

## Impacts and stakes raised by law 25

- Isabelle Langlois, RIOCM, April 8<sup>th</sup> 2004

Bill 25, although it's a very important reform of our health and social services system as we know it (a nurse union –FIIQ– compares it to the Castongay reform which takes us back to the 70's), was passed with a gag order.

A restricted parliamentary commission was hold – less then 20 organizations or people were heard among whom 18 were against bill 25 and 2 were mitigated. Nevertheless, bill 25 was assented to on December 18<sup>th</sup> 2003 by the National Assembly. You may ask yourself: Why where so many people against bill 25? Isn't it supposed to improve Quebec's health and social services system and to bring services closer to the public? In order to accomplish that, those solutions were needed:

- Finance more adequately our health care and social services system (to meet the Canadian average regarding public expenses, 2 Billions per year would be needed!); and there was almost nothing in the last provincial budget (only 200 Millions more for development – on a total of 20 Billions, it's a small amount).
- Consolidate primary social and medical services and the CLSCs network;
- Grant the community organizations the autonomy and financial support they need to accomplish their work on health determinants ;
- Encourages a medicine were physicians are considered as contributors to the public services rather than private businessmen free to choose when and were they work. This would also imply the end of the fee-for service approach which incite the multiplication of medical acts;
- Recognise that drug access is an essential part of health care access;
- Sort out the problem of unrestrained growth of drug costs ;
- Develop democratic mechanisms that enables citizens to make their voices heard concerning the management of the Quebec health and social services system, and policies for its future;

And yet, Bill 25 does not implement those solutions. Like the majority of people and organizations that expressed their opinion about Bill 25<sup>1</sup>, we (RIOCM) don't believe that such a structure reform, especially carried out in such a quick and paternalistic way, will make it possible to reach the goals of a better health care and social services system.

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<sup>1</sup> 75% des 2136 répondants-es à un sondage du MSSS ont répondu non à la question « la démarche entreprise par le ministre Philippe Couillard améliorera-t-elle les services sociaux et de santé aux citoyens? »; tiré du journal Le Soleil, 18 février 2004, p.A4

Law 25, it's the application of the re-engineering of State plan in health and social services (the Quebec Liberal party was elected on the basis that it was the « government of health », but it never announced that it would weaken Quebec's government role in health and social services!).

Here are the central elements of law 25:

- Temporary replacement of the regional health and social services boards by local health and social services network development agencies. The mission of the agencies, in addition to the powers, functions and duties of the regional boards, is to propose an organisation model based on one or more local health and social services networks on their territories.
- Creation of a local authority (or *sub-regional*; since in Montreal we're talking about 12 territories of local health and social services network instead of the actual CLSCs territories – there's 29 of them) consolidating the institutions that provide local community service centre services, long-term care centre services and, except in certain cases, hospital centre services (if it's impossible, the local authority must conclude a contract with an hospital).
- This local authority, or health and social services centre, will have the power to subcontract with "private service providers": medical clinics, private resources, pharmacies, social economy enterprises and community organizations. It's the essence of the local health and social services network. The local authority is responsible for co-ordinating the activities and services of its territory through agreements or other means.
- The law confers certain powers on the Minister, including the power to take over the provisional administration of an agency if it fails to propose an organisation model in keeping with the Act. In fact, this power concentration in the hands of the Minister– Boards nominations, definition of health and social services reorganisation (tagging of the programs offered by the local networks), agencies' functions etc. – is quite worrisome.

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Timeline:

- Bill 25 was assented to on December 18<sup>th</sup> 2003
- The agencies were created on January 31<sup>st</sup> 2004
- They have until April 30<sup>th</sup> to propose their local health and social services networks
- The " health and social services centre " will officially be created on June 15 by the government
- Then, the second phase of the reform will be implemented (including legal modifications of bill 120 – "An act respecting health services and social services")

## Impacts and stakes raised by law 25:

### ➤ **Less democracy**

Considering the importance of this reform which imposes the creation of new structures, the delays are totally insufficient to take the health and social services actors' preoccupations into account and to consult the population regarding the profound changes that are being bulldozed in their health and social services system.

Plus, agencies and local authority boards will be nominated by the Minister rather than elected by the population. And finally, the fusions will considerably reduce the number of boards in public institutions (there's roughly 400 of them right now).

### ➤ **Curative vs. social vision of health**

The fusions will reinforce a medical and **curative vision** instead of a global vision of health which recognises the importance of the health determinants such as life conditions. The CLSCs will lose their legal social mission and become services centres of the hospitals. This curative vision will also accentuate the specialisation of community organisations' actions...

In fact, some concerning changes indicate that the government could want to create a distinct separation between health and social services. It is just a rumour, but the transfer of family organizations from MSSS to the ministère de l'emploi, de la solidarité sociale et de la famille (MESSF) one year earlier than supposed reinforce this apprehension. We also anticipate a governmental running of social matters by the MESSF with an employment orientation.

### ➤ **Questioning the Right to Healthcare and the Principle of Universality**

Law 25 stipulates that the health and social services centres "must provide the people of its territory with access to a broad range of primary health and social services". This choice of words implicitly questions the public cover of some health and social services and that the universality principle of the Canadian Health Act.

The "clienteles" for which the new sub-regional health and social services networks will be responsible (besides general primary social and medical services and public health) are: perte d'autonomie liée au vieillissement, déficience physique, déficience intellectuelle et troubles envahissants du développement, jeunes en difficulté (0-17 ans), dépendances, santé mentale et santé physique. Will citizens that do not "fit" in those well-targeted "clienteles" find some answer in the sub-regional health and social services networks? Will a young girl slightly depressed be able to talk and be listened to or will she be returned home until she seriously attempts to kill herself? What if she's 19? Will there be any sort on global concerns about addictions or will the answer strictly be: "stop smoking and use patches?"

The re-definition of the public medical and social coverage is a very important change that should be discussed with Quebecers since they will be the ones to pay any loss of publicly-delivered care and services. All reductions in public services represent a loss for the people of Quebec, and particularly for women who pay the mental, social and physical price of their often "triple burden" as workers in health and social services, users of the system, and as primary caregivers in the family.

➤ **Privatisation**

With law 25, Quebec's government speeds up privatisation of our health and social services system, because articles 26, 27 and 28 of the Bill clearly differentiates that some services will be offered by the health and social services centres while other services will be offered on the territory by private service providers. Increasing privatization leads to an increase in production costs (the primary goal of private enterprises being to make profits). This leads to the risk of having to pay for services that are currently free, and the commercialization of health (which becomes more and more a mere consumption good instead of a right). For the citizens, it means being treated like consumers and forced to do without health and social services if they can't afford it; for the community organizations, it could mean introduction of some fees for activities, fees that are yet restrictive for some people with which we work.

➤ **Smart card**

The "computerisation" of the health and social services system aims to allow the free circulation of personal information in the network using a **smart card**. The risks raised by such a project (right to private life, information leak, citizens control, facilitation of services privatisation and user fees, etc.) are important. We have some serious questions about the real intentions behind this "computerised patient file", which could easily be used as a consumption control tool instead of a clinic tool, and we're also concerned about the protection of personal information confidentiality.

Anyway, this project will be formalised with the creation of sub-regional networks without any social debates. This change will probably command that computerised "user" files be filled by community organization and that personal information of the members be shared with public institutions, which questions the groups' autonomy and the trusting relationship they have historically maintained with the population.

➤ **Mandatory inscription of people with their physician and sectoring**

In light of the sectorization of health and social services, we witness that the mandatory inscription of people with their physicians gives place to an "unlimited exclusivity agreement" which denies the right to a second medical opinion. The right of freedom of choice for citizens with respect to where they receive services and by whom these services are delivered is recognised by law 120 and should be

respected. Likewise, sectoring community organisations' actions would be another unacceptable attempt to control them.

➤ **Subordination and sectorisation of the community organizations**  
**or is ACA an essential mission of the Québec's government?**

Community organizations are also affected by the strong tendency that emerges from the "re-engineering of the State" of Charest' government to decentralize governmental action towards the sub-regional and local level and to reduce the role of the State.

The Quebec government, considers community organization as cheaper private service providers which exist to help the health and social services public system to accomplish its own mission (that's what Mr. Couillard said in parliamentary commission this last summer and according to the government's document "Shine among the best": "Support to the sick and the vulnerable is assured in part by community organizations that are seen as strategic partners for the health and social services network. It is essential that the budgets of community organizations are re-enforced and reliable and that their actions are compatible with governmental priorities").

Consequently, law 25 has integrated the autonomous community organizations in the health and social services networks despite their opposition. It is the actual **subordination** of the community organizations in the health and social services system from which they would receive the directives from now on. The actual capacity of the community groups to choose autonomously their priorities, orientations and practices (their global **autonomy**) is intimately related to the funding they receive to accomplish their own mission... so let's talk about a bit about funding...

Both nationally and regionally, a 2 year guaranty for the respect of the PSOC was mentioned (from April 1<sup>st</sup> 2004 to March 31<sup>st</sup> 2005 and from April 1<sup>st</sup> 2005 to March 31<sup>st</sup> 2006). From our point of view, this "guaranty" is in fact a 2 year extension... and since those 2 years might pass reel fast (on April first 2006, the legal modifications of bill 120 will be implemented, and the groups will then face new funding parameters), we believe we should use this extension to take time to consider what we want and to take action in order to obtain it.

A "Community committee" was formed nationally with representatives of the MSSS, a representative of the agencies, a representative of CTROC and a representative of TRPOCB in order to discuss agreements parameters between the local authorities and the community organizations. The nature of the exchanges so far confirms the pressure to use the groups to work on the government's priorities. The MSSS indeed wishes that in the future, the community organizations be financed for services production within the sub-regional health and social services networks.

The re-regionalization (or localization) and **sectorisation** of the groups and the “Support program for community organizations (PSOC)”, combined with the replacement of the current institutions’ funding mode by a program / population mode with precise objectives and targeted attended results, would seriously questions the groups’ global approach. Since community organizations will be invited to sub-contract in each of the local health and social services networks for the realisation of the rigid programs, the services that those local authorities will “buy” will necessarily be more curative than preventive. Plus, the groups’ evaluations based on performance and results might be used to condition funding in the future.

The agreements of the local authorities with community organizations<sup>2</sup> could go as far as controlling the “clientele”, number of people to “serve”, practices of the groups. This way, it would actually be the private sector in support to the public sector or the independent community action movement supporting the health and social services system, because the groups would then work on the local authorities’ priorities instead of working on the priorities chose by their members.

Since its election, the Quebec government wants to make sure funding is used to give services and suggested that there’s some services duplication and that there’s too many community groups. We believe that the government will “correct that terrible situation” with the creation of the integrated local health and social services networks. The service contract approach will be the perfect occasion to choose the partners and rationalise the number of groups as well as the number of regroupements.

Like citizens that don’t fit with the targeted “clienteles”, what will happen to the community organisations that do not fit in the networks and choose to pursue the realisation of their own mission? In fact, we could bluntly ask ourselves about the mere survival of the autonomous community organizations outside the health and social services system (that is, if the group does not address the government's priorities). It is thus the nature of the autonomous community action itself that is endangered. We thus stand at a very important moment for the independent community action movement and for the population; that’s why we’ll have to work together to stand up for the survival of the democratic spaces that are the autonomous community organizations for citizens.

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<sup>2</sup> As provided by the service agreements chapter of the government policy regarding community action and similarly as the Emploi-Québec agreement model.