

**Case study on the Leadership Issues Associated With the Development of the  
Quebec Public Health Program**

**Presented to the Mid America Public Health Leadership Institute**

**by the Quebec team**

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### **Once upon a time there was a program...**

In November 2002, Quebec's department of health and social services (*ministère de la Santé et des Services sociaux*, MSSS) made public its national public health program. This program defines the scope of public health action in Quebec and sets out the priorities and activities to be undertaken for the regional partners of public health departments (DSPs) and local partners (the local community service centres or CLSCs).

Our case study focuses on the challenges involved in developing this program and the leadership exercised by various stakeholders to meet these challenges. This document is an initial assessment resulting from consultation with several key stakeholders. It will serve as a basis for a discussion of the challenges with a group of Quebec's public health leaders. This discussion will allow us to gather ideas to help implement the program and prepare and implement the action plans resulting from it.

### **Context and stakeholders**

Quebec's health and social services network, a deconcentrated system accessible to the whole population, is made up of several partners acting at different levels. At the provincial level, the MSSS funds this network and defines major orientations, policies and programs, both curative and preventive. The 18 regional boards plan and co-ordinate services, allocate resources, monitor the budgets of the institutions in their region and ensure that results are achieved for their region, while the institutions manage the care and services that they deliver. The regional boards also provide regional public health services through the mandate given to public health directors. The CLSCs provide curative and preventive services and are the local public health mandataries while the medical clinics deliver care and some preventive services. Finally, several community organizations provide preventive community services.

Over the last twelve years, the MSSS has produced about 20 documents addressed to public health stakeholders and other resources of the health and social services network. They are, for example, the Policy on Health and Well-being (1990), the Framework for the Development of the Public Health Program and the Organization of the Public Health

Network (1992), a report focusing on the development of children, literally translated as “Quebec wild about its kids” (*Un Quebec Fou de ses enfants*)(1993), Quebec Priorities in Public Health (1997), the Tobacco Act (1998) followed by the National Tobacco Control Program (*Programme national sur le tabac*) and the Public Health Act (2001). The most recent document is the Quebec Public Health Program (2002). To sum up, it seems that several documents have been introduced one after the other into the network in a short period of time, had to be absorbed but were not all associated with a plan to integrate these into practices.

The Quebec Public Health Program hoped to be different from the documents that preceded it. While striving to achieve the same high quality document as its predecessors, it is intended to serve as a platform for mobilizing public health stakeholders and partners around the full scope of public health actions that are common to all of Quebec. The program, just like the Public Health Act, which was developed at the same time, was seen as a structuring measure to consolidate the public health infrastructure. It was an element in a vast project to strengthen and enhance the credibility of public health. The Quebec health and social services network has just undergone a period of major change, that is, a shift to ambulatory services in the context of budgetary pressure. This indirectly caused some disinterest from the authorities towards public health actions as the attention of the media and politicians, in Quebec and elsewhere, was once more focused on the overcrowding of emergency rooms and the length of waiting lists.

The aim of the MSSS was to share a common vision of public health and to provide the conditions so that public health actions would be coherent, with a strong science base and carried out by all partners, that is, the health and social services network (the regional boards’ public health departments and the CLSCs) as well as community organizations and partners in other sectors. It was hoped that the program would be the product of broad-based collaboration and participation of the entire network.

The key stakeholders who influenced this process were the Assistant Deputy Minister of Public Health and the Minister for Health and Social Services who wished to strengthen

the capacity of preventive health services, the National Public Health Director who was particularly skillful at developing structuring measures, supported by a team of dynamic professionals, several public health directors, executive directors of CLSCs convinced of the advantages of working together, as well as the institute for public health (*Institut de santé publique*) which could provide high quality expertise.

### **Leadership activities linked to policy development**

The following activities linked to policy development have served as an analytical framework for this case study :

- Developing support, particularly by building coalitions, empowering other stakeholders, recognizing community assets and making representations on the health challenges targeted by the policy
- Clarifying values, creating a vision, linking that vision to the mission, using partners to establish the priorities on which this policy is to be based
- Organizing goals and translating them into action
- Organising and seeking new resources, making organizational changes to better meet community needs
- Emphasizing innovation, delegating responsibilities for programming, supervising programs resulting from the policy.

### **Initial challenges**

In autumn 2000, at the very beginning of the process of developing the Quebec Public Health Program, a number of challenges to be met were identified through interviews conducted with public health authorities at different levels. At the time, it was expected that the program would provide a way to strengthen the capacity of all public health teams to act effectively in partnership and to be recognized as such in the health and social service system and by other sectors. These challenges are as follows:

- The desire of the MSSS to increase the coherence and a more uniform access to public health services and interventions in Quebec's regions and local territories served by the CLSCs by defining the supply of public health services that are common to all regions and CLSC territories of Quebec;

- The intention of the MSSS to use the program as a lever and a tool to mobilize all public health mandataries and support decisions on resource allocation;
- The shared desire on the part of the MSSS, DSPs and CLSCs for the program to give public health a greater role in the political space of the health and social services network and to confirm the importance of promotion and prevention, particularly in CLSCs;
- The desire to conserve a degree of regional and local flexibility;
- The recognition of CLSCs as public health mandataries in their own right, which is in keeping with the spirit of the public health bill being developed at the time and the need for them to assert themselves as such;
- The fear on the part of a number of public health departments and CLSCs that a program would be too constraining and that it would stifle innovation and not take into account regional or local characteristics;
- The choice of all public health mandataries to establish a participatory process to define the program, one in which all public health organizations would be involved under the leadership of the MSSS.

Another major issue underlying the process was to reach an agreement on the content of the program, since the first attempt ten years earlier had been transformed into 7 “national priorities” in public health, because an agreement could not be reached on the content of an entire program.

On the whole, the idea of developing a national public health program, which was provided for under the Act respecting health services and social services since 1993,<sup>1</sup> but never written, originated from the MSSS. It mainly reflected the search for coherence in public health activities, which often varied from one region and one CLSC to the next, and did not address some major health challenges. This desire also reflected a recognition of the need to make more room for public health within the health and social services system.

Although several public health departments shared this vision, others feared that their regional flexibility would be reduced since the Act respecting health services and social services defined their responsibilities but not the explicit link with the central level, except in the event of a health threat. For their part, the CLSCs appeared to be happy to participate in the process but had to assert themselves as a new stakeholder in the planning of public health activities. On the other hand, they had to figure out how to restore the importance of activities that deal with the cause of health and social problems, since they had to increase their ambulatory care activities during periods of budgetary pressure, therefore often at the expense of prevention.

While the program was being written, the Public Health Act<sup>2</sup>, which was being developed at the same time, was used as another opportunity to provide the legal foundation on which to build the public health program and to confirm and specify the role and responsibility (and accountability) of the stakeholders in the program and its implementation.

### **Clarifying its foundations, orientations and values**

The task of specifying the foundations, clarifying the vision as well as the orientations and values to be conveyed by the program was a challenge in itself because there was no consensus on vision and content. Although the values were, to a certain extent, shared and supported by professionals at all levels, several schools of thought had to be reconciled in terms of boundaries of the public health domain, philosophies and intervention practices. The entire process of drafting the program, which took more than 2 years, was used in part to do this conciliation.

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1. The Act respecting health services and social services stipulated that the Minister “establish the public health program, take the measures that are best suited to ensure the protection of public health, and ensure national and inter-regional coordination” (R.S.Q., c. S-4.2, s. 341.9).
  2. Adopted in December 2001, the Public Health Act sets out 4 basic functions of public health : surveillance and monitoring; prevention, promotion and health protection, and replaces the Public Health Protection Act, which dated back to 25 years. It also defines the components of the program, the regional and local action plans and the responsibilities of the mandatories.

At the time, there was no program model from elsewhere that could simply be copied. The program was therefore written with a view to innovating and reconciling knowledge on practices that have been proven to be effective. Fairly early on in the process, the writing team, supported by the advisory committee, suggested that interventions be grouped under main areas or domains which required that, as much as possible, actions be carried out with common partners and be based on common determinants. Although several times during the writing process, doubts were raised about this “perspective,” it served as the basis throughout the construction of the program.

### **Organizing the process**

The work structure to be used in developing the program was defined in spring 2000, based on a central idea, i.e. a participatory process in which all levels of the public health organization would be involved<sup>3</sup> (MSSS, the INSPQ, DSPs, CLSCs) to ensure the highest quality product and support for the program by organizations with a public health mandate, even though the legal framework allowed the MSSS to establish the program on its own.

Partners from within<sup>4</sup> the health and social services sector joined these representatives to form an advisory committee with the responsibility of providing an opinion on the content of the program. For its part, the main working committee was made up of managers and professionals from different levels of the public health organizations (the MSSS, the INSPQ, public health departments). The working groups responsible for developing the contents of the program were mainly made up of public health professionals and resources at the regional and national as well as the local levels. Finally, a team of MSSS professionals supported the process and led the working groups. Partners from other sectors and community organizations were invited to participate in developing the program only on a few occasions.

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3. The fact that people who were “committed” rather than “representatives” had been chosen to create a product that was based on the best expertise available rather than on the interests of the parties resulted in situations of quid pro quo, in terms of the information and the involvement of stakeholders from participating organizations at several stages of the process.

4. The advisory committee included a member of each of the following organizations: College of Physicians, Professional Association of Nurses, and several others

The choice of this structure demonstrates the wish of the public health mandataries to, on the one hand, assess the situation “among themselves” in order to plan public health activities and, on the other hand, to promote the maximum participation of the public health mandataries without weighing down the process by broadening it to other sectors. It was agreed that the trans-sectoral partners and community organizations would be asked to participate later, during consultations on the draft program. However, the choice of this work structure was not neutral; rather, it reflected the need of public health mandataries to plan public health activities together before turning to outside partners. The stage of recognizing community assets was carried out by professionals who made up the working groups, who brought with them the concerns of their communities (based on needs assessments previously conducted by the CLSCs and DSPs), and then validated by the CLSCs; the program’s authors took for granted that these assets existed without describing or examining them.

### **Agreeing on “what”**

A crucial stage was defining the conceptual framework (see Diagram 1), which represented the will to clearly define the scope of public health action by the functions exercised, to structure public health activities according to intervention areas or domains<sup>5</sup>, and to guide these activities based on health and social objectives aimed at enhancing health and well-being as well as reducing the major health problems through interventions known to be effective. This was done in autumn 2000.

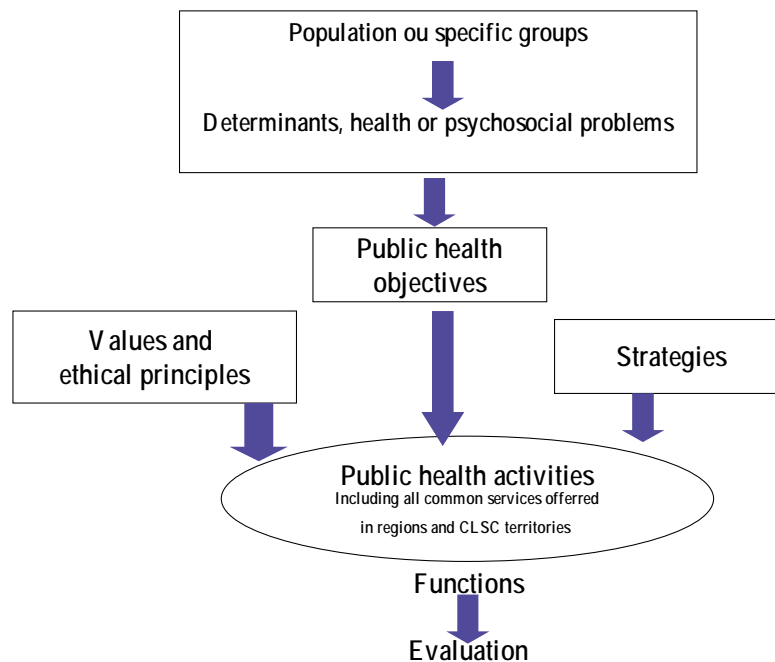
Moreover, the proposal of an ethical framework and the choice of action strategies, also in autumn 2000, helped to identify the set of fundamental values on which the program would be based. Through this process, it was possible to identify consensus on the values that would constitute guide posts to support the ethical consideration on the choice of interventions to be carried out and to guide the interventions themselves. The key values

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5. The intervention areas are: (a) development, adjustment and social integration, (b) lifestyles and chronic diseases, (c) unintentional injuries, (d) infectious diseases, (e) environmental health, and (f) occupational health.

are: the public interest, beneficence and non-maleficence, respect for confidentiality and private life, responsibility, solidarity, recognition of the potential of individuals and communities and the necessary protection of individuals, groups and communities that are at risk, and justice.

**Diagram 1 : Components of the Quebec Public Health Program**



Another crucial stage was determining the program's actions and activities, which mainly involved the identifying the main health and psychosocial problems as well as determining effective interventions to act on the problems and their determinants. This process was carried out in sub-groups by more than 200 public health professionals. It involved considerable work carried out intensively over four months (during the winter of 2001) and then continued for nearly a year, until January 2002. This process was supervised by the program's main working committee and the professional team of the MSSS. The latter was also responsible for determining whether the material met the criteria of inclusion of activities in the program. During this stage, the professionals

attempted to influence the program content through their work and expertise (but also through representations).

The sometimes poor adherence to the criteria of inclusion in the program, particularly regarding whether or not the activities belonged to the field of public health or were effective, the speed with which discussions took place between the professionals who had developed the content and the ministerial team (a speed that prevented the professionals from having the decisions validated by their working groups), the difficulty in uniformly applying the criteria of inclusion of activities, the lack of clarity about how the priorities could be determined, and the fear of seeing certain areas of expertise being left out of the program, are all elements which gave rise to tensions during that period. It was at that turning point that a professional suggested to conduct a strategic analysis of the issues in order to clarify the issues, expectations, fears, conditions for success and pitfalls, and to begin focusing on “how” to manage change rather than focusing only on “what” the content of the program should be.

### **Which priorities?**

Furthermore, the program’s advisory committee and the public health authorities met a few times to validate the proposed contents and to establish priorities. The lack of consensus on the need to use duly established criteria to determine the priorities as well as on the relative importance of the proposed activities made this operation difficult. However, an exception should be noted, that is, a meeting held at the end of the development process, in which the criteria of feasibility and opportunity made it possible to determine, on the basis of consensus, the activities to be conducted during the first stage of the program.

In general, despite efforts and good will, some deficiencies were observed in the transmission of information throughout the process of development of contents and establishment of priorities. Indeed, information was perceived to have been insufficiently

communicated or was communicated too late between the different groups (MSSS-DSPs-INSPQ-CLSCs, between the authorities and the professionals or other resources), and even within the same group. Apart from a newsletter which was disseminated by the MSSS a few times and on an irregular basis, and the information transmitted to the national roundtables on public health (which include the regional and central public health organizations, except for CLSCs) and to the management committee of the MSSS's General Department of Public Health (*Direction générale de santé publique*), few mechanisms had been specified and established to communicate information between members of the advisory committee and the organizations where they came from and between the authorities and professionals or other resources, except for a periodic and widely disseminated information letter and consultation meetings' reports.

The speed of the process involved in this stage and the lack of time to disseminate information by the drafting team account, but only partly, for the unsteady flow of the information transmitted, and especially received, during the program's development. The lack of information received only partly explains the tensions observed during this stage and the lack of synergy between the organizations and the different levels of the same organization during this stage of program development. How much of this perception of lack of information reflected the expectations of the professionals, in particular those who had been involved in the working groups, that they would participate in all stages of decision making and drafting the program?

### **The writing and consultation stage**

The writing of the program's consultation draft (first full draft of the text) began in July 2002 following an advisory committee meeting in which the majority of members agreed with the comments made. This consultation, which had been postponed for a few months in relation to the initial schedule, was to last from eight to ten weeks. However, this process was upset by the minister's agenda. Although the consultation was to be launched during the Annual Public Health Days (*Journées annuelles de santé publique*) (in November 2002), the ministers wished that the program be disseminated during this

event instead. The consultation draft therefore had to be finished sooner than expected and the consultation period was thus limited to around a dozen days. It was intended for the public health organizations only, except for the principal intersectoral ministerial partners concerned by the program. Thus it was deemed unfeasible and inappropriate to consult the national groups of community organizations during such a short time, since the latter would not have enough time to consult their members.

Within this context, it was clear that the program could not be appropriated during such a brief consultation process, in particular by the CLSCs and the trans-sectoral partners, and an appropriation stage was to be planned for later. However, the matter of the Minister missing the opportunity to launch the program was considered to be worse, given the risk of missing a key opportunity for appropriation by the Minister and decision makers in the health and social service network. The Assistant Deputy Minister thus decided to put his cards on the table during a teleconference with the regional and local public health partners.

Despite these difficult conditions, the responses to the consultation were most generous. Indeed, nearly all the organizations consulted sent their comments to the MSSS within the prescribed time. Moreover, the comments made were excellent and most were rapidly integrated. The regional and local public health leaders also seemed to agree that the opportunity provided by the ministers to rapidly disseminate the program should be grasped while the long-awaited synergy was present.

### **The home stretch ...**

The final draft of the program was thus written (including all the comments many of which involved major rewriting), formatted and printed in record time (4 weeks).

The program was launched as planned on the Annual Public Health Days by the Minister for Health, Social Services, Youth Protection and Prevention, a rallying Assistant Deputy

Minister and before representatives of all public health levels who seemed to enthusiastically welcome the first Quebec public health program.

### **What comes next ...**

The development of regional action plans followed by that of local action plans are crucial stages during which public health directors and executive directors of CLSCs will have to exercise strong leadership at their respective level in order to formulate their action plans for implementing the program in their respective territory. Moreover, these stages are critical for program appropriation by professionals in the public health departments and workers in CLSCs as well as their partners. The development of regional and local action plans will also be a key moment to involve the community organizations and other trans-sectoral partners in the development of action plans and to seek their support for the program and the action plans.

The program's implementation has begun. The Follow-up Committee of the Quebec Public Health Program, which includes representatives of all public health organizations (MSSS, INSPQ, DSPs, CLSCs) has held its first meeting. Its members accepted the mandate to jointly follow up the program's implementation as well as its evolution based on the population's health needs and the organizational and financial contexts. This committee will be required to play a key role in supporting the program's implementation. Lastly, training activities and evaluation activities, which will make use of the services of all public health stakeholders, are essential to the successful implementation of the program.

Although the program's publication is the end of a decisive stage, other issues in the implementation of the program are just as crucial :

- changes in practice to be reconciled, supported and facilitated
- changes at the organizational level to facilitate changes in practice

- professional and management leadership at all levels to promote implementation and a dynamic evolution
- coherent actions of public health teams which are based on effective or promising interventions relying on community assets, and foster innovation
- mechanisms for reconciling different perspectives with partners as well as within and between public health teams
- obtaining funding to support implementation.

## **Conclusion**

### ➤ **Building alliances...**

Special efforts were made to ensure the development of a program that fosters a broad consensus, both within the public health network and with key partners in its implementation. However, the appropriation exercise must continue, in particular in the development of regional and local action plans because the network's people were not all closely involved in the process, particularly at the local level, but also in the regional and national organizations. Training and appropriation activities will be critical for the effective implementation of the program.

### ➤ **Clarifying values...**

The program clearly raises the ethical issues associated with public health action and makes a solid synthesis of evolving concepts and practices in public health, taking account both of the importance of public policies and the empowerment of communities, while proposing actions that are most likely to have an impact on avoidable morbidity, injuries and mortality. In brief, a visionary program which will require time and sustained concerted efforts for appropriation and implementation.

### ➤ **Organizing goals ...**

The prioritization of activities must nevertheless be continued in collaboration with the regional and local partners and will be reflected in the regional and local action plans, taking advantage of the strengths and minimizing the weaknesses due to the fact that the program is vast, not having reduced the the proposed interventions enough through prioritisation.

Additional effort will be needed to quantify certain goals and promote evaluation in order to measure and follow the degree of achievement, which could not be finalised before the release of the program. Evaluation is nevertheless a major issue of the program. The aim of improving the operation of the evaluation parameters will be to facilitate the follow-up of the program's implementation as well as the capacity to report on the degree of achievement of goals. Lastly, the periodic evaluation can also be instrumental in supporting the program's visibility and implementation.

➤ **Seeking new resources...**

The program's adoption seems to have further contributed to the government's intention to increase funding for prevention. A first commitment to increase existing funding for public health actions by 25 percent has just been made by the government in March 2003. Another major issue relates to the network's capacity to promote the transition from intention to action and to invest in activities considered to be priority activities in terms of their potential impact on the health of the population.

➤ **Emphasizing innovation...**

By the very nature of its content and mission, the program leaves necessary room for innovative approaches while promoting its implementation.

In brief, through the development of the program and the resulting activities, a context that is conducive to its implementation at the political level (associated with funding) seems to be emerging. Local, regional and national organizations can take advantage of this context to intensify their collaboration, in particular by providing the conditions that are conducive to the program's implementation (achievement of the action plan). This increased collaboration should be accompanied by the identification of other means to foster stronger public health leadership and infrastructure in this new context.

**Note : special thanks to Marthe Hamel, coordinator of program development, to the DGSP, the MSSS, for the text's history and basis**

## **Professor's guide**

What kind of obstacles to an effective public health leadership can be identified in this case study?

Were the media an obstacle? Should they have been used more?

Were the political pressures to speed up the completion and dissemination of the program an obstacle?

In what way does the reduction in the time allocated for final consultation present an obstacle? How would you have dealt with it?

Does the fact of not being able to reconcile all the differences in philosophies of intervention and choices of priorities constitute an obstacle? How would you have dealt with this?

Which alternative strategies would you have developed to overcome each of these obstacles?

What lessons have you drawn from this experience for your practice?