One step forward, one step back: Quebec’s 2003–04 health and social services regionalization policy

Abstract: This article focuses on Quebec’s most recent reform in the regionalization of health care to understand why the government chose to transform the regional boards into agencies. This case study used interviews and documentary analysis. Rooted in a political science perspective, the conceptual framework is inspired by the work of John Kingdon (1995) and draws on the four variables that influence the choice of policy: ideas, interests, institutions and events. Results of the case study suggest that Quebec’s Commission of Study for Health and Social Services (the Clair Commission) in 2000 and the 2002 pre-electoral environment put the issue on the agenda. In 2003, the newly elected Liberal government passed Bill 25 – An Act Respecting Local Health and Social Services Network Development Agencies, which represented a political compromise: originally slated for eradication, the regional tier survived but in a new form. The element that sparked reform was the change in government following the elections. Different inquiry reports spread the reform’s ideas, while interest groups articulated contrasting visions on the transformation. Above all, regional institutions showed great resilience in the face of change. From a historical perspective, this regionalization policy is a step backward: the regional tier is now stronger from a managerial and technocratic point of view, but it is politically
and democratically weakened. This suggests a government intention, at that time, to maintain the regional level as a means of retaining centralized control over Quebec’s health-care system.

Public policy-makers from around the world have moved to decentralize health-care systems in recent years in the hopes of achieving better governance and a more judicious distribution of management and service production responsibilities (Denis 1997; Saltman, Bankauskaite, and Vrangbaek 2007). Originating in the 1990s, Canada’s enthusiasm for decentralization has caused regionalized health-care services organizational models to dominate the country’s provincial health-care governance schemes. One of the most prominent advocates of regionalization in Canada is the province of Quebec, which first began to regionalize health-care structures nearly forty years ago and now boasts the longest continuous experience in regionalization of any Canadian province. Saskatchewan experimented with regionalization in the 1940s but let the idea drop before reintroducing it in the 1990s (Lewis and Kouri 2004).

Established in the 1970s, Quebec’s regionalization model began with the implementation of regional health and social services councils (Conseils régionaux de la santé et des services sociaux), invested by the ministry with limited advisory powers but in charge of the planning of health-care
delivery at the regional level (Turgeon 1989; Turgeon, Anctil, and Gauthier 2003). In 1991, Quebec changed the model considerably by replacing the councils with regional health and social services boards (Régies régionales de la santé et des services sociaux – “regional boards”) that were given full decision-making authority over resource allocation and the planning and organization of services. The next significant change to Quebec’s regionalization policy took place in 2003. In that year, Quebec’s provincial electoral campaign was dominated by health-care issues, with all three leading political parties advocating large-scale reform of Quebec’s health and social services system. The issue of regionalization took centre stage after the Quebec Liberal Party pledged that, if elected, it would abolish regional-level structures of the province’s health-care system (the regional boards) (Quebec Liberal Party 2002). A few months later, in December, the newly elected Liberal Party passed Bill 25 (An Act Respecting Local Health and Social Services Network Development Agencies [Loi sur les agences de développement de réseaux locaux de services de santé et de services sociaux] [L.S.Q. 2003, c. A-8.1]). While the law did not actually abolish regional-level structures, it altered their functions substantially by transferring health and social services management responsibilities to the local level. With goals of improving accessibility, speeding integration, ensuring continuity and making it easier for patients to navigate the health-care system (Quebec, Ministry of Health and Social Services 2004), the reform was implicitly pursuing objectives of accountability, efficiency and effectiveness, all principles of the “new public management” movement (Aucoin 1990; Denis 1997; Farrell and Morris 2003).

Once rumours that the regional level would disappear had been dissipated, the proposed reform succeeded in rallying a majority of stakeholders around its objectives – this, despite initial objections to the means chosen by the government to implement the reform (Contandriopoulos et al. 2007). In the end, the government chose to retain a three-tier health-care governance structure but gave the local tier increased responsibilities. Originally slated for eradication, the regional tier survived but in a new form.

Despite many years of experimentation with regionalization in Quebec, the motives for the decision on this issue have been largely occulted from the public eye. This article will attempt to elucidate the reasons for which the crafters of the 2003–04 reform maintained the regional tier rather than abolishing it as originally planned. Analysing the question from a political science perspective, we suggest that behind the government’s public goal to decentralize power to the local level lay the hidden intention to maintain the regional level as a means of retaining centralized control over Quebec’s health-care system.

We begin this article with a brief overview of Canadian experiences with regionalization and a typology of provincial models. Next, we draw on a public policy analysis tradition inspired by the work of John Kingdon (1995) to
help us describe the principal markers of the political decision-making process that characterized the 2003–04 reform. We conclude with an analysis of the principal social and political elements that led to Quebec’s choice of a policy.

Pursuant to Bill 25, the regional level is made up of fifteen health and social services agencies – the successors to Quebec’s regional boards – and is now mainly responsible for resource allocation and management, accountability and public health. The local level, meanwhile, is the seat of the province’s new health-care services network, and it is responsible for the organization of services – an important responsibility formerly assumed by the regional boards – and the provision of services.

Regionalization past and present

In Canada, decentralization has principally manifested as regionalization, a process that John Church and Paul Barker have described as “an organizational arrangement involving the creation of an intermediary administrative and governance structure to carry out functions or exercise authority previously assigned to either central or local structures” (1998: 468). During the 1990s, all ten of Canada’s provinces created intermediate, regional-level governance structures that delegated management of the health-care system to a level considered better able to grasp subtle characteristics in the local dynamics of supply and demand of health services (Denis 1997; Denis, Langley, and Contandriopoulos 1995; Saltman, Bankauskaite, and Vrangbaek 2007). Under the pressure of deep budget cuts, provincial governments envisioned regionalization as the solution to the health-care system’s multiple ills. Regionalization, they felt, could engender greater efficiency, effectiveness and equity; improve the continuity and integration of care; inspire greater public participation in health-care decision-making; bring costs under control; improve the allocation of resources; and help cement accountability (Church and Barker 1998; Davidson 2004; Marchildon 2006; Touati et al. 2007). The fact that empirical data failed to show that regionalization could really accomplish all those goals (Black and Fierlbeck 2006; Casebeer 2004; Dwyer 2004; Lewis and Kouri 2004; Lomas, Woods, and Veenstra 1997) did not prevent the provinces from implementing a range of regionalization models, the variety of which can be explained by the decentralized nature of Canada’s health-care system due to its federalist structure and the constitutional division of powers. But while the objectives and the reasons invoked for regionalization were largely similar from one province to the next, the
models differed dramatically on several counts: territorial organization; the number of administrative levels; modes of governance, accountability and financing; and the range of powers and responsibilities entrusted to regional structures (Lomas, Woods, and Veenstra 1997; Trottier et al. 1999; Turgeon 2003). A precise evaluation of the extent to which those objectives have been reached may not be possible (Lewis and Kouri 2004; Lomas, Woods, and Veenstra 1997), but experience suggests that they were either overly ambitious or unrealistic – if not downright contradictory (Denis, Contandriopoulos, and Beaulieu 2004).

This qualification of its success notwithstanding, regionalization boasts an undeniably long and vibrant history within the Canadian federation, an idea embraced from one coast to the other. As early as 1945, nearly half a century before its resurgence in the 1990s, regionalization had already emerged as a governance mechanism in Saskatchewan’s health regions (Lewis and Kouri 2004). But what has been hailed as perhaps Canada’s most ambitious regionalization strategy took place more recently. In 1994, Alberta created sixteen regional health authorities (later reduced to nine) that consolidated the responsibilities for and the management of a wide range of services and institutions formerly fragmented under the mandate of numerous local actors (Church and Smith 2008). Not all Canadian examples were as far-reaching: Ontario’s district health councils, created in 1975, had the limited role of advising the government on health-related issues, and, while the recent inauguration of local integrated health networks has moved regionalization forward, the powers of the new structures remain small (Eliasoph et al. 2007). Whether on a large or a small scale, however, regionalization in Canada has not been unidirectional in nature. Alberta abolished its regional health authorities in 2008, and Prince Edward Island, Canada’s smallest province, abandoned its own regionalization project in 2005 on the grounds that the move had occasioned over-governance, fragmentation and bureaucratization (Marchildon 2005). Given that PEI is Canada’s least populous province (its population is less than 140,000), this experience suggests that for regionalization to work, the jurisdiction in which it is implemented must dispose of a critical mass.

History aside, an analysis of current regionalization structures in Canada in terms of their level of decentralization reveals the existence of three principal models. The first, found in British Columbia, Saskatchewan, Manitoba, New Brunswick, Nova Scotia, and Newfoundland and Labrador, comprises two levels: the provincial and the regional. In this model, regional health authorities are responsible for the entire provision of services.

The second model, found in Ontario and in Quebec, comprises three levels of governance. In 2006, Ontario adopted a network-oriented approach by creating fourteen local integrated health networks responsible for the planning, integration, coordination and financing of health-care services.
Ontario’s health-care system thus divides governance responsibilities between the ministry, the local integrated health networks and local establishments; the latter are the entities that actually provide the services (see the Local Health Integration Networks’ web site at http://www.lhins.on.ca/aboutlhin.aspx?ekmensel=e2f22c9a_72_184_btnlink). In Quebec, the provincial level consists of the Ministry of Health and Social Services, which plans the general orientations of the health-care system. The other two levels, the regional and the local, were reconfigured in 2004 (see Table 1). Pursuant to Bill 25, the regional level is made up of fifteen health and social services agencies – the successors to Quebec’s regional boards – and is now mainly responsible for resource allocation and management, accountability and public health. The local level, meanwhile, is the seat of the province’s new health-care services network, and it is responsible for the organization of services – an important responsibility formerly assumed by the regional boards – and the provision of services. It is composed of ninety-five health and social services centres (HSSCs), each of which is the product of the merger of the local community services centres (centres local de services communautaires – CLSCs), the long-term care centres (centres d’hébergement et de soins de longue durée – CHSLDs) and the hospital centres (centres hospitaliers – CH) of its territory. As part of the restructuring, about half of the HSSCs integrated hospitals and thus assume the management of both frontline and specialized services. Each HSSC is in charge of executing service agreements that will allow it to create a local service network that includes various kinds of partner organizations, such as community groups, pharmacies and medical clinics. Directed by the local HSSCs and under the obligation to offer a range of services that meet local needs, these service networks are ultimately accountable for the health and well-being of the population in their territory (Quebec, Ministry of Health and Social Services 2004).

The evolution of Quebec’s regionalization model has largely revolved around the reflections and the debate stimulated by different provincial commissions on health care, the most prominent of which were the Commission d’enquête sur la santé et le bien-être social (Commission of Inquiry on Health and Social Welfare) (the Castonguay-Nepveu Commission), in 1967, the Commission d’enquête sur les services de santé et les services sociaux (Commission of Inquiry on Health and Social Services) (the Rochon Commission), in 1988, and the Commission d’étude sur les services de santé et les services sociaux (Commission of Study for Health and Social Services) (the Clair Commission), in 2000.
The third and last model consists of provinces that have recently elected to abandon regionalization. Prince Edward Island’s health-care system currently operates without a regional level: the provincial Department of Health plans services and manages the system and local establishments provide services (see its web site at http://www.gov.pe.ca/health/index.php3?number=1018432&lang=E). Similarly, Alberta recently replaced its nine regional health authorities with a provincial governance board, the Alberta Health Services Board, a single structure responsible for managing the delivery of services throughout the province (Alberta, Ministry of Health and Wellness 2008).

Space does not permit us to explore the reasons for the diversity of Canada’s models here. What is clear, however, is that Canada’s regionalization models are still evolving. Some of the most interesting developments in this area have taken place in Quebec, and it is Quebec’s recent reforms that we shall now consider in greater detail.

**Conceptual framework and methodology**

To understand the 2003–04 reform, we used a theoretical framework that draws on a stream of extensive public policy research and literature inspired by the work of John Kingdon (1995). This choice was motivated by the fact that it is a well-known and extensively used policy analysis methodology that...
facilitates possible comparison in other contexts. Kingdon suggested that policy-making takes place in three stages: 1) the governmental agenda (a problem is picked up by the government’s radar); 2) the decision-making agenda (the government decides to act on the problem); and 3) the choice of a policy (the government chooses one policy solution from a range of alternatives). To explain the choice of a particular policy, political economy distinguishes three categories of influences: ideas, interests and institutions (Goldstein and Keohane 1993; Heclo 1974; Lavis, Ross, and Hurley 2002; Sabatier 2007; Weatherford and Mayhew 1995). The ideas category consists of the values held by government (legislators, policy advisers), by stakeholders, and by the general public and of the knowledge available to them. That knowledge can consist of research evidence, tacit knowledge or experimental knowledge (for instance, experiences from other jurisdictions), and actors use it to inform their choice of a policy (Blyth 1997; Goldstein and Keohane 1993; Hall 1989; Hall and Taylor 1996; Kingdon 1995; Rochefort and Cobb 1993). The interest category refers to the actors who influence the choice of a policy and includes actors’ perceptions of whom the policy will hurt and whom it will benefit (i.e., who wins, who loses and by how much). Interests also reflect the degree of each actor’s institutional or political maturity, independence from government, and capacity to affect the decision (Howlett and Ramesh 2003). The third category, institutions, refers to the formal and informal structures and processes involved in public policy decision-making. It includes factors like constitutional rules, policy legacies, formal decision-making structures and characteristics of the policy-making process such as openness, degree of time pressure, and the level of approval required. To these three categories we have added a fourth, that of external events. External events are variables such as economic events, technological changes, or political changes that, while not specific to the health-care sector, are still liable to affect the reform.

Using this framework, we conducted ten semi-directed face-to-face individual interviews that lasted from sixty to ninety minutes each. The interviews took place between October and December 2005, two years after the reform was first launched. We selected interviewees through purposive sampling: all informants had to have an excellent understanding of the policy, having either helped design, adopt or implement it or been part of an organization asked to participate in the process. Interviewees were professional staff or decision-makers from health and social services agencies (n = 3), professional staff or high-level bureaucrats at Quebec’s Ministry of Health and Social Services (n = 3), representatives of associations of health-care institutions (n = 2), academic experts (n = 1) and a CEO of a health-care institution (n = 1). The interview guide was designed by the research team. Questions were organized according to Kingdon’s three policy-making stages (governmental agenda, decision-making agenda, and choice of a policy) and included probes that asked
informants to reflect on events in light of the four variables of study (ideas, interests, institutions and external events). We obtained ethical approval for the project from Queen’s University and from Université Laval. With the consent of the interviewees, all interviews were tape-recorded, transcribed and revised. Transcript data was coded with NVivo software using a coding template developed by the research team and inspired by the variables of study.

In addition to conducting interviews, we analysed the grey and the scientific literature, as well as relevant documents published by the government and various organizations to further document our case study. Data was entered into NVivo in order to facilitate its management and the qualitative analysis. We conducted a thematic analysis of the entire set of data, using as our units of analysis the four variables identified above.

Analysis of the policy decision: The metamorphosis of Quebec’s model

Regionalization has been an integral part of Quebec’s health and social services system ever since 1971, when the system was created. The evolution of Quebec’s regionalization model has largely revolved around the reflections and the debate stimulated by different provincial commissions on health care, the most prominent of which were the Commission d’enquête sur la santé et le bien-être social (Commission of Inquiry on Health and Social Welfare) (the Castonguay-Nepveu Commission), in 1967, the Commission d’enquête sur les services de santé et les services sociaux (Commission of Inquiry on Health and Social Services) (the Rochon Commission), in 1988, and the Commission d’étude sur les services de santé et les services sociaux (Commission of Study for Health and Social Services) (the Clair Commission), in 2000.

Because regionalization has been such an integral part of Quebec’s health-care landscape for the past thirty years, it is impossible to point to a specific date or incident as the origins of the 2003–04 reform. Rather, we must understand the change as the product of the evolution of Quebec’s regional structures over time. History shows that Quebec policy-makers reacted to steadily increasing health-care costs over the years by gradually integrating diverse governance structures and different organizations. In the mid-1990s, however, the dire state of Quebec’s public finances required more urgent cost-cutting. The result was a major restructuring of the provincial health-care system: a shift towards ambulatory care, hospital closures, and a massive early retirement plan for health-care professionals. This was also the time that the regional boards orchestrated the first
mergers of the “Centres local de services communautaires” (CLSCs) and the long-term care “Centres d’hébergement et de soins de longue durée” (CHSLDs). The boards’ successful negotiation of this delicate political operation bolstered their legitimacy and convinced stakeholders that, despite concerns to the contrary, the boards were indeed good governance instruments and efficient levers of change.

Nonetheless, it was during the Clair Commission in 2000 that debate on regionalization crystallized to the point where the question reached the governmental agenda. Charged with the mandate “to hold a public discussion on the issues facing the health and social services system and to propose solutions for the future,” the commission dedicated much of its reflections to governance in general and to regionalization in particular (Quebec, Commission of Study for Health and Social Services 2000: 1). As early as the commission’s opening session, the principle of regionalization was questioned. The as yet insufficient integration of services and organizations and the fact that regional boards lacked accountability and interfered politically in the management of health-care institutions were cited as grounds to reduce the number of regional boards, if not abolish them entirely. Once the commission began consulting stakeholders, the public, and national and international experts, however, it began to reconsider. Rather than abolishing the boards, commission members came to agree that it was necessary to retain a regional tier that coordinated services, especially since the boards’ success with the CLSC-CHSLD mergers had proved their management expertise (Quebec, Commission of Study for Health and Social Services 2000). Accordingly, the commission “chose not to propose a change in the number of boards or in the territory of the boards, in the short term. The regional boards and the regions that they serve are the result of delicate political negotiations” (211). Nonetheless, it suggested that greater accountability was in order. Several of the commission’s proposals in this regard were taken up by the Parti québécois in the form of Bill 28, passed in 2001 (An Act to Amend the Act Respecting Health Services and Social Services and Other Legislative Provisions [Loi modifiant la Loi sur les services de santé et les services sociaux et modifiant diverses dispositions législatives. Projet de loi no 28] [R.S.Q. 2001, c. 24]). Bill 28 defined the nature of the accountability between the different levels of the health-care system, imposed new management mechanisms, and reworked the composition of the regional boards’ boards of directors so as to include more members with solid management
experience. In this way, Bill 28 foreshadowed some of the measures that would pass two years later with Bill 25.

This suggestion represented a political compromise. It fulfilled the letter of the Quebec Liberal Party’s campaign promise – the abolition of the regional boards – but not the spirit, as the boards were immediately replaced with new regional-level structures that inherited the boards’ rights and responsibilities.

As for the local level, the Clair Commission recommended that “the organization of primary-care services be decentralized and integrated in line with a population-based approach” (Quebec, Commission of Study for Health and Social Services 2000: 193). More specifically, it suggested that “primary care institutions be brought under one single authority in a given territory. This should include, within a unified board of directors, one or several CLSCs, one or several CHSLDs and, if applicable, the local hospital” (Quebec, Commission of Study for Health and Social Services 2000: 217). The 2003–04 reform would adopt this recommendation in its entirety, using it as a blueprint for the creation of the new health and social services centres (HSSCs).

The decision-making agenda: The stars are aligned

The debates of the Clair Commission had landed the policy problem on the government agenda, but it had still not reached the decision-making stage. The principal elements that would propel it there consisted of Quebec’s 2002 pre-electoral environment and an influx of ideas from Canada’s west.

Quebec’s 2003 provincial election campaign was dominated by the issue of health care and ideological tussles over the role of the state insofar as health services were concerned. Early in the pre-electoral period, in 2002, the three leading parties had already advanced various proposals where regional governance structures were concerned. The incumbent party, the Parti québécois, advocated keeping the regional boards in their actual form. The Action démocratique du Québec, Quebec’s newest political party, wanted to turn the boards into regional departments with increased powers. The Quebec Liberal Party (PLQ), meanwhile, questioned the representativeness and the accountability of the boards, characterizing them as intermediate structures that failed to provide citizens with direct services, that had no authority to collect taxes, and that lacked regulatory powers (Quebec Liberal Party 2002). Arguing that the boards had been stripped of
their *raison d’être*, the PLQ proposed to abolish them and entrust the coordination of services to the management of local health-care institutions.

The PLQ won the election in April 2003, ousting the Parti québécois and naming Dr. Philippe Couillard, a neurosurgeon, minister of health and social services. Desirous of fulfilling his party’s electoral promises, Couillard turned at once to reforming the health-care system by increasing powers at the local level. This strategy was not long in upsetting actors from different sectors of the health-care network, especially the regional boards.

The minister began by appointing a task force charged with developing an organizational model on which to structure the reform. Based at the ministry, the task force solicited the participation of the regional boards whose abolition it was contemplating. The group was mandated with studying a range of regionalization models from both Canada and abroad and developing background documents on the issue. After an in-depth analysis, Couillard showed great interest in Alberta’s two-tier (provincial/regional) model, which had integrated services to a largely unprecedented degree and had the merit of being closer to home than the international models. Alberta’s program consisted in transferring extensive responsibilities from the local to the regional level, where new regional health authorities were given the mandate to ensure and manage the provision of services. Quebec’s idea was to apply the same principle, but in reverse: in other words, to entrust greater responsibilities to the local level and remove the intermediate tier.

As the task force pursued its deliberations, however, it became apparent that the regional tier had the support of important health-care system actors and was the object of widespread social consensus. Although complaints about the health-care system were rife and the option of keeping the status quo was not particularly popular, strong public and stakeholder support of the province’s long tradition of regionalization quickly made it evident that to abolish the regional level would be more complicated than it had originally seemed. In addition, the sheer size of Alberta’s newly merged institutions, which constituted the cornerstone of its reform, was considered excessive and inappropriate for Quebec. Nonetheless, task force members did not exclude the idea of integration from the range of possible solutions, arguing that it could still take place at the local level.

**The choice of a policy (2003): The middle road**

By the fall of 2003, the task force had agreed on a general outline for the reform, and the project began to move forward rapidly. The task force’s recommendations consisted of creating local service networks that would integrate local establishments on a territorial basis while maintaining regional-level structures, which the task force felt were essential for the good
governance and coordination of the system. This suggestion represented a political compromise. It fulfilled the letter of the Quebec Liberal Party’s campaign promise – the abolition of the regional boards – but not the spirit, as the boards were immediately replaced with new regional-level structures that inherited the boards’ rights and responsibilities.

The cabinet found the compromise difficult to accept. Rather than transforming the regional boards into agencies, it advocated eradicating the regional tier altogether, as the party had promised in its electoral campaign. In the end, however, it agreed to follow minister of health Couillard’s recommendations and retain a regional entity. As the opposition, the Parti québécois, which had once advocated that more services be integrated, now opposed merging local institutions on the grounds that structural changes were superfluous and wasted resources.

Bill 25 was presented to Quebec’s national assembly in November 2003, and a parliamentary commission on the subject was formed at the beginning of December. While most of those who testified before the commission supported the general objectives of the reform, some expressed concern, if not opposition, to the means chosen to apply it, particularly the mergers and other changes to existing institutions (Contandriopoulos et al. 2007). In favour of both the objectives of the reform and the means of implementing it were the two health-care executives’ associations, the Quebec College of Physicians (the Collège des médecins du Québec), and the Quebec Order of Pharmacists (the Ordre des pharmaciens du Québec). The association of CLSCs-CHSLDs, the Association of Quebec Medical Specialists (the Fédération des médecins spécialistes du Québec), the Quebec Federation of General Practitioners (the Fédération des médecins omnipraticiens du Québec), the Quebec Hospital Association (l’Association des hôpitaux du Québec), and the Quebec Medical Association (the Association médicale du Québec) supported the objectives but rejected the means. Lastly, with the exception of the Patients’ Protection Council (the Conseil de protection des malades), which supported the reform, users’ associations, such as community groups, mental health associations, and associations for the handicapped; regional associations; the Coalition solidarité-santé; Quebec’s principal unions, and the Quebec Nurses’ Association (the Fédération des infirmières et infirmiers du Québec) all demanded that the project be abandoned (Quebec, Ministry of Health and Social Services, Direction générale de la planification stratégique de l’évaluation et de la gestion de l’information 2004). In the end, Bill 25 was adopted under the gag rule. It was voted into law in December 2003 (Act Respecting Agencies to Develop Local Networks of Health Services and Social Services [Loi sur les agences de développement de réseaux locaux de services de santé et de services sociaux] [L.R.Q., c. A-8.1]) and implementation of the reform began in January 2004.
Discussion

To analyse the factors that were involved in the 2003–04 policy-making process, we will discuss them through our conceptual framework related to four categories (ideas, interests, institutions and external events) in order to illustrate how those factors played out concretely in the case of this regionalization policy.

The element that sparked the actual reform was unquestionably the change in political parties following the 2003 elections. This event reshuffled the cards and left the health-care system wide open to change. The appointment of a new minister and a new deputy minister of health and social services, both keen on fulfilling their party’s electoral promises, propelled the issue of regionalization to the top of the new government’s agenda.

Because of their long history, however, health regions have become an inescapable reference point in Quebec’s administrative and socio-cultural universe, and politically it proved harder to remove the regional tier than first estimated.

Viewed from a historical perspective, the reports produced over the years by Quebec’s several government-appointed commissions on health care were characterized by a stable and relatively consensual vision of a three-level governance structure. These commission reports were successful in spreading ideas that influenced the reform. These reports and commissions had played a crucial role in the evolution of stakeholders’ thinking about the value and the structure of regionalization and were largely responsible for bringing actors to recognize the periodic need for change. In the 1980s, for example, the Rochon Commission insisted on the need for strong regional entities that would act as democratic instruments of political governance and rescue the health-care system from the monopoly of interest groups. By proposing to grant the regional level significant powers, especially the power to collect taxes, Rochon envisioned the regional boards as the backbone of Quebec’s decision-making system – the main decider and the mediator between provincial and local-level demands. Less than fifteen years later, the Clair Commission recommended another treatment entirely. While it too recognized the value of a regional tier in Quebec’s health-care system, it saw that value as residing in the tier’s technocratic expertise. Clair’s perspective was applied as early as 2001, when Bill 28 reformed the governance structures of health-care establishments by abandoning the democratic election of members of the boards of directors and by clarifying the lines of accountability between various levels of the system. But the 2003–04 reform went a step further by creating health and social services...
agencies invested with much greater managerial powers than their predecessors – further proof of the influence of Alberta’s model.

Even in the face of tremendous tensions and pressures, institutions showed great resilience. The regional entities were able to fight, resist change, and ensure their survival, thus highlighting the difficulty in modifying or even suppressing institutions that often end up surviving the passage of time.

During the election campaign, the three principal political contenders – the Liberal Party, the Action démocratique du Québec and the Parti québécois – had articulated three contrasting visions of health-care system changes: abolition of the regional level, modification of the regional level, and maintenance of the status quo. Each scenario was supported by different interest groups who shared their position on the issue during the parliamentary commission that preceded the adoption of the law. The College of Physicians, for example, endorsed regional agencies, as long as they were more flexible than regional boards and had more decision-making latitude. The Quebec Federation of General Practitioners wanted to retain a regional level but agreed to a revision of its mandate, while the Quebec Medical Specialists questioned the relevance of maintaining regional boards. The unions (the Centrale des syndicats du Québec, Quebec’s principal public-sector union, and the Fédération interprofessionnelle de la santé du Québec) decried any devolution of responsibility from the regional level in favour of the government and demanded retention of regional boards and the maintenance of their responsibilities for the administration and organization of services.

This said, interest groups eventually understood that Bill 25 would go forward despite their objections and accordingly fell back on the implementation phase as the moment to pursue their demands. It was then that special interests affected the reform again and even more strongly during the implementation phase, which began in January 2004. It was at that point that rational and technical arguments gave way to more political manoeuvres. Bill 25 gave the newly created agencies the mandate to negotiate with local actors in order to determine the configuration of the new local service networks, the territorial boundaries of the new HSSCs, and which local institutions would be merged and which spared. Actors from several areas took advantage of this provision to contest mergers and/or use their influence to have their institution dispensed from the integration sought by the law (Contandriopoulos et al. 2007). Thus, the 2003–04 reform underscored the fact that not all regionalization models were compatible with the interests of the entities affected, whose different stances made wholesale changes
to governance structures more complex than had been originally anticipated. Meanwhile, the strong influence of the interests behind some of those proposed models is demonstrated by the fact that an electoral defeat did not cause the proposals of the defeated parties to be abandoned. In other words, opponents of the PLQ project may have failed to prevent the creation of the HSSCs, but they succeeded in retaining a regional structure.

In other words, the regional tier survived, but in a new form: stronger from a managerial and technocratic point of view but politically and democratically weakened

Regarding the impact of institutions, this factor was especially strong when the new service organization model was conceived and developed. In some ways, the 2003–04 reform can be interpreted as the outcome of a struggle between a government administration that was attempting to restructure an institution (Quebec’s regional health-care entities) and the institution itself, which resisted restructuring. To understand this dynamic, we must look to Quebec’s long history of regionalization, a history that has left the regional tier firmly institutionalized within Quebec’s administrative system. Quebec’s administrative regions have long constituted the principal seats of public administration in spheres such as education, justice, and the environment, and it was partly for this reason that, when health and social service regions were first created, their contours roughly followed the existing administrative lines. It is true that the contours in question are somewhat artificial: the territory they cover varies tremendously, as does the population (11,000 residents in the northern part of the province versus 1,900,000 in Montreal). Because of their long history, however, health regions have become an inescapable reference point in Quebec’s administrative and socio-cultural universe, and politically it proved harder to remove the regional tier than first estimated. This was not necessarily the case for local-level changes. The 2003–04 reform mandated the creation of ninety-five local territories but left local actors free to determine the boundaries of those territories on their own. While some replicated the boundaries of the old CLSCs, others responded opportunistically by drawing new boundaries that were more reflective of the desire to take advantage of service consumption patterns than to respect the natural socio-political identities of local communities.

Quebec has traditionally regrouped health matters and social services matters under the same ministry and within the same local structures. Forty years of living with a system wherein health services and social services were integrated along regional lines had left Quebecers used to a three-tiered system. The regional tier had become a frame of reference if not an ideology that had survived the passage of time. This fundamental trait of state administration constitutes a policy legacy that curtailed the province’s
leeway to innovate and ultimately steered the reform along existing lines. It is true that Bill 25 modified the responsibilities of the different levels and, in doing so, changed the power relations between them. But by retaining all three levels, each with its own board of directors and, by extension, its own autonomy, these reforms – originally intended to effect wide-reaching change – actually legitimized regionalization, the very level of the healthcare system, and the very mode of organization, it had intended to eliminate.

Conclusion: between one step forward and one step back

Our analysis shows how different factors can converge to craft a reform process. In Quebec, buy-in for reforms is often secured by using commissions of inquiry as vehicles to spread new ideas (Pomey and Martin, forthcoming) that often jump from one report to another, as shown here. But above all, among all the different variables that were analysed to understand how decisions regarding the regional tier of governance in Quebec’s health-care system were made, the institutions in place certainly played the central role, surpassing the role of interest and indeed of the other categories of factors as well. Even in the face of tremendous tensions and pressures, institutions showed great resilience. The regional entities were able to fight, resist change, and ensure their survival, thus highlighting the difficulty in modifying or even suppressing institutions that often end up surviving the passage of time. Further research might establish whether this factor was as crucial in the context of other regionalization initiatives.

From the viewpoint of local governance, there can be no doubt that the reform of 2003–04 is a step forward. If nothing else, the new HSSCs, with the help of a network of partners, have real potential to integrate services. Both Rochon’s and Couillard’s reforms share similarities in the sense that they intended to introduce a greater coherence between the various tiers of governance within the health-care system. From a historical perspective, however, the reform is a step back, a rupture with the political and democratic model of regionalization developed and advocated by Jean Rochon in the 1980s. During Rochon’s time, the aim was to stimulate a veritable regional phenomenon structured around the establishment of strong regional entities that would reflect the socio-cultural conditions of their populations and that would organize care and services accordingly. So even though Dr. Couillard’s reform of the regional level was less drastic than planned, the significant transfer of powers from the regional to the local level still meant that regionalization suffered a blow. The regional agencies conserved the regional boards’ management authority but the mandate to plan, organize and integrate services was transferred to the HSSCs. In exchange, the agencies were given new tasks that were more technocratic in nature: increased powers
over the allocation of resources and the supervision of management and accountability agreements. In other words, the regional tier survived, but in a new form: stronger from a managerial and technocratic point of view but politically and democratically weakened. It is for this reason that we can assert that behind the decentralization towards the local level lay the ministry’s hidden desire to retain central control over Quebec’s health-care system. This can be demonstrated by the managerial authority the ministry invested in the agencies and its creation of clear lines of accountability. In contrast to the 1991 reform that created the regional boards, the intention behind the changes in 2003–04 was more to decentralize and integrate at the local level rather than to pursue the delegation initiated at the regional level. In this sense, the reform indicates an approach to health-care issues that is more oriented towards technocracy than towards democracy, as Rochon had once envisioned. The very choice of term for the new entity suggests the centralization of power: whereas boards had autonomy and mandated powers, the new agencies are state agents answerable for increased accountability and efficiency.

The question of goals and intentions aside, our analysis of the reform also highlights the importance of paying close attention to the context in which changes occur and the necessity of giving actors sufficient leeway in the planning phase. It is also a valuable example of the relatively rapid introduction of a major change to a health and social services network. Much of the rapidity and the extent of the change can be explained by the fact that the process was personally chaperoned by a minister who demonstrated sustained political leadership. Couillard was no doubt helped by his status as a doctor, which gave him credibility within the health system. But he also took advantage of the post-election grace period to position himself forcefully from the very beginning of his mandate, a strategy in which he was assisted by the expertise of the ministry, particularly the deputy minister and his team. Couillard showed further political adeptness when he secured the support of the regional boards by offering them new legitimacy – and a chance to thwart extinction.

Current governance reforms are undergoing a transformation away from regionalization and towards integration. Future research may wish to consider whether this trend can be conceptualized to the same extent as the wave of regionalization has been. In the context of either kind of reform, however, if the 2003–04 period has a final lesson, it is the necessity for reform efforts to accept compromise in order to avoid sabotage and to push change as far as possible in light of the circumstances and the opposition. The reform studied here took place because it was politically feasible, it matched dominant values and ideas, and it minimized resistance. It is now, with its structures in place, however, that stakeholders have to prove that the changes it mandated really can improve public health care in Quebec.

A little more than five years after the execution of this reform, Quebec (and indeed the world) is experiencing a difficult economic period, and once
again, the political debate is dominated by the quest for efficiency and better performance in all the state’s spheres of activity. The latest budget, submitted by the minister of finance in March 2010, indicates that the government will balance Quebec’s budget by merging or abolishing public entities and reducing the administrative spending of ministries across the board (Quebec, Ministry of Finance 2010a). The governance of the health and social services network will also be thoroughly re-evaluated and structures presumably re-grouped to boost performance and make activities more efficient (Quebec, Ministry of Finance 2010b). Few would argue that regional health and social services agencies can escape their share of this spotlight. But whether the agencies will once again find a way to survive remains to be seen.

Notes

1 Decentralization is commonly defined as “an increase in the responsibilities and autonomy of peripheral actors vis-à-vis the centre” (Polton 2004: 267, our translation). Three key dimensions capture the essence of decentralization: the level at which it takes place (local, regional or national); the sphere in which it occurs (what functions are affected), and the type of decentralization involved (the kinds of governance practices affected).

2 Ever since the inception of regional boards at the turn of the 1990s, Quebec has been organized into eighteen health and social services regions. Three of those regions (Nunavik, Baie-James and Nord-du-Quebec) assume responsibility for aboriginal populations and were exempt from the modifications legislated by Bill 25. A total of fifteen regional boards were therefore transformed into agencies, and the Centre régional de santé et de services sociaux de la Baie-James, the Régie régionale de la santé et des services sociaux du Nunavik and the Conseil Cri de la santé et des services sociaux de la Baie-James retained their original status.

3 Local networks are allowed to exclude hospital centres if there is no such centre in their territory or if integrating or regrouping the services of such a centre would be excessively complex. In this case, the local network must execute a service agreement with a hospital centre in order to ensure that the population has access to hospital services.

4 In Quebec, ninety-five HSSCs, which are local-level institutions, are responsible for organizing health and social services in their territory. Half of the HSSCs assume responsibility for the management of frontline and primary-care services. However, forty-seven of them have integrated a hospital and thus also assume responsibility for specialized services, given that the hospital doesn’t have a university designation.

5 The Clair Commission’s synthesis of its public hearings stated that “virtually no group visualizes a system devoid of regional-level coordination . . . . Regional-level institutions are considered indispensable” (Quebec, Commission of Study for Health and Social Services 2000: 262). The document also reported that the public had asked “that we continue with decentralization, given that there is general consensus about keeping all three decision-making tiers” (290).

6 More specifically, Bill 28 abolished the election of members of the boards of directors of the regional boards, providing instead for members’ appointment by the ministry on the basis of their management skills and experience in the health-care sector. It also redefined the composition of the boards of directors of local institutions, while retaining the election of some members. Finally, it enacted measures to reinforce the accountability of the regional boards. For instance, it created the position of CEO and it established performance contracts and management and accountability agreements.

7 We refer to the Quebec Association of Senior Health and Social Services Managers (l’Association des cadres supérieurs de la santé et des services sociaux) and to the Quebec
The Coalition solidarité-santé is a coalition of forty-six provincial and regional labour unions, community groups, religious organizations, women’s groups, and associations of the elderly, the disabled, and family caregivers.

These entities principally objected to the merger of establishments with different missions and philosophies, fearing that such mergers would result in the dominance of a hospital-type approach that would compromise traditional frontline care. Responding to these concerns expressed during the parliamentary commission, lawmakers modified Bill 25 so as to allow HSSCs to exclude a hospital centre in their local network if doing so would be excessively complex. The bill also allowed HSSCs to exclude institutions that offer special services to linguistic minorities.

In general, the territories of Quebec’s eighteen health and social services regions overlap the territories of its seventeen administration regions. This said, the Ministry of Health and Social Services merged two administrative regions (Region 04-Mauricie, and Region 17-Centre-du-Québec) into a single health and social services region (Region 04-Mauricie et Centre-du-Québec). The administrative region with the largest land area (Region 10-Nord-du-Québec, with over 718,000 square kilometers) was divided into three smaller health and social services regions (Region 10-Nord-du-Québec; Region 17-Nunavik; and Region 18-Terres-cries-de-la-Baie-James).

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