Quebec's Approach to Population Health: An Overview of Policy Content and Organization

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ABSTRACT

While Canada's international leadership in the area of health promotion has been widely acknowledged in the past, Quebec's approach could be better known. Canada's second largest province has indeed developed a comprehensive public health infrastructure and adopted a population health approach which features an integrated set of legislative, organizational and programmatic policy instruments. These instruments not only ensure the core functions of public health, but also foster public intervention on the social determinants of health. In addition, Quebec's policy is supported by a solid research infrastructure, networked expertise and a mobilized workforce among health professionals. In spite of the interest it represents for the larger public health community in Canada and elsewhere, this largely French-speaking province's approach remains little known because of language and cultural barriers between Quebec and Anglo-Saxon countries, and it has yet to be systematically discussed in the English-language literature. This article provides an overview of policies and administrative structures in Quebec to support public health and address socially determined inequalities in health. It analyzes the development of these policies over the past decade and offers insight to their core content.

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INTRODUCTION

Canada's international leadership in the area of health promotion has been widely acknowledged in the past (1,2). However, within Canada itself, there are several policy approaches to improving the population's health, reflecting more or less innovation. Jurisdiction over health is divided between the federal government and Canada's 10 provinces, and each province defines its own approach to policy.

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With 7.4 million, primarily French-speaking, inhabitants, Quebec accounts for a quarter of Canada's population and is the country's second most populous province. Whereas most provinces are now in the process of redefining their public health infrastructure at the provincial level (3–5), Quebec, over the past decade, created health policy instruments to support comprehensive and coordinated public action to improve population health. According to Frank and DiRuggiero, Quebec's public health infrastructure "is so much better organized and funded than English Canada's, that it could be used as a model for reform elsewhere" (6).

The scope of Quebec's policy extends beyond core public health functions – generally defined as protecting health (such as ensuring food and water safety), monitoring the population's health, preventing diseases and injuries and managing epidemics. Beginning in the mid-1980s, an international movement of health professionals intensified efforts to adopt a broader view of health, including well-being. This "new public health" refers to a particular understanding of the ways in which lifestyles, living conditions, and health outcomes are interconnected. (In addition to the core functions of public health, "new public health" approaches seek to create environments that are supportive of health. Everything that governments do or fail to do affects the population's health and well-being. Public health professionals should seek to influence other governmental sectors beyond health.)

Quebec's health promotion efforts also foster the reduction of health inequalities and the development of "healthy public policies" for the whole government. ("Healthy public policies" are general policies, programs, and services that create, maintain, and protect health and well-being – adequate income security programs, a good education system, a clean environment, adequate social housing, and community services.)

Provinces such as Ontario and Alberta focus on promoting healthy lifestyles and preventing chronic diseases to curb the growth of health-care expenditures (7). Quebec's broad and concerted efforts do far more and contribute to its enviable position among Canadian provinces (8). Its approach remains, because of language and cultural barriers between it and Anglo-Saxon countries, less known than it should be.

This article provides an overview of policies and administrative structures in Quebec that support public health and address socially determined inequalities in health. For practical reasons, the policies and administrative structures examined in this article are limited to those under the formal responsibility of Quebec's health sector, as opposed to being defined as all Quebec public policies that affect the population's health. Therefore, we exclude social and education policy and administrative structures for income security from this overview, which focuses on solely policy instruments available to the health sector to contribute to improving the population's health. We analyze the development of these policies over the past decade and offer insight to their core content.

The analysis is based on primary and secondary sources, mainly Quebec's governmental publications and specialized literature. The documentary search was complemented by five semi-structured interviews conducted in 2004 with respondents selected on the basis of their knowledge of Quebec's policy. The objective of the interviews was to supplement and clarify available materials. Because our respondents are well-known in public health in Quebec and to facilitate the openness of our exchanges, we agreed that we would not associate them with interview contents or quotes.

The first part of the article presents the major elements of Quebec's policy that structure and extend the field of public health. They constitute a series of development levers or multi-sector public health actions on health determinants. The second part examines the scope of Quebec's official policy, demonstrating that, in spite limitations of its design for addressing all social determinants of health effectively, Quebec's official policy is not merely a "symbolic" or "bureaucratic" instrument, lacking relevance to provincial practices and traditions. The third part analyses some of the organizational conditions that have fostered the emergence of Quebec's policy over the past decade. We conclude that for those who desire increased social justice, public health and health promotion strategies addressing the social determinants of health would best be tailored to the administrative arrangements and administrative culture of the targeted country or province.

PUBLIC HEALTH INSTRUMENTS

Quebec is sometimes viewed as a semi-sovereign state because of the decentralized nature of Canadian federalism and because of its particular position within the Canadian federation. The province often resists pan-Canadian programs created by the federal government, programs that use federal spending power to intervene in education, social policy, and health care – areas of provincial jurisdiction. Quebec has historically opted out of federal programs and concluded special agreements with the central government in order to maintain its political autonomy and cultural identity. In areas of shared responsibility such as public health, Quebec tends to develop and implement strong policies to preempt the expansion of federal powers.

In the past two decades, several interesting initiatives were set in place in Quebec's province-wide public health policy. These include a provincial institute bringing together public health expertise; a *Public Health Act* codifying essential public health functions and affirming the Ministry of Health and Social Services' moral authority over other governmental sectors to help protect, maintain, and improve the population's health and well-being, and a comprehensive 10-year public health program seeking to address the determinants of health and well-being.

In 1998, the provincial government created the *Institut national de santé publique* (INSPQ), advisory to the Ministry of Health and Social Services (MHSS), to help integrate existing regional centers of public health expertise, particularly in Montreal and Quebec City, the province's two largest cities, to consolidate and develop Quebec public health expertise, and to ensure improved access to this expertise (9). INSPQ supports the Ministry and regional authorities in developing of public health research, by disseminating and transferring knowledge, and by facilitating international exchanges (10). The Institute's activities extend beyond basic public health functions such as vaccination, infectious disease control, and prevention. As a government agency, the Institute engages in promoting health and well-being among vulnerable groups, and supports social and community development. It also informs the Minister about public policy impacts on the population's health and well-being (11).

In 2001, Quebec adopted the *Public Health Act*, which replaced the 1972 *Public Health Protection Act*. The earlier legislation had not specified how Ministry officials and regional public health authorities were to carry out their obligation to protect public health. Nor did it lay out how public health authorities could gain access to information allowing them to fulfill this obligation (12). In addition to a focus on essential public health functions, the new *Act* supports all public health interventions, notably a mandate to conduct health surveillance as well as prevention and promotion. It acknowledges that various laws and regulations of other government agencies can affect population health and well-being. Thus, it empowers the MHSS to undertake intersectoral action to support public policy development favorable to health. Decision-making for all government activities must take into account potential impacts on the population's health and well-being of all legislative and regulatory actions. Article 54 of the *Public Health Act* stipulates that:

> "The Minister is by virtue of his or her office the advisor of the Government on any public health issue. The Minister shall give the other ministers any advice he or she considers advisable for health promotion and the adoption of policies capable of fostering the enhancement of the health and welfare of the population. In the Minister's capacity as government advisor, the Minister shall be consulted in relation to the development of the measures provided for in an Act or regulation that could have significant impact on the health of the population."

All Ministries and agencies are required by virtue of the *Public Health Act* to consult the Minister of Health and Social Services when they are formulating laws or regulations which could have a significant impact on health. It is then incumbent upon the Ministry to advise the government.

The 10-year public health program of 2003 constitutes the third major initiative in public health. In addition to the core functions of public health, this program acknowledges three supportive functions: support for regulations; support for legislation and public policy that affect health; and support for research, innovation, and skills development.

The program intends to ensure similar services in all regions and territories for interventions and functions covered in the program.

All interventions share a common goal – reduction of health and well-being inequalities – and rely on strategies for strengthening individual potential, supporting community development, and participating in intersectoral actions to foster health and well-being. They provide support for vulnerable groups and encourage effective preventive clinical practices (13).

Quebec has thus created a set of integrated and comprehensive province-wide policy instruments in public health and health promotion to address the social determinants of health and well-being at managerial, legislative, and programmatic levels.

THE SCOPE OF QUEBEC'S OFFICIAL POLICY

Official policy is not always implemented in the manner anticipated by policy-makers (14) and with the exception of the Institute, Quebec's instruments were recently created. It is thus too early to assess results or compare relative effectiveness. We believe it appropriate, however, to assess the limitations and the potential of Quebec's official public health policy.

Quebec's policy implementation surely shows certain limitations. Indeed, the literature shows that while official policy in the 1990s engendered considerable expectations among progressive elements of Quebec society, it did not fulfill all these hopes or objectives. Until the mid-1990s, public health faced serious coordination and integration problems that hindered progress (15). Until recently, Quebec's health promotion approach seemed "ambiguous" or indecisive in terms of definition, status, and organization (16). Quebec's progressive health policy efforts remained focused on improving the distribution of health-care services. Budgets for prevention and promotion activities have remained low (17). Today, the care system has yet to shift toward prevention and there has been little real progress made in harmonizing the actions of the various sectors within the policy's scope. In some respects, Quebec's situation thus appears similar to other provinces where population health "has not resulted in adequate corresponding policy development to effectively reduce inequalities in health" (2).

These recent difficulties and outcomes, however, do not necessarily indicate a lack of commitment toward its official policy. Rather, they indicate that this province's policy is far more than a

spontaneous initiative on the part of a few concerned bureaucrats. We argue below that Quebec's policy reflects a long-term process of institutionalization and mobilization of public health and health promotion – therefore, irreducible to "bureaucratic initiatives". Quebec's public health approach, embedded within the province's health structures at all administrative levels, is supported by mobilization of professionals in the health sector – unlike elsewhere in Canada, where health promotion has been described as "a bureaucratically initiated response to broader social change" (18).

The creation of the INSPQ helped integrate and consolidate the structure of organizational cultures underway since the regionalization of the health-care system in 1992. Regionalization of Canada's health-care systems – a recommendation of the Lalonde report (19) – took place in most provinces and territories in the 1990s (20), following reviews of health-services organization, including laws and structures. During the administrative reorganization in Quebec, public health was integrated into the health-care services structure at both the regional and provincial levels. Public health, which until 1992 was handled by 32 community health departments under the aegis of regional hospitals, was turned over to new public health divisions grouped within the 18 newly created regional health and social services boards. The public health divisions were given responsibility to inform the population about its health; to develop intervention strategies; and to contribute to social development. In 1993, a new general public health directorate was created in the MHSS to integrate prevention-promotion planning activities into service organizations at the ministerial level as well. By 1998, when the INSPQ was created, the public health divisions had become better integrated into both the MHSS and the regional boards (12). Currently, public health is effectively embedded in and represents an integral component of the socio-sanitary system at the local, regional and provincial levels.

Over the past decade, Quebec's official policy has acquired greater legitimacy and garnered support within the system. Quebec's *National Public Health Program 2003–2012,* a component of the programming process was preceded by the adoption, in 1992, of a policy focused on measurable population health objectives. The *Health and Welfare Policy* was initially intended to be a programming tool to foster the care system's management toward population

health results and to ensure that health system policies be guided by health and well-being objectives (21). It laid out precise physical, mental, and public health objectives, as well as adaptation and social integration objectives to be met within an established timeframe through an intersectoral consultation process (22).

The current program was also preceded by Quebec's *National Public Health Priorities 1997–2002,* which defined intervention in public health as "action on determinants of the health and well-being of the population and the systems regulating it" (9). The document presented common public health priorities for all the province's regions organized around four guiding principles: (1) Action on the part of the entire health and social services prior to the emergence of health problems; (2) Heightened involved in communities; (3) involvement in the war against health and well-being inequalities; and (4) support for the development of concerted and coordinated interventions among its various components. Regional health authorities were obliged to take these priorities into account in planning health services (23).

The existence of an official policy has enabled public health to gain legitimacy within the socio-sanitary system's organizational structures, helped disseminate prevention-promotion values, and, importantly, it facilitated the emergence of a research infrastructure. Indeed, the 1992 *Health and Welfare Policy* was both a genuine social policy and a source of inspiration and justification for almost all socio-sanitary research funded in Quebec during a decade (22). In 10 years, the number of social research teams working in partnership with the health intervention community went from zero to around 20. Research fellows, called *chercheurs-boursiers*, funded originally through Quebec's research infrastructure, joined service establishments in the 1990s – early in the Canadian context – and worked with health professionals and managers on research questions inspired by official policy. Expert networks emerged. Research conducted in intervention settings helped guide the implementation of programs arising from the official policy (24) fostering real public health integration and mobilization within the organization of health services, while advancing its objectives and the development of a solid research infrastructure.

One respondent whom we interviewed noted that the "evaluation process (associated with Quebec's official policy) fostered a

fundamental process of change". Indeed, measurable policy objectives were evaluated annually, which helped increase the legitimacy of public health objectives and disseminate their associated values. More recently, the formulation of the 2003–2012 public health program over a 3-year period engaged 250 people from all the regional bodies and the Ministry. A broad selection of professionals in the health and social services network became committed to breathing life into the program (anonymous interview, May 5, 2004).

Quebec's difficulties confirm that the integration of public health into provincial health system structures has been arduous, drawn out, and politically sensitive. Quebec's public health infrastructure, now fully in place, indicates that the provincial government has managed to develop policy, including recent legislation and programming, as part of an unfolding policy process. Quebec's approach should be viewed as more than integrated and comprehensive tools and instruments to foster action on health determinants; its policy instruments as more than the result of the advocacy by a few experts who formulated policy statements and administrative structures. Policy-making was not limited to a process carried from start to finish by a few political lobbyists. The results extended far deeper – changing values, mobilizing the people involved, and implementing the program.

We see in Quebec's policy a complete and coherent evolution, over three decades of public health functions at the provincial, regional, and local levels, starting with the appointment of a provincial commission in 1972 and the launch, a year later, of a network of 32 regional hospitals invested with public health authority and responsibilities. Quebec sought to integrate public health functions within the health care and social services system as opposed to developing a parallel public health infrastructure (25), both institutionalizing and mobilizing for public health. Quebec's current policy instruments represent a relay point, in a two-way policy-making process, which institutionalizes already existing values and practices on the one hand, and establishes the foundation for future directions on the other.

Quebec's current policy instruments, nevertheless, remain less than fully adequate to address the social determinants of health and reduce health inequalities. Ridde notes that, even though the current public health program stresses reducing health inequalities, none of

its 87 objectives targets the elimination of health inequalities (26). *Community development* is the only area dependent on the reduction of health inequalities, and also the only area in which no objectives have been set. Ridde's believes that, in spite of official rhetoric, no policy devoted to eliminating social health inequalities has emerged in Quebec. Similarly, Comtois showed that although Quebec's new public health legislation encompasses both physical illnesses and social problems, "anticipated actions are exclusively focused on physical health". Although the *Act* mentions health inequalities among vulnerable people and groups, it makes recommendations with regard to action only in one area: to "correct health and well-being inequalities in the population" and "to counter the effects of risk factors affecting the most vulnerable groups". "The *Act* does not mention collective responsibility for either social inequalities or health inequalities" according to Comtois, and the public health mandate remains vague with regard to action on health determinants (27).

Article 54: "The Minister shall give the other ministers any advice he or she considers advisable for health promotion and the adoption of policies capable of fostering the enhancement of the health and welfare of the population" is still in the development phase. To meet its implementation challenges, the MHSS adopted a twofold strategy:

1. Setting up an intra-governmental health impact assessment process (HIA). According to Lock's definition (2000), this process is a "structured method for assessing and improving the health consequences of projects and policies in the non-health sector. It is a multidisciplinary process combining a range of qualitative and quantitative evidence in a decision-making framework". It consists of five steps: screening, framing and preliminary assessment, in-depth analysis (where necessary), adjustments and decision-making, and assessment and follow-up. (For an excellent discussion on HIA, see Parry and Stevens, 2001.) The HIA process still suffers from several weaknesses: policy proponents tend to use a narrow definition of "health", omitting health determinants and well-being concepts, when they assess impact of policy on the population's health; and that such assessment occurs at the end of the policy process, providing the MHSSs limited response time to intervene on legislative proposals.

2. Contributing to the development of research, including financial support to design new tools for assessing *a priori* and *a posteriori* effects of public policy on health, as well as a knowledge transfer program, supported by reviews and briefs to inform government ministries and agencies about the possible health impacts of laws and regulations being developed. (The MHSS and the FQRSC and FRSQ (two major university research granting agencies) jointly launched a set of funding competitions for 5-year grants to create of research teams to develop cognitive capacities to facilitate the application of the law.)

Quebec's policy faces both limits and implementation challenges, especially since the election in 2003 of a new, economically conservative, provincial government. Yet Quebec has gone farther than any other Canadian province in setting up an integrated public health infrastructure. Public health functions and programming promote health, provide support for social and community development, contribute to the reduction of health inequalities, and formally establish "moral authority" of the health sector over other governmental sectors, mandating *healthy* public policy.

Quebec's experience is in sharp contrast to most of Canadian provinces, which began to establish a public health infrastructure at the provincial level only in the aftermath of the SARS crisis, and whose province-wide health promotion activities tend to focus on the social marketing of healthy lifestyles.

A BRIEF HISTORY OF QUEBEC'S APPROACH

How was Quebec's approach possible in the Canadian context? A key condition is that Quebec is the only Canadian province that has integrated health care and social services within the same government department, thus fostering the inclusion of a "social" or progressive agenda within the organizational structures of Quebec's most important Ministry (roughly 41% of estimated government spending in 2004). This progressive agenda reinforced action in public health and on the social determinants of health.

The progressive agenda was further institutionalized in response to medical power within the Ministry itself. The 1992 creation of the Health and Wellbeing Council (*Conseil de la santé et du bien-être*)

(HWC) illustrates these dynamics. The College of Physicians had called for the creation of a government agency to maintain and strengthen physician voices in health care system reform. The Ministry and community-sector representatives asked for a Council to air the views of socioeconomic groups (anonymous interview, May 12, 2004). The Health and Wellbeing Council and the Medical Council – government agencies with mandates to advise the Ministry – were thus created simultaneously in 1992. Administrative grouping of social policy and health policy fostered a "parallelism" of mechanisms within Quebec's most important Ministry.

The HWC has reinforced Quebec's intersectoral action on the social determinants of health. In 1998, it initiated a province-wide Social Development Forum, (*Forum sur le développement social*) as well as regional and local forums. The Council mobilized professionals in health and social services networks and the community sector throughout the province for 3 years. Because of this mobilization, Socioeconomic groups were well prepared to promote and advance their views on new policy guidelines, demanding ongoing inclusion in decision-making processes about reform of health care, social services, and even social policy. Via the Council, moreover, they sustained this advocacy voice. On several occasions, the HWC spoke out on public issues, supporting, for example, the provincial war against poverty and social exclusion and the establishment of an unconditional basic income. It also opposed private funding for medical and hospital services. The Council believed that privatization "would undermine social solidarity, reduce access for the underprivileged, and compromise the health of the population and of individuals".

HWC actions on social development and the activities of public health were mutually supportive, based in part on coordination. They reflected similar approaches – population-based, with an emphasis on prevention and promotion and on developing intersectoral policy (28). Thus, while Quebec's public health was being structured via regional boards and the creation of a general public health directorate, there was also a diversification of its "social" approach through the creation of the HWC and the mobilization of public and community stakeholders in social development across the province.

The HWC illustrates how grouping health and social services under a single government department helped socioeconomic groups and representatives of the private sectors work together, a forum where important debates could take place and social compromises could be formulated. The administrative structure incorporated the interests and values of socioeconomic groups into a larger government policy process. For example, community groups were formally included in the overhaul of the Quebec welfare state, that took place as a response to draconian budget cuts by the federal government in the mid-1990s (29). Rather than privatizing services in response to the weak state of public finances, Quebec opted to develop *social economy enterprises*.

Still the progressive movement had many setbacks in the development of the social economy (30–32). The formal inclusion of socioeconomic groups in major province-level negotiations failed to achieve their core demand for "zero impoverishment" as a counterweight to the province's "zero deficit" objective for public finances in the mid-1990s (30,33).

Other provinces, such as Alberta and Ontario, kept socioeconomic groups out of the public representation process. They were able to do so by various means, such as reducing or abolishing funding, destroying representation mechanisms, and making reprisals against spokespersons who were critical of government policy. Without overstating the impact of the progressive agenda relative to other interests in the policy process, clearly the inclusion of the community sector helped define a more progressive orientation for Quebec's social and public health policy. Structuring the community sector, instead of dismantling it, supported public health progress. It fostered the simultaneous development of public health and social development, thereby amplifying the strength of the "new public health" movement and disseminating values that address the social determinants of health.

CONCLUSION

A population health strategy, based upon the health determinants literature, currently faces serious challenge when it tries to translate research findings into concrete action *vis-à-vis* public policy (2,20). The establishment in Quebec of a solid public health infrastructure

and population health approach reflects a particular characteristic of Quebec's government, in the Canadian context, and a policy process that unfolded over many years. In Quebec, public health policy, as part of a policy-process, resulted in a particular trajectory. We believe that when communities build public health strategies for addressing the social determinants of health they should tailor them to the specific administrative arrangements and administrative culture, rather than to search for examples to emulate. To increase their political efficacy, advocates should consider stepping back from the elusive goal of finding "exemplary models" and producing value-neutral scientific evidence. Instead they might consider adapting knowledge production and knowledge transfer to the intended institutional context.

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