

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

May/June 2006

TABLE OF CONTENTS

I- Introduction	3
II- Methodology	4
III- The budget allocation system for health care and social service institutions in Quebec	4
A- The process as it existed in 2004	4
B- The process implemented in 2004-2005	5
IV- The governmental agenda: Origins of the idea to change budget allocation methods (1970-2000)	7
V- The decision-making agenda: The dawning of change	9
A- The Bédard reports (2000-2004)	10
B- The proposals of the Bédard reports	10
1. The report on the budgeting and financial performance of general and specialized hospital centres	10
2. The report on budgeting and service allocation among CLSCs and CHSLDs	11
C- The outcome of the Bédard reports	12
VI- The choice of a policy: Changes to the allocation of development funds (2004)	13
A- The reasons for the government's decision	14
B- Why was physical health excluded from the calculations?	16
C- The actors' viewpoint	16
VII- The reform implementation process	17
VIII- Analysis of the reform process	19
A- The role of institutions	19
B- The role of interests	19
C- The role of ideas	20
D- The role of external and internal events	21
IX- Conclusion	22
Appendix 1: The List of Programs	25
Appendix 2: Chronology of the Reform	Error! Bookmark not defined.
Appendix 3: Interview Template	26
Appendix 4: Research template	29

I- Introduction

The idea to change budget allocation methods in Quebec -- for the ministry of health's funding 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 of resources among regions, to the extent that it takes a region's 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 use of services. ... Health care establishments and community organizations would be financed by the Regional Board or by the Ministry, according to the regional or provincial jurisdiction of the program in which they participated. At the regional level as well as the provincial level, financing would take place on the basis of programs.” (Report of the Commission of Inquiry into Health and Social Services, 1987) [*translation*]

The rationale for the Rochon proposal was to distribute resources more equitably among both regions and health care system structures. A population-based budget allocation system also had the benefit of using an accounting procedure that would clarify the costs of the various services and treatments provided by the health care system, costs which under the global system of budget allocation were largely unknown.

The fact that Quebec has only recently decided to change its resource allocation model, despite the long history of the idea, can be seen as evidence that the decision to reform was neither unilateral nor clear-cut. Rather, it was one of a series of important decisions on health and social service issues that have taken place in Quebec since the 1980s. More specifically, as the regionalization of services in the province followed its course, actors involved in the domain grew to realize the importance of funding methods to the continued success of regionalization, and the concept of population-based funding gradually gained acceptance. As we will see, however, the relationship between the regionalization of services and the change to funding methods was not evident to many of those interviewed.

We begin this paper by presenting an overview of the recent changes made to budget allocation methods in Quebec. We then address the following research question: “Why did the government of Quebec adopt a population-based budget allocation method?”. To do so, we study three phases in the public decision-

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 Quebec's budget allocation methods for health and social services. These individuals were professionals and management-level staff from Quebec's 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 also analyzed the grey literature, the scientific literature and different reports, briefs and notices published on the subject by the government and various organizations.

III- The budget allocation system for health care and social service institutions in Quebec

A- The process as it existed until 2004

Until 2004, the legislative provisions that governed the budget allocation process were as follows: (*La budgétisation et la performance financière des centres hospitaliers*, 2002):

- The ministry of health was responsible for allocating resources to the regions based on the number of residents per region. It was also in charge of establishing the rules the Regional Boards were to follow when the Boards in turn allocated resources to the health care and social services establishments located in their territories.
- The Regional Boards were responsible for service organization plans that responded to the needs of the population. The Boards were also responsible for distributing operating budgets to the establishments.
- The establishments were responsible for estimating their spending for a given period on the basis of the allowance received. They were to prepare a balanced budget and share a copy with their Regional Board. The budgets did not have to meet the approval of the Regional Boards.

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

- To take the population's needs 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 approach consisted of re-evaluating the financial needs of hospital centres according to standardized costs while also taking the needs of the population into account.

Until 2004-2005, though, global budgets for the regions were renewed on a historical basis. This method of budget allocation did not reflect accounting information, nor did it consider the qualitative and quantitative evolution of services and demography. It also failed to respect the principle of interregional equity in the distribution of financial resources.

B- The process implemented in 2004-2005

The population-based reform of budget allocation methods initiated in Quebec in 2004-2005 affected the operating budgets of all health and social programs except the program for physical health (see below). The ministry began the process by calculating the budget that each region would receive, according to the region's population and 11 pre-defined programs (for the list of programs, see Appendix 1). The ministry then determined the difference between the historical budget (the previous year's budget, adjusted for the current year) and the population-based budget. In some cases, the difference was so great that the ministry decided to adjust the budget gradually, making up the difference only with respect to development funds. In the region of Montreal, for example, where the operating budget was \$5 billion, the ministry's calculations showed a surplus of \$200 million. In order that the region not be excessively penalized, its operating budget for the year was renewed at \$5 billion. Development funds, however, which were originally to have been in the amount of \$20 million, were reduced to \$10 million, and the difference was redistributed to a region for which calculations had shown there to be a shortfall in funding.

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 the amounts they had spent on the various programs. This lack of detailed indicators made it difficult for the ministry to allocate funds to the regions on a purely program-by-program basis.

Seen another way, the budgets of 2005-2006 were established using a four-step methodology. To begin with, ministry personnel calculated reference spending (actual escalated costs) for 2004-2005. Then, using population data, anticipated spending for the same year of reference was calculated on a program-by-program basis. The difference between actual and anticipated spending was then established for each region. Finally, anticipated spending for 2005-2006 was calculated and development funds were allocated accordingly.

So while the new system uses calculations based on demographic data, it continues to allocate operating budgets on a historical basis thanks to a separate, global allowance for each region that is distributed to the health care establishments and social services of that territory (MSSS, *Nouveau mode d'allocation des ressources*, 2006-2007).

By the end of the first period, 2005-2006, the differences between the new budgets (budgets established using the new allocation method) and the old budgets (budgets established on a historical basis) had been reduced by about 10%.

While the physical health program was not included in the population-based approach, regional disparities in costs for this program were nonetheless calculated. First, an establishment's actual costs, per care episode for example, were compared to its expected costs and the actual volume of activity for the year 2004-2005. The ministry of health then ascertained the discrepancy between the establishment's historical budget and the budget the establishment should receive, given its level of activity, determined according to the Diagnostic Related Group (DRG) system. The total amount of discrepancies in funding for all the establishments of a given region was then determined. This allowed the ministry to identify the difference between actual and anticipated budgets in order to redistribute the surplus, or compensate for the shortfall, by means of development funds.

At the present time, this DRG-based resource allocation model for the physical health program accounts for almost 71% of program costs. Costs not included in the model are renewed on a historical basis (MSSS, *Nouveau mode d'allocation des ressources*, 2006-2007).

IV- The governmental agenda: Origins of the idea to change budget allocation methods (1970-2000)

Beginning in the 1970s, the administrative and regulatory entities that make up the regional structures of Quebec's health care system went through a series of reforms. During the era of the Regional Health and Social Service Councils (*Conseils régionaux de la santé et des services sociaux* -- CRSSSs), from 1971 to 1991, both operating budgets and development funds were entirely calculated and allocated by the ministry of health and social services (the MSSS). During this period, the CRSSSs played a strictly advisory role in budgeting decisions. Budgeting decisions were completely centralized: on some occasions, the CRSSSs merely suggested adjustments to budgets that had been prepared for them in Quebec City.

The Rochon Report published in December 1987 was the first official statement of the need to revise budget allocation methods in order to allocate resources on a regional basis. This suggestion was tied into the report's proposal to create Regional Health and Social Services Boards (Regional Boards).

In 1991, the 12 CRSSSs were replaced by 18 Regional Boards. For budgeting purposes, this meant that the ministry took the historical budgets of the establishments of the old CRSSSs and renewed them on the basis of the 18 newly-created territories. The Regional Boards then allocated resources to the health care and social service establishments within their jurisdictions according to the prior year's envelopes. In distributing the funds, the Regional Boards did not take the programs operated by the various institutions into particular consideration. Nevertheless, the Boards did have a small measure of leeway in allocating the money entrusted to them insofar as the year's increase was concerned.

"It dates back to the 1990s for all the institutions. So the method was really a method for inter-regional allocation, not intra-regional allocation. That winds up affecting the indicators that are used. Allocating to institutions isn't the same thing as allocating to regions." (All-02)

Despite the recommendations of the Rochon Report and the creation of a working group on the matter, the idea of improving budget allocation methods did not go much further at that time. After receiving the Rochon Report, the Liberal

Minister of Health, Thérèse Lavoie-Roux¹, backed the adoption of a program-based approach. At the end of her mandate in 1989, she was in support of regional-based financing and brought greater clarity to the concept of client-focussed programs. She was unable, however, to implement the changes in budgeting proposed in the Rochon Report.

In 1993, the Working Group for the Allocation of Financial Resources was created with the mandate of providing a frame of reference for allocating the funding for Quebec's health care system. The frame of reference was to take the following factors into account: policies, orientations, the organization of services, resource allocation and the need for accounting. Following the proceedings of this committee, however, budgets continued to be allocated on a historical basis. This meant that the initial budget of a given establishment was simply adjusted using an index and renewed for yet another year, without further consideration of the needs of the population.

The Working Group's findings centered mainly on improvements to the information systems of the general and specialized hospital centres (*Centres hospitaliers de soins généraux et spécialisés* -- CHSGSs) in order to improve the tracking of costs and activities. Inspired by the DRG system (Diagnostic Related Groups) implemented by U.S. Medicare in 1983, Quebec initiated the tracking of activity by care episode in the 1980s. The kind of information gathered by the system allowed administrators to calculate budgets by referring to the average cost of diagnoses adjusted for relative treatment difficulty. The standard costs thus determined were adjusted if the hospital in question had incurred additional costs related to teaching activities, research activities, its remote location or any other factor outside its control.

Until the arrival of the latest Liberal government in 2003, however, successive provincial government administrations lacked the political courage to address the issue of reallocating resources between regions. After the 2003 election, the Liberals were able to take advantage of their reform for the regionalization of health care structures² to tackle the problem of budgeting. Before 2003, the nature of Quebec's electoral system had made it too risky, for electoral reasons, to suggest cutting budgets in certain regions that were steadily losing population.

“Under the current system, regions that have sustained a loss of population continue, because of certain concessions, to elect the same number of members as before, which ensures that their representation in the National Assembly remains constant. Members from urban constituencies therefore tend to represent proportionately more people

¹ Mrs. Lavoie-Roux was minister of health from 1985 to 1989 under the Bourassa administration (Quebec Liberal Party).

² See our paper entitled, “The Reform of Regionalization in Quebec: The Introduction of Bill 25 Proposing the Transformation of Regional Boards Into Health and Social Services Agencies and the Implementation of Local Service Networks”.

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... so to say that you’re going to introduce a new system whereby they’re sure to lose, that’s tricky. The political agenda is, it’s... in the field of health care, it’s impossible 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 1998-1999, however, budgets started to increase again, growing by about 5% per year. In an attempt to address the problem, the government and Health Minister Pauline Marois introduced new legislation on balanced budgets. The *Act to provide for balanced budgets in the public health and social services network*, submitted in March 2000 and adopted in June 2000, prohibited health care establishments from running budget deficits. Notwithstanding the new legislation, however, the establishments continued to accumulate significant deficits when they felt justified in doing so.

For that reason, the ministry decided to turn to a budget allocation method that used efficiency measures and/or a population-based approach. With this in mind, then-Deputy Minister of Health Pierre Gabrièle urged the creation of a committee for the re-evaluation of budgeting methods for hospital centres in 2000. This committee was followed, in 2001, by a committee for the re-evaluation of budgeting methods of the CLSCs (Local Community Service Centres -- *Centres locaux de services communautaires*) and CHSLDs (Residential and Long-Term Care Centres -- *Centres d’hébergement et de soins de longue durée*). Denis Bédard, affiliated professor at the National College for Public Administration (*L’école nationale d’administration publique*) in Montreal and former secretary of the Treasury Board, was appointed president of both committees. Mr. Bédard was chosen for his prominence in the field and his expertise in finance.

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 institution's 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 back to the idea of establishments, but it's because of the fact that service programs were more about social programs than they were about physical health. Physical health was a program, and... but we were 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 on a program-by-program basis. They also proposed that the ministry create a permanent committee on resource allocation.

B- The proposals of the Bédard reports

1. The report on the budgeting and financial performance of general and specialized hospital centres

Using the information system that generates data on costs per care episode and allows institutions to be compared among each other, the ministry of health and social services had begun as early as 2001-2002 to devise transitional, population-based budgeting methods that covered 65% of the CHSGS budgets. In order to extend those methods, then, to 100% of the budgets, the Bédard committee suggested that information-gathering on costs per care episode

continue to be improved and that information systems be completed so as to gather data on all categories of services.

The report also suggested that the practice of allocating budgets to public health care institutions on a historical basis be changed at all three decision-making levels: the ministry, the regions and the health care institutions.

At the ministerial level, the report proposed that appropriations for the regional agencies be broken down according to service program and leave a certain amount of leeway for changes in the demand for services. The authors of the report considered that the interregional allocation of resources was best made on the basis of the population's needs and the average consumption of services. This, in fact, is the method identified in Quebec's *Act respecting health services and social services*. The report further recommended that the regional allowances thus distributed be adjusted to compensate for costs engendered by the exchange of services (province-wide ultra-specialized services would be charged to the regional boards of the patients' place of residence, whereas the exchange of local and regional services would be compensated globally within each region).

On the regional level, budget allowances for each Regional Board were also to be established on a program-by-program basis and adjusted for specific factors such as teaching activities, research activities and remoteness of location. Finally, health institutions were to allocate their resources on a program-by-program basis, using a normative approach that considered the services provided (volume and complexity) and standardized costs.

2. The report on budgeting and service allocation among CLSCs and CHSLDs

The committee for the re-evaluation of budgeting methods for CLSCs and CHSLDs had the mandate of proposing both an interregional allocation method and a budgeting method for the resources allocated to the CLSCs and the CHSLDs for the various services they provided. The committee found out that, as with the hospitals, the CLSC/CHSLD budgeting process took place on a historical basis at all three decision-making levels. Budgets were determined without any reference to programs or actual financial needs. The Bédard report pointed out two problems with this system. Firstly, the interregional distribution of resources did not correspond to the population's needs, as the law required: the result was that standards and accessibility to care varied largely from one region to another, and even within a given region. Secondly, no existing information systems were able to furnish data on beneficiary profiles, the relative volume of services rendered or attendant costs.

The committee therefore proposed that the new budget allocation process reflect service programs at all three levels. At the ministerial level, the volume of

consumption of services would first be estimated for each program, province-wide, and then be multiplied by average standardized costs. The budget for each program would then be distributed among the regions using a population-based approach that used standardized levels of consumption adjusted for regional factors. Regional budget allowances would be adjusted to compensate for the net effect of service exchanges between regions. The Regional Boards were to use the same normative approach to distribute resources among health care establishments, based on the volume of comparable services and standardized costs adjusted for the factors affecting a given establishment.

The committee used a three-fold argument to promote its recommendations. Firstly, budgeting would be based on an objective understanding of changes in beneficiary profiles, services and costs, making it easier to more accurately predict the financial needs of the network. Secondly, the population-based approach would ensure an equitable distribution of resources. Thirdly, the use of standardized costs would stimulate better efficiency and improved performance.

Notwithstanding the merits of this approach, the report pointed out that a crucial lack of data made it impossible to apply. It therefore suggested that information systems be greatly improved.

C- The outcome of the Bédard reports

In November 2002, Health Minister Philippe Couillard created the Permanent Consultation and Coordination Committee for Resource Allocation (*La table de concertation et de coordination permanente sur l'allocation des ressources*). The Permanent Committee was made up of representatives from the MSSS, the agencies, professional associations and the health care and social service institutions. The mandate of the committee was as follows:

- To develop a new interregional resource allocation method to be implemented as of April 1, 2004;
- To advise the minister on all questions relevant to the allocation of resources.

New Associate Deputy Minister of Health Pierre Malouin was assigned to head the committee. Malouin had been Executive Director of Financing and Equipment in Higher Education at the Ministry of Education, where he had worked on a similar budget allocation method for higher educational institutions. He brought to the Permanent Committee a budget allocation formula that had been previously used for education. But the formula turned out to be too simple to apply to the more complex field of health care.

“We’d try it because at the end of the line, when Mr. Malouin came on board, he came from education, and in education, everything is standardized. You know your consumers, you count them on September

30. I know, I've worked there. I've worked in education. So you know the 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 if you have more than 2 over 32 students, you have to pay extra, so that means that you're never going to have more than 34 people in a class... you know. Everything is standardized. Here, nothing is standardized. There's nothing, nothing, nothing in physical health. So when he came on board, his attitude was, 'Aha! My formula is "costs multiplied by volume".' First of all, volume, you know, it's not quite like that. In health care, we don't talk in terms of volume, we talk in terms of needs indicators. We don't know what the costs are. So he really... he really got a wake-up call, in health care. Because allocating resources for health care is ten times more complicated than allocating them in education. Because you don't know your consumers." (ALL-02)

In order to develop an appropriate methodology, sub-committees for service programs, support programs and special cases were created within the Permanent Committee. Their work completed, the sub-committees then submitted their results to the Permanent Committee for approval.

The principles on which the Permanent Committee based its proceedings were as follows:

- Transparency, credibility and predictability in resource distribution;
- Acceptability within the health care environment;
- Results-based management, including the identification of the results targeted, which were to include all resources, not just changes to the system and the monitoring of management practices and accounting procedures.

Following the publication of the Permanent Committee's initial results, the minister, together with his ministry, decided to go ahead.

VI- The choice of a policy: Changes to the allocation of development funds (2004)

The government decided to modify the ministry's allowance of development funds to regional agencies for all medical and social services, excluding physical health, based on the calculation of regional discrepancies. By deciding against making changes to operating budgets, the government wisely avoided redistributing funds between regions, a move which would have been politically unpopular. At this stage, the lack of data on program costs meant that the agencies and the health care and social service establishments were exempted

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* -- CSSS³) 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 that the new calculations would help curtail agency and institutional complaints about the lack of resources to attain given objectives, and put a stop to “justifiable debt” among health care institutions.

“... Having said that, and I don't say this with any resentment, but I think that the ministry should really take a consumer approach here. Firstly, it's an approach that's about, I'd say... it's a theoretical framework that favours equity. It would eliminate a lot of subjectivity, a lot of decisions, in my view... 'Yes! I like this person, I have a little soft spot for him, I'll help him out.' It would eliminate a lot of that kind of thing because it would be based on the evaluation of needs.”

³ See our paper entitled, “The Reform of Regionalization in Quebec: The Introduction of Bill 25 Proposing the Transformation of Regional Boards Into Health and Social Services Agencies and the Implementation of Local Service Networks”.

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 than 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, many pressure groups. Lobbies, pressure groups... in regions that lacked resources, mostly in Montreal, there were citizens' groups that wrote to the ministry regularly to tell it that the situation didn't make any sense whatsoever. Because 'in such a region, we're short \$40 million, and in another region, we're short ...' ”(ALL-02)

Changes to ways in which patients were treated also argued in favour of a change to budget allocation methods. For example, until the 1990s, mental health patients outside of the main urban areas were hospitalized in Montreal or Quebec City. Over time, however, with disinstitutionalization and new treatment methods, it became possible for the regions to treat patients closer to home.

“... so if you look at the historical aspect of the allowances, the problem with the allowances, especially, let's say, in mental health where the idea of treatment was... was... came from another era. A long time ago, mental health services, I mean, there were large mental health hospitals, like Robert-Giffard, Louis-Hippolyte, that meant that the population of Quebec was treated quite differently from how it's treated today. I'm thinking in terms of mental health. It meant that at a certain point, the regions, like Montreal, like Quebec City, for example, in mental health, those places were very very rich in terms of the operating budgets of their institutions. Whereas they were no longer taking... I mean that in the past, people from Beauce would come and hospitalize their mentally ill at Louis-Hippolyte, but then ... - Louis-Hippolyte or Robert-Giffard -, but nowadays, they keep them in their own region, they take care of them in homes. It's not the same kind of treatment. The budgets had never been redistributed in those regions. It means that at a certain point in time, you have a growing population, and you have changes in the way people are treated, too. And that's what the new method wants to fix: it wants to be more equitable in terms for migration but also in terms of policies. We say that we want to promote aid to youth in the field of mental health, well that

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.

“The reason that they didn’t include physical health was that it would mean more money to Montreal, and Quebec City doesn’t like Montreal to have more money. You’ll never hear it said outright, but that’s how it works”
(RG-01).

C- The actors’ viewpoint

In general, the actors involved in the process were in favour of the overall objectives of the reform, even if it meant that some regions might lose resources at the end of the line. The strategy of these actors was to refrain from fighting the reform outright and instead try to influence the ways that the budgets were calculated, especially in terms of the population indicators that would be used to determine the amount of development funds allocated per program.

“And lots of people grumbled about it, saying, ‘Well that’s not necessarily the best needs indicator’.” (REG-05).

Overall, then, the Quebec Hospital Association (QHA), the association of CLSCs-CHSLDs and the association of the executive directors of the health care establishments and the regional agency directors did not oppose the reform. In

any event, the reform has had only a limited impact on day-to-day operations to date.

VII- The reform implementation process

The principal reason for which the recommendations of the Bédard reports were not immediately applied to all of the budgets (operating budgets and development funds), as well as to physical health, was that such an approach would have been overly disruptive in certain regions.

“Take Chaudières-Appalaches, for example. It’s a region that is considered to be more or less in balance. In other words, if we applied the population-based approach, based on the population’s needs and consumption in hospital centres, the actual budget allowance of about \$600 million might vary between \$598 million and \$601 million. I mean, it’s a region in equilibrium. On the other hand, (...) the region of Montreal has a surplus of \$200, \$225 million. In Quebec City, the gap (...) is maybe \$40 million. So you can’t inject that money into the network overnight – we don’t have the means to do it -- - and deduct resources from other regions. It would mean catastrophe in the network. That’s why the ministry gave itself a window of five to seven years to remedy the situation.” (ALL-01)

“Imagine showing up in Gaspésie and saying, ‘Based on a population-based approach, you have more money than average.’ You’d better have your return ticket because they’ll throw you out. Once you start poking around, taking a look at the population, you find young people and seniors, the active workforce has all moved away, and then you say, ‘Whoops! How are we going to work this into our allocation methods?’ Nowadays everybody knows it, but nobody’s found a solution yet. It’s a much bigger worry than Montreal. About Montreal, everyone admits it ...: ‘Yes. We do have more money here, but we have to shave it off progressively, we have to go slowly so things don’t degenerate.’ In Gaspésie, you can’t tell them, ‘OK guys, send some money over to Beauce.’ You have to find... you have to find ways to adjust. We were able to accomplish a lot last year, with minimum levels, minimum teams. That made it easier to respect the more remote regions, but we still haven’t found the right solution.” (RG-05)

Because “robbing Peter to pay Paul” would have caused major difficulties for the operations of the network, the government chose to use a strategy of “one step at a time” and adjust budgets very gradually so as to avoid excessive disruptions in certain regions.

“It’s a work in progress. It’s going to take two more years, easily. Because at the same time, we’re realizing... Because the fundamental difference with respect to the model is, that the model doesn’t evaluate the level of resources required. It merely distributes the envelope. That... there too, it’s more of the same thing. They share the appropriations allocated to me by the Treasury Board. So then, we realize... and they’re sharing a gross envelope, so they need to go get the right revenue. And we realized, this year, that there’s a problem with respect to the revenues collected in the... they’re not always equally reported in the financial statements and that has an impact on the funding gaps. So that needs to be corrected. That makes it a pretty big problem. When you talk about that kind of model, it’s a model that... if you look at this year, it’s \$14 billion. So \$14 billion, that represents about... there must be \$20 billion in appropriations, at the ministry? So that’s about 75% of the ministry’s appropriations. Approximately 25% of the provincial appropriations, the spending of the province.” (ALL-01)

This step-by-step strategy was implemented simultaneously at several levels. To begin with, by only adjusting the development funds and by excluding physical health, the amount of funds given to or taken from any given region is negligible when compared to the total budget allocations the regions receive. Furthermore, while the calculations for the new regional budgets took all of the programs into account, the accounting information for the different programs varied in accuracy and detail. According to what data were available, the indicators used to calculate the allowances varied in accuracy. Each working sub-committee has therefore had to develop its own indicators and continue to improve them in order to hone its calculations (MSSS, 2006). Finally, to avoid overly-drastic readjustments, minimum levels and minimum teams were defined for some regions:

“You have to find... you have to find ways to adjust. We were able to accomplish a lot last year, with minimum levels, minimum teams. That made it easier to respect the more remote regions, but we still haven’t found the right solution.” (RG-05)

In summary, then, it is important to note that the population-based approach to resource allocation is used to accomplish two goals: 1) to measure funding gaps; 2) to allocate development funds. Insofar as the extent of the discrepancies between regions is concerned, readjustments are being spread out over seven years in order to avoid cutting operating budgets in certain regions too drastically. To take the case of Montreal:

“This year, there are budget cuts of \$10 million. Not \$225 million, \$10 million. You see? The ministry gave itself seven years to spread out this readjustment. Now it’s focussed on the aspect of budget cuts”.

VIII- Analysis of the reform process

We will now analyze the various elements that explain the reasons for this decision on new budget allocation methods. To do so, we use the framework proposed by the research team, which examines the roles of institutions, interests, ideas and external or internal events. A summary table of these elements figures in Appendix 4: the Research Template.

A- The role of institutions

To begin with, despite ongoing discussions about the so-called “fiscal deficit” in health care, at no point were relations between Quebec’s provincial government and the federal government a factor in the decision-making process.

The idea to change budget allocation methods originated in the 1980s. Nonetheless, it took the adoption of Bill 25 on regionalization to overcome ideological barriers and allow decision-makers to move the concept forward. With regionalization, the new budgeting method became inevitable: Bill 25 created health and social service centres which were responsible for a given population and a corresponding budgeting method seemed to flow from that decision. It is surprising, therefore, that hardly any of our sources linked the two events: only one commented on the matter (“Well, firstly, I’d say, it was a result of regionalization” (RG-03)). For the others, it was as the two events were completely distinct. In reality, however, they took place simultaneously and were closely linked.

In the field of physical health, budgets distributed by the ministry continue to be allocated globally but take APR-DRGs into account.

B- The role of interests

Within the provincial Liberal government, Health Minister Philippe Couillard was an ardent advocate of the reform. Within the Cabinet, the Treasury Board also supported the reform because a more equitable allocation of funds was expected to improve budget monitoring. Some elected representatives, especially those from populous regions, were not especially supportive of the measures, but given the lack of more viable alternatives and the moral nature of more equitable funding, they did not make much effort to block the Liberal reform. Mitigating discontent was the idea that the new methods would allow resources to be redistributed from the urban centres to regions that until then had received less funding.

The arrival of Pierre Malouin at the ministry of health was another determining factor in the decision-making process. Malouin came from the ministry of

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

“It’s the input of Pierre Malouin, who got there and turned it into a motivating project with the Permanent Committee for Resource Allocation, with a methodology. It’s a very important contribution to our health care system.” (REG-05)

Moreover, at the ministry, bureaucrats were finally beginning to see progress on a project that had been gathering dust for a number of years. They participated actively in promoting the reform, even though they were aware of how complicated its implementation would be. They rightly recognized that the reform was also an opportunity for the ministry of health to better showcase its financial needs and to make funding requests to the Treasury Board on more objective grounds.

The reform was also endorsed in university circles and by researchers who viewed it as a means to leave the status quo behind and fix the problems associated with historically-based allocation methods. Some university professionals even participated in the Permanent Committee on Resource Allocation in order to improve the definition and the quality of the indicators used to equilibrate the budgets. Researchers within the ministry of health and social services also documented what had taken place elsewhere, especially in the United Kingdom (the UK).

The representatives of health professionals showed no particular resistance to a project that had been in the works for such a long time.

While particular interest groups were especially vocal on the question of regionalization, they had little to say about the changes to budgeting methods. This could be because of the very technical nature of the issue. It could also be because of the fact that there was no public debate on the question of budgeting methods, as there had been for regionalization.

C- The role of ideas

It is important to note once again that the Rochon report had made explicit reference to what had gradually taken place with respect to budgeting methods. This shows that the idea had ripened for 20 years before it finally became obvious and indeed all but unavoidable. In the end, the difficulty was less about the decision itself than about the means of calculating the various budgets. Furthermore, it was known that in the United Kingdom, allocated budgets were weighted for certain demographic and clinical criteria.

“When you look... look at England, for example. They developed a whole technology for the development of capitation formulas that were weighted for the various programs. That’s how the government allocates resources to the various regional levels as well as to local entities.” (RG-03)

The electoral victory of the Quebec Liberal Party in 2003 was of capital importance to the adoption of the reform because the new budget methods were part of the party’s electoral platform: the politicians simply applied their own recommendations.

Furthermore, the new budgeting methods were seen as a way to reduce interregional inequity. For one source interviewed, however, this evolution of ideas was merely a way to camouflage a different goal: that of controlling costs. According to this source, the population-based approach and interregional equity are simply rhetorical concepts whose primary purpose has been to make the reform more politically palatable.

“The population-based approach. That’s nothing more than per-capita funding. You know, it’s another modern way to say that we’re going to budget per capita. You take the population of a given territory, how many people there are, to start with. After that, you take the profiles of the health needs: how many people are old. After that, you throw in the factors, you say, ‘Theoretically, the budget should be such-and-such.’ Based on the assumption that the information systems are sound, that to treat people at home in the Lower Saint Lawrence is the same thing as treating them in Montreal, which is not true at all: you have to use a Jeep to get around in the winter, you drive twenty kilometers per person. Then, in Montreal, it’s a whole other story: you get stuck in traffic. Anyway, you tinker with all of that, everybody’s acting in good faith. Then you get to the end of the equation: you’re always \$250, \$300 million short. So you put away the model, all that, and then you say, ‘OK, let’s do it over a longer time period.’ And then, you invent a new concept of interregional equity for resource allocation. They’re nothing more than concepts to try to get as close as possible to transferring money from the populated regions and the university regions like Montreal, in Quebec, to less-populated areas where the needs are just as great, but where there have been less resources in the past. It’s an aspect of regulation that goes well when you have new appropriations, but goes very poorly when you’re scaling back.” (RG-09)

D- The role of external and internal events

Although we refer to external events, the most significant events that led to this decision were events that can be considered internal to the province of Quebec.

The budget cuts of the 1990s had worsened regional inequalities and became an impetus for change in budget allocation structures. Even after the financial situation improved, funds continued to be in short supply. Seen from this perspective, the changes to the budgeting methods were an attempt to better control system costs. Furthermore, improved information systems were producing increasingly more reliable and relevant data, which allowed decision-makers to envision new ways of calculating budgets. Nonetheless, there is still a long way to go.

“The information systems used to measure all of this are not reliable. The entry data could be... there could be falsification. The people, it's people themselves who put in the basic data. It's not done in real time. Sometimes, the data is 18, 20 months old before the ministry can use it, analyze it.” (RG-09)

The two Bédard reports commissioned in 2000 and 2001 were the specific elements that provided the momentum and the conceptual framework that allowed the reform to proceed.

IX- Conclusion

The idea of modifying budget allocation methods in Quebec dates back to the time of the Rochon report. It took nearly 30 years, however, for the idea to be implemented. By 2003, its time had come. With the arrival of a Liberal government that campaigned on a platform that included regionalization and interregional equity, the issue of budget allocation methods rose to the top of the political agenda. In the context of the larger reforms currently being pursued by Health Minister Philippe Couillard, the changes to the ministry's budget allocation methods can be seen as an element of the progressive decentralization of services and the increased consideration of the population's needs. The reform has also provided the tools necessary for better cost control.

The main particularity of this reform was how unnoticeably it progressed and how slowly it evolved over time. In the words of one source, it was represented as “a moral reform”: because it was difficult to oppose a concept as noble as equity, it provoked little protest. The reform also benefited from the regionalization of services, an issue that attracted significant debate: budget changes, in contrast, were portrayed as a predominantly technical matter and one difficult to oppose.

Taken together, the population-based responsibility assigned to the health and social services centres (CSSSs), the creation of family medicine groups and the changes to budget allocation methods suggest that the next challenge that the health minister will face, will be that of registering patients on a geographical basis. This is not presently the case.

“The important thing, in the end, is, why aren’t we moving towards registering patients on the same basis? Right now, it’s as if we had two 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 planification et de l'évaluation. *Modifications suggérées aux critères d'allocation des ressources consenties par le ministère de la santé et des services sociaux au réseau des affaires sociales* (Québec : Gouvernement du Québec, 1987).

Committee Secretariat of the National Assembly of Québec, *Information Booklet* (Imprimerie Transcontinental Québec, 2005), <http://www.assnat.qc.ca/eng/37legislature2/commissions/csle/infobooklet.htm#csle> (accessed July 9, 2006).

Groupe de travail sur l'allocation des ressources financières, *Cadre de référence sur l'allocation des ressources dans le contexte de la gestion par programmes et de la décentralisation des activités: rapport du Groupe de travail sur l'allocation des ressources financières*. 1993.

Kingdon, J.W., *Agendas, Alternatives, and Public Policies* (New York: Harper Collins College Publishers, 1995).

Commission d'enquête sur les services de santé et les services sociaux, *Rapport de la commission d'enquête sur les services de santé et les services sociaux* (Québec: Gouvernement du Québec, 1987).

Commission d'enquête sur les services de santé et les services sociaux, *Summary of the Report* (Québec: Gouvernement du Québec, 1987).

Santé et services sociaux Québec. *La budgétisation et la performance financière des centres hospitaliers* (Québec : Gouvernement du Québec, 2005), <http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2001/01-604-01.pdf> (accessed July 9, 2006).

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

- Loss of autonomy due to aging
- Physical deficiency
- Intellectual deficiency and pervasive developmental disorders
- Troubled youth
- Addictions and dependencies
- Mental health
- Physical health

2- Support programs:

- Administration and support services
- Building and equipment management

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-based approach that takes certain needs indicators into account. I'd like to start 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?

A2a – Who first brought the question of the need to reform the methods of financing the agencies to the attention of the government? Were you or your organization involved at this stage?

A2(b). A4(b). How did this question come to be included on the government agenda? Which solutions were proposed? What were the changes expected to accomplish?

A3 (b) Were alternatives proposed to the model for needs-based financing? If so, how were they different from the model chosen?

A3 (a). Who proposed these alternatives?

B. The decision-making agenda

B1. At what point and why did the government decide that it was important to make a decision and implement a new budgeting method for the agencies?

B2. Who took charge of this issue and made the government realize that it needed to take a decision on the matter?

B3. How was this issue promoted? What made it important at this particular point in time?

B4. Why did the government decide that the problem was important enough that a decision needed to be taken?

B5. Who were the individuals or the groups that helped define the institutional framework for the budget reform?

C. The choice of a policy

C1. What were the government's objectives in implementing this new budget allocation method?

C2. When did the final decision to replace the historical method of allocating resources with a new, needs-based model take place?

C3. Who took part in the final decision?

C3 (a). Who was excluded from the final decision-making process, and why?

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)	<ul style="list-style-type: none"> No links to federalism issue.
	Policies (esp. specific domestic court decisions and/or international agreements)	<ul style="list-style-type: none"> 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 (<i>overlaps with Interests</i>)	
	Policy legacies	<ul style="list-style-type: none"> In 1971, new health authorities were created. Their territories of jurisdiction corresponded to Quebec's administrative territories.

	Other	
Interests	Elected officials	<ul style="list-style-type: none"> ▪ Health Minister Philippe Couillard was an ardent advocate of the reform. ▪ The Treasury Board supported the reform, which was expected to facilitate greater budget controls. ▪ There was the possibility to ask the Treasury Board for funds based on the population's needs. ▪ The representatives of the least populated regions (for example, the Gaspésie) opposed the reform because it tended to favour more populated areas.
	Civil servants	<ul style="list-style-type: none"> ▪ Close collaboration between the health ministry and deputy ministers: a team project. ▪ Ministry of health bureaucrats saw the reform as the culmination of a project and an idea that had been around for a long time. They participated actively in the decision-making process while respecting the political parameters set forth by Health Minister Couillard. ▪ At the MSSS, civil servants participated actively in the Bédard committee. ▪ The arrival of a manager from the ministry of education who had taken part in the reform of budget allocation methods for teaching establishments helped convey the idea that the change was possible and desirable, even if the methodology for health care proved to be much more complicated than for education.
	Policy entrepreneurs (including researchers)	<ul style="list-style-type: none"> ▪ University researchers had an active role in the development of the model and the philosophy underlying the reform. ▪ At the MSSS, research agents documented what had occurred elsewhere (the U.K.) in the matter of population-based resource allocation.

	Professional interests	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ 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 <i>Coalition Solidarité Santé</i> 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 “is”	<ul style="list-style-type: none"> ▪ 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.
	Values / views about “what ought to be”	<ul style="list-style-type: none"> ▪ Successive government administrations in Quebec had been interested in needs-based funding since the 1980s, following the publication of the Rochon report. ▪ The electoral victory of the Quebec Liberals was of capital importance because this reform proposal was at the core of their

		<p>electoral platform.</p> <ul style="list-style-type: none"> ▪ 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)	<ul style="list-style-type: none"> ▪ Influence of the Rochon Report ▪ Significant influence of the two Bédard reports
	Policy learning	<ul style="list-style-type: none"> ▪ Other Canadian experiences, not mentioned
	Other	
Internal events	Release of major report (e.g., commission)	<ul style="list-style-type: none"> ▪ The two Bédard reports of 2001 and 2002
	Political change (e.g., election, cabinet shuffle) – provincial and national	<ul style="list-style-type: none"> ▪ The change in government in April 2003 led to the formal decision to change budget allocation methods. The electoral victory of the Quebec Liberals was of capital importance because this reform proposal was at the core of the party's electoral platform.
	Economic change (e.g., recession)	<ul style="list-style-type: none"> ▪ The budget cuts of the 1990s aggravated inequity between structures, on account of the fact that new structures received less money than did old ones, for the same volume of activity.
	Technological change (e.g., MRI scans)	<ul style="list-style-type: none"> ▪ A centralized DRG system for physical health.
	New disease (e.g., SARS)	
	Media coverage (e.g., deaths on the waiting list)	
	Other	<ul style="list-style-type: none"> ▪ Better performance on the part of the information system: data was still rough but was more relevant than 10 years before. This was especially true for physical health.
External	Release of major report (e.g.,	

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	