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Québec Ombudsman'sBrief
presented to the
Commission de la santé et des services sociaux

as part of the special consultations
and public hearings on the document titled
Autonomy for All — White Paper on the Creation of Autonomy Insurance

Québec City, November 12, 2013

Mission of the Québec Ombudsman

The Québec Ombudsman ensures that the rights of citizens are upheld by intervening with Québec government departments and agencies and the various bodies within the health and social services network to rectify situations that are prejudicial to a person or a group of people. Appointed by the elected members of all political parties and reporting to the National Assembly, the Québec Ombudsman acts independently and impartially, whether an intervention is undertaken in response to a complaint or series of complaints or on the institution's own initiative.

Pursuant to the powers conferred upon it, it can propose amendments to acts and regulations and changes to directives and administrative policies with a view to improving them in the best interest of the people concerned.

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When the masculine form is used, it is intended to be gender-inclusive.

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Opinion of the Québec Ombudsman

1 These special consultations deal with the document titled *Autonomy for All —- White Paper on the Creation of Autonomy Insurance*[1](hereafter called the White Paper). Their purpose is to gather the opinions of various stakeholders and groups invited by the Commission de la santé et des services sociaux to contribute to the reflections of the parliamentarians on the major reform that has been put forward.

2 When the Québec Ombudsman submitted its 2012-2013 Annual Report on September 25, 2013, it noted that, in general, the gap between the public services announced and those that are actually accessible has continued to expand, due to increasingly intense budget pressures. This suggests that in order to make high-quality public services accessible, we need to find ways to innovate within a restricted budget. There is also a need to halt the trend toward governmental non-accountability with regard to the lack of service accessibility and quality which the Québec Ombudsman has observed in several public service sectors in Québec. From this perspective, the proposed autonomy insurance plan offers an opportunity to improve the public offer of long-term care and services.

3 With regard to funding such a plan, several important questions must be asked. What will be the respective contributions of the government, the taxpayer and the user? The answer to this question will generate considerable impact. **The Québec Ombudsman is not opposed to a potential financial contribution from the users, but it must never become an obstacle to receiving services.** The Québec Ombudsman's support for the proposed autonomy insurance plan will depend on this essential condition.

4 The user's freedom to choose their service providers is one of the fundamental features proposed by the Clair Commission and the Ménard Committee and seen in long-term care insurance plans elsewhere in the world. The White Paper puts forward the autonomy support benefit (ASB) as the means to add this feature to the proposed autonomy insurance plan, allocated in the form of service hours or a financial benefit that can be used to easily obtain services.

5 Among the alternative solutions that the public services are attempting to introduce in terms of service organization, the Québec Ombudsman has noticed a growing tendency to direct users toward community organizations or private enterprises through service agreements. The proposed autonomy insurance plan embraces this tendency with the ASB. Although the Ombudsman has no reservations about these agreements in principle, **it has nevertheless voiced concern about the lack of quality control that may arise in this particular situation**.

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[1] Ministère de la Santé et des Services sociaux 2013, *Autonomy for All — White Paper on the Creation of Autonomy Insurance,* MSSS, 45 p.

6 The Québec Ombudsman's 2012-2013 Annual Report also relates findings that reveal a cause for concern with regard to practices that currently deprive users of services they need, shifting the burden to natural caregivers and exacerbating the poor use of places in hospitals, rehabilitation centres and residential resources. From 2010 to 2013, the number of complaints the Ombudsman handled concerning home support services rose from 92 to 131. This is an increase of about 30% for this period. Over 45% of these complaints were substantiated. This significant increase in the number of complaints is of concern to the Ombudsman, which acts as a second level of recourse after the local or regional complaints and service quality commissioners. This means that the percentages may be even higher if we take into account both levels of the complaint review system.

7 Since the new Québec-wide autonomy support policy and bill will further clarify the government's intentions with regard to the reform put forward in the White Paper, the Québec Ombudsman will have to reserve judgment on the matter. It is a proposed reform that will be further elucidated in this parliamentary consultation and other hearings in spring 2014. For this reason, this brief presents recommendations on several matters that are of greatest concern to the Ombudsman, based on the observation and analysis of the situation of the people specifically targeted by the proposed reform. The Québec Ombudsman hopes, in this way, to identify the challenges to be overcome and the main guidelines to be considered for the future and to offer practical solutions.

8 To structure its comments on the integration of the proposed autonomy insurance plan into the public health and social services system, the Ombudsman drew on six major principles found in the scientific literature[2] and in Québec and Canadian social and health policy law. These principles are as follows:

- universal coverage
- equity of access
- real access to services
- quality of services
- solidarity in financing
- transparency of the plan and accountability of the actors

9 The Québec Ombudsman will conclude this brief with a list of the recommendations it is putting forward.

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[2] Thomson S., Foubister T., Mossialos E., 2009, *Financing Health Care in the European Union: Challenges and Policy Responses*, EOHSP, Observatory Studies, no.17, 225p.

1 Universal coverage

10 According to the White Paper, the proposed autonomy insurance plan will not change the current eligibility conditions for the health care, hospital and drug insurance plans. In fact, autonomy insurance will round out the public coverage already offered in terms of health and social services. Since the regulatory frameworks for these three other public plans apply to minors and their parents, the proposed plan will only cover people aged 18 and over whose condition requires long-term care and autonomy support measures, such as:

- Seniors experiencing functional or cognitive loss of autonomy or who suffer from chronic diseases
- Adults with significant, persistent physical disabilities (related to hearing, vision, language or motor activities)
- Adults with significant, persistent intellectual disabilities or with a pervasive developmental disorder

11 The principle of universal coverage formalizes a right for all citizens 18 and over whose situation requires it: the right to receive the services that the proposed autonomy insurance plan will offer. The fact that it will be publicly managed will allow this new plan to be administered as a single-payer system based on the same criteria as the other three existing plans (health care, hospital insurance and the public portion of drug insurance). **The Québec Ombudsman supports this method but is concerned about certain client groups that will not be eligible for the services.** For example, emancipated minors, as well as people in transition to adulthood with physical or intellectual disabilities or a pervasive developmental disorder, may require services such as those outlined in the White Paper. Upon reflection, the Québec Ombudsman encourages the minister in charge of this project to examine the exception provisions for specific client groups.

Whereas:

The needs of emancipated minors and people in transition toward adulthood with physical or intellectual disabilities or a pervasive developmental disorder may require services such as those outlined in the White Paper;

Citizens under 18 will not be eligible to receive the services offered under the proposed autonomy insurance plan, even if their condition requires them.

The Québec Ombudsman recommends:

R-1 **That** the Ministère de la Santé et des Services sociaux examine the exception provisions for specific client groups who will not be eligible for the proposed autonomy insurance plan, such as emancipated minors and people in transition to adulthood who have physical or intellectual disabilities or a pervasive developmental disorder.

2 Equity of access to services

12 There are two essential conditions for accessing the services of the proposed autonomy insurance plan. According to the White Paper, a person must first be evaluated and must present a needs profile that requires long-term professional aid, support, care or services. This needs evaluation will be carried out using a multiclientele assessment tool (MAT) which is already being used with adults experiencing a loss of autonomy. The Québec Ombudsman has certain reservations, not about the tool itself, but about the way it will be used.

2.1 Principal reservations arising from the use of the needs assessment tool

13 The MAT offers the acknowledged benefit of standardizing the assessment and measurement of the users' functional autonomy, thus establishing a standardized level of autonomy for every user. It is based on this assessment that the case manager will establish the level of service allocation. The risk that the Québec Ombudsman anticipates is that this will lead to an "automation" of allocation, whereas needs analysis actually demands flexibility, openness and clinical judgment.

14 Furthermore, this tool does not always provide a full portrait of the user's situation, which is a matter of great concern to the Ombudsman. Using this tool may sometimes result in an underestimation of certain realities in terms of the level of care required, realities that include serious behaviour problems, very specific health conditions, supervision needs and psychosocial problems (such as a deficient social network, mental health problems or extreme poverty).

15 As well, the White Paper states that "the profiles of individuals with disabilities are very similar to those of seniors with loss of autonomy."[3] The Québec Ombudsman has reservations about this statement and wants to point out that the ISO-SMAF profiles[4] do not explicitly take into account the idea of social and occupational integration, which is of particular importance to handicapped people.

16 In summary, **certain risks associated with the use of the MAT are of concern to the Ombudsman, which hopes that these will be carefully considered and managed, both for seniors experiencing a loss of autonomy and for handicapped people, whose needs differ in many respects.** In carrying out its mission, the Ombudsman is regularly called on to intervene in situations where rationalization efforts result in prejudice against users with regard to their right to receive health and social services that reflect the assessment of their situation and their needs. The following case offers a concrete example of one of the effects the Ombudsman fears will result from the use of this assessment tool.

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[3] Op. cit. (Note 1) p. 21.

[4] Dubuc, N., et al., 2007, *Les profils Iso-SMAF : un système pour soutenir les réseaux intégrés de services,* in Fleury, M.-J., et al., *Le système sociosanitaire au Québec*, Montréal, Gaëtan Morin, p. 245-261.

Unintended effects of the multiclientele assessment tool (MAT)

After the annual re-assessment of her individualized service plan (ISP), a woman was told that her home support would be cut by two hours a week, even though her situation had not changed. She was not given any explanations. After she complained to the CSSS, the local service quality and complaints commissioner explained the changes made to the management framework and their impact on ISPs. The new framework uses the ISO–SMAF assessment model promoted by the Ministère de la Santé et des Services sociaux. From then on, the lady would be getting two fewer service hours a week because of this model and its computer application.

When the Québec Ombudsman examined the grids, it noticed a slight difference in the ratings assigned to certain factors. The result was that the mathematical rule applied in this computer tool lowered the number of service hours required.

Source: Québec Ombudsman, 2012, *Is home support always the option of choice? Accessibility of home support services for people with significant and persistent disabilities*.

17 **As efficient as they may be, standardized assessment tools cannot replace the judgment of professionals, whose clinical opinion must be taken into consideration in the needs evaluation process.** Some countries,[5] such as Denmark, also use standardized assessment tools, and some use evaluation grids of varying degrees of sophistication, with the results validated by expert committees (Japan) or specialized regional teams (France). In Québec, it is the CSSS resource allocation committee that validates the results of the worker who evaluates the user's needs. There is no mechanism for the user to contest the results of the evaluation other than the complaint review system, which can only be used after the intervention plan has been applied. The implementation of the proposed autonomy insurance plan appears to provide an ideal opportunity to introduce this type of mechanism at the regional level.

18 Several regions also have local integrated service networks for the elderly (RSIPA). The RSIPAs are inspired by a clinical service organization philosophy that relies on nine components: single-wicket access, a case manager for 7–10% of the most complex cases, the presence of a coordinator, access to a geriatric team, the involvement of the family doctor, a needs evaluation system based on the MAT, local coordination and cooperation mechanisms, an intervention plan or individualized service plan and, finally, an effective communications system.

[5] Op. cit. (Note 1) p.42.

19 Could the RSIPAs be enlisted to this end? The RSIPA has the clinical expertise required and could effectively help validate assessment results at the regional level. It should be recalled, however, that the implementation rate for the nine RSIPA components was 62.15% on March 31, 2012, and that a rate of 70% is targeted for 2015.[6] In projecting the contribution expected from the RSIPAs, the degree of implementation must clearly be taken into account, and this varies significantly from one region to another.

20 The individualized service plan, which is also based on the MAT needs evaluation, should be attached to the individual and follow that person in their care and service trajectory, no matter where or in what region the services are provided. Due to a lack of Québec-wide standards, the agencies' and CSSSs' home care management frameworks are based on different value systems which affect the accessibility and degree of services offered to the users.

21 In some agencies and CSSSs, the goal is to provide access for as many people as possible and, based on that criterion, a minimum number of hours of service is offered to all eligible users. Elsewhere, the priority may be the level of dependency, and in this case the degree of services is adjusted to meet priority needs of this sort. In yet a third territory, other criteria are used. The consequences of applying certain criteria rather than others may lead to differing treatment of the same clientele. For example, the Québec Ombudsman has received several complaints related to a reduction of the service offer after a move, sometimes just a few streets away.

22 To rectify these situations, the Ombudsman recommends that the ISP be associated with the user, rather than the region where the user lives. The Ombudsman believes that **the ISP should be changed solely based on the needs of the person, not on their place of residence.**

23 Furthermore, the Ombudsman's investigations have revealed that the number of hours effectively allotted is often far below the evaluated needs. Faced with the scope of the demand, some CSSSs are no longer able to offer assistance with instrumental activities of daily living (IADL) and only provide assistance with activities of daily living (ADL) for free. Others have chosen to leave intact the service offer determined by the departmental policy but find themselves with impressive waiting lists. As such, it is not unusual for users to receive only a tiny portion of the hours that have nevertheless been deemed necessary to maintain their autonomy.

24 The Québec Ombudsman has also noted that most of the CSSSs have established ceilings on the number of service hours. These ceilings vary from region to region based on the type of service and even the type of clientele in question. For example, the reference framework for one region stipulates that a disabled person under the age of 65 can receive up to 21 hours of service a week, while a person over 65 who is experiencing a loss of autonomy can only

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[6] Ministère de la Santé et des Services sociaux, 2012, Rapport annuel de gestion 2011-2012, p. 24-25.

receive a maximum of 10 hours of service a week, for the same identified needs. **The Québec Ombudsman is worried about the adverse effect of service hour ceilings, especially for people whose needs are far higher than the defined limits.**

Whereas:

The use of the MAT does not always provide a complete portrait of the users' situation and risks leading to an "automation" of the service allocation;

Integration and social participation are specific needs for handicapped people and use of the MAT may underestimate the effect of certain realities in terms of the services required;

The needs evaluation process should allow users to contest the results obtained using the MAT;

The individualized service plan should be associated with the person and should follow them throughout their care trajectory.

The Québec Ombudsman recommends:

R-2 **That** the multiclientele assessment tool (MAT) consider the specific needs of disabled people, especially the idea of social and occupational integration, which is of particular importance to them.

R-3 **That** the Ministère de la Santé et des Services sociaux assign a specialized regional team to examine user disputes related to the results obtained using the multiclientele assessment tool (MAT).

R-4 **That** the individualized service plan be associated with the person and follow them in their care and service trajectory, no matter where or in what region the services are provided.

3 Real access to services

3.1 The Québec Ombudsman's findings concerning real access to home support services

25 In March 2012, the Québec Ombudsman published an investigation report on home support services offered to people with significant and persistent disabilities requiring long-term services.[7] This systemic intervention revealed the gap between the principles and the guidelines of the *Home Support Policy* adopted by the Ministère de la Santé et des Services sociaux in 2003[8] and the reality of people who receive or should receive the services their condition requires.

[7] Québec Ombudsman, 2012, *Is home support always the option of choice? Accessibility of home support services for people with significant and persistent disabilities*, 32 p.

[8] Ministère de la Santé et des Services sociaux, 2003, "*Chez soi : le premier choix — La Politique de soutien à domicile*." Québec, 45p.

26 The Québec Ombudsman brought to light several work methods that departed from the home support policy, based on an analysis of complaints received from 2009 to 2012. Its intervention revealed the following systemic problems:

- emergence of new exclusion criteria
- introduction of a ceiling on service hours often far beneath evaluated needs
- major regional disparities in the way the *Home Support Policy* is applied
- reduction in service hours
- extension of wait times

27 When this report was published, the number of complaints being received was on the rise. One year later, in 2012-2013, the complaints, although slightly down, dealt principally with:

- the reduction in service hours subsequent to changes made in the home support management frameworks
    - health and social services agencies
    - health and social services centres (CSSS)

28 In light of these findings, the Québec Ombudsman recommended that the Ministère de la Santé et des Services sociaux determine the level of funding needed for home support services and clearly set out the slate of services truly available, based on the needs of the population. In following up on these recommendations, the Department responded that the White Paper would provide the answers. The Ombudsman feels, however, that the White Paper only partially answers these questions.

29 In the Québec Ombudsman's opinion, **the proposed autonomy insurance plan will mobilize public support if it increases access to the services currently available as soon as it is launched, and to this end, a collaborative service provision model should be considered.** This model, which could be introduced during the transitional period before the full implementation of the proposed plan, would provide for cooperation among public, private and community service providers and an expansion of their service offers. The CSSSs would continue to dispense their current service offer, to which would gradually be added the services of newly accredited private and community service providers.

3.2 Real accessibility of three types of services

30 From the perspective of the actual accessibility of services, three types of long-term services will be prioritized, according to the White Paper:

- Basic professional care and services, including nursing, nutritional, rehabilitation and psychosocial services:
    - which will remain under the responsibility of the CSSS and may also be subject to a contractual agreement with a certified private residence for the elderly or a private organization.

- Assistance with activities of daily living (ADL), such as washing, dressing and eating:
  - which will be offered by social economy home help enterprises (SEHHE)[9] and may be subject to a contractual agreement with a certified private residence for the elderly or a private organization recognized for offering quality services or, on an exceptional basis for specific cases, by CSSS health and social services aides.
- Assistance with instrumental activities of daily living (IADL) such as doing housework, preparing meals and running errands:
  - which will continue to be offered by the SEHHEs and may be subject to a contractual agreement with community or private organizations.

31 The White Paper also specifies that the services of family caregivers (monitoring, relief or temporary help) will also be part of this new long-term care offer.

32 In 2012-2013, the support for elderly autonomy program (SAPA)[10] provided 194,814 users[11] with home support services. Since 2005, there has been a 20% increase in the number of users served, and over 77% of them are over 75 years old.[12] Nearly 60,000 of these seniors with diminished autonomy received home support services from health and social services aides, better known as family aides. Other seniors in the SAPA program received professional care and services, such as home nursing care.

33 The home care provided by the 5,032 family aides from the CSSSs[13] constituted 56% of all home care services provided to seniors experiencing a loss of autonomy,[14] while professional care and services constituted the other 44%. Home care includes mainly assistance with activities of daily living (ADL) and assistance with instrumental activities of daily living (IADL). For these purposes, family aides carry out, on average, 59 interventions per user per year, representing one 40-minute visit per week on average. The proposed autonomy insurance plan stipulates that from now on, it will be an SEHHE, a certified private residence for the elderly or a private organization recognized for its quality

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[9] Until recently, these were called social economy domestic help enterprises (SEDHE) (entreprises d'économie sociale en aide domestique or EÉSAD in French). The Québec Ombudsman has taken note of this change in name.

[10] Since February 4, 2013, SAPA is the new name for the age-related loss of autonomy program (PALV).

[11] Ministère de la Santé et des Services sociaux, Direction de la gestion intégrée de l'information, Système d'information sur la clientèle et des services des CLSC (I-CLSC), November 2013.

[12] Association québécoise d'établissements de santé et services sociaux, 2013, *Assurance autonomie* : Un projet collectif à réussir, AQESSS, p.3.

[13] Ministère de la Santé et des Services sociaux, 2013, L'effectif du réseau de la santé et des services sociaux, Excel chart produced by the Direction générale du personnel réseau et ministériel, Sheet A.

[14] Association québécoise d'établissements de santé et services sociaux, 2011, *Six cibles pour faire face au vieillissement*, p.28.

services that will, under the service agreement in effect, provide the ADLs and IADLs required, based on the needs established in the individualized service plan. The CSSS family aides may continue to provide such services, but only on an exceptional basis for specific cases.

34 On March 31, 2011, Québec had 101 accredited social economy enterprises serving 81,000 people.[15] Only 32 of them offered personal services such as ADL. The SEHHEs had nearly 6,800 employees, 3,623 working full time, 3,025 working part time and 144 funded by various employability programs.

35 The Ministère de la Santé et des Services sociaux L'étude des crédits 2013-2014[16] also reveals that on January 9, 2013, 1,910 seniors' residences were certified, of a total of 2,049 listed in the registry. As for private organizations recognized for their quality services, there is no information on the scope of the service offer they could provide beginning in late April 2014, the expected start date of the proposed plan for seniors experiencing a loss of autonomy.

36 This brief analysis of the service offer reveals that **there is a structural imbalance between the offer and demand for services. The proposed autonomy insurance plan risks exacerbating this imbalance, notably due to the lack of a transition period between the time when the CSSS family aides will stop providing ADLs and IADLs for free and the time when their replacements will take up the task.** The SEHHE accredited in a specific territory, the private residences for the elderly in the process of being certified and the private organizations in the process of being recognized will not actually be able to begin offering for-fee services until they have completed the preliminary steps, which will take time. **There is a serious risk of a breakdown in service continuity.**

37 This worries the Québec Ombudsman, which is already receiving complaints about dissatisfaction related to the re-evaluations undertaken by some CSSSs, arising directly, according to their comments, from the publication of the White Paper. A portion of the clientele is now being referred to SEHHEs for their ADLs, in return for a financial contribution. Before the publication of the White Paper, the CSSSs funded these activities. For some of these users, the services may become inaccessible because they are too costly. The CSSSs appear not to have carried out any analysis of the impact of these costs.

38 And yet the White Paper stipulates that the shift of resources and services to the places where seniors with diminished autonomy reside is only supposed to begin in April 2014. This will be extended, in 2015, to people with physical disabilities and, in 2016, to people with intellectual disabilities or pervasive developmental disorders. Although the Ministère de la Santé et des Services sociaux intends to introduce a nine-component implementation plan, a new Québec-wide autonomy support policy and a bill introducing the proposed autonomy

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[15] Ministère des Affaires municipales, des Régions et de l'Occupation du territoire, 2012, *Profil des entreprises d'économie sociale en aide domestique*, 34 p.

[16] Ministère de la Santé et des Services sociaux, 2013, *L'étude des crédits 2013-2014, Réponses aux questions particulières*, Volet aînés, MSSS, p.110.

insurance plan, **the Québec Ombudsman believes that the time line is unrealistic. A true transition plan is required. In the meantime, the departmental guidelines must be clear: the agencies and institutions must follow the 2003 home support policy.**[17]

Whereas:

The determination of the service offer that is actually available based on the needs of the population is a requirement for the entire network and whereas three types of long-term care will be particularly affected by the application of the proposed autonomy insurance plan.

An analysis of the service offer under the autonomy insurance plan reveals the existence of a structural imbalance between the service offer and the demand.

The establishment of a collaborative model would reduce the risk of a breakdown in service continuity during the transition period and speed up improved access to home support services.

The Québec Ombudsman recommends:

R-5 **That** the Ministère de la Santé et des Services sociaux standardize the home support management frameworks before implementing the proposed autonomy insurance plan.

R-6 **That** the Ministère de la Santé et des Services sociaux develop an effective and efficient accreditation process, based on the evaluation of service quality, and, accordingly, plan for a realistic transition period.

R-7 **That** during the transition period, a collaborative model be put in place to quickly improve access to home support services and mobilize support for the proposed plan.

3.3 Stakeholder guaranteeing the service offer

39 The CSSS is the principal stakeholder that must guarantee that the services promised by the proposed autonomy insurance plan will be effectively offered. Under the current time line, it will implement the proposed plan over the next three years, and to this end, it will become responsible for developing the individualized service plan.

40 Likewise, the CSSS will have to mandate one of its professionals to serve as case manager or navigator and act as a resource person for the individual and their family. The case manager will also be responsible for the evaluation, planning, execution and coordination of all services, as well as having the individualized service plan formally approved by the individual and their family before it is put into action.

[17] Op. cit. (Note 8)

41 As principal stakeholders in the proposed autonomy insurance plan, the CSSSs will have to grapple with significant challenges in these new responsibilities, particularly in terms of adapting the home support services basket that they currently provide through the support for elderly autonomy program (SAPA). This reorganization will have an effect on their work organization and on the training and supervision of their human resources. This in itself is a highly complex challenge to overcome.

42 Under the existing SAPA program, several CSSSs are having trouble organizing their services. In its resource optimization report in spring 2013,[18] the Auditor General pointed out that despite a legal obligation, only 48% of the files examined included an intervention plan based on a needs evaluation. Furthermore, 36% of these plans were more than a year old and were therefore not up to date.

43 These concerns are similar to those described in the Québec Ombudsman's 2012-2013 Annual Report. Despite a slight drop in complaints and reports that were found to be substantiated after investigation, 2012-2013 saw several complaints about clinical issues that were largely related to the organization of care and services, the quality of ADL assistance and oversight.[19] The Québec Ombudsman recommended that the CSSSs involved strengthen their follow-up and case management mechanisms so their users would be certain to receive the care and services they need based on the evaluation of their psychosocial condition and state of physical health. The Ombudsman is currently monitoring the implementation of most of these recommendations.

44 In addition to assigning the additional human resources required and developing effective new case management and quality control tools, the CSSSs will have to ensure that the users' capacity to pay does not stand in the way of actual access to services on the ground. Nowhere in the White Paper **did the Québec Ombudsman find clear information regarding the practical support that the CSSS will receive from the agency and the Ministère de la Santé et des Services sociaux to implement the proposed autonomy insurance plan.** Admittedly, the Department reaffirms its commitment to "meeting its responsibilities in regard to defining guidelines"[20] for the introduction of the nine component plan, but the little information presented in the plan gives the impression that the reform will be limited to the reorganization of structures already in place and the development of fee structures for users. The Department does not say that it will be directly involved in the development of standards of access, integration, quality, effectiveness and efficiency or the development of practice guidelines for clinical standards based on persuasive data for the CSSSs. This is worrisome to the Québec Ombudsman.

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[18] Auditor General of Québec, Spring 2013, *Rapport du Vérificateur général du Québec à l'Assemblée nationale pour l'année 2013-2014 — Vérification de l'optimisation des ressources*, Chapter 4, Personnes âgées en perte d'autonomie : Services à domicile, p.11.

[19] Québec Ombudsman, 2013, *2012-2013 Annual Report*, p.77.

[20] Op. cit. (Note 1) p.31.

Whereas:

The CSSS will be the public institution that guarantees the service offer established under the proposed autonomy insurance plan;

The CSSS will be primarily responsible for organizing the provision of the service offer through service agreements with external partners;

These changes will have consequences on work organization and on the training and supervision of the human resources.

The Québec Ombudsman recommends:

R-8 **That** the Ministère de la Santé et des Services sociaux develop an implementation plan that specifies the roles of the Department, the agencies and the CSSSs, as well as the responsibilities that will be entrusted to them;

R-9 **That** this implementation plan anticipate the resources that will be assigned to the proposed autonomy insurance plan in the CSSSs as well as the support that will have to be provided by the agencies;

R-10 **That** the Ministère de la Santé et des Services sociaux develop practice guidelines, based on persuasive data, for the CSSSs.

4 Quality of services

45 Currently, it is mainly workers in the public network that provide home care services to people in vulnerable situations. Service quality is not generally the subject of most of the complaints that the Québec Ombudsman receives in this sector. The quality of the work of the public network workers is rarely called into question, and the vast majority of them carry out their responsibilities with dedication.

46 In the CSSSs, home care quality assessment is carried out by the professional resource responsible for the file. This assessment is carried out during the annual review of the intervention plan, which is done for one of every two files.[21] While a few questions in the user surveys occasionally conducted by some CSSSs may also deal with the quality of services received at home, the management and accountability agreements do not include indicators for assessing the quality of home care. For residential services, there is the certification of private residences for the elderly as well as occasional inspections of some intermediary resources. The other quality control measures involve all the services offered in the network's institutions and do not specifically address home support services. These quality control measures include accreditation by an external authority, the complaint review system and the incident and accident registry. Finally, the professional orders exercise some control over the practices of their members, but in the case

[21] Op. cit. (Note 18) p.11.

of home care services, family aides who do not belong to a professional order provide 56% of the CSSSs' services.

47 The Auditor General offers a clear opinion of the current state of the quality assessment of home support services: The measures in place for assessing the quality of home care services do not give the Department, the agencies or the institutions sufficient control over quality.[22] The Québec Ombudsman seconds this opinion.

48 The public management of the proposed autonomy insurance plan will not prevent services from being offered privately, so how will the quality of these services be assessed? **The Québec Ombudsman has no reservations concerning the proposed principle of contractualization with the SEHHEs, private residences for the elderly and other accredited private organizations. It is concerned, however, about the insufficient quality control that may arise in this specific situation.** These will be brand new activities for the CSSSs, which are already struggling to assess the quality of their own services. There will definitely be a learning curve for these new responsibilities and for the development of expertise in service quality assessment when the services are provided by third parties.

49 The Québec Ombudsman's 2012-2013 Annual Report[23] also mentions the lack of supervision and verification of care and service quality in some of the private residential centres to which the public network has directed seniors experiencing a loss of autonomy while they wait for places to come free in the public CHSLDs. Furthermore, in recent years, several contractual agreements have been concluded between the CSSSs and the operators of intermediary resources. The purpose of these agreements was to quickly increase the number of places available to people deemed to be experiencing a slight loss of autonomy.

50 The Québec Ombudsman has repeatedly noted, however, that the CSSSs are not fully assuming their role in terms of supervision and quality control for the services provided to users living in intermediary resources. Beyond the number of places available in this type of resource, it is essential for the users who live there to receive the required follow-up from the public institutions in charge.

51 The Québec Ombudsman also notes that the reference framework and typical contract applicable to intermediary resources do not sufficiently address the needs and characteristics related to the loss of physical and cognitive autonomy of the clients living there. Furthermore, the quality standards expected of the intermediary resource (related to the human and physical environment, services and living environment) are vague and open to different interpretations, on the part of both the operators and the CSSSs. This leads to ambiguities in the service offer and erodes the quality of care and services provided to the users.

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[22] Op. cit. (Note 18) p. 32.

[23] Op. cit. (Note 19) p.75-76.

52 When the autonomy insurance plan is launched, certain services currently provided by the public network will be transferred to these partners. This shift from the public network — where certain quality control measures are in place — to external partners triggers a growing concern about the quality of the services. Benchmarks to guarantee quality service are required, and it would be best if they were introduced as soon as the proposed autonomy insurance plan is rolled out. The Ministère de la Santé et des Services sociaux made a commitment, in 2012, to develop a policy and ministerial action plan for the quality assurance of care and services.[24] In the Ombudsman's opinion, setting up this kind of instrument for change is essential for the proposed autonomy insurance plan. The Department, the agencies and the CSSSs will have an important role to play in the implementation of the quality assurance process for the services that will be offered.

Whereas:

The current quality assessment measure for home support services does not allow the Department, the agencies and the institutions to adequately evaluate them;

There is a lack of oversight and quality control for the services provided to users who live in certain private residences for the elderly and intermediary resources;

The quality standards expected of the intermediary resources with regard to the human and physical environment, the services and the living environment are vague and open to interpretation;

The quality control for services offered under the proposed autonomy insurance plan will require the development of quality assurance expertise, given that these services will be provided by third parties;

The Ministère de la Santé et des Services sociaux made a commitment, in 2012, to develop a quality assurance policy for care and services.

The Québec Ombudsman recommends:

R-11 **That** the Ministère de la Santé et des Services sociaux develop and release a quality assurance policy for care and services no later than March 2014, which will also apply to services provided under the proposed autonomy insurance plan.

5 Solidarity in financing

53 As stated in the introduction to this brief, **the Québec Ombudsman is not opposed to a potential financial contribution from the users, but this must never become an obstacle to receiving services.** This is a condition on which there can

[24] Ministère de la Santé et des Services sociaux, 2012, *Processus de qualité dans les organisations*, Direction de la qualité, presentation available at: http://www.cqaqualite.ca/images/colloque/documents/Sylvie-Bernier.pdf

be no compromise. The Québec Ombudsman believes, however, that solidarity in financing is effectively enacted by the fairest possible division of the financing burden assumed by "the state, the taxpayer and the user of services."[25] This division must therefore take into account the financial burden that can be assumed by the people who are the least well-off, and it must be evaluated with respect to the rights of handicapped people.

5.1 A two-stage funding proposal

54 The funding proposal presented in the White Paper is divided into two separate periods. The first covers the years 2014-2018 and is part of the funding framework proposed by the government. This framework includes the following principal components:

- the annual amount for long-term care services, indexed (estimated at $2.9 B in 2013), and the commitments of $500 M already announced for home support, spread out until 2017-2018, and subsequently recurring;[26]
- user fees corresponding to the non-refunded portion of the tax credit for home support services for seniors, amounts users are required to pay under the FAPDHS[27] and a portion of the contribution for adults who live in CHSLDs[28] ($1 B in 2013);
- fiscal expenditures equal to the rise in the tax credit for home support services for seniors, which is estimated at $15 M in 2013.

55 The second period covers the next ten years. It is here that the government proposals seem the least specific. Indeed, the White Paper presents estimates which, in total, would require an annual addition of $120 M, representing additional funding of $1.4 B to earmark for 2027-2028. The difficulty of identifying these sources of additional funding is publicly stated: "The challenge is now how to determine how the reserves will be funded" to ensure the long-term viability of the project.[29]

56 According to the government, Québec is at a crossroads. The demand for services is growing quickly, under pressure from the ageing of the population, and, consequently, the current path of service provision will not suffice. As such, user contributions will have to adjust under new rules. In summary, the funding proposal will require the government to "decide on new forms of institutional funding and [...] progressively introduce new rules for user contributions."[30] The solutions put forward during this parliamentary commission should allow the Department to specify the additional sources of funding it believes are required

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[25] Op. cit. (Note 1) p.27.

[26] Appendix IV-B of the White Paper specifies that this means $110 M in 2013, $220 M in 2014, $330 M in 2015, $440 M in 2016 and $500 M from 2017-2018 to 2027-2028.

[27] FAPDHS: Financial Assistance Program for Domestic Help Services

[28] Op. cit. (Note 1) p.29.

[29] Op. cit. (Note 1) p.30.

[30] Op. cit. (Note 1) p.28.

to ensure the financial survival of the proposed autonomy fund. The main issues to consider in this regard, in the Ombudsman's opinion, should be the following.

5.1.1 Intergenerational fairness

57 The focus on intergenerational fairness suggests that the government favours the creation of a capitalized fund against the loss of autonomy as its primary option, as recommended by the Clair Commission[31] in 2000 and the Ménard Committee[32] in 2005. For these expert committees, intergenerational fairness means not placing the burden of the ever-increasing cost of financing services for seniors with diminished autonomy exclusively on the younger generations, that is, on 18-to-49-year-olds. In short, not taking intergenerational fairness into account may create a rift between the younger generations and the older generations in Québec, which is clearly not desirable. This is also the opinion of the Québec Ombudsman.

5.1.2 Capitalization of the autonomy fund for the taxable individual according to the Clair Commission and the Ménard Committee

58 According to the Clair Commission, the purpose of an autonomy fund would be to make the service offer fair and sufficient, at home or in residences, and to recognize and support natural caregivers. To achieve this, the fund must be capitalized, in order to provide security for the babyboomers and reassurance for the younger generations. The government could establish its contribution under a financial framework like the one presented in the White Paper and entrust its administration to a recognized institution, to protect the contributors and ensure transparency. The services covered would be offered in kind or in cash[33] and determined in an intervention plan managed in a way to encourage recourse to the most appropriate public, community or private resources.

59 For the Ménard Committee, other countries' experiences funding long-term insurance show that capitalization is a challenge that has not been met. Funds of this type are capitalized using premiums established to guarantee the funding of all current needs and future beneficiaries. The more the fund is capitalized to meet future needs, the higher the premiums and the less funding remains for current needs, which are increasing and, in fact, already suffering from under-funding. This is why a partly capitalized fund[34] entrusted to an institution such as the Québec Pension Plan would be a solution to consider for Québec, given its demographic particularities. This would allow this institution to serve as a third-

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[31] Commission d'étude sur les services de santé et les services sociaux, 2000, *Les solutions émergentes, rapport et recommandations*, MSSS, 454p.

[32] Comité de travail sur la pérennité du système de santé et de services sociaux, 2005. *Pour sortir de l'impasse : la solidarité entre nos générations*, MSSS. 145p.

[33] Op. cit. (Note 31) p.192.

[34] An insurance plan is entirely capitalized at a specific date if its assets are at least equal to the total value of benefits to be paid to the users by that date. Total capitalization translates into much higher premiums than partial capitalization, which is viable as long as it contains sufficient guarantees for the amortization of the actuarial deficit projected for a pre-determined date.

party payer to fund the proposed benefits in either kind or cash[35] and allow the beneficiaries to choose their service provider themselves, including natural caregivers. This freedom of choice would be overseen by an individualized service plan, under the responsibility of a navigator from the CSSS.

60 As the White Paper suggests, this plan would be endowed with current government budget credits to which would be added the mandatory contributions of all taxpayers. The capitalization of the fund would be partial in that it would allow a sufficient reserve to be accumulated to deal with the consequences of the ageing of the population. The management framework for this new plan would be based on contractualization and would purchase services from public and private providers, including social economy enterprises.

61 The contributions would be based on age of entry to the plan and would not change subsequently, except for annual indexation. This means the babyboomers would have to pay higher contributions than younger people, which is fair from an intergenerational point of view. Basing the contributions solely on taxable individuals protects the poorest people from a financial burden they cannot assume, but not people who are not exempt from paying income taxes due to insufficient income. This is why the contributions should also take income brackets into account, to ensure the greatest vertical fairness[36] or distributive justice, that is, that the financial burden of the wealthiest people should be greater than that of the less well-off. Based on the Ménard Committee's simulations, and subject to more in-depth calculations, a partially capitalized fund would require an average contribution of $396 a year per taxable individual in 2002-2003, increasing gradually to a maximum of $548 per year in 2050-2051. Clearly, the model is similar to the one put forward, starting in January 2013, for the progressive health contribution, better known as the "health tax."

62 The service delivery and funding schemes presented above allow for freedom of choice, public oversight and adequate capitalization, while ensuring fairness among people. These schemes could be acceptable to the Québec Ombudsman on two conditions. The first is that the vertical fairness must also take into consideration the fact that people who are less well-off also have to pay user fees when they receive services. **The addition of the tax burden to the fees charged to these users may weigh heavily on them and must be taken into consideration.** The second essential condition is the transparency that must be part of the selected funding proposal.

5.1.3 Transparency in the funding proposal

63 The Clair Commission and the Ménard Committee were right: to avoid having people jump to the conclusion that the proposed autonomy insurance plan is a

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[35] Op. cit. (Note 32) p. 84.

[36] The criterion of vertical fairness is met when people in groups with significant differences in income obtain the same net benefit.This is distributive justice, which seeks to reduce gaps in standard of living among different people.

"disguised tax,"[37] the funding proposal must be transparent in order to mobilize public support. This is why these two expert committees recommended that the contributions of the members be administered in a separate fund, managed by an organization known for its neutrality and accountability: the Québec Pension Plan.

64 In fact, the purpose of this recommendation is to reassure contributors who fear that the money raised will be diverted to cover the general expenses of the government. These fears are very real. For example, the Québec Ombudsman's investigations have revealed that some CSSSs reassign to other purposes the home support budgets saved when a user dies, is transferred to another region or is admitted to a permanent residence. In the past, the amounts thus saved were usually redistributed among people awaiting services. In recent years, the CSSSs have paid these sums into their general funds to achieve the zero deficit objective. What guarantees are required to ensure the proposed autonomy insurance plan will be safe from such practices?

65 The White Paper proposes that the Régie de l'assurance maladie du Québec (RAMQ) manage the funds of the proposed autonomy insurance plan and be responsible for administering the autonomy support benefit (ASB). **The Québec Ombudsman** sees no objection to this, but **will remain watchful for measures that will increase the transparency of the options and trade-offs behind the provision of services related to the loss of autonomy**. **Depositing the sums collected in a fund held in trust and administered by a recognized public institution appears to be a solution worth examining.**

Whereas:

The purpose of the autonomy fund is to make the offer of services fair and sufficient at home or in a residence and to recognize and support natural caregivers;

The proposed benefits would be paid in the form of service hours or by means of a financial allowance to purchase services, and the beneficiaries would have the freedom to choose their service provider themselves, including natural caregivers;

The contributions would be differentiated by age of entry in the plan and would not change subsequently, except for annual indexation, older people therefore having to make higher contributions than young people, to ensure intergenerational fairness;

The contributions charged would take income brackets into account, to ensure greater vertical fairness and also consider the financial burden of people who are less well-off, who will also have to pay user fees when receiving services;

[37] Op. cit. (Note 32) p. 86.

More in-depth work is required to propose a more detailed autonomy insurance plan on which an opinion can be expressed.

The Québec Ombudsman recommends:

R-12 **That** the Ministère de la Santé et des Services sociaux carry out the work required to submit a funding proposal for the partial capitalization of the proposed autonomy insurance plan that targets taxable individuals and ensures intergenerational and vertical fairness (distributive justice).

R-13 **That** this funding proposal include provisions to ensure the transparency of the fund management and that the fund be entrusted to a recognized public institution.

R-14 **That** this funding proposal be made public and be subject to public hearings.

5.2 Autonomy support benefit and freedom of choice

66 The autonomy support benefit (ASB) will be granted to eligible users in the form of service hours or a financial allowance to purchase services. This reflects the proposals of the Clair Commission and the Ménard Committee and is one of the features seen in long-term care insurance plans around the world: the freedom to choose the service providers, formalized through benefits in kind or in cash paid to eligible users.

67 That said, the White Paper specifies that "as there can be no question of compromising the quality of services, all providers must be explicitly authorized by means of a formal process."[38] The Québec Ombudsman is also of the opinion that service quality is a fundamental objective. The evaluation of the quality of the home support services that the future providers will offer is essential, but the users' freedom of choice must not become conditional. **Cumbersome bureaucratic processes that result in growing waiting lists must be avoided, as must administrative laxness in accrediting potential service providers. The Québec Ombudsman will remain vigilant in this respect.**

68 In this brief, a recommendation was made to the Ministère de la Santé et des Services sociaux with regard to the development of a quality assurance policy that would also cover home support services offered under the autonomy insurance plan. This policy could include several measures that have been proven in other Canadian provinces or elsewhere in the world to oversee service providers. For example, in Ontario, the contractual agreements include a complete quality control mechanism; in British Columbia, a registry has been created containing relevant data on caregivers that offer community care, to protect the most vulnerable users; in Germany and Denmark, an annual visit is made to the user's home to verify service quality and the use of the allowance.[39]

[38] Op. cit. (Note 1) p. 25.

[39] Op. cit. (Note 18) p. 34.

5.3 The autonomy support benefit and its financial consequences for the user

69 Solidarity in financing is demonstrated in the fairest possible distribution of the financial burden, as well as the additional effort required of the Public Treasury, the taxpayer and the user. The Public Treasury's portion is clearly presented. The portion that falls to the taxable individual may be acceptable, as long as it achieves partial capitalization, intergenerational fairness and distributive justice. From the user's point of view, however, the proposals in the White Paper raise the question of whether it is truly fair for the user to have to pay to access services that are now provided for free by CSSS family aides.

70 The White Paper's proposal is clear: the SEHHE accredited for the local territory, certified private residences for the elderly or recognized private organizations will take over home support services from the CSSS family aides. These service providers will charge fees to provide their services, which is logical and necessary from a business perspective. The ASB that will be granted to all people who are eligible — and who have an individualized service plan — will not be enough to cover the full cost of all home support services. This is also very clear in the governmental proposal.

71 The White Paper warns that the ASB funding will require a financial contribution from the users, which "should not become an obstacle to maintaining the user's condition and access to services."[40] The plan is to gradually introduce the new user fee rules[41] starting in 2014-2015. Furthermore, this financial contribution from the user will have to take into account the frequency and degree of the services received, as well as the user's income. For the government, the "ASB and autonomy insurance provide the opportunity to harmonize fee structures among the various locations where services are provided and should tend to standardize individual contributions for services of the same kind."[42]

72 This government intention to harmonize fee structures is laudable, but it will be tested by reality and, in practice, it will be hard to apply to all users, as the following case illustrates.

Need to harmonize fee structures

A senior with diminished autonomy lived in residential accommodations for which she paid rent. There she received free bathing assistance from the CSSS family aides. Then this person, not by choice but out of necessity, had to move into a private residence for the elderly that was in the process of certification. Her monthly rent doubled. No personal care services were included in her rent, but pay-per-use services were offered at an additional cost.

[40] Op. cit. (Note 1) p. 24.

[41] Op. cit. (Note 1) p. 28.

[42] Op. cit. (Note 1) p. 24.

Based on the economic exclusion criteria in the CSSS home support service offer, since this woman now lived in a private residence for the elderly, her income had to be considered. Based on this calculation, she had the capacity to pay for bathing assistance, one of the pay-per-use services offered in her new residence. And yet her income was the same as a few months earlier, when this assistance was offered to her for free.

The residence failed the agency's certification process, which led to a change in its status. It then became a home for the CSSS and the woman was once again eligible for free bathing assistance. Since then she has received a financial allowance through the Chèque emploi service to cover the cost of a weekly bath.

73 This case illustrates that the services granted to a person differ depending on whether they live in residential accommodations or a certified private residence for the elderly, even though their income remains the same. And yet, until it is replaced by the proposed national autonomy support policy, it is the 2003 home support policy[43] that is supposed to apply. This policy explicitly states that residents in so-called private residences are eligible, at no charge, for the home support services determined by a CSSS evaluation. This policy does not in any way discriminate against people who live in private residences for the elderly.

5.4 The users' reality in their living environments

74 The first service required by a senior experiencing a loss of autonomy is quite frequently an ADL service. If this is not accessible, because it is deemed too costly for their means, they have to do without, with the predictable consequences. The immediate impact is to shift the burden to natural caregivers and, in the medium term, it exacerbates the poor use of places in hospitals, rehabilitation centres and residential resources.

75 Financially, in 1997, the poorest user covered about 20% of the SEHHE's bill, based on the terms of the Financial Assistance Program for Domestic Help Services (FAPDHS).[44] Today, it is often over 40% of the bill that must be covered, which poses a concrete service accessibility problem.

76 The real cost of a home support service provided by a social economy enterprise is variable for the user. In 2013, the maximum financial assistance that can be granted is $13 an hour[45] under the FAPDHS. In 2009, the hourly rate charged by

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[43] Op. cit. (Note 8).

[44] Regroupements d'entreprises d'économie sociale en aide domestique, 2012, *Dépôt du rapport du Protecteur du citoyen — Services à domicile : Au delà des mots, il faut agir!*, Press release, April 3.

[45] In 2013, the Régie de l'assurance maladie du Québec (RAMQ) offered a rate of $13 an hour. This includes the basic exemption, a fixed amount of $4 plus variable assistance, which is an amount between $0.60 and $9, depending on the person's income. An annual income of less than $16,406 makes the person eligible for the maximum variable assistance, set at $9.

social economy enterprises ranged, by region, from $11.70 to $28.[46] It is clear that a person living alone on an annual income of less than $16,406, even with the maximum assistance allowed under the FAPDHS, will find it very hard to pay for the three required hours of housekeeping, which generally includes errands and meal assistance. In the worst case scenario, this person will have to spend $45 a week, of the gross $308 they have available. The introduction of billing for the IADL that social economy enterprises may eventually provide will have a similar effect, but with much more serious consequences, for services that are nevertheless deemed necessary to maintain autonomy.

77 The White Paper offers a portrait of vulnerability. It states that two-thirds of women living alone have an income under the poverty threshold, that three-quarters of seniors living alone are women and that a high proportion of adults with a disability live under the poverty threshold. For these people, the smallest contribution could become a major obstacle to the purchase of services.

78 In all fairness, **the Québec Ombudsman feels that the hourly rate of social economy home help enterprises (SEHHE) should be the same all across Québec and that fee increases should be regulated by standards and compensated by an adjustment in the exemption for people who are less well-off.** It is important to remember that to receive the financial exemption, the user must call on the social economy enterprise that works in their territory. These users are a captive clientele, and this runs counter to the freedom of choice of service provider, which is nevertheless recognized as one of the basic principles of the proposed autonomy insurance plan. The Québec Ombudsman will monitor these matters closely.

5.5 The reality of disabled people in their living environments

79 The Charter of Human Rights and Freedoms formally acknowledges the right to equality, without discrimination based on a handicap or the use of a means to palliate a handicap. Specific obligations are recognized, in particular on the part of the state, to ensure that this right is effectively upheld. In practice, this could mean, for example, an obligation of reasonable accommodation without excessive constraints. To effectively uphold the rights of disabled people, these parameters should therefore be considered in the design and implementation of the proposed autonomy insurance plan.

80 On June 29, 1988,[47] after the submission of a brief on offsetting the financial consequences of the functional limitations of disabled people regardless of their income or their family's income, the Québec government recognized, by decree, the principle of offsetting the financial consequences of functional limitations in the determination of the material assistance awarded to disabled people. Consequently, since that time, for services essential to a disabled

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[46] Based on data from a survey conducted in 2009, Op. cit. (Note 15) p.ii.

[47] Gouvernement du Québec, 1988, *Mémoire des délibérations du Conseil exécutif*, June 29, 1988, session, Decision number: 88-151.

person's integration, departments and organizations cannot take into account their or their family's capacity to pay.

81 The White Paper is very vague on this important issue, however. It mentions that "in 1988 the Government of Québec recognized a principle aimed at offsetting the financial consequences of functional limitations in the determination of material assistance awarded"[48] to handicapped people. But the fact that it specifically states that "these specifications are taken into account when considering a possible monetary contribution"[49] may worry people, since the discussion stops there. **Our analysis of the White Paper leads the Québec Ombudsman to conclude that it is first and foremost designed for seniors with diminished autonomy. The services required by younger handicapped people raise other issues, related in particular to social and occupational integration. In this regard, the government's reflections will have to be pursued further, especially on the matter of upholding the rights of handicapped people and on how to consider their specific needs in any future autonomy insurance plan.**

82 As such, the boundaries of the topic raised by the White Paper were laid in 1988. If the financial contribution planned for the users concerns services essential to the integration of a handicapped person, it should not be subject to a rate structure. Conversely, if the government deems that the user contribution charged under the proposed autonomy insurance plan does not concern services essential for the integration of a handicapped person, it could be subject to a rate structure. Clearly, this is a policy decision based on the limits of the concept of integration. Organizations that represent handicapped people should be consulted on this decision. The following case illustrates some of the limitations that handicapped people have to deal with under the current public provision of home support services.

Social and occupational integration of a handicapped person

A handicapped person lives alone in adapted accommodations. He is completely dependent for all his activities of daily living and instrumental activities of daily living. He moves around by motorized wheelchair and using adapted transport for journeys outside, such as getting to his full-time job in a private company.

In 2012, his individualized service plan (ISP) included the home support service hours required by his condition, funded mainly through Allocation directe — Chèque emploi service. After he moved to take up a new full-time job, the CSSS that took over his case maintained the ISP of the previous territory for three months. Then a re-evaluation was carried out, with the result that his night services, which he needed to help him prepare for work, were cancelled. In his new territory, this type of service was only offered in residential and long-term care centres

[48] Op. cit. (Note 1) p. 24.

[49] Op. cit. (Note 1) p. 24.

(CHSLD). For this handicapped person under 40 years old, this would mean moving to a CHSLD and the end of his outside employment and his occupational and social integration.

A complaint was filed at the first level, with the local complaints and service quality commissioner, which led to an addition of four hours of service for housekeeping. The man then filed a complaint with the Québec Ombudsman, which called on the agency and the Department to ensure that this handicapped person could continue to enjoy full occupational and social integration.

After discussion, the Department agreed to support the request and ensure that the authorities in question reinstated the original ISP. Furthermore, the Department also agreed to ensure that the ISP would remain connected to the person, as a user, rather than to the region where he lives. In other words, no matter where this man moves, his ISP will only change based on his state of health and his real needs.

83 Beyond demonstrating the importance of social and occupational integration for handicapped people, this real case returns the discussion to the issues raised earlier. For example, the needs profile of most handicapped people is likely to be very different from that of seniors with diminished autonomy, and this is why the Québec Ombudsman recommended that the MAT take these specific needs into consideration (R-2). Moreover, connecting the proposed individualized service plan to the user, as also recommended earlier (R-4), will avoid many delicate situations of the sort the Québec Ombudsman has had to deal with on a regular basis. Finally, this case illustrates the importance of the Allocation directe — Chèque emploi service for handicapped people.

5.6 The Allocation directe — Chèque emploi service

84 According to the accountability report prepared by the Ministère de la Santé et des Services sociaux to follow up on the recommendations in the Québec Ombudsman's investigation report on home support services,[50] 68% of the home support service hours offered to handicapped people in 2012-2103 were provided through Chèque emploi service. This proportion is about 14% for seniors with diminished autonomy. In fact, for seniors with diminished autonomy, CSSS family aides provided nearly 40% of home support service hours in 2012-2013.

85 Some CSSSs have now adopted a new practice resulting directly from the publication of the White Paper, which consists of allotting a fixed number of monitoring hours to seniors with diminished autonomy, to eliminate recourse to the Chèque emploi service. The fact is that too many questions remain unanswered with regard to the quality control of services offered by employees hired directly by seniors with diminished autonomy using this method. It would be

[50] Op. cit. (Note 7)

beneficial for a quality assurance policy, as recommended above (R-11), to be applied to the Allocation directe — Chèque emploi service method.

86 In the opinion of the Québec Ombudsman, advances must be made in the health and social services network service offer by optimizing public services and introducing a collaborative model of service provision during a transitional period toward autonomy insurance. Indeed, the Québec Ombudsman feels that the Chèque emploi service should remain available and easily accessible to people who are capable of managing the services offered to them. A high proportion of handicapped people use this option, which allows them to hire their own aides, giving them flexibility in the service provision schedule, even at night. This is rarely possible when other types of service providers offer the services.

Whereas:

The autonomy support benefit will be granted to eligible users in the form of service hours or a financial allowance to purchase services;

The autonomy support benefit will not be sufficient to cover all the costs of home support services and users will have to contribute directly;

The Allocation directe — Chèque emploi service method must remain available and accessible to people who are capable of managing their services themselves, to ensure freedom of choice in terms of service provider;

The development of a quality assurance policy must cover home support services, including the Allocation directe — Chèque emploi service method;

Specific provisions must be included in the proposed autonomy insurance plan to protect people who are less well-off and uphold the rights of handicapped people.

The Québec Ombudsman recommends:

R-15 **That** the Ministère de la Santé et des Services sociaux establish all the parameters for the user fees planned under the national autonomy support policy, which is scheduled for publication in spring 2014.

R-16 **That** the Ministère de la Santé et des Services sociaux specify, in the national autonomy support policy, the protective measures for people who are less well-off and the results of the consultation carried out with handicapped people to take their specific needs into account in upholding their rights.

R-17 **That** a public consultation be launched on the publication of the national autonomy support policy.

6 Transparency of the plan and accountability of the actors

87 Under the proposed autonomy insurance plan, the principles of transparency and accountability are closely linked, as mentioned in the previous section on the potential capitalization of the proposed fund. Transparency also requires the public authorities to inform the citizens of the obligations they will have to assume and the benefits they may concretely receive under such a plan. These two factors must be understood by the public and by the people in charge of organizing and providing the services, who must be clearly identified and accountable for their actions.

6.1 Transparency in service organization

88 The White Paper stipulates that, barring some exceptions, CSSS employees will no longer provide ADL services. From now on, three types of providers will be preferred: certified private residences for the elderly, private organizations recognized for the quality of their services and accredited social economy enterprises. The CSSSs will remain accountable for the quality of the services offered by these providers, however, and the expectations of the CSSSs will have to be specifically defined in a service agreement.

89 As such, **in the Québec Ombudsman's opinion, the transparency of the service organization requires the complaint review system to apply to all home support services.** Even if these services are provided by a recognized private organization or an accredited social economy enterprise, the standard service agreement must provide for recourse to the complaint review system. Home support services given by these providers must therefore be able to be the subject of a complaint that can be received under this system.

90 Furthermore, the White Paper provides no options for users who wish to contest the results of their individualized service plan. As the Québec Ombudsman recommended earlier, a specialized regional team should be mandated to clinically validate the results of individualized service plans.

6.2 Transparency in accountability

91 Transparency in accountability must demonstrate to the citizens that the maximum has been achieved with the money invested. One effective way of evaluating how well the services offered reflect the services required is to assess the response rate to needs. The Québec Ombudsman shares the Auditor-General's opinion[51] and notes at the outset that the current assessment systems provide no information in this regard.

92 The proposed autonomy insurance plan provides an opportunity to introduce results indicators in the essential accountability process that will be applied. The accountable authority in the public network is the CSSS, which will file its report

[51] Op. cit. (Note 18) p.13.

under the results-oriented management framework. The proposed plan will have to be reviewed every five years, by law.

93 In the Québec Ombudsman's opinion, this five-year review should be based on an analysis of the impacts of the proposed plan, including the financial burden on the users. As such, the idea of having the Department give a mandate to the Commissaire à la santé et au bien-être should be considered, since it is developing just such a reference framework. Indeed, the Commissaire plans to develop an analysis framework to assess the impacts of government policies on changes in the population's state of health and well-being.[52]

Whereas:

The public must be informed about the obligations they will have to assume and the benefits they may concretely receive under the proposed autonomy insurance plan;

To mobilize public support, quality information and transparency must be part of the service organization and accountability;

The proposed autonomy insurance plan must not lead to the unequal handling of citizen complaints;

Results indicators are needed in the accountability process that will apply under the proposed autonomy insurance plan.

The Québec Ombudsman recommends:

R-18 **That** the health and social services network complaint review system apply to all home support services, no matter who provides them.

R-19 **That** the results-oriented management framework include the response rate to needs as an important indicator.

R-20 **That** the five-year review of the proposed autonomy insurance plan be mandatory and based on an analysis of the impact of the proposed plan, including the financial burden on the users.

[52] Commissaire à la santé et au bien-être, 2013, *Plan stratégique 2012-2017*, p.5.

Conclusion

94 The Québec Ombudsman's reflections are grounded in a vision that integrates the proposed autonomy insurance plan into the health care and social services system. In the Ombudsman's opinion, expanding the service offer for seniors with diminished autonomy has become a necessity. Due to current demographic pressure, the existing organizational framework requires improvements. The means must be found to innovate within a limited budget. Efficiency improvements are still possible within the public network; the demand for service is increasing rapidly, and this justifies the Department's current efforts to improve services for seniors experiencing a loss of autonomy.

95 The Québec Ombudsman is not opposed to possible user contributions, but this must never become an obstacle to receiving services, especially for people who are less well-off, who will also have to pay user fees when they receive services. This contribution must not further hinder the social and occupational integration of handicapped people. The Québec Ombudsman's support for the proposed autonomy insurance plan is conditional on the consideration of these fundamental concerns.

96 To assist the parliamentarians in their thought process, the Québec Ombudsman has formulated twenty recommendations based on its findings. These recommendations deal especially with fairness of access to the proposed services; the practical accessibility of these services; the quality of the services that will be offered; solidarity in the financing of the proposed plan, which remains to be defined; and transparency and accountability, including the rational application of the complaint review system.

97 The Québec Ombudsman is aware that the proposed autonomy insurance plan introduces new ways of doing things and that it promotes contractualization with private and community groups. The required assessment of the services thus provided will entail the development of new expertise. The Québec Ombudsman is proposing practical solutions to these ends and emphasizing the necessity of responding to the needs of people with diminished autonomy, in a spirit of openness and with a constant concern for the quality of the services provided and the rights of all users.

List of recommendations

Whereas:

The needs of emancipated minors and people in transition toward adulthood with physical or intellectual disabilities or a pervasive developmental disorder may require services such as those outlined in the White Paper;

Citizens under 18 will not be eligible to receive the services offered under the proposed autonomy insurance plan, even if their condition requires them.

The Québec Ombudsman recommends:

R-1 **That** the Ministère de la Santé et des Services sociaux examine the exception provisions for specific client groups who will not be eligible for the proposed autonomy insurance plan, such as emancipated minors and people in transition to adulthood who have physical or intellectual disabilities or a pervasive developmental disorder.

Whereas:

The use of the MAT does not always provide a complete portrait of the users' situation and risks leading to an "automation" of the service allocation;

Integration and social participation are specific needs for handicapped people and use of the MAT may underestimate the effect of certain realities in terms of the services required;

The needs evaluation process should allow users to contest the results obtained using the MAT;

The individualized service plan should be associated with the person and should follow them throughout their care trajectory.

The Québec Ombudsman recommends:

R-2 **That** the multiclientele assessment tool (MAT) consider the specific needs of disabled people, especially the idea of social and occupational integration, which is of particular importance to them.

R-3 **That** the Ministère de la Santé et des Services sociaux assign a specialized regional team to examine user disputes related to the results obtained using the multiclientele assessment tool (MAT).

R-4 **That** the individualized service plan be associated with the person and follow them in their care and service trajectory, no matter where or in what region the services are provided.

List of recommendations (cont'd)

Whereas:

The determination of the service offer that is actually available based on the needs of the population is a requirement for the entire network and whereas three types of long-term care will be particularly affected by the application of the proposed autonomy insurance plan.

An analysis of the service offer under the autonomy insurance plan reveals the existence of a structural imbalance between the service offer and the demand.

The establishment of a collaborative model would reduce the risk of a breakdown in service continuity during the transition period and speed up improved access to home support services.

The Québec Ombudsman recommends:

R-5 **That** the Ministère de la Santé et des Services sociaux standardize the home support management frameworks before implementing the proposed autonomy insurance plan.

R-6 **That** the Ministère de la Santé et des Services sociaux develop an effective and efficient accreditation process, based on the evaluation of service quality, and, accordingly, plan for a realistic transition period.

R-7 **That** during the transition period, a collaborative model be put in place to quickly improve access to home support services and mobilize support for the proposed plan.

Whereas:

The CSSS will be the public institution that guarantees the service offer established under the proposed autonomy insurance plan;

The CSSS will be primarily responsible for organizing the provision of the service offer through service agreements with external partners;

These changes will have consequences on work organization and on the training and supervision of the human resources.

The Québec Ombudsman recommends:

R-8 **That** the Ministère de la Santé et des Services sociaux develop an implementation plan that specifies the roles of the Department, the agencies and the CSSSs, as well as the responsibilities that will be entrusted to them;

R-9 **That** this implementation plan anticipate the resources that will be assigned to the proposed autonomy insurance plan in the CSSSs as well as the support that will have to be provided by the agencies;

R-10 **That** the Ministère de la Santé et des Services sociaux develop practice guidelines, based on persuasive data, for the CSSSs.

List of recommendations (cont'd)

Whereas:

The current quality assessment measure for home support services does not allow the Department, the agencies and the institutions to adequately evaluate them;

There is a lack of oversight and quality control for the services provided to users who live in certain private residences for the elderly and intermediary resources;

The quality standards expected of the intermediary resources with regard to the human and physical environment, the services and the living environment are vague and open to interpretation;

The quality control for services offered under the proposed autonomy insurance plan will require the development of quality assurance expertise, given that these services will be provided by third parties;

The Ministère de la Santé et des Services sociaux made a commitment, in 2012, to develop a quality assurance policy for care and services.

The Québec Ombudsman recommends:

R-11 That the Ministère de la Santé et des Services sociaux develop and release a quality assurance policy for care and services no later than March 2014, which will also apply to services provided under the proposed autonomy insurance plan.

Whereas:

The purpose of the autonomy fund is to make the offer of services fair and sufficient at home or in a residence and to recognize and support natural caregivers;

The proposed benefits would be paid in the form of service hours or by means of a financial allowance to purchase services, and the beneficiaries would have the freedom to choose their service provider themselves, including natural caregivers;

The contributions would be differentiated by age of entry in the plan and would not change subsequently, except for annual indexation, older people therefore having to make higher contributions than young people, to ensure intergenerational fairness;

The contributions charged would take income brackets into account, to ensure greater vertical fairness and also consider the financial burden of people who are less well-off, who will also have to pay user fees when receiving services;

More in-depth work is required to propose a more detailed autonomy insurance plan on which an opinion can be expressed.

List of recommendations (cont'd)

The Québec Ombudsman recommends:

R-12 **That** the Ministère de la Santé et des Services sociaux carry out the work required to submit a funding proposal for the partial capitalization of the proposed autonomy insurance plan that targets taxable individuals and ensures intergenerational and vertical fairness (distributive justice).

R-13 **That** this funding proposal include provisions to ensure the transparency of the fund management and that the fund be entrusted to a recognized public institution.

R-14 **That** this funding proposal be made public and be subject to public hearings.

Whereas:

The autonomy support benefit will be granted to eligible users in the form of service hours or a financial allowance to purchase services;

The autonomy support benefit will not be sufficient to cover all the costs of home support services and users will have to contribute directly;

The Allocation directe — Chèque emploi service method must remain available and accessible to people who are capable of managing their services themselves, to ensure freedom of choice in terms of service provider;

The development of a quality assurance policy must cover home support services, including the Allocation directe — Chèque emploi service method;

Specific provisions must be included in the proposed autonomy insurance plan to protect people who are less well-off and uphold the rights of handicapped people.

The Québec Ombudsman recommends:

R-15 **That** the Ministère de la Santé et des Services sociaux establish all the parameters for the user fees planned under the national autonomy support policy, which is scheduled for publication in spring 2014.

R-16 **That** the Ministère de la Santé et des Services sociaux specify, in the national autonomy support policy, the protective measures for people who are less well-off and the results of the consultation carried out with handicapped people to take their specific needs into account in upholding their rights.

R-17 **That** a public consultation be launched on the publication of the national autonomy support policy.

Whereas:

The public must be informed about the obligations they will have to assume and the benefits they may concretely receive under the proposed autonomy insurance plan;

List of recommendations (cont'd)

To mobilize public support, quality information and transparency must be part of the service organization and accountability;

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