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An Ethnographic Account of Implementing Reforms into Home Care Services

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Understanding Notions of 'Managed Care' in Québec: An Ethnographic Account of

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Study Period: January 2004-December 2006

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Acknowledgments

Understanding Managed Care

A. DESCRIPTION OF THE STUDY

This study sought to explore and map the understandings, intentions and implementation of 'managed care' within recent home care reforms in Québec. The study objectives were to understand: (1) the details, legislative changes, and trajectory of the recent reforms; (2) how the reforms were perceived, experienced and implemented into everyday practices by frontline workers and managers; (3) the extent to which current Québec reforms correspond with larger trends of managed care and managerialism of health and social services, and; (4) the impact of the reforms on persons giving and receiving care (i.e., vulnerable older persons). Taking a critical approach, the research aimed to assess the extent to which recent Québec-based reforms correspond with larger trends of managed care and the managerialism of public services as evidenced by changing services terminology (e.g., case management), as well as the implementation of standardized measures focused on 'risk' and performance indicators such as 'cost effectiveness' and 'efficiency'.

While this research does not assess the feasibility of reforms within the current context, it does provide important information as to whether the policy objectives can be achieved, thereby effectively meeting the needs of the persons for whom they were designed. The study's qualitative dimension reveals the intricate details of experiences and service processes, the connections and contradictions inherent in the way policy reform is implemented into varying facets of practice, identifies service gaps, and thereby provides starting points or locations for revised interventions in the interest of older persons and persons with disabilities receiving care. In this way, the project connects research on aging with policies and practices of health and social care.

Results will be discussed in relation to three main strands:

1. The process of the reform. This includes the ways in which reforms were implemented, and the difficulty in accessing information on the reform from either inside (i.e., workers) or outside the system (i.e., clients).

2. The emotional impacts of organizational change. The process of reform and organizational change had a significant impact on the work environment and morale of managers and frontline health and social service workers.

3. The impacts on clients, including the ways in which services are increasingly oriented toward 'population-health' models that are delivered within local territories and the identification of clinical projects and specializations that are territorially-based.

Note: Conducting this research was much more complicated than expected. At the time of the proposal, the intent was to study managerialism within the system. However, at the time of the award, the Liberal party had come into power and initiated the reform of health and social services. As a result, the focus of this study shifted slightly in order to understand the reform and how the reform would impact workers and clients. Further, the process of implementing reforms in a top-down structure meant that it was not yet possible to attain a sense of how the reforms impacted upon older people as service users.

Theoretical Perspective

This study takes a critical approach in order to understand the ways that powerful claims such as 'managed care' operate within local level practices and therefore, impact persons providing and receiving care. This perspective is informed by four overlapping tenets including: focus on the local or everyday interactions; attention to varying locations of power; the importance of interpretation and/or perception; and the impacts on persons who are identified as vulnerable within health and social services.

First, rooted in everyday practices and interactions, it focuses on the local as a site to witness larger issues and concerns (Bourdieu, 1991; Smith, 1987). This means, for example, that the challenges in implementing reforms will ultimately play out in the interactions between persons providing and receiving care. Second, it moves beyond traditional understandings of the powerful and powerless, to witness the varying levels and interactions of power, how power is created and reproduced differently within the system, and how this may impact persons at the margins of society (i.e., older persons in need) (Fraser, 1997; Smith, 1990a; 1990b). Third, perception and understandings are key. Allowing space for perceived power, strengths, resistance, and/or negotiations of players within the home care system is central to understanding the success and obstacles to implementing reforms and achieving intended results. Finally, focusing on access and obstacles for persons who have been labelled vulnerable (i.e., at risk) is essential to understanding whether the reform policies can actually achieve their desired impact.

Together, these four tenets provide a strong theoretical base from which to question the assumptions within 'managed care', locate these notions within the current social context, explore the implementation of 'managed care' reforms, as well as focus on the gaps and contradictions between language, intention, and impacts on persons providing and receiving care. As such, this theoretical approach addresses a gap in local level policy studies; while there is a plethora of material on macro policy issues (e.g., defining need and regulating services), there is little focus on the ways in which policy reforms are implemented and subsequently impact the local service level.

Objectives

This study aimed to understand, describe and assess the implementation of 'managed care' reforms, and the impact that these reforms have on persons who provide and receive home care service in one local community service centre (CLSC) over a three-year period.

Questions which guided the study include:

1. How do the ideas and terminology of 'managed care' operate within the policies and frameworks of home care policy and service reforms in Québec? What are the intentions of 'managed care' and reforms? What roles do these notions (e.g., standards, efficiency, and consumer choice) play between policy intentions, implementation and the receipt of services?

2. How do the various actors within home care services perceive and/or understand the intentions of 'managed care' reforms? How do they operationalize these intentions in their practices? How are administration, professionals and clients involved in the implementation of reforms (e.g., consultation, training, etc.)?

3. How are 'managed care' reforms coordinated or implemented at the local level of service delivery? How do the notions of 'managed care' and reform play out in practice? Considering the seemingly conflictual criteria of 'managed care' and the values or perceptions of service providers, can the intentions of Québec homecare policy reforms be reliably delivered in a modern service context? If so, what are the conditions that help or hinder a feasible implementation? Is there potential for the policy reforms to succeed and meet policy intentions? What lessons are to be learned?

4. How do the notions and practices of 'managed care' impact on professionals and clients within specific service domains and home care programs (e.g., changes in eligibility, professional practices or roles, etc.)? Do policy and service intentions have an impact on the lives of the persons for whom they were developed? Are groups differentially affected by 'managed care' and home care reform? Are particular within-group populations better served by the reforms (e.g., access, gaps, service restrictions, etc.)?

Methodology

This study conducted a critical ethnography in one local CLSC in order to understand the implementation of reform over a three-year period. The methods used to collect data in this study ranged from textual analysis, observations, focus groups and individual interviews with administration, service providers and clients involved with

home care services. The intended result was to provide a description of how 'managed care' was interpreted, map how notions and recent reforms were coordinated and implemented at a local level in relation to homecare, and discuss issues which arise from the observations, interviews and textual analysis, in relation to the current context of 'managed care' in Québec.

The study consisted of four main conceptual stages of research consistent with the study objectives. The qualitative nature of this study meant that these stages were not to be seen as traditional distinctive stages of data collection (i.e., design, data collection, analysis, etc.), but rather as exploratory, circular and iterative processes of research where each step builds on previous understandings, and connections made within and between the stages. The four main stages that correspond with the research activities included: (1) identifying and understanding 'managed care' and reform intentions; (2) understanding how intentions are implemented into practice; (3) identifying and understanding the impact on professionals and target populations; (4) validating, writing the report and disseminating results. The research design was integrated into the existing home care program which allowed for a focus on various within-group populations and services.

B. BACKGROUND / CONTEXT

The Shifting Context of Health and Social Care in Québec

A concise historical overview of Québec's history of health and social care illustrates key changes in the organization of health and social services. Since the shift from religious and charitable institutions to a highly centralized professional state bureaucracy (during the 'Quiet Revolution'[1]), health and social services in Québec have experienced numerous reforms that have impacted home care services. In the 1970s, the original *Act respecting health and social services network development agencies* created a structure consisting of advisory councils, hospital centres, and a system of several local community service centres (CLSCs) for frontline health and social services[2] (Pineault et al., 1993; Cawley, 1996). The result was a distinction between CLSCs – which catered to community service settings – and social service centres (CSCs) – which catered to institutional settings. Within this structure however, while the intention was to guarantee free, universal accessibility to its services, government-funded health care services were more available than the more limited government-funded social services (Begin, et al., 1999). Furthermore, because CLSCs were community-based, there were

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[1] Bélanger (1999) notes that "The Quiet Revolution is the name given to a period of Québec history extending from 1960 to 1966. The term appears to have been coined by a Toronto journalist who, upon witnessing the many and far reaching changes taking place in Québec, declared that what was happening was nothing short of a revolution, albeit a quiet one."

[2] The idea of community health centres was conceived 35 years ago in the Pointe St-Charles neighbourhood of Montréal when a group of concerned citizens and doctors thought that the needs of the community should come before the needs of medical professionals (Lesemann, 1984). CLSCs are the product of people who were critical of a work organization that was focused on technology and specialization (e.g., hospitals) as well as the biomedical model and the dependencies that it encourages. Its goal was to provide frontline health and social services to the local population as a compromise to a solely biomedical oriented system (Bozzini, 1988) and provided an alternative to traditional health care delivery.

remarkable differences in the programs and services provided in different regions (O'Neill, 1992). At this time, the mandate of the CLSCs was also changed slightly to include a home care directive in an attempt to better meet the needs of disadvantaged and oppressed populations, such as elderly people (Contandriopolous, 1991). However, only in 1992 did the government publish the paper entitled *La politique de la santé et du bien-être* (i.e., 'health and welfare policy') that broadcast the policy objectives of improving the population's health and welfare.

Influenced by the focus on 'fiscal responsibility' and budgetary cutbacks of the 1980s, health and social service reforms initiated since 1990 emphasized the high health care costs of the public system as rationale for change. The result was an altered service structure and delivery of home care services in Québec (see Bégin et al., 1999). Over the last 20 years, Québec has shifted its focus from what were considered 'expensive' institutions to less expensive community-based organizations, which were mainly delivered within the CLSC system (Rochon as Health Minister 1994; Rochon Commission report, 1998)[3]. With the publication of *Une réforme axée sur le citoyen* (i.e., 'citizen focused reform') and amendments to the *Act respecting Health and Social Services* (which transferred major medical decisions and responsibilities from physicians to the hands of bureaucrats), the Québec government began to decentralize power in the health care system and increase regional control focused on providing services to the individual (Bernier & Dallaire, 2000). In the context of cuts in federal transfers, rationalization, crisis in public financing, the 1990s also brought national parameters for equitable allocation of services and an increased emphasis on results-based management (e.g., efficiency and accountability) and standardized measures used to allocate services.

Most relevant to home care was the *Virage Ambulatoire* (AFÉAS et al., 1998), a policy that resulted in hospital and bed closures, higher numbers of day surgeries, shortened hospital stays, and increasingly identified the community as the primary site of care and convalescence (see Pérodeau & Côté, 2002). This move to deinstitutionalize and redistribute services to the community and home without the necessary accompanying resources drastically altered the profile of clients seen within public and community sectors. Public home care programs delivered through the CLSCs increasingly became the source for those discharged from hospitals, to the detriment of long-term chronic home care clients, most of whom were older persons. Reforms initiated since 2003 continue to enforce the budget restrictions and specification of public services to those only at greatest medical risk.

Home care context in Canada and Québec

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[3] The Rochon report favored the CLSC, community-based, preventative approach by reducing the fiscal transfer amounts to hospitals and increasing them to CLSCs. For example, in 1996-1997, hospitals took a cut of 360 million dollars, whereas CLSCs received an increase of 57 million dollars (Nadeau, 1996).

Under the *Canada Health Act* (1984), the provinces are responsible for the delivery of health care services. This means that the structure, organization and types of services offered in each of the provinces may differ substantially. While the extent to which home care may be situated within this public health care agenda is a key debate (Duncan & Reutter, 2006), Québec has a public model of home care where eligibility is assessed and delivered by a combination of public institutions (i.e., Health and Social Service Centres or *Centres de santé et de services sociaux* – CSSSs) and para-public partners (e.g., cleaning companies and community organizations) within territorial regions. The primary focus of this study is in relation to the policies and practices relevant to home care within Québec, however, these must also be considered within the larger restructuring agendas within Canada and abroad. While Québec has in the past received accolades for its extensive and progressive home care program, as is the case in other welfare states, these programs are increasingly under threat.

While home care systems differ between each of the Canadian provinces, they are all generally comprised of a combination of public, para-public and private services. Based on the *Canada Health Act* (1984), all professional medical services are offered at no cost. However, free access to social workers, physiotherapists, occupational therapists and home care support workers varies by province. In all provinces, the public sector conducts a needs-type assessment and either offers or sub-contracts services. In Québec, the results of the *Castonguay-Neveu Commission* (1966) led to all health and social services (including homecare) becoming public services of the provincial government which were to be offered universally and free[4]. As such, the CLSC offered free multi-disciplinary home care services, including home care support, to those determined to be 'in need'. In principle, this policy continues today. However, various changes – many of which relate to the organizational practices of assessing eligibility – have led researchers and others to question the extent to which these services are actually universal and free.

The recent history of home care within Québec reflects trends where the organization of care and delivery of services has shifted from charity-provided services, to care located and delivered through community-based approaches (in Québec this is through the CLSC model), to home care programs delivered through case management models in the 1990s (i.e., managed care within CLSCs) and now, to modernized services located within the mixed-economy of care and offered through public services, para-public and social economy sectors[5] (i.e., CSSS system). Within these trends are tensions related to inclusion/exclusion of population groups, benefits of

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[4] Services that reach beyond those deemed 'medically necessary' have an associated cost. For example, while dressings, injections and/or bathing are examples of medically necessary services, and therefore 'free', services such as meals and cleaning have associated costs.

[5] While other provinces have opted for an explicitly private model of care where services are placed directly within the economic sector, Québec's model uses the language of the social economy, which refers to the various types of private and public services such as cleaning companies and community organizations that fall outside of the key health and social services sector institutions.

centralized/decentralized models, and increasing professionalization and medicalization of home care services.

A key conceptual distinction relevant to this analysis is the shift from a focus on 'needs' to 'risk', and the ways in which services based on risk – most of which focus on the body and function of older persons' Activities of Daily Living (ADLs) and mobility – have overshadowed preventative and social type services such as transportation for medical and social outings, home cleaning assistance, housing modification and repair. The result is a practice in which public sector professionals use standardized technical instruments to assess clients' risk in order to determine their eligibility for public care and allocate services according to priority. Services are then delivered through a combination of public institutions (i.e., CSSS) and partners in the para-public or private 'social economy' sectors (e.g., cleaning companies and community organizations). Those offered by the public sector are generally more medically-focused (e.g., ADLs, such as bathing), with those in the private-profit and not for profit sector (for which there are often sliding-scale fees) more related to Instrumental Activities of Daily Living (IADLs, such as meal preparation). In this context, older people without financial resources to pay for IADL's can find it difficult to have their needs met.

In 2000, the Québec government appointed a commission to conduct an assessment of the Health and Social Service System in Québec. In its report entitled *The Emerging Solutions* (Gouvernment du Québec, 2000)*,* the Clair Commission (2000) reported deficient access to services; an outdated organization of services; institutional autonomy (e.g., agencies working in silos as opposed to an integrated network); a poor distribution of doctors; private clinics developed in parallel with the CLSC network; and a rigid service organization. Many of the findings articulated in the Clair Commission became the rationale for the reform of Health and Social Services implemented by the Liberal government from 2003 onward. As institutions proceeded with their implementation of reforms, they also began to establish clinical targets (as required by the recent reform through its 'projets cliniques' or clinical projects). As a result, the question of which services will be delivered to whom and by which types of agencies or services are again paramount. While services to older people have always had strong affiliations with the medical model recent home care policy and practice reforms in Québec have linked the current emphasis on functional and biomedical risks experienced by older people (e.g., frailty, hip fracture, hospital discharge, etc.) with more general concerns for population health, which will likely further restrict the types of services offered to older people, in particular, needs that are more social in nature. (See Chodos, 2001 and/or Maioni, 2001 for an overview of the Clair Commission).

C. FINDINGS I

SECTION I: THE REFORM

This section describes the stated intentions of the reform as articulated in key documents and as implemented in practice. It also presents a trajectory of the reforms as they occurred at the ground level. Results presented in this section derive from the review of textual documents, prolonged involvement at the research site, interviews with managers of the various settings involved in the merger as well as frontline workers. However, in the first year of the reform, workers were uninformed and relatively removed from the reform process as managers were the only ones directly involved. Prolonged engagement with the research site provided opportunities for an in-depth understanding of the implementation process. The expertise of workers and clients exposed how reforms were implemented into "everyday practice", including their level of involvement.

Key findings in the initial stages of the research were as follows: the reform was implemented as a top-down process with little, if any, consultation or decision-making power from boards, organizations and/or users; those involved were subject to the 'illusion of consultation,' where involvement was sought in relation to how to implement the reforms, rather than initial involvement in setting targets, needs, and/or decision-making; the Minister of Health (Couillard) insisted on a speedy implementation of the reform, and as a result, the time for any involvement and negotiation was reduced; legislative changes were also passed quickly in late-hour sessions of Parliament; finally, there was a lack of reliable and accessible information on the reform, its process and intended impacts. The key changes of the reform included: legislative change; the mergers of institutions and an emphasis on 'territorial responsibilities'; the replacement of the boards of directors and directors of the new institutions; and the realignment of staff and specializations (this included examples of staff moving from children's services into aging or mental health and vice versa); and the development of 'clinical projects' for each CSSS.

The 'stated' intentions of the reform

The reforms were intended to reorganize Québec's health and social services system along three hierarchical levels of control: the ministry, the Minister of Health and Social Services with the 18 health and social services agencies, and the province's 95 health and social service centres (CSSSs). Québec's stated objectives for the reform were to: improve public health and well-being, bring services closer to the people, facilitate user guidance and referral, and take on at-risk clientele. Where Québec's former health system was seen as being responsible for individuals, the reform was intended to develop a system responsible for populations, and in particular, the health of the population. Indeed, instituting a population-based approach and a hierarchical organization of services formed the two stated guiding principles of the reform.

The mandate of the newly-established health and social service centres (CSSSs) was to improve the health and well-being of the population, manage the use of services by the population, and manage the available services provided by the CSSSs. Accordingly, their responsibilities included: defining local clinical and organizational approaches according to the characteristics of the population; mobilizing and fostering the participation of professionals, establishments, and health network partners (i.e., intersectorial collaboration); organizing and coordinating local services; managing available human, material, financial, informational, and technological resources; providing a range of general and specialized services to the local population (i.e., coordinated by service agreements); receiving, assessing, and directing people to the appropriate services; taking on cases of persons at risk, accompanying and supporting them by providing continuity of service; informing the population, enlisting community participation, and measuring satisfaction; as well as fostering participation in personal health management and measuring satisfaction levels among the population.

Services were organized around key priority areas including: the loss of autonomy due to aging; physical impairment; intellectual impairment and pervasive developmental disorders; troubled youth; addictions; mental health; and physical health; (Levine, 2007, p. 51). In sum, the stated expectations for the reform circled around putting service users first, an 'integrated services network' perspective, and finally, accessibility, continuity, and quality in health and social services.

The process of the reform - what actually happened?

Recent reforms focused on structural reorganization, fiscal priorities, and the coordination and integration of services. In 2002, with the election of the Québec Liberal Party, the provincial government began a major effort to overhaul the organizational structure and delivery of its health care services. These changes were achieved through the enactment of Bill 25 (an *Act respecting local health and social services network development agencies*) which transformed regional boards into health and social services network development agencies; Bill 30 (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 para-public sectors*), and Bill 83 (an *Act to amend the Act respecting health services and social services and other legislative provisions*). Together, these legislative changes altered the structure of the health and social service sector, representation and negotiating powers of the trade labour unions, and fiscal priorities. Reforms centralized the various types of care facilities (e.g., hospital, long-term care, and CLSCs) into large health and services centres (i.e., CSSSs) and decentralized budgets to these new centralized centres (Government of Québec, 2004). Mandated to establish 'integrated health and social services networks' for all persons living in the territory[6], each CSSS was given the mandate to ensure that

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[6] Integrated service networks represent a model of inter-organizational merging, which allows an improved integration of services offered to the population by increasing dialogue between service providers (Lamarche et al., 2001, quoted in Lemieux, Bergeron, Begin and Belanger, 2003).

local residents had access to primary health care services (e.g., preventative and diagnostic treatments), support and institutional-based services (Government of Québec, Montréal, 2004). Service priorities and budget allocation are now organized according to public health models of prevention that are defined along the lines of population-based risks [see the 1974 Lalonde Report[7]; Clair Commission (Government of Québec, 2000); WHO Health Report WHO, 2000)].

The aim of reform was to create a 'continuum of services for each individual in their territory, from birth to old age'. CSSS agencies now have the mandate of establishing integrated[8] health and social services organization in their areas of jurisdiction, mobilizing services to a closer proximity of the public and assisting each individual's smooth movement through the health and social service network. Priorities to allocate budgets are given to public health models that conceptualize prevention along the lines of population-based risks (see the 1974 Lalonde Report; Clair Commission; WHO Health Report 2000 –"*Health Care Systems, Improving Performance*"). Each CSSS offers local residents access to first level, primary health care services such as preventative and diagnostic treatments as well as support services and institutional-based services. While reforms claim to benefit vulnerable populations such as those with chronic illnesses and 'frail' seniors, the tendency to locate the needs of these populations within a biomedical framework raises questions about the extent to which services can address anything outside of the biomedical health model.

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[7] "The Lalonde Report proposed that changes in lifestyles or social and physical environments would likely lead to more improvements in health than would be achieved by spending more money on existing health care delivery systems. The Lalonde Report gave rise to a number of highly successful, proactive health promotion programs which increased awareness of the health risks associated with certain personal behaviours and lifestyles (e.g., smoking, alcohol, nutrition, fitness)" (Public Health Agency of Canada, 2001, Section Population Health)

[8] Integrated service networks represent a model of inter-organizational merging, which allows an improved integration of services offered to the population by increasing dialogue between service providers (Lamarche et al., 2001, quoted in Lemieux, Bergeron, Begin and Belanger, 2003).

Legislative Changes

Bill 25

Bill 25, an *Act respecting local health and social services network development agencies*, introduced a new administrative organizational structure to Québec's health and social services organizations. The stated objective of this bill was to "bring services close to the public and make it easier for people to move through the [health and social services] network" (Government of Québec, 2003a). The Act amalgamated the formerly individually and regionally administered local community health centres (CLSCs), residential and long-term care centres (CHSLDs) and general and specialized hospital centres (CHSGSs) into 95 'local service networks', with services defined through regionally-based 'health and social services centres' (Government of Québec, Montréal, 2004). The new organizational model of these centres would, in turn, be developed, proposed and (if approved by the Minister of Health and Social Services and the government) implemented by development agencies specially appointed for this task. The 15-member board of directors for each health and social services network would be appointed by the Inspector General of Financial Institutions, once the new organizational model was approved (Government of Québec, 2003a). The mission of a local health and social services network development agency was to establish, in its area of jurisdiction, an integrated health and social services organization. Each of these local health and social services networks had to be designed to:

1. Provide the people in its territory with access to a broad range of primary health and social services, including prevention, assessment, diagnostic, treatment, rehabilitation and support services;

2. Guarantee the population access to the specialized services available in the agency's area of jurisdiction and to super-specialized services, through agreements or other means, and taking into consideration the activities of the integrated university health network recognized by the Minister and associated with the local health and social services network;

3. Allow for the establishment of mechanisms for the referral and follow-up of users of health and social services, and the introduction of clinical protocols for those services;

4. Involve the different groups of professionals working in the territory and enable them to build alliances;

5. 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; and

6. Ensure the participation of the available human resources needed to provide health and social services.

(Government of Québec, 2003)

Each local authority representing the consolidated institutions within a particular service area was required to develop an agreement (i.e., 'entente') with a hospital centre unless such an institution was either unavailable in the region or, if there were complexities in relation to the population served (i.e., exceptions were granted based on sociocultural, ethnocultural or linguistic characteristics). The local health and social services networks were also to include the activities and services of physicians and pharmacists, as well as the activities and services of community organizations, social economy enterprises and private resources in its territory. The local authority would be responsible for coordinating the activities and services of each of the local health and social services networks through agreements or other means.

In total, the new health and social service structure created 95 local services networks, 95 health and social services centres (CSSS) – including 78 mergers of local community health centres (CLSCs), residential and long-term care centres (CHSLDs) and general and specialized hospital centres (CHSGSs) as well as 17 mergers of CLSCs and CHSLDs – and 27 general and specialized hospital centres.

Bill 30

Bill 30, *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 para-public sectors*, introduced changes to the public and para-public sectors' union representation system and amended former related Acts on labour representation of these sectors in the province of Québec (i.e.; the *Hospital Insurance Act*; the *Act respecting the process of negotiation of the collective agreements in the public and para-public sectors*; and the *Act respecting health services and social services*). The Bill set out rules for certifying an association to represent employees of a public/para-public institution, including establishing 'bargaining units' made up of only four 'classes of personnel' (Government of Québec, 2003b). These are: nursing and cardiorespiratory care personnel; para-technical personnel, auxiliary services and trades; office personnel and administrative technicians and professionals; and health and social service technicians and professionals (Government of Québec, Montréal, 2004). Further, the Bill stated that "only one association of employees can be certified to represent the employees of such a bargaining unit in an institution" and that all employees represented by a bargaining unit be under the same collective agreement (Government of Québec, 2003b).

Considering the ways in which Bill 25 restricted the previous institutions into an 'integrated' system comprised of territorially-based hospitals, long-term care (LTC) centres, CSSS and community organizations, Bill 30 drastically reduced the number of

representatives of bargaining units. The measures in this Act have been described by one labour activist organization as restricting the "scope of collective bargaining" for workers in health and social care sectors, as well as limiting their right to strike, and providing government the ability to "impose wage rates in the second and third year of collective agreements" (Fudge, 2006, p. 13).

Bill 83, an *Act to amend the Act respecting health services and social services and other legislative provisions*, was largely concerned with integrating the new organizational model established through Bill 25 and making adjustments to the initial organizational structure and functioning model of health and social services. Its amendments included: mandating the responsibility for clinical and organizational projects to a more local level than that which was authorized in the initial Act; setting the coordination mandate of the agencies to focus on finances, human resources and staff; creating the integrated university health networks (RUIS), whose primary purpose is described as making proposals to the agencies or Minister on the supply of services in the recognized areas of university-affiliated centres (CAUs); medical training including the distribution of students from faculties of medicine, and preventing the interruption of services; adjusting the governance model of institutions and agencies; creating mandatory certification procedures for seniors' residences; strengthening complaint procedures for service users; and improving communication of users' information among the various health service departments (while ensuring users' rights to the responsible management of their information) (see Government of Québec, 2005).

Clinical Projects - 'Projets Cliniques'

In order to define the needs of the population within each 'Instance' or authority (i.e., CSSSs as organizational locations of service), the newly formed CSSSs were required to develop 'clinical projects'. The reforms sought to bring about a shift in the province's organizational approach to health and social service delivery, moving from a 'logic of service production' to a 'population health approach' (Carter, 2006). At the local level, this meant that each local health and social service centre's (CSSS) resource focus would be guided by the specific population groups in its service area and their respective needs, rather than having all CSSSs attempt to provide the same range and proportion of care services to the population in their service areas. Funding for each CSSS would be distributed among nine 'service programs' (i.e., general services – clinical and assistance activities and frontline medical services; loss of autonomy linked to aging; physical health; a youth centre; mental health; addiction; troubled youth; physical impairment; intellectual impairment, as well as two 'support programs' (i.e., administration and support for services; building and equipment management), both of which were defined by the Ministry of Health (Levine, 2005, p. 42).

In order to implement this organizational shift, each CSSS would develop its own clinical project, a process that involves nine steps. These are: "establish a portrait of needs; prepare an inventory of resources currently available; analyze gaps to meet objectives of access, continuity and quality; identify clinical models already in place; choose new clinical models to address gaps; define the offer of services and parameters of services agreements; define the role and responsibilities of all actors; develop the

service programs, and; ensure follow-up regarding the impact of services and population health" (Carter, 2006).

The clinical and organizational projects were intended to move health and social services from a logic of 'service provision' (provider based) to a population health approach (population based); to work in an integrated network of services – sectorial and inter-sectorial; to offer services that are interdisciplinary, based on a global services concept, continuous, and centred on the person, user responsibility for health, and efficient use of technology; and to mobilize professionals. Underlying principles included *population responsibility* (e.g., defining territorial mandates, offering a range of services, accompanying the user); *hierarchy of services* (e.g., offering complementarity to guide users between levels; providing a referral mechanism between professionals; and maintaining an obligation to refer and redirect); *vertical integration* (e.g., providing programs and mechanisms for hierarchization; moving from prevention to pathology); and *horizontal integration* (e.g., continuity of offer of a gamut of services that are continuous and complementary; adhering to the notion of 'globality' or totality of needs determined and coordination of service response) (Carter, 2006).

SECTION II: EXPERIENCES FROM THE FRONTLINES

This section outlines how managers and frontline workers experienced the reforms. In the early stages of the project, there was a great deal of uncertainty about the reform. My initial questions focused on their expectations and, in particular, if and how objectives would be achieved. However, in asking these questions, it became evident that those involved were unable to articulate expected outcomes as a result of uncertainty in relation to their organization, the overall mission and individual work roles.

In this section, managers and workers discuss their knowledge and expectations of the reform. In the initial period of observation and inquiry, it was only the most senior members of the organization who were informed of the proposed changes. This included the director general (DG) of the institutions involved, the board of directors (BOD) of the organizations, and some members of senior management. At the time, descriptions of the reform process existed only in the Liberal Party platform, the legislative bills described earlier, briefings of the Minister, and public reporting – of which there was little, especially in the English-speaking media.

This section presents interview captions collected from workers during a three-year period of reform. Presenting the reform through the understandings and observations of those involved within the organization offers an alternative view of implementation and/or access to the lived experiences of organizational reform (e.g., 'what happened'). As such, it demonstrates how information and material filtered through the organization provides the opportunity to compare stated intentions with

everyday experiences, and sets the stage for the later findings—in particular, those related to the emotional consequences of organizational reform.

How it happened: Workers' understandings and observations of the reform

The merger

In Phase I of the research (2004), several respondents—especially those involved in direct service provision—expressed uncertainty about the merger of their organizations (CLSCs, LTC facilities and so forth). Consider the following quote from a frontline worker:

> *I know what we've been told by the directors. We've had a couple of general meetings…last I heard was that the last proposal … which was going to be…determined by higher levels at the ministry, was for a merger of us, another CLSC, and the long-term care facility. I don't know what the result of that was. It was supposed to have been decided June, July something like that and I haven't had further information since then. Possible that there has been more information but there hasn't been a general meeting called…I have no idea* (405-411; Frontline: I).

Managers however, seemed to have a clearer understanding of the decision-making process around which institutions were to merge. In response to the question of how the CLSC site became connected with another CLSC site, the following managerial-level respondent explained:

> *We studied the statistics…Who is our population? And we took almost all the dimensions: linguistics, ethno-cultural, and so forth….With what type of hospitals are we working? Who are our partners? So we studied all of that…We did that with one CLSC and we did that with another CLSC…so we have a big document…where we compare: What is the percentage of anglophone versus francophone? What is the percentage of elderly? What is the percentage of families? What is the percentage of poverty? What is the percentage of…single mothers? So we took all the statistics. After that we took the statistics, in which hospitals do these people go to?…We took all of that and we made a comparative table. At the, at the end you have to see de qui vous êtes le plus près, ok? Who, who looks like you* (455-459; 461-467; 469-475; Manager).

The same respondent then explained how statistics were presented to the board of directors—at which point a resolution regarding the merger was passed. While findings on the ground reveal that the initial process of reform from 2003 was primarily conducted by those at higher levels (e.g., DG, BOD, managers, etc), respondents attested to the fact that there were later 'consultation sessions' to discuss the Montréal mergers. In 2005 for example, there were public discussions held at various senior citizens' organizations in Montréal. Considering that decisions to merge institutions had already been made, these 'public consultation sessions' would be more appropriately named information sessions. Following the process of the reform revealed that the most

significant elements of the reform, such as the mergers, were dictated at the Ministry level with minimal consultation with the population or health and social service professionals (see 'Consultation' section below). While professional bodies such as nursing associations and unions were actively involved in resisting the reforms, the institution observed had little organized expressed public reaction—the reactions of the workers and managers seemed to be present at the individual level. Elsewhere however, there were organizations who expressed serious resistance to the proposed mergers. For example, one participant discussed the case of a local hospital:

> *I don't know if you remember but at the time [the merger] was much, much bigger, it was going to include the hospital, but even in the neighbourhood there was a lot of work done. A lot of people were very active, people were coming out and saying we don't want such a gigantic crush on our neighbourhood and there were some changes made* (204-208, Frontline: I).

While the initial reform recommendations included a plan to merge the CLSCs and the long term health centres with hospitals all over Québec, many of the Montréal hospitals opted out of the reform, and as a result, the CSSS merger of one site in particular did not include a hospital, as indicated in the following:

> *So, we have no hospitals in which to fuse from. So, the true, the, the pure concept of really integrated care is not really what they had anticipated for Montréal* (602-604; Manager: I).

The new board of directors

In the next step, all former boards of directors for each of the organizations were dissolved and replaced by one large provisional board of directors (BOD) serving the newly merged CSSS. In turn, this new board assigned a new executive director as an interim director for the process. Where the former structure had 5 elected community representatives per board per institution, there were now only 4 representatives for the entire structure of the whole territory. Consider the following quote from a senior member of the organization:

> *On the 5th of July all the 90 establishments will receive a letter saying 'your board is finished, your DG is no more a DG. You have a new board, you have a new executive director'. And the job of this new board and this interim director, is to help the new board, to settle what type of DG they want and things like that, posting selection committee, we hire somebody and the new director will do the reform and things like that. So, between now and September, end of October. This is the plan* (388-394; Manager: I).

The process of dissolving former boards as such and replacing them with a new board composed of less elected community representatives caused one respondent to raise questions around how democratic the new structure would be:

> *There is the question of democracy and citizen involvement and I think you may have heard of this. All boards for each of those structures were replaced by one big board of directors. That, as it turns, out was a provisional board. So, Bill 83 lays out what the boards are going to look like. There will be 4 [elected community members] for the whole board—in our case, for 8 different structures. So we used to have 5 elected (community) reps per board per institution. Now we're going to have 4 for the whole structure of the whole territory* (279-288, Frontline: I).

Respondents were also concerned about the role and responsibility of the new BOD, and expressed some doubt as to the level of preparedness of its members. In particular, the way in which a new board may not 'know' the organization, and as a result could seriously impact the organization and its work. This also raises questions as to what extent the new board is selected to support the provincial government's mandate and/or the needs and wishes of the organization and the general community members—for whom the elected community members are intended to speak.

> *The role of the board is also something that complicates the whole process in its ability to move forward. The process of a whole new board of coming on and understanding what this whole reorganization is and you need 100% support of the board in terms of being able to move forward with any of your ideas and they are all volunteers so it is a matter of how much effort they put into trying to understand. It's much the same philosophy that I have with the new programs, anything you have to develop you have to be knowledgeable before you can move forward. You have to be given information in order to understand what the responsibilities are and what the reform is all about and not everyone is on the same page and your board is the key in all this. So I think it is important that you have strong committed people that can learn easily about what is going on. I don't think that you have to come in knowledgeable but you certainly have to have some understanding of the impact and the decisions you have to make and I think that not everyone is on the same page and it's a lot of work to move from point A to point B.* (360-374; Frontline : II).

New director general

Following the appointment of the interim director, there was a public competition for the director of each CSSS. Interestingly, only one of the respondents (M1RC)

described the process of the BOD in any detail—leading me to believe that most people were generally unaware of the details of the changes. Neither this respondent nor any others expressed any criticism around the fact that the BOD was no longer an elected body accountable to their public. Similarly, there was little, if any, dissent about the fact that the new DG was to be responsible for the various types of institutions that now formed the CSSS (i.e., CLSCs, LTC, hospitals, etc).

As mentioned above, the main responsibility of the interim DG was to develop and create the new organizational structure. In the case of the CSSS Cavendish – observed for this research – this process followed an approach whereby the DG prescribed and presented goals and missions to program managers:

> *What [the DG] did is that she decided first to do les directorates […] So, those are les directions, the services, so she determined that all the programs are going to be regrouped in four different directorates. All first line programs were in four directorates. And there would be le directorat de la réadaptation and the direction of the long-term care. So, it's six service directions. If you count it's more than six because it's one person who is doing more than one* (406-415; Manager: I).

The interim-DG defined the new service programs and allocated them to different departments. The DG held monthly meetings in order to inform and consult directors and managers.

> *The new DG here is…she made some meetings and her structure she's meeting once a month with each of the directors and once a month all the managers together. So since January she's been hired…and since March we have two meetings a month. One just administrative—just managers—and once a month it's all the managers of every program. So this[is] the way that the information is passed. When she does meetings like that she gives us our goal and our mission and we try to organize ourselves* (157-165; Manager: II).

The distribution of information in monthly meetings with managers was experienced as difficult for the managers of teams and frontline services. Managers and staff expressed confusion and lacked information on what would happen in the immediate future. This was heightened by the number of people assigned to completely new roles and responsibilities. Consider the following quote given by a manager:

> *I would like to see a clearer plan of action …3 months at a time... and then the whole team could rally around that focus as opposed to everyone guessing what the focus is and doing their own thing…A one year plan is too long, we are going through too many changes for them to be able to know the long term goals… Part of the problem is that all the directors are new. They are people who have been in the system but they are in new roles and very expanded roles, if there were a director in one place there are now directors across of all 3 places and so*

they are lost…I mean they will eventually find their way but we are in a transition, so that is the sense that I have, that they don't have a clear focus so they are not able to give it to us (280-293; Manager: II).

Reassignment of staff

As programs were reorganized to fit with the new administrative and service delivery structure being developed by the interim DG and the BOD, staff from all levels were assigned new and/or different positions. Carried out in accordance with union requirements, reassignment was presented as an alternative to job loss in what has been (and continues to be) a major reconstruction of the overall organizational structure and programs within the province's health and social service sector. While reassignment was intended to offer job security, issues around what was a significant reorganization of people's roles arose nonetheless, particularly around the increased workloads required by some of the new managerial positions, as well as the process by which reassignment occurred (for more on how job changes impacted workers, please see Part D, Section I of this report).

As the following respondents testify, guarantees were made that people would not find themselves unemployed as a result of the reform's implementation:

That director made a clear, deliberate decision that no one would lose their job. In fact, …if she had decided that some positions would be abolished, these managers would have the possibility to be relocated in other places and have two years safety. Il y a quand même un certain minimum de protection – il y a deux ans de protection (468-474; Manager: I).

Interviewer: 'What do you tell your staff at the moment?'…Respondent: 'If people are concerned about their jobs, that, that there will not be – I think that's a big concern of people: 'Will I lose my job?' – That there won't be any job loss per say. Umm…we're told that there will be amalgamations with unions' (157; 159-164; Manager: I).

Salary was the other factor guaranteed for staff, even for those being demoted from management positions. However, within the relative 'safety' of job-reassignment and salary protection, participants highlighted how these guarantees can mask the other types of loss, such as the loss of emotional attachments that were experienced during the reassignment process:

Their salary will be protected. But, they will not be part of the management team, so they can see that at a personal level as a demotion, you know? But they will have a job and things like that (449-452, Manager: I).

Well, I was …doing that job only for a short time… I don't believe that you can manage teams for years and suddenly not be the boss… when you've been the boss, it's hard not to be the boss anymore. People can say that it's easy but they are lying (62-67; Manager: II).

By Phase II of the study, workers were experiencing more tangible changes related to reassignment. Newly created and/or redefined managerial positions brought with them expanded administrative responsibilities, as seen in the following:

My official title is now ----- so, I am now responsible for all the ----- services …and the new structure… so I now have responsibilities for the units which I did not have before, and the other newly created positions of being in charge of----- and ----- at the two CLSCS—that is a whole new structure which does complicate things (17-18; 22-27; Frontline: II).

'More things to do. You have to manage various services you have to do…answer many more emails and answer many more inquiries, they want us involved in these liaison meetings with our partners to develop more links, they want us to help develop the projet clinique, hours and hours of time that is going to divided up into little bits and pieces working on all these different things at the same time' (369-376; Frontline: II).

Directors and staff alike had to re-negotiate former expectations around the increasingly administrative mandate of director positions:

So, they think now that they have a director they will have a lot-- so their expectations are high and I feel sad because I have to tell them that I have [to spread my work] between 3 different mandates. So I won't be able to give so much being alone. That will be difficult (198-202; Manager: II).

The mechanism through which workers were re-assigned was also discussed with mixed results in Phase II of the research. One respondent expressed her concern that being close to decision-makers determined one's job position:

Some people find out if they are sweet with [those making decisions] they get what they want and this game is being played now for a few months and sometimes the decisions are switched from one to the other for no logical reason just because this person happened to meet someone in the corridor (80-83; Frontline: II).

Along similar lines, one respondent described the impersonal way in which changes in staff mandates were delivered:

Interviewer: 'You said you received an email notifying you about your new position'…Respondent: 'Yes- a new title.'… I just got it this morning…(laughs)…it says that [I have] the same responsibilities for now and the same salary and that it will have to be reevaluated… so I guess some good news but not completely. Six months ago, I would have never gotten that through an email. I don't even think that my own boss even knows, it came through human resources …before I would have been called in and told that I have great news for you: 'we're changing your title this is your title', it would have been a more personal touch and this was very impersonal and [this time] it was delivered in an email' (179; 181; 185; 187; 189- 197; Manager: II).

Further, even at the later stages of the research, staff positions continued to be affected by the ongoing restructuring of services. For some, this meant simultaneously straddling both their old and new positions:

The problem is that… the adjoint cliniques are not in place yet, so I am straddling my old job which is running the team on a clinical day to day basis…[and] I'm still part of the other team…because that's how it was previously structured and I'm trying to step into my new position for the other program, so I'm kind of really in flux right now (44-49; Manager: II).

Understanding the reform: Perceptions of the stated intentions of reform

All persons interviewed (i.e., managers and workers) believed that the reform was intended to create an integrated system of health and social care that would bring services closer to the public. Respondents expressed the need to change the old organizational structure. They stated that the old structure lacked a 'continuum of care' and identified the need for integrated services, accountability and the promotion of prevention programs—all concepts touted in promotion of the reform. In the same vein, many respondents point to the purported intentions and ideals of the reform; that it would serve to improve frontline services and efficiency. This included determining services in response to population and community needs.

Many managers discussed how the operational and budgetary independence and autonomy of each pre-reform CLSC had been problematic. The former CLSC mandate to direct services to their direct catchment area meant that the director general for each CLSC was directly responsible for determining the services offered— there were no discussions between the DGs in each centre. As a result, there was ambiguity between establishment responsibilities and, as a result, clients were sent to inappropriate services, experienced delays, and would often get lost in the system. In this sense, respondents highlighted a lack of partnership and 'harmonization' of services between CLSCs. One manager compared the former budgetary independence to an adolescent rebellion and selfishness: *"It's me, me, me and the others don't count"* (115- 120; Manager: I); while another said *"we can say that we were working together, but*

…we [really] made decisions based on what we wanted" (454-460; Frontline: II). What was most interesting about these discussions, however, was the tone with which these comments were spoken—a tone that seems best described as an admission of guilt. It was as if they now felt that they were responsible for bringing on the reforms.

The language and intentions of the reform

The reform's language of 'harmonization', 'integration', and the 'continuum of care', as well as the principles of 'improved service delivery' and 'increased cost-efficiency' were consistently integrated into respondents' discussions of the reforms. The concept of 'harmonization' was a term used frequently by respondents to describe and conceptualize the unification and centralization of formerly diverse regional policies and practices:

> *So, let's say we had a policy on, I don't know, dossier management for instance...now we're going to have to take all of the policies and harmonize them into one single policy* (684-685; 702-703; 707-708; Manager: I).

> *That survey is going to be done because (M2FC)[the managers] will have the job of harmonizing the [former institutional policies]…and there's definitely a different policy [used between one CLSC and the other]…- they use their own AFS (family service workers) for direct service, whereas we use way more agencies. So that's the first thing that has to be harmonized. So, we're at the point now it's just taking inventory* (305-310; Manager: I).

The term 'integrated' was used to describe the same process, and was similarly positive in its application and association with creating a better care delivery system:

> *My understanding is that the reform…was long overdue….we've seen it coming, not exactly in that way, but we knew there was something that was going to be done—that there was going to be more of an orientation toward integrated services…a sense of accountability and a sense of promoting prevention* (57-60; Manager: I).

> *I think we have to look at this as an opportunity in improving service delivery to our clients, to the consumer in our territory. So, I see it as a lot of possible opportunities to reach consumers that might not have been reached before, probably develop a better integrated care* (261-268; Frontline: II).

Linked to this was the workers' juxtaposition of the 'continuum of care' model the reform was intended to create versus the 'silos' model of the pre-reform organization, where each organization worked in isolation:

If I look at the idea of the reform…I think, basically, it's a good idea, because I don't think we could continue working the way we have been, because there hasn't been a strong linkage in the continuum of care for clients…organizations were working more in a silo…versus working together. In an ideal world we should be working much closer. There probably are tremendous drawbacks – but the idea behind it is, I believe, a good idea. I'm not, I'm not an expert, I don't know exactly all the details that pertain to the reform. But if you look at the whole picture towards clients, hopefully, there will be a change (74-76; 80; 84-89; Manager: I).

[In the past] each establishment had to stick within their mission and you always have a gray line between [the] establishments and it is where the population does not receive appropriate services, or delays, or are lost in the system…so the idea is to try to integrate all these different missions, in one global mission, so you will not have these cuts in terms of the continuum of care (20-25; Manager: I).

This has been in the making…for [a] long time…there have been, as I said, experiments of integrated services…the reasoning beyond that was…that the systems were working in silos (55-59; 110: Manager: I).

Importantly, these and other quotes reveal the fact that workers understood the reform as being organized around two core principles: better coordinated service delivery for clients and an increased efficiency in terms of the financial cost of health and social care. Further, while workers' responses reflect an awareness of both, they also demonstrate that, from their perspectives, it is primarily improved service delivery that drives the reform:

So, the goal of the reform is to improve the link, the communication, the continuum of care for the population…and the ultimate goal is to best answer the health needs of the population (8-11; Manager: I).

So, because it will be one establishment, you will be able to see this continuum to move smooth, smoothly, smoothly…and at the end for the people to receive care more quickly, to have a better continuum, to find services (36-38; 38-40; Manager: I).

However, there was also an expressed scepticism about the stated intentions of the reform. Some respondents described how the reasoning and process of the reform was largely grounded in politics with a concern for 'making a mark' rather than improving the health care system.

So, it is not just the administrators, you know, who developed [the reform]. It was at the political level, that [it] was sold to the population, and so when the Parti Liberal was elected, they decided 'now we have to implement what we said to the population'…and I don't see many differences between what was written in that book, at the political level, and what we see now. Even if people think that it's coming with Mr. Couillard—he was part of this group—but it is not just him…it has nothing to do with the health system, it was theirs [referring to the Liberal Party platform]. Almost everything was theirs (59-64; Manager: I).

Together, the above quotations from managers and workers are interesting: first, at the linguistic level, they reveal a stark similarity between the stated rhetoric of the reform (i.e., integrated services as opposed to silos) and the workers' descriptions of a need for change; second, the statements about the need for change can be read in several ways, ranging from an admission that change is needed (e.g., almost an admission of guilt), to rationalizing the imposed conditions of the reform (e.g., reform was necessary, maybe not in that way…but…) to a sincere hope that reform would eventually result in improved services for clients. These findings provide a backdrop for interpreting the anticipated results and everyday experiences of the reform.

High hopes to improve services: The need for change

Considering respondents' emphasis on achieving a 'continuum of care' it is not surprising that they generally held high hopes for the reform of health and social services. Participants hoped that the various agencies would be able to work more closely to achieve change for the recipients of services and eradicate gaps in services so that clients could meet all of their needs in one institution. The following quotes address the potential to achieve 'complementary services' for clients:

I'm hoping that clients would have an opportunity – maybe it's unrealistic – to be able to access either one of the CLSCs, because we don't all have the same services…unless we amalgamate in such a way that we complement each other (98-101; Manager: I).

The merger is based with a community view…So, it's really more a 'vision communautaire' which is a vision that has been shared by the CLSCs…we are a hospital and a long term care facility entering into a world where the mission is 'the community' instead of our clients (135-140; Frontline: II).

Along with the notion of complementary services, there was a hope that the merger would mean that institutions could share knowledge and provide opportunities for training and professional development, ultimately developing more coherent and improved services according to the needs of the population.

Ultimately, it will be a good move… [in order to] provide the same service to the population…Ultimately, we'll have, you know, we would learn from each other, expertise as well. So, one is client, type of service and one is quality sharing our resources. [The one CLSC] is extremely strong in community development –we're strong in some practices. We're neighbors. They had no clue, no clue about who we were, what were our strengths. So, [learning from each other] that's, that's the big gain in terms of direction de service. The other thing that there is to gain is that ultimately, the projet clinique which we haven't talked too much will bring us closer to the population and closer to the partners (584-599; Manager: I).

If the organizations that we merge with…feel that the work that we're doing is beneficial and important…maybe the teams might actually grow and be able to even respond in a better way. We will have opportunities to train practitioners in the other establishments to wear the hats of being, you know, that specialized and having them involved in research (354-365; Manager: I).

Maybe, within this new restructuring we can now talk to each other in a different way whereby we can reorganize ourselves and our services so that that can better occur...I imagine a lot of this is about avoiding overlap, avoiding great bureaucracy, and communicating in a better way to be able to ensure that we give a better service (316-318; 322-324; Manager: I).

By the same token, respondents talked about the process as a new source of inspiration and as an opportunity for departments and individuals to re-evaluate their roles and responsibilities:

It could be frustrating and demotivating at times but other times it could be exciting and you don't know what it's going to be and it is intriguing and it brings new life to the monotonous routine (95-98; Frontline: II).

On the positive side I think that it's an opportunity to look at how to reorganize the service perhaps in a more effective way and a chance to revaluate what we've been doing and see what we could be doing differently and maybe to import or export ideas with the other institutions that have just merged with us. So those are the positive things (65-68; Frontline: II).

Along with this noticeably positive approach to the reform, however, existed expressions of scepticism, uncertainty and reservation in regards to the claims and intentions of the reform. Workers were also unclear as to how the details of the reform would actually work and whether it would achieve its stated objectives, in particular, that of achieving a 'continuity of care'. Predictably, respondents in the later stages of the research had significantly more to say about the changes as many elements of the merger were beginning to reach the realities of the managers and staff.

'Consultation' or the lack thereof

A basic criticism was that the reform was initiated at a political level with little involvement and/or consultation from the population, frontline staff and managers. In fact, the media was the only source of information for many of the workers. Within the agencies involved, there was a 'wait and see' type of attitude. In the interviews, respondents at various levels repeatedly identified the lack of consultation as one of the reform's greatest weaknesses:

> *I don't think specific establishments were being consulted with the actual reforms. I know we had certain pockets. I think the Ministry with the Agence had developed a committee of experts…but to say that we were actually consulted on our visions, no. This reform was a directive, this was what was going to happen, our executive director was ousted, you know, this was a major reform* (159-154; Frontline: II).

The impression among respondents was that consultation, when it occurred, took place along the hierarchical lines of the new organizational structure – i.e., with those at the most senior levels of the management structure, as opposed to those on the frontlines:

> *Maybe at much higher levels there was some consultation, I think all the executive directors were being consulted along the way, and we were given information as things were going on…– we [referring to a select group] were invited to participate on the committee d'experts because we are recognized as experts in our field [identifying information removed]. So, we gave a lot of input in terms of that, but in any other aspect I am not sure if there was that much consultation, I think we went along for the ride kind of thing* (154-160; Frontline: II).

> *[There are] many things at stake and ultimately it was the Régie that had the final power to really decide how many territories in Montréal, you know, who with whom and whom with what and sometimes they had to force and they had to also make recommendations for compromise for excluding people from the fusion, from the merger and everything* (388-93; Manager: I).

> *I find that there is less collaboration and discussion. The decisions are made from top down…which is, in terms of how they worked before when they had more autonomy. I find it very difficult. Everything has to be done 2 or 3 times because the directions are not stated clearly and I find it very frustrating again getting used to the new styles. Especially when you have to harmonize across the site policy and procedures and things like that. You can't come up with a plan until you talk to your manager on how you are going to implement those policies even if you don't see them happening yet* (56-66; Frontline: II).

Many respondents identified that the DGs of the organizations before and after the merger were the most informed, involved and in control of the consultation and decision-making process. This perception corresponded with my research conducted at the one CLSC site, where I was surprised at the lack of knowledge about the reform. Consider the following quotes from managers working within the system:

Well, before [the reform] I guess I was informed...I don't think I was, you know… The director generals were really the ones who had the most information...we were involved in the most significant discussions about the reform prior [to its implementation] (552; 556-561; Manager: I).

The first involvement was peripheral – determining who is going to be merged with whom. That took lots of energy. As a member of the management team, I was involved in assisting the director in some thinking, gathering information when needed to develop sub-scenarios that were ultimately posed to the board...I mean those kinds of things. I didn't play an active role, I mean, sometimes when the director was away, I would attend a meeting, couple of meetings with some of the potential partners or the Régie Régional and so on and so forth. It was peripheral because the main actor was the DG (375-384; Manager: I).

Beyond consultation, many respondents also cited the rapid pace of the reform combined with the limited consultation as a large part of the problem:

And so, we had information, documents, consultation, and the law came. And the law we had <u>very little time to react</u>, very little time to react. Usually, we have more time to react. And the law was passed at l'Assemblée Nationale and it had to be implemented (93-98; Manager: I).

To me, it's a new reform that follows previous reforms by bring[ing] back the essential message that if we do things to maintain our health it would be less costly…[but] it is different…It's done in a rush and it's all attached to the political agenda because the Liberals bring this because they know they have two years to act upon because the last year will be for election so if they want to make a change, they will have to make it quickly. This is sad because then it precipitates building a structure but not looking at the needs which takes some time (331-340; Frontline: II).

And everything has happened extremely quickly! So, it's happened with very little information (1007-1008; Manager: I).

They also emphasized that change within an organizational structure requires time and the development of working relationships, and they felt the reform was overlooking this important process:

I think that the reform has a lot of very positive points and it makes sense. I think that the speed at which they are trying to do it is for political reasons and I think that, like anything, if they do not invest money it is not totally going to work because there are many pieces in the puzzle that have to be put in place before it can work (309-312; Frontline: II).

The other thing we're concerned about is the rush. For example, the super hospital that we've seen, there've been debates and debates and commissions over location, and this and that. There seems to be all the time and the money in [the]world for those levels of discussion, but when we're talking about the biggest reform in health care policy in 30 years, we can't take an extra year to see what impact there is going to be (325-329; Frontline: I).

We just go fast to make [a] decision, because we want to please 'the higher-ups' at the Agency but we forget that everything we want to we're not doing alone (501-503; Frontline: II).

Overall, however, respondents expressed concern about the potentially negative impact the lack of consultation might have on the implementation process, as well as a desire for more communication and a better understanding of the organization in order to successfully integrate the changes of the reform:

There are decisions being made very fast, without consultation and if you have decisions that are imposed on you sometimes you don't go along with them. But if you involve people in your decision, they go along with it.

So I think, the lack of communication in this organization, if we're gonna deal with it …I think this is work that needs to be done because then it filters down to our staff. If we don't know what's happening, and if we don't feel part of what's going on, how can we tell our staff about that? (153-155; Manager: I).

So, we need to understand what they're doing, is there a way integrate it somehow. So, it is all open and up for discussion (52-60; Manager: I).

I think if we look at… the objective and who are we doing this for, definitely we are not doing this for ourselves because everyone would be very happy to leave things status quo. If we are doing it to improve delivery of care to consumers and families…then it's for a good reason. You know not everyone likes change and not everyone is comfortable with change but I think that if handled well and people have an opportunity to talk about their concerns openly without feeling that their would be retribution in any way, and keep the well-being of the team or teams going, I think leadership is going to be very important in this whole reform, in this

change on how people are lead, how people are managed (271-280; Frontline: II).

Improving services for clients?

Workers' repeated emphasis on improved service delivery for clients as the main objective and rationale for change continued throughout the study. However, while workers envisioned clients as the main future beneficiaries of the reform, as the reform progressed, respondents began to voice concerns that the reform was placing too much emphasis on organizational structure rather than the goal of improved service delivery:

> *It's a good reform. In a sense, to me, it's about time that we look at the community and people's needs and to adjust the system to answer that better. Instead of having a system where the professional would dictate what they are going to be doing and hope that would answer the needs, so for me it's the right way to go. But my concern is that we focus on organizing the structure of the new organization without appropriately looking at the need. So, all the managers and all the programs are organized but we don't yet know what are the community needs. So, it would have been nice to make a closer evaluation of the community needs and then from that, make the decisions. But there was a rush to organize the structure. But the reform, I think that if it is done well, it will be very positive* (280-289; Frontline: II).

This concern seems to have been well-warranted when workers responded that the reform was not producing any changes in the clients' experiences of care. It is possible, however, that the impacts of the reform will only be seen in a few years time. Consider the following:

> *Yeah, I don't think that people are aware of it but the question is, can someone in this territory go to [the other CLSC] now and get service, I don't think so, I think that things are status quo right now until things are more settled* (429-431; Frontline: II).

> *There has been no change. No change in the day to day operations….*(179-184; Frontline: II).

> *I am not sure where all the clients who have mental health programs are getting services. We are at the very, very beginning and getting to know who is doing what and who to speak to and where to get statistics from and the statistics that we are getting are they accurate because are they coded the same way that we've coded things, so there are a lot of unknowns at this point* (201-209; Frontline: II).

So, in other words, nothing has changed in the fact that we still have the same clientele in the same territory with the same needs calling daily to intake and daily, we have the same number of demands coming down into the department. So, personally, the objectives, my own objectives, my team's objectives and then the larger homecare team have not changed. We are here to meet the clients' needs and to respond to the urgencies and all that hasn't changed (67-72; Frontline: II).

Others questioned whether the service delivery experience of clients would actually change in the long-term as a result of the reforms. When asked 'What has changed?,' one worker responded:

Let's say we are talking about home care, are we going to change certain functions to match our new sister and brother organizations? As soon as we know that, we will know what things are going to change, perhaps nothing will change. Perhaps, the way in which we are working is good and effective and we are going to continue working that way. The workers on the frontline are still the same workers, nothing has changed in the day-to-day (151-158; Frontline: II).

One thing that did change, however, was the number of meetings required by the new structure and the amount of time that workers now spent in their cars. Responses in Phase II indicated that the number of meetings managers were required to attend had increased, and that managers found themselves more heavily involved in administration rather than management and service. Consider the following:

So, since March we have two meetings a month. One just administratively, you know, just managers, and once a month, it's all the managers of every program. So, this is the way that the information is passed. But before, when we were at a table, we were six managers to manage this place, but now we're maybe thirteen or fourteen (161-166; Manager: II).

D. FINDINGS II – MAJOR ANALYTICAL FINDINGS

SECTION I: IMPACT ON MANAGERS AND FRONTLINE WORKERS - THE EMOTIONAL CONSEQUENCES OF ORGANIZATIONAL CHANGE

For managers and frontline staff, the reform of health and social services in Québec produced an environment of uncertainty, confusion and anxiety, and resulted in low morale and disillusionment. Workers experienced a complex transition period where disorganization at all levels obstructed a fluid flow of information – described throughout the study as a major obstacle in workers' ability to achieve the goals proposed by the reform. For example, consider the following: "*I believe very strongly that if the communication is not better between us, and if we don't educate the staff all over the place, we cannot achieve any goal. And right now, we're not doing that*" (499-

501; Manager: II). Further, many workers expressed feeling alienated from the reform process due to restrictions on the flow of information from top levels to lower ones:

> *I mean, it's really something that…hasn't filtered down to our level yet, and I don't know to what extent it's going to, and to what extent it's decisions that are made on the level of the board or on the level of the, the management, you know* (368-372; Frontline: I).

Interview responses also highlighted how the lack of information created a sense of confusion, non-involvement and powerlessness among workers:

> *So, there's a bit of disempowerment…honestly, information about the reform, I don't have any information about the reform* (278-280; Manager: I).

> *I'm kind of a control person; I like to be in control of my life…So, I don't feel that I have much right now because I don't have any information…and people, when you ask people they can't answer you* (1718-1719; 1723-1724; 1728; Manager: I).

Not surprisingly, the lack of information and general sense of disorganization was also connected to feelings of uncertainty and confusion among workers in regards to a number of issues, including uncertainty about their roles and positions within the transitioning and future organizational structure:

> *I don't think people will lose jobs, but they might not have the job they have right now…our level, we don't know what… will happen with our level* (197-198; 207; Manager: I).

> *In terms of responsibility, yes, I expect they will change but this is where the uncertainty lies 'cause I am not sure how things will change. But that does scare me. I like challenges and I like to do new things. What makes me feel uncomfortable is not knowing what the new things are yet* (57-61; Frontline: II).

> *Well, when we have lots of change like that it's very hard and very painful because you don't know what you're going to be doing tomorrow and you don't know how your partner and you will work…and when you don't know which job you're going to have tomorrow or how it's going to be working—and if you've been doing something for ten years suddenly you have to find another way to do the same thing with your partner, you need lots of communication, lots of patience and it's not always easy* (38-40; 45-49; Frontline: II).

This 'climate' of uncertainty and insecurity further contributed to workers' perceptions that the reform had failed to articulate a discernable direction for the future structure and working environment of the organization, thereby creating uncertainty in the present:

Plus, there is insecurity because one day another change, one day you have a responsibility and the next day it is removed from you, the mandates are not clear yet, which can be normal but it sets a mood, you know, a climate (116-119; Frontline: II).

What has changed though is who my supervisor is, who my larger managers and what the overall objectives are going to [be] before development, in what direction are we going to go and those are still big questions that are still unanswered (72-75; Frontline: II).

As suggested in the above, the restructuring of departments and roles generated anxiety among workers, especially in regards to the social dynamics of their newly and often radically altered working relationships. Respondents from different levels of the organization expressed concern about working with new colleagues, especially those from other institutions and agencies with different organizational 'cultures' and work environments. Specifically, respondents showed apprehension for the latitude of their autonomy in the new organizational structure:

So, [respondent's team] are anxious about who is going to be their clinical supervisor and legitimately so, 'cause I have a certain style that has worked well with this team, it's a strong team, it's a mature team and I guess the concern is what kind of style would be coming in and how much autonomy they be given, so they are anxious about that part, but they are looking forward. Don't forget we are fusing with another team – which existed here—so that even just physically, in our own establishment, it's an adjustment … kind of like living with new people, you know, the dynamics of the existing team shifts when someone new comes in. And so…there is some anxiety (111-119; Manager: II).

As new managers were brought in to supervise already established teams, interpersonal working relationships and managerial styles had to be renegotiated and redefined. Some staff members reported feeling tense as a result of what they understood as overly aggressive supervision by incoming managers, while other employees felt they were not being trusted by their new supervisors:

If I look at [this team as an example] they have a new boss signing the check, asking for things differently than I used to. So, I can say that some staff are already feeling the changes. And what's the hardest for all of us is that you've been doing a job for ten, fifteen years, you always write your check in a blue pen, OK. It's a stupid example but the new boss wants you to write the check in red pen, so you don't understand why he wants that change, because you've been fifteen years doing the same thing, so sometimes some staff thinks that [the boss] doesn't trust them, doesn't think that they're doing a good job, is questioning a lot. But people want to understand how it works, so it's normal

that they ask questions, but it's not everybody who has the skill to ask questions and to make people feel not in question, you know (320-330; Manager: II).

Yet, managers, too, were anxious over how to successfully embrace their newly created positions that often involved significantly expanded managerial portfolios than those of pre-reform and pre-merger positions. One respondent described her new role thusly:

Well, we need to adapt to the changes. It's like changing your frame of mind because I used to be only in this institution and now I cover lots of institutions so, in that sense the responsibility is much larger and so you have to take it on. So, I guess there is some insecurity to start off with because of all the unknowns. And because nobody was doing that job before so it can not just say we are going to ask this person we are going to be creating these roles. So, in that sense it's lots of adaptation, it's interesting because there are lots of things I am learning, lots of challenges (32-39; Frontline: II).

Perspectives on organizational change from the literature

In order to understand the workers' emotional responses to the reform, we turned to a review of the literature on emotion in organizational change, which focused primarily on how to achieve objectives and implement change. The emphasis in this literature seemed to be on 'making it work'—with an implicit assumption that 'change' is for the better. This literature focuses on mobilizing workers by 'bringing them onside' and/or addressing their resistant behaviours. Within such a framework, it seems that workers and their emotions become instruments in the implementation of reform. There is however, a separate body of literature that addresses the critique of organizational change—however, even it never moves beyond the assumption that change is for the better.

Workers as instruments of implementing organizational change

The literature that addresses emotion in organizational change recognizes the roles of workers as those primarily responsible for implementing policy reforms and top-down organizational change. Workers are primarily presented and discussed in relation to their roles, and their emotions are understood in instrumental ways, as either blocking or facilitating access to change. Authors working in both health and social care and private sector contexts have approached emotion variously: as an obstacle to implementing organizational change (see Kiefer, 2002 for a review of this standard approach to emotions during change); as a barometer of the success or failure of organizational change (Tousignant et al., 2004; Ezell et al., 2002; Ware et al., 2003); as a 'natural' and even 'vital' part of the change process (Kiefer 2002; Piderit 2000); and as a factor shaping how implementation is articulated (i.e.; emotion's interactional role in creating a particular atmosphere that guides how public or private policy changes will be

received and implemented) (Akerstrom, 2006; Fulop et al., 2005; Kiefer, 2002; Vallas, 2006). Throughout this literature, workers and their emotions are seen as instruments in the organizational change process.

Ways to design and implement the management of organizational change

The literature on organizational change works from within a framework of identifying the best ways to design and implement organizational change, taking workers' emotional responses largely as phenomena to be studied so that both emotion and organizational change can be better represented, understood and significantly better managed (See especially Fulop et al. 2005; Gulliver, Towell & Peck, 2003; Piderit, 2000; Mizrahi & Berger 2005). This emphasis on 'best practices' or a 'making it work' approach to organizational change is even deeply embedded in otherwise insightful reflections on the emotional dynamics experienced by workers in organizational change settings (See especially Akerstrom, 2006; Vallas, 2006). There were no examples that spoke out against or overtly condemned the change—change through reform was, at least to some degree, consistently integrated as necessary and good. This can be seen in Piderit (2000), who advocates for a strategy of addressing ambivalence in the changing workplace as a means to create opportunities for dialogue through which workers can constructively process and engage change, as opposed to maintaining a resolutely positive or negative (e.g., support or resistance) stance among managers/employees. In keeping with the standpoint of 'managing change', however, Piderit's concern here is to "balance the need for ambivalence with the need to limit its debilitating effects" (2000, p. 791). Similarly, Fulop et al.'s (2005) study of health care provider mergers in England explores the emotional impact of a merger on staff in the context of developing better understandings of such events, in order to "anticipate and avoid harmful consequences" (p. 119).

In the context of large-scale institutional restructuring, health and social care workers can be seen as admirable and quite practical in their attempts to integrate change. At the same time however, workers are also complicit in validating and executing managed care reforms and do not have much power to position themselves outside the frame of 'making it work.' As such, their daily work is fraught with the contradiction. Mainstream approaches do not consider the complex emotional experiences of workers in reform settings as serious consequences of reform. Consequences that directly impact upon the lived realities of those, too often, taken as instruments in the broader reform process, and not as priorities in their own right. Results of this study highlight the need to reflect on the ever-increasing pervasiveness of the 'making it work' mantra, while also demonstrating how a careful analysis of workers' emotions can serve to open up critical spaces in which to reconsider current assumptions about the state of health and social care and organizational change in western industrialized contexts.

'Making it work': Organizational and individual anxieties

In contrast to the above, the psychoanalytic literature offers alternative ways of approaching emotion in organizational change. In particular, Bion's (1961) classic work on group dynamics and Menzies Lyth's (1988) work on anxiety within institutions provide insight from which to interpret the workers' responses of emotional conflict expressed within organizational change. However, the fact that this work is also deeply steeped in psychoanalytic concepts (e.g., organizations as 'containers' for individual and collective anxieties, looking at organizations as creating and created by/for people's emotions and emotional processes) means that it is sometimes difficult to make use of psychoanalytic theory in the context of this report. However, it is important to note that drawing on psychoanalytic and psychodynamic perspectives offers critical spaces within which to think about emotion and organizational change and provide an important distance from the mantra of 'making it work'.

The workers' accounts reflect the pervasiveness of the 'making it work' framework. While workers and managers do not recognize outright how they reproduce the dominant ideology, the ways in which their discourse and daily activities mirror such models can be seen in the quotes outlined earlier, as well as in those presented below. In-depth explorations of what is 'said and unsaid' reveal the conflicting emotions surrounding workers' everyday activities and decisions. Workers and managers become caught between the requirements of being responsible for implementing the reform, and their obligations to the team environment, personal aspirations and limited capacities, and the needs of clients. What emerge from these contradictory allegiances are anxieties that are expressed within the team environment, the personal aspirations of workers and the clients themselves.

Difficult position of the workers: Team, client & personal implications

Team environment

The styles of team functioning and management proposed by the reform exert new pressures and challenges on workers and managers. For example, managers reported being torn between the need to form meaningful interpersonal relationships with their staff amidst an unstable working environment and their increased administrative responsibilities. Consider the reservations expressed in the following quotes:

> *My concern would be losing sight of the day-to- day work that needs to be done and losing sight of the need to keep the wheels turning to deal with the teams*

and to deal with the staff on a daily basis and not get caught up with meetings, emails and phone calls (68-72; Frontline: II).

As a manager I really don't feel we are going to be as present for our staff because I feel we will be bogged down with much more administrative duties. And that is a concern, that we would not be as present (262-266; Frontline: II).

They [the team] are anxious, because it means that I am going to be one step further from the day to day that they are used to seeing me. 'Cause I am here and my door is always open and I am their clinical supervisor… any issues they can consult with me and I was probably one of the first members in this type of team (103-110; Manager: II).

Staff, too, felt the strain of adapting to a new working environment, as seen in the following:

And the difficult thing is that you leave your security in your other job where you already had your management team, philosophy and a team that worked well. And now, you have this new boss and these new ideas and you have to create this whole new team of managers that you have to create this bond with so it's just time-consuming and there are different cultures so it's just a way of coming up with a common philosophy; that is going to be a challenge. I mean we all are client-centred and there is a lot in common but it's just that this new management structure is different than what I am used to (46-53; Frontline: II).

Concern for clients

As those largely responsible for implementing the reform, workers also found themselves caught between the requirements of the reform and the needs of their clients. As mentioned earlier (see Part C, Section II of this report), workers objected to the increasing emphasis on how to facilitate the required changes to the health and social services system's organizational structure, and sought to bring discussions back to the stated intentions of the reform – creating a 'continuum of care' that improves access and better services to the population. This is clearly articulated in the following:

It cannot just be structural, because if it stays structural we didn't achieve the goal. The goal is not to change the structure. The goal was to make sure that the patient, that the client, can pass through all the system without waiting at each door. Our goal is that we take care of the population, we give better services, faster, and that we take over a patient and we help him, we open all the doors for him, that he doesn't have to knock on all the doors (410-416; Manager: II).

Some saw the pervasive disorganization as a threat to worker effectiveness that would in turn impact client well-being:

I mean, I made a request for an employee to work 6 days and I…I couldn't get an answer for, like, 6 weeks. It should not take more than 48 hours to get an answer on anything, it just shouldn't and then it's not fair…it then impacts on your staff and then that impacts on your client…I mean, right away, when we heard about the process, we were all scratching our heads and saying that this was going to be insane and it is insane (447-454; Manager: II).

Concern for clients was also expressed early in the reform process, as seen in the following quotes, which situate workers' approval of the reform within a hope that it will result in improved client service:

In general, I thought that was the right way to go for a couple of reasons. Mostly harmonization, the different CLSCs, each one is doing different things; they make their decisions independently… They determined how much service they give to what population, so there is no consistency. And that is bothersome for a client that lives on one side of the street in one neighborhood versus a street in another neighborhood, why shouldn't they receive the same quantity and quality of service given the same problem? And, I think for that it's a good reason for the reform is for more harmonization (317-326; Frontline: II).

And, I'm also hoping that the population will have a better understanding of what services there are and how they can access. I hope that, in the plan of this reform, that they take into consideration informing people: How do you access the service? Where do you start from? What are your rights? Where do you go? How do you complain without having fear? (391-395; Manager: I).

Personal implications

Where many workers in administrative positions saw their increased workload as an obstacle to their ability to build and maintain important interpersonal relationships, it also had an effect on them personally. The following quotes illustrate the strain experienced by managers as the demands upon them as individuals increased, while available support resources were reduced:

*Meetings at the director level, quality meetings, 'projet clinique' meetings, community meetings and many more meetings. I had my own management meetings inside. It's a lot more than we had previously.   It's double, with extra facilities, in terms of the amount of meetings you have to attend but you are still one person (*267-270; Manager: II).

I've even been cut…before the reorganization I used to have an assistant …Now I have a bigger mandate and I've lost my assistant…I fought…Finally they gave me 2 days of a consultant but I did not get the person yet and I got 2 days of

additional secretarial support for [identifying information removed] mandate but I lost my assistant so overall there is no gain there are more losses. So right now my plate is full (170-177; Manager: II).

Similarly, the reform's radical organizational restructuring resulted in an upset of many workers' personal plans for their career paths. As discussed earlier, while it was generally understood at the outset that job loss would not occur, changes in people's positions were to be expected. For many, this meant re-evaluating career expectations in accordance with the new employment and/or advancement options offered. As we saw previously, for some this resulted in the need to take on increased responsibility with less support. For others, it meant letting go of formerly held aspirations, as is clearly articulated in the following:

The change for me—I'm not very happy with my job. In my career I was going to be [identifying information removed]…and now, I'm in charge of [identifying information removed]. So, for me…it's not where I would like to be, but for the moment…this is my place. So I have to find a way to accept that job and do the best I can with my new job (53-57; Frontline: II).

In its most uncompromising moments, the reform presented workers with essentially impossible personal choices, as seen in the following accounts:

So, every manager…was given a director position. [The newly appointed director of the centre], had to place those people. She had to think of what would have been the best structure in terms of the, la réforme. So, that's what she did—she …saw who can she could put where. She asked us, our interest – first interest, second interest, and then she placed people. You know – this is your job; if you don't want it, you can leave; you have a choice. There was no choice. I mean, she did her best. It could've been worse; could always be better; when you consult people more you have the better chance of, but let's assume it's not bad. In some other places, the process was much longer, because they consulted (426-436; Manager: I).

So…it's hard to follow…it has been hard for them [the intermediate level managers] because during the merger process, all management positions were abolished—we…received a letter saying that the job was abolished and that within the next 2 weeks…the director would offer us a position, if you don't take that position that she offers you, then you are considered as having resigned, then you have no job (laughs), so the decision is relatively quick to take, really, because I need a job (87-93; Manager; II).

In this scenario, either you work within the reform or you leave the agency altogether. Accordingly, workers' accounts tended to reflect a profound loss of control over personal and professional decisions. Indeed, loss became a major, if largely under-

acknowledged theme among respondents. As seen above, while job reassignment was meant to mitigate incidents of people becoming unemployed as a result of the reform, reassignments were often simply reduced to an ultimatum, with new positions invoking personal dissatisfaction and greater workloads. For others, reassignment meant letting go of former successes and years-long investment in particular teams (i.e.; people and relationships) and projects, in order to fulfill the requirements of redefined managerial roles and responsibilities:

> *I feel that I am very open except when it comes to ----------- which is one of my main dossiers right now because I have invested so much of my management years in this place, in terms of organizing that module, in terms of getting a better quality and a better way to clients that I would find it hard to let it go* (327-332; Manager: II).

> *So, this team is built with me and the people I hired and in a sense it was my baby and most of the people on staff were hired by me, and the orientation and the direction of the team and our model of service delivery is based on the work we have done as a team. It's a phenomenal team* (103-110; Manager: II).

> *It is very hard to centralize things and to take away from people, responsibilities they had before. So, it's a whole new way of management* (164-172; Frontline: II).

Especially at the managerial level, respondents further articulated feeling a loss of autonomy in the new, more centralized (and some have said more bureaucratic) organizational structure. Within this, managers were often concerned about how their loss of autonomy in terms of decision-making and ability to 'get things done' would impact how they were perceived by staff:

> *Just a feeling that one gets, where small things like… staff person just came in, 'you know what I completely forgot'…A new staff person coming on Monday, they don't have a desk. So, before it would have been very easy, we would have gone out there, spoke to the person who's in charge, who would have tried to do something… We should have been told before… now, it's an issue, 'cause… It has to go through kind of lots of people to be bureaucratically approved …and where does the budget come from*? (309-316; Manager: I).

> *Yeah, I mean, because, because in the reality, staff sees you as having lost some autonomy, ok? Which makes them feel less, you know, having certain decision-making powers.* (303-305; Manager: I).

Others maintained a more positive perspective on the turbulent reform environment:

We could always say the change brings in chaos. Brings in loss; but from chaos other things can come out (636-637; Manager: I).

This latter quote raises the issue of how individuals make sense of the changes they experience as a result of the reform. Altogether, the responses demonstrate that workers, when faced with no real choice, often respond by accepting the inevitable and rationalizing the decisions made, as seen in the above: "*I mean, she did her best. It could've been worse; could always be better*". Even among those who discussed their new roles as a challenge, they expressed some sense of resolve. In each case, workers' responses led us to believe that the success of the reform became a personal task that was somewhat removed from the group and/or systemic level. Workers seemed to see themselves as having to shape themselves and their professional identities around the reform rather than the reform being shaped around the needs of clients, workers and/or managers. Hence, the prevalence of such statements as: "*So I have to find a way to accept that job and do the best I can with my new job*"; "*Well we need to adapt to the changes*".

The 'mental conflict' associated with workers' adaptations and experiences can be seen in the 'need to adapt' and 'learn to accept' statements that refer to the often uncomfortable environment created by the reform. Workers were sceptical and/or critical of the reform but were also hopeful and committed to realizing what they perceived as its central goals. In this, their discussions tended to stop short of rejecting or developing a radical critique of the reform. Rather, their hopes, concerns, criticisms and frustrations all occurred within the frame of 'making it work'. This is similar to the literature that fails to consider whether the reform is actually a good decision. It is likely that this is, in part, related to the need to make sense of one's daily role and function in changing the lives and experiences of clients—and the need to believe or hope that one is doing good work. Taken together, workers' emotional responses to the reform reflected anxieties that were deeply entangled in their role as its instruments—they were held responsible for the 'making it work' framework that we have argued is so pervasive in both the literature and among policy objectives of reform.

SECTION II: POPULATION HEALTH MODELS & OLDER PEOPLE

The second analytical strand focuses on the importance afforded to the population health model and asks critical questions in relation to services for older people. The reform clearly articulates a move toward the population health model (see Levine, 2005, 2007). While never clearly referenced in the literature on the reform, managers have articulated that the population health model espoused by Québec drew heavily on the Lalonde report (Lalonde, 1974).

According to the Public Health Agency of Canada (PHAC) (2004), a population approach to health care "focuses on improving the health status of the population rather than individuals…requires reducing health inequalities between groups" and operates under the assumption that "reductions in health inequities require reductions in material and social inequities" (Online). Globally, nationally and provincially, population health has been incorporated into several organized approaches to health care systems. Nationally, Canada's federal government has offered its own interpretations and guiding model of population health. According to the federal Public Health Agency (PHAC, 2004), a population health approach incorporates an understanding that factors within and outside the health system impact upon health. The PHAC's model of population health:

> considers the entire range of individual and collective factors and conditions - and their interactions - that have been shown to be correlated with health status. Commonly referred to as the 'determinants of health,' these factors currently include: income and social status; social support networks; education; employment/working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; biology and genetic endowment; health services; gender; culture (PHAC, 2004).

PHAC's model focuses attention on maintaining or improving the health status of "an entire population, or sub-population, rather than individuals" (PHAC, 2004). PHAC's population health model further envisions that:

> the outcomes or benefits of a population health approach… extend beyond improved population health outcomes to include a sustainable and integrated health system, increased national growth and productivity, and strengthened social cohesion and citizen engagement (PHAC, 2004).

In Canada, this approach was pioneered by the federal government's 1974 'White Paper', also known as the Lalonde Report (Lalonde, 1974), which suggested that improvements to lifestyle and social and physical environments would increase health status more than further investment in then-existing health care systems (Health Canada, 1999). The Lalonde Report resulted in the development of health promotion programs that raised awareness around the health risks connected with particular

'personal behaviours and lifestyles' such as smoking, consumption of alcohol, as well as nutrition and fitness (PHAC, 2004). The report also influenced the population health approach, officially promoted by ministers of health, in the report entitled *Strategies for Population Health: Investing in the Health of Canadians* (Health Canada, 1994). In addition to discussing determinants of health – also the report presented a "framework to guide the development of policies and strategies to improve population health" (Health Canada, 1999). Documents that trace the evolution of health promotion and population health includes the Lalonde report (Lalonde, 1974) and *Achieving health for all: A framework for health promotion* (Epp, 1986). Also important was the first *Report on the health of Canadians* (FPTACPH, 1996) and *Toward a healthy future: Second report on the health of Canadians* (FPTACPH, 1999). On an international level, there are also the WHO's *Ottawa charter for health promotion* (WHO, 1986) and its *Verona Initiative* (see Bertinato, 1999), which includes the benchmarks that identify and compare the health of populations within different countries.

According to the Health Canada Population and Public Health Branch (HCPPHB) - Strategic Policy Directorate (2001),

> The population health template consists of 8 key elements including: 1) focus on the health of populations, 2) address the determinants of health and their interactions; 3) base decisions on evidence; 4) increase upstream investments, 5) apply multiple strategies, 6) collaborate across sectors and levels; 7) employ mechanisms for public involvement, and 8) demonstrate accountability for health outcomes (HCPPHB, 2001, p. 5).

The WHO has adopted a population health framework, and offers information on what it identifies as 'summary measures of population health' (SMPH), describing these as "measures that combine information on mortality and non-fatal health outcomes" used to develop an "understanding of population health [which] can include comparisons of the health of a population across time, quantification of health inequities, priority setting for health services, delivery and planning, cost-effectiveness studies, health expectancies & health gaps, and the importance of disease, injury and risk" (WHO, online summary).

Importantly, the federal model is a policy guideline that provinces can interpret according to their own priorities. In the case of Québec, it is not immediately clear how its model corresponds to that promoted at the federal level. The model of population health used within the Québec reform can be seen in Levine (2005, 2007), a representative of Québec's recent health care reforms. Unfortunately, Levine's discussions of population health do not cite the particular model used for the province's population approach and make no reference to the models espoused by Canada or the WHO. Levine's description of Québec's use of Managed Care is one comprised of a 'population-based model', a 'chronic care model', and a 'hierarchical provision of services' (2007). Levine's discussion of the reform is pragmatically based in population

statistics and management models rather than a guiding theoretical perspective or overarching vision. Levine describes how Québec's 17 regional health care agencies drew upon Canadian census data and provincial health statistics to produce a portrait of the population in each service area (2007, p. 48). According to Levine, the data contributed covered information on "socio-economic status, education level, and service consumption as well as information on housing, immigration, and community organizations", in addition to 'lifestyle data' such as "tobacco consumption, levels of physical activity, and obesity rates", as well as data that defined "at-risk populations and highlight critical social issues such as homelessness and prostitution" (2007, p. 48).

Levine attributes the 'chronic-care' aspect of Québec's reform to 'Wagner's Chronic Care Model' (see Wagner, 1995, 1998; Wagner et al., 1996a, 1996b; Wagner et al., 1999 – cited in Levine, 2007), which "was adopted in order to manage the care of chronically ill patients and those at risk of developing a chronic illness" (2007, p. 48). This model is made up of four priorities: (1) Chronic care protocols for each disease and involvement of family physicians in their application and follow-up; (2) Patient self-management through education and support networks necessary to accomplish that goal; (3) Multidisciplinary primary care teams or access to such teams by family physicians, including seamless access to secondary and tertiary services as well as all corridors of service for diagnosis and treatment; and (4) Information systems that support electronic medical records, chronic disease registers and diagnostic treatment decision support tools (Levine, 2007, p. 49).

In addition to the principle of a population-based approach, Québec's model of health care provision is further defined by its other primary principle: a 'hierarchical provision of services' (see diagram below) (Levine, 2007, p. 47). According to Levine (2007), the model "distinguishes between primary and secondary care services and the more specialized services offered in regional or tertiary care centres", a distinction he claims is important for determining what services will be "provided close to the population being served" and which will be offered through "more resource-intense specialized centres", a structure that he asserts is the foundation of the concept of "corridors of service" at the heart of the reforms (p. 47). This hierarchy of services is meant to guide assessment and service delivery—providing the means by which to prioritize and ration which services are provided to whom.

Challenges to the Population Health Model

While the population health model is based on desirable outcomes of a 'healthy' population, the use of the population health model also raises three major concerns: the epistemological challenges of what counts as 'evidence', the process of implementing within the health and social care system in Québec; and the result for already vulnerable populations. First, the population health model is rooted in standardized objective assessments of health. While these may form rich and important indicators with which to compare the province of Québec to other countries and

provinces, it is primarily a model that prioritizes medical and scientific indicators of well-being (e.g., prevalence of disease and population statistics). More qualitative understandings of health and well-being are often absent from the dominant understandings and assessments of 'what counts' as population health. Further, the extent to which preventative type services – at the heart of population health models – can be included is paramount.

Second, the process of reform to date raises several concerns about the way that a population health model will be implemented and achieved within the Québec system of health and social services. Namely, to what extent will the emphasis on population health be implemented from a biomedical framework that further medicalizes health and social services, intensifies an invisibility of older people's needs, and results in the creation and maintenance of social exclusion of marginalized populations. These concerns are discussed in detail below.

Medicalization

In the current practices of health and social services, risk is already articulated as physical impairment and medical diagnosis. The creation of a hierarchy of services and articulation of clinical projects strongly suggests that services will be increasingly rationed according to medical priorities, such as those of first and second line services that already overlook social needs (Grenier & Guberman, In Press). In several of the planning sessions for the 'clinical project', I witnessed the tension between medical and social services. These tensions were embodied by the different groups present at the table—with community organizations voicing the need for non-medical services such as housing, transportation and home-visits, and the CSSS representatives focused on risk management—with medically identified risks leading the interventions (or at least the assumption of medical risks). Further, the information sessions were conducted between professionals with no visible members of service users present.

The debates witnessed at meetings were fairly clearly divided according to the context of work—community or CSSS. On several occasions, the discussions regarding the 'clinical projects' became the grounds for community organizers to defend their type of work, and try to resist the pressure of taking on the types of clients and services that would have formerly been served within the CLSC system, as has been the case with previous reforms such as the *Virage Ambulatoire*. For example, there were discussions about the importance of identifying and responding to risk within community organizations. However, there also seemed to be an assumption that the community services would organize their services according to the same models as those of the public sector (i.e., CSSS). While community organizations clearly contested such models, it did not seem that the CSSS workers (i.e., institutional workers) understood that community organizations used different models of assessment and service delivery.

So far, this dynamic has revealed increased pressure on community services with no increase in funds. At the time of Phase II (2005) community workers questioned whether they would be able to continue to provide 'innovative' and 'grassroots' types of services, as well as the extent to which they would become 'folded' into the CSSS network. Respondents identified how the reform in health and social services would not address the problems with the medical services that included under-financing, difficulties maintaining and securing a medical doctor, and the increasing medicalization of social services. While respondents highlighted the contradictions that exist within the reform, as discussed in the previous section, they also hoped that the results would favour the client. Consider the following quotes that discuss the complexity of the relationship between health and social services:

> There was not one CLSC…properly financed compared to the…norms in Scandinavia or in Toronto. So…they haven't been able to develop…because the medical is the real issue and I don't think the reform will solve it (120-125; Manager: I).

> Every health system shall be under [the hospitals] and they say it openly, they have no shame. Because for them health starts with a hospital, so it shows already what we call 'hospital-centered'. Les hôpitaux qui pensent que la santé tourne autour des hôpitaux (283-286; Manager: I).

> The Ministry is trying to tell the hospitals,'health is not equated with hospital care'. C'est pour ça que la réforme, finalement, elle amène deux concepts: elle amène le concept de l'approche populationnelle et le concept de la hiérarchie des services. La hiérarchie des services c'est ce qu'on dit première ligne, deuxième ligne, troisième ligne…who can provide, who is best situated to provide the best service at the best cost…and to try to be complementary rather than overlap or… That's one thing. L'approche populationnelle c'est l'approche de, de, que l'établissement n'a pas une responsabilité de services uniquement, mais a une responsabilité de la santé de la population de son territoire. Donc, donc, c'est là, qu'on dit au CSSS non seulement, 'vous allez abandonner, mais vous allez devoir, bien connaître votre territoire, bien connaître les besoins de la population and to try to see if you or the partners can fill the gap, but you have the responsability to do that.' Not necessarily to provide the services, but to ensure that you and the partner agree on filling the gaps (283-309; Manager: I).

The invisibility and social exclusion of older people

In principle, the population health model has the potential to address major gaps in the health of the population. However, the tendency to align the health of populations with the incidence of medical conditions within the population (e.g., diabetes, cancer and stroke) can lead to an invisibility of the specific types of health and social needs associated with particular populations. Already, the concern is that focus

on the prevalence of conditions creates an invisibility of older people. Specifically, models of population health afford limited opportunities for social planning and preventative initiatives organized around key objectives such as poverty, housing and social interactions. While the implications on older people remain to be seen, the key concern is whether the focus for the health of the population will result in a lack of commitment to older people's needs and/or a mounting crisis between younger healthier populations and older populations with impairments or chronic health conditions.

Drawing on a framework of social exclusion, however, can help identify how groups, such as older people, can be deprived of the capacity to exercise their rights (Ballet, 2001) or participate in the activities of citizens in a given society (Burchardt et al., 1999). The social exclusion framework of Guberman & Lavoie (2004) for example, holds the potential to critically question dominant social relations and policy reform as they pertain to older people. This framework focuses on the multiple and intersecting processes of social and institutional exclusion that are associated with aging in western societies, as well as the ways in which individuals and groups resist and counter these processes. In this model, social exclusion is conceptualized as comprised of the following seven intersecting forms, as shown in table 1. Applying this framework to an understanding of reforms and the resulting homecare practices can reveal how global and structural policies and practices prevent older people from being who they want to be, and living how they want to, in spite of physical impairment and/or frailty (Grenier & Guberman, 2009). It also allows us to move beyond considering issues within homecare as merely those of accessibility, quality and adequacy of care. Drawing on this social exclusion framework can provide a valuable means to critically analyze the ways in which the reform of health and social services can result in practices that limit older people's and their families' participation in society, their access to resources, and their expressions of identity and personhood.

Table 1: Forms of Social Exclusion

Domain	Definition
Symbolic exclusion	Negative representations afforded particular groups as well as the invisibility of such groups within society.
Identity exclusion	Dismissal or diminishment of the distinctive and multiple identities of the person or group through reduction to one identity such as age.
Socio-political exclusion	Barriers to civic and political participation resulting from a lack of involvement in decision-making, collective power, limited political clout or agency.
Institutional exclusion	Exclusion from social and political institutions resulting from decreased services that negatively affect their health and well-being and/or no consultation with the individual or their caregivers regarding their care.
Economic exclusion	Lack of access to income or material resources required to meet basic needs.
Exclusion from meaningful relations	Exclusion from the development and maintenance of meaningful social relationships through the absence of networks, lack of access to them, or rejection from them.
Territorial exclusion	Geographic isolation, regulation to spaces with limited opportunity for social involvement, lack of geographic mobility or control over one's environment.

(Guberman & Lavoie, 2004)

Using a social exclusion framework can clearly articulate the consequences that current care priorities can have on the daily lives and experiences of older people. The framework explicates the various intersecting ways in which older people are excluded from public services, participation in public life and community, and are increasingly relegated to the home. Rather than simply advocating for changed attitudes toward older people, drawing on social exclusion lead us to politicize two major problems within homecare policies and practices: first, the lack of attention to the social and socio-political needs of older people, including agency; and second, drawing specific attention to the experiences of a particular group of older people whom, by means of their ineligibility and limited financial resources, represent an increasingly marginalized group (Grenier and Guberman, 2009. Understanding the complex disadvantages created and sustained within the current context of care also highlights the need to reconsider current priorities in the allocation of care services for older people.

Suggestion for change: Social determinants of health

As an alternative, the social determinants of health model can address the above-mentioned limitations of the population health model. The population health model addresses the incidence of disease or illness, and addresses these through individual level interventions. As such, it tends to overlook both the commonalities that exist between social circumstances such as poverty, and the social issues such as social exclusion and poverty that may alter health and behaviour. Gottlieb (2004) discusses how the public health model that focuses on changing individual behaviours does not acknowledge the complicated processes that may lead individuals to their circumstances: "Family and the intricacies of situating relationships in a larger social context are central to people's lives, but remain absent in interventions" (2004, p. 1). The social determinants of health model however, considers the social aspects of experience that can result in poor health.

In their articulation of a social determinants of health model, Raphael (2004) and others (Raphael, Bryant, & Rioux, 2006) argue that health is less dependent on people making 'healthy lifestyle choices', than it is on whether individuals have access to the economic and social resources that would create an environment in which they have such choices available to them. Accordingly, a social determinants of health approach "directs attention to economic and social policies as means of improving [health]" (Raphael, 2004, p. 1). Raphael sees a narrow definition of health as: "whether individuals stay healthy or become ill" (2004, p. 1); and a more inclusive definition as: "the extent to which a person possesses the physical, social, and personal resources to identify and achieve personal aspirations, satisfy needs, and cope with the environment" (2004, p. 1). Instead of prioritizing "biomedical and behavioural risk factors" such as smoking, cholesterol, weight, physical activity, and diet, a social determinants of health approach emphasizes the impact of matters such as "conditions of childhood, income, availability of food, housing, employment and working conditions, and health and social services" (Raphael, 2004, p. 1). As such, this model could provide insight into the ways in which older people experience particular social needs that can impact their health and well-being.

SECTION III: THE QUÉBEC REFORM & MANAGED CARE

Strand three of the analysis considers the extent to which the Québec reform corresponds with managed care and managerialism of health and social care services. Key findings reveal that the reforms implemented within the province of Québec are an example of managerialism,whereby management principles are applied to the delivery of health and social services. This includes the restructuring of organizations and institutions, the managerial level of services, the increasing use of objective and standardized measures, and the emphasis on effectiveness, efficiency and economics. The reforms taking place in Québec correspond with the larger trend of managerialism on a national and international level—that is, there is a striking similarity between reforms that have already taken place in the province of Ontario and the UK. Further, there is a move toward rationed services based on populations at 'risk' as well as an increasing neoliberal discourse and practice within Québec's health and social services.

In recent years, global policies guiding health and social services have shifted toward a system of 'managed care' (Dean & Ellis, 2000; Neysmith, 1999). This is best seen through the transition in policy/service terminology which now includes notions such as 'case management', 'partnered services', and clients as 'consumers'. At the service level, this shift involves the use of standardized instruments that measure need according to risk, while at the managerial level; the shift involves professional accountability through performance indicators such as cost effectiveness and efficiency (Parton & O'Bryan, 2000). While the reform of health and social services implemented in Québec was initiated later than similar reforms in the province of Ontario and the UK, the basis and forms of these reforms can easily be compared, albeit nuanced within local contexts and provincial/regional differences.

In periods of health policy and service transition, questions circulate about the meanings and impacts of 'managed care' reforms. At the theoretical level, the values and assumptions within 'managed care' (e.g., cost) seem to contradict the inherent values and/or intentions of services (e.g., care, access). These potential discrepancies (e.g., access vs. exclusion, standard need vs. flexible needs, care standards vs. 'managed care') pose particular challenges in developing relevant policies and approaches within public systems of care. These seemingly competitive notions present within policy reform may also pose particular challenges to implementation at the service level. In light of these changes, there is scepticism about the claims being made, the feasibility of achieving these reforms within the current context, how these notions affect service delivery, as well as what the impact is on persons providing (i.e., multi-disciplinary professionals) and receiving care (i.e., older persons, persons with disabilities and their families).

In Québec, individual agencies and service providers such as the CLSC site for this study are responsible for implementing policies (e.g., *Maintien à Domicile*) and regulating multi-disciplinary home care services. The beginnings of "managed care"

reforms such as « *Virage Ambulatoire* » and the single entry model of « *Guichet Unique* » have transformed the nature of service provisions. The impact on professionals and particular population groups, in particular, women, has been addressed through studies about these reforms (AFÉAS et al., 1998; Bernier & Dallaire, 2000). Ongoing transition toward 'managed care' (e.g., revised policies and service guidelines), however, means that questions about how these notions continue to be implemented into practice remain paramount. This project focused in part, on how notions of 'managed care' and managerialism were present in the terminology and practices of Québec homecare services, as well as the ways in which this impacted older persons and specific within-group populations.

Managed Care

Managed Care is a system of health care that employs management principles related to service delivery and payment in order to promote the delivery of cost-effective care (Raphael, Byant & Rioux, 2006, p. 262). Managed care is a concept and practice that originated in the United States, and in particular, from private industry-based health programs in which companies would "contract physicians to provide basic medical care for their employees" (Bourgeault, 2006, p. 273). Bourgeault (2006) notes how, in the U.S., many health care organizations that subscribe to a Managed Care model have shifted from non-profit to for-profit since the early 1980s. To varying degrees, U.S. models of Managed Care have since been incorporated into both British and Canadian systems of care. Bourgeault (Figure 1) offers a concise summary of the stated principles and intended outcomes of Managed Care, as a health care system:

Figure 1: Bourgeault's Principles of Managed Care

Principles of Managed Care

Any system that controls costs through closely monitored and controlling the decisions of health care providers, which includes:
- a clearly differentiated and carefully examined member population
- a central management structure that controls
- a known group of physicians on fixed salary or capitulation
- general practitioners as gatekeepers
- specific sets of services/benefits
- an identified and limited supply of hospital beds
- an annual budget based on subscription fees

Intended outcomes are supposed to include:
- more integrated systems with greater continuity of care to help reduce duplication and gaps in the system
- increased accountability for providers and patients leading to more appropriate, higher quality care
- increased emphasis on illness prevention and health promotion to help ensure that people stay healthy

Taken directly from Bourgeault 2006, p. 274

The literature on managed care contains reference to two different concepts: first, the concept of managed care to describe the process outlined above in order to better control and ration the costs of services; second, the concept of managerialism is used to critique the ways in which health and social services have become subject to the rules, regulations and practices of management and business. The use of these concepts varies by country. Where the majority of the literature originating in the United States discusses and describes managed care and the subsequent process of case management, the literature in the UK and Canada contain references to both the process of managed care and a critique of managerialism—that is, the application of management principles. Specific terms associated with managed care include a 'continuum' or 'continuity of care' (Sekhri, 2000; Fairfield et al., 1997); the 'integration' of finances, services and/or delivery (Dziegielewski & Holliman, 2001; Sekhri, 2000); and 'cost effective' or 'efficient' care (Fairfield et al., 1997; Haycox et al., 1999; Newman, 1995; Wilson et al., 2006).

According to Levine (2007), Montréal's approach to managed care was informed by models from the U.S.A.-based Kaiser Permanente (2008); The United States Veterans

Health Administration (Petzel 2006; Jha et al., 2003 – cited in Levine, 2007); the Pujet Sound Project (Davis 2006, 2007; The Commonwealth Fund 2006 – cited in Levine, 2007); primary care trusts in England (British Medical Association 2006; Roland et al. 2005 – cited in Levine, 2007); and primary care teams in Barcelona, Spain (Deuxième Colloque 2006 – cited in Levine, 2007). As mentioned elsewhere, the Québec model of managed care has three major components: 1) a population-based model; 2) a chronic care model; and 3) a hierarchical provision of service.

The Reform: Examples of Managed Care &Managerialism

The interview transcripts on the changing organizational structure of the Québec health and social services network revealed points of convergence between their experiences and observations of the reform and some of the main characteristics of managed care. Most notable in this case were an increased standardization of care delivery; a centralization of authority and control along a hierarchical model, a loss of autonomy for managers in terms of decision-making; and perhaps most striking, an increased awareness and regulation of financial expenditure, regulation, and monitoring.

Respondents noted the reorganization of health and social service programs (e.g., home care services) along prescribed standards and budgets dictated by the institutions' 'norms of service':

> *Services intensifs soutien à domicile…we have home care services that we provide to our clients and families, who need assistance with personal care…. daily living… instrumental activities (mostly shopping, housekeeping, etc)…. And we allocate, trying to stay within that budget, and allocate the most hours possible by following norms of service. So, the case manager assesses the case, determines the client's needs, also in certain cases, does the financial evaluation* (165-171; Manager: I).

This regulation of service delivery is also linked to a centralization and hierarchization of control in the organizational structure. According to respondents, this has had consequences for the degree of autonomy possessed by managers:

> *The only thing that I can tell you, in general, about the reform, it comes to me as a manager to be very, very bureaucratic…Very bureaucratic and I think that managers lose a lot of autonomy* (281-282; 286; Manager: I).

At the same time, managers' roles have shifted, becoming more administrative and expanding the number of mandates under their responsibility. For example, one director in particular, commented on the increasing number of managerial tasks for such positions, including quality control, consultation, coordination, supervision, and ultimately, ensuring overall functioning:

As the director of ---- I cover all the institutions that are included in the CSSS…to make sure that the quality of care is up to standard in every area…. but I am also responsible for ---- for the [identifying information removed]… …So it means making sure that the business is going well…[then there is]----, another mandate which covers the entire centre de santé…. So, I am not the one putting on all the fire alarms and things like that [laugh] but I have to make sure that everything is functional and that everyone is doing the job they should do and to a ensure a safe environment and it's a legal responsibility…. So, that is a very new mandate for me that covers many different types of organizations (11-28; Manager: II).

This, in turn, has meant that managers play more of a controlling and administrative function but maintain less of an everyday connection to frontline workers and local level operations:

The higher management isn't local anymore because it's removed, you know, even our director and a lot of our directors are no longer here within the CLSC. Before I had direct contact with our director, we would able to talk to them at any time. It was much more direct now it's removed it's a distance it's not…the communication is not as close or direct. It's not because of the person it's just gotten too big to do (76-81; Frontline: II).

Perhaps most significant is the notable concern for cost in respondents' descriptions of the new organization's delivery of health and social care. One participant linked the reform's mandated population health approach directly to a quality and cost understanding of care, stating:

Now the CSSS are given la responsabilité populationnelle [population responsibility], so to have la responsabilité populationnelle means that ultimately, the CSSS is responsible for ensuring the services at the best cost; the best services at the best cost (73-75; Manager: I).

In this same vein, financial evaluation and fiscal responsibility proved a major theme throughout the study, particularly when discussing expenditures. The following quote describes the decision-making process around financial evaluation and approval:

[The case manager] does a financial evaluation. And there are two forms, they can either come to me personally… it's not just me as well, it's [another worker] and myself primarily. There's also the other managers. If they arrive prepared with a plan and a request for service, and they can approve that individually if they are alone in the case or if a crisis; if it's urgent. If there is more than one discipline involved, they're encouraged to bring that situation to the I team. The I team is not primarily for approval. It's for a case consultation. However, we like to kill, you know, all birds with one stone and make it effective and efficient so if

you also need health care services you also need referrals, you bring it there and expect one stop, one shop. One shop, one stop (180-190; Manager: I).

The pressure to maintain a fiscal balance and the challenges this creates is evident in several of the responses:

You know, we all read about financial constraints in the papers all the time and hospitals are certainly facing them. You're not allowed to put yourself in a deficit situation but at the same time, are we meeting the needs of everybody… who is requesting services? I know clearly, that we don't necessarily meet everyone's needs, but I think that there is an effort…Certainly I can speak for this CLSC, there's a major effort on the part of this organization to try and address the needs as much as possible. We're also trying to be, fiscally responsible as well… (286-289; 292-294; 298-303; Manager: I).

We use a lot more agencies [fee-for service], this is the clincher, because we use agencies it makes it less expensive. We're able to provide a lot more hours of service. We do this by balancing our use of agency and our use of our own AFS [CLSC public home support workers]. But as I understand it, we really do need to look at it possibly hiring more AFS. We have to identify the most vulnerable? Which client groups need our AFS and which will be okay with other agencies or économie sociale? (423-431; Manager: I)

It's hard to... give them everything that they want in terms of client services if, financially… you don't have the personnel to offer it. You know if there aren't enough occupational therapists, physiotherapists, to be able to do physiotherapy. I mean, people will say "Well, I need physiotherapy, how come I can't get it?" (337-341; Manager: I).

The reform's measures to reduce expenditures further included moves to reduce upper management and increase middle management. Yet, some respondents put into question the efficiency of such a strategy:

I guess my concerns lie in all these structural changes they have let go certain people, all of a sudden they have hired certain people, I mean these are decision makers several levels above me but are they really saving money? I thought that this was supposed to save money (326-329; Frontlines: II).

Significantly, amidst a climate of cost-consciousness, one respondent criticized the lack of investment in facilitating what has been a major organizational change:

Communication if it is not present or poor quality, it becomes an obstacle. We have to do the reform without new money it has to be done within your own budget but what about helping to adapt to change what about giving people the

time to think about what is the best if they have to do that within their own hours of work. So, there is no money for supporting change. All big transformation in any private industry requires some investment. All the studies show that and here we do that without money and here we have to be even more efficient because we are spending too much money. So, that is a big problem (309-317; Frontlines: II).

Together, these quotes reflect the changes occurring within the health and social sector in Québec, and in particular, the movement toward managerial models. In doing so, the managers and frontline workers raise criticisms about the cost savings of such measures, the way that such changes may impact the day to day work of professionals, and most importantly, how this perspective will impact the clients of their services. In the case of this study—focused primarily on older people—workers often expressed concern for the vulnerable populations and the need for a vision that took into account the medical and social needs, rather than simply being driven by economic rationalism.

CONCLUSION

This report has outlined the process of reform and the ways in which reform was experienced at the ground level of services. Main findings focused on the lack of information circulating about the reform, and the ways in which this caused uncertainty for the workers; the tension between stated objectives of improving services for the clients, and achieving a reform of the organizational structure of the health and social service system; as well as the increasing size and complexity of the health and social service centres. This report has clarified the process by documenting key moments in the reform, as well as given light to the way these were implemented within one local CLSC. In particular, it has highlighted the difficulty in accessing information as managers, workers and researchers,with one wondering how clients who are typically less knowledgeable about the intricacies of the system would get the information they need in order to access care.

Key analytical directions that emerged from this report include: the emotional impacts of organizational change; the ways in which the new direction of 'population health' may impact on marginal groups such as older people; and the extent to which the reform pushes the health and social services toward managerial models, including opening the doors to privatization. While the actual outcomes of the reform have yet to be completely seen, especially in regards to actual impacts on the clients of services, the process of implementing reform and prolonged involvement at one local site of care has raised several challenges for the future health and social service system. These impacts relate to the 'chaos' experienced within the work environment that surely will trickle down to services users—if it hasn't already. Most importantly, we must consider how such reforms will impact those who are already vulnerable, isolated and/or marginalized. Will their actual needs become lost in the gaps between their realities, population health and managerialism? Professionals, academics, organizations and

older people themselves must continue to seek information and become involved in raising critical questions in relation to ongoing public health care reform in Québec, and whether this corresponds with the health and well-being (including social needs) of older people.

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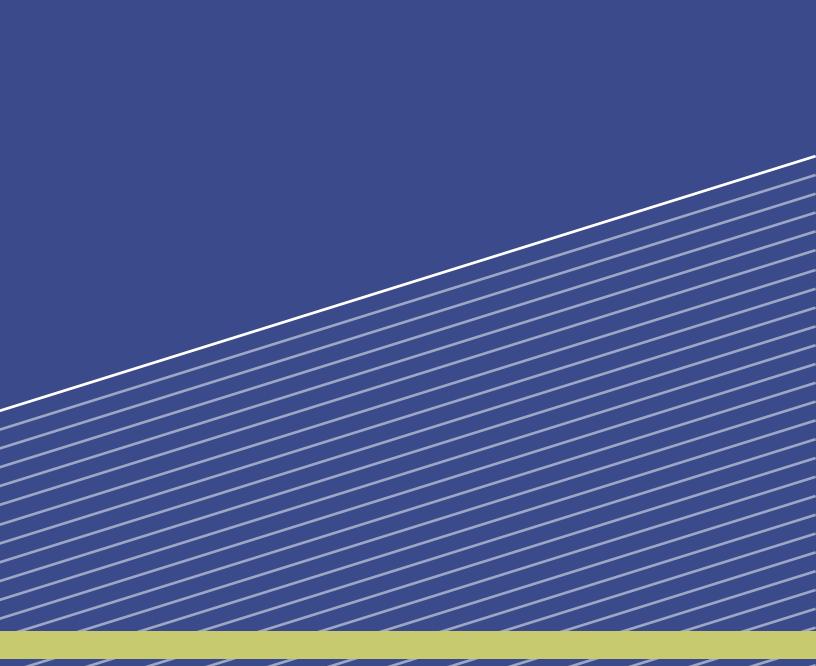
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