

**A Cross-Provincial Comparison
of Health Care Reform Policy in Canada**

**INDECISION-MAKING:
THE PRIVATIZATION OF
HEALTH CARE IN QUEBEC**

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“It’s easy enough to get treatment for a serious illness, a heart attack, for example, or even a common illness like the flu. For moderately-serious disease, though, ‘you’re in no man’s land’ ” (Le Devoir, August 19, 1999, p. A8).

In recent months, Quebec has made front-page news: on one hand, because of its part in the Supreme Court of Canada’s ruling on the Chaoulli case, a case that has opened the door to the introduction of private health care services in Canada; on the other hand, because of the examples of exclusively private health care services provided in the province, particularly in the field of medical imaging. Despite this, the government of Quebec has not made a clear decision with respect to the possibility of allowing private insurers to cover services already covered by the RAMQ, or allowing doctors to offer covered services in private practice. The situation at present is that stipulated in Article 15 of Quebec’s *Health Insurance Act*:

“No-one may initiate or renew a contract of insurance or make a payment by virtue of a contract of insurance by which a covered service is provided or the cost of such a service is paid to a person who resides or is believed to reside in Quebec or to another person in his or her stead, in whole or in part.”

In essence, Quebec reacted to the dilemma in two ways. At first, it made no move to limit the introduction of private service providers. Thereafter, it sought out solutions that would allow it to develop public/private partnerships.

For this reason, we have sought in this study to understand the reasons for which, after Quebec commissioned a report entitled, *The complementarity of the private sector in the pursuit of the fundamental goals of Quebec’s public health care system: Observations and recommendations for possible solutions*, the province failed to follow up on the recommendations of the Arpin Report and neglected to make a political decision on this subject.

I- Presentation of the Arpin Report

In October 1998, Minister Jean Rochon entrusted to Roland Arpin the mandate to take stock of the question of the complementarity of the private sector in the pursuit of the fundamental goals of Quebec’s public health care system.

“The request [...] of Mr. Rochon was to... explore the collaboration, the bridge-building possible between the private and the public sectors. Never do I recall Mr. Rochon talking about privatization, in his mandates or elsewhere.” (PR-03)

After having worked as a teacher for several years, Roland Arpin embarked upon a career as an administrator and successively occupied the roles of Head Principal of the Cégep de Maisonneuve, Assistant Deputy Minister of Education, Deputy Minister of Cultural

Affairs and Secretary of the Treasury Board. In 1987, he became the director of the Museum of Civilization in Quebec, where he remained for 14 years. Winner of several prestigious titles and awards, such as Officer of the Order of Quebec, Arpin is also the author of numerous articles, papers, reports and conferences on culture, education and management. Nonetheless, prior to his nomination to the head of Rochon's committee, his experience in the area of health had been close to inexistent.

The mandate of the working group was organized around two principal goals: (i) to obtain a picture of the nature and evolution of health care spending in the private sector; (ii) to determine the role the private sector should play in the health care (MSSS, 1999).

Having replaced Rochon as health minister on December 15, 1998, Pauline Marois confirmed the mandate of the working group established by her predecessor. The final report of the working group was submitted to the minister in July 1999 and included a certain number of recommendations to "plan" the role of the private sector in the field of health care in Quebec.

1. The role of the private sector in the Quebec health care system

In 1998, private spending represented 30.9% of total health care spending in Quebec. Ten years earlier, in 1989, private spending had represented 25%. The relative proportion of private health care spending grew more rapidly in Quebec than in most other provinces but remained inferior to the proportion of such spending in Ontario. Over this ten-year period, private health care spending in Quebec grew at an average annual rate of 6%, that is, twice as fast as public health care spending, which grew at an average rate of 2.5% per year. Total health care spending, in contrast, grew an average of 3.5% per year. While both public and private sector spending increased at a comparable rate until 1991, the growth of public sector spending slowed much more dramatically than did private sector spending thereafter. Overall, therefore, increases in both private and public sector health care spending slowed during the 1990's, but public sector spending increases slowed much more significantly than did private sector spending increases.

The significant change in the growth curve of spending between 1989 and 1998, with 1991 acting as the turning point, shows a clear demarcation allowing two sub-periods to emerge: a period of rapid and comparable growth of private and public spending from 1989 to 1991, and a period of slowing of growth at different rates, from 1991 to 1998.

The increase in the proportion of private sector spending as part of total health care spending during the 1990's is not, therefore, the result of a "growth spurt" in private spending. Rather it is the result of the conjunction of different rates of curbing of both public and private sector health care spending. Public expenses are defined as those which are paid by the government; private expenses are those for which consumers or insurers are ultimately responsible. Among private expenses, 55% are paid directly by individuals and 35% are paid by insurance companies pursuant to claims. Furthermore, when we refer to private health care expenses, we refer essentially to expenses for

services other than those covered by the universal, public health care system: for example, complementary services such as chiropractic, osteopathy, etc.

The Arpin Report stressed that not a single medical service had been removed from coverage by Quebec's public system over the course of the prior decade. Only a very small number of medical services considered "not required" from a medical viewpoint had been targeted for restrictions in their conditions of admissibility (for example, the treatment of obesity and breast surgery for aesthetical reasons, or superior quality prostheses for cataracts). Doctors were not allowed to provide universally-covered services privately unless they disassociated themselves entirely from the public health care system. Finally, even though the supply of private practice medical services grew slightly, it remained a very marginal part of the system overall.

The report concluded that the growth in private sector health care spending slowed much less significantly than did public sector spending over the course of the 1990's. In general, therefore, the increase of the relative proportion of private spending over the 1990's was not, in fact, the result of an increase in private spending, accompanying a move toward the substitution of services, but rather the indication of measures taken by the government and the system to respect budgets with the goal of achieving a zero deficit.

Buoyed by this analysis, the Arpin Report concluded that the public health care system in Quebec was not, in fact, in the process of privatization. Over the long term, private health care expenses showed a tendency to grow more quickly than the economy, namely, at about 1.4 times the rate of growth of the GDP, indicating the increase of wealth in the population and the public preference for health-related goods and services. As a result, insofar as the government strove to keep the growth in public health care spending at a rate below or even comparable to that of the GDP, it was foreseeable that the proportion of private sector spending as a part of total health care spending would tend to increase progressively, albeit at a slower rate than that of previous years. Such an increase would not, however, in and of itself signify a deterioration of the principle of financial accessibility to available public health care services. Given that doctors may not offer publicly-covered medical services without completely disassociating themselves from the public system, and that insurers are not allowed to provide coverage for private medical services, the private health care service market essentially provides goods and services other than those covered by the public system: it does not, as a rule, provide substitutions for publicly-covered services. In the absence, therefore, of significant structural change within the public system (for example, the withdrawal or reduction from coverage of medically-necessary services), the proportion of private spending as a part of total health care spending would seem destined to evolve essentially in response to the magnitude of cost-control efforts deployed by the government by means of its remuneration policy and the scope of efforts initiated by the public network to increase efficiency.

2. Promising prospects of greater complementarity between the public and private sectors

The suggestions of the Arpin Report focussed mainly on general principles without proposing specific actions. Its goal was to position patients at the center of health and welfare services with the mission of improving their health and well-being. All potential strategies and measures were to prioritize the same aim: “to improve the public system by adopting innovative methods without compromising the integrity of the system.” These principles revolved around 19 ideas.

- 1- Make the best possible use of the current organization of services.
 - Adopt management strategies focussed on clinical and financial results.
 - Adjust means of financing establishments to render them more appropriate to users and to the mission of the establishment in question.
 - Enlist employees’ participation in the reduction of costs of peripheral services and espouse new management models.
 - Review ways to remunerate doctors in order to increase flexibility both with respect to the organization of the system and with respect to certain working conditions of salaried employees.
- 2- Remodel programs, organization methods and practices.
 - Modify services and financial support programs for the elderly by overhauling the programs currently available.
 - Introduce new models of “integrated service management”, such as the integrated service model for elderly persons with decreasing autonomy (SIPA Project).
 - Prioritize the collaboration of partners while introducing a measured dose of “internal competition”, keeping the emphasis on relationships of confidence all the while.
- 3- Limit the creation of parallel private sector health care services for medical services already covered under the universal public health care system.
 - Consolidate services and reduce problematic wait times.
 - Disallow dual practices and private coverage of medical services, that is to say, do not allow doctors in private practice to provide medical services already covered by the public health care system without completely disengaging themselves from the health care program administered by the RAMQ; maintain government measures by which private insurers may not provide coverage for medical and hospital services.
- 4- Optimize revenues from the billing of certain services while ensuring respect of the principles of accessibility and equity.
- 5- Enhance and support voluntary financing activities.
- 6- Capitalize on excess equipment capacity, creating a basis for new partnership opportunities.

- Make it possible to rent certain under-utilized equipment or space, making sure that to do so would not compromise the optimal functioning of the system; make it possible to create service cooperatives that would allow the creation or the protection of jobs.

7- Avoid creating conditions favourable to the sale of medical or hospital services to foreign residents.

8- Ensure better management of relationships with community organizations.

9- Foster the creation of a network of high-quality, non-profit home care services.

10- Review the regulation of certain non-profit activity.

11- Ensure that current practices and regulations do not act as obstacles to innovative projects.

12- Foster the dissemination of innovative projects and increase their chances of success.

13- Entrust private clinics with a role better adapted to the shift towards outpatient care within the integrated network of primary care services.

14- Better define the concept of “affiliated clinic” offering medical technology or laboratory services.

- Control conferral of the status of “affiliated private clinic” by means of service agreements established on the basis of an agreement of affiliation with a hospital center, as allowed by the *Act Respecting Health Services and Social Services* (...).

15- Foster new forms of technological partnerships when such partnerships would permit the improvement of services and the reduction of costs.

16- Encourage the purchase of living accommodations in private seniors’ residences, when to do so would be more economical, by issuing invitations to tender.

17- Reinforce the regulation of private services for elderly persons with decreasing autonomy.

18- Encourage private enterprise providing minor services to the elderly to assume greater responsibility while reinforcing quality standards.

19- Study the possibility of extending the formula of the prescription drug insurance program to other services.

II- The conception of the idea (1990-1998)

Beginning in the early 1990's, personal spending on non-covered health care services embarked upon a period of growth, and the volume of private services offered on the market also increased. This was the result of several factors, which together influenced the government into tacitly allowing a private sector in health care services to develop (PR-01 + AM-12). It was a development that occurred slowly and did not follow a formal political decision. Nonetheless, Minister Marc-Yvan Côté had had the principle of an accredited private sector inscribed in the *Act Respecting Health Services and Social Services* in 1991.

“Marc-Yvan started it in ‘91. First, by putting into the law the accreditation of the private sector, the registration of the private sector. It works very well.” (PR-01)

1. Market pressure

The evolution of science and technology had caused health care costs to increase. In order to finance new technology in the face of pressure on public finances, new financial resources emerged from the private sector and became the means by which private services progressively appeared. The services in question catered mostly to the elderly personnes âgées ... A significant trend also emerged in hospitals, in the form of the sub-contracting of so-called non-essential services (for example, laundries and catering). Furthermore, completely private clinics (clinics that operated only on private financing and whose medical staff was independent of the RAMQ) also appeared. Most frequently, these clinics were specialized in a specific treatment (they were, for example, eye clinics, orthopaedic surgery clinics, or clinics for radioscopic diagnosis) for which there were significant wait lists.

“Of course. And also, you have to remember that at the end of the government term before the election... there had been the question of the zero deficit. And there was also, at the time, in the background, a move to look into the possibility of divesting the system of sectors that were not fundamental to hospitals, like the management of laundries.” (PR-02)

“Furthermore, there were completely private clinics, be it for – take eye clinics for example, for eye operations, well of course there were plenty of people who were already going to those clinics because, you see, they didn't want to wait, it was urgent, they could afford it, whatever reason you like.” (AM-12)

2. The cutbacks of the 1990's

The reaching of the zero deficit and the implementation of the shift toward outpatient care brought in their wake a significant decrease in both human and financial resources in the field of health care. Rationalization resulted in problems of accessibility and significant wait times at emergency rooms. The health care system was dysfunctional and resources were scarce.

3. The appearance of a third sector

The social economy sector also began to develop. This favoured a transfer of activity from the network of CLSC's to the social economy and the cooperatives, since, in some cases, the CLSC's were no longer able to offer a complete range of services.

“There was, too, the appearance of a third sector in the social economy. In fact the World Social Forum ... that was in 1998, in essence it preceded the Arpin Report that had led to the creation of social-economic enterprise in the sociosanitary sector. Part of that was due to a transfer of activities from the CLSC network to social economic enterprise, the cooperatives. The other part was the fact that the CLSC's were no longer able to cover that kind of program. They themselves had to regroup. It wasn't just because of substitution.” (PR-02)

“And I believe that there is plenty of room for not-for-profit private sector activity. That's what happened with the social economy. And I'm very proud of what we accomplished with the social economy in Quebec, that was an idea that had been put forward by community organizations.” (PR-04)

III- The decision-making agenda

1. What were the reasons for the decision to go ahead with the creation of the Arpin Committee?

Several factors joined together. Within the Council of Ministers existed a trend that wished to take better advantage of the private sector in order to offset the failings of the public system. In fact, the pressure of budget cuts on establishments with a view to achieving the zero deficit had given rise to problems of accessibility to services. It was also considered desirable that the State dispose of relevant information with respect to the true role of the private sector in the system and how that role might be shored up. For those reasons, Jean Rochon was under pressure, particularly from the Council of Ministers, to open the door to the private sector in order to address problems of accessibility.

“There was tremendous pressure from his colleagues. I saw Dr. Rochon frequently and he was under a lot of pressure from his colleagues to possibly privatize the health care system (...), and he ... wasn't gung-ho to create a committee, that's why he created a committee with a very limited mandate.” (PR-03).

Furthermore, there was, in public opinion, the fear that after years of budget cuts, an insidious and passive privatization of the health care system might be taking place.

“I think that one argument was that there was a trend in public opinion to the effect that insidious privatization had actually taken place. There was a trend, in

fact, that transferred part of the responsibilities of the public sector toward the private sector, a trend toward a significant increase of spending in the private sector... .. especially in support services, I would say, following the zero deficit.” (PR-02)

Polls also showed that public opinion was not hostile to the entry of the private sector into the system. Print media as well as television and radio had produced a number of reports that underlined, on one hand, the inadequacies of the system and, on the other hand, the possibility to address those inadequacies by opening the door to the private sector. The American system was frequently cited as a model of accessibility. It was frequently stated that it was becoming increasingly reasonable to purchase health services in order to obtain better accessibility.

“Yes, the media. So, when the front page of the Journal de Montréal tells you: ‘Well, now... Monsieur X has been waiting for a heart for four months, and he’ll croak if he doesn’t get his operation’, well, then, on that morning, it’s compelling. (...) That’s because there was a study that had been done: headlines on health issues increase circulation by 8%. And it works.” (PR-01)

“That’s the third reason why people were in favour of private care: because there were more and more... it was because there were waits, but there was mostly, now, the possibility to be treated elsewhere than in the public system. And this possibility to be treated elsewhere than in the public system, it had become more... more... better known, better known and possible.” (PR-01)

2. The strategy deployed by Jean Rochon

To respond to the pressure coming from within the government, Jean Rochon resolved to appoint a study group and commission a report. The main reasons for this decision were to win time and to demonstrate, to some extent, good will. Notwithstanding, Jean Rochon was profoundly convinced of the importance of the public sector in health care. He did not want a two-tier medical system.

“He was open enough, but he was very concerned to not have one set of services for the poor and another for the rich.” (PR-03)

Given that Jean Rochon did not support private sector health care, he deployed strategies to reduce the import of the work of the Arpin Committee. Firstly he chose someone with great credibility, a high-ranking civil servant, but who was unknown to the medical world. Secondly, he asked Arpin to study the bridge-building and collaboration possible between the public and private spheres. He purposely did not ask how the government could assist in the privatization of the system in order to improve the public health care system as a whole. The truth is that Jean Rochon did not want the report to address privatization of the health care system and for that reason, he asked Arpin to study only a part of the issue, namely, the possibility of establishing partnerships between the private

and public sectors. Jean Rochon also made it clear to the committee that he did not wish to be encumbered by a document that would be too unwieldy.

“He even said so, he didn’t hide it, he said that he didn’t want to wind up with a document... that would be too heavy, too difficult for a minister to work with.”
(PR-03)

Finally, the report was commissioned during an election campaign, when the parties knew full well that there was a possibility that the health minister might be replaced. For that reason it was clear that the report would probably be submitted to another minister, possibly diminishing its impact or even resulting in its being overlooked entirely.

IV- The Final Indecision – Analysis

1. Interest Group Factors

The working group had submitted its report to Health Minister Pauline Marois. The government received the report relatively well. Pauline Marois was not really in favour of an increase in the role of the private sector in the health care system. The report suited her because it did not call the public system into question and its proposals were relatively vague, ruling out a rapid decision.

The proposals of the report were, in contrast, poorly received by unions and social groups, which found them to be overly favourable to private sector solutions.

As for individuals providing private sector health care services for the aged, this contingent perceived the Arpin Report as an act of disengagement of the public sector from the network of senior living facilities, a disengagement that was accompanied by the imposition of very strict quality standards on the private sector without special financing to help implement these obligations.

“Yes. That in some cases, in all cases, the State stepped back and there was no real compensation with respect to its disengagement.” (PR-08)

“I really think that it’s the same thing for the network of senior living facilities, there is a big gap, there is no, there is no real public-private partnership. The public sector stepped back and the private sector took over. And the more the public sector steps back, the more the private sector takes over, but the more the gap widens between the two and the more people fall between the cracks.” (PR-06)

“So... that’s why I say the gap continues to widen, more and more, because the public sector takes on less and less because it can’t handle it anymore – and I’m not criticizing the public sector, that’s just the way it is – and it unloads it on the private sector. And after that, they say: OK, you take care of it, but on top of that we’re going to regulate you, we’re going to saddle you with requirements for certification, for approval, for quality standards, it’s much too much for the private facilities, we’ll wind up with requirements without the income to go with it.” (PR-06)

2. Institutional factors

As Health Minister, Pauline Marois was responsible for ensuring the legacy of her predecessor, and it was difficult for her to completely brush the report aside. But the issue was not truly a priority either for the government or for Marois herself. Because the proposals of the report would have required significant action in order to be implemented, it was relatively easy for the minister to avoid getting involved in the debate, especially since the issue was so controversial.

“Madame Marois (...) was even more... it got even more diluted, if you’ll allow the expression, even more diluted because of what... what she gave us. Because Madame Marois reacted by receiving us well, receiving the Commission well, she listened carefully, she made intelligent comments, but she didn’t... she didn’t take action on behalf of the government. Actually, I’m not sure it’s even possible to take action on such a... touchy subject. In my opinion, it’s possible to... do a certain number of pilot projects, we can call them pilot projects, pilot research, whatever. This is a field where nobody wants the government to do anything that can’t be undone.” (PR-03)

“The work done by the Commission wasn’t very definite, actually, in terms of firm recommendations for the private-public dilemma. Actually, that group wasn’t really favourable to... did not turn out to be strongly in favour of... privatization. But there were extremely competent people in that Commission. And their opinion was, let’s privatize, but we mustn’t say so.” (PR-03).

“But I assume that if Rochon had stayed there, that he would probably have moved forward certain recommendations, he was the one who ordered the report. But his successor wasn’t of the same thinking, she took the report and she shelved it.” (PR-05)

“... As far as I remember, I don’t recall having had a single discussion in nine years, at the Council of Ministers, on the role of the private sector. Not a single discussion ...” (PR-01)

It is interesting to note that the members of the Arpin Committee knew that their recommendations would not be followed up:

“When the report was submitted to Madame Marois, she received it well, but we felt right away that it was the end of the line. It would go no further, we knew that. Those weren’t her priorities, those kinds of issues, she didn’t want to get involved with that. Since she is a very political woman... and that it’s a very... a very controversial question... in fact she started the process right there, I don’t recall that she talked about it much (...), she went very little into it. It wasn’t a priority for her. It wasn’t a priority for the Council of Ministers either actually.” (PR-03)

The private sector perceived the State as lacking the means to continue to provide coverage as formerly and tending to step back as a consequence. The attainment of the zero deficit and the shift to outpatient care resulted in a considerable decrease of resources in health care. Rationalization caused problems of accessibility. This disengagement on the part of the State took place passively and non-explicitly, that is to say, without a clear policy on the issue. Through its long-term care facilities, the public sector assumed responsibility for a very needy clientele and the rest of the clientele was increasingly left to the private sector in private facilities that provided neither assistance

nor care. Furthermore, the State demanded high quality standards without specific financial assistance. Finally, home care was not well developed.

This passive privatization harmed the fundamental principles of the system more than if there had been an organized plan to reinforce the complementarity of the public and private sectors, within the context of a single-payer system.

“And the public sector bought living space in the private old age home sector or in public-private long-term care facilities, that’s not a partnership... In a partnership, fundamentally there’s risk-sharing. Whereas in the purchase..., in a public-private partnership, normally, there’s a long-term agreement where there is risk-sharing, where there is the sharing of common goals, and... let’s say that the idea is that you’re looking for a win-win situation. Whereas in purchasing, as in the selective purchase of space in private facilities for autonomous individuals, first of all, often it’s poor quality of services because you’re buying, because you’re buying for the immediate short term and because it’s just to bail yourself out.” (PR-07)

3. Ideational factors

An idea that surfaced frequently in the interviews is the impression of a certain carelessness in the privatization of some health services in Quebec, without the government taking a clear stance on the issue. For that matter, the numbers confirm that private financing is increasing its presence in the health care system, especially for medium/long term treatment. The word ‘privatization’ is taboo in Quebec.

“It was taboo. Until the Arpin Report, the subject was taboo. Arpin was, I think, something of the forerunner, even if it wasn’t... even if it wasn’t clearly articulated, it was still something of the forerunner ...” (PR-08)

“Because in health care, in Quebec, the moment you bring up the word ‘private’, you’ve committed high treason.” (PR-01).

It was an area where nobody wished to see irreversible measures implemented. If the idea of privatization were brought up, it was always in terms of a partnership with the public sector, never in terms of the privatization of given services. In fact, Roland Arpin reported that over the course of the entire report preparation period, no-one among the 28 groups consulted by the Committee proposed the privatization of the health care system (July, 1999).

In the public and among health care workers, there exists a certain confusion between private financing and private services. The distinction has been poorly explained and there is a general lack of knowledge on the issue. More demagoguery than pedagogy informs the discussion.

“But there’s pressure by the unions behind all of this. The population is, in general, ready. Various polls have shown something in the order of 60 or 70% in favour of private sector participation in the health care system. There was a poll by Léger and Léger on the subject. For partnerships, the same thing. But it never happens. Why? Because the organized unions keep up the pressure. They’re not educated on the definition of a public-private partnership. There’s education to be done. The politicians know a bit of what it’s all about, then you hit the administrative machine starting with the minister and working your way down to the institutions on the ground, and they don’t know what you’re talking about. So there’s education to be done there. And the day that we’ll have educated those in charge, maybe it’ll happen. Because the way it stands now, people think ‘public-private partnerships = privatization of services’.” (PR-08)

“I’d say it’s a drop in the bucket. It’s not a useless document, far from it, it clarified a certain number of concepts, a certain number of proposals, and it’s a cautious document.” (PR-03)

“Among the public, when there are polls on the role of the private sector, in general more people are in favour of greater implication rather than less.” (PR-05)

“As soon as you say the word ‘private’, first of all there’s confusion between private financing and the private provision of services... and second of all you’re excommunicated before you can say anything else. In fact you’re lucky if you’re only excommunicated...” (PR-07)

In the final analysis, the debate on privatization has not been a rational but an emotional one. Players tended to conjugate the concepts of universality and accessibility with the concept of freedom from charge. For that reason, it was socially and politically difficult to implement the recommendations of the Arpin Committee.

“And furthermore, when you look at their conclusions, if you know what I mean, or their recommendations, what they were telling us, it was, basically, to see if there weren’t better, if there weren’t partnerships that we could consider, that could improve the way the system worked. But they weren’t proposing a revolution, no way. And so... if I remember well, there wasn’t much follow-up to the Arpin Report.” (PR-04).

“As soon as you go there, it’s not longer... a... rational debate, it’s an emotional one.” (PR-07)

“But in Quebec, and the PQ, the Parti Québécois... were largely at fault... were largely at fault for the line they took, for our dogmatism, our insistence on linking universality and accessibility with the concept of services being free from charge. We hammered that in way too hard.” (PR-01)

4. External Factors

That the report was submitted during an election campaign and that the issue was so sensitive were two factors largely responsible for the lack of follow-up on the report's proposals.

“In my opinion, that was why. I think that the report had been partly commissioned for, what shall I say, for election strategy reasons, and then given that there was a change in ministers, Madame Marois... Madame Marois, she kind of took it... she used it as a segue to other issues.” (PR-02)

The means found by the government to resolve the issue was the creation of a new commission with an expanded mandate, the Clair Commission, in June 2000. Rather than follow up on the Arpin Report, Pauline Marois decided to form the Clair Commission in order to produce an overview of the health care system as a whole. The Clair Commission would flesh out the details of certain recommendations of the Arpin Report.

“You mentioned it earlier, it's my feeling too that there was very little follow-up to the Arpin Report. But what I'd like to point out is that between Arpin and Clair there's a certain continuity, basically. The Arpin Report was more general in scope, the Clair Report had very clear recommendations.” (PR-04)

“Oh, yes. Yes, yes. Because I'll tell you why: we had to go listen to people. Because there's a difference between... because I think that Mr. Arpin and his team listened to people as well, but it was, like you said, it was at a more general level. The Clair Report goes into all of our institutions, the whole of the system, what we'll offer in terms of services, the results we were achieving, etc., but by listening much more closely to the players in the health and social network. And the Clair Report was produced after huge consultations, you know. They went to meet with people, they held public audiences. So it had a greater scope. Whereas the Arpin Report was more of a study, I'd say ... not in a vacuum, because that's not how it was done, but it was a more limited study, I would say, compared to what Michel Clair and his team came up with, and it's what they were asked to do as well.” (PR-03)

The mandate of the Clair Commission had been envisioned in such a way as to explore means by which the State could suscite the participation of the private sector in the pursuit of the State's objectives, within the context of a single-payer system. The Clair Report concluded that effort would be needed in order that the private sector not act as a competitor and contribute to the destruction of the health care system, but rather take on the role of ally in the development of a policy framework (PR-07).

“And the Commission, if you recall, explored... -- I use the word 'explored' deliberately because it wasn't a ready-made solution... -- but it explored the ways it could seek out the participation of the private sector in the achievement of the

goals that the State had set itself for public health, while working within the single-payer system.” (PR-07).

“They recommended a policy that would be generally favourable to a partnership between the public and the private sectors while remaining within the framework of public financing, not in order to have two waiting lists but in order to shorten the one that was already there, and to stimulate a little competition in some sectors. So in the areas where it was recommended – including, by the way, the private non-profit sector, that was clear – so that meant, as I recall, long-term care, home care, affiliated clinics, real property, computer technology...” (PR-07)

Conclusion

The government of Quebec deliberately chose to ignore the Arpin report and not act on its recommendations. It seemed, however, that the issue remained latent until resurfacing with the Supreme Court’s decision on the Chaoulli affair. This decision makes it possible for individuals to contract private insurance for health care services included in the public health insurance and hospitalization programs.

The political regimes of Quebec’s past have systematically avoided the question of privatization. As a consequence, there has never been a clear political choice for or against privatization, but rather an unspoken decision to let things take their own course, resulting in the passive privatization of the health care system. Since the 1980’s, the cases of exclusion from coverage of some services, according to the place where the service is rendered, have multiplied: as it stands, certain diagnostic exams, such as ultrasounds, scans, and magnetic resonance imaging, are no longer covered when delivered outside of a hospital center. Furthermore, certain services covered by the public hospitalization program are presently offered in clinics by doctors who have disaffiliated from the RAMQ, for example, in ophthalmological clinics. Normally, these services would not be eligible for coverage under a private insurance program because they are included in the basket of services provided by the public hospital and medical insurance programs.

Nonetheless, only a marginal portion (4%) of the services covered under the public system are presently provided privately. For that reason, it would not be accurate to consider that such services are, as yet, privatized.

The current Liberal government has, however, made the implementation of a public/private partnership a key issue; indeed, it has created an institute to that effect. It has also let it be understood that in order to respond to the Chaoulli decision, it would allow doctors to charge both public and private fees and would allow residents of Quebec to purchase private insurance for services presently covered by the public medical and hospital insurance programs. Measures such as these would result in the significant privatization of the Quebec health care system and could have significant consequences on the way resources are distributed (CSBE, 2001).

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¹ On June 9, 2005, The Supreme Court of Canada rendered its decision on the Chaoulli case, named after the Quebec physician who initiated the petition. In its ruling, the Court invalidated Quebec's position with respect to its prohibition against private insurance on the grounds that it is contrary to the Charter of Rights. This ruling revokes two articles of the Hospital Insurance Act and the Health Insurance Act, which prohibit private insurers from providing coverage for medical services covered by the public system.

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

RESEARCH TEMPLATE

Province: Quebec

Case study: partenariat public/privé – The Arpin Report

Category	Subcategory	Data
Institutions	Structures (esp. federal government and/or department or legislative committee mandates)	<ul style="list-style-type: none"> ▪ Rapport Arpin remis à la Ministre Pauline Marois qui l'a bien accueilli mais sans chercher à lui donner suite (PR-04). Elle devait assurer l'héritage de son collègue, donc s'était difficile pour elle de balayer complètement le rapport du revers de la main (PR-04). ▪ La problématique ne faisait pas partie des priorités du gouvernement et de P Marois. Elle ne voulait pas s'embarquer dans ce débat. Elle est une femme très politicienne et il s'agit d'un sujet très chaud (PR-03). ▪ Les membres du comité savaient que les recommandations ne seraient pas reprises (PR-03). ▪ Le ministère de la santé a été très peu consulté dans ce dossier ? ▪ Présentement, on assiste à un désengagement de l'État, mais on écarte du même coup le recours au privé. Il y a donc une cassure entre les deux secteurs (PR-07). ▪ Les CHSLD publics ne prennent qu'une clientèle lourde requérant énormément de soins et les résidences privées n'offrent que des services d'assistance et pas de soins. De plus, les soins à domicile ne sont pas très développés (AM-12).
	Policies (esp. specific domestic court decisions and/or international agreements)	<ul style="list-style-type: none"> ▪ L'atteinte du déficit zéro et la mise en place du virage ambulatoire ont entraîné une diminution considérable des ressources dans le domaine de la santé (PR-01-02-04). ▪ La rationalisation a entraîné des problèmes d'accessibilité (PR-01). ▪ Durant la période de rationalisation des années 1990, il y avait eu tout un mouvement de la sous-traitance dans les secteurs non fondamentaux des hôpitaux (par exemple : buanderies, services alimentaires) (PR-02). Ce mouvement avait donc créé une impulsion pour le développement de services privés. ▪ Le gouvernement a permis tacitement qu'un secteur privé se développe (PR-01 + AM-12 +

		<p>PR-03).</p> <ul style="list-style-type: none"> Le Ministre Marc-Yvan Côté a fait inscrire le principe du privé conventionné dans la Loi sur les services de santé et les services sociaux en 1991 (PR-01). Exemples de services privés : cliniques de l'œil & cliniques médicales privées.
	Policy networks (<i>overlaps with Interests</i>)	<ul style="list-style-type: none"> Les alliances entre les acteurs qui ont intérêt à ce que les choses ne bougent pas sont tissées très serrées (surtout les alliances syndicales) (PR-08). Il faudrait davantage d'incitatifs financiers pour que ça bouge (PR-01 – PR-07). Même ceux qui ont intérêt à ce que le privé progresse préfère le statu quo à un débat national, d'où la privatisation passive du système (PR-03). Cette privatisation passive porte davantage atteinte aux principes fondamentaux du système que s'il y avait un véritable plan pour renforcer la complémentarité du système public et privé, dans le cadre d'un payeur unique (PR-03).
	Other	<ul style="list-style-type: none"> Not mentioned by any participant.
Interests	Societal interest groups	<ul style="list-style-type: none"> Rapport relativement bien accueilli par le gouvernement péquiste (accueil poli & réservé). Rapport mal accueilli par les syndicats et les groupes sociaux. Impression que le public se désengage dans le réseau de l'hébergement tout en obligeant le privé à suivre des normes très strictes de qualité et sans donner de financement particulier pour mettre en œuvre ses obligations (PR-06).
	Policy entrepreneurs (including researchers)	<ul style="list-style-type: none"> Pour répondre aux pressions concernant l'accessibilité et la place du privé dans le système, Jean Rochon a décidé de mettre sur pied un groupe d'étude et de commander un rapport. Il a mis sur pied le comité Arpin pour gagner du temps (PR-03-PR-05). Jean Rochon était profondément convaincu de l'importance du public en santé. Il ne voulait pas d'une médecine à deux vitesses (PR-03).
	Elected officials	<ul style="list-style-type: none"> Certains membres du conseil des ministres exerçaient des pressions sur le Ministre Jean Rochon pour qu'il ouvre la porte au privé pour régler les problèmes d'accessibilité (PR-03).

		<ul style="list-style-type: none"> ▪ Ils voulaient voir où en est le privé, faire un état de la situation et voir ce qui pourrait être fait (PR-04). ▪ Le parti libéral est plus enclin à développer les PPP que le parti québécois
	Civil servants	
	Other	<ul style="list-style-type: none"> ▪ Mouvement dans l'opinion publique à l'effet qu'il s'était passé une privatisation sournoise suite aux années de compression (PR-02).
Ideas	Knowledge / beliefs about what "is"	<ul style="list-style-type: none"> ▪ Impression qu'il existe un laissez aller dans la privatisation de certains soins au Québec ▪ Chiffres montrent une place de plus en plus importante du financement privé dans le système de santé, surtout dans le moyen/long séjour. ▪ L'univers de référence des fonctionnaires et sous-ministres) qui pourraient faire bouger des choses est très limité. Ils sont peu au courant de ce qui se fait ailleurs et ils sont peu exposés aux nouvelles idées qui stimulent l'innovation (PR-07).
	Values / views about "what ought to be"	<ul style="list-style-type: none"> ▪ Jean Rochon ne croyait pas au privé, il a utilisé des stratégies pour réduire la portée du travail du comité Arpin en lui donnant un mandat très ciblé portant sur la problématique des partenariats possibles entre le public et le privé (PR-03). ▪ Pauline Marois n'était pas non plu positive au privé dans le système. ▪ Les valeurs de la société québécoise favoriseraient plutôt le public dans le système mais les pressions médiatiques sur l'accessibilité a progressivement ouvert la brèche dans les mentalités ceci encouragé par la non intervention de l'état dans la prise en charge par le privé de certains services qui normalement devraient être couverts (PR-01-PR-03).. ▪ Les Québécois sont de plus en plus riches en terme de couverture d'assurances privées (ils ont de plus en plus les moyens de se le payer) (PR-01). ▪ Les opportunités d'être traité ailleurs que dans le système public sont plus grandes et plus connues (PR-01). ▪ Les gens veulent des services. S'ils ont l'argent, ils sont généralement prêts à payer pour leur santé (PR-03). ▪ Le mot privatisation est un mot tabou au Québec. Les mots privatiser et public-privé

		<ul style="list-style-type: none"> ▪ sont suspects (PR-01- PR-03). ▪ Il y a une confusion entre financement privé et prestation privée (PR-04-PR-07). ▪ Manque de communication pédagogique sur le sujet (PR-01). ▪ C'est une question ou personne ne veut qu'on enclenche des actions irréversibles (PR-03). ▪ Débat surtout émotionnel et moins rationnel (PR-07). ▪ Lie universalité et accessibilité avec gratuité (PR-01). ▪ Socialement et politiquement difficile de faire le suivi des recommandations du comité Arpin (PR-04).
	Combined (e.g., commission recommendations)	<ul style="list-style-type: none"> ▪
	Other	<ul style="list-style-type: none"> ▪ Not mentioned by any participant.
External events	Release of major report (e.g., commission)	<ul style="list-style-type: none"> ▪ Le rapport Arpin est sorti en 1999 et n'a donné lieu à aucune prise de décision sauf la mise en place d'une nouvelle commission ▪ Recommandations du rapport Arpin assez générales (PR-03 et 04) ▪ Mise en place de la commission Claire (commandité par Marois) en juin 2000 qui devait plancher plus largement sur le système de santé québécois, ceci comportant le problème de la participation du privé dans le système. ▪ Le mandat de la Commission Clair a été conçu de telle sorte à explorer des pistes dans lesquelles on pouvait rechercher une contribution du secteur privé en fonction des objectifs que l'État se fixe, dans le cadre du payeur unique (PR-07). ▪ Le rapport Clair concluait qu'il fallait qu'un effort soit fait pour que le secteur privé plutôt que d'être un compétiteur et de contribuer à détruire le système de santé, soit un allié dans le développement d'une politique cadre (PR-07).
	Political change (e.g., election, cabinet shuffle) – provincial and national	<ul style="list-style-type: none"> ▪ Demande du rapport en période pré-électorale en sachant qu'il y avait ainsi la possibilité que le rapport soit relégué aux oubliettes (PR-02) ▪ Élection en 1998, sujet délicat et pas très vendable politiquement, surtout pour un gouvernement péquiste.
	Economic change (e.g., recession)	<ul style="list-style-type: none"> ▪ Politique du déficit zéro a permis au privé de prendre plus de place

	Technological change (e.g., MRI scans)	<ul style="list-style-type: none"> ▪ Not mentioned by any participant.
	New disease (e.g., SARS)	<ul style="list-style-type: none"> ▪ Not mentioned by any participant.
	Media coverage (e.g., deaths on the waiting list)	<ul style="list-style-type: none"> ▪ Déclencheur du problème des services privés au Québec : la crise médiatique sur l'hébergement des personnes âgées et handicapées en 2004 qu'à eu à gérer le Ministre Philippe Couillard. Cette crise a relancé le débat sur la gestion de la qualité dans ces établissements (PR-02).
	Other	<ul style="list-style-type: none"> ▪ Not mentioned by any participant.