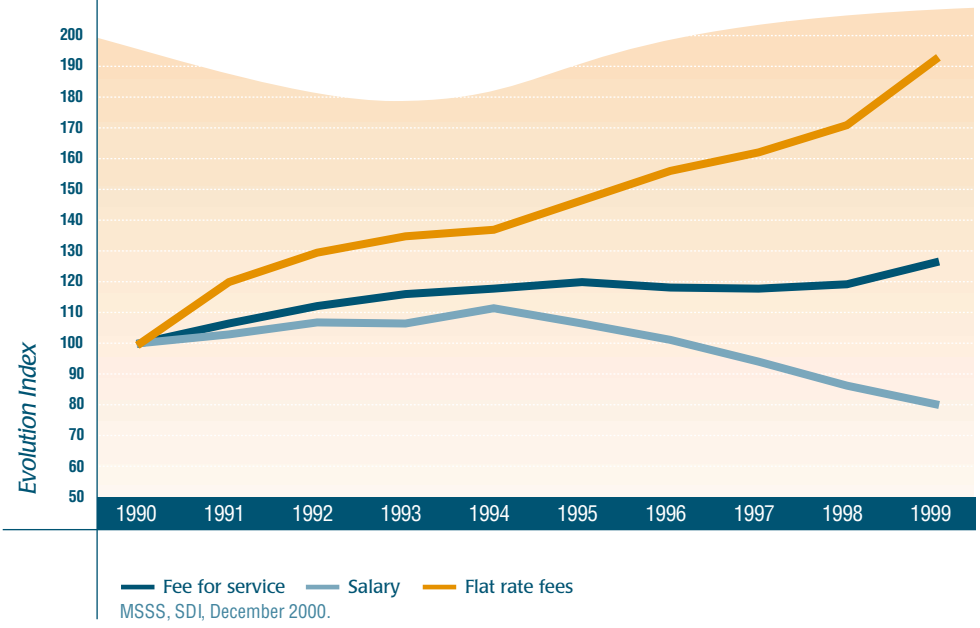
PROGRAMS ADMINISTERED BY THE RAMQ

In 1999-2000, the cost of the programs administered by the RAMQ, including the administration costs of the Board, were $4.3 billion, or 52% more than in 1990-1991, representing an average annual growth of 4.3%. It should be noted, however, that two-thirds of this increase are attributed to the increase in expenditures of the "Drugs and Pharmaceutical Services" program since the inception of the Pharmacare Plan in 1996. In addition, in 1999-2000, total expenditures increased by almost 18% over the previous year.

Expenditures in the "Medical Services" program (which, at 62% of total costs in 1999-2000, is the most important), grew by 42% over the period analyzed, reaching $2.7 billion. Of this amount, $2.2 billion is devoted, in 1999, to compensation for general practitioners and specialists. This is an increase of 21% over 1990, or 2.2% annually. In 1999, more than 86% of total compensation is paid according to the fee-for-service method ($1.9 billion). Salary-based compensation, which represents less than 3% of the total, has been dropping since 1994. Flat-rate-fees compensation, that is, sessional payments and blended compensation (fee for service and on a per diem basis), has been growing since 1990 (an increase of 92%). This represents nearly 11% of total compensation in 1999; ten years ago, the corresponding proportion was only 7%, which works out to an average annual increase of almost 7% for this method of paying doctors.

Figure 60

Change in the Compensation of "Active" Québec Physicians, by Method of Compensation, *1990 to 1999*



MSSS, SDI, December 2000.

In 1990, the average annual compensation of a general practitioner was $98,637, or 66% of that of a specialist ($150,323). In 1999, a general practitioner earned, on average, $129,086, that is, 70% of the average annual earnings of a specialist ($184,489). Whereas the average earnings of general practitioners grew 31% between 1990 and 1999, that of specialists grew half as quickly (increase of 14%) until 1998. However, in 1999, the average compensation of specialists jumped 7% over the previous year.

The "Drugs and Pharmaceutical Services" program is the second in importance among those administered by the RAMQ. In 1999-2000, it accounted for more than 28% of total costs. Since 1990-1991, the costs of the program have more than doubled, going from $518 million to more than $1.2 billion in 1999-2000. The creation of the Pharmacare Plan, in effect since January 1, 1997,[7] has made a sizeable contribution to this increase, as shown by the increase of nearly 18% in 1998-1999, and of more than 19% in 1999-2000. Presently, eligibility has widened to include everyone who is not covered by private insurance (group plan), whereas previously it was only persons aged 65 years and older and those receiving employment assistance benefits who were insured.

Indeed, for the fiscal year ending on March 31, 2000, the General Drug Insurance Plan incurred expenditures of $1,562.6 million. For the same period, the contributions of insured persons were $332 million, which means that the net cost was $1,230.6 million.

Since the mid-1990s, the costs of the "Dental Services" program declined as a result of stricter eligibility criteria. In 1995-1996, the costs were $120.5 million; and in 1999-2000, they were $97.2 million.

Between 1990-1991 and 1998-1999, the "Hospital Services Outside Québec" program saw a decrease in expenditures, at an average annual rate of 3.3%, both for services provided outside Québec to Québec residents as well as for services provided in Québec to residents of the other provinces. However, in 1999-2000 there was a slight decline of only 0.7%.

During the decade, the costs of the "Technical Aids" program went from $45.8 million to $75.6 million, for an average annual increase of more than 5%.

On the other hand, the "Optometric Services" program, because of significant changes in coverage beginning in 1993, went in the opposite direction, its costs diminishing by more than 50%, or by an average of 6.9% per year.

During the period analysed, the administrative costs of the Board rose from $69.2 million to $94.7 million, representing an increase of 37% or an average annual increase of 3.2%.

7. Some of the provisions of the plan came into effect on August 1, 1996.

Table 35

Administrative Costs and Program Costs

for Programs Administered by the Régie de l'assurance maladie du Québec, *1990-1991 to 1999-2000*

Program	Indicator	90-91	91-92	92-93	93-94	94-95	95-96	96-97	97-98	98-99	99-00	AAV[1](%)
Medical services[2]	$,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	3.58
	Evolution index	100	108	112	116	119	119	120	116	120	142	
Drugs and pharmaceutical services[3]	$,000	518,093	629,383	653,934	694,283	755,780	821,878	739,627	876,332	1,032,160	1,230,623	9.04
	Evolution index	100	121	126	134	146	159	143	169	199	238	
Dental services[4]	$,000	116,411	140,836	110,384	116,189	116,792	120,542	106,694	109,087	94,502	97,153	-1.79
	Evolution index	100	121	95	100	100	104	92	94	81	83	
Hospital services[5]	$,000	127,021	133,337	124,231	113,571	119,035	112,485	99,064	94,372	93,567	94,196	-2.95
	Evolution index	100	105	98	89	94	89	78	74	74	74	
Technical aids[6]	$,000	45,835	47,876	71,378	89,828	93,596	88,738	87,677	68,256	71,733	75,610	5.13
	Evolution index	100	104	156	196	204	194	191	149	157	165	
Optometric services[7]	$,000	52,490	59,732	42,819	26,431	24,570	25,293	24,794	24,247	23,776	25,758	-6.87
	Evolution index	100	114	82	50	47	48	47	46	45	49	
Grants[8]	$,000	28,336	32,763	13,133	13,169	13,192	13,050	8,545	8,767	9,060	10,509	-9.44
	Evolution index	100	116	46	46	47	46	30	31	32	37	
Home support services[9]	$,000								3,410	8,023	19,890	
Administrative costs[10]	$,000	69,240	72,800	85,940	77,992	74,572	73,223	81,968	90,428	92,839	94,678	3.18
	Evolution index	100	105	124	113	108	106	118	131	134	137	
TOTAL[11]	$,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	4.29
	Evolution index	100	111	113	117	121	123	120	122	129	152	

1. Average annual variation.
2. Compensation of general practitioners and specialists.
3. Introduction of drug insurance, August 1, 1996.
4. Gradual withdrawal for certain clienteles.
5. Hospital services outside Québec.
6. Prostheses and ortheses.
7. Gradual withdrawal for certain clienteles.
8. Study and research grants.
9. Financial exemption for home support services established in October 1996, administered by the RAMQ since December 1997.
10. In 1992-1993, special measures required $12M additional credits.
11. Amounts collected from responsible third parties and foreign residents for hospital care were not deducted ($92.8M in 1998-1999 and $94.7M in 1999-2000).

MSSS, SDI, December 2000.

Expenditures by the Network's Missions

The institutions in the network are grouped under five major missions: the CH mission (which covers the CHSGS and the CHSP), the CLSC mission, the CHSLD mission, the CR mission (which includes the CR PAT, the CR PDI and the CR PDP), and the CJ mission (which comprises the sum of the CPEJ, the CR JDA and the CR MDA).

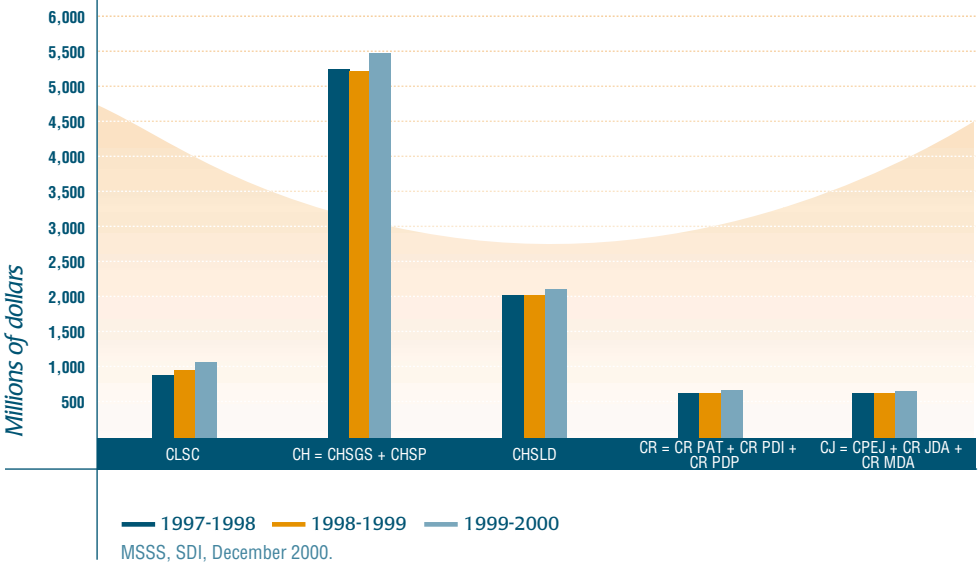
In 1999-2000, the CH mission represents 55% of the total gross direct costs related to the principal activities of institutions. Next in line is the CHSLD mission with 21%, whereas the CLSC mission accounts for 10.6%

The CR and CJ missions represent 6.9% and 6.7% respectively. From 1997-1998 to 1998-1999, the CLSC mission was the only one to undergo a significant increase in its relative share of costs, going from 9.4% to 10.1%, largely as a result of the injection of money into home support services (care and assistance). However, in 1999-2000, all of the missions saw their expenditures increase. Expenditures rose 10.5% for the CLSC mission, 6.9% for the CR mission, 5.4% for the CJ mission, 5.1% for the CH mission, and 3.1% for the CHSLD mission.

Figure 61

Gross Direct Costs Related to the Principal Activities

of Québec Health and Social Services Institutions, by Exclusive Mission, *1997-1998 to 1999-2000*



MSSS, SDI, December 2000.

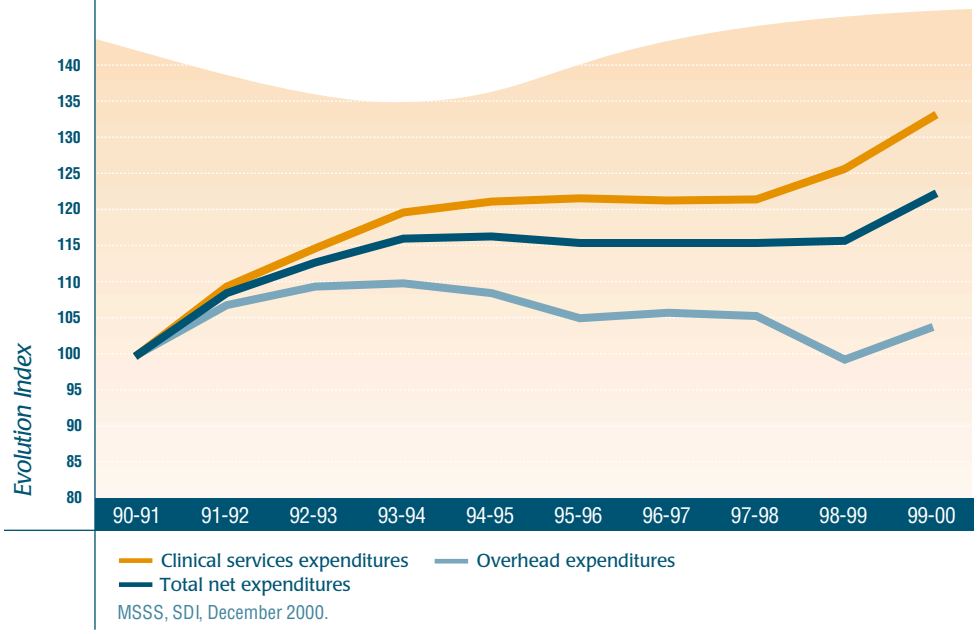
Expenditures on "Clinical Services" versus Expenditures on "Overhead" Services

In 1990-1991, 62.5% of the net expenditures related to the principal activities of institutions were incurred for direct services to users (clinical services), the rest (37.5%) being spent on overhead for these services (administration, operations, etc.). In 1999-2000, the relative share of expenditures on "direct services" reached more than 68%, having experienced an average annual increase of 2.9% since 1990-1991 (or a 33% increase over the entire period analysed). During this time, "overhead" expenditures increased less than 4%. In fact, between 1993-1994 and 1998-1999, "overhead" expenditures declined by 9.6%. In 1999-2000, these expenditures increased by 4.6%.

Figure 62

Change in Net Expenditures

of the Québec Network of Health and Social Services Institutions, by Expenditure Coverage,
1990-1991 to 1999-2000



MSSS, SDI, December 2000.

Table 36

Distribution of Net Expenditures

of the Québec Network of Health and Social Services Institutions, by Expenditure Coverage,
1990-1991 to 1999-2000

Field of coverage	90-91	91-92	92-93	93-94	94-95	95-96	96-97	97-98	98-99	99-00
Total fields	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	9,809,303
% field	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	6,681,032
% field	62.5	63.1	63.6	64.5	65.1	65.9	65.7	65.8	67.9	68.1
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
% field	12.7	12.7	12.8	12.3	12.2	11.8	11.0	10.6	10.5	10.6
Operations	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
% field	23.4	23.0	22.5	22.0	21.6	21.2	20.2	19.6	19.7	19.3
Research, training and development	64,031	65,037	64,769	64,359	59,118	56,692	62,060	30,411	14,338	14,405
% field	0.8	0.7	0.7	0.7	0.6	0.6	0.7	0.3	0.2	0.1
Miscellaneous	40,909	37,519	38,684	51,525	47,654	47,509	221,126	342,800	167,729	180,136
,% field	0.5	0.4	0.4	0.6	0.5	0.5	2.4	3.7	1.8	1.8
Total overhead[2]	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
% field	37.5	36.9	36.4	35.5	34.9	34.1	34.3	34.2	32.1	31.9

1. Net expenditures, i.e., excluding deductions and revenues derived from the institutions principal activities, as well as all ancillary activities, immovables and non-distributed costs by activity centre.

2. Sum of expenditures in administration, operations, research, training and development, as well as the "miscellaneous" part.

MSSS, SDI, December 2000.

The Principal Activities of Institutions

The principal activities of institutions gave rise to close to 338 million paid hours[8] in 1999-2000. In the early 1990s, these activities entailed more than 347 million hours. In 1990-1991, 79% (or 274 million) of these paid hours were hours actually worked[9]; and by 1999-2000, this proportion was 77% (or 261 million hours worked).

At the beginning of the period, salaries and benefits made up more than 77% of the gross direct costs; in 1999-2000, this proportion is 74.1%. In 1990-1991, the average hourly gross salary (total salaries and benefits/number of paid hours) was $18.21; at the end of the period analysed, the figure is $22.06. In total, an hour worked costs $29.89 (total of gross direct costs/number of hours worked) at the beginning of the period studied. In 1999-2000, it costs $38.47.

Table 37

Trends in Selected Statistical Indicators of Hours Devoted

to the Principal Activities of Institutions
in the Québec Health and Social Services Network,
1990-1991 to 1999-2000

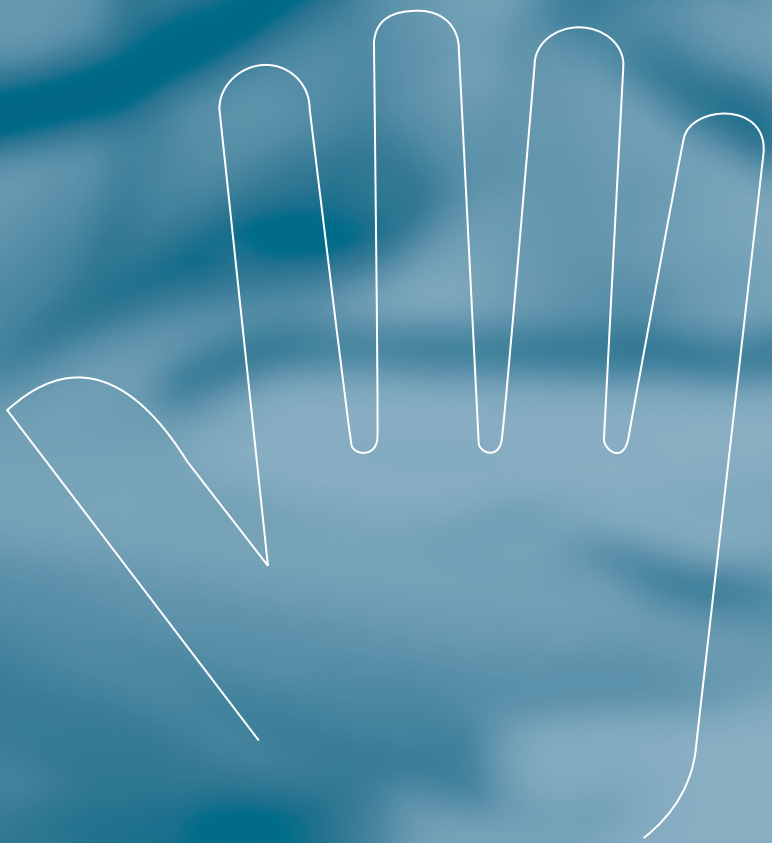
Indicator	90-91	91-92	92-93	93-94	94-95	95-96	96-97	97-98	98-99	99-00
Number of hours worked	274,037,023	277,296,620,	278,144,091,	278,157,023,	274,415,708,	267,702,849	258,039,673	250,527,819	252,140,071	261,235,218
Number of hours paid	347,428,720	352,360,436	354,531,360	351,940,772	349,416,982	342,680,598,	335,134,642,	324,906,201,	324,364,271	337,615,820
Salaries and benefits ($)	6,325,816,584	6,888,078,135	7,180,888,066	7,286,548,473	7,320,864,091,	7,275,864,733	7,295,398,232,	7,261,811,592,	7,137,924,639	7,448,276,145
Gross direct costs ($)	8,191,892,203	8,877,810,040	9,223,781,413,	9,504,225,533,	9,546,589,084	9,472,231,355	9,478,092,546	9,489,150,335	9,538,735,757,	10,049,632,698
Hrs worked/Hrs paid ratio	0.79	0.79	0.78	0.79	0.79	0.78	0.77	0.77	0.78	0.77
Sal.+ ben./gross dir. costs (%)	77.22	77.59	77.85	76.67	76.69	76.81	76.97	76.53	74.83	74.11
Sal.+ ben./Hrs paid ($)	18.21	19.55	20.25	20.70	20.95	21.23	21.77	22.35	22.01	22.06
Gross dir. costs/Hrs worked ($)	29.89	32.02	33.16	34.17	34.79	35.38	36.73	37.88	37.83	38.47

1. Principal activities are those directly linked with one or more missions that the institution must normally operate; ancillary or commercial activities must, in principle, be self-financed.

MSSS, SDI, January 2001.

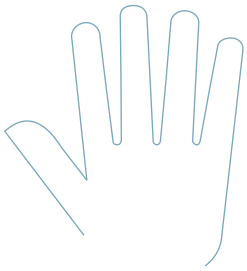
8. A paid hour includes both salaries and benefits.
9. An hour worked only includes salaries.

Health and welfare of the population: results



- Perceived Health Status
- Disability and Activity Limitation
- Life Expectancy
- Fœtal and Infant Mortality
- General Mortality
- Potential Years of Life Lost
- Principal Health Problems
- Psychological Distress
- Induced Abortion
- Lifestyle

HEALTH AND WELFARE OF THE POPULATION: RESULTS



The purpose of the health and social services system is to improve the health and welfare of the population, by striving to reduce and rectify the social and health problems that affect it. Thus, the resources devoted to health and social services must be considered not only in relation to their availability, utilization and cost, but also in relation to the improvement or lack thereof in health and welfare, that is, in relation to the results obtained.

Moreover, a statistical profile of the health and welfare of Québeckers is the best way to bring out the strengths and weaknesses of the system of services, which will in the long run help guide actions in a coherent way in order to improve the health and welfare of the population as well as to reduce the differences that continue to exist between the groups therein.

Although it is true that health and welfare are in large part linked with individuals' physical, social and economic environment, the reduction of the differences, whether between men and women (for example, excess male mortality) or between groups from advantaged and disadvantaged environments (free, universal health care services), is possible only if action is taken as close as possible to the source of problems, so as to re-establish and even to establish the conditions and lifestyles that foster better health and welfare.

Obviously, these actions will be effective only if, first, they are coordinated with those of other activity sectors, because of their impact on the health and welfare of the population; and, second, they occur early in people's lives, when the foundation for future health and welfare of people are being laid.

In addition to the differences in health and welfare which exist in the population, rapid population aging also exerts intense pressure on the system of services, just like the fact of having to respond to the needs of an increasing number of people who are living with a disability. Hence, the urgent need for measures to help people have access to a better quality of life, first by adding life and health to years, then by reducing suffering and periods of disability, and facilitating access to transportation and recreation, in brief, improving the living conditions of seniors, people living with a disability and their caregivers. In this respect, the health and welfare system must also produce results.

The statistics on the population's health status which are presented here are mostly drawn from data obtained from the three surveys of Québeckers conducted in 1987, 1992-1993 and 1998 by the Direction Santé Québec of the Institut de la statistique du Québec (ISQ).

PERCEIVED HEALTH STATUS

Self-rated health status, that is, the perception that each person has of their own health problems is, according to experts, an indicator that is highly useful for directing the available resources towards the right targets.

The majority of Québeckers consider themselves to be in good health, and this assessment is closely linked to educational level, income level, and activity level.

SOME FIGURES

In Québec, in 1998, 89% of the population (88% women and 90% men) rated their health as good to excellent, and approximately one in five persons described it as excellent. Although this perception improved from 1987 to 1994, a decline of 0.7 percentage point was noted for 1998 among both men and women.

When the population aged 15 and over is divided into age groups, it is noted that, among women, the decline occurred in the 15 to 24 and 25 to 44 age groups, whereas this perception improved among those aged 45 and over. Among men, this perception improved only among the 45 to 64 age group, while among the 15 to 24 age group and those aged 65 and over, there was a sharp decline (1.2 percentage point) compared to 1994.

Table 38

Percentage of Québec Population Aged 15 +

who Rate their Health as Poor, by Sex,
1987, 1993, 1994 and 1998

Sex	Indicator	87	93	94	98
Women	%	12.2	11.5	11.2	11.7
	Evolution index	100	94	92	96
Men	%	10.4	9.8	9.6	10.1
	Evolution index	100	94	92	97
Both sexes combined	%	11.4	10.7	10.4	11.1
	Evolution index	100	94	91	97

Note : Data from the ISQ Santé-Québec surveys of 1987, 1992-1993 and 1998.

MSSS, SDI, September 2000.

Table 39

Percentage of Québec Population Aged 15 +

who Rate their Health as Poor, by Sex and Age Group,
1992-1993 and 1998

Sex	Age group	92-93	98
Women	15 - 24	6.8	7.6
	25 - 44	7.0	7.2
	45 - 64	14.3	13.3
	65 and over	24.4	22.9
Men	15 - 24	4.9	6.1
	25 - 44	6.6	7.0
	45 - 64	13.7	12.6
	65 and over	21.1	22.3

Note : Data from the ISQ Santé-Québec surveys of 1992-1993 and 1998.

MSSS, SDI, September 2000.

Table 40

Percentage of Québec Population Aged 15 +

who Rate their Health as Poor, by Selected Socio-Economic Characteristics,
1998

Characteristic	Category				
Educational level	Lower	Low	Average	High	Higher
	17.6	12.5	8.8	9.9	7.7
Income level	Lowest	Low	Low to middle	Middle to high	Highest
	22.9	19.2	11.9	7.2	6.6
Activity status	Employed	In studies	Homemaker	Retired	Unemployed
	5.3	7.5	15.1	23.4	33.3

Note: Data obtained from the ISQ Santé-Québec 1998 survey.

MSSS, SDI, September 2000.

Lastly, when the population aged 15 and over is divided into cohorts based on selected socio-economic characteristics, the figures speak for themselves. Thus, the higher the relative level of education, the more people rate their health as good. The lower the income level, the more people rate their health as poor. And, the less busy they are, the poorer their health seems to be.

DISABILITY AND ACTIVITY LIMITATION

Disability days are defined as the average number of days related to losses of functional autonomy due to short- or long-term health reasons.

The number of disability days is higher among women than men. In general, this number decreases when income level increases and it increases when activity level decreases.

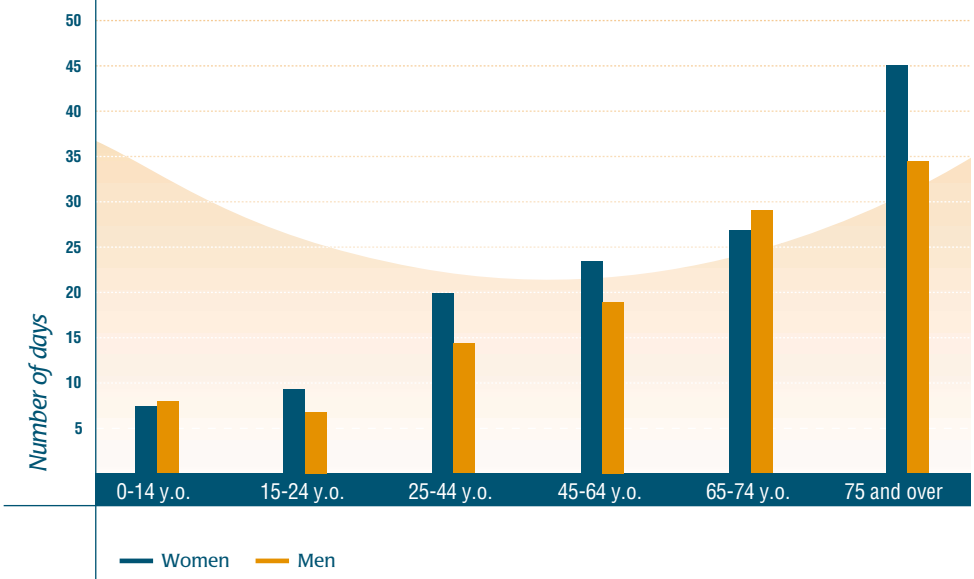
Activity limitations caused by a health condition or a chronic physical or mental disease, that is, the degree to which an individual is limited in performing a type or volume of activity, is also a reliable measure of the level of disability within a given population. In total, more than 9% of Québeckers had an activity limitation in 1998. This rate is higher among women than men, and the difference is becoming more marked.

SOME FIGURES

In 1998, every Québec man and woman had an average of 15 disability days. The number of disability days obviously increases with age, especially from the age of 75. Except for the 14 or under and 65 to 74 age groups, women have a much higher number of disability days than men, particularly among the 75 and over age group (10.5 days or 23% more).

Figure 63

Annual Average Disability Days per Person,
by Age Group and Sex, Québec,
1998



Note : Data from ISQ Santé-Québec 1998 survey.
MSSS, SDI, November 2000.

Table 41

Annual Average Disability Days per Person Aged 15+,

by Selected Socio-Economic Characteristics, Québec,
1998

Characteristic	Category				
Income level	Lowest	Low	Lower to middle	Middle to high	Highest
	29.4	23.2	17.0	13.2	11.7
Activity status	Employed	In studies	Homemaker	Retired	Unemployed
	11.6	8.2	23.4	31.6	72.6

Note: Data from the ISQ Santé-Québec 1998 survey.

MSSS, SDI, September 2000.

Table 42

Rate of Activity Limitation Among the Population in Private Households,

by Sex and Age Group, Québec,
1987, 1992-1993 and 1998

Category		87	92-93	98
Sex	Women	7.6	8.0	10.4
	Men	7.1	6.4	8.2
	Both sexes combined	7.4	7.2	9.3
Age group	14 or under	3.1	2.2	2.3
	15 - 24	3.1	3.6	4.0
	25 - 44	5.3	6.1	7.4
	45 - 64	13.4	10.2	14.0
	65 - 74	16.8	17.2	20.3
	75 and over	21.7	22.7	26.7
	All ages	7.4	7.2	9.3

Note: Data from the ISQ Santé-Québec surveys of 1987, 1992-1993 and 1998.

MSSS, SDI, September 2000.

Table 43

Percentage Distribution of Activity Limitations Among the Population in Private Households,

by Cause, Québec,
1987, 1992-1993 and 1998

Cause of activity limitation	87	92-93	98
Mental illness	5.6	6.0	8.3
Respiratory diseases	7.6	12.9	10.7
Accidents	10.3	7.3	8.2
Cardiovascular diseases	15.9	13.1	13.7
Arthritis/rheumatism problems	24.0	26.5	26.8
Other	36.6	34.2	32.3
Total	100.0	100.0	100.0

Note: Data from the ISQ Santé-Québec surveys of 1987, 1992-1993 and 1998.

MSSS, SDI, September 2000.

It is also found that the number of disability days decreases as income level increases. Moreover, the number of disability days varies considerably according to activity status. Thus, the number of disability days is four times higher for retirees than for students and six times higher for the unemployed than for the employed.

In 1998, in Québec, it was estimated that the proportion of people of all ages affected by activity limitations due to health reasons was 9.3%. This is a marked increase compared to 1992-1993 when the proportion was 7.2%. It should be noted that the rate of activity limitation for women is considerably higher than that for men, and this difference is increasing.

The rate of activity limitation obviously increases with age. Among people aged 14 or under, the rate fell from 1987 to 1992-1993 and has remained relatively stable since. Among those aged 45 to 64, the rate fell from 1987 to 1992-1993 and rose again in 1998. Among the other age groups, the rate increased steadily throughout the entire period.

Among the causes of activity limitation, mental illness and respiratory problems have been rising since 1992-1993, whereas accidents, cardiovascular diseases and arthritis/rheumatism problems remained relatively stable.

LIFE EXPECTANCY

In 1998, the life expectancy at birth of women was greater than 81 years, whereas as that of men was more than 75 years. With time, the gender gap narrows, except when life expectancy at 65 years old is considered. Moroever, material and social disadvantage has a stronger effect on male rather than female life expectancy.

SOME FIGURES

In Québec, life expectancy at birth markedly increased over the last two decades, an increase of 5.4 years for men and 4.3 years for women. Thus, in 1998, the life expectancy at birth of Québec women was 81.3 years, whereas that of Québec men was 75.3 years, or a difference of 6 years.

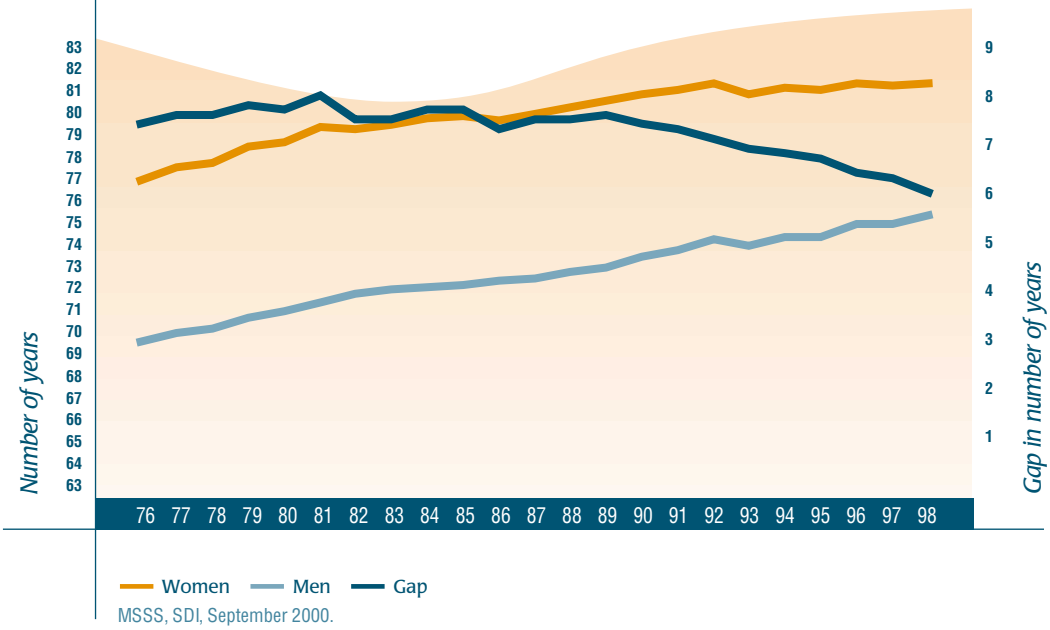
Except for 1981, when the gender difference in life expectancy at birth reached a high of 8 years, it has since remained relatively stable until 1989. However, since the early 1990s, the difference has steadily and significantly decreased (1.6 years since 1989).

However, the gender difference in life expectancy at 65 years old is more pronounced. Even though life expectancy at 65 years old has improved among both sexes, this improvement was more rapid among women, at least until the mid-1980s. The difference has since remained stable. Thus, in 1998, life expectancy at 65 years old was 20 years for women and 15.6 years for men; in the early 1970s, it was 16.7 and 13.3 years respectively.

Figure 64

Life Expectancy at Birth

within the Québec Population, by Sex, and Gender Differences,
1976 to 1998

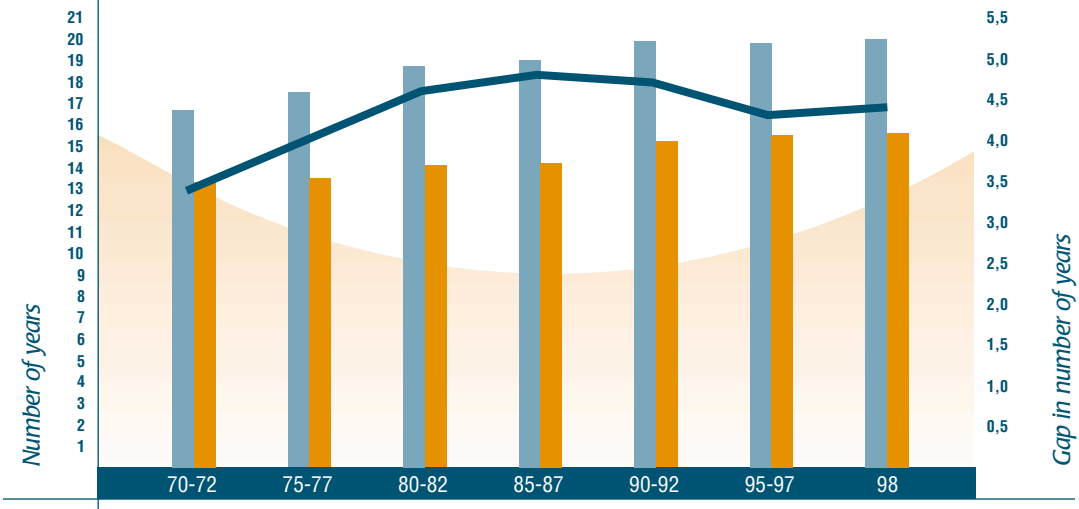


MSSS, SDI, September 2000.

Figure 65

Life Expectancy at 65 Years Old

within the Québec Population, by Sex,
1970-1972 to 1998



MSSS, SDI, November 2000.

If only the population living at home is considered, in 1997, the life expectancy at birth of Québec women was 83.7 years and that of Québec men was 75.8 years, or an average expectancy of approximately 79.8 years for the population as a whole.

When this population is distributed by type and quintile of disadvantage, differences appear. Among women, material disadvantage has a negative effect on life expectancy whereas social disadvantage seems to have no effect at all. Among men, material disadvantage also has a negative effect on life expectancy whereas social disadvantage produces the same effect only in the lowest two quintiles.

If the effects of both types of disadvantage are combined, a rather small difference is noted between the life expectancy at birth of advantaged women (Quintile 1) and that of disadvantaged women (Quintile 5), that is, 83.7 years and 81.1 years respectively. For men, the difference is much greater, that is, 79.7 years for advantaged men compared to 71 years for disadvantaged men.

Table 44

Life Expectancy at Birth of Population Living at Home, by Type and Quintile of Disadvantage, Québec, *1997*

Type of disadvantage	Sex	Quintile of disadvantage[1]				
		1	2	3	4	5
Material	Women	84.9	84.0	83.7	83.6	82.5
	Men	78.5	76.4	75.5	75.3	73.7
	Both sexes combined	81.9	80.4	79.7	79.5	77.9
Social	Women	82.0	83.6	84.6	84.2	82.9
	Men	76.5	76.7	76.5	75.8	73.4
	Both sexes combined	79.0	80.0	80.7	80.2	78.4
Material and social	Women	83.7	N/A	N/A	N/A	81.1
	Men	79.7	N/A	N/A	N/A	71.0

1. Quintile 1 = advantaged; Quintile 5 = disadvantaged.

MSSS, SDI, September 2000.

FŒTAL AND INFANT MORTALITY

There are three categories of fœtal and infant mortality which are mainly linked with early death. First, stillbirth is when there is absolutely no sign of life at birth. Second, perinatal mortality includes stillbirths and deaths of infants in the first week of life. Third, infant mortality means mortality of live-born children who die in the first year of life.

The stillbirth rate is the ratio of the number of stillbirths (fœtus weighing 500 grams or more) to the total of live births and stillbirths. Perinatal mortality is the ratio of the sum of stillbirths and deaths of children under 7 days' old to the total of live births and stillbirths.

Infant mortality over a given period of time is measured as the ratio of the number of deaths of children under 1 year old to the total of live births recorded during that period. Infant mortality can be divided into three sub-categories: early neonatal (under 7 days), late neonatal (7 to 27 days) and post-neonatal (28 days or more).

For 20 years, all indicators of fœtal and infant mortality – stillbirth, perinatal mortality and infant mortality – have practically been divided by two, or even more, whenever it involves post-neonatal mortality. It should, however, be noted that infant mortality is higher among boys than among girls, but the difference has been considerably reduced since the early 1970s.

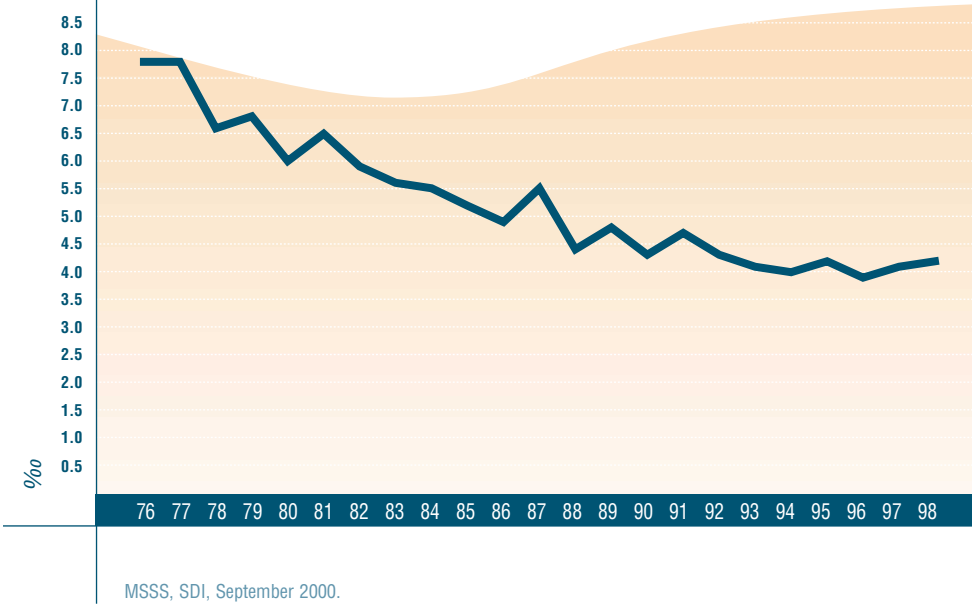
SOME FIGURES

In 1976, Québec had 769 stillbirths, 73% of which occurred after 28 weeks' gestation. In 1998, 320 stillbirths were recorded, 69% of which occurred after 28 weeks' gestation. Thus, during this period, the stillbirth rate dropped from 7.8‰ to 4.2‰, or a reduction of more than 46%.

If infant deaths at under 7 days old are added to stillbirths, a perinatal mortality rate of 7.4‰ is obtained for 1998. Twenty two years earlier, perinatal mortality was two times higher (14.2‰).

Figure **66**

Stillbirth Rate,
Québec,
1976 to 1998

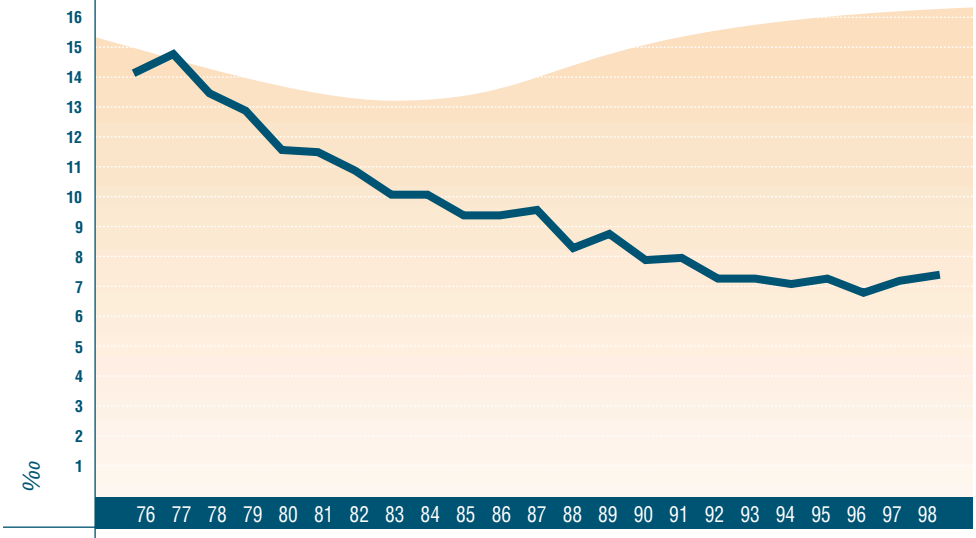


MSSS, SDI, September 2000.

Figure 67

Perinatal Mortality Rate,

Québec,
1976 to 1998

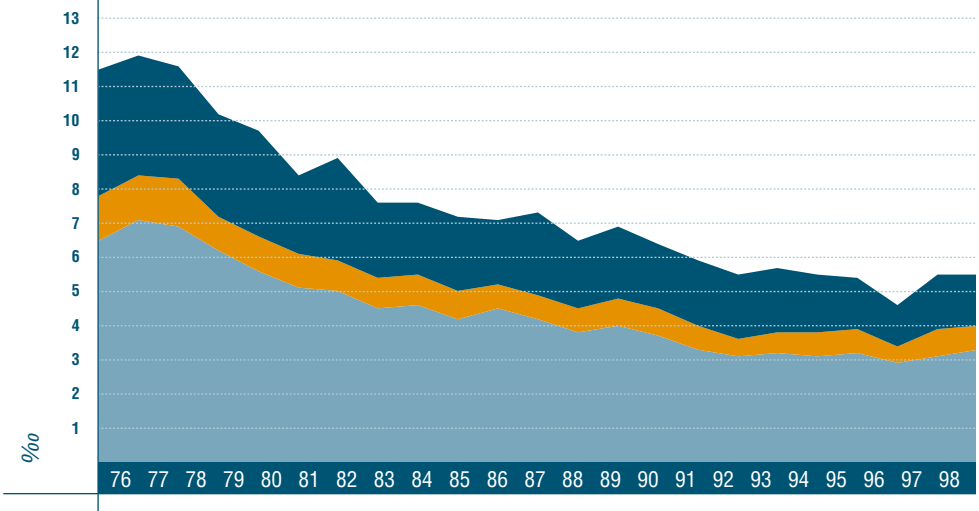


MSSS, SDI, September 2000.

Figure 68

Infant Mortality Rate,

by Category, Québec,
1976 to 1998



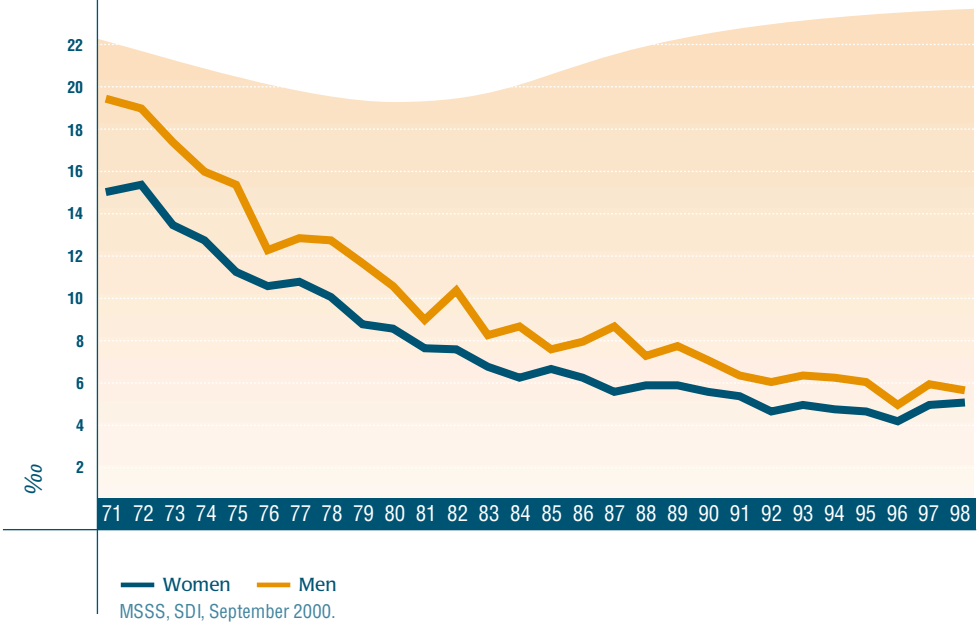
MSSS, SDI, September 2000.

In 1976, Québec had 1,125 infant deaths, 68% of which occurred within 28 days of life. In 1998, 413 infant deaths were recorded, 72% of which occurred within 28 days of life. The infant mortality rate thus dropped from 11.5 deaths for 1,000 live births in 1976 to 5.5‰ in 1998, or a reduction of more than 52%. If infant mortality is divided by category (number of days of life before death), a reduction from 6.5‰ to 3.3‰ is noted in the rate of early neonatal mortality (decrease of 49%), a reduction from 1.3‰ to 0.7‰ for late neonatal mortality (decrease of 46%), and a reduction from 3.7 ‰ to 1.5‰ in the rate of post-neonatal mortality (decrease of 59.5%).

Moreover, it should be noted that infant mortality is higher among boys than among girls. In 1971, the infant mortality rate rose to 19.4‰ for boys and 15.1‰ for girls. However, since then, the gap has reduced markedly; in 1998, the infant mortality rate was 5.7‰ for boys and 5.1‰ for girls.

Figure 69

Infant Mortality Rate,
by Sex, Québec,
1971 to 1998



MSSS, SDI, September 2000.

GENERAL MORTALITY

The general death rate in Québec has been on the rise since the early 1980s, after a 30-year period of decline.

However, the population is increasing and aging while life expectancy is rising. Therefore, to gain a better understanding of changes in mortality, it is necessary to adjust mortality rates in relation to a reference population. The Québec population as observed in July 1996 was retained here as the base population.

Thus, the adjusted general mortality rate had markedly declined since the mid-1970s, from 1,017 deaths per 100,000 population in 1976 to slightly over 719 deaths for 100,000 population in 1998. Moreover, a great difference was observed between adjusted rates of male and female mortality, in favour of women, but that this difference is decreasing with time. The adjusted mortality rates are identical for both sexes, only among children aged 1 to 4.

Mortality due to diseases of the circulatory system had been declining for 20 years, but these diseases are still the leading mortality cause in Québec. The second leading cause, malignant tumours, generated an adjusted mortality rate which has been stabilized since the late 1980s. Only diseases of the respiratory system show a rising mortality rate.

In 1998, mortality due to malignant tumours came very close to that due to diseases of the circulatory system. Among men, the adjusted mortality rates due to the main forms of cancer were either declining or stabilizing. Among women, the adjusted mortality rate due to cancer of the trachea, bronchi and lung rose steadily and even exceeded that of breast cancer in the early 1990s.

"Societal" mortality causes such as AIDS, alcoholism and cirrhosis as well as motor vehicle accidents, all show a falling adjusted mortality rate, whereas that linked with diabetes mellitus remains stable. Moreover, for the last 10 years, the adjusted mortality rate due to suicide has been increasing markedly.

SOME FIGURES

Population and number of deaths are both increasing. If the population increases more rapidly than the number of deaths, the general mortality rate then decreases; this was observed in Québec from 1951 to 1981, when the general death rate per 1,000 population fell from 8.6 to 6.5. Obviously, if the situation was reversed, the general death rate would increase, as was seen in Québec since 1981; in 1999, the general mortality rate was 7.4 deaths per 1,000 population.

Adjusted Mortality Rate

It is known that the population is aging, but the risk of dying before the age of 70 is decreasing, as reflected in the increase in life expectancy. Therefore, the best way to measure death risks and visualize their trends is to calculate an adjusted rate (also called comparative or standardized rate) of mortality, which cancels out the effect of population aging. The adjusted rates presented here were calculated based on the Québec reference population observed in July 1996.

Since the mid-1970s, the adjusted mortality rate within the Québec population has fallen by more than 29%. In 1998, the rate was 719.4 deaths per 100,000 population.

Mortality by Sex and Age

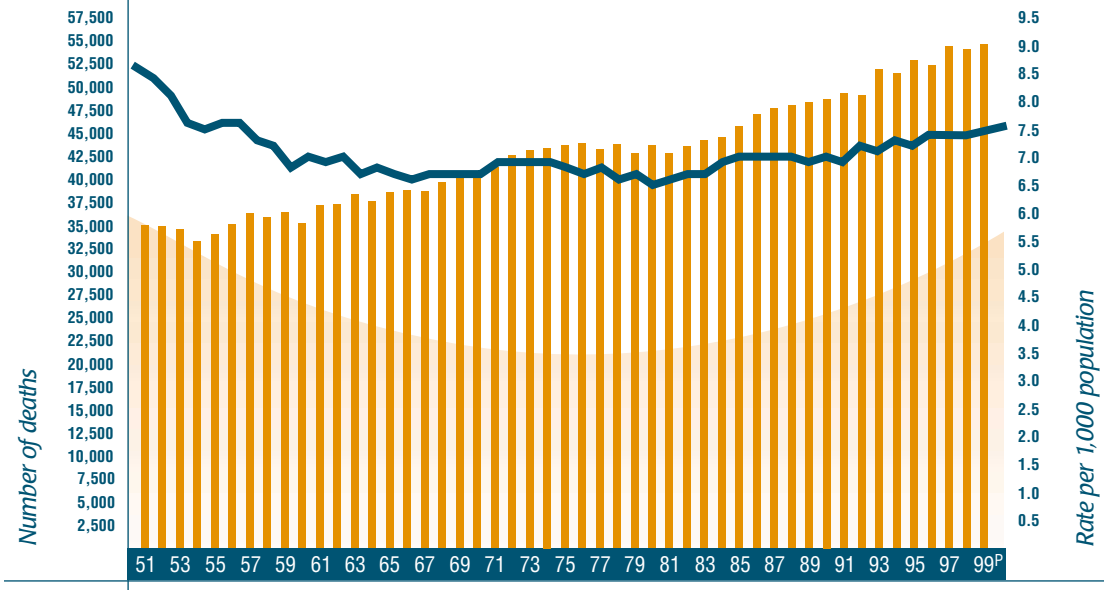
There is a great difference between women and men in mortality by sex and age, although this difference is decreasing over time. In 1976, the adjusted mortality rate for women was 7.8‰, whereas that of men was as high as 13.2‰ accounting for a difference of 5.4. Twenty years later, the rates are 5.5‰ and 9.6‰ respectively, or a difference of 4.1 between both sexes.

When mortality is stratified by age group and sex, it is observed that the gender differences in adjusted rate are particularly great among the 15 to 35 age group, with the highest rate found in the 20 to 24 age group. The differences then decrease until the age of 50, and rise again towards a new high in the 65 to 69 age group. From that point on, the difference decreases, especially from age 80 onwards. The male and female rates are identical among a single age group, that of children aged 1 to 4.

Figure 70

Number of Deaths and General Mortality Rate

within the Québec Population,
1951 to 1999



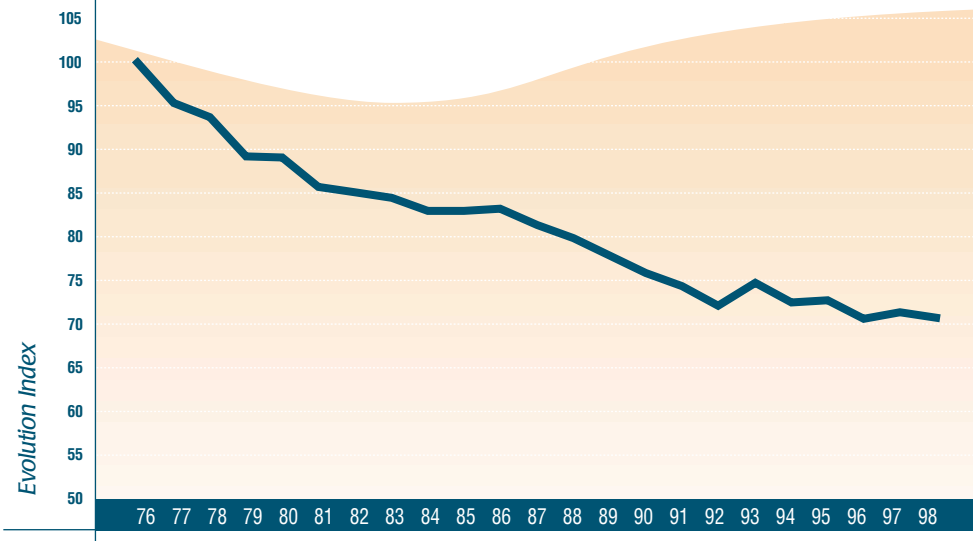
P = prediction
Number of deaths — General rate

MSSS, SDI, September 2000.

Figure 71

Change in Adjusted General Mortality Rate,

Québec,
1976 to 1998

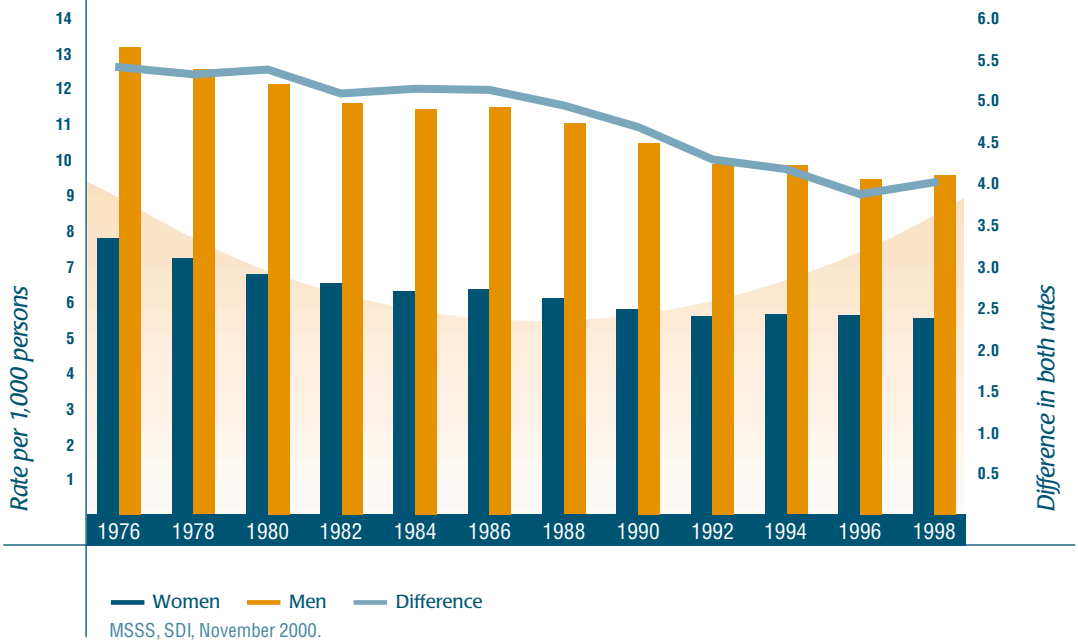


MSSS, SDI, November 2000.

Figure 72

Adjusted General Mortality Rate,

by Sex, Québec,
1976 to 1998

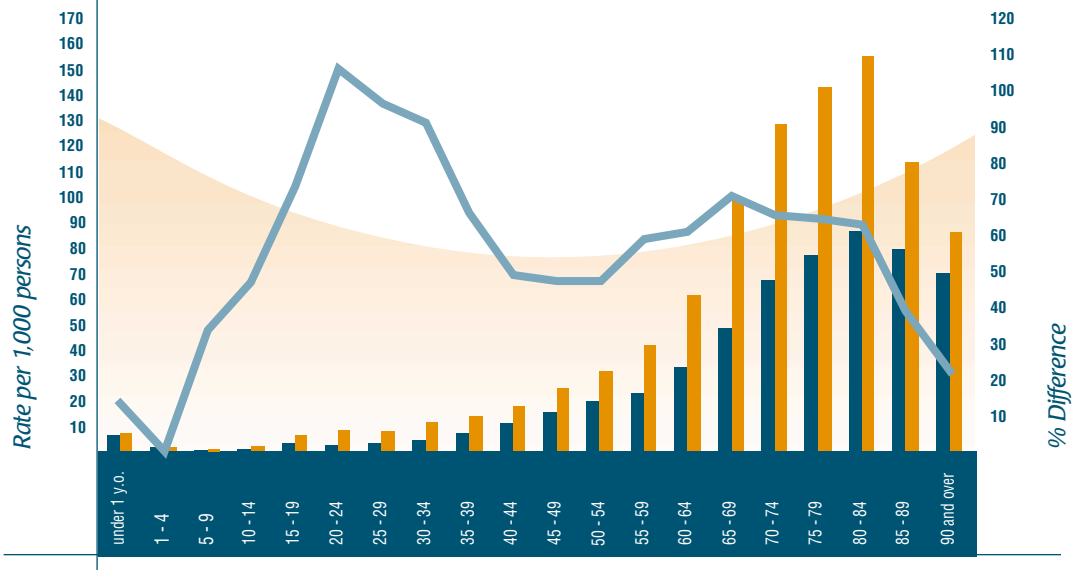


MSSS, SDI, November 2000.

Figure 73

Adjusted General Mortality Rate,

by Sex and Age Group, and Percentage Difference in the Rate for Both Sexes Combined, Québec,
1998



MSSS, SDI, November 2000.

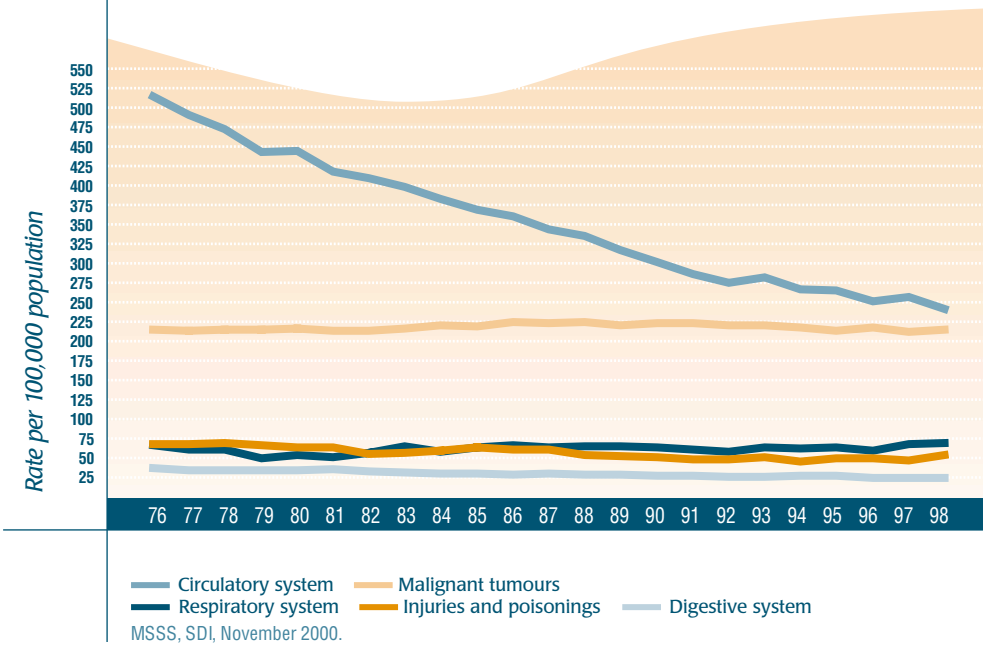
Main Mortality Causes

Diseases of the circulatory system, malignant tumours, diseases of the respiratory system, injuries and poisonings as well as diseases of the digestive system make up the five main mortality causes, accounting for more than 84% of all deaths in Québec.

The adjusted mortality rate due to diseases of the circulatory sytem, although still the leading mortality cause, has been decreasing markedly for 20 years. It was reduced by half during this period, from 516.2 deaths per 100,000 population in 1976 to 242.3 in 1998. The mortality rate linked to malignant tumours, a second leading cause, rose until the late 1980s and has since stabilized and even tended to decrease. Among the five major mortality causes, only diseases of the respiratory system generate a rising adjusted mortality rate; it rose from 67.5 per 100,000 population in 1976 to 70.1 in 1998.

Figure 74

Adjusted Mortality Rate According to Five Main Mortality Causes, Québec, *1976 to 1998*



MSSS, SDI, November 2000.

Mortality Due to Cancer

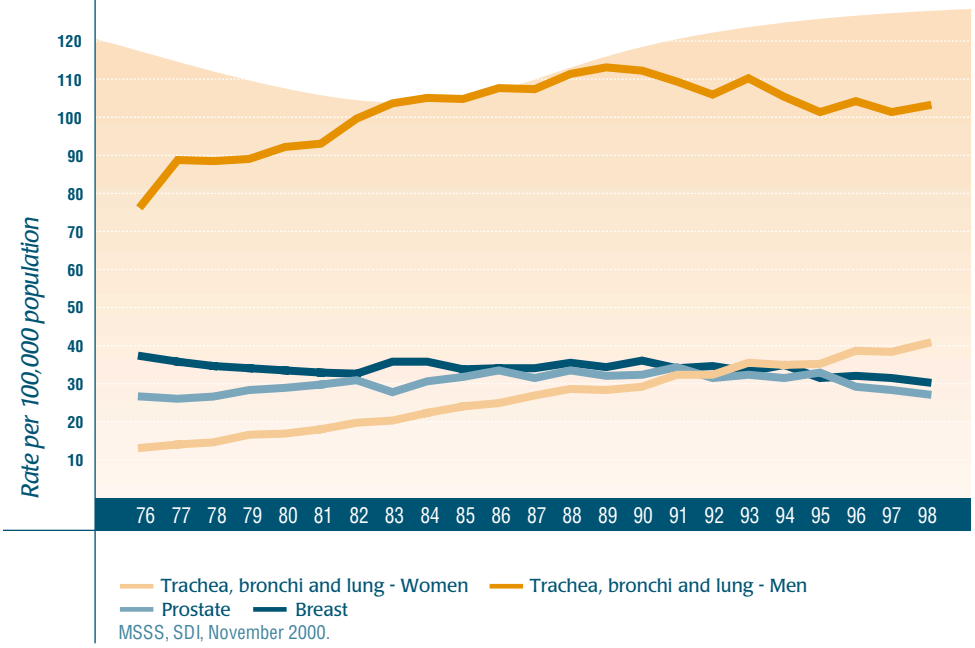
Mortality due to cancer remained high over the last 20 years, so much so that the adjusted mortality rate due to malignant tumours nearly caught up with that linked with diseases of the circulatory sytem in 1998; in 1976, it was lower than half of the latter (216.3 deaths per 100,000 population versus 516.2).

Among the main forms of cancer, breast cancer generates an adjusted mortality rate whose trend has been falling slightly since the early 1990s. The trend has been similar for the rate related to prostate cancer but the started a long time ago, since the mid-1980s.

Cancer of the trachea, bronchi and lung is by far the most deadly form of cancer for men. The adjusted male mortality rate for this form of cancer has stabilized and even slightly decreased since 1993, after having increased considerably from 1976 to 1990. On the other hand, for women, the rate rose steadily and even exceeded that related to breast cancer in the early 1990s. In 1998, the adjusted female mortality rate linked with cancer of the trachea, bronchi and lung was 40.6 per 100,000 population, compared to 30.4 for that related to breast cancer.

Figure **75**

Adjusted Mortality Rate
Due to Selected Forms of Cancer, Québec,
1976 to 1998



MSSS, SDI, November 2000.

Mortality Due to So-Called "Societal" Causes

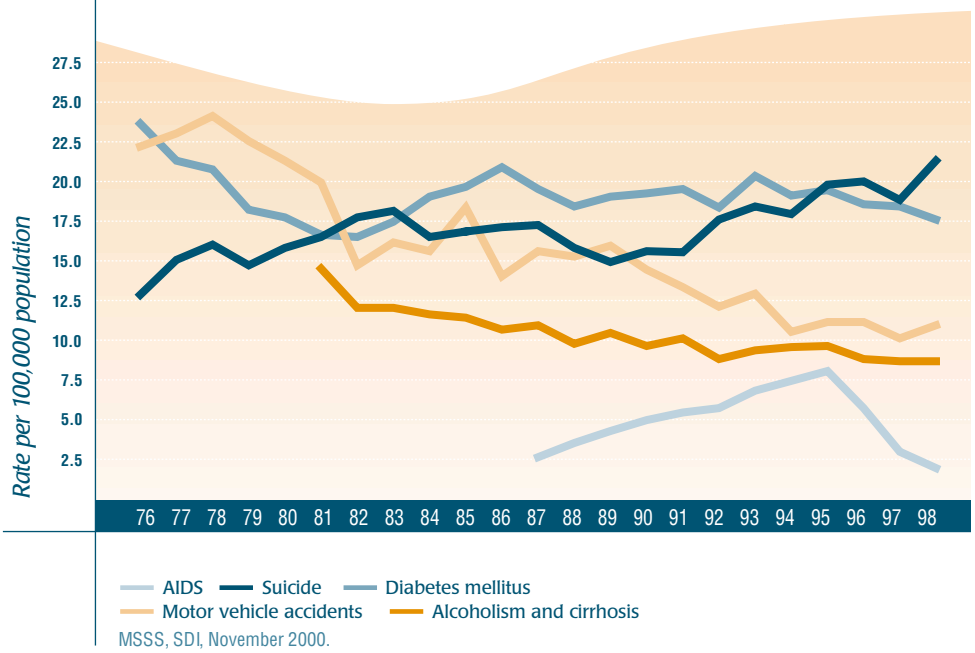
Some "societal" mortality causes such as AIDS, suicide, motor vehicle accidents, diabetes mellitus, alcoholism and cirrhosis are of particular interest.

The adjusted mortality rate due to AIDS rose steadily until the mid-1990s and has since fell markedly. The rate linked with alcoholism and cirrhosis is also falling, but in a much less spectacular way. Moreover, efforts invested by Québec over the last 20 years in promotion and prevention in the area of road traffic, appear to have yielded results, since the adjusted mortality rate due to motor vehicle accidents has declined steadily since 1976. The rate was reduced by half from 22.3 per 100,000 population in 1976 to 11.0 in 1998. As for diabetes mellitus, even though the incidence of the disease is rising, mostly as a result of better screening and greater awareness among the population of this disease and its effects, its adjusted mortality rate appears to have been quite stable since the mid-1980s. However, it should be noted that a large part of the population affected by this disease are not aware of their condition due to lack of early screening.

Lastly, among these so-called "societal" causes, suicide is the one that most strikes a chord with the population, not only because of what it is, but mainly because the adjusted mortality rate associated with it has been increasing markedly for nearly a decade. In 1976, the rate was 12.9 per 100,000 population. Over the following decade, it hovered around 16 per 100,000 population, but rose to 21.4 per 100,000 persons in 1998, or nearly double the rate at the beginning of the period, and 36% higher than in 1990.

Figure 76

Adjusted Mortality Rate
by Selected So-Called "Societal" Causes, Québec,
1976 to 1998



MSSS, SDI, November 2000.

Table 45

Adjusted Mortality Rate

by Cause and Adjusted Mortality Rate by Sex, Québec, *1976 to 1998*

Mortality cause	76	78	80	82	84	86	88	90	92	94	96	98
Circulatory system	516.2	473.6	446.0	411.2	384.3	362.2	336.3	302.5	276.8	267.7	252.6	242.3
Tumours	216.3	215.7	217.4	214.1	221.2	225.4	226.2	223.9	221.7	218.7	219.1	215.4
Trachea, bronchi and lung	41.5	47.2	49.6	54.2	57.5	59.7	63.2	63.9	62.9	64.0	65.5	66.0
Breast	37.2	34.6	33.6	32.6	35.9	34.2	35.5	36.0	34.6	34.8	32.2	30.4
Prostate	26.7	26.6	28.9	30.9	30.6	33.6	33.5	32.4	31.5	31.6	29.2	27.3
Respiratory tract	67.5	62.2	55.2	57.3	58.7	67.7	65.8	64.6	58.7	62.8	60.4	70.1
Injuries and poisonings	68.8	70.1	64.5	56.1	61.0	61.1	55.2	51.9	49.5	47.0	50.4	54.1
Motor vehicle accidents	22.3	24.2	21.4	14.8	15.7	14.1	15.3	14.5	12.2	10.6	11.2	11.0
Digestive system	38.5	34.7	35.2	33.1	30.5	29.4	29.1	27.4	26.1	27.6	25.1	25.6
Suicide	12.9	16.1	15.9	17.8	16.6	17.2	15.9	15.7	17.7	18.0	20.1	21.4
Diabetes mellitus	23.7	20.8	17.8	16.6	19.1	21.0	18.5	19.3	18.4	19.2	18.6	17.7
Alcoholism and cirrhosis				12.1	11.7	10.7	9.8	9.7	8.9	9.6	8.9	8.7
AIDS							3,6	5,0	5,8	7,5	5,8	2,0
Women	777.3	720.4	676.2	650.1	628.9	635.0	608.8	577.5	557.3	564.5	559.0	554.3
Men	1,316.9	1,250.9	1,212.7	1,158.2	1,141.7	1,146.3	1,101.2	1,044.2	984.6	981.4	945.3	955.4
Both sexes combined	1,017.1	953.7	906.6	866.1	844.8	846.7	811.8	771.5	733.8	737.3	718.7	719.4

SSS, SDI, November 2000.

POTENTIAL YEARS OF LIFE LOST

Potential years of life lost (PYLL) indicate premature mortality within a population, taking into account the incidence of early deaths. This indicator measures the difference between age at death and threshold age, in terms of years, for each individual who dies before reaching the age threshold set. Thus, the PYLL rate is expressed as the ratio of the sum of PYLLs to the population whose age is lower than the threshold set. In this case, the threshold is set at age 75 and the rate is per 100,000 population.

On the whole, the Québec PYLL rate is falling. However, although the gender difference is becoming smaller, the rate is still much higher for men in all age groups.

Tumours are the cause of a third of all PYLLs accounted for while injuries and poisonings represent a quarter of all PYLLs. For the leading causes of PYLL, except for diseases of the circulatory system, a considerable difference is noted between the number of PYLLs observed in men and that observed in women, the rate being in favour of the latter.

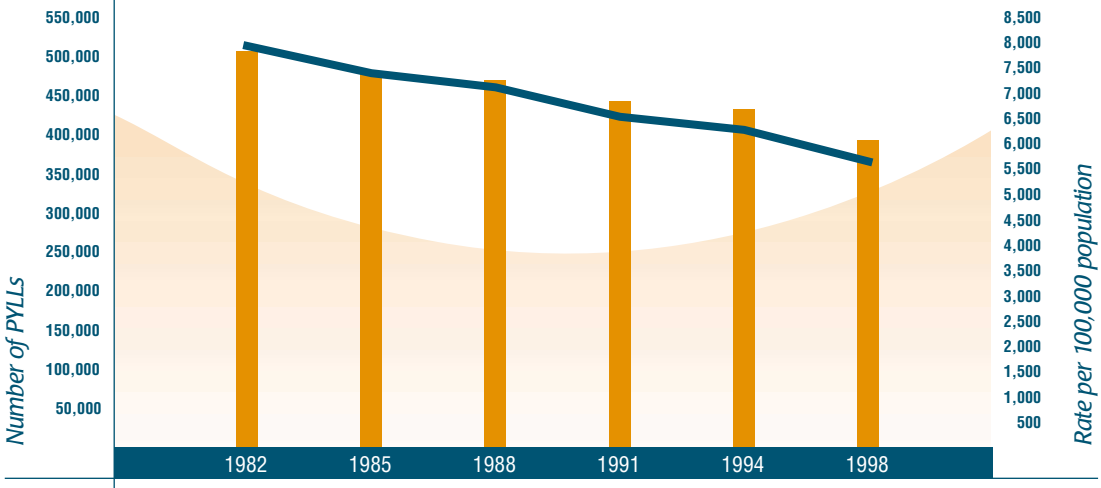
SOME FIGURES

In the early 1980s, there were approximately 170,000 PYLLs among Québec women and approximately 340,000 PYLLs among Québec men, that is, a PYLL rate that is nearly two times higher for men than for women. In 1998, the PYLL rate per 100,000 men under the age of 75 was still much higher than the rate for women (7,133 versus 4,122), but the difference is becoming smaller. However, the rate is falling in both cases, reflecting a reduction in the number of PYLLs among both men and women. Given the increase in population, the falling trend in the rate is more pronounced than that in the number of PYLLs.

The distribution of the number of PYLLs by age group and sex in 1998 confirms the general trend. In fact, in all five-year age group without exception, the number of PYLLs among women is lower than the number observed among men. For both sexes, it is between the ages of 45 and 70 that the highest number of years of life is lost, the maximum being between the ages of 55 and 60 for women, and between the ages 50 and 55 for men. Except for children under one year of age where the number of PYLLs is around 15,000, it is before the age of 15 that the fewest years of life are lost, numbering between 1,500 and 3,200 by sex and age group.

Figure 77

Number of Potential Years of Life Lost (PYLLs),
and Rate per 100,000 Population, within the Québec Population,
1982 to 1998

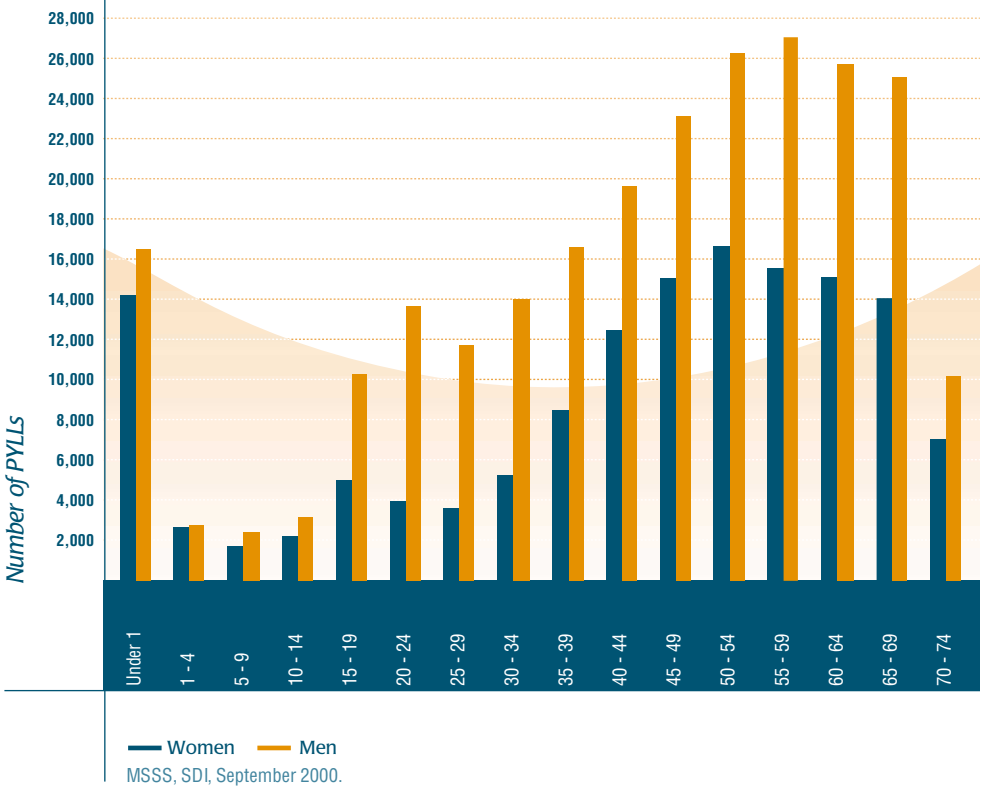


1. Threshold age set at 75.

MSSS, SDI, September 2000.

Figure 78

Number of Potential Years of Life Lost (PYLLs),
by Age Group and Sex, Québec,
1998



MSSS, SDI, September 2000.

Among men, in 1998, injuries and poisonings were the leading cause of years of life lost (with more than 71,500 PYLLs), followed by tumours (more than 68,500 PYLLs). Among women, tumours were the leading cause (33%), followed by injuries and poisonings (24%). Although, the gender difference is relatively small for tumours and diseases of the respiratory system, the same cannot be said about diseases of the circulatory system (including acute myocardial infarction), about injuries and poisonings (including motor vehicle accidents), and suicide, where the differences are considerable, that is, up to three times more PYLLs recorded for men than for women.

In total, in 1998, tumours were the cause of a third of PYLLs, injuries and poisonings were responsible for a quarter, and diseases of the circulatory system 18%.

PRINCIPAL HEALTH PROBLEMS

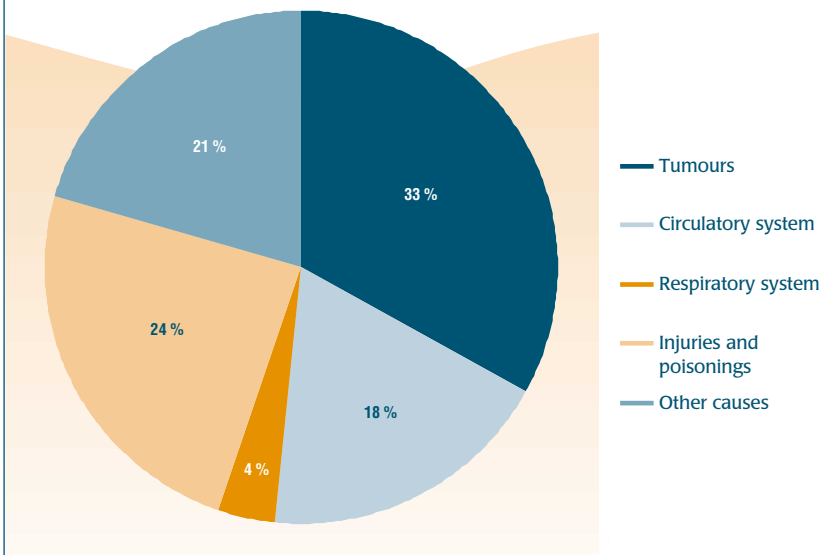
A number of health problems that affect a population are of particular interest either because of their incidence or because they are on the increase, or just simply because they strike a chord with the population. Therefore, a closer examination is needed to identify the characteristics of the overall health status of the Québec population.

Among chronic health conditions, those related to arthritis and rheumatism are most common within the population, with a ratio of 13.2 cases per 100 persons in 1998. Asthma and diabetes, on the other hand, have increased the most over the last ten years.

The incidence of AIDS has dropped sharply since 1994. In 1999, the number of new AIDS cases was 13 times lower than in 1995. However, the situation is totally different from that of diabetes, whose incidence is rising markedly despite a definite underestimate due to the survey method as well as a lack of screening. In 1998, among people aged 45 and over, more than one in ten persons was diabetic.

Figure **79**

Percentage Distribution of Number of Potential Years of Life Lost (PYLLs),
by Cause, Québec,
1998



MSSS, SDI, September 2000.

Mortality due to cardiovascular diseases is falling, but considerable differences still exist based on people's income level. In 1998, the adjusted mortality rate due to these diseases was 22% lower for men with a high income and 11% lower for women with the same income level.

Given that cancer affects older persons more and that the Québec population is aging rapidly, the incidence of cancer is following the same trend, that is, it is increasing at an annual rate of 3%. The incidence of lung cancer, among the most common form of cancer in both women and men, is rising. This trend alone counterbalances the fall observed for the total of all other cancer sites.

For 20 years, the incidence of chronic obstructive pulmonary diseases has increased three times more among women than among men, although in 1998, the adjusted mortality rate due to these diseases was still 2.5 times higher for men than for women. Moreover, mortality linked with pneumonia and influenza is once again on the increase.

In 1998, over two-thirds of deaths due to injuries and poisonings occurred among men. The adjusted mortality rates related to these problems have been falling for 20 years, except for suicide and non-intentional falls. The increase in suicide appears to be exclusively among men, whereas it is mostly people aged 80 and over, most of them women, who are victims of non-intentional falls.

SOME FIGURES

Chronic Health Conditions

In 1998, the chronic health conditions that were most often reported by Québeckers were, in order of importance: arthritis and rheumatism, hypertension, respiratory illnesses, heart diseases, asthma, and mental disorders. These were followed, in order of importance, by diabetes and bronchitis or emphysema.

A comparison of 1998 data with those of 1987 shows that there is a widespread increase of these conditions within the population. Conditions that have developed the most are asthma, whose number of cases has more than doubled in ten years, and diabetes, which has increased by nearly 65%. Cases of mental disorders, on the other hand, have basically stayed the same, with a slight increase of 4.3%.

AIDS

Although during the last decades, the prevalence of infectious diseases has fallen drastically as a result of efforts in prevention and protection, new problems, including AIDS, have appeared.

Table 46

Relative Importance of the Principal Chronic Health Conditions Reported by the Québec Population, *1987 and 1998*

Type of health condition	Number of conditions per 100 persons		
	87	98	% variation (98 / 87)
Arthritis and rheumatism	10.7	13.2	23.4
Hypertension	6.3	8.5	34.9
Respiratory illnesses	4.3	5.8	34.9
Cardiac diseases	4.2	5.2	23.8
Asthma	2.3	5.0	117.4
Mental disorder	4.6	4.8	4.3
Diabetes	1.7	2.8	64.7
Bronchitis or emphysema	1.9	2.5	31.6

Note: Data from the ISQ Santé-Québec surveys of 1987 and 1998.

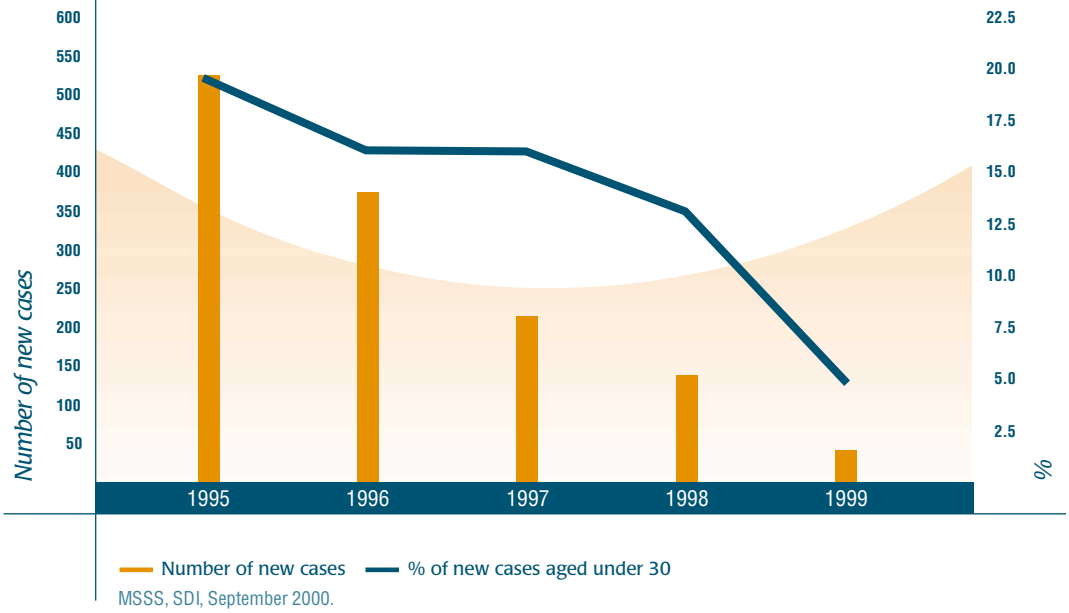
MSSS, SDI, September 2000.

In 1994, 4,275 AIDS cases were reported in Québec. More than three-quarters of these cases were diagnosed when the infected person was between 25 and 45 years of age. On December 31, 1999, the prevalence of AIDS (total number of infected persons) was 5,565 cases, or 30% more than in 1994. However, the distribution by year of the 1,290 new cases recorded during these two years shows an impressive fall in the incidence of the disease. Thus, there were 41 new cases of AIDS in 1999 whereas in 1995, there were 524 cases, or close to 13 times more. From 1995 to 1999, the proportion of new cases among people aged under 30 when they were diagnosed dropped from 20% to 5%.

Figure 80

Incidence of AIDS

and Proportion of New Cases Among People Aged Under 30, Québec, *1995 to 1999*



MSSS, SDI, September 2000.

Table 47

Prevalence of Reported AIDS Cases,

by Age of the Infected Person at the Time of Diagnosis, Québec, *1994 and 1999*

Age group	94		99		% variation 99 / 94
	Number of cases	% distribution	Number of cases	% distribution	
Under 15	72	1.7	97	1.7	34.7
15 - 19	17	0.4	20	0.4	17.6
20 - 24	154	3.6	175	3.1	13.6
25 - 29	620	14.5	738	13.3	19.0
30 - 34	987	23.1	1,251	22.5	26.7
35 - 39	926	21.7	1,233	22.2	33.2
40 - 44	693	16.2	912	16.4	31.6
45 - 49	396	9.3	567	10.2	43.2
50 - 54	187	4.4	270	4.9	44.4
55 - 59	111	2.6	154	2.8	38.7
60 and over	112	2.6	148	2.7	32.1
Total	4,275	100.0	5,565	100.0	30.2

MSSS, SDI, September 2000.

Diabetes

Diabetes is a disease which is clearly on the rise. Moreover, given the self-reporting method used during the surveys and the fact that many people who have the condition have not yet been diagnosed, it can be asserted that the available data, including data recorded in RAMQ files, underestimate the problem.

In 1998, data provided by the RAMQ showed that close to 6% of the population aged 15 and over were diabetics (Type I and Type II combined). This percentage rises to nearly 11% if only the population aged 45 and over is considered and to 15.5% if only people aged 65 and over are considered.

Cardiovascular Diseases

Although the adjusted mortality rate due to cardiovascular diseases has considerably decreased over the last 20 years (a decrease of 50% for both sexes), these diseases were still the leading mortality cause in Québec, with close to 19,000 deaths in 1998.

Moreover, even though mortality due to cardiovascular diseases is decreasing, irrespective of income, disparities still exist within the population. Thus, in 1987, the difference between adjusted mortality rates was 29% for men and 21% for women, the rate being in favour of people with a high income, compared to people with a low income. However, it should be noted that this difference has decreased significantly; in 1998, it was 22% for men and only 11% for women.

Cancer

Cancer is, relatively speaking, a disease of older people. As the Québec population is not only growing but also aging, this is directly reflected in the incidence of cancer. Thus, in 1999, the number of new cancer cases was estimated at 31,800, while there were just under 26,600 cases, or 20% fewer cases, in 1990. In the coming years, the incidence of cancer should continue to rise, at a yearly rate of close to 3%.

Three particular cancer sites account for more than half of all new cases in both men and women. For men, they are lung cancer, prostate cancer as well as cancer of the colon and the rectum. For women, breast cancer is added to lung cancer, colon cancer and cancer of the rectum.

In 1998, cancer was the second leading mortality cause, with more than 16,400 deaths. Since 1976, the increase in deaths by lung cancer has counterbalanced the decrease in deaths due to other types of cancer, so much so that, on the whole, the cancer mortality rates observed in 1998 were more or less the same as those observed in 1976. However, it should be noted that the rates increased until 1990 and decreased thereafter.

In Québec, on average, the many forms of cancer result in some 600,000 hospitalization days per year, a third of which relate to adults aged 45 to 64.

Whereas mortality rates linked to other forms of cancer decreased by 15% in 20 years, the lung cancer mortality rate among women increased by over 200% from 1976 to 1998 (from 13.1 to 40.6 per 100,000 women). During that time, the breast cancer mortality rate decreased by 18%, from 37.2 to 30.4 per 100,000 women, despite the rising incidence.

Respiratory Diseases

In 1998, diseases of the respiratory system were the third leading mortality cause, with more than 5,400 deaths, some 3,000 of which were due to chronic obstructive pulmonary diseases. Mortality rates related to the latter are 2.6 times higher in men than in women. However, for the last 20 years, the incidence of obstructive pulmonary diseases has risen three times more among women than among men (a rise of 150% and 52% respectively). Between 1976 and 1998, the adjusted male mortality rate due to these diseases increased from 42 to 64 per 100,000 men, whereas the female rate rose from 10 to 25 per 100,000 women.

After having decreased since the late 1980s, the adjusted mortality rate for pneumonia and influenza is once again on the increase. The highest rates are, of course, observed among older persons.

Injuries and Poisonings

Injuries and poisonings were responsible for more than 4,000 deaths in 1998, two-thirds of which were among men. Close to 2,000 deaths occurred among persons under the age of 50.

In 1998, there were some 390,000 hospitalization days to treat injuries and poisonings, 28% of which involving women aged 75 and over, and 23% involving men aged 25 to 64. However, the average length of hospital stay of the former was three times longer than that of the latter (15 days versus 5 or 6 days).

From 1976 to 1998, the adjusted mortality rate due to injuries and poisonings fell from 69 to 54 per 100,000 population, as a result of the significant drop in mortality due to motor vehicle accidents. However, during the same period, the adjusted mortality rate due to suicide rose from 13 to 21.4 per 100,000 population, that is, an increase uniquely attributed to the rise in suicide among men (especially among those under the age of 50), reflecting a spectacular increase of 82% in the male rate.

After having decreased until the late 1980s, mortality due to non-intentional falls, which mostly affects people aged over 80, has since been increasing.. Thus, given that the population is aging, the weight of this mortality cause among non-intentional causes of mortality should increase in the coming years.

PSYCHOLOGICAL DISTRESS

Psychological distress, which is highly prevalent among the Québec population was measured with an index that includes four factors: depression, anxiety, cognitive disorders and irritability. A high level of psychological distress corresponds to an index that is equal to or higher than 22.6 on the measurement scale.

The psychological distress index (PDI) is associated with a number of behaviours or dysfunctional behaviours, for example, increase in alcohol or psychotropic drug consumption, increased use of health services, or a negative "self-rated" health status. However, this measure is not accurate and covers several dimensions that cannot be fully grasped with the usual statistical instruments. Thus, in order to accurately measure the level of psychological distress prevalent in the population, several other qualitative and quantitative measuring instruments must be added.

For the purposes of this report, only the development of psychological distress and suicidal tendencies within the population aged 15 and over since 1987 will be examined.

Psychological distress has gained ground in Québec over the last ten years. In 1998, one in five persons rated high on the psychological distress index. The problem is markedly worse in women than in men. Moreover, psychological distress is much more present among young people aged 15 to 24. Indeed, the older the age, the less acute the problem. However, with time the problem worsens among all age groups, except for persons aged 65 and over. Among the latter, the problem is relatively small and tends to lessen.

A considerably greater proportion of people with a high psychological distress index is found among single people compared with married people, and this is true of both sexes. The same is true of the unemployed as well as women who are engaged in studies and men who are homemakers.

Moroever, for the last ten years, there has been an increase in the proportion of men and women who have suicidal thoughts. Furthermore, this phenomenon is growing among all age groups, except among persons aged 65 and over, for whom the problem is decreasing.

SOME FIGURES

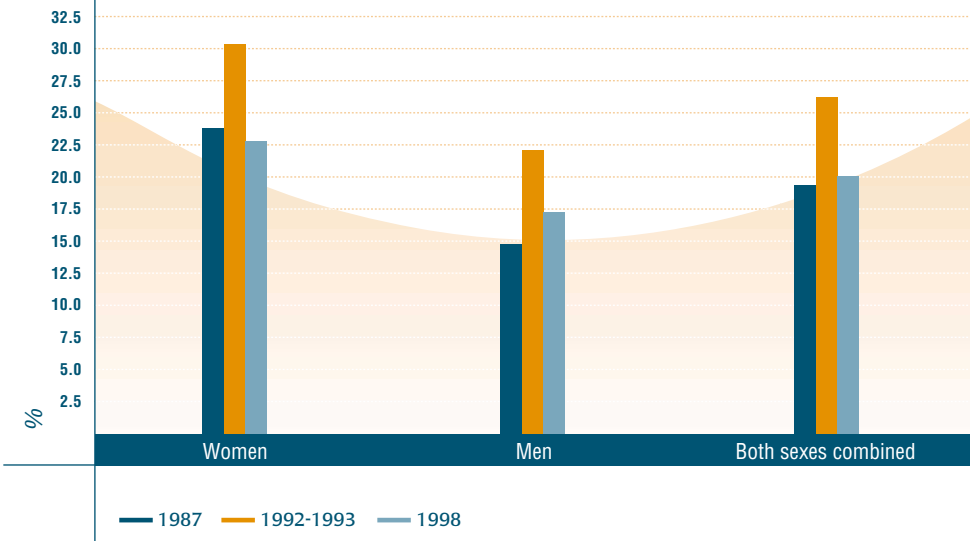
In 1987, more than 19% of the population aged 15 and over rated high on the psychological distress index (PDI). Five years later, the proportion had risen to more than 26%. In 1998, it was slightly above 20%. In general, the proportion is 7 to 8 percentage points higher among women than men.

The greatest proportion (over 28% in 1998) of people with a high IDP is observed among people aged 15 to 24, and the proportion decreases steadily as age increases. Thus, the smallest proportion (under 11% in 1998) is found among people aged 65 and over, and unlike in the other age groups, it has been decreasing since 1987.

Figure 81

Proportion of Population Aged 15 +

with a High Psychological Distress Index, by Sex, Québec,
1987, 1992-1993 and 1998



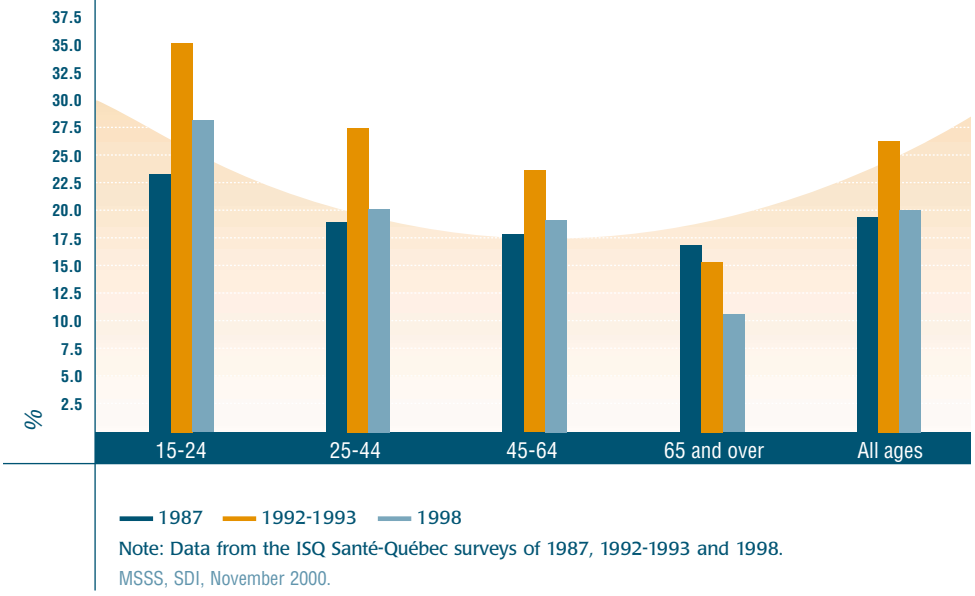
Note: Data from the ISQ Santé-Québec surveys of 1987, 1992-1993 and 1998.

MSSS, SDI, November 2000.

Figure 82

Proportion of Population Aged 15+

with a High Psychological Distress Index, by Age Group, Québec,
1987, 1992-1993 and 1998



Note: Data from the ISQ Santé-Québec surveys of 1987, 1992-1993 and 1998.

MSSS, SDI, November 2000.

In 1998, the stratification of the population according to marital status and activity status yields some interesting points. For example, in both women and men, the proportion of people with a high PDI is considerably greater among single people than among other groups. Moreover, a greater number of women who are engaged in studies (35.3% in 1998) or are unemployed (33.3%) have a high PDI. Among men, the greatest proportion is observed among unemployed men (28%) followed by men who are homemakers. For both sexes, the lowest proportion is found among the retirees.

When the population aged 15 and over is observed over periods of 12 consecutive months, it is noted that there has been an increase in the presence of suicidal thoughts since 1987. In 1987, 3.2% of women and 3% of men had suicidal thougths. Ten years later, 3.9% of both men and women reported having such thoughts.

Moreover, suicidal thougths are increasingly present among all age groups, except among people aged 65 and over. Among the latter, barely 0.5% of the population reported having had suicidal thgoughts in 1998, a proportion that has been decreasing for the last ten years.

On the other hand, among people aged 15 to 24, the proportion was 7.4% in 1998, or 2 percentage points higher than in 1987. However, this proportion is comparable to that observed in 1992-1993 (7.3%).

Table 48

Proportion of Population Aged 15+

with a High Psychological Distress Index, by Marital Status and Sex, Québec, *1998*

Marital status	Women	Men	Both sexes combined
Married	18.3	12.4	15.3
Cohabitation	23.4	19.2	21.3
Widowed, separated or divorced	22.9	19.7	21.8
Single	30.0	23.1	26.3

Note: Data from the ISQ Santé-Québec 1998 survey.

MSSS, SDI, November 2000.

Table 49

Proportion of Population Aged 15+

with a High Psychological Distress Index, by Activity Status and by Sex, Québec, *1998*

Activity status	Women	Men	Both sexes combined
Employed	22.8	16.0	19.0
Engaged in studies	35.3	21.8	28.5
Homemaker	18.5	22.5	18.9
Retired	15.2	10.6	12.6
Unemployed	33.3	28.0	30.0

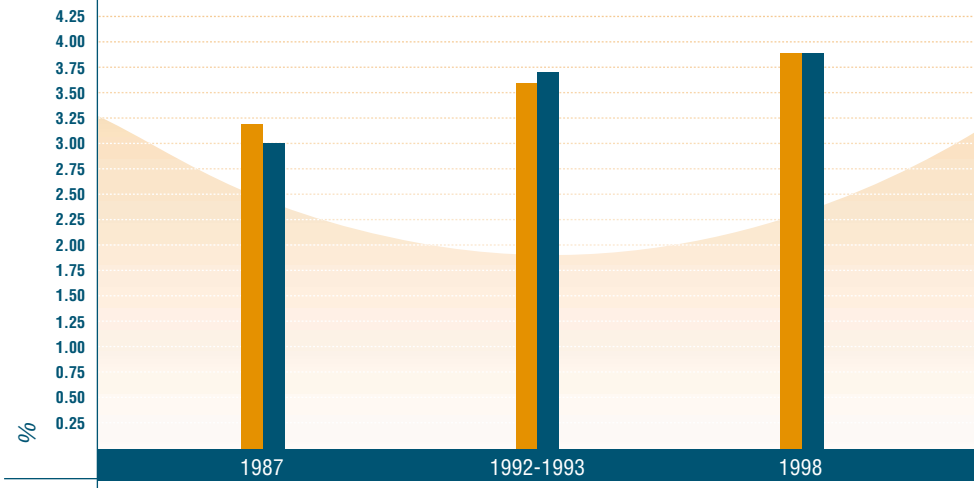
Note: Data from the ISQ Santé-Québec 1998 survey.

MSSS, SDI, November 2000.

Figure 83

Proportion of Population Aged 15+

Having Expressed Suicidal Thoughts During the 12 Months Preceding the Survey, by Sex, Québec, 1987, *1992-1993 and 1998*



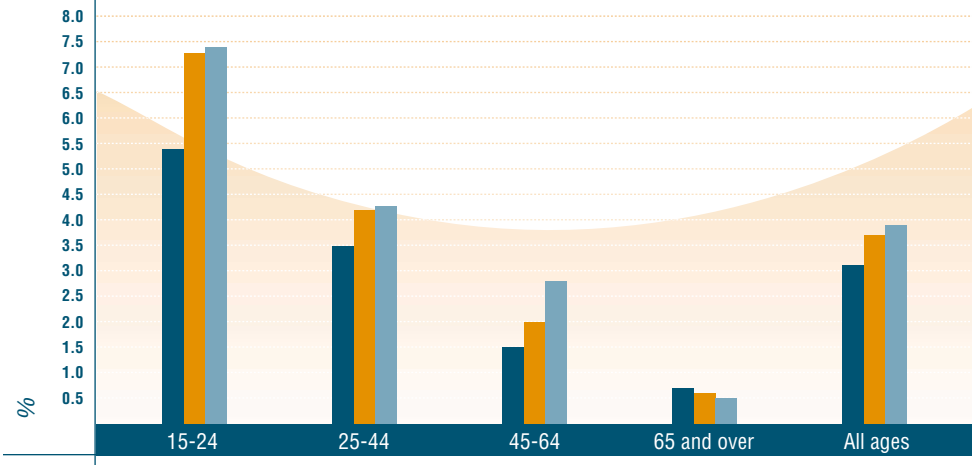
Note : Data from ISQ Santé-Québec surveys of 1987, 1992-1993 and 1998.

MSSS, SDI, November 2000.

Figure 84

Proportion of Population Aged 15 +

Having Expressed Suicidal Thoughts During the 12 Months Preceding the Survey, by Age Group, Québec, *1987, 1992-1993 and 1998*



Note : Data from ISQ Santé-Québec surveys of 1987, 1992-1993 and 1998.

MSSS, SDI, November 2000.

INDUCED ABORTION

For the last two decades, there has been a relatively steady increase in the use of therapeutic abortion in Québec. The trend is seen in all age groups, up to age 44, but the greatest increase is among women aged 18 to 24, a rate that is 2.5 times higher in 1998 than in 1980.

The total abortion rate is an accurate measure of the phenomenon and its evolution. It calculates the average number of abortions per woman, by age, in a given year, based on a generation of women whose abortion rates have been observed.

Thus, it can be estimated that, in 1980, 19% of women of childbearing age whose abortion rates were observed at each age corresponding to this childbearing period, resorted to at least one induced abortion during their lifetime. If the same estimates were made based on abortion rates observed in 1995, the percentage would be 34%.

In fact, 12% of pregnancies ended with an induced abortion in 1980; this proportion more than doubled (26%) in 1997.

SOME FIGURES

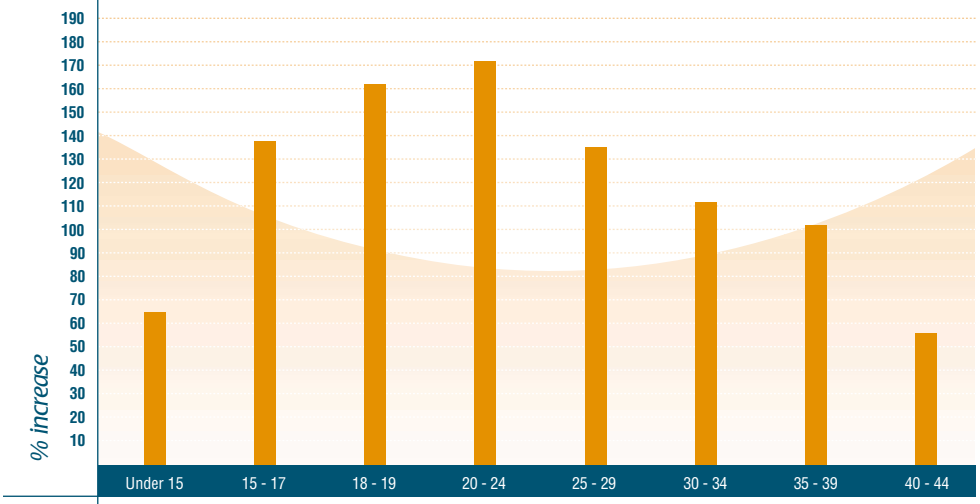
From 1980 to 1998, the rate of therapeutic abortion for women aged 14 to 44 rose from 9.0 to 18.2 abortions per 1,000 women, or an increase of more than 100%.

The increase was even greater (131%) among women under age 18. However, the highest number of women resorting to abortion are aged 18 to 24, and it is also among this age that the phenomenon is increasing at the highest rate. In 1998, there were 37.5 abortions per 1,000 women in the 18 and 19 year-old group whereas there were 14.3 abortions in 1980. The same trend is observed in women aged 20 to 24, with the rate rising from 14 to 38.1 during the same period. Only the groups under age 15 and aged 40 to 44 have not seen their abortion rate at least double. In 1998, the rates for these two groups were 65% and 56% respectively.

In 1980, the total abortion rate, that is, the average number of abortions per woman, was 0.26. In 1998, it was 0.61, or 2.3 times higher.

Figure **85**

Percentage Increase in Abortion Rate per 1,000 Women of Childbearing Age, by Age Group, Québec, *from 1980 to 1998*

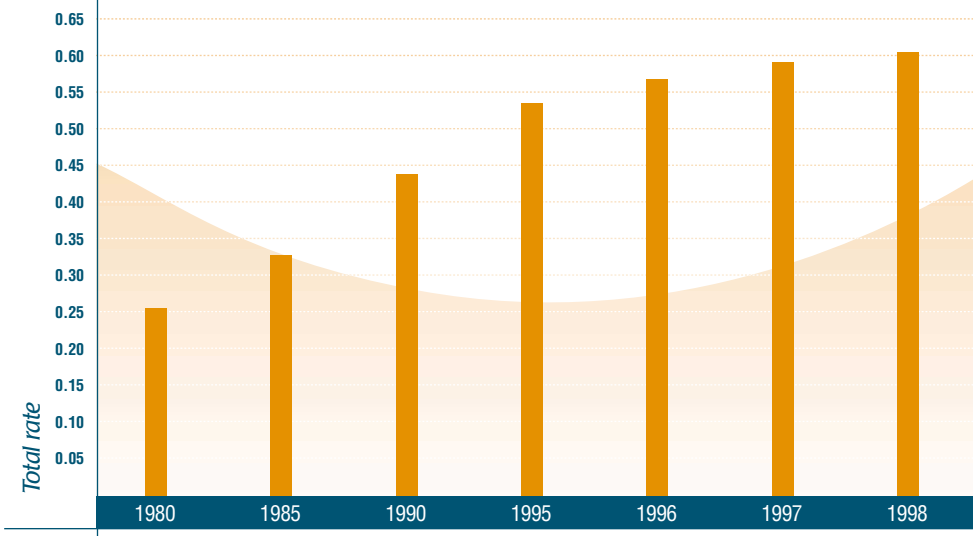


MSSS, SDI, November 2000.

Figure 86

Total Abortion Rate per Woman,

Québec,
1980, 1985, 1990 and 1995 to 1998



MSSS, SDI, November 2000.

Table 50

Abortion Rates[1] per 1,000 Women,

by Age Group, Québec,
1980, 1985, 1990 and 1995 to 1998

Age group	80	85	90	95	96	97	98
Under 18	5.9	9.2	11.2	12.1	12.6	13.2	13.6
Under 15	2.0	3.2	3.7	4.4	3.8	4.3	3.3
15 - 17	7.1	11.2	13.7	14.7	15.4	16.0	16.9
18 and 19	14.3	18.7	26.2	33.5	34.7	35.6	37.5
20 - 24	14.0	18.8	27.5	34.1	35.9	38.3	38.1
25 - 29	11.7	14.2	18.9	23.7	25.5	26.4	27.5
30 - 34	8.1	10.3	12.5	14.9	16.3	16.8	17.2
35 - 39	4.8	5.7	7.3	8.5	9.1	9.4	9.7
40 - 44	1.8	1.8	2.0	2.5	2.6	2.8	2.8
45 and over	0.3	0.2	0.1	0.2	0.2	0.2	0.2
14 - 44	9.0	11.2	13.9	16.2	17.1	17.8	18.2

1. Data compiled from those pertaining to the R-12 file of the RAMQ, and from unpublished data from the CLSC and institutions where abortions that are not compensated as a fee for service are carried out; this data compilation was done at the ministère de la Santé et des Services sociaux du Québec.

MSSS, SDI, November 2000.

LIFESTYLE

The physical, social and economic environment as well as lifestyle have a determining influence on individuals' health.

Although great progress has been achieved as a result of certain behavioural changes, for example, the reduction of traffic accidents by 50%, attributed in part to the marked decrease in the incidence of drunk driving, the fact remains that some lifestyle choices still have a great, negative impact on the health of Québeckers.

Physical activity contributes greatly to the good health of a population. It is widely known that the regular practice of a moderate physical activity leads to a significant reduction in premature mortality, obesity, hypertension, cardiovascular diseases, diabetes and osteoporosis.

In 1998, half of people aged 15 and over stated that they practised a recreational physical activity at least once a week. However, the proportion of physically active persons who exercise two times or more per week has increased, while those who exercise less than once a week, are exercising even less. Thus, a physically inactive (sedentary) trend among a large proportion of the population leads us to expect negative effects on the prevalence of numerous diseases.

In Québec, the proportion of overweight people has increased steadily since 1987 and this problem markedly affected for men than women. As age increases, the problem worsens, except among people aged 65 and over. Moreover, in this age group, the problem is slightly more serious for women.

Excess weight is basically the result of physical inactivity combined with a high fat and high sugar diet. It constitutes a high risk factor for early death. In fact, obesity increases the risk of developing cardiovascular diseases and some forms of cancer. Moreover, it is the cause of several debilitating diseases linked with hypertension, strokes, diabetes mellitus and disease of the joints and arthritis.

Excessive alcohol consumption is one of the worst risk factors for the health and welfare of individuals. Apart from creating family, professional and social problems, it causes traffic accidents, work-related accidents, family violence and injuries. Moreover, a high level of alcohol consumption increases the risk of developing cirrhosis, certain forms of cancer and hypertension, not to mention the risks of strokes and birth defects.

According to the Health and Social Survey conducted in 1998 in Québec, approximately 10% of regular or occasional drinkers stated that they had had 14 or more drinks during the seven days preceding the survey. However, the proportion of those who did not have any drink is increasing compared to the situation prevailing ten years ago (from 25.9% in 1987 to 37% in 1998).

The proportion of young drinkers aged 15 to 24 who stated that they had got drunk over the 12 months preceding the survey is not only very high compared to that of older people, but is also inscreasing sharply.

Smoking is the risk factor linked to the greatest number of preventable diseases. It is the cause of numerous types of cancer (in particular, 90% of lung cancer) and numerous respiratory diseases. It increases the risk of low birth weight, sudden infant death and allergies. Moreover, smoking doubles the risk of heart attacks. Lastly, it is estimated that 50% of people who are regular smokers will die as a result of problems caused by their smoking, and 50% of these people will die before the age of 70.

In Québec, the situation has improved over the last ten years, with a decrease in the proportion of smokers by 15%. At the same time, the proportion of those who have never smoked increased by 6%. However, up to age 45, the proportion of regular smokers is greater than that of ex-smokers, while after age 55, the proportion of ex-smokers is two times greater than that of regular smokers.

On the other hand, the situation of young people is of great concern given that one in three youths aged 15 to 19 smokes occasionally or regularly. Over one-third of them smoked their first cigarette at age 12 and 80% at age 14. Lastly, the proportion of young female smokers is 26% higher than that observed in boys of the same age.

Furthermore, drug consumption can be the cause of numerous social and health problems, the extent of which is determined by the nature, quantity and pattern of consumption of mood-altering drugs. There are any number of consequences of drug addiction ranging from a light physical problem (e.g., decreased salivation) to physical or psychological dependency, including unfortunate pregnancy problems (e.g., miscarriage or congenital malformation) and a whole range of dysfunctional social behaviour.

In Québec, since 1992-1993, the proportion of persons aged 15 and over who have never taken drugs has remained more or less the same, around 69%. In total, in 1998, one in ten persons stated that they had smoked marijuana, one or several times during a period of 12 consecutive months preceding the survey. If all drugs are taken into account, the ratio increases to close to one in five persons and two in five persons among those aged 15 to 24 years.

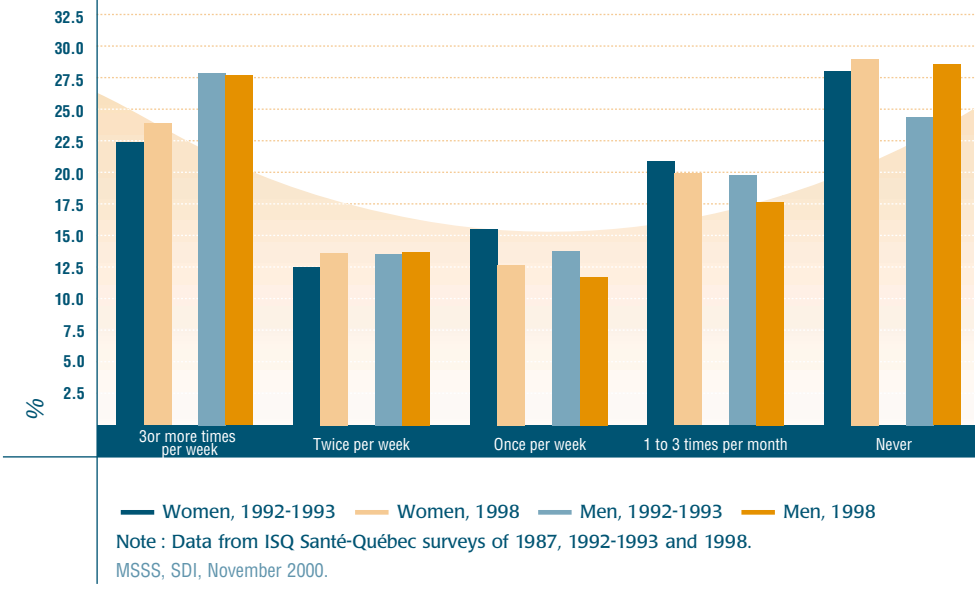
SOME FIGURES

Physical Activity

In 1998, in Québec, 54% of men and 50% of women stated that they practised a recreational physical activity at least once a week. However, 29% of the population aged 15 and over never do any recreational physical activity, that is, 2.6 percentage points more than in 1992-1993. Although a decrease in physical activity is observed among those who exercise at most once per week, for both sexes, there is an increase among those who exercise twice or more times per week. Thus, 28% of men aged 15 and over and 24% of women of the same age stated that they practised a recreational physical activity three times or more per week.

Figure 87

Proportion of Persons Aged 15+
who Practised a Recreational Physical Activity, by Frequency of Practice and Sex, Québec,
1992-1993 and 1998



Note : Data from ISQ Santé-Québec surveys of 1987, 1992-1993 and 1998.
MSSS, SDI, November 2000.

Excess Weight

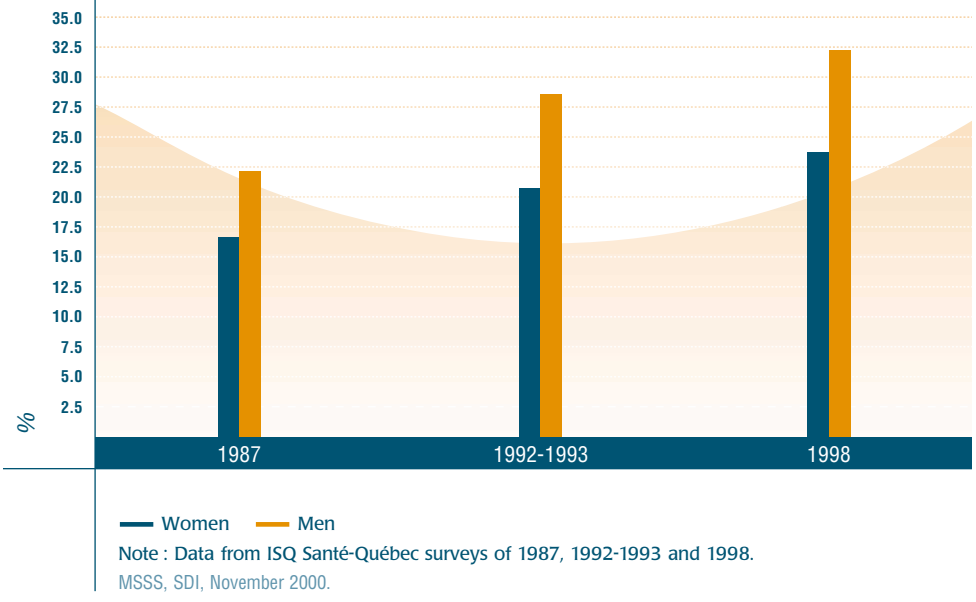
If persons aged 15 and over whose body mass index (BMI) is equal to or higher than 27 (weight measured by dividing one's body weight measured in kilograms by the square of one's stature measured in metres) are considered, it is noted that the proportion of overweight people in Québec has increased, from 19.4% in 1987, to 24.7% in 1992-1993, and to 28.1% in 1998. In 1998, this proportion is, however, higher among men (32.4%) than among women (23.8%).

If the data are stratified by age, it is observed that the proportion of people whose BMI is 27 or higher increases as age increases, except among people aged 65 and over. Among the latter, unlike the other age groups, the proportion of women whose BMI is 27 or higher is greater than men.

Figure **88**

Proportion of Population Aged 15+

Whose Body Mass Index was 27 or Higher, by Sex, Québec, *1987, 1992-1993 and 1998*



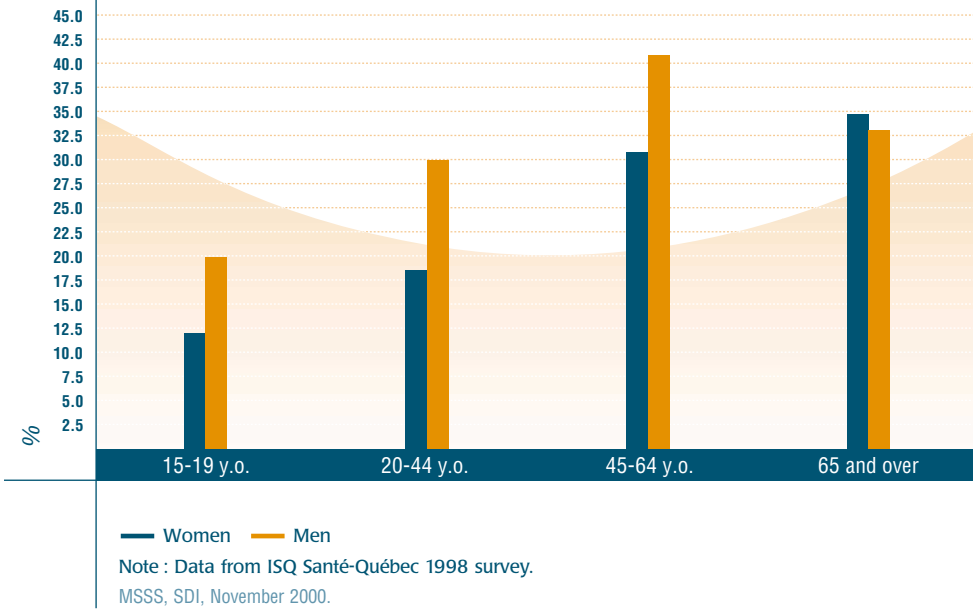
Note : Data from ISQ Santé-Québec surveys of 1987, 1992-1993 and 1998.

MSSS, SDI, November 2000.

Figure 89

Proportion of Population Aged 15+

Whose Body Mass Index was 27 or Higher, by Sex and Age Group, Québec, *1998*



Note : Data from ISQ Santé-Québec 1998 survey.

MSSS, SDI, November 2000.

Alcohol Consumption

In the mid-1990s, In Québec, 9% of persons aged 12 and over stated that they had 14 or more drinks per week, 57% had one or more drinks per month, 24% had fewer than one drink per month, and 10% totally abstained from drinking.

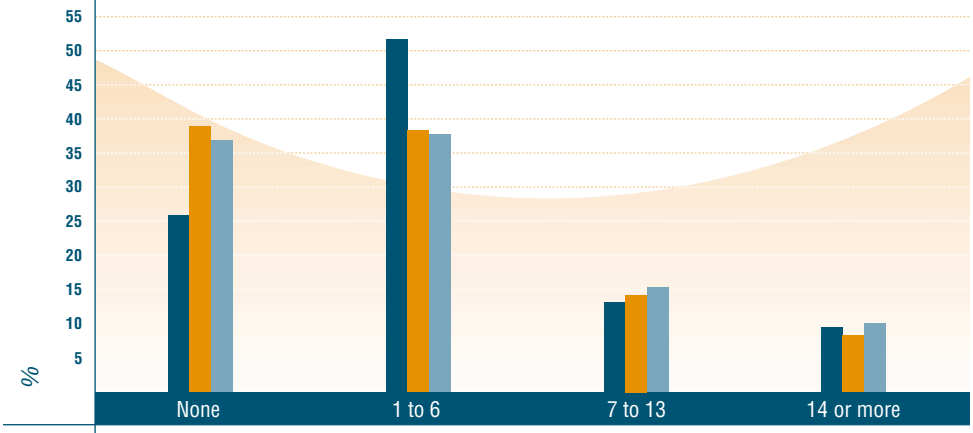
However, if we consider occasional or regular drinkers aged 15 and over who had consumed alcohol during the 12 months preceding the survey since 1987, those who stated having consumed 14 drinks or more during the seven days preceding the survey made up 10% of the cohort in 1998, a proportion that has been increasing slightly since 1992-1993. There is also a slight increase in the proportion of those who consumed 7 to 13 drinks and a decrease in the proportion of those who consumed 1 to 6 drinks. In 1987, the proportion of those who consumed 1 to 6 drinks was twice as high as the proportion of those who did not consume any (52% versus 26%). Ten years later, the proportions are basically identical, that is, 38% and 37% respectively.

In the same cohort, in 1998, close to 29% of persons aged 15 to 24 stated that they got drunk at least five times during the 12 months preceding the survey, a proportion that is markedly higher than in the other age groups (3.5 times more than those aged 25 to 44) and has been increasing, compared to 1992-1993.

Figure 90

Among Occasional or Regular Drinkers Aged 15+

Who Had Consumed Alcohol During the 12 Months Preceding the Survey, Proportion of Those who Drank During the Seven Days Preceding the Survey, by Number of Drinks, Québec,
1987, 1992-1993 and 1998



1987 1992-1993 1998

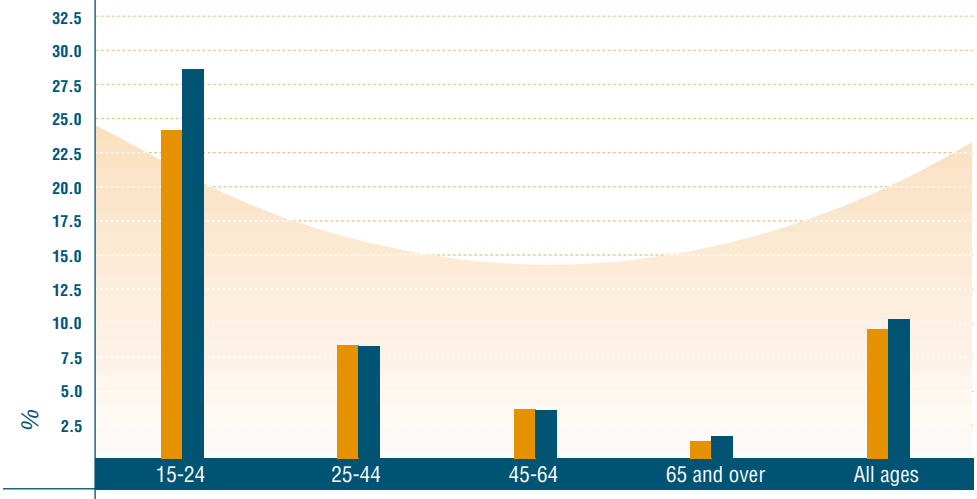
Note : Data from ISQ Santé-Québec surveys of 1987, 1992-1993 and 1998.

MSSS, SDI, November 2000.

Figure 91

Proportion of Occasional or Regular Drinkers Aged 15+

Who Got Drunk Five or More Times During the 12 Months Preceding the Survey, by Age Group, Québec,
1992-1993 and 1998



1992-1993 1998

Note : Data from ISQ Santé-Québec surveys of 1992-1993 and 1998.

MSSS, SDI, November 2000.

Smoking

In 1987, close to 40% of the population aged 15 and over were regular or occasional smokers. Ten years later, the proportion was 34%. During the same period, the proportion of those who have never smoked increased by 1.8 percentage points (from 30.6% to 32.4%). The proportion of ex-smokers remained more or less at the same level as in 1992-1993 (34%) but is approximately 4.5 percentage points higher than in 1987.

In 1998, the highest concentration of regular smokers (over 37%) was found among persons aged 35 to 44. The lowest concentration was found among persons aged 65 and over (under 18%). Up to age 45, the proportion of regular smokers is higher than that of ex-smokers. From age 45 onwards, the situation is totally reversed. After age 55, the proportion of ex-smokers is even twice as high as that of regular smokers.

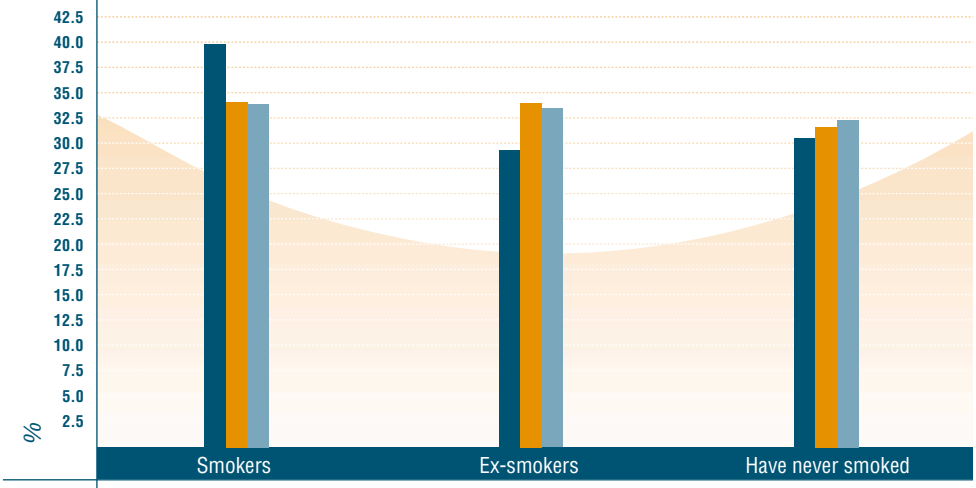
In total, in 1998, 34% of persons aged 15 and over were ex-smokers and 30.5% were regular smokers. However, although the number of smokers among the population aged 15 and over has dropped, a considerable increase in the number of young smokers is noted. Thus, based on recent figures (1999), 36% of young Québeckers aged 15 to 19 are occasional or regular smokers.

Québec is thus characterized by a serious smoking problem among young people. In 1999, 35% of young smokers had smoked their first cigarette at age 12 and 80% at age 14. Among smokers aged 15 to 17, two-thirds were already daily smokers. Among young high school students, the proportion of occasional and regular smokers is higher for girls than boys (23% versus 17%).

Figure 92

Proportion of Smokers Within the Population Aged 15+,

by Type of Cigarette Use, Québec,
1987, 1992-1993 and 1998



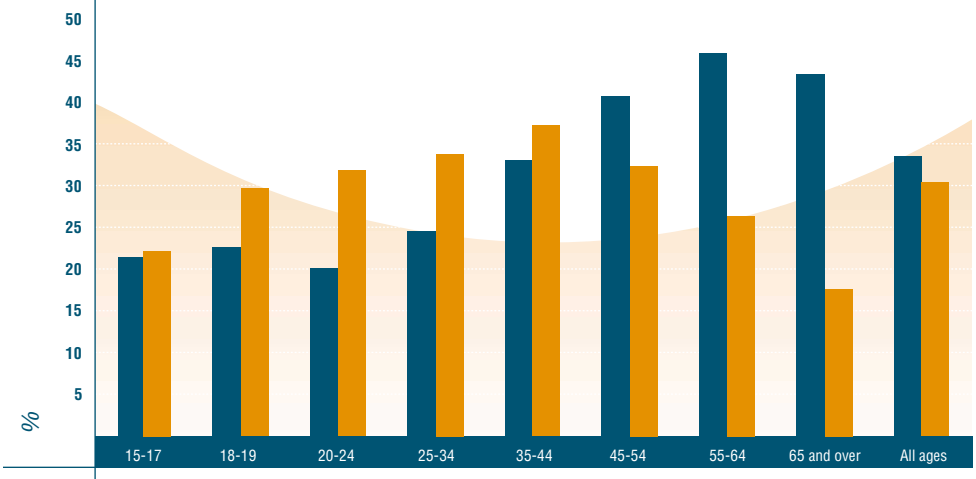
Note : Data from ISQ Santé-Québec surveys of 1987, 1992-1993 and 1998.

MSSS, SDI, November 2000.

Figure 93

Proportion of Ex-Smokers and Regular Smokers

Within the Population Aged 15+, by Age Group, Québec,
1998



Note : Data from ISQ Santé-Québec 1998 survey.

MSSS, SDI, November 2000.

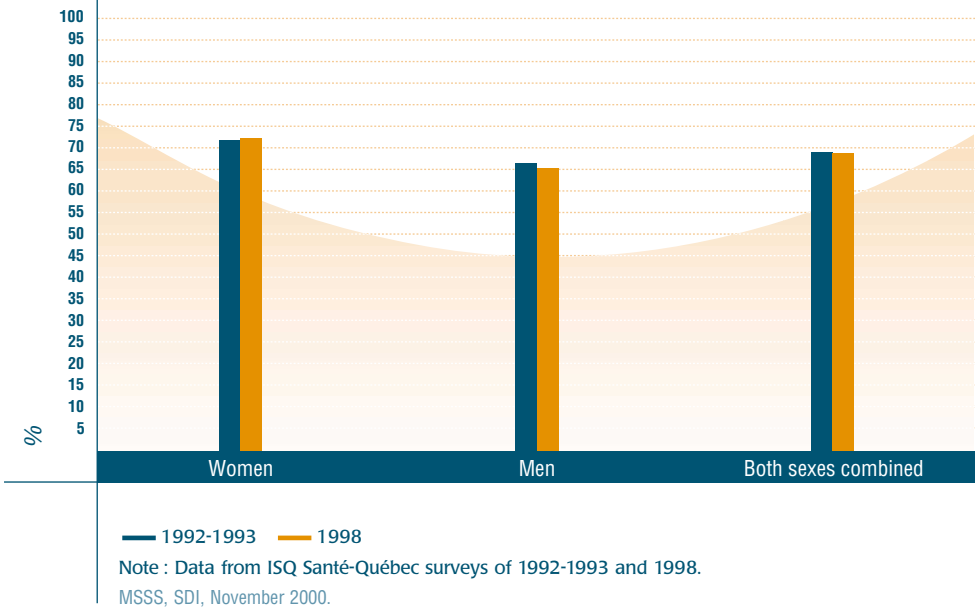
Drug Addiction

In 1992-1993, close to 70% of persons aged 15 and over asserted that they had never taken drugs. In 1998, the proportion had hardly changed, except that it had increased slightly among women and decreased slightly among men.

During the 12 months preceding the 1998 survey, 10.3% of persons aged 15 and over stated that they had smoked marijuana once or several times. This proportion rose to 17.4% if all drugs were considered. The highest number of drug takers was found among persons aged 15 to 24. In fact, 40% of this group had taken at least one type of drug during the period of 12 consecutive months, and 26% had smoked marijuana at least once. From age 25 onwards, the proportions dropped considerably.

Figure 94

Proportion of Population Aged 15+
Who Had Never Taken Drugs, by Sex, Québec,
1992-1993 and 1998

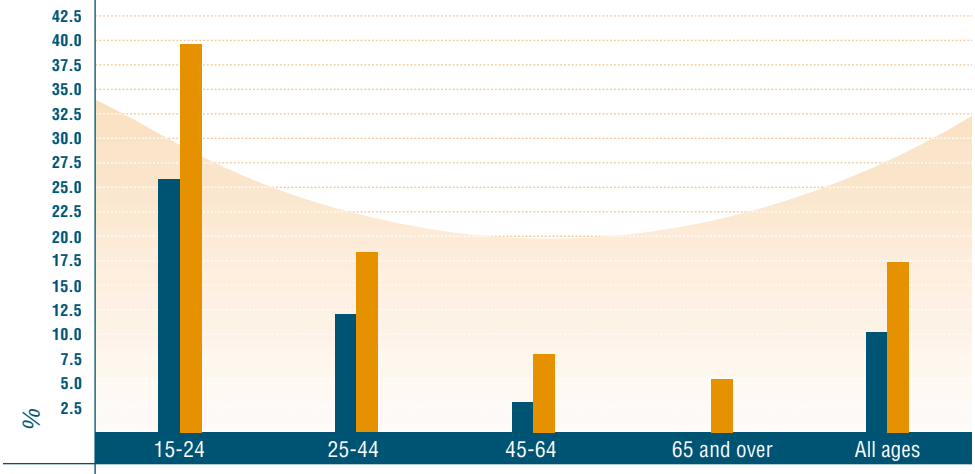


Note : Data from ISQ Santé-Québec surveys of 1992-1993 and 1998.
MSSS, SDI, November 2000.

Figure 95

Proportion of Population Aged 15+

Who Had Taken One or Several Drugs During the 12 Months Preceding the Survey, by Drug Type and Age Group, Québec, *1998*



Marijuana only — All types of drugs

Note : Data from ISQ Santé-Québec 1998 survey.

MSSS, SDI, November 2000.

A PERSPECTIVE

The Québec health and social services system is characterized by its originality and dynamism. It is one of the most important social assets of Québec society. Thus, the reform undertaken in the early 1990s marked a crucial stage in the development of intervention in the field of health and welfare. The Health and Welfare Policy, on which this reform was based, laid out a global, multisectoral perspective, defining the parameters of the system's activity.

Two fundamental questions are thus raised: Which social choices can offer the best possibilities for improving the health and welfare of the population? In which way can the network of services best contribute to this goal?

While the first question has an impact on all activity sectors of collective life, the second requires that all actors in the health and social services system strive for effectiveness and efficiency by undertaking activities which would result in a reduction of problems and maximum utilization of and return for invested resources.

Thus, an operation called "transforming the network" was conducted by the MSSS in collaboration with the regional authorities and workers in the health and social services sector. This operation included three goals:

- Adapting the system to the changing needs of the population;
- Making the most of new intervention technologies;
- Protecting social assets in spite of the budgetary context.

These goals have been achieved in the sense that resources in short-term hospital services were rationalized and home support services were developed in order to bring services closer to the people's living environment, in particular for clienteles with decreasing autonomy. The improvement in certain procedures and the development of new technologies have also made it possible to avoid long-term hospital stays. In addition, day surgery has been increasingly used and lighter resources have been developed in order to avoid hospitalization for some and delay placement in residential care for others. Lastly, fiscal consolidation has led to major re-investments in view of consolidating services and reorganizing the finances of institutions.

REDOUBLING OUR EFFORTS

Under the operation aimed at transforming the health and social services network, a number of structuring actions were undertaken and should be brought to completion. However, other actions represent avenues that should be explored more in-depth and which require further experimentation. In both cases, it is important to analyze the necessary conditions for success as well as the implications involved. Thus, the work of the MSSS and its collaborators is aimed at:

- Establishing resource allocation processes that entail the fair distribution of the regional resource envelope as well as the amount of the envelope for national and supra-regional services;
- Making rules related to work organization more flexible in order to give local organizations more room to manœuvre in implementing the range of basic services, in particular with regard to staff mobility and skill development;
- Increasing collaborations with professional associations in order to improve the quality of interpersonal relations and foster interdisciplinary work;
- Searching for compensation methods that are most likely to meet the goals of the network of integrated services and establish practice plans in the university networks;

- Taking performance into consideration in institution funding and budget allocation;
- Encouraging innovative projects that promote improved continuity of services;
- Promoting locally-based liaison projects with other activity sectors, in particular schools and municipalities;
- Developing, in compliance with confidentiality rules, the technological supports that are necessary for transmitting information (smart card, information highway, remote supervision, telemedecine), informing the population, training human resources and decision making.

In the late 1990s, the Québec government achieved fiscal balance. Owing to the surplus generated by favourable economic growth, financial resources were thus released, allowing for major investment to be made in the continuity and development of services to the population. Thus, in its 2000-2001 Budget, Québec injected an additional $2.7 billion into the health and social services sector.

The government's substantial financial outlay came with a review of management methods which were henceforth result-oriented and centred on the establishment of true accountability. To this end, several legislative and administrative measures were implemented so as, first, to ensure that institutions comply with the balanced budget requirement, second, to promote a management approach that is performance-based and result-oriented, and third, to specify the sharing of responsibilities between the MSSS and the network.

The massive influx of funds into the sensitive health and social services sector satisfied the wishes of Québeckers. These additional resources should ensure universal access to services without compromising their quality.

However, in the medium and long terms, it will be necessary to "invest" in determinants such as poverty and social roles before problems arise and to ensure that the "shift to ambulatory care" also comes with a "shift" towards prevention and promotion. Orientations and goals retained in the Health and Welfare Policy should also be updated.

IN SEARCH OF A NEW BALANCE

The dynamic whereby costs are increasing at an accelerated pace, largely as a result of demographic changes and technological revolution, is still cause for concern. Thus, in the foreseeable context of needs and resources, it is evident that the future of the Québec health and social services system, like that of most developed countries, hinges on a new balance to be found between changing needs, the system's ability to manage the services and society's ability to pay. Moroever, the fact that we recognize that this ability has limits necessarily leads us to be efficient, that is, to search for the best results at the best price, and effective, that is, to make choices and take actions that will allow us to achieve this goal.

To this end, in June 2000, the government of Québec created the Commission of study on health and social services, chaired by Mr. Michel Clair, to determine the necessary conditions for this new balance from the population, the network's partners, representative organizations and several experts on issues related to the organization of services and funding of the system.

Armed with its mandate, the Clair Commission first made a realistic diagnosis of the problems affecting the health and social services system. Following its findings, the Commission put forward a new vision of the future that is likely to gain the support of all Québeckers in order to take on the double obligation of choosing and performing. Then, based on a series of guiding principles, the Clair Commission brought out several emergent solutions, grouped under four major themes, that is, the organization of services, the human resources needed, the funding of services, and governance or management of services.

Whether this involves configuring services in a more hierarchical way, focusing the system on primary care services provided by CLSCs and groups of family physicians, developing "corridors" of integrated services for target clienteles, creating an insurance fund to deal with rapid population aging, or ensuring that all actors – from user to ministerial authority – participating in the system are aware of their responsibilities, all of these solutions should revolve around a continuum of actions, that is, deciding, acting, evaluating, and adjusting.

However, for the project to be successful, rigidities which currently paralyze the system must be lessened, if not eliminated. These rigidities are either due to the particular interests of certain groups of care providers or to constraints inherent in the numerous collective agreements that are in force or in the bargaining process itself. Thus, the Clair Commission recognized that the very foundation of the entire structure – the prerequisite for this new balance – lies in the participation of every actor and the willingness of everyone to collaborate and coordinate their efforts in order to bring this major project to completion.

Thus, in its report made public in January 2001, the Clair Commission submitted 95 solutions, including 36 general recommendations and 59 related proposals, which are likely to provide the necessary impetus to achieve and maintain the balance needed for the health and social services system to function smoothly. Its difficulties aside, the overwhelming majority of Québeckers are strongly attached to and extremely proud of their health system.

Furthermore, in its 2001-2004 Strategic Plan, the MSSS adopted five major orientations which will serve as the basis of its entire strategy, that is, to agree on priority goals for health and welfare which the different actors must work towards; to improve access to services and ensure optimal organization of resources; to staff the network with qualified human resources and provide it with adequate EDP assets and appropriate budgeting methods; to stabilize the funding of services and the increase in expenditures; and to clarify the responsibilities of the various actors and make them more accountable.

Thus, through an appropriate strategy, the support of its many partners and the judicious use of all of its policy levers, the MSSS has very intention of continuing to successfully carry out its mission of maintaining, improving and restoring the health and well-being of Québeckers by making available quality, integrated health and social services, thereby contributing to the social and economic development of Québec.

Current efforts as well as ongoing discussion either within the MSSS or with its partners, or in debates in which the Québec population as a whole is encouraged to participate, are aimed at making the health and social services system perform even better, that is, in making the system even better able to respond to the numerous needs of the different groups it serves.

Whether it be through the system's heightened awareness of its possibilities for improvement or continuous adaptation to the society changes, the perspective is guided by the search for a new balance.

APPENDICES

APPENDIX 1

FEDERAL GOVERNMENT PARTICIPATION

To understand the structure of health and social services programs that are in force in Québec, the fact that Québec has been a member of the Canadian Confederation since 1867 must be considered. Unlike a unitary state, a state which 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.

Moreover, the federal government contributes to the financing of various provincial services, including health and social services, through cash and tax transfers established on the basis of sharing rules, such as equalization, or specific laws, such as the Hospital Insurance and Diagnostic Services Act.

Equalization, instituted in 1957, is a mechanism for sharing and stabilizing the provinces' tax revenues. Its aim is to raise the poorest provinces' revenue-raising ability to a standard which allows them to provide services comparable to those provided by the richest provinces.

In the same year, 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.

From 1977 onwards, the funding of these established programs was ensured under the Established Programs Financing Act.

The financing of established programs 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 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 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 which have markedly reduced transfers to the provinces.

The decreased participation of the federal government 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.

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 which aimed at increasing transfers under certain conditions set by the federal government, but which were strongly criticized by some provinces, especially Québec.

APPENDIX 2

LIST OF LAWS IN FORCE IN THE FIELD OF HEALTH AND SOCIAL SERVICES

An Act respecting the Conseil de la santé et du bien-être

An Act respecting the Conseil médical du Québec

An Act respecting health services and social services

An Act respecting health services and social services for Cree Native persons

Midwives Act

Health Insurance Act

An Act respecting the Régie de l'assurance maladie du Québec

An Act to ensure that essential services are maintained in the health and social services sector

An Act respecting the protection of persons whose mental state presents a danger to themselves or the others

Public Health Protection Act

An Act to secure the handicapped in the exercise of their rights

Hospital Insurance Act

Burial Act

Non-Catholic Cemeteries Act

An Act respecting the Ministère de la Santé et des Services sociaux

Tobacco Act

An Act respecting prescription drug insurance

An Act respecting Héma-Québec and the haemovigilance committee

An Act respecting the Institut national de santé publique du Québec

An Act respecting the Corporation d'hébergement du Québec

Youth Protection Act

BIBLIOGRAPHY

ANCTIL, Hervé, Pierre MONTAMBAULT and Marc-André ST-PIERRE. *Santé et bien-être: La perspective québécoise*, ministère de la Santé et des Services sociaux, Québec, 1993.

BEAUPRÉ, Michel and Marc-André ST-PIERRE. *Le système sociosanitaire québécois en quelques chiffres,* ministère de la Santé et des Services sociaux, Québec, 1992.

BÉDARD, Denis. "Le financement des soins sociosanitaires: Une nouvelle étape possible dans la réforme du système," *Observatoire de l'administration publique,* ENAP, 2000.

BÉLISLE, Georges, Louise GUYON, René PERREAULT, and Christian SASSEVILLE. *Les affaires sociales au Québec,* ministère des Affaires sociales, Québec, 1980.

BOUCHER, Caroline. *Description du système préhospitalier d'urgence au Québec: Historique, évolution et enjeux,* ministère de la Santé et des Services sociaux, Québec, 1999.

CHOINIÈRE, Robert and Danielle ST-LAURENT. *Surveillance de la mortalité au Québec: 1976-1997,* coll. "Analyses et surveillance," No. 13, ministère de la Santé et des Services sociaux, Québec, 1999.

COMMISSION D'ÉTUDE SUR LES SERVICES DE SANTÉ ET LES SERVICES SOCIAUX. *Consultation publique sur le financement et l'organisation des services de santé et des services sociaux,* Guide d'animation, ministère de la Santé et des Services sociaux, Québec, 2000.

COMMISSION D'ÉTUDE SUR LES SERVICES DE SANTÉ ET LES SERVICES SOCIAUX. *"Emergent Solutions,"* Report and Recommendations, ministère de la Santé et des Services sociaux, Québec, 2001.

COMITÉ NATIONAL SUR LA RÉVISION DES SERVICES PRÉHOSPITALIERS D'URGENCE. *Un système à mettre en place,* Report, ministère de la Santé et des Services sociaux, Québec, 2000.

COMITÉ NATIONAL SUR LA RÉVISION DES SERVICES PRÉHOSPITALIERS D'URGENCE. *Un système à mettre en place,* Executive Summary, ministère de la Santé et des Services sociaux, Québec, 2000.

DAVELUY, Carole, Lucille PICA, Nathalie AUDET, Robert COURTEMANCHE, France LAPOINTE et al. *Enquête sociale et de santé 1998,* Institut de la statistique du Québec, Québec, 2000.

GROUPE DE TRAVAIL POUR LA RÉVISION DU CADRE DE RÉFÉRENCE SUR LES SERVICES À DOMICILE. *Pour une politique de soutien à domicile des personnes ayant des incapacités et de soutien aux proches,* Internal Report, ministère de la Santé et des Services sociaux, Québec, 2000.

GUYART, Patrice. *Les services préhospitaliers d'urgence*, leaflet produced by the Direction générale au suivi et au soutien du réseau, ministère de la Santé et des Services sociaux, Québec, 1997.

LESSARD, Carolle. *Indicateurs repères sur l'application de la Loi sur la protection de la jeunesse, 1993-1994 à 1998-1999: Repères sur l'évolution des pratiques et de l'application de la LPJ,* ministère de la Santé et des Services sociaux, Québec, 2000.

LESSARD, Carolle. *Indicateurs repères sur l'application de la Loi sur la protection de la jeunesse, 1993-1994 à 1998-1999,* ministère de la Santé et des Services sociaux, Québec, 2000.

MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX. Financement: État de situation et perspectives, *Financement et organisation des services de santé et des services sociaux,* ministère de la Santé et des Services sociaux, Québec, 2000.

MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX. La santé et les services sociaux: Enjeux, orientations stratégiques d'un système en transformation, *Summit on the Economy and Employment,* ministère de la Santé et des Services sociaux, Québec, 1996.

MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX. Organisation des services: État de situation et perspectives, *Financement et organisation des services de santé et des services sociaux,* ministère de la Santé et des Services sociaux, Québec, 2000.

MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX. *Plan stratégique 2001-2004,* ministère de la Santé et des Services sociaux, Québec, 2001.

MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX. Santé et Services sociaux: Des réponses – *Notre souci, toujours mieux informer la population,* leaflet, ministère de la Santé et des Services sociaux, Québec, 1998.

MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX. Santé et Services sociaux: Services, objectifs, moyens, résultats – *Les services à la population,* leaflet, ministère de la Santé et des Services sociaux, Québec, 1998.

MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX. Santé et Services sociaux: Les principes – *Nos convictions,* leaflet, ministère de la Santé et des Services sociaux, Québec, 1998.

MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX. Santé et Services sociaux: Ressources humaines – *Notre force, des personnes compétentes et dévouées,* leaflet, ministère de la Santé et des Services sociaux, Québec, 1998.

MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX. Santé au Québec: Quelques indicateurs – *Financement et organisation des services de santé et des services sociaux,* ministère de la Santé et des Services sociaux, Québec, 2000.

MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX. *INFO-MED-ÉCHO, Bulletin d'information sur l'hospitalisation pour soins de courte durée au Québec,* ministère de la Santé et des Services sociaux, Québec, 2000.

MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX. *INFO-SAS, Bulletin d'information générale du Service de l'analyse statistique,* ministère de la Santé et des Services sociaux, Québec, 1999.

MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX. *Le système de santé et de services sociaux: Un actif à consolider,* ministère de la Santé et des Services sociaux, Québec, 1999.

MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX. *Le virage ambulatoire en santé physique: Enjeux et perspectives,* ministère de la Santé et des Services sociaux, Québec, 1998.

MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX. *Les dépenses de santé du Québec et le financement des programmes établi: Problématique et enjeux,* ministère de la Santé et des Services sociaux, Québec, 1995.

Ministère des Finances. "Budget de dépenses 2000-2001," *Livre des crédits,* Vol. 1, ministère des Finances, Québec, 2000.

MINISTÈRE DES FINANCES. *Budget 2000-2001: Discours sur le budget,* ministère des Finances, Québec, 2000.

MINISTÈRE DES FINANCES. *Budget 2001-2002: Discours sur le budget,* ministère des Finances, Québec, 2001.

MINISTÈRE DES FINANCES. *Budget 2000-2001: Plan budgétaire,* ministère des Finances, Québec, 2000.

MINISTÈRE DES FINANCES. *Budget 2001-2002: La situation financière du gouvernement en 2000-2001 et les emprunts du secteur public,* ministère des Finances, Québec, 2001.

MINISTÈRE DES FINANCES. *Budget 2001-2002: Le système de santé, un maillon vital,* ministère des Finances, Québec, 2001.

PAGEAU, Michel, Marc FERLAND, Robert CHOINIÈRE and Yves SAUVAGEAU. *Indicateurs sociosanitaires: Le Québec et ses régions,* coll. "Analyses et surveillance," No. 4, ministère de la Santé et des Services sociaux, Québec, 1997.

PELLETIER, Gilles. "L'hospitalisation pour soins de courte durée au Québec: Statistiques évolutives 1982-1983 à 1997-1998,", coll. "Données statistiques et indicateurs," No. 36, ministère de la Santé et des Services sociaux, Québec, 1999.

RÉGIE DE L'ASSURANCE MALADIE. *Rapport annuel, 1990-1991 à 1999-2000,* Régie de l'assurance maladie, Québec.

RÉGIE DE L'ASSURANCE MALADIE. *Statistiques annuelles,* 1990 à 1999. Régie de l'assurance maladie, Québec.

RHEAULT, Sylvie and Marie-Ève BROUARD. *Validité de l'indicateur québécois des dépenses de santé sur le PIB dans le contexte de la péréquation canadienne,* Background Document, ministère de la Santé et des Services sociaux Québec, 2000.

ROY, Yvonnick, Alain SAUCIER and Marc-André ST-PIERRE. *Le système de santé et de services sociaux au Québec,* ministère des Affaires sociales, Québec, 1985.

ST-PIERRE, Marc-André. *Le coût et l'efficacité des services de santé et des services sociaux,* ministère de la Santé et des Services sociaux, Québec, 1996.

ST-PIERRE, Marc-André. *Le système de santé et de services sociaux du Québec: Un aperçu,* ministère de la Santé et des Services sociaux, Québec, 1989.

TRAHAN, Lysette, Pauline BÉGIN, Marie DEMERS and Pierre LAFONTAINE. *Évaluation des changements dans l'offre et l'utilisation des services hospitaliers et des services ambulatoires,* ministère de la Santé et des Services sociaux, Québec, 1999.

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