McGill Centre for Research on Children and Families

Reorganizing health and social services in Québec in the name of austerity: Too much, too fast and too centralized?

Background discussion paper prepared by (in alphabetical order): Delphine Collin-Vézina; Melanie Doucet; Élodie Marion; David Rothwell; Catherine Roy; Nico Trocmé & Jaime Wegner-Lohin.

Centre for Research on Children and Families, McGill University
April 8th 2015

In the name of fiscal responsibility, the government of Québec has recently launched a major restructuring of the province's health and social services system. Promising not to cut direct services to the population, the reorganization focuses on reducing middle and senior levels of management. The scope of the changes, and in particular dismantling 182 community boards and management teams, raises questions about a fundamental shift away from local governance to centralized management of health and social services. This background paper outlines some of the questions that arise from these changes.

Are public sector spending cuts needed?

There is no denying that Québec's financial situation is pressing, and that tough decisions need to be made regarding public spending. Of all Canadian provinces, Québec has both the highest net government debt per capita, standing at $22,316 on March 31, 2014, as well as the highest net debt as a percentage of GDP, calculated at 50.1% in March 2014.[1] Ontario is second highest on both these measures, with a per capita net debt of $19,717 and a net debt representing 38.4% of its GDP. Factoring Québec's portion of the federal debt, Québec's combined net debt is 87% of its GDP[2]. Comparing combined debts across countries, the IMF ranks Canada as having the 13th highest gross debt to GDP ratio among the 30 most advanced economies.[3] As a society, we must be mindful that debt cannot continue to increase without consequences. Québec is paying more and more towards interest rather than paying for investment in human and social services.

[1] http://www.stat.gouv.qc.ca/statistiques/economie/comparaisons-economiques/interprovinciales/chap13.pdf
[2] http://business.financialpost.com/entrepreneur/cfib/canadian-debt-levels-arent-as-they-appear?__lsa=cba8-8590
[3] http://www.imf.org/external/pubs/ft/fm/2013/01/pdf/fm1301.pdf

How are services being reorganized?

The *Loi modifiant l'organisation et la gouvernance du réseau de la santé et des services sociaux notamment par l'abolition des agences régionales*, adopted February 7, 2015, calls for a major restructuring of the health and social services system in Québec, and has been touted as a cost-saving measure. It came into effect on April 1, 2015. The reform has led to the abolishment of the regional health and social service agency boards[4] (initially created in a reform of the early 1990s), thereby wiping out a level of management in the health and social services network, cutting it down to only 2 managerial levels. The lower level of management has also been greatly reduced: the number of public institutions and public institution boards dropping to 34 from the previous 182.[5] The agencies and public institutions of each of the 16 socio-health regions affected by the law have been fused to create 13 *Centres intégrés de santé et de services sociaux (CISSS)*, with a further seven establishments remaining independent (établissements non-fusionnés)[6]. Each CISSS is at the heart of a *Réseau territorial de services (RTS),* and is governed by a Board of Directors named by the Minister of Health and Social Services. Management of each CISSS is entrusted to a President-Director General, also named by the Minister.

Is bigger better?

Service integration has been defined by Contandriopoulos et al. (2001) as the organization of "sustainable consistency in time between a value system, a control surface and a clinical system to create a space in which the actors (organizations) are interdependent and find sense and a benefit to coordinate their actions in a particular context" (p.38). Lamarche et al. (2001) have suggested that, in order for service integration to achieve its desired results, focus must be placed on "the organization of service delivery rather than on the merger or integration of institutions" (p.71). These authors have stressed that, in service integration, efforts must be directed towards understanding and influencing human, clinical and organisational factors rather than purely structural factors (Lamarche et al., 2001).[7]

Proponents of institutional mergers tend to assert that larger, integrated systems will be able to achieve greater efficiencies and improve outcomes (Gaynor et al., 2012; Tsai & Jha, 2014). Yet, research in the health and social services field indicate results are not always convincing. Larger hospitals for example, do not necessarily benefit from economies of scale and service concentration does not necessarily lead to improved patient outcomes (Posnett, 1999). According to Weil (2010), merging organizations does not generate cost savings nor improves quality of care. In a study examining the impact of mergers on

[4] The Conseil Cri de la santé et des services sociaux de la Baie-James remains untouched by the reform.
[5] When the new law was introduced there were 182 public institutions in the province: 94 *Centres de santé et de services sociaux*; 68 *Établissements assumant, de façon unique ou multiple, les missions d'un CH, d'un CR ou d'un* CHSLD; 16 *Centres jeunesse*; et 4 *Établissements, situés dans les régions nordiques, assumant toutes les missions*.
[6] *Centre hospitalier de l'Université de Montréal; Centre hospitalier universitaire Sainte-Justine; Centre universitaire de santé McGill; Institut de cardiologie de Montréal; Institut Philippe-Pinel de Montréal; Centre hospitalier universitaire de Québec; Institut universitaire de cardiologie et de pneumologie de Québec*
[7] Organisational factors include the mission of the organisation, objectives, sharing responsibilities, mode of communication, and organisational culture (Goyette et al., 2006). Clinical factors include training, the type of interventions, and the capacities of the service professionals (Goyette et al., 2006). The human/personal factors include the values, relational abilities, and attitudes of staff (Sloper, 2004; Darlington & al., 2005; Goyette & al., 2006).

outcomes such as financial performance, productivity, waiting times and clinical quality, little evidence was found that mergers do achieve gains in these areas (Gaynor et al., 2012). In fact, consolidation efforts are hindered by the fact that those in leadership positions often lack the necessary understanding and appreciation of the differences in culture, values and goals of existing facilities (Weil, 2010). Differences in organisational culture can act as a significant barrier to bringing organizations together (Fulop et al., 2002). As a means of overcoming this barrier, Posnett (1999) suggests that policy makers should prioritize ensuring services are local and easily accessible. As an example of a promising structure, Kazepov (2014) describes a strong local autonomy that is nonetheless organized centrally, with the State retaining its primacy in the decentralization process and attempting to reduce territorial variations. This is in line with the principle of subsidiarity, which means that the responsibility of a public action is to be allocated to the smallest entity capable of solving the problem itself for better outcomes (Andreotti et al., 2012). Other means of increasing efficiency and effectiveness include cross-agency collaboration and team-based integrative service delivery (Pfeiffer & Reddy, 1998; EECD, 2010; Frankford, 2007).

How have mergers worked in other provinces?

In 2009, the Ontario government established a Commission to Promote Sustainable Child Welfare, which had a three-year mandate to develop and implement solutions to promote the sustainability of child welfare in Ontario. Early findings of the Commission indicated that the services children and families received varied based on the Children's Aid Society (CAS) that they came into contact with, where some experienced a higher degree of coordination of services than others (Commission to Promote Sustainable Child Welfare, 2010). The Commission developed a four-tiered strategy to promote sustainable child welfare system across the province. The first tier within this strategy involved reconfiguring the organization of CAS structures and service delivery based on a child population threshold, an agency size threshold and the presence of logical local partners (Commission to Promote Sustainable Child Welfare 2010; 2012). In contrast to the model of service integration in Quebec, the reconfiguration of services in Ontario involved an *incremental* approach. By April 2012, 13 out of 53 CAS were amalgamated to create six new organizations (Commission to Promote Sustainable Child Welfare, 2012).

While the focus of reconfiguration of services was primarily focused on child welfare, integration of children's services was encouraged where warranted by community circumstances (Commission to Promote Sustainable Child Welfare, 2010). Though not widespread across the province, the Ontario government encouraged some communities to move toward integrated models for providing related services that vary in structure and funding, including child welfare, youth justice and children's mental health (Commission to Promote Sustainable Child Welfare, 2010; Ontario Association of Children's Aid Societies, 2014). The integrated service models are structured in various ways, ranging from blended organizations that have amalgamated with other social service agencies to others that end up performing more services than they are funded and mandated for due to a lack of community supports (Ontario Association of Children's Aid Societies, 2014). In some circumstances, Children's Aid Societies receive funding from the government to provide additional services, whereas others work with the community to receive donations and funding to provide supports to the children and families (Ontario Association of Children's Aid Societies, 2014).

Since 2010, New Brunswick has been piloting a regionally-based integrated service delivery model in two regional sites involving child and youth serving departments and regional agencies, specifically the departments of Social Development, Health (specifically Mental Health and Addictions Services and Regional Health Authorities), Early Childhood and Education (including School Districts), and Public Safety. This new service delivery approach came about as a response to the province's Ombudsman and Child and Youth Advocate high profile *Ashley Smith* and *Connecting the Dots* reports, which outlined the need for departments to work better together in addressing the needs of at-risk and high risk children and youth. Based on an extensive review of best practices in other jurisdictions and an extensive consultation process with provincial and regional stakeholders, regional governance structures and Child and Youth Teams were implemented to deliver on site integrated assessment and intervention services within the school, family and community contexts, with each team assigned a cluster of schools from elementary to high school within their given region. The teams are comprised of an interdepartmental workforce devoted on a full-time basis through pre-defined work arrangements and are tasked to develop collaborative working relationships and service linkages with other specialized, departmental and community agencies that provide essential supports to meet the adaptation needs of children, youth and their families. A provincial governance structure was also established to support the regions and make high-level decisions pertaining to the sustainability of the pilot project.

An evaluation of the pilot sites was completed in 2013 by the *Centre de Recherche et de Développement en Éducation* (CRDE) at Université de Moncton, which showcased promising impacts of integrated service delivery approaches on child and youth outcomes. For instance, a significant reduction in wait times for services was seen in both pilot sites (89% and 100% reduction in mental health services waiting lists), as well as a decrease of mental health issues and an increase in classroom adaptation in children and youth. In contrast to Canadian mental health services statistics, where only 1 in 5 youth receive the services they require, in the pilot sites over 3 out of 5 youth in need received treatment services during the two year evaluation period, with service accessibility constantly improving. A pre- and post-pilot phase costing analysis[8] was also completed, which demonstrated that nearly double the number of children were being serviced since implementation of the new approach, and that the recurring costs associated with the project would be balanced in less than 3 years, with subsequent cost savings to be achieved thereafter. These findings combined with the qualitative and quantitative pilot phase evaluation demonstrate that the benefits of implemented integrated service delivery approaches via multidisciplinary service delivery teams and interdepartmental integration are considerable, both on a systems efficiency level and a child and youth outcomes level.

[8] B. Eckstein, personal communication, January 16, 2015

A focus on how service integration might affect youth protection services.

The merger of youth protection centres into regional multi-service health and social services agencies is likely to destabilize a complex risk management system leading to a significant increase in youth protection cases. Responding to reports of possible child abuse or neglect and providing protective services requires a decision-making and service delivery structure that can respond in an effective and timely fashion to these complex situations. Under the guidance of the Director of Youth Protection, front-line social workers supported by supervisors with extensive youth protection experience must find the right balance between intervening in situations where youth protection involvement is absolutely necessary versus referring families to more appropriate community and prevention services. This response system rests on clearly delineated lines of responsibility within organizations that are focused on the youth protection mandate.

Compared to other jurisdictions across Canada, Quebec has a particularly efficient youth protection triage and case management system[9]. Ontario, for example, conducts four times as many child protection investigations per capita, yet ends up providing a similar number of services on an ongoing basis. Merging Youth Protection Centres with large regional health and social service agencies runs the risk of undermining the delicate risk management system that characterizes Quebec's efficient youth protection system. This change could lead to an increase in the number of youth protection investigations, diverting scarce resources away from prevention and intervention services.

Moving forward

The merger of health and social service agencies has occurred. Services will be delivered through significantly larger a more centralized organizations. Moving forward means focusing on the opportunities for better integration of services and greater inter-sectoral and inter-professional collaboration. The loss of local governance structures will require greater efforts to engage communities in service delivery. As social work professionals we can play a key role in ensuring that the potential for collaboration across services in maximized and that these structures remain community focused; as social work researchers we must monitor and evaluate the impact of these changes.

[9] Trocmé, N., Collin-Vézina, D., Roy, C. et al. (2014) Projet de loi 10 et services de protection de la jeunesse: des impacts à considérer. Centre for Research on Children and Families, Montréal, Qc.

References

Brousselle, A., J.-L. Denis, & A. Langley (1999). *What Do We Know About Hospital Mergers? A selected annotated bibliography*. Ottawa: Canadian Health Services Research Foundation.

Commission to Promote Sustainable Child Welfare. (2010). *Towards sustainable child welfare in Ontario*. Toronto, ON.

Commission to Promote Sustainable Child Welfare. (2012). *Realizing a sustainable child welfare system in Ontario: Final report*. Toronto, ON.

Contandriopoulos, A-P., Denis J-L., Touati N. & Rosario R. (2001). Intégration des soins, dimensions et mise en œuvre, *Ruptures, revue transdisciplinaire en santé, 8*, 38-52.

Darlington, Y. & al. (2005). Interagency collaboration between child protection and mental health services: Practices, attitudes and barriers, *Child Abuse & Neglect,* 29, 1085–1098

Department of Early Childhood and Education (2004, July). Integrated Service Delivery description. EECD: Fredericton, N.B. Internal document shared via email communication, January 16, 2015.

EECD - New Brunswick Department of Early Childhood and Education (2010). An Integrated Service Delivery Framework for New Brunswick: Synthesis of the Literature on Integrated Service Delivery, Fredericton, N.B. 52p.

Fulop, N., & al., (2002). Process and impact of mergers of NHS trusts: multicentre case study and management cost analysis. *British Medical Journal, 325*, 246.

Gaynor, M., Laudicella, M. & Propper, C. (2012). Can governments do it better? Merger mania and hospital outcomes in the English NHS. *Journal of health economics, 31*, 528-543.

Goyette, M., C. Bellot, & J. Panet Raymond (2006). *Le projet Solidarité jeunesse. Dynamiques partenariales et insertion des jeunes en difficulté*, Collection Problèmes sociaux et interventions sociales, PUQ, 184 p.

Horwath, J. & Morrison T. (2007). Collaboration, integration and change in children's services: Critical issues and key ingredients, *Child Abuse & Neglect, 31*, 55–69

Kazepov, Y. (2014). Les nouvelles frontières de la citoyenneté sociale : Les villes au sein de dispositifs de gouvernance multi-niveaux en Europe, *Sociologie,* [en ligne], http://sociologies.revues.org/4819.

Lamarche, P., Lamothe, L. Begin, C., Leger, M. & Vallières-Joly, M. (2001). L'intégration des services: enjeux structurels et organisationnels ou humains et cliniques ? *Revue transdisciplinaire en santé, 8*, 71-92.

Ontario Association of Children's Aid Societies. (2014). *Ontario child welfare report*. Toronto, ON. Retrieved from: http://www.oacas.org/newsroom/releases/2014/2014_child_welfare_ report.pdf

Posnett, J., (1999). The hospital of the future Is bigger better? Concentration in the provision of secondary care. *British Medical Journal, 319*, 1063-1065.

Sloper, P. (2004). Facilitators and barriers for co-ordinated multi-agency services. *Child: Care, Health & Development, 30,* 571–580

Trocmé, N., Collin-Vézina, D., Roy, C. et al. (2014). *Projet de loi 10 et services de protection de la jeunesse: des impacts à considérer*. Centre for Research on Children and Families, Montréal, Qc.

Tsai, T.C. & Jha, A. (2014). Hospital consolidation, competition, and quality: is bigger necessarily better? *JAMA, 312*, 29-30.

Weil, T. (2010). Hospital mergers: a panacea? *Journal of Health Services Research & Policy, 15*, 251-253.

Williams, P. (2013). We are all boundary spanners now? *International Journal of Public Sector Management, 26*, 17-32.

http://www.msss.gouv.qc.ca/en/reseau/reorganisation/faits-marquants

http://www.msss.gouv.qc.ca/reseau/etablissements.php

https://www.aqesss.qc.ca/docs/public_html/document/Documents_deposes/Tab_com_PL10_20141003.pdf

http://www.acssss.qc.ca/wp-content/uploads/2014/01/R%C3%A9sum%C3%A9s-des-changements-Projet-de-Loi-10.pdf

http://www.rpcu.qc.ca/pdf/communiques/amendements_projet_loi_10.pdf

http://www.fin.gc.ca/afr-rfa/2014/report-rapport-eng.asp

http://business.financialpost.com/entrepreneur/cfib/canadian-debt-levels-arent-as-they-appear?__lsa=cba8-8590

https://data.oecd.org/gga/general-government-debt.htm

http://www.imf.org/external/pubs/ft/fm/2013/01/pdf/fm1301.pdf

http://www.finances.gouv.qc.ca/en/page.asp?sectn=36&contn=335