Infoletter

The evolution of health-system management and evaluation practices

GETOS Chair CHSRF/CIHR on Governance and transformation of health care organizations

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The territorial approach to improving population health: what is the role of the CSSS?

Initiatives for improving a population's health and well-being don't necessarily correspond to the territorial boundaries of a CSSS, and they aren't all understood by CSSSs in the same way. What happens in such situations? What aspects need to be considered when constructing social relationships aimed at improving a population's living conditions? Two of the articles in this issue each present a different experience of the integrated territorial approach and of the role played by CSSSs and their territorial partners in supporting and organizing this type of action.

In the *Thema* section, Gérard Divay and Yousef Slimani present the Integrated Urban Revitalization (IUR) program, a territorial approach for the Montreal region that is aimed at combating poverty and includes a social development dimension. They describe some of the ways in which CSSSs can contribute to these types of processes.

In *Point of View*, Jacques Couillard describes the experience of the CSSS Sud de Lanaudière and discusses the issues that the CSSS must tackle if its interventions are to have a greater impact on population health.

Finally, to round out this issue, Roxane Borgès Da Silva presents the results of her doctoral thesis on the relationships among general practitioners' practice settings according to their geographical environment and the provision of healthcare services.

The Infoletter says good-bye

After 19 issues, the *Infoletter* is coming to an end. This edition of the *Infoletter on the Evolution of Health System Management and Evaluation Practices* is the final one to be published by the Chair on Governance and Transformation of Health Care Organizations. The Chair's activities will end, at least in their current form, as of June 30, after ten years of operation.

The GETOS Chair was created in July 2000 thanks to the CADRE program, a partnership between the Canadian Health Services Research Foundation (CHSRF) and the Canadian Institutes for Health Research (CIHR) aimed at increasing the capacity of applied research in health care services and nursing. This program created 12 Chairs in Canada, each with a maximum term of ten years of funding; six of these Chairs were in the field of health care organization. The *Fonds de la recherche en santé du Québec* (FRSQ) also provides funding within the framework of this program. We offer our sincere thanks to these organizations for their generous support.

Finally, we would like to thank all our colleagues who have contributed to the *Infoletter* over the past seven years, sharing their analyses, their perspectives and their experience. Thanks go, as well, to our readers for their continued interest in our publication.

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The medical practice of general practitioners: the influence of organizational and geographical environments

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The reorganization of primary care services is central to all healthcare reforms in Quebec, as it is in many countries. Implementation of these reforms requires a thorough understanding of the practice of general practitioners. Yet, there are almost no studies in the literature that analyze physicians' provision of health services while taking into account their many organizational affiliations, even though many authors insist that organizational affiliation influences

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Thema

Integrated urban revitalization: bringing healthcare back to health?

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Integrated urban revitalization (IUR) is an urban variant of the integrated territorial approach promoted in the *Government Action Plan to Combat Poverty and Social Exclusion.*

"This [approach] entails having all stakeholders work together, intervening in various sectors in a way that places the focus on improving the living conditions of community members, and empowering both communities and the individuals that compose them. It is an approach that enhances the synergy between local economic development and social development and better coordinates the various sector-based strategies aimed at improving living conditions in underprivileged areas" (p. 69)[1].

In 2003, the City of Montreal, in the context of an agreement with the MESS, launched a pilot project in three neighbourhoods. The project was expanded to include five more neighbourhoods in 2006. In its official presentation,

"IUR entails …

- Adopting a comprehensive and shared vision of the situations of the districts and neighbourhoods concerned;
- Taking integrated action in multiple domains (housing, built environment, health, employment, culture, recreation, environment) according to the realities of each neighbourhood;
- Concentrating, coordinating and adapting public, community, and private actions;
- Involving people from the targeted areas in planning, implementing and monitoring the interventions;
- Acting upon the factors that engender poverty so as to produce sustainable change"[2].

Given its aim of improving all the living conditions of people residing in underprivileged areas, IUR is necessarily interested in all the determinants of health. Thus, the aim of IUR and the mission of the CSSSs intersect. From this standpoint, IUR projects provide an interesting ground in which to observe the connections between a process of holistically focused sectoral action (the population-based responsibility of CSSSs) and a process of holistic community action with sectoral consequences (IUR).

This note offers several commentaries on these connections, based on the results of a study done in 2009 to evaluate five IUR projects. This study, sponsored by the partner agencies that funded the IUR projects, specifically looked at IUR implementation processes. Even though the connections with CSSSs were not specifically part of the evaluation objectives, certain observations made in the five experiences allow us to explore this issue. After briefly positioning the five projects geographically and institutionally, we will describe the contribution of the CSSSs; then we will examine certain aspects of their connections, paying particular attention here to issues raised by interventions that are situated within an institutional environment that is fragmented on different spatial levels.

The IUR projects

Territory

The five IUR projects studied were in areas that varied in size, in terms of both land area and population (see table 1). Their defining boundaries and their urban features (types of building, road infrastructure) are more or less pronounced. These areas are located at different distances from the city centre, and therefore the pressures on their real estate markets are quite varied.

Funding

As shown in table 2, the funds allocated annually since the beginning of the experience are between $100,000 and $200,000 per IUR district and come primarily from the City of Montreal. These funding envelopes allocated to each district do not, however, leave much room for projects after the consultation and mobilization expenses (basically, the salary of a coordinator and possibly a development officer) are covered. Carrying out these projects often requires a combination of various sources of funding. It should be noted that these amounts represent only a tiny fraction of all the public funds spent in these areas.

1. Québec (2004). *Government Action Plan to Combat Poverty and Social Exclusion*, p. 69.

2. Montréal. Social development. Urban revitalization. http://ville.montreal.qc.ca/portal/page?_pageid=2239,2891961&_dad=portal&_schema=PORTAL (consulted April 15, 2010; page in French only)

Table 1. Territories and populations of the five IUR areas

	Operation Galt	Saint-Pierre	Sainte-Marie	Saint-Michel	Montreal North
Territory	Galt district	Former Ville Saint-Pierre	Sainte-Marie District	Saint-Michel District	North-east District
Popul.[3] (residents)	3,400	4,700	20,600	53,610	14,000
CSSS	Sud-Ouest / Verdun	Lachine / Dorval / Lasalle	Jeanne Mance	Saint-Léonard / Saint Michel	Ahuntsic / Montréal-Nord
Population (2004)	129,580	131,850	136,545	123,180	161,480
Shared characteristic	All are underprivileged districts				

Institutional characteristics

Each IUR project was required to set up a "local revitalization committee". These committees have evolved and present differences in terms of their status, their organization and their links with institutions. Three of the five IUR committees were constituted as non-profit organizations. The other two report to their district's community coordinating committee as either a subcommittee or a working group. Moreover, the committees share, to a more or less marked degree, one characteristic: autonomy with respect to the district's public institutions.

The institutional evolution of the IUR committees also reflects the diversity of their settings. The five experiences demonstrate, in fact, that historical relationships among local stakeholders condition their dynamics and their effectiveness.

Table 2. Main sources of funding for IUR projects between 2003 and 2008.

Project / source of funding	City budget	Poverty contact	Urban Renewal Program	Total
St-Pierre	$886,799	$177,084	$100,000	$1,163,883
Galt	$886,799	$177,084	$100,000	$1,163,883
Ste-Marie	$886,799	$177 084	$100,000	$1,163,883
Montreal-North	$333,414	$143,750	$100,000	$577,164
St-Michel	$333,414	$143,750	$100,000	$577,164
Total	$3,327,225	$818,752	$500,000	$4,645,977

Source: special compilation. Social Development. City of Montreal.

Observations on the processes

The results of the process evaluation show that the mandates assigned to the IUR districts were achieved at different levels of intensity. The five local committees that were created were comprised, in varying proportions, of different types of stakeholders from the public sector (city, schools, CSSSs, CLEs), community groups, and the private sector. These committees produced local revitalization plans. Local stakeholders were mobilized, with uneven results depending upon the type of stakeholder. The "integrated organization and management model" experiment was conditioned by the ambiguity of the concept of integration, often perceived as being synonymous with a collaboratively developed plan. Moreover, on the whole, the activities of the public organizations were not necessarily inspired by IUR.

CSSSs in the IUR projects

Presence on the committees

CSSSs were represented in all five processes. With the boroughs, they were one of the pillars of institutional representation in the IUR processes. Thus, among the 29 public sector representatives, eight came from the health sector. CSSS repre-

3. Some data are taken from the 2006 census and others from that of 2001.

Even though the IUR projects were launched and sustained by public organizations at different levels, they did not follow the classical model of public intervention where the objectives, resources and means remain under the direct control of a public authority.

sentation on IUR committees or subcommittees involved not only executive directors but also community organizers. The members of local revitalization committees considered that the CSSSs exhibited moderate to elevated levels of mobilization. They also appreciated the CSSSs' good understanding of the process and the attention given to its activities and projects.

Health themes in the plans

The five IUR plans accorded different priorities to health-related themes. While health objectives were sometimes expressed in very vague terms—"general health of the population", "determinants of health"—it is worth noting that, nevertheless, four of the five processes were concerned about the issue of food security, and particularly about access to good-quality fresh foods (fruits and vegetables) and the promotion of healthy nutritional habits. The other IUR process concentrated its health-related activities on projects that focused on the family.

Conditions for viability and success factors for IUR projects

Even though the IUR projects were launched and sustained by public organizations at different levels, they did not follow the classical model of public intervention where the objectives, resources and means remain under the direct control of a public authority. They tested a model of collective action in which all the stakeholders—and in particular, the citizens—in a local community are called upon (mobilized) to reinvest (through words and actions) in the district at all levels, both in their individual activities and in the context of shared projects. This holistic collective action, which is targeted at very broad objectives related to all of a district's characteristics, is also expressed in concrete sectoral initiatives. It inevitably raises concerns among sectoral agencies, and probably more so, those whose mission endows them with a holistic purpose (CSSSs, boroughs, and to a lesser extent, schools). This produces tensions that affect both the conditions for viability and the success factors for IUR projects.

Notwithstanding the diversity of the five experiences, we can derive from the general observations certain conditions for viability related to the projects' resources, to their status and strategic approach, and to the administrative culture of the participating public organizations.

The *resources* made available to the projects need to be substantial and reliable over the medium term; however, the CSSSs tended to provide resources sporadically.

IUR projects can only succeed if they have the status of a long term partnership agreement, even if this agreement is not formalized; from this, it should follow that the public partner organizations should accept the IUR committees as the preferred agents for community consultation and should consider themselves to be linked by collectively defined orientations, particularly when it comes to sectoral decisions about priorities. In practice, however, the tendency to hold window-dressing consultations and to minimize community priorities persists, despite IUR consultation.

The multipartite project steering committees for the IUR projects need to maintain a *strategic attitude* of proactive neutrality; they should not be subservient to any of the partners, since they are, in a way, the guardians of the collective qualities of the district and not the executors of sectoral programs. They cannot maintain this strategic attitude if one or another of the public participants shows any sign of wanting to take control or is not at ease practising collaborative leadership.

Even more fundamentally, the IUR experiences are of concern to certain elements of the dominant *administrative culture* of public organizations because of the paradoxical nature of their existence itself. In the usual categories of administrative action, these are "projects" (limited duration, specific resources…) whose purpose is to influence ongoing "processes" of community transformation whose tangible effects are seen over the medium and long terms. Yet societal processes do not happen only by means of micro projects, even though from a certain conception of performance, these are appealing. IUR requires us to reconsider one of the major functions of the State. Aside from its functions of regulation, redistribution and provision of public services, the State should ensure that the public conditions needed to support individual and collective development are maintained and improved throughout the territory. This latter function has tended to be overlooked on government agendas, obscured by the provision of many different services. IUR forces the State to refocus on the condition of the environment, which should, in principle, satisfy all those who are concerned about taking effective action on the determinants of health.

However, beyond their common situation of being underprivileged areas, the environments in which the IUR projects unfold differ greatly in many respects. In addition, none of them corresponds fully to the geographical boundaries of a CSSS. Under these circumstances, how can a CSSS's efforts to mobilize all the actors in its administrative area be aligned with the intensive mobilization of an IUR project on a fraction (sometimes quite small) of this area?

The territorialization of a delocalized community action

As the evaluation did not address this question, the reports only allow us to

make incidental comments. From the standpoint of population-based responsibility, a CSSS's strategy for action in a given area should address issues on various levels: acquiring better knowledge about local conditions related to determinants of health; stimulating investments that will get stakeholders involved in making changes to each of these determinants; optimizing the effectiveness of these interventions (particularly in prevention); maximizing the connections between people and the resources appropriate to their needs. Mobilization around each of these issues is challenging for the CSSSs. At the knowledge level, there needs to be dialogue between the various field-experts (people who have experiential knowledge of the issues and the determinants). At the action level, health must be introduced as one of the routine factors in decision-making. At the prevention level, they need to identify the people and groups that can serve as "amplifying" intermediaries. Finally, at the level of connections, they need to increase the numbers of people doing one-on-one encounters (individuals or groups who can meet individually with people in need). These challenges must be met in order to activate personal responsibility for health (in every person, business, group, and institution).

However, every initiative undertaken by a CSSS to confront these challenges is likely to create problems not only for the CSSS but also for the community. The logic of sectoral organizational intervention (its purpose, motivations, and program theory) can be reconciled with that of the community's (*milieu*'s[4]) self-management of its living conditions, but most often by way of compromise and mutual accommodation rather than by spontaneous convergence. With regard to knowledge, if the CSSS tries to bring together everyone's shared perceptions of objective data on the conditions and determinants of health, the local community action system will make more of an effort to set up a collective intelligence network. With regard to action, the CSSS will obviously want stakeholders to invest in health-related programs with the fastest impacts, while the local community action system will want health initiatives to be subject to collectively determined public priorities. In terms of prevention, the intermediary stakeholders will try to preserve their autonomy while still contributing to the CSSS's mandates. Finally, in terms of connections, if the CSSS is expected to establish a balance between a general awareness campaign and a strategy of individual screening via the local community action system's stakeholders, these stakeholders will expect their connection with the CSSS to be an asset in their representations and policy positioning.

Are these tensions intensified by the discrepancies between the broad administrative areas of the CSSSs and the IUR projects' areas that are sometimes quite small? Certainly, devoting particular attention to small areas puts pressure on resource utilization. However, beyond this issue of resources, the treatment of IUR areas is only problematic, as singularl and potentially non-standard cases, when there is a geo-administrative conception of local action. The IUR experiences demonstrate that local interventions are part of a system of collective action that involves all the stakeholders who have an influence on a community's fate, whether or not these stakeholders are "local". This system is largely delocalized, both in its normative aspects and its stakeholder configuration. Every territory, and every place where there is collective action, is positioned from the start on various levels. IUR projects provide an opportunity to learn about taking action at multiple levels in many areas simultaneously; in short, it is a simple case of collective action in a complex system.

It is from this perspective that the satirical title of this brief note should be understood… ◈

4. A term (in French) that is both commonly used and misleading as to the existence of one local community actor; our analyses led us to replace this with the term "local community action system", which is more concerned about institutional sluggishness and socio-political tensions, but much less practical…

Point of View

Potential pathways for linking intersectoral intervention with the mission of the CSSSs

***Jacques Couillard**, Director of general public health programs and services and of community development, CSSS du Sud de Lanaudière*

Collaboration among various partners on intersectoral interventions, such as integrated urban revitalization, appears to be a very promising means of acting upon the determinants of health, as well as of giving a sense of power to those involved, who see this collective action as offering them the opportunity to "make a difference". For a health and social services centre (CSSS), this type of intervention can provide an environment in which innovation becomes possible, allowing the institution to step outside the rule-bound environment in which it is increasingly embedded.

The current dynamics of a CSSS

The young CSSS du Sud de Launadière, with its five years of history, 3500 employees and modern hospital, is currently under very strong pressures: a large portion of its population is aging, while at the same time, many young families are moving into the area and seeking services. Long wait times for home care, emergency room overcrowding, too many young parents unable to find a family doctor for their newborn children—these are some indicators, among others, that have the CSSS's management team on high alert.

In this situation, balancing the budget becomes a struggle, given that it takes time to redistribute resources equitably across Quebec's regions. To maintain its service offering, every institution must set productivity objectives for sustaining and improving clinical performance based on the best productivity ratios achieved by comparable institutions. Like all CSSSs in Quebec, it has to implement Ministry programs, provide regular reports on, among other things, its management and accountability contracts, and meet the quality standards of various evaluation bodies. When preoccupied with these constraints or this situation, the CSSSs may neglect, or not adequately recognize, the potential of intersectoral collaboration.

Communities in evolution

The Sud de Lanaudière territory, located on the outskirts of Montreal, and with a population of around 265,000, enjoys the particular distinction of undergoing the fastest population growth in Quebec. The mushrooming areas that can be seen in the foreground hide an enormous territory consisting of two regional county municipalities (MRC - *municipalités régionales de comté)*, each of which has cities and towns with their own dynamics and histories.

Collaborative sectoral and intersectoral activities have increased considerably in both MRCs over recent years, leading those most involved in them to reassess how things are done. In each MRC, various partners—community organizations, cities, offices of MNAs (Members of the National Assembly), school boards, day care centres, CSSSs, and others—with the help of community organizers from the CSSS, have undertaken a structured process of reflection that has led them to propose a revival of collaborative practices and to become better equipped.

In each MRC, a more comprehensive and intersectoral collaborative environment is emerging. As the process continues, there is also the question of who the partners will be (those already involved in the process and those further removed from it, such as chambers of commerce or social clubs). Likewise, those currently involved in the process are seeking to obtain resources to ensure this initiative can be sustained. They would like to see the process opened up to include more citizen participation. Finally, even though the MRC is the designated territory for broad-based collaboration, experiments of integrated urban revitalization or organized territorial activities have, up to now, been carried out in smaller territories, among socially underprivileged communities. The selected sub-territory, the "lived territory", needs to offer a certain amount of potential so that the actors will be able to experience some successes.

What role can the CSSS really play?

The last health care reform saw the birth of the CSSSs and the emergence of new concepts, not always easily definable, such as the local services network and population-focused responsibility. Moreover, the CSSS has been designated the coordinator of the local network, within which it is charged with the task of mobilizing stakeholders in the territory to improve the population's health and well-being. Yet the CSSS has, to all practical purposes, been left to its own devices when it comes to actualizing this role, possessing few levers for carrying it out and no dedicated funding. Ministry decisions in recent years have even tended to push the CSSS further away from this role. One such decision is the designation of a medical coordinator for the local network who does not report to the CSSS. Another is the creation of management organizations set up with private funding (Chagnon Foundation) which turn out to be parallel, independent structures whose role is also to mobilize partners around targeted issues such as healthy lifestyle promotion or child development. In this situation, the local network coordinator role that the CSSS should assume is dependent on the good will of the stakeholders, who either accept, or not, to legitimize it in that role.

In addition, various factors such as the extent to which CSSS workers are motivated to carry out health programs, staff shortages and team instability, the value placed on the role of specialized experts, improve-

ments in productivity and in the ability to respect a variety of standards, all leave little room for these workers to become significantly and sustainably involved with other partners in the community.

In this situation, some questions remain: How to involve workers and managers in intersectoral action? How to make sure that action priorities arising out of intersectoral collaboration converge with the priorities currently in place in the CSSS?

Looking for pathways

The CSSS Sud de Lanaudière created five new clinical departments when its new organizational structure was set up, less than a year ago. Currently on the agenda is an internal review of the Centre's services, including those that complement services provided by partners. This time, during which each department is redefining or reaffirming its areas of practice and competency, is proving useful for listening, exchanging ideas, and gaining a better understanding of each other's experience. For the partners, this environment that has been created for discussion allows them to focus on current and past successes, as a basis for developing a positive vision of the future.

It is particularly instructive to observe representatives of the CSSS describing to partners the significant problems experienced by young people in difficulty and their families with regard to accessing services, and to realize at the same time that these partners are also, in some way, dealing with the same situations. For example, the rapid rise in the number of young families is forcing municipalities to adapt accordingly, school boards to review their plans for school services, and community organizations to deal with an over-abundance of clients. Meanwhile, the chambers of commerce want to ensure that delays in service development will not slow down economic development.

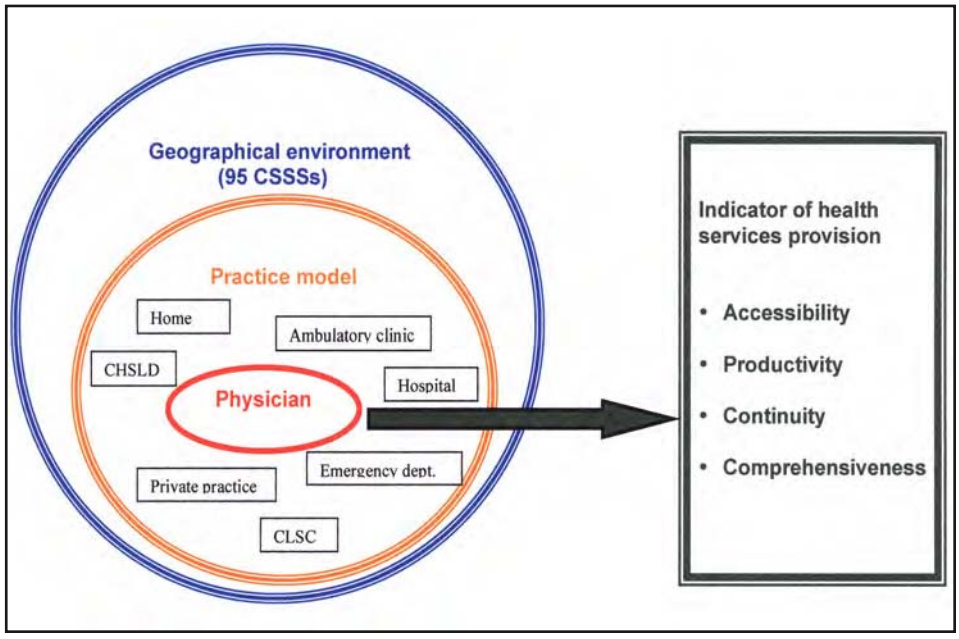
The collective acknowledgement of problems encourages awareness and promotes mobilization. Might it then be possible to define collective priorities and to identify areas of action that are both large enough to effect social change and specific enough to mobilize partners, who are lacking in resources and caught up in the need to respond every day to people's immediate needs? Perhaps the partners will see this as an opportunity to assume their power to act, by investing in this new public environment that is provided by intersectoral action. First, however, they will need to gather the momentum needed to break free of longstanding habits and even widen the circle to include citizens, who are, after all, fundamentally intersectoral! ◈

The medical practice of general practitioners: the influence of organizational and geographical environments

(continuation of page 1)

physician practice (Eisenberg, 2002). In this study, we examined the relationships among the practice settings of general practitioners in Quebec according to their geographical environment and the provision of healthcare services. Based on Donabedian's theoretical framework (Donabedian, 1973), we have broken down the determinants of health services provision into three levels: the individual level (physician), the organizational level (practice model), and the environmental level (geographical environment) (Figure 1). To take into account the complexity of organizational phenomena, we based ourselves on organizational theory and used a configurational approach (Rouleau, 2007; Meyer et al., 1993). Thus, general practitioners were grouped according to their professional practice settings and their provision of health services was analyzed in relation to their geographical environment.

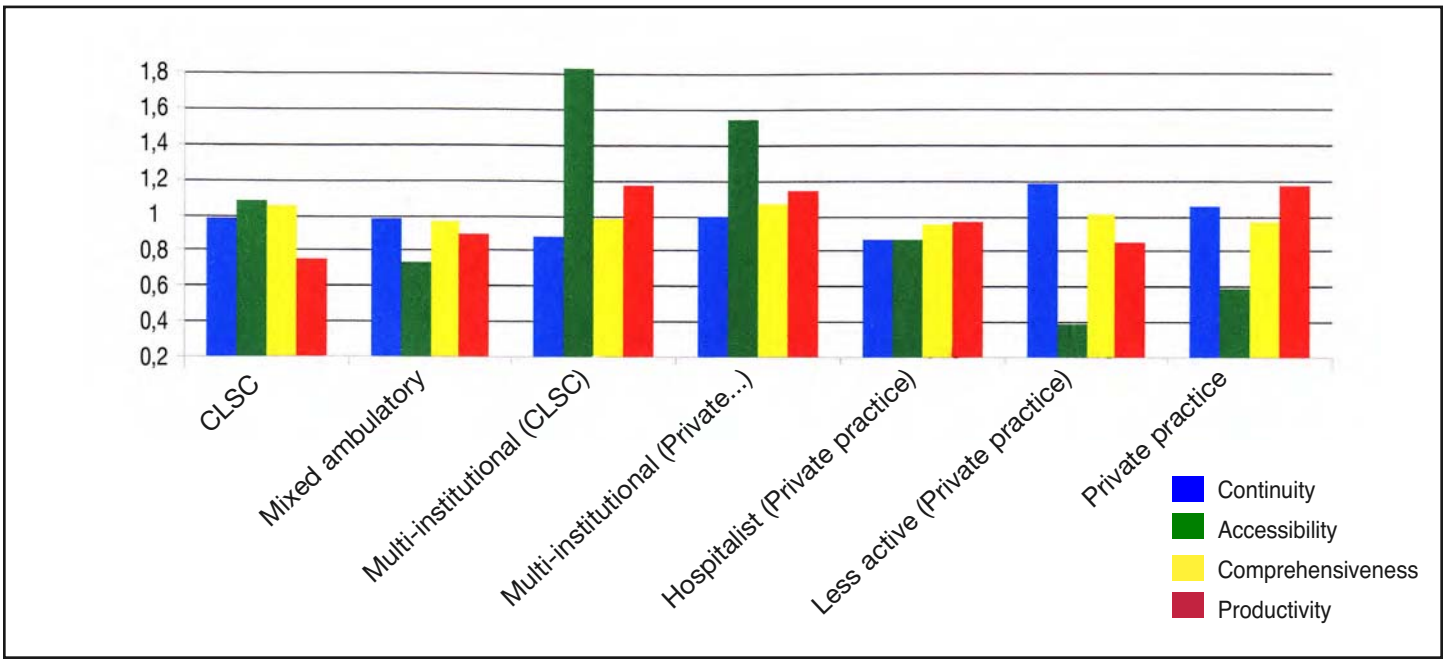
Figure 1. Conceptual framework



Method

We used a merged database from the *Collège des médecins du Québec* and the *Régie d'assurance maladie du Québec*, as well as the ICLSC database. After applying the exclusion criteria, our sample was comprised of 70% of the general practitioners from the year 2002. We used multiple correspondence analysis and ascendant hierarchical classifications to construct the two taxonomies. The first one covers the physicians and was produced

Figure 2. The seven practice model profiles and their provision of health services



using their revenues in the different practice settings. The second one covers the 95 CSSS territories in their geographical environments and was produced using population density, level of deprivation (Pampalon, 2000) and the number of health care facilities available on the territory. Based on Starfield's theoretical framework, we conceptualized the provision of health services using four indicators to assess continuity, comprehensiveness, accessibility and productivity (Starfield, 1998). These indicators were validated by comparing them with those of a population survey (Pineault et al, 2008).

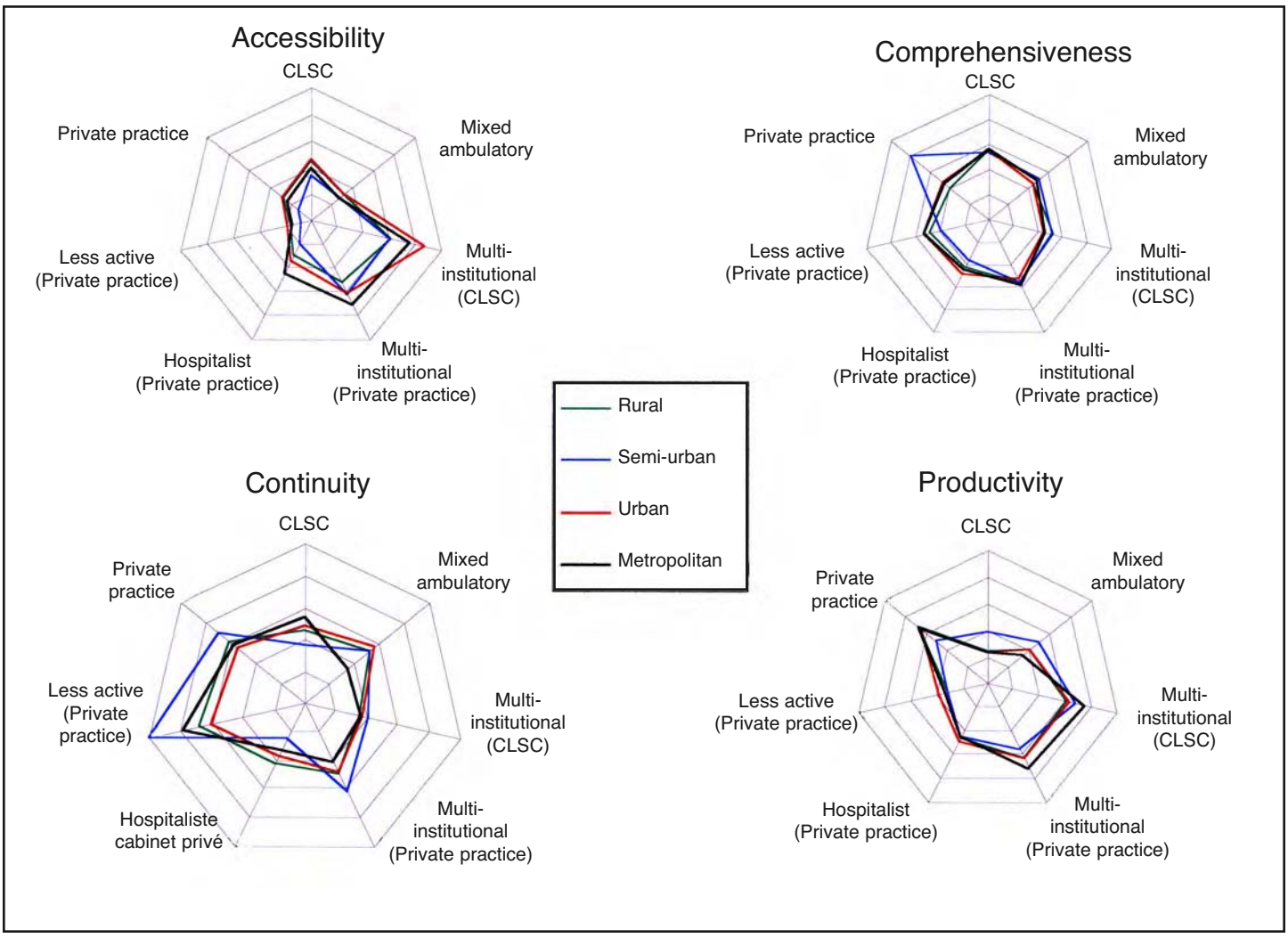
Results

The physicians were distributed into seven practice model profiles (Figure 2). Two single-location practice models emerged: the private practice model (last bars on the right, Figure 2), characterized by high levels of continuity and productivity, and the CLSC-practice model (first bars on the left, Figure 2), which exhibited a low level of productivity and levels of comprehensiveness and accessibility that were slightly above the average. In the five other practice models, the physicians provided services in several professional settings. The mixed ambulatory practice model is comprised of physicians who divide their practice among a CLSC, a private practice, and a CHSLD (long-term care). These physicians show poor results on all the indicators when compared against other practice models. The two multi-institutional models—the multi-institutional CLSC model and the multi-institutional private practice model—include physicians who divide their time among emergency rooms, hospitals and private practice or CLSC. Physicians in these two groups showed very high levels of accessibility and productivity. The hospitalist practice model is made up of physicians who spend the majority of their time in the hospital setting, with a small portion of time devoted to private practice. In this practice model, all the indicators are weak. Finally, the practice model called the less active is comprised of physicians working in private practice and in CHSLDs. Their level of activity is below the average. They are characterized by a very high level of continuity.

Based on our analyses, the CSSS territories were divided into four types of geographical environments: rural, semi-urban, urban and metropolitan. The prevalence of practice models varied according to these environments (Figure 3). In rural settings, the multi-institutional private practice model attracted nearly one-third of the physicians. In semi-urban settings, physicians were much more often found to be in CLSC-dominated practice models. In urban settings, the less active and hospitalist practice models attracted nearly 40% of the physicians. The general practitioners were distributed nearly equally among the other practice models. Indicator levels varied according to the geographical environment. Thus, accessibility is higher, and conversely, productivity is lower in rural settings. Continuity of care is higher in metropolitan and rural areas. Comprehensiveness shows almost no variation from one environment to another.

Some practice models (hospitalist, mixed ambulatory and the two multi-institutional models) that could be considered emergent attract more young physicians. The less active practice model and the private practice single-location model are characterized by their high numbers of older physicians. This distribution of physicians by age is worrisome, as these models may eventually be forced to disappear. Yet these models seem to respond better to the needs of the population than do the emergent models, at least according to our indicators.

Figure 3. The seven practice models and their provision of health services by regional groupings



Conclusion

In conclusion, our study shows that physicians' provision of health services depends on both the geographical environment and the practice model. Depending on the health needs of the populations in the regions, we must ask ourselves what practice models should be encouraged to ensure a balance among service accessibility, continuity, comprehensiveness and productivity. Depending on the environments, different combinations of practice models make it possible to attain good levels in the four indicators of provision of health services in a given territory, for a given population. Thus, when developing a medical manpower plan, it is important to take into account the environment and the configurations of practice models in place.

The issue for each of the CSSS territories is to identify and promote the combinations of practice models that enable optimal provision of health services. It is therefore important to develop incentives that will encourage physicians to practice in accordance with practice models that will best match services provision to population needs.

In fact, if no measures are taken to stop the current trend, service performance in Quebec is likely to deteriorate. The disparities in healthcare services between rural and urban areas will likely increase, since young physicians practice less and less in rural areas, and their service performance is weaker on several of our indicators. In addition, in urban and metropolitan areas, continuity of care is ensured mainly by physicians in the private practice model that attracts very few young physicians. Thus, there is a danger that continuity of care would decrease significantly in the more densely populated areas in the future as physicians retire. Finally, if nothing is done to encourage young physicians to practice in models that promote both continuity of care and accessibility of services, there is a risk that Quebec will be confronted with steadily increasing unmet health needs as the population ages. Recent healthcare system reforms saw the creation of Family Medicine Groups (FMGs). This new primary care model, which seems to be attractive to young physicians, offers both accessibility and continuity of care to its

registered patients. Only the future will tell if these reforms will succeed in reversing the current trend.

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Even though the *Infoletter* is ending, our research activities on health care organization, governance and transformation have acquired new momentum with, among others, the receipt in 2008 of a CIHR team grant on health systems reconfiguration. This research grant also allows us to integrate students and to prepare the next generation. These research activities could not be carried out successfully without the sustained contributions of all those practice settings that welcome our researchers and graduate students, share with us their interpretations of our research findings and help us to understand more clearly their implications. We thank them wholeheartedly for their collaboration.

This final issue of the *Infoletter* simply marks a transition in the development of our research activities and of our partnerships with health care organizations. We will keep you informed of any new developments, and we are convinced that there will be many more opportunities for us to share and collaborate again on issues related to improving health care system performance.

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