A Cross-Provincial Comparison
Of Health Care Policy Reform in Canada

Budget allocation reform in Quebec: Using a population-based approach to allocate resources for medical and social services (except physical health)

Marie-Pascale Pomey, Elisabeth Martin,
and Pierre-Gerlier Forest

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I- Introduction

The idea to change budget allocation methods in Quebec -- for the ministry of regional-level structures as well as for regional-level funding of health care establishments -- first appeared in the Rochon Report of 1987.

> [The] financing [of Regional Boards] would be on the basis of a global budget corrected on a per-capita basis. This financing formula has two advantages. First, it ensures a certain degree of equity in the distribution
>
> population into account. Second, it gives the Regional Boards some latitude in their use of resources in order to achieve their objectives and priorities. This would mean that the budgetary envelope of each region would take into account its size and characteristics of its population such as age, gender, or other factors that might affect the

making process: the government agenda, the decision-making agenda and the choice of a policy (Kingdon, 2003). We then analyze the decision-making process with regard to four variables: institutions, interests, ideas, and external and internal events.

II- Methodology

This case study is based on semi-structured individual interviews and an analysis of funding-related documents. Between October and December 2005, we conducted seven interviews with individuals who had participated in the decision-making process and the implementation of changes to budget allocation methods for health and social services. These individuals were professionals and management- Health and Social Services Agencies (Agencies), professionals and senior bureaucrats from the Ministry of Health and Social Services (MSSS), representatives from the associations of health care institutions, policy analysts and directors of health care establishments. The interviews were transcribed, coded and analyzed. We

In theory, the budgeting process based on these provisions respected three principles:

- To take into account while aiming for interregional equity;
- To fund the services identified in the service organization plans;
- To attempt to achieve balanced budgets.

Despite the theory, however, year after year, the ministry renewed the budgets of the Regional Boards on a historical basis. The population-based approach was used only marginally.

After 1994-1995, the Regional Boards allocated resources to the health care establishments using one of two approaches. The first approach consisted of distributing the resources requested according to a pre-established budget, while trying to keep the cost of services as low as possible. The second

The reference levels used for the new appropriations were based on the appropriations of 2004-2005. The partitioning of previously global budgets into program-based budgets, however, was not a simple matter. As stated above, the ministry did not allocate funds on the basis of a population-based forecast alone, but took an establishment s prior budget into consideration as well. For this reason, the ministry sought to obtain accounting information from the individual establishments. This information was, however, largely unavailable: accounting systems had simply not been configured to collect the necessary data and health care and social service establishments were unable to specify

At the present time, this DRG-based

than do Members from rural constituencies. (Select Committee on the Elections Act, National Assembly of Quebec, p. 8.)

This imbalance in political representation has led, in the words of one source, to the following situation:

> For regions that have lost population, whether you like it or not, the politicians try to get the votes of those counties at every election to system whereby
> icky. The political agenda is,
> le to avoid. (ALL-02)

As we will see, the decision that was eventually made, while far from cosmetic, was nonetheless limited in terms of the interregional redistribution that it has been able to achieve.

V- The decision-making agenda: The dawning of change

Between 1994 and 1998, the annual budget of the general and specialized hospital centres (the CHSGSs) was approximately $6 billion per year. During those years, the growth of the budget had stabilized. Beginning in 1 in3(n)-3(t)-3(r9e3(p)4(o)-3(li)

A- The Bédard reports (2000-2004)

Instead of creating a single committee to examine budgeting methods, which would have reflected the service program approach, the ministry decided to create two separate committees that would better accommodate the historical reality of the health care and social service institutions. Separate committees would be better adapted, it was thought, to significant differences in the ways of thinking and the information systems of the two environments. Among CHSGSs, for example, the implementation of DRGs allowed users to predict an ins future performance by comparing the costs of treatment of a given pathology between two institutions and adjusting budgets for increased efficiency. In the CLSC and CHSLD environment, however, where there was a dearth of standardized data, calculations were based on volume: how many seniors needed shelter? How many young people needed to be housed in youth centres? And so on. Some of our sources admitted that the creation of two separate committees, corresponding to the different kinds of institutions, seemed to go against the idea of allocating budgets on a population and program-based approach. The program of physical health, however, was treated in hospitals and was considered so different from other programs that it could not be treated in the same way as the rest.

> Sometimes, at the ministry, we talk about service programs, and yet we kept coming
> that service programs were more about social programs than they were about phys
> talking more about institutions, more about specialized care. In the end, models are sometimes developed according to the historical context. (All-02)

The first of the Bédard reports, on the CHSGSs, was submitted to the deputy minister in December 2001. The second report on the CLSCs and CHSLDs was published in June 2002. Both reports clearly recommended that budgets be allocated

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continue to be improved and that information systems be completed so as to

consumers, the collective bargaining agreement is super-standardized, so you can easily use cost multiplied by volume. The cost is pretty much your working conditions, your profs. In high school, there are rules about making up classes, class content. You know that it you have more than

from having to allocate development funds or operating budgets on a program-by-program basis.

A- The reasons for the government's decision

Our sources identified several reasons for which the government adopted this technique for reforming its budget allocation methods. For one thing, no counter-proposals had been suggested, and as a consequence, no alternatives were on the table. Furthermore, even if changes to budget allocation methods were likely to take resources away from certain regions, the fact that the changes were still restricted to development funds and did not yet affect operating resources made it difficult for the regions to oppose the measures. Moreover, because the reform was framed in terms of eliminating interregional inequity, a principle already codified in existing law, it would have been difficult for the regions to adopt a position defending the status quo.

The government cited additional factors to justify the changes: namely, the principles of better accessibility, greater equity among regions and more accountability.

In terms of accessibility, the question of waiting lists was a top priority. The new budgeting method allowed the ministry to channel development funds and ask the agencies and the Health and Social Service Centres (*Centres de santé et de services sociaux* -- CSSSs[3]) to set specific performance targets, including targets to reduce wait times.

With respect to equity and accountability, the new system had the merit of justifying budget allocations in terms of the actual needs of the population and not on the basis of historical precedent or political influence. The government also hoped tha socia6udgh3(e)6a( )ts[(f3v)10(e)-3(rnm)-7(e)-3(n)-38e,

qm(o)68t.06 3326.95 Tmcul3(u)-3(l)12(a)-3(-3(g)6(it)-3(w)12(o)io)6(n)-3( )] TJETBT11 0 0 1 90.024 33(d)6(t)lpon g

Over the course of the previous 15 years, the population of certain regions had decreased while the population of others had grown. Allocating budgets on a historical basis did not take such variations of population into account, and disparities in financing between institutions had been the result. For example, newly-created CLSCs were sometimes found to have smaller budgets that older CLSCs, and because budgets were renewed on a historical basis, the inequity was prolonged. This dynamic meant that historical budgeting had prevented policy-makers from reaching the objective of equitable distribution of financial resources among regions.

Pressure also came from the population. Some individuals wrote directly to the ministry to complain about the disparity in budgets between regions.

> In the health care system, there are always pressure groups. Many,

means that we have to be consistent and give money to the right places. (All 02)

Finally, because renewing budgets on a historical basis did not require that accounting take place, or that services be assessed on qualitative and quantitative grounds, the adoption of the new population-based budgeting methods argued in favour of better accounting.

B- Why was physical health excluded from the calculations?

The MSSS has explained that it excluded physical health from the new budget allocation method because of the significant difference between the information system used for physical health and the information systems used for the other programs. Physical health was the only program for which managers disposed of APR-DRG data (All-Patient Refined Diagnostic-Related Group data) weighted by the NIRRU (relative use of resources), which allowed them to compare average costs between hospital centres and to allocate resources in a more optimal fashion.

Other sources, however, have suggested an alternative hypothesis for the exclusion of the physical health program. According to these informants, it seems that the inclusion of physical health in the calculation of regional allowances would have reduced the surplus of the Montreal region by 50%. At the ministry, this situation was unwelcome.

mean

more money to Montreal, more money (RG-01).

like Montreal to have how it works

C- The actors' viewpoint

In general, the actors involved in the process were in favour of the overall objectives of the reform, even if

any event, the reform has had only

education armed with a calculation methodology designed to even out the discrepancies between regions.

input

When you loo
technology for the

The budget cuts of the 1990s had worsened regional inequalities and became an

The important thing, in the end, is,
registering patients on the same basis?
systems, the CSSSs are responsible for a population defined according to
territory (RG-03)

References

Ministère de la santé et des services sociaux. Direction générale de la

Appendix 1: The List of Programs

1- Service programs:
Programs to serve the population
- Public health
- General services clinical and support activities
Specific issue programs
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Appendix 2: Interview Template

Interview Template
(September 2005)
The Case of Regional Budgets

During the course of this interview on changes to the financing methods of regional agencies, I would like to ask you questions about three main stages in the life of this policy. When I speak of changes, I refer to the change of budget allocation methods from a historically-based approach to more of a population-

by asking you about the period during which the government first began to take interest in these matters. After that, I will ask you about how policy-makers came to reach a decision. Finally, I will ask about the choice of a policy and its implementation.

Introduction

To begin, could you please tell us about your career, your education and your professional experience?

A. The government agenda

A1. The government of Quebec became interested in reorganizing budget allocation methods for the allocation of resources to the regional agencies. An important component of this reform was the implementation of a method more oriented towards a population-based approach that took certain needs indicators into account. Can you tell me when this issue was first brought to the attention of the government?

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C3(b). Were any individuals or groups involved in the final decision, who were not part of the government or traditional decision-making networks?
If so,

Identify the specific individuals or groups in question and try to explain the role they played and their influence on the final decision.

C4. Why did the final decision to adopt the new budgeting method take the form it did? What were the internal or external factors that influenced this decision?

In conclusion

What significance do you attribute to this new configuration of regional budget allocation methods in the history of health service financing in Quebec?

What stage, in your opinion, will follow this reform?

Appendix 4: Research template

A CROSS-PROVINCIAL COMPARISON OF HEALTH CARE POLICY REFORM IN CANADA

RESEARCH TEMPLATE

Province: Quebec

Case study: Regionalization

Category	Subcategory	Data
Institutions	Structures (esp. federal government and/or department or legislative committee mandates)	No links to federalism issue.
	Policies (esp. specific domestic court decisions and/or international agreements)	Bill 25 of 2003 replaced Regional Boards with Local Health and Social Services Network Development Agencies (Agencies). The CLSCs, CHSLDs and hospital centres of a given area were merged into a local service network responsible for a given population: budget allocation methods had to change in order to reflect this mission. Allocation methods for physical care were changed to a care episode-based method.
	Policy networks *(overlaps with Interests)*	
	Policy legacies	In 1971, new health authorities were created. Their territories of jurisdiction corresponded to administrative territories.

	Other	
Interests	Elected officials	Health Minister Philippe Couillard was an ardent advocate of the reform.

	Professional interests	Doctors made no move to contest the reform. The association of directors of health care institutions did not oppose it either. The AQESSS (association of hospitals, CLSCs and CHSLDs) did not oppose the reform.
	Societal interest groups	The public did not feel concerned by the reform, which mainly affected health care system structures, even though its ultimate goal was to improve access to services. Community groups, unions and the *Coalition Solidarité Santé* did not take a position on the issue. Compared to their visibility in the debate on regionalization, they were hardly present.
	Other	
Ideas	Knowledge / beliefs about what	Ever since the appearance of the Rochon Report, the belief among health ministry staff and politicians seemed to be that the practice of allocating budgets based on a historical approach was untenable because it failed to consider a number of essential factors. Because of that failure, historically-based budgeting resulted in regional inequity, problems of accessibility and a lack of accounting. There was the knowledge that it had been successfully done elsewhere (the U.K.) The main principles underlying the regionalization reform: the integration of structures and services, population-based responsibility, the transformation of the regional tier and governance structures. The corollary: changes to budget allocation methods. Successive government administrations in Quebec had

		electoral platform. There seemed to be consensus about the goals of the reform, and no counter-proposal existed, apart from the status quo, which nobody felt to be optimal. Changes to budget allocation methods appeared to be a way to resolve problems of inequity between regions. The Quebec Liberal Party introduced the idea of reforming regional structures in its platform for the elections of April 2003.
	Combined (e.g., commission recommendations)	Influence of the Rochon Report Significant influence of the two Bédard reports
	Policy learning	Other Canadian experiences, not mentioned
	Other	
Internal events	Release of major report (e.g., commission) Political change (e.g., election, cabinet shuffle)	The two Bédard reports of 2001 and 2002

events	commission)	
	Political change (e.g., election, cabinet shuffle) provincial and national	
	Economic change (e.g., recession)	
	Technological change (e.g., MRI scans)	
	New disease (e.g., SARS)	
	Media coverage (e.g., deaths on the waiting list)	
	Other	