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Improving Accessibility to Services and Increasing Efficiency Through Merger and Centralization in Québec

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Abstract

On 25 September 2014, Bill 10 was tabled to reorganize Québec's health and social services network through the abolition of an administrative layer at the regional health authority level and institutional mergers of health and social services facilities under a new governance structure. Thus, the province's 182 health and social services facilities were merged into 34 *Centre intégré de santé et des services sociaux* (CISSS) / *Centre intégré universitaire de santé et des services sociaux* (CIUSSS). CISSS/CIUSSS are responsible for delivering a range of health and social services in a designated territory through the administrative integration of facilities including: local community health centres, generalized and specialized hospitals, psychiatric hospitals, child and youth protection centres, residential and long-term care centres, and rehabilitation centres. These mergers were operationalized notably by a new governance structure whereby the minister-appointed board of directors in each CISSS/CIUSSS reports directly to the Minister of Health and Social Services. As such, a centralization of powers was also achieved. While formal evaluations of reform performance have yet to be completed, analyses projecting potential difficulties of the reform were presented during special consultation hearings. Among the key concerns identified was whether there was evidence to support claims that administrative mergers increased efficiency by achieving economies of scale. Additionally, implicit to Bill 10 is the assumption that continuity of care will follow from administrative mergers. Strategic mergers through professional networks can promote more streamlined approaches to information sharing.

Le projet de loi 10, déposé le 25 septembre 2014, a mis en œuvre une réorganisation du réseau québécois de la santé et des services sociaux québécois à travers l'abolition des postes administratifs liés aux régies régionales de santé et services sociaux et la fusion institutionnelle des établissements de santé et de services sociaux. Ainsi, les 182 établissements de santé et de services sociaux de la province ont été fusionnés en 34 Centre intégré de santé et des services sociaux (CISSS) / Centre intégré universitaire de santé et des services sociaux (CIUSSS). Les CISSS / CIUSSS sont chargés de fournir une gamme de services sociaux et de santé sur un territoire désigné grâce à l'intégration administrative des établissements suivants: centres de santé communautaires locaux, hôpitaux généraux et spécialisés, hôpitaux psychiatriques, centres de protection de l'enfance et de la jeunesse, centres hospitaliers de soins de longue durée, et centres de réadaptation. Ces fusions ont été opérationnalisées notamment par une nouvelle structure de gouvernance où le conseil d'administration nommé par le ministre dans chaque CISSS / CIUSSS relève directement du ministre de la Santé et des Services sociaux. De fait, cette réforme a résulté en une centralisation des pouvoirs vers le ministre. En dépit de l'absence d'évaluations d'impact formelles de la réforme, maintes parties prenantes ont témoigné de leurs inquiétudes en regard des effets

potentiels de la réforme au cours des audiences à l'assemblée générale. Parmi les principales préoccupations identifiées, notons le manque d'évidence concernant l'argument que les fusions administratives augmenteraient l'efficience en réalisant des économies d'échelle. De plus, l'argument que les fusions administratives amélioreraient la continuité des soins a été questionnée comme justifiant la réforme. Les fusions stratégiques à travers des réseaux professionnels peuvent en effet également promouvoir des approches rationnelles du partage de l'information, sans nécessiter de réformes aussi fondamentales du système.

Key Messages

- Bill 10 in Québec achieved greater centralization of powers through the abolition of an administrative layer at the regional health authority level and institutional mergers of health and social services facilities under a new governance structure.
- This reform comes 10 years after the latest major organizational reform in Québec.
- The reform has the potential to facilitate access to and continuity of care by integrating service delivery silos across the continuum of health and social services.

Messages-clés

- *Le projet de loi 10 au Québec a résulté en une centralisation des pouvoirs à travers l'abolition des régies régionales de santé et des fusions institutionnelles d'établissements de santé et de services sociaux sous une nouvelle structure de gouvernance.*
- *Cette réforme survient seulement 10 ans après la dernière grande réforme organisationnelle au Québec.*
- *La réforme a le potentiel de faciliter l'accès et la continuité des soins en intégrant des silos de prestation de services en un continuum de services de santé et sociaux.*

1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORM

On 25 September 2014, Bill 10 was tabled to reorganize Québec's health and social services network through institutional mergers and new management structures. The reform resulted in a centralization of powers with the Minister of Health and Social Services, through the abolition of regional health authorities (*Agences de santé et des services sociaux*), and the merger of health and social facilities into integrated health and social services centres (*Centre intégré de santé et des services sociaux*, CISSS or *Centre intégré universitaire de santé et des services sociaux*, CIUSSS) with a direct report to the minister. These mergers reduced the number of health and social services facilities in the province from 182 various facilities to 34 CISSS/CIUSSS (*Radio-Canada* 2015). Furthermore, this reform abolished an administrative layer, that of the 18 regional health authorities formerly serving as an intermediary between the ministry and 95 local health and social services networks (*Centres de santé et des services sociaux*, CSSS). The 2014 reform thus rescinds administrative structures created in a previous organizational reform in 2004 that sought to promote a network of institutions in the public, private and community sectors, notably to support a population health approach to service delivery (Bourque and Quesnel-Vallée 2014).

The second component of Bill 10 was a change in the governance model that instituted a direct reporting relationship between the Minister of Health and Social Services and the minister-appointed board of directors (BoD) in each CISSS/CIUSSS. Under the reform, each CISSS/CIUSSS is responsible for ensuring access to the full range of health and social services in its territory. Accordingly, the BoD for each CISSS/CIUSSS now manages one overarching budgetary envelope for its different subsidiary health and social service institutions including: local community health centres, generalized and specialized hospitals, psychiatric hospitals, child and youth protection centres, residential and long-term care centres, and rehabilitation centres (SQ 2015, c 1).

2 HISTORY AND CONTEXT

Earlier organizational reforms in Québec in 2004 tasked the 18 regional health agencies with overseeing the development 95 local service networks (CSSS). The CSSS resulted from merging long-term care facilities, local community health centres, and a general or specialized hospital centre within specific geographically-defined areas (territories) to promote continuity of service delivery across different health care sectors. Furthermore, the merger aimed to ensure that service delivery arrangements met the needs of the population within the territory of each CSSS. The creation of the CSSS was credited with granting health managers more flexibility in resource distribution by expanding the conventional approach of service delivery to also include public health interventions that were relevant to a territory's population (Breton *et al.* 2009). Bill 10 pursues the centralization agenda further

by abolishing regional health agencies, adopting the administrative amalgamation of public institutions with government-appointed boards of directors, and including other social services in its mandate, such as youth protection.

However, Québec is not the only province in Canada to have pursued centralization activities in the recent past. In 2008, the government of Alberta went to greater lengths in its controversial restructuring of the health care system by creating a single health authority "super board," Alberta Health Services, that oversaw service delivery across Alberta (MacAdam and Mackenzie 2008). The objectives of the reform were to increase transparency and accountability in the health system, increase efficiency by abolishing levels of management, and standardize health service delivery across Alberta so that all users have access to the same services. Opponents voiced their concerns about the super board in the early implementation phases of the reform by denouncing its focus on administrative efficiency at the expense of responsiveness to the demands on the health system (*Edmonton Journal* 2015). Stakeholders in rural areas argued that their needs could not be adequately met under the super board model. There were also concerns that the reform would stifle local health care leadership and innovation (MacAdam and Mackenzie 2008).

In Québec, Bill 10 was criticized for its hasty upheaval of the health system's organization and the lack of an evidence base for justifying the change (Contandriopoulos *et al.* 2014). Reforms that either regionalize or centralize health services in Canada have been critiqued for their inconsistent application. This is explained in part by the lack of defined performance indicators to gauge whether restructuring has improved aspects of management and health service delivery (MacAdam and Mackenzie 2008). As such, assessments of reforms are usually limited in their ability to determine what has changed in response to the introduction of a reform. The absence of performance indicators, in addition to the lack of measures of baseline performance, impedes evidence-based analyses of reform impacts. Bill 10 mentions the need for institutions to develop performance indicators for approval by a board of directors yet it does not indicate whether these indicators will be known to the public nor whether institutional performance will be publicly reported.

3 GOALS OF THE REFORM

3.1 Stated goals

While there is evidence to show that decentralized models of service delivery contribute to improved health outcomes, they have been found to do so at a greater monetary expense making their potential to reach greater efficiency questionable (Alves, Peralta and Perelman 2013). Bill 10 targets the decentralized aspects of the health system management with the aim of promoting integration of health services. It has three explicit objectives, in line with other international reforms pursuing the "triple aim" (Berwick, Nolan and Whittington 2008) of: *1*) improving the accessibility of services, *2*) improving the quality and safety of services, and *3*) increasing efficiency.

3.2 Implicit goals

The reform fundamentally restructures the governance of health and social services facilities in Québec. Formerly, each facility functioned under the governance of institutional boards of directors comprised of elected individuals along with user committees that ideally operated together to serve the interests of the community. Merging these establishments and creating one overarching governance structure provides increased capacity for aligning the incentive structures of these establishments and integrating services. This offers the potential for overcoming concerns about fragmented services under the previous regional health authority model. Beyond service integration, however, the ministerial power to appoint the boards of directors can result in politicized institutions if individuals who are sympathetic to the reform's objectives are named to positions of authority (RPCU 2014).

4 FACTORS THAT INFLUENCED HOW AND WHY THE ISSUE CAME ONTO THE GOVERNMENT AGENDA

4.1 Interests

Bill 10 responds to the minister's objectives to increase accountability and transparency in the health care system during his mandate. Abolishing the regional health authorities reduces bureaucracy and theoretically establishes direct communication between the minister and the individuals overseeing health care institutions across the province. Proponents of Bill 10 argue that a centralized model will promote integrated services and improve experiences of care among users. Fewer actors in positions of authority indeed streamlines the monitoring of activities and the accountability exercise of institutions within the health and social service networks.

In light of the major restructuring imposed by Bill 10, special consultation hearings were held with different stakeholders who mobilized to present briefs to the minister. These actors included public institutions, professional associations, universities, academic/research institutes, members of the health and social services network, and community organizations. Few of the stakeholders that presented during the consultation hearings were in favour of the reform. A common interest was the desire to maintain adequate autonomy and representation amidst the mergers. Representatives of the social services, particularly in youth protection, raised concerns about the medico-centric orientation of the amalgamations and the subsequent budgetary decisions that would be dominated by the demands of the hospital centres.

4.2 Ideas

The stakeholders were in general agreement on the objectives pursued by the government in its reform, namely increased access to care, improved quality and safety, and greater

efficiency. Rather, it is the policy instruments used to implement the reform that were contentious. Arguments in favour of institutional mergers cite their potential to streamline service delivery and improve the coordination of services (RPCU 2014). Yet the evidence showing the effectiveness of administrative mergers in increasing access to and improving the quality of services is tenuous (Béland *et al.* 2014). Nonetheless, the policy is consistent with the minister's orientation toward greater accountability, transparency, and productivity in the health care system.

Bill 10 implies that the most efficient way of organizing the delivery of goods and services is through a hierarchical top-down approach to management. Conversely, health care organizations have also been described as complex institutions that are shaped by professional interactions (Béland *et al.* 2014). Vertical integration to avoid the silo effect can be achieved through professional networks by facilitating the conditions under which information can be shared (e.g., electronic health records). Administrative mergers assume that the populations served by separate institutions are similar, which potentially undermines population health approaches to service delivery, particularly if institutions span wide geographic areas (Béland *et al.* 2014).

4.3 Institutions

Bill 10 overhauled the health and social services sector and reoriented the responsibilities of existing levels of management. The government-appointed board of directors reduced the amount of influence health service user committees have in decision-making. While they were an elected body prior to the reform, Bill 10 allows them to be appointed by the minister. Furthermore, the inability to elect those who are expected to represent community interests can result in redirecting a focus away from patient engagement in care toward meeting access, efficiency, and productivity targets. Indeed, the reform is decreasing the number of health service user committees (*Comités des usagers*) from 300 to 28 (RPCU 2014).

5 HOW THE REFORM WAS ACHIEVED

5.1 Policy instruments

Bill 10 was implemented through centralization of power and administrative institutional integration. The reform marks a shift away from regionalization by changing the health and social services governance model. Namely, this refers to the creation of new boards of directors that are government-appointed as opposed to being elected members. Consequently, the new governance model grants the minister significant leverage over the organization of the institutions including the power to intervene at the managerial level when decisions are deemed in opposition to overarching health system goals (SQ 2015, c 1). Related to the changes in governance model was the integration of health and social services through the

administrative mergers of institutions. Amalgamations supported the creation of a single board of directors to oversee the delivery of services on their respective territory-defined networks (MSSSQ 2016).

5.2 Implementation plan

Regarding changes related to the governance of institutions, the minister appoints a board of directors on a three-year term basis. The board consists of a president and executive director, medical professionals, a representative of the user committee, seven to eight independent individuals, and finally, if applicable, a representative affiliated with a university hospital (MSSSQ 2016). The board is responsible for organizing services so that they meet provincial objectives. Furthermore, it must equitably distribute human, physician, and financial resources to the institutions in its territory. In turn, the minister oversees the coordination of services and facilitates the creation of service delivery corridors between territories when necessary (SQ 2015, c 1).

Certain regions in northern Québec are excluded from the clauses outlined in Bill 10, ostensibly because of low population density and indigenous self-determination agreements. Conversely, in recognition that some areas contain a greater population density than others, these areas have multiple CISSS/CIUSSS as opposed to one for the entire territory. These areas include the island of Montreal on which five regional institutions are present (SQ 2015, c 1). Following the special consultation hearings, the Montérégie area was granted three regional institutions in response to a request raised by the representatives of user committees (RPCU 2014).

6 EVALUATION

Given the application of Bill 10 in February 2015, changes are in the early stages of implementation and therefore formal evaluations of performance indicators have yet to be released. To date, no study has been published on the impacts of Bill 10 on indicators of health system performance. Bill 10 references a framework for evaluating institutional performance to which the CISSS/CIUSSS boards of directors are accountable. Under the framework evaluation criteria, every institution included in the CISSS/CIUSSS must devise indicators for access to health services to be approved by the board of directors, and in some cases, the health minister.

While formal evaluations of reform performance have yet to be completed, analyses projecting potential difficulties of the reform were presented during special consultation hearings held over the course of two weeks in the Fall of 2014. Among the key concerns identified was whether there was evidence to support claims that administrative mergers increased efficiency by achieving economies of scale (Contandriopoulos *et al.* 2014). Indeed, the optimal size of the organization is an important consideration if an objective is to maximize efficiency. Larger health care institutions are not inherently more efficient if they

are inflexible in their response to changing demands (Béland *et al.* 2014). Furthermore, concerns have been voiced by multiple stakeholders that the majority of health regions will now count just one CISSS to conduct the activities that were once pursued by multiple CSSS (Béland *et al.* 2014; Contandriopoulos *et al.* 2014; FMOQ 2014; RCPU 2014).

If the administrative mergers are successful and promote information sharing between institutions, then Bill 10 does present an opportunity for improved continuity of care between tertiary and primary care services. Functional networks that existed prior to the reform have a chance at improving on their service to patients if they have access to more resources within the system. Ultimately, professional attitudes and organizational cultural change will be critical determinants of the legitimacy of imposed changes (Béland *et al.* 2014).

7 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

The briefs submitted by different stakeholders prior to the special consultation hearings informed this analysis of the strengths, weaknesses, opportunities and threats of Bill 10. The stakeholder perspective is indicated in brackets.

Table 1: SWOT Analysis

Strengths	Weaknesses
• Greater oversight of the delivery and organization of health and social services (*minister*) • Increased transparency and accountability in the health system (*minister*, *administrators*) • Potential to facilitate access to and continuity of care by dissolving service delivery silos (*users*, *providers*, *minister*)	• Institutions are perceived as mechanical entities as opposed to complex and dynamic ones with community roots (*administrators*, *community*, *users*) • Removing democratic processes for electing institutional boards of directors and replacing them with government-appointed boards (*administrators*, *physicians*, *community*) • One board of directors to oversee delivery of diverse health and social service mandates within a large territory (*administrators*, *physicians*, *community*) • Professional networks are overlooked as important components to high functioning institutions (*administrators*, *providers*)

Opportunities	Threats
• Possibility of reducing health system expenditures by removing layers of bureaucracy (*minister*) • Increased government influence in the organization of health and social services through appointment of boards of directors (*minister*) • Administrative mergers can support service corridors and facilitate patient navigation of the health and social services system (*users*) • Increased transparency and accountability in the health system (*community*, *users*) • Larger establishments could allow for economies of scale and a critical mass for developing increased specialized capacity (*all stakeholders*)	• Reduced focus on population health due to creation of large territories with different service user needs (*users*) • Centralization limits leadership and innovation from within institutions (*administrators*, *providers*) • Lack of representation from different institutional sectors, particularly social services, leading to misallocation of resources (*administrators*, *community*)

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