

Unpacking the Meaning of Quality in Quebec's Health-care System: The Input of Commissions of Inquiry

Oscar E. Firbank

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Abstract The paper explores how several commissions of inquiry established in Quebec, Canada, have, over time, contributed in redefining the meaning of quality in health-care and its management. Adopting an interpretive analysis of commissions' reports, the paper examines the particular 'conceptual boxes' used by their members to tackle quality and the embedded nature of their work. It is shown that although quality was always considered, this was generally done by bringing into focus specific quality domains and issues, some new, others not so new. In addition, the various management approaches to quality featured in the reports were informed by evolving templates; although this evolution was not as straight and unwavering as some retrospective studies of quality in health-care seem to indicate. A common thread to all commissions is the fact that, beyond the definition of general principles, responsibility for quality oversight was not clearly assigned and criteria on whether quality initiatives should be voluntary or compulsory were often left unspecified. Further, quality was never regarded by the commissions as a strategic aspect of health-care. It is speculated that these failings on the part of commissions may partly explain the unassertive course of action taken by the provincial government in the area.

Keywords Quality of health services · Health-care policy · Commissions of inquiry · Interpretive analysis · Quebec

O. E. Firbank (✉)

Groupe de recherche sur les aspects sociaux de la santé et de la prévention (GRASP), Université de Montréal, Succursale Centre-ville, P.O. Box 6128, Montreal, QC, Canada H3C 3J7
e-mail: firbanko@grasp.umontreal.ca

Introduction

‘Quality is in the eyes of the beholder’, suggests a commonplace statement found in the literature on health-care quality; a statement that rightly conveys the difficulty in formulating an all-encompassing definition, making quality a discernable concept. But much like beauty, beholder’s views of quality evolve, among other things, according to prevailing assumptions about ‘good and bad care’ embraced by a community of professionals, decision-makers and the population at large, and the saliency of health-care shortcomings at a given point in time. So does the attention a beholder (*viz.* decision-maker) may lay on specific causes for health-care quality or lack of quality, which in most jurisdictions has moved away from its initial emphasis on the acts of professionals to a broader focus on organizational structures, care processes and outcomes. The fact beholders’ opinions on what constitutes quality care are embedded in a particular, evolving context, also impacts on the provisions for how services are to be evaluated, problems monitored and changes implemented [35].

Not surprisingly, countries have adopted different approaches to quality oversight and improvement, which are rooted in different socio-political and institutional traditions, but also on developing conceptions of ‘what quality health-care is’ and how it should be best managed [6]. In the U.S., for example, the paradigm of consumerism and the debate surrounding malpractice have been central in shaping the quality movement in health-care [46]. Likewise, in the U.K., the logic of ‘managed competition’ and efforts geared at regulating the purchaser–provider split established the grounds for most of the quality initiatives adopted during the 1990s [30, 39]; whereas in France, the ethos of confidentiality, resistance from the medical lobby and, most recently, concerns about the efficiency of service provision seem to have been the main parameters underpinning debate and policy formulation in the area [11, 17].

In the case of Canada, things have evolved considerably since the early 1960s, when a Royal Commission headed by Justice Emmett M. Hall recommended the creation of a public health insurance plan, promoting ‘universal access to high quality’ care. The equivalent of this Commission in the province of Quebec, the Castonguay–Nepveu Commission (1969–1972), tackled quality in a more elaborate manner, although one of its main concerns remained the issues of ‘appropriate access’ to and rationalisation of services. Other commissions and task-forces set up in the course of the years helped in conceptualizing a particular vision of quality, governments in Quebec considered, altered or sought to actualize. In fact, the reports and recommendations such commissions elaborated, were reflective of a particular way of thinking about and handling of quality issues in health-care at a given moment, but also played an influential role in highlighting a set of assumptions about where quality flaws resided and what corrective strategies were to be adopted [43]. Overall, commissions have represented critical moments—albeit with uneven and sometimes delayed effects—in the long-term trajectory of the concept of quality in health-care and its handling.

This paper proposes an interpretive analysis of the ‘particular views’ held on health-care quality by successive public commissions of inquiry, established in

Quebec, Canada, just prior to and following the inception of Medicare in the province. By ‘particular views’ it is meant how these commissions conceptualized quality, what perspectives they adopted, and what management strategies, if any, they proposed to correct major systemic problems identified in health-care. The paper proceeds in six sections. The first two sections discuss alternately how health-care commissions of inquiry and the evolving context of quality management have been addressed in the literature. Following that, section “Health-Care Quality in a Changing Context” deals with the theoretical framework and methodology used for the study. Sections “An Interpretive Perspective on Commissions’ Reports” and “Quality in Health-care: A Tale of Three Stories” present the results from our investigation in a sequential as well as thematic fashion. The conclusion synthesizes findings and draws attention to the broadening spectrum of quality domains and management strategies featured in the commissions’ reports, while highlighting the variable, and at times unspecific manner in which the issue has been dealt with in the province, as informed by evolving quality templates.

Health-care Commissions as Manufacturers of Ideas

In Quebec, as elsewhere in Canada, health-care commissions of inquiry are appointed with relative ease, usually in connection to a government change in direction, political turbulence or widespread concerns about significant policy problems. Two types of commissions of inquiry can be distinguished according to how they are appointed and what their composition and mandate are. ‘Ministerial task-forces’ are appointed by provincial or federal health ministers (or sometimes a prime minister), and largely draw on ministerial staff and resources, whereas ‘Royal commissions’ are appointed by virtue of the federal or a provincial *Inquiries Act* and rely on out-of-government expertise [40]. Either type of commission is only advisory to government. In addition, commissions are ‘political instruments,’ and are set as much for explicit reasons—informing government—than implicit ones—i.e. ‘framing’ issues and seeking consensus among strategic stakeholders, legitimizing an official agenda, testing the waters about potential changes to be implemented, or for ‘dramaturgical symbolic purposes’ [15], including delaying action.

The degree of independence commissions enjoy is an important, yet questionable feature. Some authors contend that although commissions are relatively free in the way they interpret their mandate, consider facts and formulate recommendations, their independence “may be more aspirational than factual” [36], as a result of being too closely aligned with the government that creates them, or that beneath a veneer of rhetoric and symbols, they “often hide the interests that are being objectively served” [48]. Others, on the contrary, point to their “capacity to be, and to be seen to be, independent and objective” [1] or maintain that commissions “have the capacity to engage in discursive policy analysis by providing a forum for both expert and non-expert forms of knowledge in the policy process” [50]. Scholarly analysis has also emphasized the importance of Royal commissions as instruments for citizen involvement and stakeholder consultation [27, 4].

As regards Quebec, a number of studies have examined the functioning, recommendations and perceived impact of various health-care commissions of inquiry, generally in connection to a specific reform undertaking [48, 31, 33, 37], but at times from a comparative perspective as well [19, 14]. Although quality of care is occasionally addressed in these studies, the subject is not a central theme of the analysis. The work by Dubois and Denis [13] is perhaps the one that most closely approximates an interpretive analysis of commissions, yet it focuses on the issue of accountability alone.

Health-care Quality in a Changing Context

If we now turn to retrospective overviews of quality in health-care, Canadian research on this area is sparse, if not non-existent. Within the available literature, most studies have dealt with policy developments in a particular country, and only a few with cross-country comparisons. Differences on individual jurisdictions aside, an implicit perspective adopted in many studies views quality and its management as an evolving and adapting construct. Hence, in comparing developments in the USA and the UK, Ellis and Whittington [16] posit the existence of three discernible stages—which chronologically they identify as embryonic, emergent and mandatory—each stage associated to a particular approach to quality improvement, but also considered to be inherently more comprehensive and ‘advanced’ than the previous one. Likewise, Graham [22] suggests that the development of three models for organizing health care—namely professional, bureaucratic and industrial—translated into distinct definitions of quality and contributed in expanding the focus of quality activities, to include ‘more advanced’ techniques developed in industry, such as Quality Improvement or Total Quality Management. In the UK, Harvey [26], for his part, identifies successive models of quality evaluation according to their approach to and means of achieving quality: quality at an individual level, quality as an exercise in inspection, and quality as a method for continuous improvement. The initial model would correspond to the “embryonic stage,” as defined by Ellis and Whittington [16], whereas the “emergent” and “mandatory” phases should be associated with a more explicit and compulsory approach. Again, tracking developments in the UK up until the late 1990s, Donaldson [12] postulates that the quality agenda has evolved through a series of stages, making quality in health-care a more clearly defined and systematic objective. In a similar vein, reviewing quality trends in health care in Singapore, Lim [34] points to a long-term “paradigm shift, from a traditional focus on structural approaches to a broader multidimensional concept which includes the monitoring of clinical indicators and medical errors.” Finally, as regards Québec, Hadad et al. [24] argue that ever since the introduction of Medicare in the early 1970s, government would have adopted different—i.e. more advanced—perspectives on quality in accordance with the prevailing organisation or “model” of care delivery, the social representation of quality, and the particular health-care objectives that were pursued at a particular moment.

Some scholars, however, while acknowledging the changes in the way of tackling quality in health-care, caution that developments have not been as linear and uniform as it might seem. Buchan [6], for example, claims that quality systems often progress in an uneven manner: “Some parts of our health-care seem to have stayed in the niche that was established generations ago.” Further, she states, “we may find that variation between countries in values and concepts of quality is less important than the variation within systems that has evolved.”([6] at 566).

Overall, in spite of differences in the characterization of how the ‘quality movement’ has unfolded in various countries and the recognition of cultural and contextual dissimilarities, there is a degree of convergence among authors who tend to depict this movement as a progression, moving from a somewhat ‘primitive’ phase of quality management—grounded on an individualistic view of medical practice and the application of peer-review procedures—to a more ‘evolved’ phase—specially concerned with service processes and care outcomes, and a systems-wide approach to quality. Each phase, and the management strategies they entail, are usually presented as being informed by a particular understanding of quality in health-care. Implicitly, these studies tend to adopt a rational-choice view of policy, whereby the elaboration of a (new) quality agenda would reflect a higher understanding among (well informed) stakeholders of quality problems and the way to correct them.

An Interpretive Perspective on Commissions’ Reports

Our study is informed by an interpretive policy approach, as developed by Yanow [52]. Accordingly, we focus on the meaning attributed to a particular aspect of policy—the definition and management of quality in health-care—and on “actors’ practical reasoning in particular situations: What are their conceptual boxes?” as reflected on commissions reports [52].

Textual material forms the core of data used for the paper. A series of final reports and discussion papers produced or commissioned in the course of an inquiry were selected and thoroughly analyzed. Three commissions were chosen for the study given the breadth of their terms of reference and importance in shaping Quebec’s health-care system: The Castonguay-Nepveu [7], Rochon [49] and Clair [9] Commissions, spanning over 30 years [32, 2, 3]. During this period, smaller inquiries and reports dealing with a specific population or health condition, clinical issues or organizational matters also contributed in modelling the system and, at times, tackled quality issues, yet their influence is not deemed as significant.¹ All commissions resorted to extensive public consultations and received a large number of submissions; the analysis of this documentation, though pertinent, was beyond the scope of this research.

¹ The material produced by the three commissions was nevertheless considerable; the Castonguay-Nepveu Commission published a seven-volume final report (1,752 p) and twenty-one sponsored studies, the Rochon Commission released an extensive final report (803 p), supported by 45 commissioned studies, whereas the Clair Commission, of more modest proportions and shorter duration, issued a final report (454 p) and a separate volume featuring annexes (419 p).

Commission reports are viewed as the expression of a collective work, containing arguments, ideas and narratives that are the creation of such collectivity or “community of meaning” [47]. In addition, all related studies sponsored by a commission, are thought of as ‘generative documents,’ part of “the machine tools by which other documents are produced” [47]; although it is known for a fact that commissions rely on them in a pick-and-choose manner. Further, the commissions’ documents are considered as ‘situated products,’ heavily dependent on the political and social context in which they were manufactured; their content, therefore, is interpreted with reference to the particular circumstances underlying their production.

Four main themes concerning quality were identified for the purpose of documentary analysis: definitions, issues, domains, and management strategies. The ‘domains’ category, in particular, was segmented by relying on a taxonomy proposed by the Joint Commission on Accreditation of Health Care Organizations in the US, that is widely used in the field and identifies eight quality dimensions, namely: efficacy, appropriateness, availability, continuity, effectiveness, respect and caring, safety and timeliness [28]. Such taxonomy, however, was not applied as a normative frame of reference for what quality is, but rather as an heuristic device to designate aspects of health-care to be considered when reviewing the materials published by Commissions and circumvent the fact that, as we shall see, Commissions generally refer to quality in an implicit and indirect manner. The taxonomy also helped in organising the discussion while providing some uniformity to the analysis of reports.

Finally, in tackling the quality of health services we stayed away from proposing a generic definition of the concept and adopted a ‘pragmatic’ point of view or, as put by Harteloh [25], we considered that its meaning “can be found by studying [its] use on the debate on the quality of care;” that is, by considering how quality was dealt with by Commissions at particular points in time.

Quality in Health-care: A Tale of Three Stories

The setting up of the Castonguay-Nepveu Royal Commission undoubtedly marked a turning point in the history of Quebec’s health-care system; an event that served to establish the main parameters of the system as we know it today or, as put by Tuohy [51], that contributed in defining its “distinctive logic.” As such, the work accomplished by the Commission played a critical role in the subsequent direction of health-care change in the province, including the framing of quality.

The Castonguay-Nepveu Commission: Setting up a Unified System,
Consolidating State Stewardship and Assuring Universal Access to Care

The Commission’s creation was largely driven by Ottawa’s willingness to establish a uniform Medicare program across Canada, in the face of a Liberal provincial government that was ambiguous, if not reluctant, about endorsing such proposal.

This, and the considerable scope of its mandate—to inquire about the entire field of health *and* social welfare in the province—has led some observers to conclude that government’s primary objective in creating the Commission was ‘to drown the issue’ [48]. Whatever the case may be, the Commission and the set of ideas it generated, acted as a ‘facilitator’ between a public opinion, favourable to an expansion of public health insurance, and part of the medical establishment and sectors of government, that remained opposed to the idea; thus, operating a significant change in policy direction and legitimizing the need for reform.

The Commission’s work was framed in the context of federal–provincial negotiations and the set of provisions established in the 1996 *Medical Care Act* so that provinces could qualify for their share of federal funding. By and large, however, the main parameters regarding the delivery of services were to be established by each province. *Access* to health-care was apparently initially considered as a condition for federal funding; as stated by Lazar et al. [29] “[The] reasonable access provision was apparently intended to exclude provincial charges for physicians’ services [...]. In any case, to the extent that access may not have been a co-equal fifth principle then, it gradually evolved to gain that status.” It remains that, with the exception of access, considerations about the quality of service provision were never brought up as an explicit issue and an integral part of this negotiation process.

In many ways the Commission’s recommendations were quite elaborate and innovative. Quality was explicitly addressed, although it did not represent one of the most important aspects of health-care to have been considered. “The health-care program has to assure the delivery of quality care on a scientific, human and social level,” maintained the Commission. But “quality refers to a relative and multidimensional concept whose meaning varies” over time, that which prevents the formulation of an all-encompassing, operational definition of quality care. Moreover, “it would be unrealistic to pursue an abstract ideal of quality in the face of multiple, specific needs and scarce resources.”

Most important, different parties hold different views of what quality means. “For health-care professionals, quality is synonymous with care provided in accordance with generally accepted professional standards.” A user, on the other hand, “has a different perception of quality: he or she demands care that takes into account their psychology, anxieties and needs.” Likewise, “for society, the notion of quality mainly consists of evaluating the outcome of a program.” Also, and differences of opinion notwithstanding, people often find it difficult “to evaluate the quality of care they receive.” Furthermore, the quality of health-care is essentially equated to the *competence* of professionals: “the technical and scientific competence of physicians or any other health-care professional certainly constitutes the most essential factor for quality health-care” ([7], at 1:90–91 and 4(2):21).²

A more fine-grained analysis of quality can be found in connection to specific aspects of service provision. *Accessibility*, for instance, was undoubtedly *the* most important issue addressed. Access to health-care services, states the Commission,

² Unless otherwise indicated, all reports excerpts have been translated from French into English by the authors.

“means that each citizen is entitled to the care he or she needs within a reasonable time, as required by the urgency of his or her situation” ([7], at 4(1):118). Being able to access services, therefore, referred not just to financial barriers, but also to the availability of services and personnel in different regions of Quebec, and to services that adequately met the needs of people, particularly among marginalized groups.

The projected reform also paid attention to problems of *continuity*. More specifically, it was hoped that “the unification of the existing system and the implementation of the principle of continuity of care will lead to a double integration of available resources: on the one hand, a vertical integration of different levels of care and, on the other hand, a horizontal integration of material resources within a given geographical area” ([7], at 4(2):22). Newly established Regional Health Offices were to be responsible for the development of ‘integrated service networks.’ Further, the renewed health-care program should enforce work by multi-professional teams, inserted in Local Health Centres (LHC), responsible for users follow-up and coordination with other service providers. Facilitating service integration was also intended as a means to improve service *effectiveness* and *efficacy*—seen as separate constructs from quality. The Commission was also critical of prevailing medical practice, in many respects regarded as inadequate and lacking *pertinence*. Also, the existence of a private for-profit system of care was singled out as one of the main contributing factors: “For the business sector to work at preventing or limiting hospitalisation or institutionalisation, or at promoting substitutive measures which are better suited to the needs of clients, would be tantamount to acting against its own interests” ([7], at 4(1):114, 4(2):22, 7(2):45). In addition, users were to be treated as active agents in their treatment rather than as passive recipients of medical instructions, and the system should renew its efforts at responding to their particular needs and values –i.e. improve the *acceptability* of care.

Managing quality meant above all *evaluating* different aspects of care, including, first, “professional competence, performance in the execution of tasks and the technical value of acts;” second, “the accessibility, continuity and humanization of care;” and third, “the population’s standard of living and the efficiency of the plan” ([7], at 4(3):124). The idea of ‘cooperation’ between administrators, health-care facilities and professionals, rather than ‘supervision,’ was endorsed as the guiding principle for quality appraisal; a principle intended at facilitating the engagement of professionals and instilling a blame-free approach to practice evaluation.

An elaborate system for quality evaluation was to be gradually put in place, based on voluntary and mandatory reporting instruments, and internal as well as external mechanisms. Accordingly, every administrative and professional level was to play a role, from the Ministry, responsible for “regulation, control and the study of outcomes”; to the Regional Health Offices, in charge of overseeing that service providers “respect minimum standards of quality and the availability of care,” [...] “follow up on evaluation results” and “make the necessary changes to the organisation of care” within the region; including public service providers, mandated to evaluate “medical files” and practice “as a means to develop continuous education programs,” and, when necessary, enforce disciplinary

measures. Internal evaluation conducted by service providers was not to replace external ones, though. In particular, professional associations had the mandate to “revise clinical files and apprehend the quality of care in accordance with accepted norms of professional practice.” Such evaluation, however, was intended at “stimulating” practitioners rather than “regulating” them. The Canadian Council on Hospital Accreditation (founded in the late 1950s) was recognized for its positive influence on the creation within hospitals of quality oversight committees, yet little attention was given to its potential role within the overall evaluation system laid out by the Commission. Also, patient rights were to be protected by the provincial Ombudsman, especially in relation to medical malpractice and formal complaints. Finally, a system of incentives for rewarding service providers’ efficient management and discouraging poor performance was to be introduced by the new plan.

Yet, in spite of its apparent comprehensiveness, much of the quality system envisioned centered on the evaluation of professional competence and technical value. Different quality flaws relating to pertinence, acceptability or effectiveness of care were to be ironed out with better competence supervision. In addition, rhetoric about cooperation among actors and trust aside, the approach was quite hierarchical in nature since decisions on quality management and evaluation were essentially framed at the Ministry, with partial delegation of responsibilities to the RHOs. Further, in the Commission’s eyes, issues such as accessibility and continuity of care were to be inherently addressed through the proposed one-off system redesign and the complementary nature of providers, albeit with a strong emphasis on top-down administrative controls.

The Rochon Commission: Re-examining Achievements while Questioning Systemic Rigidities and the Power of Professional Groups

Fifteen years following its introduction, the Quebec health-care system was frequently praised for its accomplishments and performance. As reported by the Rochon Commission, “almost 80% of Quebecers believe Quebec’s health-care system is one of the best in the world.” However, cautioned the Commission, “such a positive assessment should not conceal the negative side of the system as it developed” ([49], pp. 396–397). To be sure, universal and free access to care had for the most part been achieved and people’s health had collectively improved. But, as implemented, the system had not been capable of bettering coordination and continuity of services as initially planned, in many services waiting times were an endemic problem, care treatment remained largely impersonal and regionalization was at an impasse. Also, despite pressures, public health-care expenditure had remained stable since the beginning of the 1980s, paralleling increases in GDP but, in a changing economic environment, many suggested that health-care was becoming a burden in the economy and that funding mechanisms would have to be reconsidered. During this period, relations between provinces and the federal government had become ever more acrimonious as a result of Ottawa’s relinquishing of the open-ended funding formula, and the tolerance by a few provincial governments—other than Québec though—of extra-billing by specialists and for

some hospital services, thus restricting “reasonable access” to health-care in some parts of the country. The passing in 1984 of the *Canada Health Act* and its provisions on necessary services was the expression of a renewed partnership between Ottawa and its provincial counterparts, meant to ensure that equal access to a similar range of medical services was a reality in all parts of the country. Such was the context when a left-of-centre *Parti Québécois* government—weakened by an unsuccessful referendum on sovereignty—decided in 1985 to appoint Jean Rochon to head a Commission of inquiry and bring health-care back into the agenda. The new Commission’s mandate was more focused than the previous one but no less comprehensive: “Evaluate the functioning and financing of the system,” particularly as it relates to the responsibilities of different administrative echelons, coordination of decision-making, evaluation of effectiveness and efficiency, the role of professionals, the degree of public participation and the relation of health-care with different sectors and actors that impact on people’s well-being.

In establishing a lengthy diagnosis of health-care’s ills, two main themes retain the Commissions’ attention. First, “the system had been taken prisoner by a host of special interest groups”—i.e. unions, service provider associations, professional groups—at the expense of the public ([49], p. 407). Second, the system was badly managed as a result of poor planning, organisational rigidities and sparse information on service and clinical performance. Thus, the proposed ‘treatment’ aimed at transforming the health-care system in ways that would deactivate the “internal power dynamics,” while reasserting the user-centeredness of service provision and the importance of evaluating results.

Quality was not explicitly addressed by the Commission or any of its sponsored studies; rather, it is dealt with indirectly, as an extension of particular issues, in many respects revisiting what had been accomplished (or not been accomplished) since Castonguay-Nepveu. For instance, although *accessibility* had been greatly expanded—“one of the most precious achievements of the 1970s reform”—it remained problematic because of geographic, physical, socio-economic and sometimes financial barriers. But accessibility had to be reconsidered in light of the new context: “the last recession and financial constraints remind us that coverage and free access to services cannot be expanded limitlessly,” stated the Commission. Thus, the ‘new’ universality objective “does not mean that all services have to be covered and free of charge in all times and places” ([49], pp. 452–453).

Instead of focusing on universal access, it was asserted, “what the state should do is to provide for the maintenance of health and well-being by resorting to the most appropriate and *efficient* means.” Accomplishing this meant that the public sector was to engage in the evaluation of the actual “cost-effectiveness of invested resources;” or, in other words, determine if ‘value for money’ could not be attained by alternative means; although the Commission took pains not to suggest the outsourcing or privatization of certain services as a potential solution ([49], pp. 453–454). *Continuity* of care remained a central concern for the Commission; inter-professional work and the bringing together of social and medical aspects of care had been largely achieved but, it was emphasized, facilities and programs were still poorly coordinated. However, changes could not be enforced from the outside; rather, health-care facilities “should be allowed the initiative and creativity, and

given the responsibility to decide their own strategic position within the health-care network.” Commissioners also decried problems with the *acceptability* and *pertinence* of service provision, pointing, for instance, at “the gap between professionals and patients with regard to attitudes and values, which can get in the way of mutual comprehension and accessibility,” or at “a system that finds it difficult to keep in tune with the evolving needs of the population” ([49], pp. 397, 407, 413). Yet again it was above all professional *competence* which was at the source of many of the problems and which had the most potential for improving quality.

Thus, oversight of professional competence was maintained as an important means of achieving quality; however, it was extended and completed by an ‘evaluation of programs’ and, most important, a focus on ‘results.’ In this respect, a gradual but significant shift can be detected as far as quality management is concerned. On the one hand, outcomes became a fundamental feature for how the system was to be evaluated and, by extension, quality managed. On the other hand, service providers and Regional Boards—whose mandate was to be strengthened—were entrusted with the responsibility for evaluating programs and interventions. The intended repartition of responsibilities meant that Regional Boards were to focus on measuring program results so as to “evaluate the performance of various facilities and organisations, and their capacity to attain the set objectives.” In addition, Regional Boards were instructed “to elaborate quality appraisal programs for service providers,” at the same time as they upheld responsibility for the management of users’ complaints and, as a new mandate, regularly conduct satisfaction surveys. Boards should also introduce a system of incentives and sanctions to encourage good performance. Service providers, in turn, were to concentrate on internal evaluation, “of the *monitoring* kind, that is to say, overseeing program implementation and controlling its realization.” Lastly, while the setting up of a centralized data management system had been slow and disjointed—a far cry from what Castonguay and colleagues had proposed—the Commission reiterates the importance of developing a series of indicators and of consolidating clinical information systems for the purpose of program monitoring and outcomes assessment ([49], pp. 604–606).

Noteworthy, in comparison to the previous Royal Commission, a new managerial rhetoric is used in reference to how quality issues were to be taken in hand, by resorting to terms like ‘objectives-centred approach,’ ‘outcome-based evaluation,’ ‘change monitoring,’ ‘performance assessment indicators,’ ‘value for money,’ other. Also, whereas patient focus and responsiveness, and the need to revitalize public participation are recurrent themes in the report, users’ actual contribution to quality management was relegated to being consulted through satisfaction surveys, being appointed to health-care facilities’ boards and, when necessary, appeal decisions through a complaint system. As well, outcomes measurement was regarded as a mechanism for assessing performance and detecting quality failures, but also, in the face of a system ‘held captive’ by special interest groups, as a would-be instrument for making informed resource allocation decisions.

The Clair Commission: Redesigning Delivery Systems in Favour of Coordination and Economies of Scale

By the time the Clair Commission was appointed in 2000, the Quebec health-care system was perceived by many as over-extended and over-stressed. Health-care accounted now for over 40% of the provincial budget, and the steady increase of health-care-reliant elderly people, combined with the introduction of expensive new technologies and pharmaceutical costs, were promising to burden the system even further. Backlogs and long waiting times had become a major political issue both in the federal and provincial arenas. During the 1990s, an official policy-orientation report (in response to the Rochon recommendations), a Parliamentary Commission and a White Book on health-care had propelled a series of reforms aimed at ‘rationalizing’ the system—among other things, by means of a *shift to ambulatory care* and budgetary cuts—but systemic problems persisted and there was a renewed sense of urgency to find more fundamental and long-lasting solutions. Also, many of the measures adopted during the previous decade—incidentally with Rochon as the Ministry of Health—were unpopular and controversial, and government officials seemed in need of legitimizing their actions by calling in ‘expert opinion’ [20].

Concerning quality, several other developments had taken place. For instance, the Canadian Council on Health Services Accreditation (CCHSA) had introduced the principles of quality assurance and organisational competence to a progressive core of Hospitals in Quebec. The establishing in 1995 of the Quebec Council of Accreditation (QCA) anticipated a similar process with regard to primary care and long-term care settings. Also, occasional incidents involving elderly people and reported by the media had underscored the need to make accreditation of private residential facilities a requirement. Despite its voluntary nature, by the end of the 1990s just about 40 per cent of all primary care settings in Quebec had submitted a demand for accreditation to the QCA. Meanwhile, the provincial Ministry of Health had released a study aimed at conceptualizing a framework for quality which departed from a traditional view of quality as an exercise in assessing professional competence [5]. Gradually but surely the depiction of quality as an attribute of the ‘care system’ was making its way into the health-care sector.

Also, during the 1990s the federal–provincial partnership had continued to deteriorate as a result of two decades of Ottawa’s diminishing funding contributions. Provinces were increasingly confronted with the dilemma of how to maintain the coverage of services on uniform terms and conditions (i.e. Medicare’s universality principle), while Canadians appeared to be ever less satisfied with a system whose performance was called into question.

Set against this backdrop, and similar to previous inquiries, the Clair Commission began its work by reviewing the most pressing health-care problems afflicting the system—“a severe diagnosis” demanding a “New Vision” for radical change. The *Emerging Solutions*, as the report was called, highlighted the “inevitability of making choices,” since all types of services could not be covered by the plan, and the need to review the organisation of service delivery while focusing on performance. A parallel insurance fund for long-term care services was also proposed to tackle demographic aging and increasing demand.

In many respects the rhetoric used by the Commission parallels that of its predecessor—“The quality, effectiveness and efficiency of care services calls for systematic evaluation of practices and approaches;” “It is necessary to build on agreed upon indicators that determine as accurately as possible the accomplishment of expected results.” But the commissioners also introduced a new terminology that resonates with quality improvement and its methods—“a culture of excellence is required;” “a culture of innovation;” “an approach consistent with a continuous improvement process.” A “quality improvement framework” is in fact proposed by the report, largely inspired by the plan-do-check-act or Deming cycle. ([9] pp. 51, 137). However, its application is not explicitly outlined; as in the past, quality issues are largely dealt with as separate constructs.

Predictably enough, given the media and political attention it received, *accessibility* was the first quality component to be dealt with by the Commission, which advocated a re-strengthening of primary care, based on the existing network of CLSC, and the formation of new “group family practices.” *Timeliness* of care was also regarded as significant, and called on a reinforcement of the system’s “reactivity,” that is, “the rapidity of attention, reasonable waiting times, and the possibility of choosing a care provider.” The organization of care should also be “*effective* and *efficient*, aiming both at the quality of service provision and the excellence of results.” It was, however, in relation to problems of *continuity* and system governance, that the Commission recommended a “quiet revolution.” Service organization in Quebec reflects the reality of the 1970s, stated the Commission, at a time when autonomy and individual practice was valued. Working “in silos,” however, entails a troublesome fragmentation of care provision, where “everyone protects his or her own field of practice,” and “each service, department and facility works independently from each-other.” For this problem to be fixed, a seamless, integrated delivery system, allowing for “service corridors” between local, regional and provincial agencies and providers, was required ([9], pp. 2, 3, 25, 30).

Part of the New Vision that was put forward concerned the steering of service provision. “The culture of our network is based on a hierarchical, bureaucratic and partitioned approach, where each new client represents one more problem. A new culture of excellence based on results” is needed ([9], pp. 2, 3, 25, 30). The ‘vision’ also included a better definition of accountability between central, regional and local levels of government, based on “performance contracts” and agreed-upon goals and indicators. Measuring outcomes remained therefore an important component of the suggested arrangement.

“Contractual agreements” between service providers, more flexible than hierarchical rules and more effective than unregulated markets, were also advocated for the purpose of coordinating activities and establishing ‘service corridors.’ Further, contracts were viewed as a central component of the ‘subsidiarity principle’ promoted by the Commission—meaning that the state could and should turn to the private sector when costs were likely to be reduced and the effectiveness of service provision optimized. On the whole, the notion of ‘contracts,’ found throughout the report, provides the imagery for the type of mechanism endorsed by the Commission for how best to regulate the interface of different stakeholders. On

the one hand, contracts alluded to the principle that most arrangements, including quality oversight, were to be negotiated rather than vertically implemented; but on the other hand, they also conveyed the idea that such arrangements should be binding, committing all parties involved to a (pre)defined course of action or a common goal.

The Multiple Faces and Treatments of Quality

Looking at the Commissions from a thematic, comparative perspective, it appears that quality health-care has encompassed changing definitions and embraced multiple dimensions and issues. Quality has also been informed by different templates, translating into specific management approaches and a changing distribution of responsibilities among concerned actors—more or less hierarchical and centralized depending on the Commission.

A Variable, yet Sedimentary Definition of Quality

With regard to its meaning first, only the Castonguay-Nepveu Commission dealt with quality health-care as a specific domain—while recognizing the difficulty in harnessing diverse perspectives into a coherent, single definition. The two Commissions that followed it, regularly alluded to quality—an inescapable attribute of care—sometimes, as in the case of the Clair Commission, even proposing an analytical framework for service improvement. But the treatment they accorded it was mostly indirect and implicit. In this regard, commissioners appear to have either not been concerned about the relevance of approaching it as a unified aspect of health-care requiring a unified strategy of action, or have assumed that a blueprint for quality services would not add much value to the large structural changes that were generally promoted.

Still, all Commissions tackled quality in a disaggregated manner, by bringing into focus specific quality attributes or dimensions, some emerging and new, while others relatively constant and fixed over time. Among these dimensions, *access* to care and service *coordination* are regular topics, whose characterization and meaning evolved according to the particular concerns of the moment but invariably represented significant aspects of the Commissions' thinking—for instance, access was initially considered in relation to financial barriers but later on to waiting times and shortages of human resources. Likewise, other quality dimensions, such as professional *competence*, are persistent concerns, although the attention it gets seems to wane over time and its focus to broaden, by integrating elements of organisational competence. In contrast, dimensions like *effectiveness* or *efficiency* gained in importance as the system's solvency took centre stage and a managerial approach to health-care became more prominent. Finally, quality issues such as the *acceptability*, *timeliness* or *pertinence* of interventions receive variable attention, whereas others like the *safety* of care or professional errors are practically absent from the Commission's reflection.

From 'Competence Supervision' to 'Management by Results' to 'Contractualism'

Perhaps most striking of all is the fact that as quality of care gets partially redefined from one Commission to another and quality issues are added and qualified, the 'templates' informing quality management also change. The Castonguay-Nepveu Commission had provided an elaborate analysis of quality health-care, centered on the evaluation of various aspects of care and the adoption of a range of reporting instruments. However, much of its proposed arsenal for quality management was based on the principle of 'competence supervision,' to be conducted by peers on a formative rather than a blameful and punitive manner. At a time when co-opting the medical profession and a range of private providers into the new plan represented one of the Commission's main objectives, the evaluation of quality and service performance had to be done with a minimum of constraints. Terms such as 'cooperation' among actors, 'stimulation' of good practice, and 'incentives' for appropriate management are frequently used in the report to qualify how evaluation or the interaction between the public and private sectors were envisioned. In this context then, managing quality through 'competence supervision' could be seen as the expression of a compromise between, on the one hand, the Commission's goal of rationalizing and unifying the system of care and, on the other hand, the need to enforce compliance while limiting the extent of state control. Additionally, as in other areas of North America, in the late 1960s health-care in Quebec was still characterized as a 'cottage industry,' a sector in which 'dedicated and talented physicians' were considered to be the principal guardians of quality care. This traditional representation of service provision appears to have also moulded the quality template proposed by the Castonguay-Nepveu Commission.

With the Rochon Commission, however, the main focus of quality is displaced from 'competence supervision' to outcomes, or what we call 'management by results.' Given the Commission's depiction of health-care in Quebec as being 'held captive' by various stakeholders and professional associations, evaluating results represented not only a means to assess quality, but also an instrument for making allocative decisions as uncontroversial as possible. Multiple, conflicting actors had to be made more accountable for their actions, and the monitoring of outcomes provided a powerful instrument for this purpose. Further, whereas the system was by then established on a secure foundation and most private providers were operating within the public insurance plan, a tightening of regulation and control seemed less contentious. The renewed interest on outcome measurement was also in line with the need to reassert the user-centeredness of the system. Reflective of this change in orientation, the conversion to 'management by results' brought about the use of different language which, as previously indicated, became more business oriented and concerned with 'performance,' 'efficiency' and the 'value' of invested moneys. It should be noted, however, that Rochon was shy about the possibility of enhancing the role of private health-care within the public system; something that some 15 years later would begin to change with the arrival of a new governmental commission of inquiry.

The framework for quality is again redefined by the New Vision for health-care put forth by the Clair Commission, in which the principle of ‘contractualism’ was paramount. For members of the Commission, contracts embody a way of rethinking the interface between stakeholders—particularly at a time when the outsourcing of services was being openly advocated—and redefining accountability among providers and public agencies. As with other changes in orientation, ‘contractualism’ has to be understood by situating it in its broader context. Many of the quality ills afflicting health-care, such as lack of coordination and continuity, ‘turf wars,’ or restricted accessibility had become chronic despite previous efforts at rationalizing the system. In addition, not only recent reforms had been unpopular, but some stakeholders claimed the burden of cuts and restrictions was being unequally distributed. What is more, health-care was described as unresponsive to public concerns and, in a system structured ‘in silos,’ no one appeared to be truly committed at making things work better. A different decision-making approach was therefore needed and, in the spirit of the proposed reform, contracts provided a useful instrument for ‘committing’ all parties involved to a series of set goals. Contracts also had the potential to help formalize relations among actors on a mutually consensual basis, and, in doing so, avoid the pitfalls of a hierarchical approach to implementing changes or regulating activities. Finally, while symbolically alluding to fairness and equity, contracts could ease the adoption of controversial policies, some of which involved the ‘inevitable’ rationing of services and the reduction of coverage.

Who is Responsible for the Management and Appraisal of Quality Anyway?

Assigning responsibility for quality management and appraisal was a concern for all three Commissions but, depending on the context, a thorny issue as well. In addition, striking a balance between mandatory and voluntary initiatives was no less delicate for the fact it entailed obligations, that had to be enforced, and for some an expectation of retribution. In the case of the Castonguay-Nepveu Commission, reasserting the state’s authority over the entire field of health-care seemed a prerequisite for the setting up of the new plan. Evaluating and managing quality was one of many functions to be assumed by central government, in conjunction with the Regional Offices, seen as more attune than the Ministry to local concerns. Yet, for the plan to be workable, providers were to retain a certain degree of autonomy and decision-making power. Moreover, providers were to share responsibility for quality oversight with professional associations, in charge of peer review and professional audit. The end result was a management arrangement in which everyone was to play a part, but, beyond principles, responsibility was diffuse and largely unspecified. Further, although the possibility of sanctions in response to poor quality performance was considered, much of this was the prerogative of professional associations. Overall then, quality management appeared to be caught in a predicament wherein the Commission expressed the need for government to take things in hand and better regulate the field of health-care, but could not afford to

take a robust approach to service evaluation and supervision that might generate resistance on the part of providers.

Such reservations about tightening evaluation and quality controls are less manifest in the Rochon Commission, for which the system had to be better managed and rescued from the existing power struggle. In fact, the monitoring of outcomes conveyed the idea that the state's role in overseeing providers and professional activity had to be reinforced. Yet similar ambiguities with regard to quality management methods and the repartition of responsibilities persist. Thus, although government was to reassert its authority, health facilities "should be allowed the initiative and creativity" to make decisions on their own. Likewise, Regional Boards were now responsible for the elaboration of quality appraisal programs, but it was up to service providers to apply them where relevant, while concentrating on the monitoring of activities. Again, quality incentives and sanctions are mentioned as part of the Board's mandate without specifying how and in what situations they should be applied. Finally, in spite of a quality framework built around 'management by results,' formative evaluation by service providers and peer review remain essential.

The new culture of governance promoted by the Clair Commission once more strives to amend previous models of quality management, without necessarily dispelling some of the vagueness characteristic of previous Commissions. As mentioned before, the proposed arrangement was different with regard to the principles that preside over it—based less on hierarchy and rule, and more on consensus and trust among members of the health-care network. Also, at the same time the Ministry was to re-focus its mandate on strategic planning, and Regional Boards become leaner and concentrate on the application of provincial orientations within their territory, the duties and responsibilities of public facilities were to be expanded. Thus, by extension, the remit for quality management should also be assigned to local public facilities. However, little is said about the precise mandate of facilities in this area or whether quality initiatives should become an obligation or not.

Conclusion

From this overview of quality in health-care as constructed by three commissions of inquiry, it is apparent that in Quebec the 'quality agenda' has evolved significantly since Medicare was first introduced; yet, conceptually at least, this progression has not been linear and consecutive, nor has it been shaped by the same external forces as evidenced by developments in the US and some European countries. Adopting an evolutionary perspective, and as in other jurisdictions, the focus of quality has shifted away from professional competence—what Ellis and Whittington [16] call the 'embryonic stage' of quality—in favour of care processes and an emphasis on continuous improvement. However, such a characterization provides only a stereotypical and cursory understanding of the changes that, over time, have affected the concept of quality, its 'framing' as a policy issue and its management. Moreover, although quality in health care was always dealt with by Commissions,

and a ‘modern’ approach seems to be emerging, quality has generally been more the subject of rhetoric than policy [30]. A generic, comprehensive definition of quality and an explicit strategy for its management were never advocated.

The manner in which Commissions looked at quality was framed by a particular constellation of factors. In this respect, contrary to what happened for example in the U.S., where consumerism, the malpractice crisis of the 1970s, or the implementation a decade later of prospective payment mechanisms seem to have been the main forces that stimulated debate on quality and motivated action from public agencies and service providers [46], in Quebec these issues have never been high-profile. As indicated before, risk management and the safety dimension of quality were practically absent from the agenda of either of the Commissions under study. In fact, recognition of medical errors as a systemic problem is a recent development in Canada [23]. Similarly, the marginal role played by private health-care after the inception of Medicare helps understanding why quality-oriented regulation of this sector has not been a major preoccupation for government—even when things have evolved over the last few years [44]. By comparison, problems pertaining to universal access to health-care services, continuity of treatment in a fragmented and conflict-ridden system or, more recently, the evaluation of efficiency and effectiveness of care in a resource-limited environment, have been the main considerations underpinning policy debate both within and outside Commissions.

Two additional forces having influenced the environment in which Commissions operated merit consideration: the federal government’s regulatory capacity and the financing method of health-care facilities in the province. With regard to the first, although federal legislation establishes the guiding principles under which provincial governments should organize their health systems, quality standards are not contemplated by the law. Ottawa’s spending power, however, has had a strong structuring effect on how service coverage and accessibility have been defined by provinces over time. For instance, the Castonguay-Nepveu Commission’s tackling of these issues largely built on the dispositions laid out by the federal government during the 1960s. Again, in the 1980s, the federal government’s withholding of funds from provinces unwilling to comply with the principle of accessibility as stipulated in the *Canada Health Act*, set the tone for how Rochon and colleagues would deal with access, private financing and private provision of health-care. In recent years, as Ottawa has sought to redefine its regulatory approach to health-care—by means of what Graefe [21] calls ‘quality-time’ initiatives—reporting mechanisms and quality have become more prominent aspects of federal–provincial relations. The signing by First Ministers in 2003 of the *Accord on Health Care Renewal* would lead Quebec to the setting up of an information system aimed at monitoring waiting times for high-demand diagnostic and elective surgery services. Similarly, the federal government’s creation of the Health Council of Canada appears to have provided the impetus for redefining the mandate of Quebec’s Council on Health and Welfare by making quality and performance evaluation one of its primary focuses [38].

A second noteworthy element affecting the policy context concerns the mechanism used by the provincial government to finance service provision which, up until very recently, was open-ended and based on historical cost. Such a payment system would have a significant impact on providers' behavior vis-à-vis service quality, given its in-built incentive to encourage quantity at the expense of quality. Further, it partially helps understanding why, in contrast to other jurisdictions—particularly in places where the financing of providers is capped and pay is linked to performance—in Quebec the voluntary setting up by hospitals or other facilities of quality related initiatives has always been sparse [8]. Historically, neither service providers nor consumer associations would represent an important driver for change in the area of quality health-care in the province.

In spite of their shortcomings, commissions of inquiry played a strategic role in quality developments. They elaborated innovative ideas and made recommendations, many of which were context-driven, but also an expression of their own reading on what was the source of problems and how best they could be corrected. The approaches to quality adopted by each of them were in congruence with the particular templates informing discussion, which, as described before, substantially changed the way quality problems were to be tackled and responsibilities for evaluation and improvement distributed. It should be pointed out that although these templates were the result of a combination of existing institutional arrangements, internal reflection by commission members and a given policy context, they were not necessarily exclusive to Quebec. In the UK for example, contractual arrangements have been used for some time now to enforce health-care quality standards [10], regulate quasi-markets [45] or monitor outcomes [18]. And while the UK influence is difficult to ascertain, some of the proposals put forward by the Clair Commission have a distinctive Third Way flavour to them. Likewise, the emphasis on quality outcomes, as manifested by the Rochon Commission, has been widespread and part of a 'modern approach' to quality pursued in the U.S. since the middle of the 1970s [35].

Changes in orientation notwithstanding, a particular troubling issue for all of the commissions investigated is that quality was never regarded as a front-and-center aspect of health-care, to be addressed in a unified way. A fragmentary, multidimensional approach to quality would result in it neither being conceptualized as a distinct policy domain, nor it being tied to a well defined set of objectives, committing government to a particular course of action. In other words, although various quality issues were tackled and corrective measures proposed, defining a 'blueprint for quality' was not regarded by commissioners as a necessary condition for a better health-care system. The absence of a quality plan, combined with the prevailing institutional dynamics among different actors involved in health-care, would have as consequence that the repartition of responsibilities for quality management will often be left unspecified. The initial 'compromise' established by the Castonguay-Nepveu Commission—implying that government was to reassert its command over health-care but should avoid a regulatory approach to quality perceived as stifling by professionals and service providers—would be the basis of a tension over 'who is accountable for what' in the management of quality; a tension that other commissions would address but not necessarily overcome. Additionally,

no criteria will be formulated by either of the commissions, beyond broad guidelines for the definition of indicators and the evaluation of results, to clarify whether quality initiatives should be a requirement for service providers or, on the contrary, remain a voluntary endeavour. And this ambiguity would apply as much to public as to private facilities.

Finally, while an analysis of the Commissions' actual impact on quality policy and practice is beyond the scope of this essay, charting some of the changes which over the years have taken place in this area may prove insightful. As previously indicated, despite the fact both Castonguay and Rochon headed the Ministry of Health for extended periods of time, many of the proposals they formulated will not be implemented or only partially applied. For instance, the idea of monitoring outcomes would not entirely materialize, the result of data management systems being fragmented and poorly developed. In fact, improving data collection and the tracking of quality information would be a recurrent theme among Commissions. Also, some isolated initiatives aside [41], Regional Boards will not fully assume responsibility for evaluating the performance of facilities or elaborating quality appraisal programs. But various policy reforms implemented by government would rely on—and largely be validated by—the Commission's recommendations. Indeed, most of the structural reforms undertaken by government in the aftermath of Commissions—concerned, for instance, with service organization and delivery, care coordination, or the regionalization of decision-making and responsibilities—though not always successfully implemented, were the offspring of their work and proposals. Still, other developments affecting the management of quality—such as the initiative in the 1990s to create a provincial accreditation body (the CQA)—were not always connected to Commissions or were molded in other health-related task forces dealing with a particular population or category of services—i.e., the elderly, mental health, primary care, other.

All in all, in Quebec quality of health-care has never been a central priority for government. Only very recently has accreditation become a requirement for all public facilities and private nursing homes. Lately, government has also expressed the need to render incident reporting mandatory and to strengthen the quality oversight of service providers [42]. Yet, notwithstanding renewed attention to the subject, the quality movement in Quebec has been slow to unfold. Understanding why this is the case undoubtedly requires an analysis that goes beyond the work of Commissions and their output. However, to the extent that Commissions played a critical role in shaping policy by conceptualising issues and moving concerns and ideas to the political arena, it could be argued that their variable thinking about quality and, most important, their failing to recognize it as a strategic aspect of health-care explain in large part why Quebec has not taken a more assertive and proactive stand in this area.

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