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des soins de santé au Québec – 18 octobre 2000**
*Conference on the future of health care financing
and delivery in Quebec – October 18, 2000*

The Canadian health care system

M. MICHEL KELLY-GAGNON:

So we're going to move along immediately to the presentation of Dr. Jonathan Meakins. This means that we're going to skip the cookie period that was initially planned but the cookies are back there and if you all behave properly, I promise that they will stay there and that when we have the informal discussion period that we promised afterwards when we're going to add up, you can use them at that time but we want to make sure that everybody has the time to hear the presentation of the various speakers.

So without further due, notre dernier conférencier, le docteur Jonathan Meakins est un praticien de la santé qui travaille sur le terrain dans les réseaux québécois.

Il est d'ailleurs un chirurgien connu et respecté à Montréal et dans l'ensemble du Canada. Il est co-rédacteur du *Journal canadien de chirurgie*, chef des services de chirurgie du Centre Hospitalier de l'Université McGill et professeur de chirurgie à l'Université McGill.

Fort de son expérience clinique et académique impressionnante, le docteur Meakins fut invité en octobre dix-neuf cent quatre-vingt-dix-neuf (1999), en compagnie de d'autres membres du Conseil médical du Québec à participer à un comité mis sur pied par la ministre Pauline Marois afin de faire le point sur l'apport du système de santé dans le système... du système... du secteur privé dans le système québécois.

In other words, Dr. Meakins was a member of the... the commission that was appointed, governmental commission.

In his speech, he will review the evolution of the role of private actors in Quebec health care system and discuss the complementary role that private provider can fulfil in our public system.

He will explain how greater alliance on incentive efficiency can be achieved without privatization of the system.

So without any further due, Dr. Jonathan Meakins.

DR. JONATHAN MEAKINS:

Thank you very much, Michel. I feel a little bit either like the fox in a hen house or the hen in the fox house in the sense that I come as someone who believes implicitly in the principles of the Canada Health Act.

I've worked in that system now for twenty-six (26) years or so and has found that, in general, until at least the last few years, that it served both me and the patients I look after extremely well and as well has served the patients that we manage in the department of surgery at the McGill University health center.

I think it's important for me to declare that I have no understanding of the funding of non-hospital health care and that when we talk about hospital health care, we're not talking about health care as the gentleman who brought up prevention a moment ago, we're talking about disease care.

And disease care is where a big part of the costs are in the system and it's where virtually all of the waiting lists are.

So that the hospital sector in Canada and in particular in Quebec uses a large majority of the funds that go into funding Medicare or the Quebec Hospital Act, Canada Hospital Act and the Canada Health Act.

So it's within that framework that I believe in this system but in the last couple of years, as the manager of a sixty-four million dollar (\$64,000,000.00) budget to look after surgical services at the Montreal General and the Royal Victoria, I've come to the conclusion that we need management principles that are simply different from the present ones we have and accounting systems that take that into account.

Some of these slides we're going to drop poorly, it's a pity this one isn't going to drop because it is a cartoon of a gold health care card.

And I'm against gold health care cards on the principle that it does take service away from individuals.

When my father was practising as a pulmonary specialist through the sixties ('60s), he was very much in the private system.

In nineteen seventy (1970), he noticed, as the Canada Health Act originally came into effect, a dramatic change in the population that he looked after.

Looking after pulmonary disease in those days as related to smoking but also to TV and other health diseases related to poverty and he suddenly had a dramatic increase in the number of people who came from St-Henri, Pointe St-Charles, Verdun and so on, individuals who never had access to his expertise in the past.

I thought that was pretty useful. The other area that I worry about the gold health card is that when doctors talk about privatization, we're at severe risk of appearing to be significantly self-serving and I, therefore, I'm not willing to examine that but believe that the Swedish model that you've heard which has to do with still a single payer funding but a different management system is the route we ought to go.

Thirdly, if you think that a privatized health care system that incorporates orthopaedics, cataract surgery, cardiac surgery, access to all quality of life issues, many of which are procedure based and much of which is done in surgery is going to leave any of the topnotch surgeons, researchers and teachers in the public system, you're crazy.

They're all going to go to the private system and you will have a teaching environment, a research environment that simply doesn't produce the quality of physicians and surgeons, specialists that we have in Quebec at the present time.

So let me just touch on a couple of things that make it a little muddier than it seems to have been presented thus far.

Every country in the world, every Western world country, all of the OECD countries are having a problem with health care costs.

The distribution of those costs is noted here in nineteen ninety-eight (1998) in six (6) countries and there are two (2) points that are interesting, one, that five (5) of those countries spend more or less the same amount per capita on their population.

The United States, almost forty percent (40%) more than everybody else but the range in GDP is dramatically different from seven percent (7%) in Luxembourg to over fourteen percent (14%) in the United States.

That means that wealthy countries have different choices to make in terms of how they spend their health care dollars.

That is a bit trying, I have to tell you. So this is the health care systems ranking that you saw a little while ago.

And, in fact, what it was, this is from The Gazette, I've only gone down to Luxembourg on one side so there are few people missing underneath that.

And New Zealand, on the other but there were some of the... New Zealand was one of the countries that used fund holding, it's not been a success.

Canada is noted there as being thirtieth (30th) but what, in fact, is ranking is, it's not whether people are healthier or not, it's whether the dollars are used to the best effect according to a set of five (5) criteria identified by the World Health Organization.

And it's interesting to note that a lot of Western world countries do worse actually than Canada does and that includes the United States, Denmark, Australia.

And the difference between those various countries is quite marginal. It's extremely interesting that France and Italy come up as Number 1 because that is not where they rank in a variety of other settings.

Further international comparisons have to do with privatization of the health care system. You may not be aware that somewhat around the third, these data go to nineteen ninety-seven (1997), but in the year two thousand (2000), one third (1/3) of health care costs in Quebec and the rest of Canada are on the private sector.

They just don't happen to be in hospitals and in doctors whereas if you look at the United States, it's up towards fifty-three percent (53%).

But interestingly in the parallel systems that have already been mentioned such as France, Germany and Holland, they are less privatized than Canada is, they're just privatized in a different way so that there are some private hospitals and a large private physician sector so that there are major choices made by countries as to how they wish to spend their moneys.

This is an example of that kind of data. In the United States, somewhere around seventy percent (70%) of physicians services in nineteen ninety-four (1994) were out of the private sector whereas in Quebec, it's zero point four percent (0.4%).

Canada, as a whole, is around one percent (1%) and you can see there are variations between France, Germany and the Netherlands that are quite dramatic despite the fact that overall, health care costs for those last three (3) countries were, at the time these data were collected in ninety-six ('96), somewhere around twenty-one percent (21%).

So, again, you have choices made within a country as to how it wishes to distribute its money. Now, in the United States, I go there for about six (6) to eight (8) weeks a year and if you think there are complaints in Canada about health care system, you should spend some time in the States talking to the physicians there and some of the patients.

And some of the issues that are a problem are as follows: the employers have to pay for health care so they want insurance costs down so they drive profits out, normal free market phenomena.

Providers, that's the hospitals, they don't want to do anything that's going to cost more than they can get, more than they can charge the insurance company.

Drugs and insurance companies are both interested in profits and Wall Street is driving all of them.

The patient sees that the costs are paid by some third party and therefore, they have no interests in reducing costs either.

So they are cost drivers as well as physicians are cost drivers. Nobody has mentioned the companies that have gone bankrupt in the States.

If you were insured by Oxford, you'd be an unhappy camper. I was in Boston when the Harvard Medical Plan went belly up and the Massachusetts State government had to step in to pick up the pieces.

There was chaos both in the public sector and amongst the big hospitals, the Massachusetts General, the Brigham Women's and other hospitals that were largely supported by the Harvard Medical Plan.

Columbia HCA, if you've been following its stock, has had a wild ride over the last five (5) or ten (10) years, is actually before the Courts, again, for cheating on their Medicare costs and upgrading services that were provided.

So there are big problems in this kind of HMO system and it is deteriorating rapidly in the States.

(inaudible) one of the key hospitals in Boston is bankrupt and is selling five (5) of its buildings. Penn University Hospital, University of Pennsylvania Hospitals are also bankrupt and are in a major problem. A lot of this is being driven by Wall Street.

Now, here's a headline... anyone want to guess what country they're talking about? Oh boy! ... no, that's...

... dramatically different. And so, depending on whether you're on the right, the middle or the left side of the political spectrum, your interpretation of exactly the same data is quite different. So my view is that we have a problem of short term solutions to long term problems. And that has been most evident in what has happened in terms of the buy-out systems that we've seen in the recent years where nurses, physicians, radiology technicians, support personnel, physiotherapists and occupational therapists have all been given an option to retire and not come back into the system for

two (2) years unless it turns out we really need them very badly.

And what we've had is the law of unintended consequences. The law of unintended consequences is, in this instance, we run out of an (inaudible), we don't have enough pathologists, we don't have enough radiologists, there's a nursing shortage around the world which is worst in Quebec than anywhere else in Canada.

Ontario comes to Canada to take Quebec nurses. United States goes to Ontario to take both Quebec and Ontario nurses.

So we are extremely short of technical support, a very important problem. The other big thing that's happened in recent years is that the government has off-loaded responsibility for not micromanagement but for the management of the system by cutting budgets without providing directions.

So if anyone had been watching health care as it's supplied in hospitals in the United States in the middle eighties, they would have seen that, one (1), DRG systems were coming in as a funding formula, that is activity based funding and two (2), the shift ambulatory care was very clear.

In Canada, none of these things happened, we just had budget cuts, the way you had with every hospital solving their budget problem in some different way.

Most of the time, we solved it not by reengineering but by... by getting rid of people. So that the funding formula that we need to think about is a little bit along the line of what they done in Sweden but has to do with activity based costing and has to do with zero based budgeting.

Now, if you're running a business, and I presume many of you are business people, when you're developing your budget, you build it from the bottom up, not from the top down.

And the way our budgets are built, we're simply given an allowance, it's like a kid, we're giving an allowance and expect it to spend it, which we do, of course, but like most kids, we overspend it as well.

And the problem is that we don't have the accounting systems, we don't have the information tracking systems to allow us to use that budget appropriately.

So our budgets are not activity based, they're not zero based at any time, they are historically based.

So last year, the McGill University health center got about four hundred million (400,000,000) in allowance from the government, this year, we're going to get four hundred and thirty-three million (433,000,000).

Our actual budget runs closer to five hundred million (500,000,000) because there are other sources of revenue that are too complex to insert here but fundamentally, by giving global budgets, we become a cost center, not a revenue center.

So as a cost center, what happens is you have only two (2) ways to change how much it costs to do something or how much it costs to run your operation.

One (1), you can improve your efficiency which has been done... there's probably a small flex in efficiencies in our system given the way in which our accounting is done but mostly, you cut costs by cutting service, that is the problem with a cost center.

If you have no revenue side and you're not a revenue center and you have no revenues centers in

your system, you have no way to deal with what is basic business practise.

So, with respect to what any sensible manager would do in our system, because we're cost centers, everyone else is the cost center.

So we'll take hospital A and B. Hospital B comes in on budget and Hospital A is fifteen percent (15%) overbudget and the government picks up your budget, what does that really mean?

What it means is the base budget for hospital A has gone up and the base budget for hospital B has gone down so there's no manager in his right mind who will ever come in on budget.

So, in my setting, where I'm competing with obstetrics, gynaecology, medicine, et caetera, for base budget, the year I came in on budget, I realized that medicine got a piece of my money.

So I have never come in on budget since. Now, if I'm really clever, I overspent by more, I exaggerate to make a point but if I'm really clever, I'll over-expend by five percent (5%) more than medicine and get some of their money transferred to me.

Now, that is not a good way to run a corporate structure, particularly one that has a budget of five hundred million dollars (\$500,000,000.00).

So we're in a position where we have authority... sorry, we have responsibility without authority and that is a fundamental problem where we are service driven by the emergency departments, by people needing cardiac surgery, by people needing hip replacements.

We have a service obligation without the ability to actually realize it in the appropriate way.

So the system unquestionably needs money but that money needs to be focused and it needs to be rethought in terms of how it's delivered.

So I... my real proposal, and I have to tell you that I'm fundamentally a social democrat, is that we have to introduce private sector management techniques and financing into the way in which our system works.

So I would take the Swedish thing that Johan has indicated to you. You have to understand he's still talking about a single pair.

So the funding system is the same, it's the way in which the money is managed that's different. And I'm in complete support.

So I think that budget makeup needs to be built on three (3) basic things, it has to be activity base, which is zero base budget, it has to include the nature of the structure.

I won't ask any of you to come into some of our older buildings but if you think it costs the same to run Hôtel-Dieu or the Royal Victoria as it costs to run a hospital like Pierre-Boucher or Anna-Laberge, which were built in the last ten (10) years, you're nuts, it costs an infinite amount more in terms of maintenance, in terms of heating, light, electricity, everything costs more.

At the Vic, we have pipes that were put in a hundred (100) years ago. Any of you who have a house that's a hundred (100) years old, which we actually do, and we've repiped it recently, it cost me a bundle.

Imagine doing that at the RVH. So I believe we need to create incentives that are linked to a real budget that has to be developed as a zero based operation and the incentives have to do with exactly what Mr. Hjertqvist was explaining to you.

So we have a five hundred million dollar (\$500,000,000.00) budget and so, the management, salary structure should be equivalent to what it is in the private sector for five hundred million dollar (\$500,000,000.00) operation.

The ceiling on income for the director general of hospitals in Quebec is either a hundred and thirty-five thousand (135,000) or a hundred and sixty-five thousand (165,000), you can't buy anything for that in the private sector.

So we... we're lucky we have people as good as they are. We need new sources of financing, we need a revenue side to our operations which can be any number of things but we have to be allowed to develop that revenue side, examples would include inter-regional transfers which were brought up by Dr. Roper.

But if a patient from the South Shore comes to one of our hospitals, that budget comes out of 6A, it doesn't come out of the South Shore budget, it's crazy.

About a third (1/3) of our patients come from off the island. We should be able to set up operations that deal with uninsured services so that we can actually compete with the other practitioners in the community who do exactly the same thing on a cost per hour basis rather than a cost per case basis, the example being you get eighty... ninety-three dollars (\$93.00) to do an extensive plastic surgical procedure that's unfunded by RAMQ, when it's done downtown, it's four hundred dollars (\$400.00) an hour.

Other examples include health maintenance operations, (inaudible) operations, issues that are not paid for by RAMQ but which people who have health-seeking behaviour wish to participate in.

And lastly, out of province and out of country revenue should be allowed to be kept by those institutions that can capture it.

We need to create a competitive environment, not only within institutions but most particularly between them so that if I can deliver hip replacements and cardiac surgery cheaper than someone else and at a better quality than other people in the city, I should not only be allowed to do it but I should be allowed to benefit from it.

And when I say "I", be clear, I'm talking about the institution. So that there should be competition for clinical programs that are based on cost and on quality.

And we now have the mechanisms to measure quality outcomes, what we do not have is an ability to measure costs.

So we don't have any idea what it costs to process a patient through our (inaudible) department. We sort of know what it costs to do a heart operation but we don't really know because you can't factor in any of the cost allowances you get for equipment, for depreciation, for fixing the roof, et caetera.

We need information systems that will give us accounting measures that we can use to develop these cost concepts so that if we know what the costs per clinical activity is, the manager of that area can actually do something about it.

McDonald's knows more about what it costs to produce a hamburger than I know about what it costs to do a cardiac operation and that is crazy. So we need information. We need physician managers. If you think somebody who has no understanding of how to deliver surgical care is going to be able to come and talk to a high profile... well, they're not all difficult but surgeons are sort of big capricious and fundamentally, it takes a surgeon to tell another surgeon how to function and how to change behavior.

And I believe that physician managers are an important part of what this is, that if we have the information where we can deal with activity base budgeting and that that individual is responsible for performance which is cost base activity and quality, that we will get a competitive environment that allows us to deliver more service for fewer dollars.

I would point out that in the present legal situation in Quebec, it is illegal to pay physician administrators so the global budget clearly has to have that incorporated into the way in which it's structured.

Finally, I think we need to reward good management and the reward, of course, is to do more cases, at least, that's... or to treat more disease or do better prevention, to create more health but to develop new programs and at the present time, developing new programs is very difficult.

Finally, the summary slide really says accountability so I believe we need to be accountable for what we do, that's cost and quality, we need to be accountable to the public and the payer, that's a single payer, for the resources used and the results achieved and I don't think that can happen unless there's environment competition and individual entrepreneurial and interpreneurial management that will allow that to happen. Thank you very much.

M. MICHEL KELLY-GAGNON:

Thank you very much, Dr. Meakins. So, again, we have a fifteen (15)-minute period for Q and A.

UNIDENTIFIED VOICE:

One quick point, the family doctors are now paid with administrate, I know that because I'm head of family practise at the General, we just got that six (6) months ago so that's... that's a welcome change for the family doctors and not surgeons yet.

I agree with your approach and I agree with the Stockholm approach, I think if we're going to make the Medicare system work, it has to absorb some private principles, I think the idea of single pair in access, equal access is morally right.

I... there is one area that I have a bit of difficulty with now. If... if we allow people from other countries to come and access our services, and as you said, hospitals that are using that money for private services, these people are coming, are presumably flying in for a week, getting their surgery when our OR's wouldn't be open or whatever, if we can do that for people from United States, from Europe or Central America, can... is there not some sort of contradiction that we can't do it for people from Alberta, from Vancouver or Newfoundland?

DR. JONATHAN MEAKINS:

I'd be happy to do that but the government at the present time doesn't allow us to keep that money.

We can't, if we... if somebody comes from Saudi Arabia, and I've had a couple of people come from Saudi Arabia, we've trained their surgeons there so I don't know why they come here, but in any way, whatever they pay goes to Quebec City, it doesn't stay in the hospital.

UNIDENTIFIED VOICE:

Oh no, I... that's not my question. But the fact you... I agree with you that that should go to the hospital but if we're going to accept that from international people, if we're trying to go by the tenants of Medicare, we can't accept it from Canadians. So is it...

DR. JONATHAN MEAKINS:

Oh, I... the slide says that you can take out of province, that... my whole point is...

UNIDENTIFIED VOICE:

Oh, okay.

DR. JONATHAN MEAKINS:

... that... Ontario, we do eleven (11) or twelve (12) liver transplants for Ontario residents a year, that pays eighty-six thousand dollars (\$86,000.00) which is... which is a bundle in our system. And Quebec takes it, I don't see it.

And my transplanters don't see it, they say, "Why should we do this if we're not allowed to use that to develop our program to a better endpoint?"

And I... when I went to our chief financial officer, well, I didn't get a very... the answer I got was I can't have it and it isn't available and nobody knows where it is and if anybody could find it, it would be in Quebec City, one way or another.

UNIDENTIFIED VOICE:

Oh, I agree with most of the points in the presentation. I wanted to know... and I guess if I had to summarize it, I would... I would guess you say that we basically... we need a revolution in thinking in terms of the medical profession.

How can we do that quickly and smoothly and the reason I say "quickly and smoothly" is because I guess the public is getting disenchanted and then... and if it keeps up like this, I mean, accountability is well, the public is not working, private is working, that's the answer.

DR. JONATHAN MEAKINS:

But you want it fixed by the time you practise. The real issue we're dealing with is change in behaviour and it's a (inaudible) issue, it's the win-win slide that we saw from Stockholm.

And the way... I'm having trouble changing behaviour now but in the past, when we changed behaviour is where everyone got a benefit and the sort of mantra we used in the early nineties ('90s) when we were trying to switch to day surgery and short stay was, "I'll give you all the beds you want or all the OR time we can afford" and the surgeons thought about it for a while and they switched to day surgery and... and short lengths of stay because they got... what we need is OR time.

But it's a little more complex right now. But those are the kinds of things we have to do.

UNIDENTIFIED VOICE:

I have a question which is a little bit off topic but I think related and very relevant and if anybody could answer it, maybe you could, I've been wondering this for a while.

We see that there's a shortage in terms of MRI availability, CT-scan, radio-oncology but clinics tend to close at four o'clock (4:00) and why is it that there can't be a second part-time shift from, let's say, four o'clock (4:00) to nine o'clock (9:00) especially since a lot of patients would probably prefer that than taking a day off and then maybe we wouldn't have to send people to the States so there'd be less incentives to go to something like (inaudible) or Clark.

DR. JONATHAN MEAKINS:

It's because we're a cost center. It's just as simple as that.

UNIDENTIFIED VOICE:

Can you just elaborate?

DR. JONATHAN MEAKINS:

We're a cost center and so, to open it, we have to hire the people to manage it and that increases costs without any concomitant change in revenue because we've got a global budget so it's not an activity based operation.

So if I open the... for years, I've been trying to open the breast clinic at seven (7) so women who work can go or keep it opened till seven (7) so people who work can show up without coming during working hours.

We can't do it because the salary requirements go way, way up and the technical support for the nurses, the secretarial staff and so on go up without any concomitant change in institutional revenue.

So I could keep it open but I'd have to close something else or we'd have to close something else and so, we just kind of model along.

But that is an obvious answer, if we had the human resources to keep the operating rooms opened and the cost base to do that and enough (inaudible) to keep the operating rooms opened, I'd be happy to start at seven (7) and keep elective surgery going until seven (7) in the evening.

You do have some places in the States that function that way because it's a capital resource and someone's put the capital into that operation and they've got a capital cost allowance, they want to depreciate it fast so they can turn it over and buy a new operating room.

We can't do any of that here so when you heard about that ultrasound machine earlier, those machines have a life span that's normal, we keep them as a rule twice as long as they should be kept because depreciation is not a part of the way in which our system is financed.

So when... when it... in business, when your equipment is depreciated to zero value, you move it out and you replace it with something that's more modern.

And in a life, in our life, in the last ten (10) years, your medical school life, we will see an almost total turn-over in some of the technical ways in which service is delivered.

And those technical things of five (5) years ago are now vetuste, yet, we're having trouble replacing them.

MR. JOHAN HJERTQVIST:

May I just comment on that as your question is quite relevant for the Stockholm's experience too. Dr. Meakins is quite right, as long as you look upon yourself or defined as a cost center, of course, your main topic is how to reduce costs, how to cut down on services and so on.

If you transform into a profit center, you will adopt quite a new... sorry, way of thinking, then you shift towards thinking how could we increase profits or costs and what does that mean, that means that you catscan people during nights, for example.

To the patients, it's quite all right, you... et caetera. So it's a dramatic shift in... in perspective from... from thinking of cutting costs till increasing services.

And, of course, that's one of the solutions when it comes to long waiting lists. So Dr. Meakins is quite right, it's a dramatic shift and you can see one institution that has a very pessimistic attitude towards most things, mainly budget perspectives.

And then you turn it into a profit center, you become quite new attitudes, quite new way of thinking so that's one of the... the main solutions, I would say.

M. MICHEL KELLY-GAGNON:

So thank you very much. One more question and please try to make it brief.

UNIDENTIFIED VOICE:

I hate to be the person who tries to sum everything up but I think basically what we're talking about is a disconnect between the needs of the population and the money available to treat the population and that disconnect is largely due to the fact that we don't reward performance, we don't reward quality, we just reward people who stay within their budgets irrespective of what they've done to treat the population.

DR. JONATHAN MEAKINS:

No, actually, we don't even reward people that stay within their budgets, we reward people who overspend the most which... which is a total... it is... it creates a mind set that is a very troublesome situation.

Now, I think that earlier in the nineties ('90s), the system was adequately funded, the waiting lists weren't anything like they were, there was some maldistribution which could be fixed with an injection of money, it was clear that if you used some management approaches, you could get a lot more work done in a variety of different ways up until around ninety-four ('94), ninety-five ('95).

At that point, it seemed very obvious to me at any rate that we were... we were underfunded, we were having a lot of trouble developing new programs or expanding programs within the envelope.

And we've managed up until about ninety-eight ('98) and I was only working at one (1) hospital at that time.

Now that it's much broader, technology is much more relevant, it's a much more difficult task and we... I think our service is underfunded.

I might just point out to you that there is a private system in Quebec, it's run by the Quebec government and it's called the SSAQ which the Société pour l'assurance-automobile du Québec and if you're hit by a bus or if you're part of an injury associated with workman's compensation or CSST, you can get your MRI tomorrow, they will pay for it at one of the private MRI clinics, they will pay for private physiotherapy, private operative therapy because if they don't, they have to pay that patient from the insurance pocket.

So because the government is paying both pockets, that is if someone is off work because of an accident related to work, the government has got to pay that person out of the uninsurance pool, whatever it is.

So it's in their interest to get that patient back to work as fast as possible. I would have assumed that

was applicable to the entire population.

On the other hand, in the rest of the population, these moneys come out of different pockets so if you're a manager of a company and you have unemployment insurance that pays for one thing, you have disability insurance, that comes from another pocket, you have sickness insurance, that comes from a third pocket, they all came from the same pocket, you... you'd have pretty quick convergence about the way in which you're going to solve that problem.

And Quebec, with respect to SAAQ, and with respect to CSST, has demonstrated that. If you need physiotherapy, you get private care immediately, if you need an MRI, you get it immediately, if you needs a CT, you get it immediately and that's because the pockets are all the same, at least, that's my assumption, I can't imagine what else it could be.

But it is clear that that is... that's private medicine and it's in the interest of the government to pursue that when they're paying the whole shot.

M. MICHEL KELLY-GAGNON:

Thank you very much, Dr. Meakins, for this very interesting presentation.