Profiles of Public Health Systems in Canada: Québec

Report | 2022

Centre de collaboration nationale sur les politiques publiques et la santé

National Collaborating Centre for Healthy Public Policy

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About this research project: context, team and partners

The *Profiles of Public Health Systems in Canada* are part of a research project titled *Platform to Monitor the Performance of Public Health Systems,* led by Principal Investigators Dr. Sara Allin, Dr. Andrew Pinto and Dr. Laura Rosella from the University of Toronto. The project involves the participation of knowledge users, collaborators and an inter-disciplinary team of scholars from across Canada, and aims to develop a platform to compare public health system performance across Canada. To achieve this aim, the project comprises three phases:

1. Produce detailed descriptions of the public health financing, governance, organization, and workforce in each of the 13 provinces and territories using a literature review with results validated by decision makers.
2. Conduct a set of comparative in-depth case studies examining implementation and outcomes of reforms, and their impacts on responses to the COVID-19 pandemic.
3. Define indicators of public health system performance with structure, process, and outcome measures.

The National Collaborating Centre for Healthy Public Policy (NCCHPP) joined the research project working group in the early months of the COVID-19 pandemic, and is now proud to publish their work as a series of 13 Canadian Public Health System Profiles, with supplementary methodological materials. The series of public health system profiles are available on the NCCHPP website at: https://ccnpps-ncchpp.ca/profiles-of-public-health-systems-in-canadian-provinces-and-territories/.

About the National Collaborating Centre for Healthy Public Policy (NCCHPP)

The NCCHPP seeks to increase the expertise of public health actors across Canada in healthy public policy through the development, sharing and use of knowledge. The NCCHPP is one of six centres financed by the Public Health Agency of Canada. The six centres form a network across Canada, each hosted by a different institution and each focusing on a specific topic linked to public health. The NCCHPP is hosted by the Institut national de santé publique du Québec (INSPQ), a leading centre in public health in Canada.

Contents

List of acronyms V

Introduction 1

1 Historical and Contextual Background 3

2 Organizational Structure 5

2.1 Provincial 5

2.1.1 Ministère de la Santé et des Services sociaux (ministry of health and social services) 5

2.1.2 Direction générale de la santé publique (Québec's general directorate of public health) and the Directeur national de santé publique (Québec's national public health director) 5

2.1.3 Institut national de santé publique du Québec (Québec's national public health institute) 6

2.1.4 Institut national d'excellence en santé et en services sociaux (Québec's national institute of excellence in health and social services) 6

2.1.5 Health and Welfare Commissioner 7

2.1.6 Other ministries with public health responsibilities 7

2.2 Regional 8

2.2.1 Directions régionales de santé publique (regional public health departments) 8

2.2.2 Directeur régional de santé publique (regional public health director) 9

2.2.3 Centres intégrés de santé et de services sociaux (integrated health and social services centres)/Centres intégrés universitaires de santé et de services sociaux (integrated university health and social services centres) 9

2.3 Local 10

2.4 Sharing of public health responsibilities among the *MSSS*, the *INSPQ* and the *CISSSs/CIUSSSs* 10

2.5 Integration, Intersectoral Coordination and Inter-jurisdictional Partnership 11

2.5.1 Inter-jurisdictional Partnerships for Indigenous Peoples 11

2.5.2 Plan d'action régional/Plan d'action régional intégré (regional action plan/integrated-regional public health action plan) 11

2.5.3 Tables de concertation nationale (national consultation committees/roundtables) 12

2.5.4 Politique gouvernementale de prévention en santé and its Plan d'action interministériel 2017-2021 (2017-2021 inter-ministerial action plan for the government policy of prevention in health) 12

3 Governance 13

3.1 Legal and Policy Framework for Public Health 13

3.1.1 Public Health Act (2001) 13

3.1.2 Section 54 of the Public Health Act 13

3.1.3 Other laws regulating public health in Québec 13

3.1.4 Programme national de santé publique (national public health program)....14
3.2 Performance and Evaluation....14
4 Financing....15
4.1 Public Health Spending....15
5 Public Health Workforce....21
5.1 Size, Composition, Recruitment and Retention....21
5.1.1 Public Health Workforce at the *DGSP* and the *INSPQ*....21
5.1.2 Public Health Workforce in the CISSSs/CIUSSSs....21
5.1.3 Public Health Physicians....21
References....23

List of acronyms

AHSSS	Act respecting health services and social services
AMHSSN	Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies
CBHSSJB	Cree Board of Health and Social Services of James Bay
CISSS	Centre intégré de santé et de services sociaux (integrated health and social services centre)
CIUSSS	Centre intégré universitaire de santé et de services sociaux (integrated university health and social services centre)
CNESST	Commission des normes, de l'équité, de la santé et de la sécurité du travail (commission on labour standards, equity and occupational health and safety)
CLSCs	Centres locaux de services communautaires (local community service centres)
CSEP	Cadre de suivi et d'évaluation préliminaire (preliminary monitoring and evaluation framework)
CTQ	Centre de toxicologie du Québec (Québec's toxicology centre)
DGSP	Direction générale de la santé publique (general directorate of public health)
DNSP	Directeur national de santé publique (national public health director)
DRSPs	Directions régionales de santé publique (regional public health departments)
EPHOs	Essential public health operations
FNIHB	First Nations and Inuit Health Branch
HIA	Health Impact Assessment
HWC	Health and Welfare Commissioner (in French: Commissaire à la santé et au bien-être)
INESSS	Institut national d'excellence en santé et en services sociaux (Québec's national institute of excellence in health and social services)
INSPQ	Institut national de santé publique du Québec (Québec's national public health institute)
LSPQ	Laboratoire de santé publique du Québec (Québec's public health laboratory)
MAPAQ	Ministère de l'Agriculture, des Pêcheries et de l'Alimentation du Québec (ministry of agriculture, fisheries and food)
MELCC	Ministère de l'Environnement et de la Lutte contre les changements climatiques (ministry of the environment and the fight against climate change)

MTESS	Ministère du Travail, de l’Emploi et de la Solidarité sociale (ministry of labour, employment and social solidarity)
MSSS	Ministère de la Santé et des Services sociaux (ministry of health and social services)
NRBHSS	Nunavik Regional Board of Health and Social Services
PAR	Plan d’action régional (regional action plan)
PARI	Plan d’action régional intégré de santé publique (integrated regional public health action plan)
PATT	Plan d’action thématique tripartite (tripartite thematic action plan)
PEM	Plan d’effectifs médicaux (medical workforce plan)
PGPS	Politique gouvernementale de prévention en santé (government policy of prevention in health)
PNSP	Programme national de santé publique (Québec’s national public health program)
PREM	Plan régional d'effectifs médicaux (regional medical workforce plan)
PSOC	Programme de soutien aux organismes communautaires (community organizations support program)
RSPSAT	Réseau de santé publique en santé au travail (public health network for occupational health)
RSS	Région sociosanitaire (health and social services region)
STIs	Sexually transmitted infections
TCNs	Tables de concertation nationale (national consultative committees/roundtables)

Introduction

Objectives

As Canada deals with the COVID-19 pandemic, one of the biggest public health challenges of our time, the need to strengthen public health systems has never been greater. Strong public health (PH) systems are vital to ensuring health system sustainability, improving population health and health equity, and preparing for and responding to current and future crises. There are considerable variations across provinces and territories in how public health is organized, governed and financed, as well as in how public health systems have been reformed and restructured in recent years. This report builds upon prior reports and describes Québec's public health system prior to the COVID-19 pandemic, including its organization, governance, financing, and workforce. It is part of a series of 13 public health system profiles[1] that provide foundational knowledge on the similarities and differences in the structures of public health systems across provinces and territories. In addition to summarizing what is known, these profiles also draw attention to variations and gaps to inform future priorities. This series will serve as a reference for public health professionals, researchers, students, and decision makers seeking to strengthen public health infrastructure in Canada.

Approach

Details on the jurisdictional review methodology are presented in the document *Profiles of Public Health Systems in Canada: Jurisdictional Review Methodology*.[1] The research team sought out information from peer-reviewed journal articles and publicly available grey literature (e.g., governmental and non-governmental organization reports, documents, webpages, legislation), and data sources (e.g., provincial/territorial budget estimates). The World Health Organization's essential public health operations (EPHOs) were used to define programs and services that constitute public health activities, and enabler EPHOs were used to define public health governance, organizational structure, financing, and workforce (Rechel, Maresso, et al., 2018; World Health Organization, 2015). The search terms were also informed by the research questions presented in a standardized data abstraction form adapted from the European Observatory for Health Systems and Policies (Rechel, Jakubowski, et al., 2018). A narrative synthesis was used to develop detailed profiles that were reviewed internally by the research team and externally by experts from each jurisdiction (e.g., public health policy makers and practitioners) for accuracy, completeness, and reliability. The reports were reviewed by public health key informants in each jurisdiction to assess the validity of our findings. We incorporated their comments and formally acknowledge their contributions at the start of each report.

Limitations

Despite this comprehensive iterative review process and our attempt to highlight information gaps, it should be noted that the process used to compile information was not a formal systematic search, and thus information sources may have been missed. Further, a detailed review of the role of the federal government and of First Nations, Inuit and Métis approaches to public health was beyond this project's scope and should be made a priority for future work. Moreover, by relying in large part on the published documents and websites of the key government actors and agencies in public health, we may not have fully captured how the system functions in practice, and whether and how actual roles and relationships may deviate from what is written in legislation and policy documents. Finally, these profiles describe the public health system prior to the COVID-19 pandemic; we do not review the governance structures, advisory groups and partnerships that were established in response to the COVID-19 pandemic.

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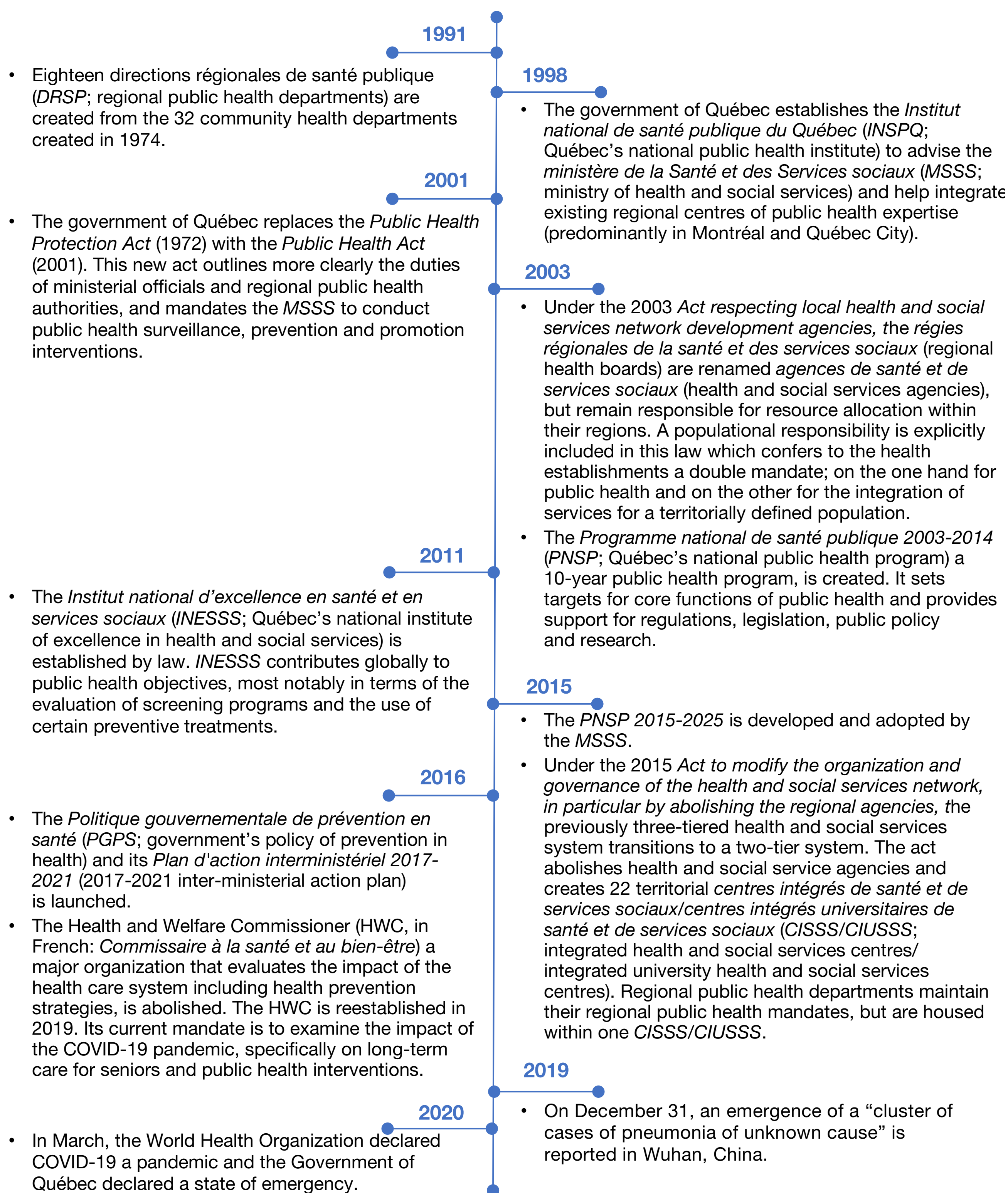
[1] The series of 13 public health system profiles and the jurisdictional review methodology document are available at: https://ccnpps-ncchpp.ca/profiles-of-public-health-systems-in-canadian-provinces-and-territories/.

1 Historical and Contextual Background

A public health reform is any fiscal or structural policy change aimed at directly impacting public health system governance, organization, funding or financing, workforce, and population health outcomes (Ricciardi et al., 2016). Public health emergencies, such as the SARS epidemic in 2003 and the COVID-19 pandemic in 2020, highlighted the need for major reforms in public health services to strengthen the public health system. Some of Québec's most important public health reforms include the passing of the *Public Health Act* (2001), which more clearly outlined public health roles and responsibilities in Québec, and the 2015 health system reform that notably led to the abolishment of regional agencies and folded regional public health departments into new regional entities (*Centres intégrés de santé et de services sociaux* [*CISSSs*; integrated health and social services centres]/*Centres intégrés universitaires de santé et de services sociaux* [*CIUSSSs*; integrated university health and social services centres]). These reforms directly affected public health governance. The following timeline presents a summary of proposed and enacted reforms impacting Québec's public health system.

Figure 1. Timeline of major public health reforms in Québec



Sources: Act respecting local health and social services network development agencies, 2003; Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies, 2015; Bernier, 2006; Breton et al., 2009; Ministère de la Santé et des Services sociaux, 2015b, 2018b; World Health Organization, 2020a, 2020b)

2 Organizational Structure

This section describes the organizational structure of Québec's public health system as of July 2020. We present the roles, responsibilities, and supervisory relationships of governmental and arms-length governmental institutions with a legislated role in public health, including health authorities, public health units, and key figures within each that lead the planning and delivery of public health services. Our focus is on those with public health as their primary role; therefore, we do not provide a detailed description of organizations and service providers in other sectors (e.g., primary care, mental health and addictions, social services, and non-governmental organizations) that may perform essential public health functions as part of their work (e.g., immunization, health promotion).

2.1 Provincial

2.1.1 MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX (MINISTRY OF HEALTH AND SOCIAL SERVICES)

The *ministère de la Santé et des Services sociaux* (*MSSS*; ministry of health and social services) is responsible for overseeing health and social services in Québec (Gouvernement du Québec, n.d.). The mandate of the *MSSS* is to "maintain, improve and restore the health and well-being of Québecers by providing access to a range of quality and integrated health and social services, thereby contributing to the social and economic development of Québec" (Ministère de la Santé et des Services sociaux, n.d.-b). It achieves these goals by collaborating with government agencies, local authorities and other actors, utilizing a variety of financial and policy instruments, and setting provincial priorities. Under this wide umbrella, the Ministry's responsibilities include the pursuit of public health objectives delineated within the *Programme national de santé publique* (*PNSP*; Québec's national public health program) and the *Public Health Act* (Ministère de la Santé et des Services sociaux, 2019c).

The public health responsibilities of the *MSSS* include agenda setting, policy development and implementation, the development of a provincial public health plan, resource allocation and stewardship, service coordination between different regions and sectors, the appointment of provincial and regional directors of public health, and province-wide evaluations of health outcomes (Collège des médecins du Québec, 2020). Twelve government offices and organizations report directly to the Minister (Ministère de la Santé et des Services sociaux, n.d.-a). For public health, this includes the Institut national de santé publique du Québec (INSPQ; Québec's national public health institute), a leading expertise and reference centre for public health, but also the *Institut national d'excellence en santé et en services sociaux* (*INESSS*; Québec's national institute of excellence in health and social services), and the Health and Welfare Commissioner (HWC; in French: *Commissaire à la santé et au bien-être*) who also contribute to public health files (Ministère de la Santé et des Services sociaux, n.d.-a).

2.1.2 DIRECTION GÉNÉRALE DE LA SANTÉ PUBLIQUE (QUÉBEC'S GENERAL DIRECTORATE OF PUBLIC HEALTH) AND THE DIRECTEUR NATIONAL DE SANTÉ PUBLIQUE (QUÉBEC'S NATIONAL PUBLIC HEALTH DIRECTOR)

The *Direction générale de la santé publique* (*DGSP*; Québec's general directorate of public health) is the primary branch within the *MSSS* responsible for public health. The *DGSP* was created in 1992 and coordinates public health activities across the province, most notably through the *PNSP* (Breton et al., 2009; Gouvernement du Québec, 2015). The *DGSP* is led by an Assistant Deputy Minister who also holds the position of *Directeur national de santé publique* (*DNSP*; Québec's national public health director), and he or she reports to the Deputy Minister of Health and Social Services (Ministère de la Santé et des Services sociaux, n.d.-a; Act respecting the Ministère de la Santé et des Services

sociaux, s.5.1, 1970). As the head of the *DGSP*, the *DNSP* has a mandate to “support the Minister in all matters related to public health, including public health emergencies” and “coordinate, with regional public health directors, the Québec Public Health Program” (Canadian Public Health Association, 2019). The *DNSP*’s role aligns with the “Loyal Executive” typology for Chief Medical Officers of Health in Canada (Fafard et al., 2018). He or she acts as an assistant deputy minister, with the advisory and managerial responsibilities of a member of the senior public service and the ability to wield authority during a public health emergency (Fafard et al., 2018).

2.1.3 INSTITUT NATIONAL DE SANTÉ PUBLIQUE DU QUÉBEC (QUÉBEC'S NATIONAL PUBLIC HEALTH INSTITUTE)

Established in 1998, the mission of the *Institut national de santé publique du Québec* (*INSPQ*; Québec’s national public health institute) is to “support Québec’s Minister of Health and Social Services, regional public health authorities, and health and social services institutions in carrying out their public health responsibilities, by offering [their] expertise and specialized laboratory and screening services” (Institut national de santé publique, n.d.). Specific examples of the *INSPQ*’s functions include its responsibility to contribute to the “development, consolidation, dissemination and application of knowledge in the field of public health,” to inform the *MSSS* and the population on the state of public health in Québec and on emerging public health crises, and to advise the *MSSS* on public health actions and orientations (Act respecting Institut national de santé publique du Québec, s. 3, 1998), including for the development and implementation of the *PNSP*. It also collaborates with public health professionals and experts (e.g., universities, professional orders, agencies) on teaching and research in public health and establishes channels of communication with public health experts in Canada (e.g., Public Health Agency of Canada) and internationally to share knowledge in public health. The *Act respecting Institut national de santé publique du Québec* also lists specific laboratory functions under the purview of the *INSPQ*, including the administration of the *Laboratoire de santé publique du Québec* (*LSPQ*; Québec’s public health laboratory), which is specialized in microbiology, and the *Centre de toxicologie du Québec* (*CTQ*; Québec’s toxicology centre), which is specialized in toxicology. The *Act* also mandates the *INSPQ* to establish a public health ethics committee, whose main function “[…] is to give its opinion on the ethics of the proposed surveillance plans and surveys on health and social issues drawn up under the Public Health Act […]” (Act respecting Institut national de santé publique du Québec, s. 19.2, 1998).

2.1.4 INSTITUT NATIONAL D'EXCELLENCE EN SANTÉ ET EN SERVICES SOCIAUX (QUÉBEC'S NATIONAL INSTITUTE OF EXCELLENCE IN HEALTH AND SOCIAL SERVICES)

Created in 2011, the *Institut national d’excellence en santé et en services sociaux* (*INESSS*; Québec’s national institute of excellence in health and social services) aims to “promote clinical excellence and the efficient use of resources in the health and social services sector” (*Institut national d’excellence en santé et en services sociaux*, n.d.-a). Some of the institute’s primary functions include assessing the clinical and cost advantages of technologies, medications and interventions through cost-benefit analyses, preparing public reports on clinical guidelines, and providing recommendations to the *MSSS* on required updates to the list of interventions and therapies listed in the *Act respecting prescription drug insurance,* the *Act respecting health services and social services*, and the *Act respecting health services and social services for Cree Native persons* (Act respecting Institut national d’excellence en santé et en services sociaux, 2010). The *INESSS* also hosts a variety of clinical excellence committees focused on chronic disease screening, health services, and social services (including youth and families, mental health, addictions, and homelessness) that overlap with work in public health led by other government bodies (Institut national d’excellence en santé et en services sociaux, n.d.-b).

2.1.5 HEALTH AND WELFARE COMMISSIONER

The Health and Welfare Commissioner (HWC; in French: *Commissaire à la santé et au bien-être*) is responsible for monitoring the performance Québec's health and social services system (Commissaire à la santé et au bien-être, n.d.; Act respecting the Health and Welfare Commissioner, 2005). According to a key informant, the HWC adopts a reflexive approach in its monitoring and evaluations of the health system with a strong concern for equity, rather than a normative one, focused on control. The HWC actively informs citizens and the *MSSS* of its results. For example, it "submits advisory opinions to the *MSSS* on the state of the health and welfare of the population in light particularly of retrospective analysis of the impact of government policy" (Act respecting the Health and Welfare Commissioner, 2005, s. 14). The results produced by the HWC are also disseminated more broadly through public reports.

Recent work led by the HWC includes publications on the use of emergency mental and physical health services and the perceptions of health care quality among the elderly in Québec (Health and Welfare Commissioner, n.d.). The HWC was abolished in 2016 but then reestablished in 2019. Its current mandate is to examine the impact of the COVID-19 pandemic on Québec's health system. The HWC is appointed for a term of five years in accordance with the dispositions set out in section 7 of the *Act respecting the Health and Welfare Commissioner.*

2.1.6 OTHER MINISTRIES WITH PUBLIC HEALTH RESPONSIBILITIES

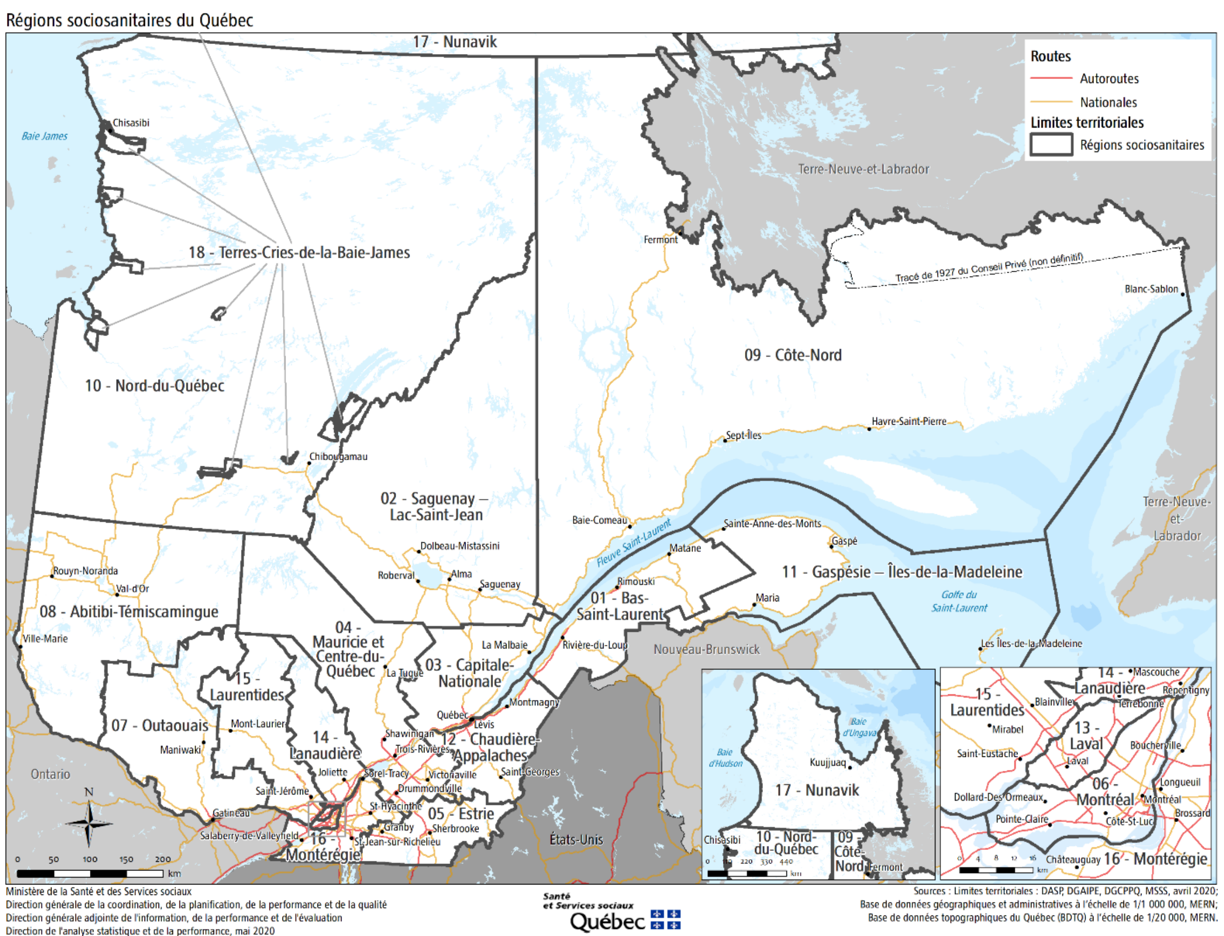
Public health is a shared responsibility among various ministries. Although the MSSS retains the primary responsibilities related to governance, planning objectives and resource allocation decisions, other ministries such as the ministère de l'Environnement et de la Lutte contre les changements climatiques (MELCC; ministry of the environment and the fight against climate change), the ministère de l'Agriculture, des Pêcheries et de l'Alimentation du Québec (MAPAQ; ministry of agriculture, fisheries and food) and the ministère du Travail, de l'Emploi et de la solidarité sociale (MTESS; ministry of labour, employment and social solidarity) have public health responsibilities related to occupational health and safety, as well as food hygiene and sanitation. For example, part of the MAPAQ's mission is to conduct surveillance activities to protect public health (Ministère de l'Agriculture, des Pêcheries et de l'Alimentation du Québec, 2019). It ensures compliance with the laws and regulations on matters related to food quality and hygiene. Establishments involved in the production, processing, distribution and retailing of food as well as restaurant services must abide by the Food Products Act (Food Products Act, 1981). The MELCC seeks to contribute to sustainable development in Québec by providing leadership on how to address climate change and support environmental protection and conservation (Ministère de l'Environnement et de la Lutte contre les changements climatiques, 2019). It has legislative responsibility for environmental health regulations related to municipal wastewater treatment as well as drinking and pool water sanitation (Ministère de l'Environnement et de la Lutte contre les changements climatiques, 2020). Lastly, the MTESS, along with the Commission des normes, de l'équité, de la santé et de la sécurité au travail (CNESST; Québec's commission on labour standards, equity and occupational health and safety), has public health responsibilities related to occupational health. The CNESST's responsibilities for overseeing complaint procedures and taking action to remedy health-related problems in the workplace are outlined in the Act Respecting Occupational Health and Safety (S-2.1 - Act Respecting Occupational Health and Safety, 1980). In addition, the CNESST allocates funds to occupational health interventions and to public health teams in the Réseau de santé publique en santé au travail (RSPSAT; Québec's public health network for occupational health) (Réseau de santé publique en santé au travail, n.d.-a, -b). The RSPSAT works with numerous partners (e.g., MSSS, INSPQ) and complies with legal frameworks to protect workers' health. In addition to supporting workers, the RSPSAT helps employers establish safe workplaces (Réseau de santé publique en santé au travail, n.d.-b).

2.2 Regional

2.2.1 Directions régionales de santé publique (Regional public health departments)

The *directions régionales de santé publique* (*DRSP*s; regional public health departments) are responsible for regional public health priority planning and resource coordination in the province's 18 *régions sociosanitaires* (*RSS*; health and social services regions) (Figure 2). Each one is administratively tied to one of the 22 health establishments, more specifically a *CISSS* or a *CIUSSS*. In three health regions where there is more than one *CISSS/CIUSSS*, the *DRSP* is administratively housed in one *CISSS/CIUSSS*, but its legal public health mandate is for the entire health region. It therefore coordinates public health programs for more than one *CISSS/CIUSSS* (Poirier et al., 2019). This is the case for Montréal (*RSS* 06), Montérégie (*RSS* 16) and Gaspésie-Île-de-la-Madeleine (*RSS* 11).

Figure 2. Québec's health and social services regions in 2018



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The *DRSP*s manage different types of interventions: indirect services to the population, such as mobilization programs, support or collaboration services, and direct public health services, such as the management and mitigation of risks to population health, clinical prevention and health promotion

programs (Litvak et al., 2020). Responsibility for delivery of public health services largely rests with each *DRSP*'s *CISSS/CIUSSS* (Loi modifiant l'organisation et la gouvernance du réseau de la santé et des services sociaux notamment par l'abolition des agences régionales, 2015; Québec, 1991). Local teams may be accountable to the *DRSP* or to other departments with a mandate in public health (e.g., *Directions jeunesse* [youth directorates], *Directions de cancérologie* [cancer directorates], *Directions des services généraux* [general services directorates]) (Poirier et al., 2019). The *MSSS* allocates funds to *CISSSs/CIUSSSs*; funds allocated to public health are placed under the fiscal and planning purview of the *DRSP*. The *DRSP* allocates resources according to the *PNSP*, the *Public Health Act,* the *Act respecting health services and social services*, the *Act respecting occupational health and safety* and the regional needs outlined in the *Plan d'action regional/Plan d'action régional intégré* (*PAR/PARI*; regional action plan/integrated regional action plan) (Direction de santé publique de la Montérégie, 2016; Santé Montréal, 2016). Professionals working in DRSPs interact with partners at various levels, such as municipalities, community organizations, clinical sectors, education and labour, higher education, research and various provincial ministries (Public Health Physicians of Canada Resident Council, 2019).

2.2.2 Directeur régional de santé publique (regional public health director)

Each *DRSP* is led by a *directeur régional de santé publique* (regional director of public health). As outlined in the *Act respecting health services and social services* (AHSSS, s. 372), the regional director must be a physician trained in community health or have five years of experience in the practice of community health. Regional directors are appointed by the *MSSS* on the recommendation of the *DNSP*, and their tenure is for a maximum of four years, but it can be renewed.

The regional director must inform the *DNSP* of any and all public health emergencies in their region (AHSSS, 1991, s. 375). The *DNSP* has the power to request regional updates from the regional director (AHSSS, 1991, s. 371.0.1). Since 2017, according to the *AHSSS,* the regional director acts as the director of professional services for physicians and dentists of the clinical department of public health in each region (AHSSS, s. 192.0.1). Some regional directors are also the head of their region's clinical department of public health; in this role, they oversee hiring and define the mandates of public health physicians and dentists for their region (Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies, 2015; AHSSS, 1991). According to the *AHSSS* and the *Public Health Act*, regional directors have distinct powers and responsibilities vis-à-vis *CISSSs* and *CIUSSSs*, to which they are administratively accountable, in addition to being appointed by the *MSSS*. Their status in the *CISSS/CIUSSS* is therefore different from that of other directors, as they have a "double accountability": they are legally accountable to the *MSSS*, but they are also accountable to the executive director of the *CISSS/CIUSSS* (Public Health Physicians of Canada Resident Council, 2019; AHSS, 1991, s. 4.2).

2.2.3 Centres intégrés de santé et de services sociaux (integrated health and social services centres)/Centres intégrés universitaires de santé et de services sociaux (integrated university health and social services centres)

In 2015, Québec's three-tier health system was reduced to a two-tier system with provincial and territorial levels (Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies, 2015). Health and social services within Québec's 18 *régions sociosanitaires* (i.e., *RSS*s; health and social service regions) are planned, funded, coordinated, and delivered by one or more (i.e., depending on geographic and population size) *centres intégrés de santé et de services sociaux* (*CISSSs*; integrated health and social services centres) or, if affiliated with a university, by a *centre intégré universitaire de santé et de services sociaux* (*CIUSSS*; integrated university health and social services centre) (Act to modify the

organization and governance of the health and social services network, in particular by abolishing the regional agencies, 2015; Public Health Physicians of Canada Resident Council, 2019). Each *CISSS/CIUSSS* is led by an executive director appointed by the Council of Ministers on the recommendation of the *MSSS*. There are 22 *CISSSs/CIUSSSs* in the 18 health regions. In three health regions where there is more than one *CISSS/CIUSSS*, the *DRSP* is administratively tied to one of the *CISSSs/CIUSSSs* but retains responsibility for coordinating public health activities across the entire region.

The Nunavik Regional Board of Health and Social Services (NRBHSS) and the Cree Board of Health and Social Services of James Bay (CBHSSJB) have administrative authority for health and social service delivery within the Nunavik and James Bay Cree Territory administrative regions (Cree Board of Health and Social Services of James Bay, n.d.; Nunavik Regional Board of Health and Social Services, n.d.). Their mandates are defined under the *Act respecting health services and social services* (Act respecting health services and social services, 1991; Nunavik Regional Board of Health and Social Services, 1995) and the *Act respecting health services and social services for Cree Native persons* (1991) (Nunavik Regional Board of Health and Social Services, n.d.).

There are also seven "non-amalgamated" institutions (which remained unmerged following the 2015 reform). They have administrative responsibility for the provision of healthcare in Québec; however, these are largely university-affiliated hospital organizations (Collège des médecins du Québec, 2020). Each institution (i.e., *CISSS/CIUSSS*, NRBHSS, CBHSSJB, and non-amalgamated institutions) determines its own organizational structure, but all have a board of directors that oversees an executive director or president and chief executive officer (CEO). The board of directors of each institution is responsible for organizing "the institution's services in keeping with province-wide orientations," "adopting a strategic plan," and "approving a management and accountability agreement with the *MSSS*," among other tasks (Collège des médecins du Québec, 2020).

2.3 Local

Since 2015, local health services have been amalgamated into the *CISSSs* and *CIUSSSs*. Within each *CISSS/CIUSSS*, direct public health services (i.e., vaccination campaigns) are delivered through primary care clinics, such as the *centres locaux de services communautaires* (*CLSCs*; local community service centres) but also through the coordination efforts of the *DRSP* (e.g., call schedules for public health, public health investigations in the case of an infection outbreak, occupational health and safety interventions) (Litvak et al., 2020; Ministère de la Santé et des Services sociaux, 2018c).

2.4 Sharing of public health responsibilities among the *MSSS*, the *INSPQ* and the *CISSSs/CIUSSSs*

Since 2015, shared responsibility for public health is described in the *Plans d'action thématiques tripartites* (*PATTs*; tripartite thematic action plans). These responsibilities are referred to as "tripartite" to indicate that public health responsibilities are shared by the *MSSS*, the *INSPQ* and the *CISSSs/CIUSSSs*. For example, in the case of outbreaks of sexually transmitted infections (STIs), the *MSSS* is responsible for providing the population with updates on population health trends; the *INSPQ* provides scientific knowledge to the *MSSS* and the *CISSSs/CIUSSSs* on the risks of STIs; and the *CISSSs/CIUSSSs* ensure that STIs are detected and materials for reducing harm and preventing the spread of infection are distributed (e.g., condoms, material for safe injections and inhalation) (Ministère de la Santé et des Services sociaux, 2016b).

Within the *CISSSs/CIUSSSs*, the *DRSP*s have the legal mandate to coordinate public health interventions across the entire territory of a *CISSS/CIUSSS*. Direct public health interventions, such as vaccination campaigns for infants, are primarily delivered locally by primary care providers (physicians, nurses) practising at a *CLSC* (Public Health Physicians of Canada Resident Council, 2019). This mandate for direct public health interventions also applies to the NRBHSS and the CBHSSJB. Other examples include STI detection services, vaccination campaigns, and health promotion efforts such as smoking cessation campaigns. As indicated in the *PATT*, it is important to note that cancer screening programs are carried out in collaboration with the *Direction générale de cancérologie* (cancer division) of the *MSSS*. According to our key informants, the majority of the costs related to cancer screening are not part of the public health budget

2.5 Integration, Intersectoral Coordination and Inter-jurisdictional Partnership

Integrated health services provide users with seamless and easy navigation through the health system as well as coordination of service delivery (e.g., programs, services, information), governance (e.g., policies, stewardship), and financial arrangements (e.g., funding models and agreements) between providers and formal and informal partners (World Health Organization, 2008, 2018). Our search identified several programs and services that may constitute integration and intersectoral coordination within and beyond health sectors, as well as inter-jurisdictional partnerships designed to support public health systems in indigenous communities.

2.5.1 Inter-jurisdictional Partnerships for Indigenous Peoples

The federal government is responsible for funding and/or providing public health services to First Nations and Inuit communities in Québec through the First Nations and Inuit Health Branch (FNIHB) of Indigenous Services Canada. It has also delegated authority and transferred funding to select regional health authorities (such as the NRBHSS and the CBHSSJB) (Government of Canada, n.d.). The Common Surveillance Plan of Health Status and its Determinants among First Nations of Québec, operated by the First Nations of Quebec and Labrador Health and Social Services Commission, is responsible for monitoring and surveying Québec First Nations communities and activities related to planning, evaluations and interventions (First Nations of Quebec and Labrador Health and Social Services Commission, 2019; Commission de la santé et des services sociaux des Premières Nations du Québec et du Labrador, n.d.). The Quebec First Nations Regional Portal of Health and Wellness Indicators (PRISM) and its information system are used to measure and monitor population health and wellness among Indigenous communities across nine domains (First Nations of Quebec and Labrador Health and Social Services Commission, 2016; Disant, 2020).

2.5.2 Plan d'action régional/Plan d'action régional intégré (Regional action plan/Integrated-regional public health action plan)

Regional public health departments develop and coordinate resources to apply the *Plan d'action régional/Plan d'action régional intégré* (*PAR/PARI*; regional action plan/integrated regional action plan), which is aligned with the objectives of the *PNSP* and regional needs. Where there is more than one *CISSS/CIUSSS* on the territory of a *DRSP*, a *PARI* is developed (Public Health Act, 2001). For example, Montréal's public health department has a *PARI* detailing 30 priority areas affecting public health, and its work is coordinated with the various *CIUSSS*s on the island (CIUSSS du Centre-Sud-de-l'Île-de-Montréal, 2017). These priority areas address child and adolescent development, the promotion of healthy lifestyles and environments, the control of infectious diseases, and risk management and emergency preparedness (CIUSSS du Centre-Sud-de-l'Île-de-Montréal, 2017).

2.5.3 TABLES DE CONCERTATION NATIONALE (NATIONAL CONSULTATION COMMITTEES/ROUNDTABLES)

The *Tables de concertation nationale* (*TCNs*; national consultation committees/roundtables) coordinate public health efforts between regional (*DRSP*s), ministerial (*DGSP*) actors, and the *INSPQ* in order to achieve the objectives outlined in the *PNSP* (Blackburn & Soucy, 2018; Ministère de la Santé et des Services sociaux, 2016c). Under the leadership of the public health *TCN*, five *TCNs* on various topics represent efforts related to: (1) surveillance, (2) infectious diseases, (3) environmental health, (4) occupational health, and (5) health promotion and disease prevention. The *TCNs* are expected to evolve and adapt in response to the new *PNSP* structure and objectives (renewed every 10 years) while maintaining coordination between actors. The *TCNs* are also expected to account for the broader context and populations as well as local needs and realities when applying the *PNSP* (Ministère de la Santé et des Services sociaux, 2016c).

2.5.4 POLITIQUE GOUVERNEMENTALE DE PRÉVENTION EN SANTÉ AND ITS PLAN D'ACTION INTERMINISTÉRIEL 2017-2021 (2017-2021 INTER-MINISTERIAL ACTION PLAN FOR THE GOVERNMENT POLICY OF PREVENTION IN HEALTH)

In 2016, Québec's former Minister for Rehabilitation, Youth Protection, Public Health and Healthy Living launched, in collaboration with other ministries, the *Politique gouvernementale de prévention en santé* (*PGPS*; government policy of prevention in health) (Ministère de la Santé et des Services sociaux, 2018b). The objective of this new policy was to promote population health and wellbeing by strengthening the existing efforts of actors working in public health, health promotion and prevention, and by reinforcing cross-sectoral collaborations. The *PGPS* laid out four interrelated orientations: (1) developing the capabilities of young people from an early age, (2) developing healthy and safe communities and territories, (3) improving living conditions to promote health, and (4) strengthening prevention in health and social services. The *PGPS* adopts a "Health in All Policies" perspective and specifies that reducing health problems and achieving health promotion goals will only be possible through action on the social determinants of health.

In 2018, the *MSSS* and the Government of Québec published the *Plan d'action interministériel 2017-2021 de la Politique gouvernementale de prévention en santé* (2017-2021 inter-ministerial action plan for the government policy of prevention in health). The *Plan d'action interministériel* (*PAI*) represented a planning and structuring mechanism for applying the *PGPS* and realizing its four objectives. The PAI involved the collaboration of decision-makers and professionals from various ministries and government organizations. According to a key informant, the *INSPQ*, academic experts and university institutes also played an important scientific support role during its development. For each orientation under the *PGPS*, the *PAI* set out some specific complementary actions, outlining the roles and responsibilities of various public health actors, timelines and funds allocated. It also included some evaluation, follow-up and accountability mechanisms. For example, under the second orientation ("promoting healthy and safe communities"), section 2.6 describes the objective of supporting municipal governments as they develop environments favourable to population health promotion. This section aims to provide support for the analysis of the potential health effects of municipal territorial planning and development through health impact assessments. The *PAI* also identifies the distinct roles played by various actors in section 2.6, such as the *MSSS* serving as the primary authority, the *Ministère des Affaires municipales et de l'Occupation du territoire* (Québec's department of municipal affairs and land use) serving as the primary collaborator, as well as the roles of the *INSPQ*, the *Réseau québécois des Villes et Villages en santé* (Québec network of healthy cities and villages), and the *DRSP*, to name a few of the organizations involved as key partners. In total, $2.3 million was allocated to this section. Overall, the *PAI* represented an investment of $80 million total over four years ($20 million per year) for the realization of the *PGSP* objectives.

3 Governance

Public health system governance consists of the legal, regulatory and policy frameworks (e.g., public health legislation, regulations, standards, guiding policies) that define the roles and responsibilities of the key actors and the strategic vision, mission and goals directing the public health system (World Health Organization, 2015). Performance measurement and evaluation of public health activities are fundamental to assessing whether systems produce the intended outcomes and facilitate the continuous improvement of programs and services (World Health Organization, 2015).

3.1 Legal and Policy Framework for Public Health

3.1.1 PUBLIC HEALTH ACT (2001)

The *Public Health Act* (PHA) is the primary law governing public health in Québec (Bernier, 2006). It outlines the duties of ministerial officials and regional public health authorities, and mandates the *MSSS* to conduct public health surveillance, prevention and promotion interventions (Public Health Act, 2001). It defines the province's core public health functions and interventions, and specifies the roles played by ministerial officials and regional public health departments (Public Health Act, 2001). It grants the provincial government authority to declare public health emergencies, allowing the government to restrict the movement of people in Québec, close schools and other institutions, require the disclosure of personal information, and require that Québec residents be vaccinated (Block et al., 2020). The PHA also outlines the responsibilities of provincial and regional actors (e.g., regional public health directors) in terms of planning public health services. Finally, the PHA empowers the *MSSS* to undertake intersectoral action to support public policy development that is favorable to population health as stipulated under section 54 of the PHA (Bernier, 2006). The PHA does not state that responsibilities regarding water and food quality are conferred on the *MSSS*; rather these responsibilities are delegated to the *MAPAQ* and the *MELCC*.

3.1.2 SECTION 54 OF THE PUBLIC HEALTH ACT

Section 54 of the *Public Health Act* (PHA) represents a unique mechanism that facilitates health impact assessments (HIA) for the purpose of developing healthy public policies and legislation within and beyond the health sector. Under section 54, all ministries and agencies are required to consult the *MSSS* when formulating laws or regulations that could have a significant impact on population health. Bills proposed by other ministries and government organizations can be subject to an HIA, undertaken by the ministry or organization proposing the bill, with the support of the *MSSS* in partnership with the *INSPQ* (Ministère de la Santé et des Services sociaux, 2006). HIAs, through section 54, guarantee knowledge transfer and the development of policies that allow for intersectoral collaborations between public health actors and other sectors, such as agriculture and food production, labour, environment and transportation (St-Pierre et al., 2014; St-Pierre & Mendell, 2011).

3.1.3 OTHER LAWS REGULATING PUBLIC HEALTH IN QUÉBEC

In addition to the laws listed above that describe the roles and responsibilities of various public health actors (i.e., the PHA), there are numerous other laws in Québec regulating public health, either directly or indirectly, such as the *Tobacco Control Act* (2015), the *Act to amend the Pharmacy Act* (2011), the *Medical Act* (1973), the *Professional Code* (1973), the *Medical Act: Regulation respecting certain professional activities that may be engaged in by dietitians* (2018), the *Medical Act: Regulation respecting certain professional activities that may be engaged in by a nurse* (2015), and the *Medical Act: Regulation respecting certain professional activities that may be engaged in by respiratory therapists* (2005).

3.1.4 PROGRAMME NATIONAL DE SANTÉ PUBLIQUE (NATIONAL PUBLIC HEALTH PROGRAM)

The *Programme national de santé publique 2015-2025* (*PNSP*; Québec's 2015-2025 national public health program) is a 10-year public health framework developed by the *MSSS* and its collaborators. The program is focused on fulfilling essential public health functions related to "surveillance, promotion, prevention, and protection of population health" (Gouvernement du Québec, 2015). The *PNSP* is based on five pillars: one transversal pillar relating to continuous monitoring of the health status of the population and its determinants, and four thematic pillars: 1) the overall development of children and youth, 2) the adoption of healthy and safe lifestyles and environments, 3) prevention of infectious diseases, and 4) health risks and threats management, and emergency preparedness (Gouvernement du Québec, 2015).

3.2 Performance and Evaluation

A formal Québec public health performance system or framework was not identified in the public documents we consulted. However, certain public health organizations such as the HWC have specific performance and evaluation mandates. In addition, we note that the *INSPQ* is regularly called upon for scientific support in evaluations of the performance of specific aspects of the public health system. For example, one report from the *INSPQ* analyzed the effects of the *Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies* (2015) on the implementation of the *PNSP* (Poirier et al., 2019). Other examples of evaluations can be found on the INSPQ's website (Institut national de santé publique du Québec, n.d.).

The *PGPS* is to be monitored by the *Cadre de suivi et d'évaluation préliminaire* (CSEP; preliminary monitoring and evaluation framework) in collaboration with participating ministries and government agencies and the evaluation department of the *MSSS*. The evaluation will examine the achievement of objectives and intersectoral governance (Gouvernement du Québec, 2019). The *PGPS* seeks to achieve the following objectives by 2025:

1. "Increase to 80% the proportion of children who start school without developmental vulnerabilities;
2. Ensure that 90% of municipalities with a population of 1,000 or more adopt measures to develop communities that support safety, sustainable mobility, healthy lifestyles and the quality of life of their residents;
3. Increase the supply of affordable, social and community housing by 49%;
4. Decrease the proportion of daily and occasional smokers to 10%;
5. Achieve a high level of emotional and psychosocial well-being in at least 80% of the population;
6. Increase the number of seniors receiving home support services by 18%;
7. Achieve a minimum consumption of five fruits and vegetables each day, in more than half of the population;
8. Increase by 20% the proportion of young people aged 12 to 17 who engage in active recreation and travel; and
9. Reduce by 10% the gap in premature mortality between the most disadvantaged and the most advantaged in terms of socioeconomic status" (Ministère de la Santé et des Services sociaux, 2018b, p.4).

4 Financing

Financing represents an essential public health operation according to the WHO. Financing refers to the "mobilization, accumulation and allocation of resources to cover population health needs, individually and collectively" (World Health Organization, 2015). Our search sought publicly available data from provincial budget reports. Where public health expenditures were not specified, we turned to audited financial statements of key public health actors receiving provincial health funding (e.g., provincial and regional health authorities).

4.1 Public Health Spending

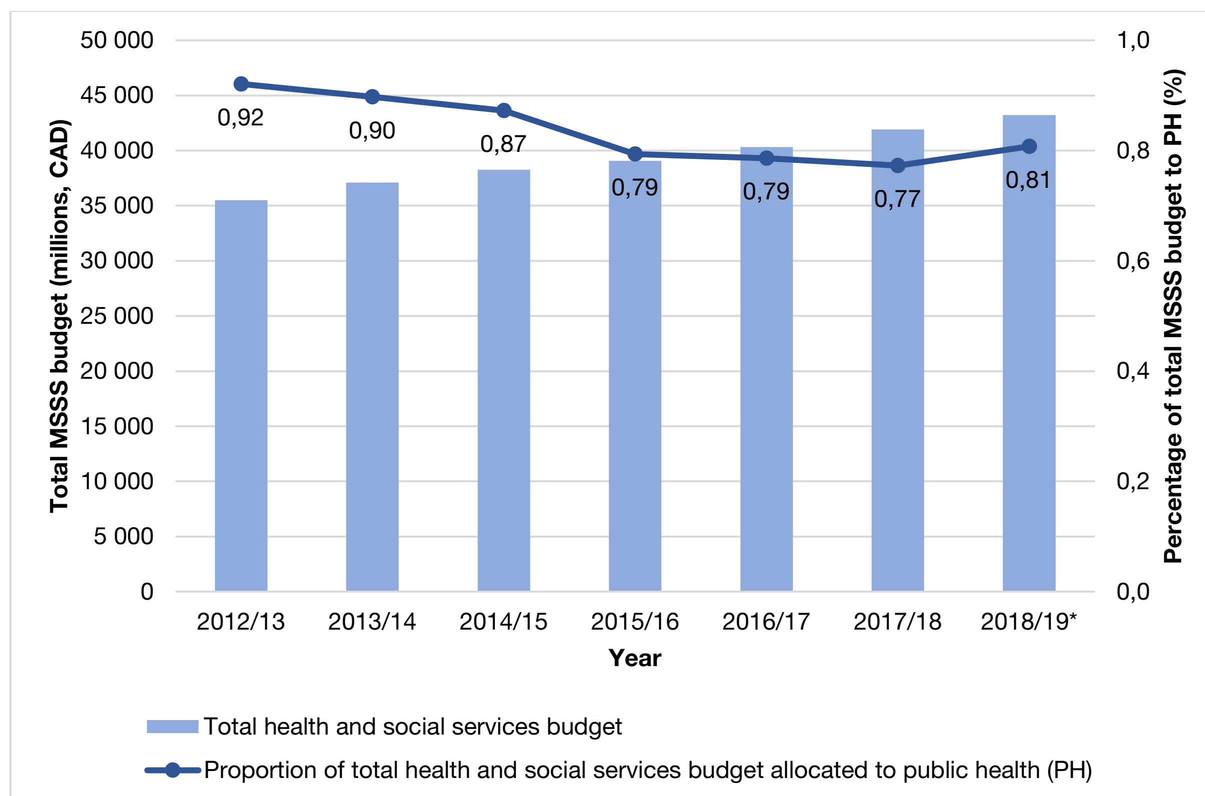
In the 2018-2019 fiscal year, the total *MSSS* budget was $43.2 billion, of which $349.0 million was allocated to public health (0.8% of the total *MSSS* budget) (Ministère de la Santé et des Services sociaux, 2020c). Figure 3 shows public health spending as a share of the total *MSSS* budget from 2012-2013 to 2018-2019 (seven fiscal years). Over time, the share of the total *MSSS* budget allocated to public health has decreased, with the largest drop in 2015-2016. This sharp decrease reflects the reorganization of Québec's health system in 2015 (Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies, 2015), which reduced the number of health establishments and removed an administrative layer, moving from a three-tiered to a two-tiered system (Quesnel-Vallée & Carter, 2018). The latter change required merging local public health agencies (departments) into a lower administrative layer of the newly created *CISSS* and *CIUSS*, and this was followed by major cuts to public health spending (Guyon & Perreault, 2016). According to a recent analysis, in 2015-2016 public health spending was cut by $23.5 million, representing a 7.1% change from the previous fiscal year (Fiset-Laniel et al., 2020). This $23.5 million reduction in spending translated into spending cuts of about 30% in the *DRSP*s (Poirier et al., 2019).

Funds allocated to public health are most clearly delineated within the context of the *MSSS*'s service and support program accounting structure. Service programs are groups of services delivered by health care and social service professionals to address the service needs of the entire population (i.e., general services) as well as the unique needs of population sub-groups (i.e., specific services) (Fiset-Laniel et al., 2020; Ministère de la Santé et des Services sociaux, 2004). Support programs are activities related to administrative (e.g., organizational management) and technical (e.g., IT, equipment maintenance) support for the management of service programs (Fiset-Laniel et al., 2020; Ministère de la Santé et des Services sociaux, 2004). The *MSSS* allocates funds to nine service programs and three support programs (Fiset-Laniel et al., 2020; Ministère de la Santé et des Services sociaux, 2004). Public health services provided within a *CISSS*/*CIUSSS* and as part of the *PNSP*, the *PATT*s and the *PAR*/*PARI* are financed by the public health service program (Fiset-Laniel et al., 2020; Ministère de la Santé et des Services sociaux, 2004). In fiscal year 2018-2019, the total *MSSS* budget allocated to service and support programs was $24.3 billion (56% of the total *MSSS* budget). This was much larger than the *MSSS* funds allocated to the *Régie de l'assurance maladie du Québec* (*RAMQ*; Québec's health insurance agency), which funds physicians and the public pharmaceuticals program. In 2018-2019, the RAMQ budget was $12.5 billion; about 64% of the funds ($7.8 billion dollars) were spent on physicians and 29% of the funds ($3.5 billion dollars) were directed to pharmaceuticals (Régie de l'assurance maladie du Québec, n.d.).

Figure 3 shows the service and support programs budget allocated to public health and other programs. For the fiscal year 2018-2019, public health expenditures represented 1.4% of the total service and support programs budget ($24.3 billion) (Ministère de la Santé et des Services sociaux, 2020c). This was one of the smallest allocations of all the service and support programs. For

purposes of comparison, physical health (37.1%, $9 billion) and support to seniors (16.3%, $4 billion) received the largest shares of the total service and support programs budget.

Figure 3. Public Health Spending, *MSSS*, fiscal years 2011-2012 to 2018-2019 (in millions of $CAD)



Notes: Actual expenditure data from sections 1.2 and 2.6 of the *MSSS* health accounts reports (McCann, 2019; Ministère de la Santé et des Services sociaux, 2015a, 2016a, 2017, 2018a, 2020a). Expenditures have not been adjusted for inflation; *expected spending.

Each health region receives funds for service and support programs that mirror the accounting structure presented in Table 1. However, there are regional differences in the allocation of the total service and support budget to the public health program, as highlighted in Table 2. For example, a higher proportion of total service and support programs spending is allocated to public health in Nord-du-Québec (10) and Nunavik (17) (4.4% and 4.6%, respectively), compared to other regions such as Montreal (06) and Quebec City (03) (1.1% and 1.2%, respectively). These shares do not reflect absolute amounts of allocations nor per capita spending, simply regional budget allocations (Ministère de la Santé et des Services sociaux, 2020d). Since 2013 (the earliest year that financial reports were published by region), the largest increases in public health service program expenditures relative to total service program spending were in the Nunavik (225.1%) and James Bay Cree Territory (45.4%) regions, while the largest decreases in the shares of public health spending were observed in the Montérégie (-15.2%)[2] and Gaspésie—Îles-de-la-Madeleine (-13.2%) regions (data not shown).

[2] This reduction may be attributable to the 2015 health system reform. Among other changes, the reform included a reorganization of the Montérégie region, which reduced its subregions from 13 to 11. The two regions that were removed are now part of the Estrie region.

Table 1. Expenditures on *MSSS* support and service programs, fiscal year ending March 31, 2019 (in millions of CAD)

	Program expenditures ($)	Share of the total (%)
Service programs		
Physical health	9,012.7	37.1
Support for seniors	3,965.9	16.3
Mental health	1,444.4	5.9
Youth in difficulty	1,408.3	5.8
Developmental disorders and ASD	1,100.4	4.5
General services	1,008.1	4.1
Physical disabilities	711.2	2.9
Public health	349.8	1.4
Addictions	134.9	0.6
Support programs		
Building management	1,854.6	7.6
Service support	1,763.6	7.3
Administration	1,561.6	6.4
Total support and services	24,315.8	100.0
Total *MSSS*	**43,200.0**	

Note: This table is adapted from the annual reports of the MSSS (AS-471); estimates are submitted to the MSSS by the CISSS/CIUSSS (Ministère de la Santé et des Services sociaux, 2020e).

Table 2. Public health service program expenditures by health region, 2018/19 (in millions of CAD)

Health regions	2018/19		
	Total expenditures by *DRSP* ($)	Public health program expenditures ($)	Share of total expenditures (%)
01 Bas-Saint-Laurent	662.1	9.8	1.5
02 Saguenay--Lac-Saint-Jean	866.6	14.5	1.7
03 Capitale-Nationale	2,619.0	30.3	1.2
04 Mauricie et Centre-du-Québec	1,435.5	24.3	1.7
05 Estrie	1,365.8	20.2	1.5
06 Montréal	7,921.3	84.0	1.1
07 Outaouais	854.2	16.0	1.9
08 Abitibi-Témiscamingue	481.8	9.5	2.0
09 Côte-Nord	353.5	8.2	2.3
10 Nord-du-Québec	62.8	2.8	4.4
11 Gaspésie--Îles-de-la-Madeleine	353.5	7.4	2.1
12 Chaudière-Appalaches	1,005.3	15.9	1.6
13 Laval	897.5	13.2	1.5
14 Lanaudière	946.6	18.4	1.9
15 Laurentides	1,158.7	18.7	1.6
16 Montérégie	2,790.9	41.8	1.5
17 Nunavik	283.3	12.9	4.6
18 Terres-Cries-de-la-Baie-James	257.5	2.1	0.8
TOTAL	**24,315.8**	**349.8**	**1.4**

Notes: This table is adapted from the annual reports of the MSSS (AS-471); estimates are submitted to the MSSS by the CISSS/CIUSSS (Ministère de la Santé et des Services sociaux, 2020d).

MSSS allocations to service and support programs have traditionally been based on historical budgets (Ministère de la Santé et des Services sociaux, 2004). The *MSSS* previously intended to integrate population health, sociodemographic, and service need characteristics into resource allocation decisions (Direction des communications du ministère de la Santé et des Services sociaux, 2003; Ministère de la Santé et des Services sociaux, 2004). More recently, the public health network in Québec has employed a formula to determine “normalized costs” to determine all expenses related to updating the *PNSP* by health region. This approach was adopted with the former 2003-2012 *PNSP* (Gouvernement du Québec, 2008). Financial reports from the *CISSSs/CIUSSSs* and the Boards of Health and Social Services for the Nunavik and James Bay Cree Territory regions indicate

that organizations delivering public health services and programs are largely funded through block grants from the *MSSS* (Cree Board of Health and Social Services of James Bay, 2018; Ministère de la Santé et des Services sociaux, 2019a, 2019b; Nunavik Regional Board of Health and Social Services, 2018).

It is important to note that the public health estimates described above do not capture all spending on public health. The service and support programs budget do not include funds allocated to the *DGSP*, the *INSPQ* and the *INESSS*, nor salaries and honorariums for the public health physicians and dentists paid by the *RAMQ*. In addition, it excludes debt servicing, financial activities toward retirement plans, as well as funds for community organizations funded through the *Programme de soutien aux organismes communautaires* (*PSOC*; the community organizations support program) (Fiset-Laniel et al., 2020; Ministère de la Santé et des Services Sociaux, 2020c). Financial reports from the *CISSSs/CIUSSSs* indicate that certain funds delivered to community organizations with public health missions may come from the public health service program. However, these funds are not for operations, which are funded by the *PSOC* (Centre intégré de santé et de service sociaux (CISSS) de Laval, 2020; Centre intégré universitaire de santé et de services sociaux (CIUSSS) du Centre-Sud-de-l'Île-de-Montréal, 2020).

An examination of the annual budget reports of public health organizations may provide some evidence of the public funds allocated to these organizations. As of March 31, 2019, *INSPQ* operating expenses totalled approximately $72.7 million (Institut national de santé publique du Québec, 2019b). Approximately 86.0% of these expenses ($62.5 million) were covered by unspecified grant revenue from the provincial government (Institut national de santé publique du Québec, 2019b). Additional revenue came from the sale of services ($9.4 million), the federal government ($2.0 million), and other sources ($1.7 million) (Institut national de santé publique du Québec, 2019b). An area for further analysis includes examining changes in the *INSPQ* budget before and since the 2015 provincial health and social system reform, as well as the degree to which *INESSS* and *RAMQ* expenditures can be classified as public health expenditures.

5 Public Health Workforce

The core public health workforce includes "all staff engaged in public health activities that identify public health as being the primary part of their role" (Rechel, Maresso, et al., 2018). This excludes professionals such as midwives, community pharmacists or family physicians who may promote public health, but only as part of their job. Our search sought information detailing the size and professional discipline composition, and recruitment and retention trends and strategies for the public health workforce in Québec.

5.1 Size, Composition, Recruitment and Retention

5.1.1 Public Health Workforce at the *DGSP* and the *INSPQ*

The number of employees from agencies such as the *DGSP* and the *INSPQ* are reported in the annual reports of these organizations (Ministère de la Santé et des Services sociaux, 2020f). For example, in 2019-2020, the *DGSP* had 110 employees and 5 public health physicians (Ministère de la Santé et des Services sociaux, 2020f). The *INSPQ* reported 685 employees (including laboratory staff) (Institut national de santé publique du Québec, 2020).

5.1.2 Public Health Workforce in the CISSSs/CIUSSSs

Detailed information was not found on the number and type of public health professionals working in the *CISSSs/CIUSSSs*. However, the number of hours worked by managers and non-management staff are reported in each *CISSS/CIUSSS* annual financial report (Ministère de la Santé et des Services sociaux, 2019a). By cross-referencing this data with the data presented in each organization's annual reports, it would thus possible to reach an approximate estimate of the proportion of the *CISSS/CIUSSS* workforce devoted to public health, and how many FTE employees support public health service planning and delivery at the local level.

Different compensation schemes are devised for each type of public health professional in a *CISSS/CIUSSS*. Public health nurses, dental hygienists, nutritionists, occupational therapists and social workers all have quasi-exclusive public health practises and are paid by salary. Unless they have a management role, public health physicians and dentists are generally autonomous workers who are remunerated by the *RAMQ* on a fee-for-service basis. They are accountable to the public health clinical department of the *CISSS/CIUSSS*.

5.1.3 Public Health Physicians

Among the regulated professions, Scott's Medical Database indicates that from 2010 to 2018, the number of public health and preventive medicine specialists working in Québec increased by approximately 6%, from 189 to 201 (Canadian Institute for Health Information, 2020). These physicians are officially deemed public health and preventive medicine specialists after a clinical residency of five years. This title is discerned on them by the Royal College of Physicians and Surgeons of Canada or by the *Collège des Médecins du Québec* (Québec's medical association). According to a key informant, other physicians work in the public health sector but are not deemed public health specialists; as such, they are not included in the Scott's Medical Database, nor are they indicated in the annual *Plans d'effectifs médicaux* (*PEM*; medical workforce plans).

In Québec, unlike other provinces, the region where a physician may practice is determined by the provincial government. Family physicians must be registered with a *Plan régional d'effectifs médicaux* (*PREM*; regional medical workforce plan), whereas specialists must be registered with a *PEM*. Registration guarantees a contract and payments from the *RAMQ* (Public Health Physicians of Canada Resident Council, 2019). Established in 1997, the *PREM* and the *PEM* determine the distribution of physicians in each specialty based on estimated health needs identified by the *MSSS* (based on population density and characteristics) of all the regions of Québec. A physician cannot apply to work in a region where all the *PREM* and *PEM* positions for their specialty are filled, the aim being to ensure a fair distribution of physicians across Québec's regions so that the population of each region has equitable access to care. For public health specialists, the *PEM* projected that a total of 200 specialists would be needed in 2022 (Ministère de la Santé et des Services sociaux, 2022).

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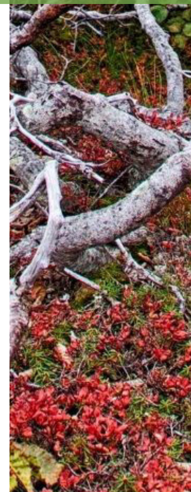

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