Incorporating Public Health More Closely Into Local Governance of Health Care Delivery: Lessons From the Québec Experience

Mylaine Breton, PhD,¹ Jean-Louis Denis, PhD,² Lise Lamothe, PhD³

ABSTRACT

Background and Objective: In 2004, the Quebec government undertook a major reorganization of its health care system by integrating public health more formally into local governance structures. In all, 95 new organizations – Health and Social Services Centres (CSSS) – were created and given a population-based responsibility. This mandate required that CSSSs broaden their range of services by adopting a population-based plan and integrating public health into their activities. To accomplish this, they needed to link public health and health care issues more formally within a single governance structure. The aim of this article is to identify and analyze various activities undertaken by CSSS managers to fulfill their population-based responsibility.

Methods: We conducted a longitudinal case study of two CSSSs (2005-2008). Our analyses are based on real-time observations of 144 meetings of decision-makers/managers and professionals at the regional and local levels, 46 interviews with managers, as well as secondary data.

Results: CSSSs focused on five areas of population-based responsibility: primary health care, specialized services, vulnerable groups, health promotion and social services. Over time, the activities developed by CSSSs in relation to these five areas reflected an increasingly population-based perspective on the delivery of health care services.

Conclusion: Service planning in the two cases under study is now based on a broader view of the health care continuum, and managers invest more time and resources in preventive interventions. Our study provides key information on the process of integrating a population-based perspective and preventive approaches in the planning and delivery of primary care services.

Key words: Population-based responsibility; public health; health care; Québec

La traduction du résumé se trouve à la fin de l'article.

Can J Public Health 2010;101(4):314-17.

The World Health Organization has identified two sectors of service delivery by which health care systems meet population needs: i) personal services, including preventive, diagnostic, therapeutic, rehabilitation and palliative care services consumed by individuals, and ii) collective or non-personal services, consisting of health promotion and disease prevention activities applied to population groups.¹ In this view, public health and health care delivery coexist within the health care system. Traditionally, activities in public health and in the health care system have evolved in parallel, with little interaction.^{2,3} However, recent developments have improved synergies between them and created the need to renew health intervention modalities. Epidemiological and demographic transitions and developments in knowledge and technologies have transformed the environment in which the public health and the health care system are evolving.^{4,5} These two sectors of services delivery are becoming more naturally convergent, benefiting from each other's expertise and resources to respond more effectively to complex health problems such as chronic diseases.⁶ Several countries have undertaken reforms designed in part to encourage closer interactions between the public health and health care sectors.⁷

In Québec, the government undertook a major reorganization of its health care system in 2004 by integrating public health more formally into local governance structures. The government created 95 new organizations called Health and Social Services Centres (CSSS),* which resulted from the merger of long-term care facilities, local community services centres (CLSCs) and, in most cases, a hospital. In addition to providing care and services to individu-

als, CSSSs were given a population-based responsibility⁸ to improve the health and well-being of specific, geographically-defined populations. This new responsibility may lead to changes in many areas of activity. Managers had the mandate to extend their organization's aims to include the development of services adapted to the needs of their territory's population. CSSSs had to develop and coordinate local services networks with other resources and establishments on their territory (see Figure 1). This dual responsibility – for both health care delivery and public health – required that CSSSs broaden their range of the services by adopting a population-based plan and integrating public health into their activities.⁷ To accomplish this, they needed to link public health and health care issues more formally within a single governance structure. Few studies have looked at the challenges presented by combining this dual responsibility within a common governance structure.

Author Affiliations

1. Postdoctoral student, Département de santé communautaire, Université de Sherbrooke, Sherbrooke, QC
2. Professor, École Nationale d'administration publique, Montréal, QC
3. Professor, Département d'administration de la santé, Université de Montréal, Montréal, QC

Correspondence: Mylaine Breton, Département de santé communautaire, Université de Sherbrooke, Campus Longueuil, 150, place Charles-Lemoyne, bureau 200, Longueuil, QC J4K 0B8, Tel: 450-466-5000, Fax: 450-651-6589, E-mail: mylaine.breton@usherbrooke.ca

Acknowledgements: This article benefited from insightful contributions and comments from Dr. Raynald Pineault. This study was part of the "Governing Change and Changing Governance in Health Care Systems and Organizations" project funded by the Canadian Institutes of Health Research (CIHR) (grant no. MOP – 74668; 2005-2008). Mylaine Breton was supported by GRÉAS-1 and GETOS chair Doctoral Research Awards.

Conflict of Interest: None to declare.

Figure 1. Schematic representation of local territory

Source: Agence de développement de réseaux locaux de services de santé et de services sociaux (2004). The Populational Approach: New Vision and Action for Health Information Kit, p.6, Québec City, Gouvernement du Québec.

The aim of this article is to identify and analyze various activities undertaken by CSSS managers to fulfill their population-based responsibility.

METHODS

To examine how CSSS managers' activities changed in response to their new population-based responsibility, we conducted a longitudinal case study of two CSSSs in a major urban region of Québec and of their respective networks. Out of 12 CSSSs on the island of Montreal, we intentionally selected two cases that presented significant variety. For example, an important criterion was the presence of an acute care hospital in one of our cases. The implementation of a local health network involving the merger of establishments with a hospital appears to be a much more complex process.⁹ Table 1 presents some characteristics of the two CSSSs studied.

Data collection

To ensure the thoroughness of our case study investigations over a three-year period (2005-2008), we used multiple sources of data. We observed 144 meetings of strategic committees at the local and regional levels. We carried out 46 semi-structured interviews with CSSS managers at two points in time, i.e., 30 interviews at the start of the study and 16 interviews approximately 18 months later. Signed consent was obtained from participants for all observations and interviews, which were also tape-recorded. In addition, we systematically reviewed archival materials (i.e., minutes of meetings, formal agreements, media articles, government reports and other documents).

Data analysis

We used process theory to analyze the data.¹⁰ Process research seeks to understand how events take place over time and why they unfold as they do. This approach is helpful for condensing information and identifying patterns.^{10,11} To classify our data and describe the evolution of two CSSSs under study, we based our preliminary analyses on four categories commonly used in organizational studies: a) vision, b) planning, c) organizational structures and d) social network. Based on these categories, we wrote narrative histories on each case.

* Centre de santé et de services sociaux (CSSS).

Table 1. Characteristics of the Two CSSSs Studied

	CSSS 1	CSSS 2
Institutions Merged	2 CLSCs 3 long-term care facilities	1 hospital 2 CLSCs 5 long-term care facilities
Population	128,392	132,779
Employees	2,095	3,810
General practitioners	61	102
Budget (2005-2006)	\$100 million	\$170 million
Life expectancy at birth	81.9 years	76.4 years
Single-parent families	26.6%	42.4%
Immigrants	47%	17%
Population living under the poverty line	30.2%	36%

Source: Montreal Health and Social Services Agency (2007)

RESULTS

In taking on population-based responsibility, managers have gradually expanded the areas of activity targeted by CSSSs, and their thinking about services organization has been strongly influenced by public health issues. The analysis of the activities done by each organization to appropriate their population-based responsibility reveals a set of core areas that constitute innovation practices in management of these organizations: primary health care, specialized services, vulnerable groups, health promotion and social services (see Figure 2). These five areas emerged from our analysis. They allowed us to cluster together similar activities developed by CSSS managers and to show how their efforts evolved.

Over time, the activities undertaken by CSSSs in relation to these five areas reflected an increasingly population-based perspective on the delivery of health care services. Temporality was fundamental to identify the nature of the change process following the attribution of a population-based perspective to these organizations. Activities in each of the areas expanded gradually and cumulatively through the study period. Initially, managers engaged in activities more traditionally associated with the health care system and with which they were more familiar. As time went on, they gradually engaged in other activities to improve the health and well-being of their populations, including health promotion interventions and social projects.

For services delivered more directly to the population, such as *primary health care*, *specialized services* and care to *vulnerable groups*, a territory-based organizational vision emerged gradually. The philosophy that sustained the development of service delivery transcended the CSSSs' organizational borders as managers started to support and help other organizations on their territory. According to one manager, "For me, the CSSS has become a network. It should be viewed as a whole. There should not be a separation between the various organizations of the CSSS, we really are all together."

We observed several examples of managers investing time and efforts in these three areas of population-based responsibility. For instance, we observed negotiations with hospitals for privileged access to high-tech support for primary health care organization, referrals of vulnerable patients with no family physician, support for medical clinics during their accreditation process (Family Medicine Groups), and formalization of integrated services networks for specific clientele such as seniors and mental health patients.

Managers tried to develop contractual agreements and alliances (virtual integration) with different partners, including private primary health care organizations, to improve the delivery and integration of services offered to the population of their territory. One manager exclaimed, "the public/private partnerships with physi-

Figure 2. Five areas of CSSSs' population-based responsibility

cians on our territories are the reform!" This effort represented a significant development in managers' practices, since public and private primary care organizations have historically evolved in parallel.¹² A number of managers seemed to agree that the most important gains to date were in the CSSSs' commitment to improve the overall supply of primary care services, whether these were provided in private or public settings. Another manager said, "Five years ago, we did not talk about that, we did not know private clinics. Now, they really are our partners. It's a major step."

In terms of *health promotion*, the CSSS managers sought to improve the support for professionals carrying out preventive interventions. For instance, they promoted the development of preventive clinical practices, more screening activities, and lifestyle counselling. Managers increasingly acted to reach potentially vulnerable clientele before diseases and psychosocial problems emerged. For example, CSSSs in Montreal set up "health education centres" to expand the range of preventive services. These centres support health care professionals who carry out prevention activities specifically on smoking, nutrition and physical exercise.

"The ultimate objective of the clinical prevention system is to bring more prevention to front-line services. The first step towards this objective is to counsel people on their health lifestyles. So, we ask physicians to discuss their patients' health lifestyles with them and possibly to refer them to the health education centres in the CSSSs."

Also, over time, CSSS managers invested more in the development of the *social area* by leading and participating in different projects in their local communities. This type of activity was a natural extension of a mandate that the CLSCs previously had. Including social and health areas within a single governing structure enabled the CSSS managers to continue to invest in the community by taking advantage of links that were already established. For example, representatives from CLSCs were already involved in a number of local consultations. CLSC managers had been putting a lot of effort into this activity, and the reform led CSSS managers to take this even further. More than before, managers said, they had an important role to play on their territories to facilitate and coordinate community projects that were likely to improve the health and well-being of their populations.

"The law gives us a leadership position with regard to the health of our population and I think we should use that leadership even more. At the start, it's always about the pace of change and we are currently assessing that pace. For me, we must exercise our leadership at the community level, I mean the community at large, where we work together to ensure we are part of social development such as the development of social housing."

For example, managers tried to increase community partnerships by organizing "partners' forums" in which different local actors participated, e.g., city representatives, school board members, workers from social organizations, and police. In the two cases we observed, these forums involved over 100 people discussing potential strategies that could have a positive impact on the health of the local population.

Managers in both CSSSs observed in our study invested in the same areas of activity. However, the pace and level of investment in different areas of activities varied. This can be explained partly by differences in their organizational attributes, respective histories and local contexts. The *presence of a hospital* led the managers of CSSS 2 to invest heavily in the development of specialized services. They were pressed to manage hospital admissions, surgeries and emergencies and worked over a much longer time to harmonize services across the different organizations that had to merge under the 2004 reform. Because merging different health care institutions with a hospital is apparently more complex,¹³ managers of CSSS 2 were slower to establish partnerships than were those of CSSS 1. However, over time, as more steps were taken to harmonize practices within the CSSS, the presence of a hospital, coupled with a history of community development, appeared to facilitate the creation of alliances with various partners on the territory. The presence of the hospital seemed to empower managers on both the organizational and economic levels, allowing them to gain a strategically advantageous position for developing alliances with their local communities.

DISCUSSION

Although population-based responsibility facilitates greater convergence between public health and the health care system, intrinsic tensions remain. In particular, the health care system targets more specifically users of services, while public health is aimed at the community. The first looks at restoring the health of individuals to a state of non-disease, while the second strives to protect and improve the population's health overall. Their targets are fundamentally different, which undeniably presents significant management challenges. The CSSS managers must respond to the needs of individuals who come to their institutions and, simultaneously, develop services to meet current and potential needs of the residents of their territories. To carry out this dual responsibility, managers must work simultaneously with i) organizations on their territory that provide care and services and ii) residents of the territory, for prevention and health promotion interventions. Thus, attention is focused either on the location of residence, in the case of services provided to individuals, or on the geographical area where services are delivered, in the case of health promotion interventions for the general population. The CSSSs will always need to provide short-term services in response to acute problems. At the same time, they have to be proactive and act more efficiently on the potential needs of their population, in terms of promotion and prevention. Our study shows that the CSSSs worked with various inter-sectorial partners, either as a leader of certain initiatives or to support projects initiated by their local partners in a preventive perspective.

The different activities put in place by CSSS managers indicate that public health and health care concerns are getting closer within a local governance structure. But some tensions will always exist. Also, several interventions, although associated with public health, do not fall within the competence of health care professionals. The areas of interest to public health, such as the environment, public infrastructure, safety at work, etc., are much broader and more diverse than those covered by the health care system. How far should the CSSSs go to maximize synergy between the two sectors at the local level? Indeed, many actions go beyond the local level and call for higher-level decision-making.

Some organizations, such as Kaiser Permanente and the Veterans Health Administration in the US, have attempted to link public health and health care issues more formally within a single governing structure. In these models, managers seek to optimize health care management of their insured clientele through various interventions along a continuum of services.¹⁴⁻¹⁸ These organizations focus more on prevention at an individual level. Other international models, such as that of Finland, adopt a different, community-based approach.¹⁹ These models take a population view and invest more in health promotion and in the social components of communities. We think the Quebec example allows for the development of a hybrid model at the local level. The Quebec model is based not only on better management of the population's health through a continuum of services, but also on a more comprehensive perspective that seeks to act on local community development to influence other determinants of health.

CONCLUSION

Our results show that assigning population-based responsibility to CSSSs has led to greater integration of two sectors of service delivery that until now were considered to be incompatible within a single local governance structure. Quebec's reform can be viewed as an opportunity to maximize potential gains from greater convergence between public health and the health care system. The reform initiated an important process of change in managers' activities as they integrated a population-based perspective and preventive interventions into their thinking to progressively expand the services offered by CSSSs. Analysis of these two cases' evolution over more than three years shows progressive evolution toward incorporating greater concern for public health into health care planning. Service planning is based on a broader view of the health care continuum, and managers invest more time and resources in preventive interventions. Gradually, attention is more oriented toward territorial planning, where managers seek to improve not only the services provided by their organizations (CSSSs) but also other services available on their territories, in order to develop services adapted to the needs of their population. This reform, introduced less than five years ago, is still in its early stage. An important shift has begun, but much remains to be done to move forward along this path.

REFERENCES

1. Murray CJL, Frenk J. A framework for assessing the performance of health systems. *Bull WHO* 2000;78(6):717-31.
2. Bergeron P, Gagnon F. La prise en charge étatique de la santé au Québec: émergence et transformations. In: Lemieux V, Bergeron P, Bégin C, Bélanger G (Eds.), *Le système de santé au Québec. Organisation, acteurs et enjeux*. Saint-Nicolas, QC: Les presses de l'Université Laval, 2003;7-34.
3. Lévesque J-F, Bergeron P. De l'individuel au collectif: une vision décloisonnée de la santé publique et des soins. *Rupture* 2003;9(2):73-89.
4. Broemeling A-M, Watson D, Black C. Chronic conditions and co-morbidity among residents of British Columbia. Vancouver, BC: Centre for Health Services and Policy Research, 2005.
5. McMichael A, Beaglehole R. The changing global context of public health. *Lancet* 2000;356:495-99.
6. Bergeron P, Gaumer B. Une participation croissante de la santé publique à la gouvernance du système de santé québécois? In: Fleury M-J, Tremblay M, Nguyen H, Bordeleau L (Eds.), *Le système sociosanitaire au Québec: gouvernance, régulation et participation*. Montreal, QC: Gaëtan Morin, 2007;51-62.
7. Breton M, Lévesque J-F, Pineault R, Lamothe L, Denis J-L. Integrating public health into local healthcare governance in Québec: Challenges in combining population and organization perspectives. *Healthcare Policy* 2009;4(3):E159-E178.

8. Government of Quebec. *Bill 25: An Act Respecting Local Health and Social Services Network Development Agencies*. Quebec, QC: National Assembly, 2003.
9. King A, Fulop N, Edwards M, Street A. The interface of acute and community services in British health care providers: Integration versus co-operation? In: Ashburner L (Ed.), *Organisational Behaviour in Health Care: Reflections on the Future*. Basingstoke, England: Palgrave, 2001.
10. Langley A. Strategies for theorizing from process data. *Acad Manage Rev* 1999;24(4):691-710.
11. Miles MB, Huberman AM. *Qualitative Data Analysis: An Expanded Sourcebook* 2nd Edition. Thousand Oaks, CA: Sage Publications, 1994.
12. Lévesque J-F, Roberge D, Pineault R. La première ligne de soins: un témoin distant des réformes institutionnelles et hospitalières au Québec? In: Fleury M-J, Tremblay M, Nguyen H, Bordeleau L (Eds.), *Le système sociosanitaire au Québec: gouvernance, régulation et participation*. Montreal: Gaëtan Morin, 2007;63-78.
13. Denis J-L, Lamothe L, Langley A. The struggle to implement teaching-hospital mergers. *Can Public Admin* 2008;42(3):285-311.
14. Borgès Da Silva G, Borgès Da Silva R. La gestion intégrée des soins: l'expérience de Kaiser permanente et de Veterans health administration, aux USA. *Rev Médicale de l'Assurance Maladie* 2005;36(4):323-35.
15. Feachem R, Sekhri N, White K. Getting more for their dollar: A comparison of the NHS with California's Kaiser Permanente. *Br Med J* 2002;324:135-43.
16. Ham C, York N, Sutch S, Shaw R. Hospital bed utilisation in the NHS, Kaiser Permanente, and the US Medicare programme: Analysis of routine data. *Br Med J* 2003;327:1257-62.
17. Kizer K, Demakis J, Feussner J. Reinventing VA health care: Systematizing quality improvement and quality innovation. *Med Care* 2000;36(6):7-16.
18. Perlin J, Kolodner R, Roswell R. The Veterans Health Administration: Quality, value, accountability, and information as transforming strategies for patient-centered care. *Am J Managed Care* 2004;10(2):828-36.
19. Ministry of Social Affairs and Health Finland. Health Care in Finland. Brochure of the Ministry of Social Affairs and Health, 2004;11.

Received: October 13, 2009

Accepted: March 8, 2010

RÉSUMÉ

Contexte et objectif : En 2004, le gouvernement québécois s'est engagé dans une importante réorganisation de son système de santé en intégrant plus formellement la santé publique à la structure de gouvernance locale. 95 nouvelles organisations ont été créées, les Centres de santé et des services sociaux (CSSS), qui se sont vu attribuer une responsabilité populationnelle. Cette réforme demande aux CSSS d'élargir leur offre de services en adoptant une planification basée sur une perspective davantage populationnelle ainsi que d'intégrer plus d'interventions de santé publique à leurs activités. Ce mandat demande d'incorporer plus formellement les préoccupations de santé publique et de soins au sein d'une même structure de gouvernance. L'objectif de cet article est d'identifier et d'analyser différentes activités mises en place par les gestionnaires des CSSS pour répondre à leur responsabilité populationnelle.

Méthode : Nous avons réalisé une étude de cas longitudinale de deux CSSS (2005-2008). Nous avons observé 144 rencontres avec des décideurs/gestionnaires et des professionnels des paliers de gouvernance régionaux et locaux, réalisé 46 entrevues avec des gestionnaires de même que consulté différentes documentations.

Résultats : Les CSSS se sont investis dans cinq domaines d'activités pour répondre à leur mandat de responsabilité populationnelle : les services de première ligne, les services spécialisés, les clientèles vulnérables, la promotion de la santé et la dimension sociale. À travers le temps, les activités développées par les CSSS en relation avec ces cinq domaines reflètent tous, à des degrés variables, une plus grande planification de services selon une perspective populationnelle.

Conclusion : Dans les deux cas à l'étude, les services de santé planifiés sont davantage appuyés sur une vision élargie du continuum de santé. Les gestionnaires investissent davantage de temps et de ressources dans les interventions préventives. Notre étude procure des informations clés sur le processus d'incorporation de la perspective populationnelle dans la planification et la prestation de services de santé.

Mots clés : responsabilité populationnelle; santé publique; système de santé; Québec