

**A Cross Provincial Comparison
Of Health Care Policy Reform in Canada**

**The Reform of Regionalization in Quebec:
The Introduction of Bill 25 Proposing
the Transformation of Regional Boards
Into Health and Social Services Agencies
and the Implementation of Local Service Networks**

**Elisabeth Martin, Marie-Pascale Pomey
and Pierre-Gerlier Forest**

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Introduction

“The oldest of its kind in Canada, Quebec’s experience with the regionalization of health care began over thirty years ago. The regionalization process consisted of transferring decision-making powers from the provincial government to the regional level. To do this, the government created regional structures endowed with significant authority over the planning and administration of health care services within designated geographical territories. Looking back now, regionalization proved to be an essential tool of political governance that simplified the management of the health care system while bringing decision-makers and decisions themselves closer to local populations” [*translation*] (Martin and Gauvin, 2004, p. 423).

Established in the 1970s, the Regional Health and Social Service Councils (*Conseils régionaux de la santé et des services sociaux* -- CRSSSs) were replaced, in the early 1990s, by Regional Health and Social Services Boards (*Régies régionales de la santé et des services sociaux* (RRSSS) – Regional Boards). In 2003, Bill 25, the *Act respecting local health and social services network development agencies* (ADLSNSSs or Agencies), significantly changed the face of regionalization in Quebec. On one hand, the law decreed that the Regional Boards be transformed into Agencies; on the other, it ordained the establishment of Local Health and Social Services Networks (*Réseaux locaux de services de santé et de services sociaux* -- LSNs). After presenting the principal characteristics of this new way of organizing regional and local health care governance structures, we analyze the stages that led to the adoption of this reform, paying particular attention to the following question: Why, in its desire to improve the management of health and social services, did the government decide to transform the Regional Boards into Local Agencies?

Methodology

The data gathered for this project comes from 10 semi-structured interviews conducted between October and December 2005 with key actors who participated in the elaboration of Bill 25 and the establishment of LSNs in Quebec. Our sources were Agency professionals and members of Agency management teams; professionals and senior bureaucrats from the Ministry of Health and Social Services (the MSSS); representatives from institutional associations, experts and the directors of health care establishments. The interviews were transcribed, coded and analyzed. We also analyzed the grey literature, the scientific literature and various reports, briefs and notices published on the subject by the government and various organizations.

A brief history of Quebec's experience with regionalization

Three distinct and consecutive governance structures -- the CRSSSs, the Regional Boards and the Local Agencies – embodied Quebec's policy on the regionalization of health and social services, initiated in the early 1970s.

The Regional Health and Social Service Councils (CRSSSs)

Quebec began the process of regionalizing public health care services in 1971, after the Castonguay-Nepveu Commission's recommendations on health care were made public. Decision-makers of the time did not apply the commissioners' recommendations for regionalization to the degree suggested in the Commission's report. Instead, they sub-divided the province into 12 regions, each of which came under the management of a separate CRSSS. Decentralized entities with limited responsibilities and resources, CRSSSs only had the power to advise the ministry on various issues related to the organization and regional planning of services.

In 1987, the Rochon Commission "criticized the operations of the CRSSSs and suggested transforming them into Regional Health and Social Services Boards (*Régies régionales de la santé et des services sociaux*) invested with true management authority. Rochon proposed that government resources be decentralized towards regional authorities that would be governed by a board of directors elected by and accountable to the population" [*translation*] (Martin, 2003).

The Regional Health and Social Services Boards (Regional Boards)

In 1991, the CRSSSs were replaced by Regional Boards invested with real decision-making power. "The *Act respecting health services and social services and amending various legislation* instituted 18 Regional Boards administered by regional assemblies made up of 80 to 150 individuals each. The government shied away, however, from decentralization to the extent urged by the Rochon Commission. The Regional Boards were not given the authority to levy taxes, nor were they to be elected by direct universal suffrage" [*translation*] (Martin, 2003).

Insofar as health care and social services were concerned, the Regional Boards had inherited significant power: "The main object of a regional board is to plan, organize, implement and evaluate, in the region, the orientations determined and policies established by the Minister" (Government of Québec, 1991, Article 340).

“More specifically, they were responsible for identifying the health and welfare needs and priorities of their respective regions and for developing service organization plans accordingly. They were to allocate resources for institutions, infrastructure and social and community services and implement measures to protect public health. They were also responsible for ensuring the coordination of the medical services provided by the various kinds of establishments, be they hospitals, youth centres, local community service centres (*les centres locaux de services communautaires* – CLSCs), residential and long-term care centres (*les centres d’hébergement et de soins de longue durée* – CHSLDs), or rehabilitation centres (*les centres de réadaptation* – CRs). Each of these institutions had its own board of directors” [*translation*] (Martin, 2003).

In 1995, policy-makers changed the governance structure of the Regional Boards. The regional assemblies elected by universal suffrage were abolished and replaced by boards of directors of 23 to 24 members who were elected indirectly. The Regional Boards served an average population of 411 000 inhabitants each and were accountable to the ministry; the local establishments were accountable to the Regional Board” [*translation*] (Martin, 2003).

The Local Health and Social Services Network Development Agencies (Agencies)

The adoption of Bill 25 in December 2003 was a turning point that moved the management of health care services from the regional to the local level. The Regional Boards were transformed into Local Agencies responsible for establishing local health and social services networks.

The Introduction of Bill 25

The two main goals of the new legislation were to transform the Regional Boards into Agencies and to create local service networks (LSNs) by merging certain kinds of local institutions.

The transformation of the Regional Boards into Agencies

One of the purposes of Bill 25 was to “establish an integrated health and social services organization [...] in order to bring health and social services closer to the general public and make it easier for people to move through the health and social services network. [...] Local health and social services network development agencies [...] are hereby established. Each of these agencies is a legal person that succeeds, by operation of law and without further formality, the regional health and social services board designated in the schedule opposite its name.” (Government of Québec, 2003, explanatory notes). The power and mandate of the Agencies thus remained identical to those of the Regional Boards, with one exception: the obligation to present the minister of health with a proposal for a regional organizational model for the establishment of

LSNs. The Agencies were to be governed by boards of directors composed of 16 members appointed by the minister.

The creation of Local Health and Social Services Networks (LSNs)

The essential element of the reform launched by Bill 25 consisted of the establishment of LSNs. Each local service network was to be composed of a local instance fashioned from the merger of the local community service centres (*centre local de services communautaires* -- CLSC), the residential and long-term care centres (*d'hébergement et de soins de longue durée* -- CHSLD) and the hospital centres (HC) of a given territory. The local instance thus created would form a new institution known as a Health and Social Service Centre (*Centre de santé et de services sociaux* -- CSSS). Headed by a single board of directors, the CSSS would be responsible for building agreements with other partners, such as pharmacies, medical clinics, FMGs and community groups, with a view to creating a truly-integrated local service network. The CSSS would thus be in a position to offer a wide range of services to the population for which it was responsible.

The law stated that the LSNs should be designed so as to fulfill the following requirements:

- “provide the people in its territory with access to a broad range of primary health and social services [...];
- guarantee the people in its territory access to the specialized services available [...] through agreements or other means [...];
- allow the establishment of mechanisms for the referral and follow-up of users of health and social services [...];
- involve the different groups of professionals working in the territory and enable them to build linkages [...];
- foster the cooperation and involvement of all the stakeholders in the other sectors of activity in the territory that have an impact on health and social services [...];
- ensure the participation of the available human resources needed to provide health and social services [...]” (Government of Québec, 2003, Article 25).

It was possible that a given LSN not include a hospital centre, because of either of the following factors:

- “the absence of such services in its territory; or
- the complexity involved in integrating those services or consolidating them with the other services provided through the local authority, particularly considering the size of the territory served by the institution, the number or capacity of the facilities situated in the territory, or the sociocultural, ethnocultural or linguistic characteristics of the population served.” (Government of Québec, 2003, Article 26).

The boards of directors of the CSSSs were to be made up of 15 provisional members who would be selected after consultation with the institutions concerned. These members were to take office for a period of 2 years. The board of directors of each CSSS was to include one member of the board of directors of each pre-existing institution (each CLSC, CHSLD, and hospital).

It is important to note that Bill 25 was an interim law valid for a period of two years. As such, it was set to expire in December 2005.

The decision-making agenda: Origins of the initiative to transform regional structures and decentralize towards the local level (≈1980-2000)

In order to understand the origins of the new model of regionalization, it is important to study the events in Quebec that first raised the issue of transforming regional structures and decentralizing services towards the local level. In hindsight, regional structures seem to have evolved naturally in this direction over the course of time. Over a period of 25 years, the system continuously turned towards increasingly-integrated structures and organizations (REG-09).

The first stages of decentralization

Several of our sources informed us that the will to establish regional operations dates from the creation of Quebec's health care system in the late 1960s (REG-06). Around that time, the Castonguay-Nepveu Commission argued in favour of a decentralized system in which regions would be invested with significant autonomy and responsibilities.

"The Castonguay template was a decentralized system. A system that was decentralized regionally, a certain number of large regions, larger than the health regions, but still large regions. In all, there were four or six regions in Quebec, each with its own kind of autonomy. Each territory had a university centre responsible for tertiary and quaternary care. Then you had the modified hospitals, plus modified primary health care services. Those were the health centres of the time. So the whole Castonguay model was a decentralized model." (REG-08)

When the health care system was actually established, however, decentralization was not implemented to the extent suggested by the commission. The implementation of the new health care system constituted a major political project that could only take place under centralized governance.

"When Castonguay became minister, he put the reform in place, but he didn't pursue decentralization. It was a centralized system and the idea of having regions wasn't applied, it wasn't put in place." (REG-08)

"Implementing public health care was a challenging political project. And it's obvious that that project...it was hard to work it into decentralization." (REG-08)

The fact that the tools necessary for decentralization were not yet in place made the project that much more difficult.

"The fiscal system was not decentralized, the political system was not decentralized. So there were no tools for decentralization... there was no existing system for the decentralization of politics..." (REG-08)

For that reason, the government decided in favour of creating CRSSSs. The borders of the CRSSSs' territories followed those of the administrative regions of the time.

"From the start, the CRSSSs were really advisory bodies, coordination bodies, they didn't have much authority but they defined the health regions which started out the same as the administrative regions of Quebec..." (REG-08)

The evolution of health care system costs in the 1980s

In the early 1980s, the integration of institutions and services appeared to be a promising solution to the problem of the significant increase in costs of the health care system.

"It started with the first crisis, the first oil crisis of 1980-'81-'82, when it became clear that the growing costs of health care weren't compatible with the growth of the gross domestic product and the public sector's capacity to pay. So that was the first shock, saying, 'Health is going to account for more and more public spending. We need to start integrating.' So an initial effort took place, people started thinking about the regionalization of health care." (REG-09)

"They started to integrate. In my opinion, it began there. It's a general trend. Plus, somewhere along the line, people realized that it wasn't the structures that were providing the services. So that made them say, 'We have to cut down a bit on the structures.' And then different initiatives were taken, starting with the hospitals." (REG-09)

This desire to control costs by integrating took several forms. First, the rate at which the network of CLSCs was being developed was slowed down.

"We've already experienced initiatives towards integration, in fact. To start with, there were attempts to limit the creation of new instances, they took place at different levels. Like, they finished developing CLSCs in Quebec. They limited the project, even though the project itself was one of expansion." (REG-09)

Second, the health care sector was merged with the social services sector. This was also the time of the first talks about the integration of university hospital centres (the *centres hospitaliers universitaires* – CHUs). The trend became even more pronounced in the late 1980s.

"So in my opinion, ever since the Rochon Report, ever since Mrs. Lavoie-Roux, there's been the trend, firstly, to regroup institutions according to size: small hospitals, middle-sized hospitals, small nursing homes." (REG-07)

In this way, the tools that would later help implement larger-scale integration projects were slowly being put into place.

The evolution of regional structures in the 1980s and 1990s

Even if decisions in the health care sector tend to be centralized, Quebec has always demonstrated a concern to preserve regional-level structures (REG-09). The pressure to regionalize came partly from regional-level administrators wished retain a means of leverage vis-à-vis centralized decisions.

"There's the Quebec of the cities, and there's the Quebec of the regions, the countryside. I would even say that there's the Quebec of Montreal and the Quebec of the rest of Quebec. And the countryside has always wanted to have decision-making opportunities or strong decision-making tools to try to protect their local reality. And health care has always been a major player: in the smaller cities, the hospital or the health care system is often the biggest employer. So people--politicians tried to keep hold of regional tools, regional means of leverage so that they could influence central decision-making. They relied on local mechanisms, first the CRSSSs, then the Regional Boards that became Agencies, to keep that leverage, that political influence on decisions about how services were organized." (REG-09)

In addition, successive health ministers in the late 1980s and in the early 1990s considered regionalization to be an essential element for the good governance of the system and put their weight behind the movement.

"When Mrs. Lavoie-Roux started... well, I'm not saying that it started with her, but regionalization was already on the agenda." (REG-07)

"Marc-Yvan Côté really wanted to give the regions more power. His idea was to cut down on the Ministry of Health and develop Regional Boards that would be extremely functional. And when that was happening and costs were being cut, the

Regional Boards really defined their role. When the time came to make difficult choices, the decisions had to be decentralized." (REG-09)

The trend towards regionalization was confirmed with the establishment of the Regional Boards in 1991.

"There's always been, in Quebec, the desire to have local health care operations: CRSSSs, way back when, or Regional Boards or Agencies. Of course in Jean Rochon's time, the trend was really towards regionalization, and I'd say... I'd go so far as to say it was true decentralization, not deconcentration, with local actors, politicians, given the power to manage their own health care services." (REG-06)

The appearance of the Regional Boards coincided with a period of major budget cuts in the public sector.

The reforms of 1995-1998

"In the mid 1990s, the Quebec system entered a period of crisis marked by profound structural change. The state of public finances in Quebec required a reduction in public spending, which led in turn to a major restructuring of the entire health care system: the shift towards outpatient care, hospital closures and massive retirement programs. The Regional Boards played a central role in the process, helping to arbitrate the changes and holding vast consultations with local actors on how to proceed with the reorganization of health care and social services in their territories" [*translation*] (Gauvin, Martin *et al.*, 2006, forthcoming).

In order to address budget requirements at this time, the government required health establishments to merge and, in some cases, to close.

"But in 95, the big stuff was attacked first, followed by the mergers of small hospitals, middle-sized hospitals, small CLSCs, nursing homes. Now that shook things up." (REG-07)

This unique context forced local structures to make difficult and controversial decisions and spend significant energy on the management of sporadic crises. Some players complained about using newly-created local structures to execute budget cuts.

"Decentralization wasn't used to reform the health care system but to make cuts in health care so as to balance the budget. So the reform got left behind and the balanced budget took over, but the health care system was weakened as a result and it still hasn't fully recovered." (REG-08)

Notwithstanding these difficulties, the Regional Boards were reinforced by the experience. They had proved to be an important governance tool and they capitalized on their new reputation.

"At that point, the Regional Boards became a significant political power." (REG-08)

"Once that hard decision was behind them, if you ask me, the Regional Boards left their role behind. They started to... to act as resource allocators, to act almost politically. I wouldn't say that they overdid it, but some Regional Boards made agreements that went beyond their jurisdiction. And they became very functional. So much so that some of the decisions they made impacted certain government decisions." (REG-09)

Overall, the events of the 1990s ended an era of regionalization marked by the ever-increasing movement towards greater integration.

"It began with the thinking that took place in '80-'81-'82, and over the course of 20, 25 years, attempts to implement integration took place in different stages." (REG-09)

The Clair Commission

In 2000, the proceedings of the Clair Commission made an unmistakable contribution to paving the way for the reform legislated by Bill 25. The chapter on governance in the Commission's final report presented six guiding principles for the health care system's three levels of governance: population-based responsibility, territoriality, accountability, subsidiarity, performance management and the participation of citizens (Emerging Solutions, 2001, p. 193-195).

When the Clair Commission first began its proceedings, the very principle of regionalization was under threat. Indeed, the commissioners stated that "the regional boards are accused of interfering in the internal management of institutions while the boards criticize these same institutions for bypassing regional decisions and at the same time trying to cut deals with the MSSS without taking into account the possible effects on the regional network of services" (Emerging Solutions, 2001, p. 212). For this reason, the Commission initially considered reducing and even abolishing the Regional Boards altogether.

Discussions with expert panels, however, helped confirm the need to entrust the Regional Boards with additional powers as opposed to less, given the Boards' proven ability to manage the health care system. In the end, the Commission decided 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" (Emerging Solutions, 2001, p. 231). Rather, the Commission recommended to the government that "the MSSS confirm the necessity of regional boards that are responsible and accountable

to it, that have considerable manoeuvring room and autonomy to implement departmental orientations in health and social services, organize services in the region and allocate resources” (Emerging Solutions, 2001, p. 232). The commissioners expressed a clear warning, however: unless suggested improvements were made (see below), it would be better to abolish the Boards altogether.

With respect to the services provided by the various kinds of establishments, the Commission favoured integrating the entire provision of services. Its observations were to the effect that “the existing structures reinforce organizational “silos” and foster isolationism on the part of certain institutions as well as all too frequent “petty quarrels” between institutions responsible for serving the same territory” (Emerging Solutions, 2001, p. 192). Furthermore, it was impossible, on the ground, not to notice the lack of adequate case management and problems with the accessibility and continuity of care.

“That was the major failure of our system. That the patient wasn’t being followed because everybody was doing his own job.” (REG-01)

The Commission’s solution was to decentralize and integrate primary care services in line with a population-based approach (Emerging Solutions, 2001, p. 213).

“The diagnosis of the Clair Commission was very clear. The silos had to be torn down, and then you had to build bridges between the silos. At the time, they recommended complete integration of the whole supply of services on a territory-by- territory basis, but politically it was difficult.” (REG-09)

One of the Commission’s more specific recommendations would later become a cornerstone of the reform launched with the adoption of Bill 25. This was that “primary care institutions be brought under one single authority in a given territory. This should include, within a unified board of directors, the CLSCs, CHSLDs and, if applicable, the local hospital” (Emerging Solutions, 2001, p. 217).

While Clair was in favour of regionalization, he believed that current management and governance methods needed adjustment (REG-02). Accordingly, the Commission suggested changes to how members of the boards of directors were selected. For local establishments, it proposed that some members “be elected while others be appointed so as to increase administrative skills, to ensure that health and social professionals continue to work in the community and that citizens continue to participate” (Emerging Solutions, 2001, p. 240). It recommended that the boards of directors of the Regional Boards be reinforced in order to “clarify their accountability link” (Emerging Solutions, 2001, p. 212). The Commission also

recommended that each board of directors be composed of 14 members appointed by the government. To encourage popular participation, Citizens' Forums would be created in each territory.

The Clair Commission also suggested clarifying the accountability links between the MSSS, the Regional Boards and the local establishments. More precisely, it recommended that "the responsibilities and accountability of the regional board to the central authority be expressed concretely in a three-year performance contract that is negotiated between the two parties and evaluated and adjusted annually" (Emerging Solutions, 2001, p. 214). Along the same lines, the Commission proposed that the executive directors of the Regional Boards be appointed by the boards of directors, subject to the minister's approval.

"At the end of the PQ administration, when they reached the zero deficit, one of our biggest problems was the lack of control on the budget for health care and social services. So the Clair Report was filed and the Treasury Board performed several analyses and it was suggested that the accountability between the ministry and the Regional Boards of the time be clarified somewhat, and that's when the president-executive directors were appointed." (REG-06)

Finally, Clair suggested endowing the Regional Boards with certain supervisory and inquiry powers.

From the perspective of our sources, the philosophy of the reform instituted by Bill 25 was a clear legacy of the Clair Commission.

"I think that he [Health Minister Couillard] takes up some of Clair's analysis, he may generalize it somewhat but... a mix of Clair and what Rochon started to do with the MRCs¹, which was to integrate the establishments of a given geographical area responsible for a given population." (REG-08)

Bill 28

In response to the Clair Report, the PQ government presented the *Act to amend the Act respecting health services and social services and other legislative provisions* (Bill 28) on May 15, 2001. The bill was adopted by the National Assembly on June 21, 2001. In the opinion of several sources, Bill 28 prepared the ground for the implementation of Bill 25, even though that was not the goal at the time.

As early as 2000, even as the Clair Commission was in session, policy-makers at the MSSS were already considering how best to proceed with the issue of regionalization.

¹ MRCs are *municipalités régionales de comté*, territorial designations similar to counties. There are 96 MRCs in the province of Quebec.

"Because, basically, as early as 2000, there were talks and proceedings to re-evaluate the role of the regional level, its accountability to the ministry and various mechanisms for managing regionalization. All of that started in 2000." (REG-02)

The major realization of the time was that there was a flagrant lack of accountability throughout the health care system (REG-02).

"There were specific problems with the Agencies' accountability to the ministry, with decision-making at the regional level... there were, sometimes... there were times when the minister had to reverse regional decisions because positions in the regions had become too inflexible or because what was happening there didn't necessarily respect ministerial guidelines." (REG-02)

It did not take long after the Clair report was filed for its recommendations to begin to be incorporated into the new draft bill.

"So, well, the process began in 2001, in the winter of 2001, that led to 28 where, to Bill 28, what was happening, basically, was that provincial- and regional-level responsibilities were being revised, regional responsibilities were reinforced, they weren't reduced but changes were made to the relationship between the Agencies and the ministry. So the management relationship between the ministry and the regions was firmed up and mechanisms of accountability between the ministry, the agencies and the establishments were put in place." (REG-02)

By and large, Bill 28 took up the measures proposed by Clair:

- Termination of the election of the members of the boards of directors of the Regional Boards. Henceforth, the boards of directors were to be composed of 16 or 17 members appointed by the ministry on the basis of recognized management skills and experience in the health care sector.
- Changes to the boards of directors of local establishments. The bill retained the election of some members, but remaining members were to be designated by co-optation, by the board of directors or by the Regional Board (Forest *et al.*, 2003).
- Increased accountability of the Regional Boards by means of various measures such as government appointment of a president and executive director.
- The establishment of performance contracts and management and accountability agreements between the Regional Boards and the ministry and between the Regional Boards and the public institutions (management to be based on results and reporting).
- The awarding to the Regional Boards of certain supervisory and inquiry powers to be exercised with respect to institutions.
- The implementation of People's Forums made up of citizens designated by the Regional Boards.

These measures were implemented during 2001 and 2002.

According to our sources, Bill 28 made only minor changes to the health care system. Some sources suggested that the bill had been devised for budgetary reasons and that its principal goal was to provide the government with the tools necessary to control health care costs, not really to implement greater accountability and transparency.

"So, much more centralization so as to keep control of the budget. The main issue was financial control of the budget of the provincial government and the growing proportion of health care costs." (REG-06)

"So with Trudel we wound up with Regional Boards with president-executive directors liable for the ministry's directives, they weren't really their own regional unit, they were much more accountable to the central power than they were accountable for local-level operations. I think that the first rupture took place then, in Quebec. And it wasn't about managing the health care domain like Rochon had suggested, really it was much more about cost control." (REG-06)

In short, Bill 28 laid the groundwork for the establishment of a future reform, the one that would implement LSNs.

"But [...] I think that the principal basis of Bill 28 was results-based management. That meant... there had been time to prepare things beforehand to a certain degree, so that made it easier in the context of the time." (REG-02)

The decision-making agenda: The release of the election platform of the Liberal Party of Quebec (late 2002)

While it is true that Bill 28 brought up the question of integration and started to introduce some of the elements necessary for the implementation of LSNs, the real reason for which the issue appeared on the government agenda can be attributed to the unveiling of the election platform of the Quebec Liberal Party (QLP) in late 2002.

The content of the election platform

The QLP stated that "the regional health boards were created in 1970 and modified in 1990. However, many people still question the pertinence of their existence. Are they really representative? Are they accountable to the populations they serve? Are they one more middle man that adds to the bureaucracy? Regional health boards are not an organization that offers direct services to the population, nor are they policy making bodies. They do not have regulatory powers or the power to impose taxes" (QLP, 2002, p.124). Further on, the document maintains that "in 2001, the Government of Quebec increased its control on regional health boards by eliminating elections completely. . . . The centralization of the regional boards has stripped them of their mission, and for these reasons we would abolish them" (QLP, 2002, p. 125).

In summary, the vision of the QLP was the following: “A Liberal government will entrust to the direction of the establishments the coordination of services to citizens. However, instead of trying to do large scale coordination, such as the attempt with the regional health boards, we will come back to a much more local and humane scale” (QLP, 2002, p. 126).

This document, then, clearly identifies two elements: the abolition of the Regional Boards and closer relations with the local level.

“The Liberal program simply abolished the regional level, really made big changes to the regional level.” (REG-02)

According to our sources, the platform was a commitment to significant and unmistakable change.

“It was an element of the Liberal Party agenda that came out clearly in the platform of 2000... of late 2002, early 2003. And it was... it was a clear reference point: ‘We’ll abolish the Regional Boards. We want to get closer to the local level.’ Those two elements of the platform were clearly identified. Before that, there had been talks on how to improve the operations of the Agencies, and there were a few ideas about reporting. Should we name the executive directors or not, should we name members of the board? But all that was small stuff. This was entirely different. This was an unmistakable change, it stood to make a real difference to the system and it evolved into a commitment. And that’s where it came out clearly for the first time, in the Liberal Party program.” (REG-05)

The beginning of proceedings at the Ministry of Health

In late 2002, the MSSS considered the imminence of the elections and the possibility that the QLP would win and began to review and reflect upon the party’s electoral platform (REG-05). While there seemed to be consensus within the ministry on the desirability of going further with integration, not all of those concerned agreed with abolishing the regional level.

“What was clear during the deliberation phase, before Mr. Couillard came on the scene, was that we weren’t ready to go from a three-level system, three-tiered management to two-tiered, that is to say the local level and the central level. And so we looked for all kinds of formulas for how to deal with responsibilities at the regional-level. Everyone pretty much agreed that we had to take it further. Regionalization as we’d known it in Quebec had been a stage, not a final destination.” (REG-05)

The elections of April 2003

Following their victory in the general elections of April 2003, the QLP replaced the Parti Québécois (the PQ) at the head of the Government of Quebec. Dr. Philippe Couillard, a neurosurgeon from the Sherbrooke

area, was appointed Minister of Health. As a consequence of the Liberal victory, the party's electoral platform became an official program that the new government wished to pursue: they could not proceed, however, without making waves at the MSSS and within different network establishments. Without a doubt, the Liberal suggestion of eliminating the Regional Boards was badly received: indeed, the majority of those concerned doubted that elimination would even be possible (REG-02).

"Well, it caused a certain stir, that's for sure, I mean... before doing something like that, it's really important to take a good look at the implications, to weigh the pro's and con's, plus to evaluate the benefits of regionalization and its possible accomplishments, and what it won't be able to accomplish, and the pitfalls in it all. It really mobilized people... the ministry worked a lot with the Regional Boards. It didn't exclude the Boards from the deliberation process, far from it. They felt threatened, but they were involved in the process. I personally think that people didn't really think that it would be possible." (REG-02)

"And so politically, there was a right-wing political commitment, to say, basically, 'Let's cut down on administration, let's cut down on things that aren't productive. So, let's cut down on the Regional Boards. And let's have a strong ministry'." (REG-08)

Because its platform had been largely based on the elimination of the regional level, the QLP had to act on the issue in spite of resistance. For political reasons, it needed to fulfill its electoral promises.

"They had to move, and really move because, you know, their whole election at the time was based on 'Let's change health care'." (REG-01)

Very early in his mandate, the new minister informed bureaucrats of his intentions.

"Mr. Couillard was very clear on two things: 'This goal is not up for negotiation. We will do it. We can talk about how to do it, though, and I'm open to suggestions.' And then we went into work mode to explore different scenarios." (REG-05)

According to our sources, the idea was not so much to revise the structures as it was to revise the operating mechanisms of the services in order to integrate them and achieve greater decentralization in favour of local-level administration (REG-02).

The choice of a policy: The elaboration of Bill 25 in the summer of 2003

The elaboration of the law by the MSSS: June 2003 to October 2003

As early as June 2003, the MSSS began to work on the law that would launch the reform. The process lasted about 6 months. A working group made up of professionals from the MSSS and the health care network was formed in order to develop a service integration project. At the same time, a management committee made up of the president and executive directors of the Agencies and the deputy ministers of the MSSS was formed in order to reflect collectively on the issue. The MSSS planning team was responsible for learning about Canadian and foreign experiences in the matter and producing supporting documentation for the proceedings of the management committee. Although their very existence was threatened, the Regional Boards participated throughout the legislation-drafting process (REG-02).

The influence of Alberta's model of regionalization

At the very beginning of the process, Minister Couillard proved to be extremely interested by Alberta's two-tier (provincial and regional) model of regionalization and by the philosophy behind the changes implemented in the "sunny province".

"There was also the influence of the Albertan model at the time. We had to study it very closely, we didn't end up keeping it, but we had to study it very closely, it was two-tiered, but regional, the second tier was regional, there were no more local instances." (REG-02)

"And at the beginning of Bill 25, he wanted to give the health and social service centres the choice of buying services from the public or the private sector in order to meet clients' needs." (REG-06)

At this point in the process, the Albertan model was a vital source of inspiration for the project taking shape in Quebec. Upon further analysis, though, not all elements of the model were retained. The MSSS was interested in the idea of integration, but balked at the large size of the amalgamations thus achieved. As for the minister, he was quick to realize the risks of applying such a model to the situation in Quebec.

"You have to give him that. Mr. Couillard knows the network, he has a phenomenal ability to grasp what's going on in that world. So he was quick to understand what was at risk." (REG-02)

"He couldn't go too quickly, plus Alberta may have been interesting, but in Quebec something else comes into play. Our system isn't the same as other systems. We have both the health aspect and the social aspect. We're the only ones to have that kind of integration." (REG-02)

As work progressed, it quickly became apparent that, the QLP's electoral promises notwithstanding, it would be necessary to retain a regional tier. The idea of importing the Albertan model was therefore abandoned, even though some sources see Bill 25 as a manifestation of the same philosophy, but at the local level.

"Yes, it's real regionalization, but they mainly applied the Albertan model to the local level." (REG-06)

While Alberta's experience played an important role in the reflection process, the MSSS also had other sources of inspiration. The ministry had developed some fifteen criteria according to which it could evaluate Canadian and foreign experiences with structural integration. Working with the minister and his deputies, those responsible for elaborating the law studied different organizational scenarios with a view to identifying their benefits and drawbacks (REG-02). They also met with university experts in order to address the question of how to execute the reform package and how to anchor the development of the model on current evidence about the integration of services. Some sources also said that the MSSS paid particular attention to a service organization model developed by the Regional Board of the Eastern Townships (*l'Estrie*) in the city of Sherbrooke. This model had been designed to create integrated entities in the MRCs (see footnote 1) by merging CLSCs and CHSLDs (REG-08).

Other sources took a historical perspective and suggested that the Clair Commission report and even the Rochon reform experience of the 1990s provided ideas to the MSSS at this time (REG-08). Still others believed that models implemented in Scandinavian countries played just as much of a role when it came time to developing a similar project in Quebec.

"We are often inspired by Scandinavian countries where the size of the population is more or less the same as ours, where the political geomorphology looks like ours, the climate is similar, the behaviour, the population trends, the kinds of illnesses, and so on. We are often inspired by those models. At the same time, we have the good luck to be in America. So, we have a little bit of the "business" approach, despite everything, in my opinion, and we also have the operational approach, professionally speaking. We try to take the best from the model... from different models." (REG-09)

The adoption of the model's main principles

After having worked in partnership with several actors, then, the team responsible for drafting the bill came to propose the LSN model that aimed at integrating establishments on a local and territorial basis. The new institutions resulting from the mergers were to offer a range of services to a given population for which they would be responsible.

"There was a lot of interaction. What happened was, the developers of the model built the model, had it validated within the ministry, sought expert advice within and without the ministry, the minister followed the process very very closely... the decision was made quite quickly." (REG-02)

Nonetheless, this proposal did not altogether follow the political guidelines set forth by Minister Couillard, guidelines that had been inspired by his party's political platform. The difference lay in the proposal's maintenance of regional governance bodies.

"In the end, the answer to that political requirement, but it didn't correspond 100% to the political requirement [*sic*]. It was no longer possible... the project wasn't about abolishing the Regional Boards, it was about reinforcing the integration of services in the system, better defining the various levels of management, more decentralizing, making sure that the responsibility for services to the population was assigned to the right level, reducing the number of institutions, too, because there were still, after all, a lot of institutions." (REG-02)

Minister Couillard proved to be very open to the proposal but he had difficulty selling the project to the Cabinet, which wanted to fulfill the party's electoral promise.

"The assessment process changed rapidly. I think that he had a tough time, though, convincing his colleagues in the Cabinet that what he had done was well-founded." (REG-02)

The introduction of the bill and the holding of a parliamentary commission (November and December 2003)

Bill 25 was submitted to the National Assembly on November 11, 2003. The bill was studied by a parliamentary commission, the Commission of Social Affairs, on December 2, 3 and 8, 2003.

The actors' positions on the main principles of the bill

Although the actors who testified in the parliamentary commission agreed with the main goals of the reform, many were concerned about or even opposed to the means devised to implement the changes. They were especially opposed to the disruption of existing structures (REG-02).

"And there was the same resistance that there had been before, you know "small is beautiful" from 25, 30, 40 years before." (REG-07)

"What was surprising was that by and large, the public rhetoric, the arguments voiced at the commission were rarely consistent with the evidence. Lots of researchers worried about possible catastrophe, but I found it rather surprising to see how people lost track, during the debates, of what the evidence had to say about how we'd developed our reform package." (REG-05)

Only the Quebec Hospital Association and the medical federations appeared to support the project. Unions, community groups, social and grass-roots organizations, the association of CLSCs and CHSLDs and the *Coalition Santé Solidarité* all opposed it.

Several specific aspects of Bill 25 provoked strong reactions in the actors concerned.

The integration of services

A majority of actors seemed to be satisfied with the principle of service integration on which the reform was based, all the more so given that the MSSS had based its development of the bill on real-life experiences with the implementation of actual service integration models (REG-02).

"Then there was evidence to the effect of, 'We have to integrate the entire provision of services'. And if that were accomplished, it would probably take us 70% of the way. The remaining 30% would be to integrate doctors' offices." (REG-09)

"So the diagnosis was accurate: integration has to happen one day or another, we have to get started. And at some level, he had to put his foot down and say, 'We have to do it. It's what makes sense.' And people could see where it made sense. As for the "how" of how it was done, if you ask me it wasn't done too badly." (REG-09)

Population-based responsibility

Once implemented, the LSNs would be responsible for developing clinical projects to establish case management mechanisms for populations with special health needs (REG-01).

In general, health care system actors were favourable to the principle of population-based responsibility, seeing it as a value-added aspect of the philosophy that had governed the provision of services until then.

"...an establishment was responsible for the care it provided to its patients. You go to the hospital, they provide you with care. Now, under the new law, it was responsible for the health of the population in its territory. Even if you don't go to the hospital, in the normal course of things, the health centre is responsible for... I mean, for the health of its population. That changes everything." (REG-01)

Indeed, some saw in the proposal the opportunity to go further with a concept that had begun to be developed under the CLSC model.

"I would even say that it's a result of the creation of local community service centres. The CLSCs have always had clearly-delineated territorial responsibilities, clearer in some programs than in others, without, in my opinion, having the leverage to fulfill them. I think the conditions for fulfilling those responsibilities are better now than before, but it's always been..." (REG-03)

Nonetheless, some sources admitted to fearing the new measures retained for executing such a principle on the ground. It seems that at the beginning, there was the idea that the LSNs might be allowed to purchase services from the private network in order to meet the requirements of population-based responsibility: this raised some concern (REG-06). Other sources saw population-based responsibility as a mere pretext used to justify institutional mergers.

The transformation of Regional Boards into Agencies

Instead of being eliminated, as the QLP had originally intended, the Regional Boards were changed into Agencies with the two-year mandate of instituting LSNs.

"We didn't want to change the borders of the territories because it would have sparked a debate that went way beyond the issue at hand. Our concern was to get to the local level." (REG-05)

By proceeding in this fashion, policy-makers symbolically complied with the political directive to abolish the Regional Boards. In reality, however, they retained an intermediary body that was directly responsible for implementing the reform package.

"So, symbolically, we abolished the Regional Boards. We abolished them by giving them a new name and a new role. And we moved some of the responsibilities to the local level." (REG-05)

"We took the structure that we had on the regional level and we used it to make the regional level into an advocate of the change, we put it in charge of the change. And that was quite different. And we slowly started to change the structure to make it more and more of a management structure. And we moved clinical coordination entirely over to the local level." (REG-05)

"Because the important thing was the integration of services at the local level. That was the basic message. The symbol of change was the abolition of the Regional Boards." (REG-05)

Some actors, especially the local institutions, were relieved to see the regional level survive.

"Strangely enough, it was mostly the institutions themselves who asked that a regional entity continue to exist for a certain time. [So that there'd be] an interface -- [a mediator] between the local level and the institutions with [wider] mandates, the local level and the IUHSs², the specialized institutions. All those operations needed someone to be in charge. Plus sometimes, maybe, someone to arbitrate." (REG-05)

Others decried the fact that the regional tier lost power to the new local CSSSs in the name of integrating services.

"It was as if the regions, as an entity of the regional Agencies, still more or less existed but had lost a lot of power. Real local entities had been created, the CSSSs. But their creation didn't have a political corollary. They weren't politically legitimate in the sense of being representative." (REG-08)

"And as a consequence, the bigger the health centres grew, the more the regions lost power over the organization of services." (REG-01)

"The role was really about saying, 'I'm going to allocate more power lower down the ladder, and I'm taking it from the regional level.' Whatever the president-executive directors of the Agencies have to say about it, the regional level lost power." (REG-01)

Still others denounced the strictly symbolical nature of the change.

"They simply changed the Regional Boards that they were supposed to abolish, it's written in the QLP program. They changed them into Regional Agencies. They're nothing short of regional offices of the ministry of health. But they kept up the pretence of being administered by the public. They created boards of directors that were supposed to govern, but in reality, when the president-executive director is appointed by the government, the Agencies are just a regional office of the ministry." (REG-09)

Many sources felt that the government couldn't afford to let go of a body that had acquired years of expertise in the organization of services.

"Because even if you argue that it doesn't do it any more, the expertise was still there. You can't cut an expert in half, all of a sudden, just because you have four local networks. These are structures that are very... there is a tremendous amount of staff involved. And there are still a lot of challenges." (REG-02)

² IUHS are Integrated University Health Networks, *Réseaux Universitaires Intégrés de Santé (RUIS)*.

"And then they realized that they couldn't get rid of all of the regional expertise after all. So there was a small compromise. But there was also the fact that there was a pre-existing bias, if you will, against the Regional Boards." (REG-01)

The transformation of Regional Boards into Agencies thus allowed the system to continue to benefit from professionals' expertise, using it to create the local service networks.

"Because we needed the people from the regions to put the local network structure in place." (REG-09)

"The term "Agencies" was probably not an accident. They aren't a Board in the sense of delegated authority. They're an agency of the State, they're the tool..." (REG-08)

Lastly, some actors worried about the interim nature of the law, which meant that the regional level could still be eliminated once the law expired. Network participants had a hard time seeing how the system would continue to be managed in the absence of regional structures.

"The Liberal Party had said, 'Let's abolish the Regional Boards. Let's make Agencies. The Agencies will create local networks. After that, we'll reabolish the Agencies.' But you can't abolish those kinds of organizations. You can't pull the rug from under yourself." (REG-09)

Institutional mergers

Bill 25 ordered that the CLSCs, the CHSLDs and the hospitals of a given territory merge together in order to create a new local entity: the CSSS. The premise was that merging establishments would facilitate the management of the new instance (REG-02). In general, the establishments slated for merger and the associations that represented them on the provincial level were fiercely opposed to this proposal. To begin with, some felt that as long as local-level services were properly integrated, many mergers became pointless. Others questioned the feasibility of merging establishments with such disparate visions and philosophies.

"It could have been done without merging structures, but there are advantages, too, with merging structures. Especially when the major premise is the reorganization of services." (REG-02)

"Yes. The spine... the spine is the structures, the mergers. That's the spine. So why shake up the structures, why merge establishments, why force it? How far can you push it?" (REG-02)

"Even if theoretically, mergers are advantageous, there are so many practical problems that they never work. People never get along. They spend their time fighting instead of cooperating. It's way too much work for the results." (REG-01)

Most of the difficulty was with the idea of merging hospitals into the local entity.

"Because when the hospital centres were introduced, the debate changed. There was a lot, really a lot of hesitation. In the parliamentary commission, that's where the trouble arose." (REG-05)

During the 1990s, some regions had merged CLSCs and CHSLDs in order to execute budget cuts required by the government. In most cases, these mergers were successful. In the context of Bill 25 as well, merging a CLSC and a CHSLD with a hospital seemed feasible when the hospital in question offered primarily front-line services. In the case of a specialized hospital, however, it was another story (REG-02).

Primarily socially-oriented establishments, CLSCs and CHSLDs were fiercely opposed to merging with hospitals. Neither did the hospitals seem enthusiastic about joining the CLSCs and the CHSLDs.

"So the CLSCs were in favour, the hospitals pretended to go along but really they were against the whole thing but they didn't want to show it because they really didn't want to look like the bad guys." (REG-07)

"Everyone was affected. There was the CLSC-CHSLD-hospital dichotomy. People didn't want to hear about it. The hospitals said, 'I don't want to hear about merging with a CLSC. What's a CLSC anyway? What's it good for? Nothing.' Everyone wanted to retain his own specialty." (REG-01)

"And they hesitated because the social organizations really got up in arms, the CLSCs, from the beginning, they were strongly opposed to that kind of merger." (REG-06)

"We watched the CLSC go at it, and then the hospitals. And they really went at it." (REG-07)

The CLSCs-CHSLDs were afraid that the more imposing administrative structures of the hospital institutions would mean that the hospitals would supplant them and dilute or even extinguish the specific nature of their missions.

"The CLSCs were literally trying to save their skin. The minister was saying, 'Well, henceforth, there may no longer be CLSCs.' You know, the very concept of CLSCs was fading." (REG-07)

The merging of university hospital centres (CHUs) into local entities also caused apprehension. Themselves the result of institutional mergers, the CHUs had been created at the time of the Rochon reforms in the 1990s and some actors maintained that they were still so fragile that new changes could threaten their very existence.

"In order to succeed to do that, in the cities, the CHUs would have had to be taken apart again. They would have had to be redone. And that's a can of worms, to take structures apart again. Union regulations applied. In the end, the structures aren't what provide the services." (REG-09)

"A large, large, large regional hospital with teaching responsibilities, it would have been hard to stick that together with a long-term care centre plus a CLSC. It would have been a little like the elephant that might fall on the mouse and cripple it." (REG-09)

Additional concern centered on the question of human resources. The proposed mergers represented a significant reduction in the number of management positions because of the fact that the establishments would now be united under a single governing body (REG-07).

"So now on one hand I'm supposed to tell the executive directors... that they're going to be relieved of their positions, that they're all going to be let go, and then I have to tell them to help me accomplish the reform because after all it's important." (REG-01)

"Because then, you see, there were at least 100 executive director positions that were abolished in the final year. That's a lot." (REG-07)

The merger of territories

Because the reform was designed to amalgamate establishments, it was understood that institutions from different territories within a given region might have to merge. The issue was not discussed much during the parliamentary commission, when the association of CLSCs and CHSLDs was alone in warning the government against the temptation to create territories that were overly large. The association wanted the government to reaffirm that the MRC territories would form the basis of the new organization.

"The problem was the whole question of the territories where services were provided. The territories were extremely large and they didn't necessarily overlap with the territories for local development projects or the territories of local institutions such as the MRC or the municipality." (REG-06)

"So we told ourselves, 'There are about 95 MRCs. If we wind up with 95 health and social service centres, it's still manageable.' So for that reason, we worked on the size of the health centres and the territories, the territories people belonged to [*territories d'appartenance*]." (REG-06)

Although it was not a major focus at the time, the issue would resurface later, becoming the object of debate once the regions began developing their respective LSN organization projects.

The revamped project

In response to the fears expressed at the parliamentary commission, Bill 25 was modified so that the CSSSs could leave out a given hospital centre if its inclusion into the new entity proved too complicated. Exceptions were also made for establishments that offered services tailored to a linguistic minority community: by law, these institutions could also be exempted from the requirement to merge into a CSSS.

The adoption of the bill

The National Assembly voted in favour of Bill 25 on December 17, 2003. The law was adopted after the government invoked parliamentary closure, a motion that suspends the Assembly's regular rules and limits debate of a bill (the "gag rule"). In general, opponents to the reform quietened down after the bill was passed (REG-05). The legislation thus complete, implementation began and quickly made progress.

The implementation of the reform package

January 2004: The transformation of Regional Boards into Agencies

Bill 25 took effect on January 30, 2004, when the Regional Boards were officially replaced by Local Health and Social Services Network Development Agencies (Agencies). Each of the 18 Agencies thus created had only three months to organize consultations and develop a regional organization model to submit for approval to the minister of health and social services before April 30, 2004. The organization model was to specify the number of LSNs to be implemented in a given region, define the territorial boundaries of each region and identify the institutions that would be affected by mergers (REG-02).

January to April 2004: The development of regional LSN organization models

The core of the MSSS's strategy to implement the reform package was to assign the task of developing the LSN projects to the health regions and their local territories. To spur on the reform, the MSSS wanted the reorganization projects to originate within the community, eschewing the traditional "top-down" process in favour of a "bottom-up" one. Because of this, the regions were given the role of supporting the territories and the local institutions in the project development process.

"It was all about being able to say, 'The movement's going to come from the local territories. The regions will lead it and the province will ratify it, not the other way around.' And once we hit on that formula, the movement took off and it took off at a phenomenal rate." (REG-05)

"It's extremely demanding for the central apparatus and the regional apparatus to think in those terms because it forces them to actually think instead of making rules across the board." (REG-05)

Bill 25 did not provide precise directions for the development of the regional organization models. Instead, it merely decreed the main principles that were to govern the process. The idea was not to dictate a single model but let various proposals percolate up from the regions. As a result, there was no single set of rules: it was expected that models might well differ in terms of the size of their networks, their territorial boundaries, the institutions they included and how their networks were organized (REG-02).

To support the implementation process, the MSSS created discussion forums on the daily progress of the LSN development projects. Four sets of actors were invited to participate: community organizations, institutional associations, physicians and management associations (REG-05).

In the process of amalgamating territories and establishments, a certain number of political factors had to be considered (REG-01). In general, resistance came mostly from urban areas, where little amalgamation had taken place at the time of the Rochon reforms. Several regional areas, in contrast, had prior experience in the matter, having been obliged to merge entities in order to improve services to the population (REG-02).

As a consequence of the above, progress was slower in certain areas, especially the more populated and urbanized zones such as Montreal, Quebec City and the Montérégie. These areas were characterized by institutions offering ultra-specialized services; service consumption profiles that did not follow territorial lines; and CHU mega-structures with vastly diverse responsibilities (REG-09). In other regions, like the Laurentians and Chaudière-Appalaches, other issues slowed the process: criticism there centered on the amalgamation of territories as well as on mergers.

"But we didn't force anything. There was the option of exemption if the circumstances warranted it. Some places did that and surprisingly enough, others preferred integration, structural mergers." (REG-02)

"In some regions it went smoothly, in other regions it was tough. Some regions didn't push it: if there were already seven CLSCs, they kept seven territories. For all kinds of reasons, justifiable reasons, they were more prudent. Others insisted on reorganizing things. Sometimes it was voluntary, other times it was forced." (REG-02)

By the time the process was over at the end of April 2004, all 18 Agencies had submitted their reorganization proposals.

April to June 2004: The evaluation of the proposals and the ministry's decisions

All of the models submitted to the minister were analyzed according to a strict set of criteria (REG-02). Because the MSSS's strategy had been to avoid proposing a single model, the ministry had to evaluate the proposals on a case-by-case basis.

"The minister's idea was not to do things across the board but to have a solution tailored to each case. When you're talking about changes to a health care system, that's a hard thing to manage. Each time that a decision to amalgamate was made, we had to be able to justify it on its own merits and not according to a theoretical model like, 'We're amalgamating the CLSCs, the hospitals and the CHSLDs.' And we had to be able to say, 'In this particular territory, given the geography, the history, the culture, given the way consumption works here - because we considered consumption data very carefully, it told us about the habits of the residents of the territory - because of that, it makes sense to amalgamate in this way.'" (REG-05)

After the proposals were submitted to the minister, some constituencies who had opposed the project submitted by their local Agency tried to convince the minister not to proceed with certain mergers. In three cases, the minister decided against the Agencies' proposals³.

"But Mr. Couillard's best quality was that he didn't work from that premise. He worked from another premise: 'Is this the best scenario I can get today? That's the one I want. Even if it may be called into question five years from now: today, can we do better?' Those were always the terms in which he had us think. It forced us to relinquish our reference diagrams a little." (REG-05)

"The minister was very strict, very rigid. He didn't accept much in the way of compromise." (REG-07)

At the beginning of the month of June, the ministry submitted its proposal to the Cabinet.

"But the Agencies showed up with proposals and the decisions were made in the Cabinet because, well, that was another challenge. There wasn't just one minister. The whole Cabinet had to agree with each local territory in each of the regions of Quebec. And it all had to be done before the summer recess because if you leave a territory hanging, it's all over. So on June 23... on June 22 or 23, it was all tied up, it was all settled." (REG-05)

³ In the region of Chaudière-Appalaches, the Agency had recommended creating four LSNs. Instead, the ministry authorized the creation of five LSNs based on the arguments of the representatives of the territory of Etchemins who did not wish their territory to be merged with the territory of Beauce. In the Laurentians region, the Agency had recommended creating six LSNs. Instead, the ministry authorized the creation of seven LSNs based on the arguments of representatives from the territory of Pays-d'en-Haut who did not wish their territory to be merged with the Laurentians. In the Montérégie region, the Agency had recommended the creation of ten LSNs. Instead, the ministry authorized the creation of eleven LSNs based on the arguments of representatives from the territory of Presqu'île who did not wish their territory to be merged with the territory of Beauharnois.

Finally, on June 23, 2004, following approbation by the government, the minister announced the creation of 95 LSNs throughout the province.

The implementation of the LSNs (July 2004 to the present)

Although implementing the new LSNs was the responsibility of the local establishments and the Agencies, the team in charge of Bill 25 at the MSSS played a front-line role in explaining their expectations to the actors concerned.

"So you create something, you go around explaining it, presenting it. You make it so that people take it over. If they bring it up to you, it's even better than if you bring it up to them." (REG-05)

Changes to governance

Now that the new entities, the CSSSs, had been created, the government had to appoint new managers and new board members.

"All the local-level decision-makers, the Regional Boards that were renamed when they were made into Agencies, the health and social services centres." (REG-06)

The law decreed that the boards of directors be made up of representatives from the former institutions (CLSCs, CHSLDs and hospitals). Each former institution was to hold a third of the seats. Given the CLSCs-CHSLDs' apprehension that the hospitals would dominate the new entities, this set-up was meant to ensure that the social sector was adequately represented (REG-06).

For the MSSS, it was not an easy task.

"I don't know if you know what it means to create boards of directors that respect local territories, that respect the various missions of the various institutions, male-female relations, territorial quibbling, distinct linguistic communities, ethnocultural characteristics, the reputations of all these people, by appointment, it was an incredible feat. It wasn't the way we usually proceeded but it allowed us to move quickly." (REG-05)

Some sources felt that the exercise looked suspiciously like the government trying to take control of the health care system in order to impose the reform package.

"So in the first year of the mandate, with respect to the government's most strategic dossier, namely, the issue of health care, the same issue that had caused

the downfall of the previous government, they were able to reappoint all the members of all the boards of directors of all the establishments. It was a political purge just about everywhere..." (REG-06)

The clinical projects

As soon as the managers were appointed, the CSSSs were given the task of defining their clinical projects, that is, their service organization models for priority clientele. Given their expertise in the matter, the Agencies had the mandate of supporting the CSSSs in this process, it having been determined that the CSSSs were not always capable of fully assuming their new role. The organization of services was to be done in accordance with set targets and according to the principles of results-based management (REG-02).

While the government's strategy had been to ask for rapid proposals for the amalgamation of institutions and the implementation of CSSSs, the MSSS gave the CSSSs significant time and latitude to develop their clinical projects. Wanting the projects to originate within the community, the MSSS had very little to do with the process. This way of proceeding was not a little contrary to the ministry's traditional practices.

"The change in culture that it caused within the ministry: that was far from insignificant... no agenda, no due dates, no this, no that... are we ever not used to that. And people within the ministry got flustered: 'We won't get to see the clinical projects, we won't have a framework for the analysis of the clinical projects?' It wears on you. It wears on you. Really a lot of coordination within the ministry." (REG-05)

"And once the local territories were established, once the boards of directors were appointed, things kind of calmed down." (REG-05)

The evaluation of the implementation

A team of MSSS professionals was put in charge of evaluating the implementation of the reform package. It was felt that the reform posed a threat to certain principles of the Quebec system, like everything that touched health promotion and prevention and front-line health and social services in general (REG-02). The team was responsible for monitoring the respect of those principles throughout the implementation process.

"So then you have a working group, just as big as the group that implemented the change, in charge of following the project, understanding it, analyzing it, working with the sites selected for the evaluation process." (REG-05)

"It's an educational evaluation that allows us, here at the ministry, to get results and help improve and adjust things." (REG-05)

Conclusion

A major reform

Most sources concur that in the history of Quebec's health care system, the advent of Bill 25 constitutes one of the most important reforms, if not the most important reform, since public health care was introduced in 1970. While Bill 28 helped pave the way for this change, the new reform allows policy-makers to move forward on several fronts, such as the organization of work and the allocation of resources. It also provides the health care system with sound organizational foundations (REG-02). Nonetheless, insofar as regionalization was concerned, several sources felt that the process did not go far enough.

"Deconcentration, yes, that's true, but not decentralization, not real regional autonomy, the development of unique regional models that can participate in local agreements within larger provincial parameters, that can have significant local variations. That doesn't exist." (REG-08)

Bill 83

With Bill 25 soon to expire, the *Act to amend the Act respecting health services and social services and other legislative provisions* (Bill 83) was introduced in the Quebec National Assembly on December 10, 2004. It was adopted on November 25, 2005. Developed to support the new LSN model of organization, Bill 83 followed directly from Bill 25. More specifically, "the bill proposes an adjustment of responsibilities between local authorities, other institutions, health and social services agencies and the Minister of Health and Social Services. Local instances will be responsible for defining a clinical or organizational project for the territory they serve, while agencies will be more involved with the coordination of financing, human resources and specialized services" (Government of Québec, 2005, p. 2).

With respect to the universities, "integrated university health networks are established whose object is to make proposals to the agency concerned or to the Minister, as the case may be, on various subjects, in particular the supply of services in the recognized areas of expertise of institutions designated as university institutions, medical training, the distribution of students from faculties of medicine, and the prevention of interruptions of services" (Government of Québec, 2005, p. 2).

Bill 83 confirmed the existence of a regional tier in the Quebec public health care system. According to the new law, the Agencies were to remain active but change roles, becoming a regional coordination body for the support of LSNs. Although the CSSSSs now had the mandate to organize and plan services, the Agencies assumed strategic planning insofar as larger regional goals were concerned. They were also put in charge of allocating resources, monitoring results and management agreements, and planning the workforce at the regional level (REG-02). The bill also recognized that although the Agencies were no

longer in charge of organizing services, expertise in the matter remained on the regional tier: for that reason, the Agencies were expected to support the CSSSs as they went through the process of developing their clinical projects. Overall, the Agencies came into a role of control and arbitration and assumed partial oversight of wider regional guidelines (REG-05).

"They're defining the levels of accountability, I mean the local level will be accountable to the regional level, but the regional level won't be there to support the local organization. So you'll have a regional level whose role is much more about control than about support." (REG-06)

While some governance practices were affected by the law, others went unchanged. The government continued to appoint the members of the Agencies' boards of directors: this was expected to reinforce management of the Agencies and clarify authority at that level. The election of certain board members of the CSSSs was also preserved. While this latter procedure is not particularly efficient, it was difficult to eliminate for political reasons (REG-02).

Future prospects

The regional tier

Bills 25 and 83 have proved to be successful at shaping the roles and responsibilities of the regional Agencies and at developing integration mechanisms at the local level. Challenges, however, still remain. The still-uncertain future of the regional tier is one of the principal issues facing the government in years to come.

"In my opinion, the fight right now is about where the regional level fits in. I mean ideally, the minister wanted local and provincial levels, he no longer wanted a regional level with the exception of the very large regions." (REG-06)

Although the existence of the Agencies has been confirmed, then, it is possible that regional structures will be modified again in the future.

"The beauty of it is that we've kept the door open to a two-tier system. We haven't boxed ourselves into a dogma insofar as the structures are concerned." (REG-05)

Our sources' opinions differed on this matter. Some felt that the Agencies were destined to disappear, while others believed, on the contrary, that they would inherit increasing power over time.

"It could be that the regional tier will disappear, but only, I'd say, over the space of a number of years." (REG-03)

"So in the current draft bill they're actually giving back a strong role to the regional level, a role that's stronger than the role they had in the first version." (REG-06)

One source felt that the government would be better off not abolishing the regional tier, if only for system management reasons. It is true that the government is likely to find it easier to interact with 16 regional bodies instead of 95 CSSSs (REG-06). If the regional level were to be eliminated, of course, it would become necessary to rework governance mechanisms at both the provincial and local levels.

"So there might one day be the possibility of putting the CSSSs under the control, so to speak, of the CRÉ [*Conférence régionale des élus*⁴] instead of being more under the control of the Agencies." (REG-06)

Integration and decentralization towards the local level

Some sources informed us that further amalgamations of establishments can be expected as part of the drive towards greater integration. For example, in the Laval region, where there is one Agency and one LSN, it is possible that the two entities be merged into a single tier (REG-02). Were the Agencies to be eliminated, of course, the local tier would be called upon to assume greater responsibilities.

"Which means that we can be confident in thinking that even if Bill 83 gave the Agencies a new mandate, it's not... that mandate could well turn out to be temporary, things could change all over again. Leaving more room for the local level." (REG-05)

The networking and integration of professionals

While the local instances (the CSSSs) are now operational, local networks of partnerships remain to be built throughout the province. These networks will include medical clinics, pharmacies, community groups and social economy enterprises.

"It involves doctors in the organization of services, links with the "grass roots", the FMGs, the local medical community, very very important. There are really a lot of elements." (REG-02)

In the eyes of many, the exercise would be made easier if the physicians and other health care professionals were to become stakeholders in the construction of the network and its subsequent operation. To achieve this, it would be necessary to include doctors' offices in the global provision of local-level services and ensure that there were incentives for the professionals involved.

"I think it'll work. I'm confident. It depends on whether the doctors, the professionals are in on it. That's what worries me right now. We're too focussed on

⁴ The *Conférences régionales des élus* are regional development entities made up primarily of local-level elected officials.

the principles of the regional plan for the organization of integrated services, we're too focussed on the population-based approach. We're really, really, really into the concepts, but we've forgotten to go get the physicians, the care providers, and explain to them what we mean by it all. So there's some rallying work to be done." (REG-09)

Some sources foresaw difficulties with negotiations, given the political stakes involved.

"Integrating doctors' offices into the provision of services. But it doesn't follow the same political reasoning. A doctor's office is a relatively autonomous industry, it's part of the provision of services. It's not institutional. We've integrated institutions to a certain degree, that's already a huge step forward. But in a few years, five or six years probably, we're going to succeed in finding a model that integrates the provision of services from doctors' offices as well." (REG-09)

"The doctors want to stay on the regional level. They don't want to confront one another on the territory where they practice. Because that's a lot more one-on-one, and so, they want to keep some negotiations at the regional level." (REG-06)

Insofar as human resources are concerned, the institution of LSNs will have to mesh with the implementation of Bill 30⁵, a bill aimed at regrouping collective bargaining units.

"The implementation will of course be trickier. There's another element that has to be looked at, that's Bill 30, on union accreditation and the organization of work because they were adopted at the same time. Sure, there were mergers but above and beyond that, if you want to regroup the bargaining units in the merging organizations, that... Here we were afraid that would cause a much bigger stir. I admit that it hasn't been a big problem up until now but we really are afraid of negative incentives. Something that could slow down or even throw off the larger objectives that underlie the project." (REG-02)

It is clear that the reform will have to overcome significant challenges in terms of the mobilization and integration of personnel before staff can be expected to operate in line with the goals of the reform and assimilate strategic and operational changes related to the change in structure (REG-02). In other words, it will be necessary to bring the reform down to the level of the workforce that actually provides the population with services (REG-01).

⁵ *An Act respecting bargaining units in the social affairs sector and amending the Act respecting the process of negotiation of the collective agreements in the public and parapublic sectors.*

The clinical projects and population-based responsibility

With the merger of institutions behind us and the complete integration of local structures currently underway, the challenge now is to begin concentrating on clinical matters and care and services for the population.

"We are presently in a system that is spending a tremendous amount of energy on putting the new structures in place... A lot, a lot of time and energy, whereas care itself, well, that's not solved yet." (REG-08)

"And their biggest challenge right now is their clinical projects. They each have to define a clinical project for the population of their territory that will determine the service organization model for priority clientele. The ball's really in their court. And what's interesting to see as well is the dynamic with the Agencies. The Agencies are very present. Because even if you say that the responsibilities are at the local level, they're not necessarily able to assume them right away. The Agencies have figured out that they have a role to play." (REG-02)

"They told them: 'But now, we're going to have a director of prevention, not just a director of nursing care. We're going to have a director of prevention. We're going to take care of our population. We're going to look into things.' I don't think that the enthusiasm has trickled down to the workforce yet." (REG-01)

Financing the CSSSs

Decision-makers are currently modernizing the ways in which resources are allocated to the CSSSs in order to reflect the new environment. Will new resource allocation methods correspond to the principle of population-based responsibility for which the CSSSs have become accountable?

"How will the financing system be organized? If the CSSSs have a real budget that winds up being a population-based budget and real autonomy in the way they use their budget to run their network, then we're probably heading towards a stronger form of local decentralization. But if the budgets are controlled from higher up, and the money is given to the large establishments, then there'll only be deconcentration." (REG-08)

Living with the reform

Above and beyond the changes, a majority of sources felt that it was now necessary to step back and let the new reform ripen, if only to allow time for the real integration of structures to take place (REG-09).

"The process has been ripening since the mid 1990s. Then one fine day, after ten years have gone by, you say, 'Well now it has to be done.' You do it, you make the whole architecture, and then after that, you have to live with it." (REG-09)

"The new administrators are coming into two years of experience managing their health care centres according to the needs of their populations. So they'll have put down new roots, roots that were no longer there. In the first year, the CLSCs, the CHSLDs, the hospitals didn't have roots any more because they were waiting for the

reform, and the first year, the administration didn't have any roots. So I think we can expect a new balance of power..." (REG-06).

In light of the general elections that will take place in Quebec in 2007, the future of the reform still remains to be seen.

"I think it's a winning formula. For sure there will be all kinds of new difficulties when it comes to applying it. Basically it's too soon to judge. There are political factors, economic factors, operational factors. The tools have to be there, people have to come on board, the money has to be there, there has to be... you know. It's going to require resource transfers, organizational changes. We are going to try to live with it a while before making more changes. That's always the risk. Political change in two years. Maybe yes, maybe no. It's a possibility. It always has a huge impact." (REG-02)

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Appendix 1: Chronology of the Regionalization Reform

Between 1966 and 1972

- The Castonguay-Nepveu Commission is formed and develops the first outlines of regionalization in Quebec.
- The Commission suggests major changes to the Quebec health care system, changes to take place through decentralization and popular participation.

1971

- Quebec embarks on the process of regionalization by creating Regional Councils for Health and Social Services (CRSSSs), decentralized entities with limited responsibilities and resources. The province is subdivided into 12 regions, each of which is overseen by a CRSSS.
- Decision-makers of the day do not implement the Castonguay-Nepveu Commission's recommendations for regionalization to the extent suggested.
- In the end, the CRSSSs are only given the power to advise the ministry of health. The government limits popular participation to a formal context, the boards of directors.

1987

- Forming of the Rochon Commission.
- The Rochon Commission criticizes the functioning of the CRSSSs and proposes transforming the entities into Regional Health and Social Services Boards (Regional Boards) to be invested with real management authority.
- With this measure, Rochon proposes the decentralization of government resources towards regional authorities governed by boards of directors elected by and accountable to the population.

Between 1989 and 1992

- Quebec is the first province to establish regional health authorities invested with decision-making power.
- The *Act respecting health services and social services and amending various legislation* institutes 18 Regional Boards, each of which is administered by a regional assembly made up of 80 to 150 individuals.
- The government backs away from the advanced decentralization program proposed by the Rochon Commission. The Regional Boards are not given the authority to impose taxes, nor are their members to be elected by direct universal suffrage.
- The Regional Boards obtain significant authority with respect to health and social services. In general terms, "the main object of a regional board is to plan, organize, implement and evaluate, in the region, the orientations determined and policies established by the Minister" (Government of Québec, 1991, article 340).

- More specifically, the Boards are to identify the health and welfare needs and priorities in their territory of jurisdiction and develop an appropriate means of organizing services in consequence.
- They are to allocate resources for establishments, infrastructure and social and community services. The Regional Boards must also implement measures to protect public health.
- The Boards are responsible for ensuring the coordination of medical services offered in various categories of establishments such as hospitals, youth centres, Local Centres for Community Services (CLSCs), residential and long-term care facilities (CHSLDs) and rehabilitation centres.

1995

- The Regional Boards are no longer administered by regional assemblies elected by indirect universal suffrage.
- The assemblies are abolished in 1995 and are replaced by boards of directors made up of 23 to 24 indirectly elected members.
- The Regional Boards serve an average of 411 000 people and are accountable to the ministry of health.
- The institutions are accountable to the Regional Boards.

January 2001

- Submission of the recommendations of the Clair Commission.
- The recommendations of the Clair Commission give rise to the elaboration of Bill 28.

June 2001

- Adoption of Bill 28.
- This law modifies the composition of the boards of directors of the Regional Boards. The boards of directors are now made up of 16 or 17 members appointed by the ministry on the basis of recognized management skills and experience in the health care sector.
- The changes made to the operation of the Regional Boards by Bill 28 of 2001 result in the creation of “People’s Forums” composed of 15 to 20 members appointed by the Regional Boards. The forums are responsible for consulting the population to determine its satisfaction with services and to identify where better organization of health service delivery is needed.

December 2003

- Adoption of Bill 25 (*Act respecting local health and social services network development agencies*).

- This law marks a change in direction, re-centering service management at the local level.
- The Regional Boards are transformed into Regional Agencies responsible for implementing local health and social services networks.
- The key element of this reform consists of the merger, for a given territory, of CLSCs, CHSLDs and, barring exception, hospital centres.
- By means of agreements with other participants in the local network, namely community pharmacies, medical clinics and community organizations, these newly-created entities are responsible for ensuring the delivery of health services and social services to the population of a given territory.

January 2004

- As 2004 begins, the Health and Social Service Agencies embark upon the process of developing a model for the regional organization of services to be presented to the health minister by the end of April at the latest.

April 2004

- By April 30, 2004, all 16 agencies have submitted their respective models.

June 2004

- The minister announces the creation of local networks and implements 95 Health and Social Service Centres (CSSSs) in Quebec.

After June 2004

- The agencies pursue the implementation of local networks and develop their own respective clinical projects.

December 2004

- Bill 83 is submitted to the National Assembly.

November 2005

- Bill 83 is passed by the National Assembly.

Appendix 2: Research Template

A CROSS-PROVINCIAL COMPARISON OF HEALTH CARE POLICY REFORM IN CANADA RESEARCH TEMPLATE

Province: Quebec

Case study: Regionalization

Category	Subcategory	Data
Institutions	Structures (esp. federal government and/or department or legislative committee mandates)	<ul style="list-style-type: none"> ▪ The government of Quebec has long been interested in the regionalization of health care services, having instituted regional bodies (CRSSSs and Regional Boards) beginning in the 1970s. ▪ Over the course of its proceedings, the Clair Commission became interested in the issue and recommended changes to the operations of the Regional Boards in order to increase the accountability of the Boards and modify their governance structures. ▪ Bill 28 laid the groundwork for the reform brought about by Bill 25 by introducing results-based management, management agreements between the Regional Boards, the MSSS and health care establishments, and changes to the make-up of the boards of directors. ▪ In its platform for the elections of April 2003, the Quebec Liberal Party proposed reforming regional structures. ▪ The MSSS was given the mandate of proposing a new model for the organization of regional structures. Work committees were set up at the ministry. ▪ The implementation of the reform was a priority for the Liberal government at the beginning of its mandate. ▪ The minister and deputy minister of health played a central role in promoting the reform.
	Policies (esp. specific domestic court decisions and/or	<ul style="list-style-type: none"> ▪ Previous government decisions impacted the way in which the reform was handled.

	international agreements)	<ul style="list-style-type: none"> ▪ The <i>Act respecting health services and social services</i> of 1971 had introduced regional structures at the same time that the health care system was put into place. The Regional Health and Social Service Councils (CRSSSs) were deconcentrated regional bodies with very little authority (they acted as advisors to the minister). ▪ When the statutes were consolidated in 1991, the government introduced Regional Health and Social Services Boards (Regional Boards) endowed with real decision-making powers (the planning and organization of services, resource allocation). ▪ Bill 28 of 2001 introduced significant changes to the operations of the Regional Boards. Policy-makers reassessed governance practices (instituting a People’s Forum and revising the ways members were appointed to the boards of directors of local establishments and Regional Boards) and accountability links (introducing management agreements, annual reporting and the appointment of the executive directors). ▪ Law 25 of 2003 transformed the Regional Boards into Local Health and Social Services Network Development Agencies (Agencies). This reform package required local CLSCs, CHSLDs and hospital establishments in a given territory to merge and form local service networks (LSNs).
	Policy networks <i>(overlaps with Interests)</i>	<ul style="list-style-type: none"> ▪ Several groups of establishments (including the CLSCs and the CHSLDs) opposed the reform out of fear that the specific nature of their missions would be lost. ▪ Because its principal impact was on health care system structures, the public did not feel concerned by the reform, even though the end goal was to improve access to services. ▪ The government encountered significant reservations when Bill 25 was debated in the parliamentary commission.

	Other	<ul style="list-style-type: none"> ▪ Not addressed by the sources.
Interests	Societal interest groups	<ul style="list-style-type: none"> ▪ The population wanted improved access to services, but its demands lacked cohesion. ▪ The community groups, the unions and <i>Coalition Solidarité Santé</i> opposed the reform. ▪ Management associations and the executive directors of the health care system tended to be impartial on the issue. They were in favour of the basic principles even though it meant that several of their number would lose their positions. ▪ The health care system users' associations demanded that the bill be withdrawn (they agreed with the ends but not the means). The Council for the Protection of the Sick tended to be impartial (it agreed that a reform should take place). ▪ The association of CLSCs and CHSLDs opposed the merger of institutions. ▪ The Quebec Hospital Association (AHQ) supported the reform. ▪ The physicians' professional associations (the Quebec Medical Association, the <i>Fédération des médecins omnipraticiens</i> (FMOQ), the <i>Fédération des médecins résidents</i> (FMRQ), the Federation of Medical Specialists of Quebec (FMSQ) and the <i>Collège des médecins</i> (CMQ)) supported the reform. ▪ The <i>Fédération des infirmières et infirmiers du Québec</i> opposed it.
	Policy entrepreneurs (including researchers)	<ul style="list-style-type: none"> ▪ University researchers became very involved in the development of the model and the philosophy behind the reform. They advised the government on ways to execute integration. ▪ The faculties of medicine and the representatives of the university hospital centres (CHUs) opposed the integration of the CHUs into the LSNs. ▪ At the MSSS, research staff documented foreign experiences with structural regionalization reform.

	Elected officials	<ul style="list-style-type: none"> ▪ The minister of health took great interest in the Albertan regionalization model and the models proposed by the Regional Board of the Eastern Townships of Quebec (the Sherbrooke model). ▪ The Cabinet was reticent to transform the Regional Boards into Agencies, preferring that the regional tier be abolished altogether. Eventually, however, it agreed to the proposal of Health Minister Couillard. ▪ The members of the opposition criticized the reform. They were in favour of the underlying philosophy of integration, but opposed merging establishments in order to attain that objective (structural changes were unnecessary).
	Civil servants	<ul style="list-style-type: none"> ▪ The bureaucrats of the ministry of health had to decide on the basic principles of the reform package while adhering to the political directives of Minister Couillard. ▪ At the MSSS, a small team made up of professionals for strategic planning, deputy ministers and counsellors participated in the elaboration of the reform package.
	Other	<ul style="list-style-type: none"> ▪ Not addressed by the sources.
Ideas	Knowledge / beliefs about what “is”	<ul style="list-style-type: none"> ▪ Researchers at the MSSS identified foreign experiences with regionalization but focussed mainly on Canadian models. ▪ The (two-tiered) Albertan model inspired the greatest interest. The principle of integration seemed interesting, but the size of the merged institutions was felt to be excessive. ▪ University research data on the regionalization and integration of services was also consulted. ▪ The Clair Commission was another source of inspiration. ▪ The main principles underlying the reform package were the following: the integration of structures and services, population-based responsibility, the transformation of the regional tier and changes to governance practices.
	Values / views about “what ought to be”	<ul style="list-style-type: none"> ▪ There seemed to be consensus on the objectives behind the reform package,

		<p>but not on the means of attaining them (forced mergers).</p> <ul style="list-style-type: none"> ▪ Integration seemed to be a solution to problems of access to services. ▪ There were also differences of opinion on the concrete ways in which the concepts would be put into effect.
	Combined (e.g., commission recommendations)	<ul style="list-style-type: none"> ▪ Significant influence of the Clair Commission.
	Other	<ul style="list-style-type: none"> ▪ Not addressed by the sources.
External events	Release of major report (e.g., commission)	<ul style="list-style-type: none"> ▪ The Clair Commission report stimulated interest in possible modifications to regionalization. ▪ The Liberal electoral platform was responsible for putting the idea on the agenda.
	Political change (e.g., election, cabinet shuffle) – provincial and national	<ul style="list-style-type: none"> ▪ The reform was launched as a result of the change of government of April 2003. The Liberal victory was of capital importance because the reform proposal was at the core of the party's electoral platform.
	Economic change (e.g., recession)	<ul style="list-style-type: none"> ▪ The budget cuts of the 1990s influenced the evolution of the regional structures.
	Technological change (e.g., MRI scans)	<ul style="list-style-type: none"> ▪ Not addressed by the sources.
	New disease (e.g., SARS)	<ul style="list-style-type: none"> ▪ Not addressed by the sources.
	Media coverage (e.g., deaths on the waiting list)	<ul style="list-style-type: none"> ▪ Not addressed by the sources.
	Other	<ul style="list-style-type: none"> ▪ Not addressed by the sources.