Understanding Multilevel Governance Processes: The Case of the Québec Healthcare System

Nassera Touati, PhD[1]

Associate Professor

Lara Maillet, Ph.D[1]

Post-doctoral fellow

Marie-Andrée Paquette, Ph.D[1]

Post-doctoral fellow

Jean-Louis Denis, PhD[1]

Full Professor

Charo Rodríguez, MD, PhD[2]

Associate Professor

1 : École Nationale d'Administration Publique (ENAP), Quebec, Canada

2 : McGill University, Quebec, Canada

Correspondence should be sent to

Nassera Touati : Nassera.touati@enap.ca

Paper presented at the International Conference on Public Policy

1-4 July, 2015, Milan

Introduction

Taking into account the complexity of social problems, several countries in Europe and America strive, since the beginning of the 2000's, to reinforce the role of local governments that have to provide integrated solutions to problems experienced locally (Gilsing, 2007, Klein, 2003; Regmi, 2012). Henceforth, it is recognized that they can't be solved by universal models emerging from the central government (Coaffe and Johnston, 2005). This governance approach that some call "new localism" (Coaffe and Headlam, 2008), could translate into a greater autonomy of instances close to the communities that, in partnership with various stakeholders, will have to elaborate and implement pragmatic solutions to prioritized problems in their territory.

New localism thus falls into an older movement of decentralization of decision decision-making power within the public administration (Pollitt, 2005.). However, it puts emphasis on the importance of partnership with all stakeholders, and in that perspective it substitutes to the notion of local *government* that of local *governance*. By including "all processes of governing, whether undertaken by a government, market or network, whether over a family, tribe, formal or informal organization or territory and whether through laws, norms, power or language" (Bevir, 2013), the notion of governance relies on the statement that governments are unable to influence the evolution of society on their own.

This decentralization of decision-making power would have several advantages; more precisely it would allow to (Pollit, 2005): 1) better take into consideration the needs of services users 2) promote an adaptation of services to the local context and 3) encourage innovation. Empirical studies suggest however that decentralization also has its limits. For example, some studies (Pavolini and Vicarelli, 2012) seem to show that decentralization can be prejudicial to the equity of access to services between territories. In some contexts, there is also a dilution of emerging strategies at the local level, in the sense that they were aligned with local habits and therefore less consistent with the new expectations of social problems management (Jansson and col., 2011). That is why more and more analysts consider that decentralization should go hand in hand with a certain centralization (Charbit, 2011 ; Pavalini and Vicarelli, 2012). In other words, a multilevel governance should be implemented, which would take into account the interdependence of various actors in decision-making. This interdependence engages, among others, the levels of public administration and can refer to various aspects, among which we may cite: institutional (when the allocation of roles and responsibilities is not exclusive); financial (when central and subnational governments are co-funders of public spending) and socio-economic (when issues and or outcomes of public policy at one level have impact on other regions and the national level) (Charbit, 2011). The notion of multilevel governance is characterized by, as we will argue, a certain ambiguity. But for the time being, we have to keep in mind that multi-level governance consists in sharing responsibilities and power of influence, both horizontally (between ministries and

between actors at the local level) and vertically (between various government levels), for the development and implementation of public policies.

The major challenge of multilevel governance is thus to manage the complex relations of interdependence between the actors involved in public action. Consequently, several research works are interested in instruments mobilized by upper levels of government to align the actions of lower levels on central objectives. Despite their interest, these works adopt a vision where the central overlooks the local (Divay and Paquin, 2013) and put less emphasis, among other things, on the interventions of local actors. In summary, these works do not account for the distributed and polycentric nature of the multilevel governance processes.

Through this article, we propose to contribute to a better understanding of multilevel governance processes. More precisely, we will mobilize the example of a change implemented in the Quebec health care system to analyze the processes of governance. As we will argue, the implementation of this change needs a close collaboration between interdependent actors, acting at various levels of governance. Our objective is twofold: 1) to propose a reading of the processes of governance that reflects the polycentric and distributed nature of those processes, and 2) to better understand the impact of these processes on the adaptability of systems. To do so, we will adopt the theory of complexity, which postulates that "the whole (system) is more than the sum of the parts (individual agents), while at the same time, developments of the whole stem from the interaction of the parts". As we will see, some concepts advanced by the theory of complexity are particularly relevant to analyze the multilevel governance processes. In this respect, we concur with the position of Klijn (2008, p. 303), which affirms that "complexity theory can enhance our understanding of phenomena and challenge our basic assumptions about governance".

Current Evidence on Multilevel Governance : a summary

Our reflection on the issues of governance within the context of the transformation of health systems is part of the research on multilevel governance. A recent review carried out by Divay and Paquin (2013) highlights, on the one hand, the expansion of this research and, on the other hand, the ambiguity of that notion that became "popular" since the 90's and which was applied to the analysis of public policies in various fields (economical, environmental, etc.). Divay and Paquin (2013) note that authors frequently insist on one dimension (governance versus multilevel), at the expense of the other. Some works will then focus on relations between various government levels (Charbit, 2011) and don't necessarily take into consideration the presence of non-governmental actors, which is crucial to public governance. They are in that closer to the tradition of research on intergovernmental relations. That being said, these authors underline the distinctive nature of intergovernmental relations that are not purely hierarchical anymore. Peters and

Pierre (2001, p.131) thus propose to define multilevel governance as "*negotiated, non-hierarchical exchanges between institutions at the transnational, national, regional, and local levels*." The test of multilevel governance would find itself in the reciprocal consideration of the various preoccupations of the levels of governments, in a context of permanent *jumping scales* of issues (Mahon, Andrew and Johnson, 2007). In order to go beyond the enlargement of intergovernmental relations conception, other authors proposed a definition of the multilevel governance that incorporates the various dimensions. For instance, Ongaro and his colleagues (2010, p.1) characterize multilevel governance as "the study of the crossroads of the vertical (intergovernmental) and horizontal (state society) dimensions." This distributed and polycentric vision of governance processes translates into a greater flexibility of role sharing (Divay and Paquin, 2013). For example, the elaboration of solutions adapted to local contexts supposes an integration of points of view and resources from various levels and different stakeholders. Similarly, the actors of lower levels should have enough leeway to be able to experiment new ways of doing, while being "guided" by central orientations.

For our part, we will consider a definition of multilevel governance that is not restricted to intergovernmental relations.

Beyond the debates on a definition of governance, Divay and Paquin (2013) make the following conclusions on the state of the research on this topic:

- Public corporate actors, encompassing all institutionalized decision-making bodies, are frequently put forward in multilevel governance analysis. The role of the citizens had but little attention. This is also the case for the professionals, in spite of their important role in public policies.
- Vertical relations between actors were more studied; the studies distinguish themselves according to the levels taken into consideration (international, national (federal and provincial), regional, local, even infra-local). Given the relevance of multilevel governance for the treatment of wicked issues that require intersectoral collaboration, the study of horizontal relations was not neglected. However, oblique relations (ie. the indirect interactions between governments through a third party) were less analyzed.
- The research works were also interested in administrative practices. Several of them examined the role of instruments, particularly for the coordination of collective action. It has to be noted indeed that the coordination of collective action is confronted to many issues, such as (Charbit, 2011, p.16):
    - The information gap. This difficulty translates into an asymmetry of accessible information to the various stakeholders; hence the importance to share information.

- Capacity gap: refers to deficiencies of capacity and resources (human, expertise, infrastructure, etc.).
- Fiscal gap: is represented by the difference between sub national revenues and the required expenditures.
- Policy challenge results when line ministries take purely vertical approach to be territorially implemented. Limited coordination among line ministries may provoke heavy administrative burden, different timing and agenda in managing correlated actions. It can even lead to strong inconsistencies.
- Administrative gap occurs when the administrative scale for policy making, in terms of spending as well as strategic planning, is not in line with functional relevant areas: for example, municipal fragmentation can lead jurisdictions to set ineffective public action, by not benefitting from economies of scale.
- The objective gap refers to different rationalities from stakeholders that create obstacles for adopting convergent strategies.
- The accountability challenge results from the difficulty to ensure the transparency of policies across different constituencies and levels of governments.

Taking into consideration these issues involves the use of a certain number of instruments. Charbit (2011) gives a few examples: co-financing, agreements, experiments, etc. “Typologies” were incidentally proposed (see, for example, Radin (2007)).

An overall observation emerges from this literary review: the analysis of multilevel governance processes, notably of the mechanisms of coordination, tended to neglect what springs out of top-down relations. The contribution of lower levels in the development of public action was, in a way, neglected. As Divay and Divay (2013, p.12) argue, the contribution of these levels doesn’t necessarily proceed from a bottom-up approach; it can be stimulated by a strategy of the upper level. The polycentric and distributed nature of governance processes is not sufficiently conceptualized.

This research should contribute to fill this knowledge gap.

Complexity theory for a better understanding of multi-level governance:

Klijn (2008) argues that the perspective of complexity is particularly interesting to understand the processes of governance. Indeed, the notion of interdependence is central in both lines of research.

The perspective of complexity (Morin, 1990) refers in facts to various theories (example, the theory of chaos, the theory of complex adaptive systems, the theory of autopoietic systems) that are not necessarily similar. That being said, all of these theories insist on certain characteristics of so-called complex systems, in this case: complex systems evolve in a non-linear way, they are dominated by self-organization and co-evolve with other systems.

Indeed, complex systems frequently show signs of instability or temporary stability (Farazmand, 2003). This is due to the fact that that equilibrium is sustained by complex feedback loops (Rickles and col., 2007) that can be positive (reinforcement) and susceptible to produce change, or negative (balancing or moderating), hence more favourable to stability. The dynamic of these systems is also non-linear insofar as the incentives or factors can lead to variable effects; depending on contexts.

Concerning the capacity of self-organization of complex systems, it refers to emerging properties of the system: systems show emergent properties because of the interaction of their individual elements (Mitleton-Kelly, 2003). In this way, the macro structure of the system is related to its micro-structure (interactions between agents), without the need for active steering (Chekland, 1981). Also, for some authors (Kaufman, 1993) the capacity of self-organization implies spontaneity. Furthermore, certain theoretical visions of the capacity of self-organization, particularly those in force in public administration, refer to an idea of closure: if systems are self organizing, they "will have their own distinctive dynamics and react to the environment in their own specific ways. This means that they are, to a certain extent, closed to outsiders or external pressure or at the very least have unique responses to such pressure" (Klijn, 2008, p. 308).

Finally, the concept of co-evolution doesn't only apply to the elements of a system but also to the relations between systems. Co-evolution can be described as the evolution of one domain or entity that is partially dependent on the evolution of other related domains or entities or that one domain or entity changes in the context of the others (s) (Mitleton-Kelly, 2003, p.7). A co-evolution doesn't necessarily occur simultaneously. Thus, complex systems can be seen as multiple, inter-related interactions and relationships that influence each other in direct and indirect ways.

According to several authors (Begun and col. 2003; Glouberman and Zimmerman (2002), healthcare organizations, which are the subject of our analysis, are ideal cases for the applications of complexity theories. These organizations are conceived as adaptive complex systems; i.e. systems able to change and learn from their experience. Three processes are at the heart of the adaptation of these organizations: self-organization, self-eco-organization and co-evolution.

Self-organization: it directly refers here to the autonomy of the operational base and to its capacity to be creative and innovative. The self-organization capacity can be implemented by an individual or more generally by a group of individuals who develop

over time a common understanding of issues. Cognitive schemes of actors, as well as their strategic interests, strongly influence the actions taken.

The capacity of self-eco-organization implies a process of adaptation of the actor, in interaction with his environment. The environment is defined as the ensemble of actors gravitating around healthcare organizations (agencies, the ministry, community organizations, etc.). The processes of self-eco-organization are particularly important in a context of integration of services that requires handling the interdependences between actors.

Finally, co-evolution is the process by which the organization and the environment influence each other; particularly through games of power and manipulation regarding the diversity of interdependences they have or not (Levinthal & Warglien, 1999).

In the end, multi-level governance consists in conferring autonomy to the actors of the organization, necessary to the process of self-organization, as well as sustaining processes of self-eco-organization, susceptible to reinforce the coherence between actions of the organizations' actors and of the environments' actors.

THE RESEARCH PROCESS

Context. We report the results of an empirical study conducted in the Quebec healthcare delivery system. As in the rest of the country, most healthcare services in this Canadian province are funded by the government through taxpayer contributions, and provided by public organizations that offer primary, secondary and tertiary health services. Whereas this is a publicly-funded healthcare system, physicians affiliated with are autonomous entrepreneurs, either in private practice or working in public institutions, being basically paid on a fee-for-services basis.

The Quebec healthcare delivery system experienced a major reform in 2004. As it was already the case in the past, this new reform aimed to replace a producer-oriented logic by a population-based approach. Its main objectives were to: (a) preserve people's health and consider its determinants, (b) take responsibility for a population residing in a territory, and (c) involve citizens in healthcare decision making.

The first decision taken by policy makers was to create 95 Health and Social Service Centres (HSSCs) across the province. The new HSSCs resulted from merging several former independent healthcare organizations operating within the same geographical territory, i.e. community health centres, which offered primary health and social services; long-term care institutions; and general acute-care hospitals. Hence, decision-making power concerning health services organization was decentralized to HSSCs. The regional agencies were just mandated to support the implementation of health services networks.

At the same time, politicians aimed to reorganize frontline primary medical care through the creation of new family medicine groups of practice (FMGs). Family physicians were

then incentivized to work together in FMGs, a new organizational form that overlaps prior contexts of practice (Rodríguez and Pozzebon, 2010; Rodríguez and Bélanger, 2014), which also included nurse practitioners, and further collaborate with the rest of the professionals and organizations of the local healthcare network. Besides multidisciplinary teamwork, improving medical collaboration across levels of care delivery was, therefore, a critical feature of this reform.

Research strategy. We adopted case study as methodological approach in this investigation. More specifically, we conducted a multiple longitudinal qualitative case study (Stake, 1995) from 2012 to 2015. Each of the two cases involved in the study corresponds to a continuum of care associated with a chronic condition characterized by varying medical complexity: diabetes (a stable illness), mental illness (uncertainty and complexity). Fieldwork was carried out in the largest HSSC of the island of Montreal (hereafter HSSC-A).

Within the framework of these case studies, we have examined in particular the processes of governance implemented in the context of development of collaboration practices between levels of care. Both of these cases are particularly interesting for the analysis of multi-level governance. In fact, there is institutional inter-dependence between levels of governments (HSSC and Regional agency), knowing that both have services organization prerogatives. It also has to be reminded that the power of influence within the Québec health system is largely between the hands of the physicians, which do not fall within the administrative hierarchy, hence the interest to analyze the role of these actors in the processes of governance.

Participants, data collection and analysis. We conducted face-to-face semi-structured interviews with 49 participants: 14 family doctors working in different group practices; 9 medical specialists (3 endocrinologists, 3 psychiatrists, 2 internists, 1 cardiologist); 7 decision-makers or advisers from the regional agency (including 3 family physicians); 11 HSSC-A managers; and 8 other health professionals (nurses, pharmacist) working as clinicians. Interviews lasted 25 to 100 minutes, and allowed us to obtain respondents' views about patient management and the development of collaborative practices between levels of care.

Finally, we gathered a significant amount of organizational documents that described the plans and interventions for the management of patients suffering from chronic disorders, and the integration of services.

All interviews were entirely transcribed and coded with the support of NVivo-9 software. Two main strategies were used for data analysis : 1) a deductive-inductive thematic analysis technique (Brown and Clarke, 2006), based notably on our conceptual framework and 2) a temporal bracketing strategy (Langley, 1999), consisting in the decomposition of data into time periods, which enables analysis of how the actions of one period lead to changes in the context that will affect actions in the subsequent periods.

Results

This section will analyze, in a longitudinal way, the processes of multi-level governance for each of the studied cases; by mobilizing the concepts presented above.

The development of new practices around the management of diabetes: a very distributed multi-level governance

A program was created in order to develop the practices of collaboration between levels of care. It was focused on inter-disciplinarity and formalization of coordination mechanisms between professionals intervening with diabetic patients. The Referral center (CR) is one of the main pillars of this programme. Globally, the governance process can be conceptualized as a co-evolution process, through which the organization (i.e. the HSSC) and its environment (i.e. the regional agency, as well as the family physicians; the patients of the territory and the other HSSC of the region) influence each other.

Phase 1: Development of the programme (2006-7)

The first actions made by the HSSC in the direction of development of this programme simultaneously respond to two types of inputs of the environment, either 1) a call for proposals carried out to HSSCs by a consortium composed of the regional agency and the HSSCs of the territory, aiming at developing projects for the management of chronic illnesses, and 2) a particularly high prevalence of diabetes within the population of the territory.

The programming development around the management of diabetes also finds its relevance in the perception, within the managers of this HSSC, of a problem of overload of specialists with simple and/or stable cases that should be managed by family physicians.

In order to answer the call for proposals, managers from the HSSC *self-organize* internally and start to outline the organization of a programme taking in charge diabetes, which would consist in particular to implementing a referral center. This center would aim at supporting family physicians in the management of the diabetic patients. The project submitted to the regional agency by the managers of the HSSC is then only defined in very general terms. The acceptance of this project by the regional agency is linked to the allocation of the necessary funding for the HSSC for the realization of the project. This new injection of external resources allows the HSSC to initiate a more operational definition of its programme. To do so, the managers of the HSSC take on a collaboration with an internist, who became the medical leader of the project.

> *"… It was a HSSC where the managers, the direction were willing. We chose to work on programmes on chronicle illnesses, then to mobilize our people on it. A will that comes from the top, that's already very*

good. And there was a medical willingness. That, too. So the two met. We had specialized physicians that where committed, that believed in the teams (…) if we have a champion, a specialist, who believes in it, and if we have managers that believe in it too, well, together, we will succeed to mobilize." (Regional agency, A professional)

Phase 2: Implementation (2007-9)

Thus begins an implementation process dominated by a self-*eco-organization* logic, through which medical leaders and managers of the organization cooperate closely with some actors of their environment (here regional agency and family physicians of the territory and physicians outside of the programme) in order to precisely determine operational procedures of the RC. Indeed, managers of the HSSSC, the internist, responsible of the center, as well as representatives of the regional agency, worked jointly to fix ways of doing. To do so, this clinical-administrative team leans on the good results obtained in similar projects (*benchmarking*):

"… we support the HSSC, but we also define the clinical programming with the HSSC (…) So there is a specialized physician of the HSSC with our specialized physicians, then managers of the HSSC. We sit together to define, depending on evidence what should be the programming, the care process. Who should refer? Which clientele? Where do we do that? Then once we have our clientele, what do we have to offer?" (Regional Agency, A professional).

It also regularly consults the family physicians in order to know their needs. The works of this clinical-administrative inter-organizational team lead to the adoption and implementation of a RC from which the programming is twofold: 1) a programme of change of life habits, where the family physicians refer the diabetic patients to an interdisciplinary team for a follow up; 2) an educational programme and a treatment involving the participation of the patient to a 3-day intensive training during which he benefits from the services not only of the interdisciplinary team, but also of an internist of the programme. In both cases, the patient benefits from a 2-year follow-up (professional and/or medical). The implementation of the RC was thereafter actively promoted to physicians of the territory by the responsible internist (visits of the clinic and training):

"So, we toured the clinics of the region. We did a short presentation, depending on the clinic's demand, some want a short scientific presentation, and I did that, during that tour. So I was doing, in certain cases, clinical cases of diabetes. We talked, the pharmaceutical company paid for the lunch. In other cases, we just had to do a presentation on our project, and then people had questions. We did that

during the first 6 months. In fact, even before we opened, we did that. After a year and a half, we had a decrease of ridership, then, we did it again. Other clinics that we didn't see" (RC, internist)

Various comities, as well as a regional registry, are also created to monitor the implementation of the RC. An internal committee mainly composed of physicians from the RC and intermediate managers of the HSSC, is constituted in order to coordinate the activities of the program.

Phase 3: Consolidation and dissemination (2009-…)

I. *Consolidation*

Then begins a period of time during which the internal committee of the HSSC is busy consolidating the programme, adding adaptations and improvements it deems necessary, especially after family physicians of the territory expressed some needs. Self-*organization* prevails during this period of time. Indeed, the different measures developed to allow the RC to better corresponds to the needs and realities of the patients and the referring physicians ensue primarily from the initiative of the responsible physicians who, in some cases, find support from the managers and other resources of HSSC in order to ensure their implementation.

Facing complaints from several family physicians regarding the transmission of information, the team of the programme initiated at first to systematize the transmission of progress notes to referring physicians. Besides this initiative, the consolidation efforts responding to inputs of the environment are carried out primarily through the development of particular sectors. Thus, for example, several family physicians are confronted to patients for whom a medical follow-up would beneficial, but who don't want (or can't) follow the intensive training programme (at first, the only way to access such a follow-up). Facing this issue, the RC's physicians changed the conditions of access to a specialized physician of the programme, by allowing referring to the RC simply for a medical consultation. Furthermore, noting the unawareness of the RC by the emergency personnel (translating into an underuse of the RC's resources), and whishing to reduce the misuse of emergency services, the internist responsible of the centre proposes to implement particular mechanisms in order to facilitate (thanks to the establishment of a partnership with an emergency liaison nurse) and to encourage (by organizing training and sensitization activities specific to this practice environment) referring patients from the emergency room.

The increase of attendance at the RC by a clientele referred by the emergency department leads the RC team to the realization that an important part of its clientele is

now composed of orphan patients (who don't have a regular physician). This brings them to develop mechanisms of management and liaison aiming at ensuring a certain continuity of services for orphan patients. These mechanisms involve the development of an agreement with the access counter for orphan clientele that should facilitate the search of a family physician for the patient. Internists proposed also an "alternative" when there are no family physicians to take over after the 2 years initially scheduled:

> *"For example, we decided that we accepted patients who didn't have a family physician. For example, a patient referred from the emergency room. Because we told ourselves, we can't refuse those patients because they don't have a physician… It's them who need it the most, in the end. So the patients, we decided that we accepted them, and then we negotiated with the HSSC, a kind of agreement where they were prioritized in the centralized waiting list… They are taken in charge because, usually, for us, the problem is that those patients came in with their list of other medicine, and told us, you are my only physician. There we said: 'oh no, we can't prescribe all kinds of pills that are not, in addition, in our field" (RC, internist)*

Some adaptations come, furthermore, from the RC's physicians' own initiatives, the most important being to date the recent integration of two endocrinologists to its activities. Indeed, it is thanks to the internist responsible of the programme, who in the meantime became chief of department, that two new endocrinologists integrated the HSSC and, by doing so, the CR team. The reorganization of services and the revision of the distribution of tasks that followed mainly translate in the addition of new time frames for medical consultation, allowing to reduce the burden on internists as well as increasing the frequency of appointments for patients who require it. Consequently, the integration of these two specialists to the team seems to run smoothly.

Quite conscious of the RC's added value (interdisciplinary team in particular), these endocrinologists are looking however to repatriate all of their diabetes cases, including those who do not come from the HSSC's territory. This required a process of negotiation:

> *"… we held talks about this topic, then for the endocrinologists, we accept to take their patients that are out of the territory. It has always been clear that we took the patients of the territory or a physician of the territory who would refer a patient, even if this patient lived outside of it. But then, she was found to, derogate to this rule, because she's a physician from the territory, but it was in the context of clinic she was doing on an other territory…" (RC, internist)*

II. *Dissemination*

In addition to these efforts of consolidation, various interveners of the HSSC involved in the RC realized a work of dissemination. And because the support of the regional agency involves requirements in terms of knowledge transfer, the HSSC organizes exchange activities with other HSSCs (environment).

> *"My teams repeatedly went all over to make presentations in various HSSCs. We welcomed people from different HSSCs to come and visit us. So, there is really an exchange of collaboration because the mandate that was given to us, it's… OK, yes, it comes with money, but it also comes for a transfer of knowledge inside the region of Montreal" (manager HSSC-A, manager).*

These activities resulted in a large diffusion of the model of services organization developed by the HSSC A. All the HSSSC of the region have implemented a referral center,

Phase 4: Capitalization (2011-…)

Since 2011, the activities of the RC also evolved so that new health issues were handled capitalizing on resources, structures and ways of doing acquired through the experience of the RC in diabetes. Indeed, the first initiatives in that direction were in a large part made possible by the positive consequences of the deployment of the RC's activities which, by reinforcing the follow up capacity by general practitioners, would have contributed to progressively decrease the number of references made towards the RC and, by doing so, to release the resources (human and material) necessary to the development and deployment of other activities.

An interdisciplinary programme (without a medical follow-up) of modification of life habits for hypertension (HTN) was first introduced by an initiative from one of the physician (general practitioner) from the RC, before being followed by, upon request of the regional agency and the HSSC, a programme of medical follow-up (by a respirologist) on Chronic Obstructive Pulmonary Disease. A programme of the same kind is also taking shape regarding osteoporosis, under the leadership of the internist responsible of the RC.

Every time, the dynamic of *self-eco-organization* is almost the same as the one that prevails for the implementation of a diabetes programme: close collaboration between physicians of the RC, managers of the HSSC and representatives of the regional agency; new projects funded, for their pilot period, conjointly by the regional agency and a pharmaceutical company; sustainability ensured by efforts of optimization and use of resources within the RC.

Overall, we note that the implementation of the RC led to an adaptation within the HSSC, going through a greater collaboration between the clinical and administrative spheres translating sometimes into compromises on both sides, as well as an adaption of the environment arising from *self-eco-organization*. This adaptation of the environment particularly translates into a shift in practices of the Regional agency that had to develop its accompaniment role. This allowed it to develop a regional vision regarding the follow-up of chronic illnesses (a regional reference framework was elaborated following the experience described here). The HSSCs of the region also beneficiated from this governance process, following exchange and dissemination activities. As we observed, the general practitioners of the territory also adapted their clinical practices, becoming more and more autonomous with regard to the follow-up on diabetes, which enabled the HSSC A to develop new programmes. In short, the governance process gave place to an actual co-evolution of the organization and its environment.

The development of new practices for managing mental health: a limitedly distributed governance

The development of collaboration practices in the mental health sector in the territory of the HSSC-A essentially consisted in introducing a certain number of measures to support the role of the general practitioners. The ensemble of these changes refers to a process of co-evolution favouring new ways of working. However, the governance process was in that case much less distributed.

Phase 1: Development of the mental health programme

The measures under discussion here ensue from a ministerial plan (2005-2010) that targeted among others the reinforcement of primary services in local communities and the implementation of a services organization model encouraging a fluid transition between levels of care. The ultimate aim is to tackle the stigmatization of persons suffering from mental illness, and to give back to those persons a place in society. In that perspective, the implementation of a new structure has been proposed (centralized waiting list), to coordinate the access to services: this structure assesses the needs of the whole clientele consulting for mental health issues and guides them towards the right service provider. The aim is to optimize the use of services. The creation of a new function has also been proposed, that of a respondent psychiatrist to support the general practitioners and primary mental healthcare teams in HSSCs. At the local level, the elaboration phase of the local programme was dedicated to taming the mental health action plan. The liaison mechanisms between levels of care had to be, among others, better formalized. From the point of view of the actors, this work of formalization is still perfectible.

Phase 2: Implementation 2007-2012

The first steps of the mental health plan implementation on a provincial level consisted in a transfer of resources from the secondary towards the primary line of care. These transfers did not consider local contexts (habits of collaboration in the territory). The actors concerned thus lose their benchmarks, and have to get used to new work places, new structures and new internal and external resources (community, etc.).

> *"The Access Plan was appalling. They come in, they announce « You will be transferred to local services centers ». …Like soldiers, we should listen. And we listen. We went into the community. But there was no esprit de corps, no team spirit in the local services center. There was people borrowed in various hospitals of the region, we don't know each other, eh, we have, so, 20 years, 30 years of experience in an institution, you don't put us together, we're parachuted in a system we don't know and we don't know each other, our way of working. And you say: work together." (Psychiatrist)*

By imposing this change in services organization, the ministerial plan has repercussions on the whole network, breaking a *self-eco-organized* balance. This balance is broken at the level of the primary and secondary lines: it constitutes an "imposed" co-evolution to local mental health networks because the ensemble of actors gravitating around it (environment: patients, community organizations, other HC, other HSSCs, etc.) is also affected by this loss of benchmarks. That particularly created difficulties into the appropriation of new practices and thus waiting lists have lengthened:

> *"These interveners, these professionals landed in primary line with a practice they had in secondary line, they landed with the same toolbox, with a little mentoring to buoy the context of the primary line, the thing is that interventions can be moderately long, similarly to what the services, in terms of duration, do in secondary line" (HSSC-A, manager)*

Beyond the measures implemented at the provincial scale, local actors also envisaged three avenues to implement the national policy: 1) implementation of the respondent psychiatrists' role, 2) set up of a pilot project aiming at developing the collaboration between the teams of the HSSC and the medical clinics of the territory and 3) operationalization of a *fast-track* for the access of mental healthcare services of the HSSC (for the patients of the largest medical clinic of the territory).

1. Development of the role of respondent psychiatrist in adult mental health

After a first unsuccessful attempt of the psychiatric hospital to recruit a respondent psychiatrist, two leaders of the psychiatry sector proposed themselves in 2012 to fulfill that role. It has to be noted that the deployment of the role of psychiatrist-respondent essentially depends on the psychiatric hospital and not on the mental health team of the HSSC, or on the HSSC itself. Thus, this avenue (or action strategy) that is the role of respondent psychiatrist directly acts on the inner capacities of the HSSC (in the sector of mental health) and those of the medical clinics of the territory to take in charge and better respond to the needs of the patients. However, the leverage power mainly depends on another (third) organization. In other words, in that case, the possibility to call upon the self-eco-organized capacities of the HSSC is limited.

2. Implementation of a pilot project to reinforce the collaboration between the HSSC and medical clinics

The HSSC, taking note of the lack of knowledge on its services, decided in 2011 to implement a pilot project (self-organization) to develop the collaborations with the physicians of the community.

> *"And the physicians are totally right to say that they've… they've little support. Because actually, the mental health teams didn't deploy, hum, collaborations or… links of collaboration, hum, efficient and effective." (HSSC-A, manager)*

The activities of the pilot project were identified in interaction with the environment (*self-eco-organization*) and sum up by *a la carte* trainings, conferences and discussions on cases with the interveners of the mental health team. Intending to be flexible and adaptable to the needs of the physicians of the territory, the activities offered by the pilot project were rapidly focused on conferences, meetings and discussions of cases exclusively with respondent psychiatrists: the physicians wished indeed to learn more via the experts in psychiatry.

That is when we observe an unexpected evolution of the project: the involvement of respondent psychiatrists within the project ousts the role of the HSSC interveners. The medical formation aspect of the specialists took over.

> *"And then I realize that clinics request less training from the HSSC' team. But, the training requests concerning respondent psychiatrist rather increase." (HSSC-A, manager)*

The role of respondent psychiatrist is more and more well known and general practitioners progressively appeal to it.

3. Operationalization of medical clinic-health center *fast track*

Taking into account some difficulties, the HSSC decided this time to facilitate the access of services for patients coming in without appointments (*self-organization*). Indeed, general practitioners mentioned that they feared to "come upon cases of mental health" during walk-in clinics, knowing that a follow-up would be necessary and that they wouldn't be able to do it. Consequently, a HSSC' nurse has been asked to work in medical clinics during certain hours,

Without really explaining how such a partnership would be useful, the physicians do not change their usual practice to send the patient towards an intervener (that they don't know) in the next office. The initiative ends in a failure: the nurse is not used. There are multiple causes but they ensue in part from the fact that the HSSC poorly interacted at this step with the physicians of the medical clinic (*self-eco-organization*) to influence the latter.

> *"So we told them, "we will give you a…" because we had waiting lists, at that time, it was a bit more complicated, so I said, "we will give you what we call a fast track" (HSSC manager)*

The managers of the HSSC, based on the needs expressed by the physicians, then propose in 2011 another strategy (self-eco-organization) : free timetables at the HSSC for the patients referred from the walk-in clinic towards the interveners of the mental health team.

In exchange of what the referring physicians are committed to meeting the patient at least 3 times. This new initiative is partially successful. The physicians use the timetable and refer the patients to the mental health team.

> *"The results are extremely positive. What we do is that, everyday at 10 a.m., there's a timetable that is reserved to the southwest medical clinic, from Monday to Friday. From Monday to Friday, every morning, at 10 a.m., there's a possibility, and its managed by their general secretary, who tells our secretary. Oops, tomorrow morning, 10 a.m., there's one of the patient who is referred here. So, there's always someone at the counter who, each day, is available at that time." (HSSC-A, manager)*

However, the follow-up that has to be done by the physicians is not always done, depending on one physician to the other.

"Yes, because the client has to have an appointment before he leaves, the physician has to say "I'll see you in two weeks", and they don't do that. Frequently they don't even initiate the medication, the adjustment disorder or something, he just started an antidepressant and he sends him right away in psychiatric eval. But you don't even know what effect it has. Maybe with what you prescribed, it's OK. It's poorly organized, I think." (HSSC-A, nurse)

Phase 3: Consolidation of the programme and dissemination (depending on avenues proposed) (2012-)

Because the *fast track* avenue was considered successful, at least by some, other medical clinics wish now to beneficiate to an access to the timetable offered at the HSSC. The latter hence decided to expand this format (*self-eco-organization*). The process led to certain tensions among the mental health team of the HSSC:

"The project of the X clinic we, like, evaluated that five days of timetables, it was a lot. And the team here, we found it unfair why one clinic and not the rest. Here we negotiated to decrease by three days their timetables to give two days to another clinic. This way we'll expand gradually" (HSSC-A, manager).

Dissemination activities were relatively limited: the project was the subject of one publication in a newspaper and presentations were made at the regional agency and the ministry.

Overall, we find that in the case of mental health, the multilevel governance essentially leaned on the adaptation of the HSSC to the needs expressed by the physicians. The governance process involved only actors at the local level. This led to a co-evolution of practices of the HSSC and of a part of the external environment (some medical clinics and psychiatric hospital). However, this co-evolution escaped in some respects the HSSC's control.

Discussion and conclusion

Our analysis of multilevel governance processes perfectly illustrates that they don't limit to purely ascending or descending vertical relations between government levels: on the one hand, other actors are strongly involved in these processes (example, health professionals) and on the other hand, these relations are multidirectional (vertical, horizontal and oblique). Our analysis also shows that the governance processes can be more or less distributed, depending on the role played by the actors. A distributed process engages actors of the local and regional levels, and of the administrative and clinical spheres. The clinical sphere focuses on phenomena related to the clinical aspects, while managing the interface with the administrative sphere. The administrative sphere focuses on organizational phenomena in interface with the clinical sphere, to which it is dedicated to serve (Lamarche et al., 2008).

Furthermore, the comparative analysis of these two case studies is interesting because it allows a comprehension of the influence of governance processes on the adaptation capacity of an organization to its environment. The adaptation is assessed particularly through the response to the healthcare needs of the clientele in question. The results of our study reveal that the distributed governance process, implemented in the context of the development of collaboration practices between levels of care in the management of diabetes (case 1), contributed to the emergence of a better adaptation. Indeed, from the perspective of the study participants, the quality of the follow-up in primary care of diabetic persons of the territory improved through time. Moreover, the positive feedback on the changes for diabetes encouraged the actors to implement other change processes, for chronicle illnesses (cf. capitalization), by replicating the same model of organization of services and the same governance process. This would match a phenomenon of path-dependency (Greener, 2002). These changes are also likely to improve the quality of the management of other health problems.

The situation is completely different in the case of mental health (case 2), in which we observe a much less distributed governance process. Indeed, in the case of mental health, even if medical collaboration between levels of care is progressively developing in the territory of the HSSC A, it remains that the practices of the general practitioners evolve more slowly, from the perspective of some respondents, particularly regarding the continuity of care. Similarly, we note that the changes in the environment of the HSSC are much more limited, insofar as they essentially concern a few clinics of the territory.

The distributed governance process observed in case 1 actually encouraged the actors to be more prepared to face the issues of coordination of collective action, namely: capacity gap, fiscal gap and rationality gap; and that thanks to the processes of self-organization and self-eco-organization. The self-organization process implemented by the internal actors of the HSSC, in response to the stimuli of the environment, emerging among others from superior governance levels (regional agency) ensured an exit to the status quo

situation and produced through time radical transformations of practices. Through their action, the actors of the organization generated a learning of "good" practices (for example, the necessity to be more flexible on the admission requirements to the referral center programme). The involvement in the self-eco-organization processes allowed an enrichment of this collective learning. For illustrative purposes, the analysis work within the clinical-administrative inter-organizational team (gathering representatives of the regional agency and actors of the HSSC) led to a better utilization of evidence related to the management of diabetes. This learning beneficiated to the actors of the HSSC, as well as the regional agency. The regional agency' role of support also allowed transfer of learning to the other HSSCs of the region.

The regional agency also encouraged the exchanges between the HSSC A and other HSSCs of the region, inducing oblique relations between actors (Divay and Paquin, 2013). All of these interactions and relations reinforced the expertise of the HSSC's actors and its environment. The development of these capacities at different scales led to the fact that the change carried out at the regional as well as the local levels. Beyond the reinforcement of the expertise, the role of the regional agency was essential for filling the fiscal gap. Indeed, as we mentioned, the experimentations at the local level beneficiated from the funding of the regional agency: in a context where there is little organizational slack in the healthcare network, this funding of innovative initiatives by the regional agency was all the more useful. Overall, we can note that the role of a regional agency at the governance processes level can be crucial regarding the development of capacities (Touati and col. 2007).

Our analysis of case 1 also revealed the importance of self- eco- organization processes as a reconciliation lever of the rationalities of the various actors, thus contributing to the filling of the objective gap. Indeed, as we observed, the interaction between the HSSC and the specialized physicians recruited by the referral center programme forced a negotiation for the reconciliation of the professional logic (offering the same care to the whole clientele, without discrimination regarding the residential location of the user) and of the administrative logic, advocating a responsibility towards the population of a given territory.

Beyond the management of the issues related to collective coordination, the combination of self-organization and self-eco--organization also led to the "management" of the adaptation paradox, namely the *"novelty, variation, risk taking and a diversity of perspective"* as well as *"constancy, homogeneity, shared identity and common purpose"* (Moore and Kraatz 2010:16). Indeed, the various actors, from the organization as well as the external environment involved in the governance process were able to introduce new and differentiated perspectives regarding the management of diabetes but progressively various visions and interests had to converge. In short, the governance processes in that case ensured that the various actors (in particular at the local level) enjoyed a certain autonomy, while being led to act in a more defined global framework (Lozeau and col. 2002).

All of this was made possible thanks to the clinical-administrative leadership (Touati and col., 2006) practiced in the context of the diabetes services reorganization. This leadership, supporting a population-based approach, strongly contributed to promote and implement a common vision centered on the needs of the populations. We can also think that other factors favoured the effectiveness of the governance processes: the improvement of the follow-up on certain chronic illnesses (including diabetes) constitutes a priority for the HSSC and the regional agency. Diabetes is a relatively simple disease that general practitioners more easily accept to follow.

Adapting to the populations' needs in the case of mental health has proved to be more delicate. This is explained by the combined effect of the particular context of this continuum of care and the dynamic characterizing the processes of self-organization and self-eco-organization that are implemented.

On the one hand, the self-organization capacity of the HSSC was relatively less used in the sense that the HSSC proved to be less creative at the level of organization of services. It was more devoted to apply the "prescriptions" of the mental health plan; knowing that this plan rather outlined the means to improve management.

On the other hand, the self-eco-organization processes were strongly influenced by the "interests" of some doctors; not always aligned with those of the population needing mental healthcare services. It has to be noted that the particular status of the physicians in Québec (cf. autonomous entrepreneurs) gives them an important power. The way that the mental health reform was introduced led to the growth of their power of influence. Indeed, the way that the transfers of human resources was made during the implementation of the reform, which created certain difficulties within the mental health teams of the HSSC (growing waiting list), made the managers of the HSSC perceive that they should make some efforts to answer the particular expectations of some physicians (booking timetables); and that despite of the equity of access to services.

It appears that the absence of clinical-administrative leadership at the local and regional levels in the mental health sector also influenced the governance processes and their related effects. This is also the case for the clientele's profile, which is perceived as more complex.

In conclusion, our study suggests that the effectiveness of multi-level governance processes doesn't only goes through the implementation of instruments aiming at aligning the action of lower government levels with the objectives of the upper levels. This effectiveness also goes through practices and mechanisms that encourage a distributed learning involving actors of various spheres where each fuels the learning of the other. Contrary to a mechanistic rationality, which considers that the solutions to issues are known and that they just need to be applied, the question then is to privilege an interactive rationality (Ponssard, 1994). This interactive rationality emerges from the interactions between a variety of actors who use a temporary model as a reference for action; which constantly has to be outgrown.

References :

Begun, J., et al. (2003). Health care organizations as complex adaptive systems. In *Advances in Health Care Organization Theory, S. M. Mick and M. Wyttenbach (eds.).* San Francisco, CA, Jossey-Bass.: 253-288.

Bevir, M. (2013). *Governance: A very short introduction*. Oxford, UK: Oxford University Press.

Braun, V. and Clarke, V. (2006). *Using thematic analysis in psychology*. Qualitative Research in Psychology, 3, 2, pp. 77-101.

Charbit, C. (2011). Governance of public policies in decentralized contexts. The multi-level approach. OECD Regional development working papers. OECD Publishing

Chekland, P. (1981). System thinking, System practice. John Wiley and Sons.

Coaffe, J. and Johnston, l. (2005). The management of local government modernization : area decentralization and pragmatic localism. *International Journal of Public Sector Management*, 18 (2), pp. 164-177.

Coaffe, J. and Headlam, N. 92008). Pragmatic localism uncovered : the search for locally contingnt solutions to national reform agendas. *Geoforum*, 39, pp. 1585-1599.

Divay, G., and Paquin, S. (2013). L'administration publique dans la gouvernance multiniveau infranationale : état de la question et perspectices. *Telescope*, 19 (1), p. 1-24.

Farazmand, A. (2003). Chaos and Transformation Theories: A Theoretical Analysis with Implications for Organization Theory and Public Management. *Public Organization Review,* 3(4): 339-372.

Gilsing, R. (2007). Intergovernmental relations and the effectiveness of local governance : the case of Dutch youth policy. *International review of Administrative Sciences*. 73 (1), pp. 45-64.

Glouberman and Zimmerman, B. (2002). *Complicated and complex systems : what would successful reform of medicare look like ?.* Commission on the future of health care in Canada. Discussion Paper 8. Ottawa.

Greener, I. (2002). Theorising path-dependency: how does history come to matter in organisations?. *Management Decision*, 40, 6, pp.614 - 619

Kaufman, S. (1993). *The origins of order : self organization and selection in evolution.* Oxford: Oxford University Press.

Jansson, E. et col. (2011). National public health policy in a local context. Implementation in two Swedish municipalities. *Health Policy*, 103, 2-3.

Klijn, E-H. (2008). Complexity theory and Public Administration : what's new ?. *Public Management Review*. 10 (3), pp. 299-317.

Lamarche and col. (2008). Lamarche, P., R. Pineault and Y. Brunelle (2008). "L'obligation de faire des choix difficiles, et même très difficiles." Document de travail, Université de Montréal, GRIS.

Langley, A. (1999). Strategies for theorizing from process data. *Academy of management review*, 24, 4, pp. 691-710.

Lozeau, D., and col. (2002). The corruption of managerial techniques by organizations. *Human relations*, 55 (5), pp. 537-564.

Levinthal, D. A. and Warglien, M. (1999). Landscape design : designing for local action in complex worlds. *Organization Science*, 10 (3), pp. 342-357.

Mahon, R. and col. (2007). *Policy analysis in an era of globalization : capturing spatial dimensions and scalar strategies.* In Orsini and Smith (ed.), Critical Political STudies, Vancouver, UBC Press.

Mitleton-Kelly, E. (2003). *Ten principles of complexity and enabling infrastructures*. In Mitleton-Kelly (ed.) Complex systems and evolutionary perspectives of organisations : the application of complexity theory to organizations, Elsiver.

Moore, J. H., and Kratz, M. S. (2010). Governance form and organizational adaptation : lessons from the savings and loan industry in the 1980s. *Organization Science*, published online before print September 30, 2010, DOI:10.128, p. 1-19.

Morin, E. (1990)). *Introduction à la pensée complexe*. Paris, Seuil "Points Essais".

Ongaro, E. and col. (2010). *Governance and intergovernmental relations in the European Union and United States : theoretical perspectives*. Edward Elgar.

Pavolini, E. and Vicarelli, G. (2012). Is decentralization good for your health ? Transformations in the Italian NHS. *Current Sociolgy*, 60 (4), pp. 472-488.

Peters, B. G. and J. Pierre (2001). Developments in Intergovernmental Relations: Towards Multilevel Governance, *Policy & Politics*, vol. 29, n° 2, p. 131-135.

Pollitt, C. (2005). *Decentralization*. in Ferlie, E., Lynn, L., Pollitt, C. (ed.). The Oxford handbook of Public Management. Oxford University Press.

Ponssard, J-P., (1994). *Formalisation des connaissances, apprentissage organisationnel et rationalité interactive*. In A. Orléan, *Analyse économique des conventions* Economica..

Radin, B. A. (2007). *The instruments of intergovernmental management*. In G. Peters and J. Pierre (ed.). The Handbook of Public Administration, London, Sage.

Rodríguez C, and Pozzebon M. (2010). The Implementation Evaluation of Primary Care Groups of Practice: A Focus on Organizational Identity. *BMC Family Practice*,11, 15 doi:10.1186/1471-2296-11-15

Rodríguez C, and Bélanger E. (2014). Stories and Metaphors in the Sensemaking of Multiple Primary Care Organizational Identities. *BMC Family Practice,* 15, 41 doi:10.1186/1471-2296-15-41

Regmi, K. (2012). Multi-level governane : an approach to reform decentralised primary healthcare services. *Primary health care : Open Access*, 2 (4)

Rickles, D., P. Hawe and A. Shiell (2007). A simple guide to chaos and complexity. *Journal of Epidemiology and Community Health,* 61(11), pp. 933-937.

Stake, R.E. (1995), *The Art of Case Studies*, Sage, Thousand Oaks, CA.

Touati and col. (2006). Clinical Leaders at the Forefront of Change in Health-Care Systems : Advantages and Issues : Lessons Learned from the Evaluation of the Implementation of an Integrated Oncological Services Network. *Health Services Management Research*,19, 2, pp. 105-122

Touati and col. (2007). Governance, Health Policy Implementation and the Added Value of Regionalization / Gouvernance, mise en oeuvre des politiques de santé et valeur ajoutée de la régionalisation", *Healthcare Policy*, pp. 97-114.