Institut économique de Montréal

Conférence sur l'avenir du financement et de la prestation des soins de santé au Québec – 18 octobre 2000
Conference on the future of health care financing and delivery in Quebec – October 18, 2000

Table ronde

M. MICHEL KELLY-GAGNON:

We're going to move along immediately to a very interesting part of the day that I was personally waiting for for quite a while, the panel expert discussions.

So we're going to move along immediately some five (5) chairs or so and the panellists are going to join in front and that's... we were going to...

Alors, avant de commencer le panel de façon formelle, permettez-moi de vous présenter le modérateur de ce panel, le docteur Léo-Paul Landry.

Comme tous les autres participants d'aujourd'hui, il a une connaissance approfondie du milieu médical, fruit d'une longue expérience sur le terrain et dans diverses organisations pendant vingt-cinq (25) ans.

Il a été impliqué dans l'Association des médecins de langue française du Canada, l'Association médicale du Québec, l'Association médicale du Canada ainsi que l'Association médicale mondiale.

Le docteur Landry est en ce moment directeur médical de l'Institut de réadaptation de Montréal et a également présidé une compagnie... et préside également une compagnie offrant des services de design d'organisation, de développement de stratégies et de développement d'affaires à la fois pour le secteur public et privé.

Nous avons la chance de profiter de son expérience comme collaborateur à l'Institut économique de Montréal.

Le docteur... Dr. Gratzer is very graciously taking a little risk in stretching it to the limit but he will have to run to catch a plane at some point in time so please don't think it's because he didn't like a particular answer or something like that.

Je laisse donc le soin au docteur Landry d'expliquer comment se déroulera la table ronde, merci.

DR. LEO-PAUL LANDRY:

Merci, bonjour, mesdames, messieurs. Premièrement, mon rôle ici today, the only thing I'd have to do is to spark debate amongst the participants so... and be traffic cop.

I am neutral, if I do make some crazy statements as to try and get these fellows fighting and nothing else.

A measure of success, I wondered how will I know if I'm successful and I decided that I will be successful if I can get Ed Coffey and Jacques Chaoulli fighting one another because they've been seeing things the same way for years.

Okay, divergence and convergence are necessary for creativity, innovation and adaptedness of any social system.

We have today some convergence but we also have a lot of divergence. First, convergence. One of the themes running through all of the presentations today is the need for change, everybody wants change but as I listen to the... the proposals for change and what the solutions might be, I'm reminded of an old saying that, you know, everybody wants to go to heaven but nobody wants to die.

So as we look at the call for change, I am just wondering who will... is ready to give up something so that we can all get on with things and solve some of the problems we have or address some of the challenges we face.

And in trying to spark debate, I want to start off with an easy question and I'd like to address that to Dave right off the bat.

The title of this conference is "The future of health care in Quebec", we could say in Canada, we could say in Sweden, we could say throughout the world but let's focus on Quebec and Canada.

So that's a theme or the title of this conference.

David's presentation focused on the crisis situation that he described and he gave a whole bunch of anecdotes and some results of polling and research.

And so at the end of all of that, I have to ask the first question, it was: in all of the presentations today, what is the solution for the future of health care in this country, in this province?

Is it the singlety of private system, is it a singlety public system or is it a mixed, a two-tier system.

So that's the question: why... I'd like to have each one of you to provide the answer, your answer, explain why and what kind of problems do you expect to solve by the option you have chosen, that's the easy one. Dave, you want to start off?

Dr. DAVID GRATZER:

I'm not looking forward to the more difficult questions. I think that... I think that this is a great issue for society because we spend quite... quite a number of years now viewing ourselves as having the best health care system in the world and being very proud of... of what we considered to be a great system and both great and compassionate, now, we're having to settle on the compassionate end of things.

Really in all of the world, there's only one (1) other country that offers no private option and that's Cuba so I... I think that really, there's not much doubt that a private system would be helpful and would take some of the weight off the public system.

I don't think however that a private public mix, which we don't have now, would solve the problems with the public system, I don't think it has solved the problems in Australia or Great Britain, I think you could argue that patients there tend to be happier, I think the greater question is what can you do to make the public system better.

And I... I think what's kind of surprising is that you have people from very different backgrounds speaking today and in different countries for that matter.

And there's some agreement on what you ought to do and what you ought not do and there's profound agreement and what we do now is pretty poor in terms of global budgeting, as the last doctor observed, there's some problems in the lack of accountability, I guess the real question is how can you introduce that into a public system?

Sweden has made steps within internal market, I think until really you... you switch the focus and funding from the provider to the patient, whether you do that through internal markets or you do that through medical savings account, you're not going to have any dramatic change within the public system.

I have some hesitation in the internal markets because I'm not sure that goes far enough but I really think that the larger question isn't: do we need a public private mix but how can we introduce efficiency into the public system.

And I think the present approach we can all agree is wrong, the only question is how you're going to... to write it and I think by funding patients through medical savings account would be probably the most definitive answer and it seems to have worked well in the experimentation in other countries.

DR. LEO-PAUL LANDRY:

Ed, you don't have to agree with him.

DR. EDWIN COFFEY:

No, my impression is that I would like to suggest that what we need is not necessarily mixes but we need a pluralistic approach.

We don't know what the best system is and I don't think we'll ever know until we do some testing experimenting.

And the important thing in my estimation is to... is to adapt the approach and the attitude and the (inaudible) of plurality pluralism rather than this monistic system, this single payer, single targeted system.

And I think we can achieve that as long as we protect... always protect the people who have difficulty accessing the system, the low income, the poor, the intellectually challenged, there are a lot of people out there that need assistance.

And I think we have to always be careful about that but at the same time, in order to give them ultimately better care, better services and so on, we have to develop and experiment and discover some better ways of providing services.

So pluralism rather than monism in the health system.

DR. JACQUES CHAOULLI:

Okay, as far as I'm concerned, very briefly, two (2) points I believe, that first, the money should follow the patient, obviously, nevermind what kind of a system.

The money should follow the patient and the patient should be empowered in order to choose to which facility he wants to direct his power of spending the... the money.

So both, the freedom to choose the provider being public provider or private provider and to give him the power to exercise his choice with this concept of the money following the patient.

DR. LEO-PAUL LANDRY:

So, Johan, if I might, Johan, you're not from Quebec and you're not from Canada but since we need all the help we can get, we'd ask you to answer the same question.

MR. JOHAN HJERTQVIST:

Okay, let's make a try. One good thing with not being first on the road to answer is that you can refer to earlier statements, as I agree.

And I really agreed to... to a lot of what was said with my... from my three (3) colleagues here on my right. Let me add a couple of words when it comes to what I've seen in Sweden and that goes probably for Canada and Quebec as well.

First, that I'm quite convinced that during the coming ten (10) years, we'll see that the patients, consumer, citizen will demand more and more of influence on choice, et caetera, and that means that it's in the long run or the medium long run term difficult to see that any of the present systems could answer to those demands.

So I don't think... you don't have to (inaudible) amount of money used on the system, et caetera, it will be very difficult to, in a unified current system, answer to all those challenges, I would say.

The second one is that, of course, in a democracy health care system, as other systems, there's got to be acceptable and legitimate to people and in Sweden, we have a background of egalitarian tradition, you can say, which is not the same as... don't have to be the same as socialist (inaudible) for example.

But Sweden, in general, do not favour health care systems which allow large differences in how you will be treated, et caetera.

So I would say that in Sweden, the kind of development I would describe here, that you have a large number of producers working in the common framework is accepted, I doubt that, at least, coming in ten (10), twenty (20) years, a system with large influence of private financing would be accepted.

And you can say that's good or wrong but in a democracy, that's the way it works. So I think, as you provoked me and asked about some kind of judgment when it comes to Canada, as a large number of people evidently not satisfied with the present situation, I think you have to implement some kind of reform that could be accepted and as we... when it comes to mentality, you seem to have the same background in Sweden as... as Canada.

I could imagine that it should be concentrated upon increasing productivity within in the present system, I'd say.

DR. JONATHAN MEAKINS:

Although the funding is not privatized, the clinical practise of medicine is, in fact, (inaudible) in the sense that it is free for service.

You get paid for what you do, if you don't do any work, you don't get paid. People who operate more earn more than people who operate less.

So in that sense, a lot of patient choice is available, as I outligned originally. So I'm... I'm given three (3) choices so, in fact, I would opt for a single payer with dramatic differences in the way in which a budgeting is done and accountability on a quality and cost provider basis.

And that individual practitioners are obliged to defend the way in which they utilize the public purse which, at the present time, they are not.

DR. LEO-PAUL LANDRY:

Second round, does anybody want to challenge anybody else's statement? Jacques.

DR. JACQUES CHAOULLI:

I would like to...

DR. LEO-PAUL LANDRY:

Challenge Ed Coffey?

DR. JACQUES CHAOULLI:

No. No, I would like to just address a question to Dr. Meakins about his standpoint on the privatization in... in favour or against.

If I understood well, Dr. Meakins, you kind of been in favour of the Swedish approach in contracting out with... including private facilities, contracting out with public authorities.

As far as I'm concerned, this is a form of a privatization in the sense that the government transfer the public money to a private provider being a private hospital for providing medical services to the population.

So am I right... am I right in assuming that you are not opposed to that kind of a privatization?

DR. JONATHAN MEAKINS:

I guess so, it's exactly what I said in terms of the management problems we have in our hospitals presently.

How it's actually implemented, I think, is going to turn out to be a matter of debate, it's going to be very difficult to get any of our provinces to buy into that kind of an approach but as someone who has sixty-four million dollar ($64,000,000,000.00) budget, I can't see any other way to develop new programs other than to bring in private sector management techniques, incentives, competition between institutions, whether that is contracting out or not, I guess that's all negotiable.

But fundamentally, we can't get people to change behaviour until the budgets are real, until you're accountable for the money, until you're accountable for the quality because the two (2) are intimately integrated.

Because if you do it for nothing and the results are terrible, that's actually worse than not doing it in

the first place. So you must be accountable for quality.

DR. JACQUES CHAOULLI:

May I ask another question to... to our Swedish guest?

DR. LEO-PAUL LANDRY:

I'm sorry but I don't want you to ask, I want... I want to see a challenge and give hell to somebody and...

DR. JACQUES CHAOULLI:

Okay.

DR. LEO-PAUL LANDRY:

... get into a fight here.

DR. JACQUES CHAOULLI:

Okay, a kind of a... okay, a kind of a challenge which I have in mind about the Swedish experience and the presentation of our dear guest here is that if we understand your presentation, you seem to assume that in... in Sweden, it is the single payer but the single payer, as you mentioned, there is still... even small but a parallel private sector with a private financing, private insurances, private doctors, private hospitals making profits out of it, a small size but still existing.

And don't you think that... in other words, is it compatible in your view to have a parallel, whatever the size a parallel, private sector with (inaudible) motives with a acceptable form of universal coverage.

MR. JOHAN HJERTQVIST:

Stockholm model allows profits, you can even say that a profit is a condition for being able to work as a contractor, otherwise, of course, you can't deal with investment education of your personnel, et caetera, so the system welcomes profits within the public contracting, I can say.

The... that's correct that we have a totally private health sector in Sweden, it's less than one percent (1%) of the total sector so it's very small and that had never been controversial, no government has ever tried to... to abolish that activity, that's the way in Sweden, you're allowed to do most of it as long as you not asked for tax subsidies.

If you pay a hundred percent (100%) out of pocket, it's... it's not controversial as it goes well saying than you reduce the... the demand so trongly so it never becomes a political question, so to say.

I see complications with... with two-tier system, that's correct and that's the... the approach in the Stockholm region too that you look for a multitude of producers but that you stick to the one-tier system and... as said here before, I think that the two-tier system opens for a lot of very difficult judgments.

In theory, that system might work but what I see up till now is that it... in reality, it's quite complicated to make a balance in that system.

To me, private savings account is... as these are financed by taxes or public money, let's say, the development of one-tier or one (1) payer system.

So... but of course, the longer you develop that system, the more complex will it come and the more questions will rise about how to put extra money into it, so... so it's quite complex. But I'm naive enough to believe in the... that Swedish reform system.

DR. JACQUES CHAOULLI:

But how can you call a one-tier system in Sweden when you have a parallel private sector where people can pay and get the services they want and when you have inside Sweden, outside Stockholm area, according to your presentation, places where there is a long waiting time outside Stockholm and in Stockholm, you have a short waiting time.

So isn't it that make a multi-tier system inside an internal market and don't you think that you cannot avoid, it's impossible to avoid a multi-tier system except if you want to adopt a communist side regime of a completely egalitarian system in which everybody should be equal to each other which is, at my view, completely an utopia.

MR. JOHAN HJERTQVIST:

Or dystopia maybe and it's nothing to look forward to, we're moving away, I would say, from... from the central planned system in Sweden as... and I tried to describe that within the public framework, you... you're allowed to be very creative today.

I wouldn't say that this is a very small proportion of... of a hundred percent (100%) private, less than one percent (1%) open for a two-tier system but... and that one council pays another council for... for treatments, I... that stays to me is still in... within the internal markets and I can't see any complication with that.

I agree with you when you say that... as I said to myself before, in the long run, I guess that the demand of... of stronger individuals will make it complex to satisfy demand within any kind of... of collective, if you want to use that word, collective system as demand will be... become more and more specific, more and more complex, more and more oriented towards your individual needs.

So... and, of course, the old system was built all over the world for patients, (inaudible) being patient, ready to wait half a year or whatever it was for... for treatment, accepting what the doctor said, not questioning what the authority said.

As we're moving away from that, of course, it becomes more and more challenging to create a system that satisfies the... the strong individual needs.

So I haven't made up my mind, I am trying to describe what's happening in Sweden, I see a lot of lessons you might draw from that.

But I think this future... it might sound like a silly statement but the future is so complex so it's... to me, it's rather difficult to say that solution A or B or C will solve the problems.

DR. LEO-PAUL LANDRY:

Ed...

DR. EDWIN COFFEY:

Yeah. Could I just challenge Dr. Meakins just to...

DR. JONATHAN MEAKINS:

What about, what about?

DR. EDWIN COFFEY:

I see that we're... we're very well situated on the left and right, physically at least. Dr. Meakins, now, in Quebec, we seem to have accepted the concept that we can have multi-tiered education, many of our children go to public school, many go to private school, we all maintain a public education sector that we pay taxes to willingly.

We can't opt out of those taxes. But above that level, some of us save our money, instead of buying a second car, we wan't to enrol our children in a private school, for one reason or another.

Now, to me, that's a two-tiered education system, we do the same with postal services, communication, technology, practically every area of the economy, we have agreed to multi-tiered approaches, why is it that in health care services and health insurance, we seem to be so timid to move into that area?

DR. JONATHAN MEAKINS:

I don't know. But I don't have to agree. And seeing that this is, to some extent, a polemic of point of view, not agreeing is not an illegitimate point of view.

And so as I stated clearly early on, I believe in the principles of the Canada Health Care Act as renewed in nineteen eighty-four (1984).

And it worked for a long time and so I see reforming the act rather than throwing the baby out with the bath water.

And the idea of isolated testing areas of a new way of delivering care, I see as simply not... not feasible, I don't think you can isolate anything geographically anymore.

And to isolate a health care system within a country such as Canada is not possible. The most testing that's gone on is actually in the United States where if you go through a wide range of states, you will see health care systems that are reasonably pretty close to Canadian.

If you go to the Pacific northwest and to Minnesota, their approach to funding, state based and federally based Medicare, is very similar to the Canadian philosophy whereas if you go to Texas, Florida, a variety of other southern states, (inaudible), their view is dramatically different.

California is actually the place we should watch the most carefully because they're testing constantly, they're five (5) to fifteen (15) years ahead of us in almost... us being the rest of the world, in almost all social programs or application of public dollars.

So a lot of the experiments are going on in the States and if we look carefully, you will see clearly that the HMO concept is dead and it's... it's dead because people went bankrupt, they insured all the young kids and expected that they wouldn't grow old and they wouldn't get sick, it doesn't make any sense.

That's why Harvard went broke, it's why the University of Pennsylvania went broke. Columbia HCA just tried to cheat on what it was billing for.

And that's... that's a big problem and... so I don't actually have a solution but I was asked... I had three (3) choices, so I'm going for a single payer but I'm going to introduce private sector concepts of management, not punishment, I hate punishment but reward so that good programs get better because they're good programs, they deliver what they're expected to deliver on budget, on cost

with good quality.

That's why you go to... that's why you buy... you must have a Mercedes or an Audi or something. But that's why people buy those cars. They get value for money.

We had an old Mercedes 242D for fifteen (15) years, that's three (3) life cycles in this country of a car, paid many times over. Can't do it anymore, of course.

DR. EDWIN COFFEY:

Just a very, very quick rejoiner, getting back to the testing and comparing with United States, of course, the one difference is they don't have the universal publicly funded system and that is a baseline that I think we... we have and any testing or difficulties in testing, we always rely on that as a fall back.

The Americans don't have that so it's not quite applicable.

DR. JONATHAN MEAKINS:

Well, actually they do, they have Medicare and Medicaid. Medicaid is for people who are poor, on welfare and don't have access to paying for their own private insurance.

Medicare is for all haemodialysis in-stage disease who want sort of another transplantation and people over the age of sixty-five (65) and maybe a couple of other things that I've forgotten.

The real problem in the United States, independent of the fifty million (50,000,000) who are uninsured and therefore, covered presumably by Medicaid, is the under-insured, that is what the real problem is and that is seen in two (2) areas.

The first is families that decide they can only afford a certain level of insurance, they work for small companies that don't pay health insurance.

Or they work for larger companies who under-insurance, as a matter of course, because over-insuring or adequately insuring cuts into profits.

If you watch the NAFTA negotiations at all, you will have seen that the Americans tried to bring health care to the table because General Motors pays a ton per employee, per car, I think it's... what is it, a thousand dollars ($1,000.00) a car for a... it's a thousand dollars ($1,000.00) a car for a twenty-five thousand dollar ($25,000.00) car or something like that.

So that's... that's real money, that's four percent (4%) of the cost of the car. And they argued, they didn't win that one but they argued that they should have a recourse for those costs because that was a benefit of residence in this country.

So there is a certain... actually network there it's hard to find.

DR. LEO-PAUL LANDRY:

Mesdames et messieurs, j'ai choisi de conduire cet exercice en anglais parce que il y a pas de traduction simultanée et deuxièmement, je pense que la majorité des... des présentations et des gens qui sont dans la salle parlent surtout l'anglais.

Alors, je voulais expliquer ça, c'est pour ça, in the interest of time, that's why I was conducting this exercise almost exclusively in English.

Okay, ladies and gentlemen, you have before you the Quebec government cabinet. One of the ministers chose to leave probably because of a plane but maybe it was heating up too much, I don't know.

But let me... let me focus on that. We've had a lot of debates and a lot of presentations and I'd like to summarize some of the things that we heard today.

Dave started off by saying there is a crisis, the problem is structural, we need to change the structure, amongst other things, the solution would be the introduction of MSA's, medical savings account.

Johan said, "I'm sorry, it's not a structural problem, it's a market problem. And the solution is an internal market."

Chaoulli and Coffey said, "The hell with both of you, it is a market problem" but then they started with a design, a graph that said... you thought they were going to suggest an internal market and it very... looks very much like some of the drawings that Saltman and (inaudible) published a few years ago.

But when the explanations come out, it's not an internal market, it's really a free market they're looking for.

Then, at the end, in a typical surgical surgeon style, Jonathan gets up and says, "Well, I don't know, what I think we need is to tackle management practises."

Now, that's at halfway down a whole list of things. And he started off by saying, "What we really need to do is to put in place requisite management practises" and where he would start is to get rid of perverse incentives and the flip side of that is to align incentives.

But then he went on to say, "It's not enough, we need a change in health policy at a government level".

And that was expressed in his use of the word, "We need to allow this, we need to allow that" and I'm not going to go into the details, he gave that.

He was begging for more flexibility within the system so like he had the top down policy, bottom up, and all of a sudden, he said, "We have to bring in private sector management to fully implement the requisite management practises in the system."

Well, my first question to Jonathan: do you think surgeons or physicians in general are ready... if we... let me back off, if we implement just the aligning the incentives that you called for and we make the assumption that policy has changed, we have the requisite management practises, the first ones to screen are going to the physicians because of the way they're paid in the current system.

How in the name of God do you see society in general and physicians in particular or providers giving up something, it comes back to everybody wants to go to heaven but nobody wants to die, who is going to give up what so we can get on with things, make decisions and don't forget, you have to build a consensus amongst yourselves because you're all divided right now.

DR. JONATHAN MEAKINS:

Well, it's not a simple problem. I hurt cats for a living. If you go into a law office and trying to get forty (40) partners to agree on anything, it's hopeless.

But you have to come forward with some kind of a vision about where you're going to go. And so, I would divide my department into, say, six (6) divisions, pay the head of the division, performance based salary and fire him if he doesn't perform providing I'm giving him the information that he needs to make the appropriate choices in terms of technology, in terms of drugs, who to apply different forms of technology to, how to manage certain types of problems, that we have the ability to discharge patients in an appropriate time so that we don't have patients sitting in the hospital because we can't move them to a convalescent home because there's no bed or there's no one at home to look after the... the patient and those kinds of obstructions which we deal with on a regular basis.

But given that all of that is possible, I think it, in fact, is, with proper management systems and, in fact, the States... if you go to a hospital in the States, they will give you an itemized bill for every single thing that has happened to you, every IV, every dressing, every four by four (4 x 4), every two by two (2 x 2), every piece of tape, the number of minutes you're in the operating room, the number of minutes you're anaesthetized in the operating room, the amount of minutes you're in the recovery room and you will be charged their going fee for each one of those units.

We don't have any of that in our system because we've never had to have it, it's been a global budget and we've just kind of muddle through.

The problem is life is much more complex than it was ten (10) or twenty (20) years ago and it is not possible to manage these very complex organizations with a complex type of delivery care that we give in the same sort of manner.

So an example would be a cardiac surgeon who takes two (2) hours to do a by-pass compared to a cardiac surgeon that takes four (4) hours.

Well, if I'm managing cardiac surgery, I'm going to give more OR time to the guy that takes two (2) hours to do the case rather than four (4) hours.

And the guy who takes four (4) hours is going to have to figure out how he's going to deal with that.

And pretty soon, he'll decide he's going to do something else because he's not going to get enough from OR time to make the kind of living he gets right now because we divide time equitably between all of the performers.

Now, you have to understand that we get paid fee for service, it has to do with the number of cases you do but if you're getting into a cost based activity funding scheme, it has to do with how many cases you could do, with what kind of outcome per unit time as you would apply it to any other type of corporate business practise.

So, General Motors is... is interested in the number of cars it produces per unit time that run, it's not interested in the ones... it's interested in the ones that don't run and that's what CQI is about and, in fact, CQI is Continuous Quality Improvement, something which we have not applied in any form to any of our management practises within the hospital system, we're trying but it's very difficult.

And in the final analysis, we don't have the levers to make people change. The levers have to do with what kind of cost drivers individuals become.

Now, you have to understand that I'm talking only from the hospital sector, I really have no understanding what happens in family practise groups, in... outside of hospital delivery of any form of care.

My whole life is... is spent in a little ivory tower up on the hill but we deliver pretty complex care that society seems to want and that's the most expensive component of what the government spends on

health care.

So it does have some relevance from a management point of view. I don't know if that completely addresses what you're driving at, Dr. Landry.

DR. LEO-PAUL LANDRY:

That's not for me to answer, your colleagues will certainly give you the answer to that question.

DR. EDWIN COFFEY:

I guess a very brief comment some of your approaches, Jonathan, you're looking at your staff... your staff of surgeons or whatever as... from an employer-employee relationship.

Unfortunately, as in all the other professions, we have a mix of employer-employee relationships but a good number of self-employed.

And in medicine, as you very well know, that can be sometimes difficult to reconcile the interest of a self-employed individual who has a following of patients using a facility who are asking him for service, him or her for service and he is then asking the facility for facility to work in. And that... you know, that creates another (inaudible)

DR. JONATHAN MEAKINS:

Actually, I don't find that all troublesome. Performance has a lot to do with what we're talking about and quality of outcome.

And an individual does not have a right to access, to excess public funds. So if you can't get your work done in some appropriate period of time, on some appropriate cost basis, then I think you're going to work some place else and I'll certainly help you find a job.

But you're not going to work in our institution because you're using a disproportionate number of resources.

And I have to tell you, I fight this battle constantly to the point where I'm sort of bored with it.

And it comes up at committee meetings all the time and I... I delegated down to division heads but if we had a true costing approach, we could come to you and we could say, "Hi, Ed, look, it's taking you half again as long to do your tubal and half again as long to do your hysterectomies and I know you're teaching a lot and I look forward to you doing it in the meantime of your group and here's... we'll be keeping track of the data for the next three (3) months", I'll bet you anything that you come into the (inaudible)

So when I had people who were using excess resources, I'll give you a small example, we thought that a patient should come in the same day of their operations, standard practise in the U.S. for years and we thought they should come in completely worked up, no chest X-ray, EKG bloods required, history and physical done consent (inaudible) arrive at the operating room seven o'clock (7:00) in the morning, ready to go to the operating room at a quarter to eight (7:45).

So we implemented all of the infrastructure required for that and individual surgeons used it differently and individual services used it differently.

So I had a meeting of everybody and I put the data up without any identifiers. But everyone knew who everybody was.

Everybody knew which divisions were at eight percent (8%) and pre-admission work ups and same day admission and everyone knew who is at ninety percent (90%).

Two (2) months later, they were all at eighty-five percent (85%). That kind of peer pressure is intolerable, it's intolerable because it makes public the fact that you're wasting my resources, you... because you, "I've got a big practise so I got to have access to all these resources because I'm an important doc around town and all that bla", I listen to that all the time.

It's nonsense, it's absolute nonsense and all you have to do is put it out publicly and everyone in the room will look at the person who's the outlier and within a month, that person will be performing.

But we need the data and the data is hard to get and once we got over a certain couple of humps, it was even harder to get but if you have the information systems and you have a transparent administrative program...

DR. EDWIN COFFEY:

But, Jonathan, why don't you have the information systems?

DR. JONATHAN MEAKINS:

It's estimated, at the McGill University health center, that we need a hundred and twenty million dollars ($120,000,000.00) over the next five (5) years to develop the appropriate information systems to do the things that I'm talking about as well as to manage the hospital in its totality from a financial and every other point of view.

DR. EDWIN COFFEY:

And where will you get the hundred and twenty million dollars ($120,000,000.00) in the current system?

DR. JONATHAN MEAKINS:

Well, one more time, I don't know.

DR. EDWIN COFFEY:

Okay.

DR. JONATHAN MEAKINS:

But that's...

DR. EDWIN COFFEY:

So...

DR. JONATHAN MEAKINS:

... where the underfunding that I mentioned, the genuine underfunding really exists because in many respects, that investment pays dividends, that's how McDonald's knows how much it costs to make a Big Mac and why they can charge what... what is it, a dollar two ($1,02) or something for it, and still make money.

DR. LEO-PAUL LANDRY:

Jacques is signalling that he has the answer.

DR. JACQUES CHAOULLI:

Dr. Meakins, with all respect I have for you, well, when you are speaking about underfunding, please let me tell you that you are wrong because how can it be underfunding when Canada is spending more than most of the... as countries of Western Europe, like Sweden, for example, where Sweden have a better ranking on the WHO 2000 scale, you know, and reducing the... the waiting list problem, and with spending less, how can you say... and so many other countries are spending less, how can you say that we are underfunding, underfunded?

DR. JONATHAN MEAKINS:

Well, you've actually supported my most important argument which is management. I believe that management is the heart of the problem.

The environment in which I live, where we don't have an MRI and we don't have a second CT-scanner and we're short on ultrasound and it's hard to buy laparoscopic equipment and we can't build the OR's that we want, et caetera, that looks like underfunding to me and we can't get the hundred and twenty million (120,000,000), that looks like underfunding.

But if all of the dollars that are devoted to health out of the public system actually were perfectly managed, I agree with you, we probably aren't underfunded and that was really the point of my bringing all of that stuff up, in terms of cost per population.

DR. LEO-PAUL LANDRY:

I'm going to close. Thank you, we're starting to build a consensus so it's time to stop. I'm out of time, I'm out of time...

UNIDENTIFIED VOICE:

One comment, one comment, I've listened (inaudible) arguments (inaudible) we need a management information system, (inaudible) costs along the line and to say that we are really funded, sufficiently (inaudible) because we don't have that...

DR. LEO-PAUL LANDRY:

We need you... we need you on the Quebec government for the next election. Thank you very much, I'm reminded - I have to close now - of André Pouliot's comments when he started the session this afternoon, he talked about three (3) things, the mandate of the Institute, the attitude of the Institute and the ultimate objective.

I'd like to remind you of those because I think they're very important. The mandate of the Institute is to find des solutions originales, original solutions to today and tomorrow's challenges and influence the government policy.

He was very clear when he said the Institute's attitude is one of openness, not only to what goes on in this country but goes on throughout the world.

And finally, he said the ultimate objective is to make a contribution to the world being of Canadian society, Quebec society and prosperity.

I believe that everyone here today shares those values, that's why you're here so I want to thank the

participants for being here, I want to thank the presenters, the speakers for their very interesting presentations and finally, I want to thank and congratulate the Institute for this initiative. Merci and have a safe trip home.

Michael... Michael needs a few minutes with you before we close.

M. MICHEL KELLY-GAGNON:

Well, actually, just a few seconds just to let you know that on October twenty-seventh (27th), we're going to have another public policy event, this one is for early birds, it starts at seven thirty (7:30) A. M. and it will finish at nine thirty (9:30) A.M.

It's about education. We've produced a study evaluating all secondary schools of the province of Quebec, both private and public.

In *La Presse* newspaper of today, it was said that... by certain people who attack us in the newspaper, that that's impossible to do that, well, maybe but, you know, we have two (2) people who've been working full-time since the last year to do it so at least, come on down to listen to what they have to say and we'll see if we have done something that is foolish or actually something that is useful.

But at any event, we've done it and we're the first ones who have done it on a systemic basis and we're quite proud of that.

So, October twenty-seventh (27th) at Delta downtown which is at 77 University Street and all the information is on our Web site again.

So thank you and as I had said to you, the speakers are going to stick around so if you just want, on an informal basis, to form small group and chat some more, I think that that's possible. So thank you very much.