Understanding gaps in the co-existence between different modes of governance: A case study of public health in schools in a multi-level system

Abstract

Governing contemporary public services across industrialised countries typically draws on a mix of different modes of governance. The literature on governance has raised the issue of the specific co-existences between different modes of governance. The focus is on fits and clashes, whereas there is less attention on situations, where different modes of governance do not connect. The contribution of the present paper is to more systematically account for the 'what' and 'why' of such 'gaps'. What are their specific characteristics? How can their existence be explained? Based on a critical case study of supporting coordination in public health services in Québec, the paper argues: that gaps in the co-existence between different modes of governance can be thought of as disconnects in the management of public services; and that this reflects a de facto lack of governance capacity to connect different modes of governance to each other.

Introduction

Governing contemporary public services across industrialised countries involves coordinating a wide range of activities across different levels, actors and policy sectors. It typically draws on a mix of different modes of governance, combining hierarchy, networks and markets in specific ways (for example, Bouckaert et al, 2010; AUTHOR et al, 2009; Keast et al, 2006; Newman, 2001). Besides mapping out governance arrangements, the literature has raised the issue of the specific co-existences between different modes of governance (for example, Conrad, 2015; Fenwick et al, 2012; Martin and Guarneros-Meza, 2013; Newman, 2001). Tenbensel and colleagues (2011) make a plea for a more systematic approach and in their analysis of the 2001 health reform in New Zealand, the authors also identify 'gaps' in governance arrangements. This is when different modes of governance neither complement, nor clash with each other, but simply do not connect with each other. The authors conclude that this new type of co-existence is particularly interesting and give some tentative indications where gaps occur.

Building on this, our contribution is to more systematically account for the 'what' and 'why' of 'gaps' in the co-existence of different modes of governance. What are the specific characteristics of such gaps? How can the existence of such gaps be explained? We argue that gaps can be thought of as disconnects in the management of public services, that is between modes of governance used in public management functions; and that this reflects a lack of governance capacity on the part of governments to connect different modes of governance to each other. The analysis is based on a critical case of supporting coordination of public health services in schools in Québec.

SchoolHealth is a procedural and intersectoral programme to support prevention and health promotion in schools. It builds on an agreement between the provincial Ministry of Health and Social Services and the Ministry of Education and their respective regional/local authorities support implementation. The program is based on a partnership between health and social services, education and local communities. Québec health services should be well prepared for the implementation of this program. Despite its multi-level governance context (Hooghe and Marks, 2003; Young, 2012), the province is generally characterised by a high governance capacity. Through its own version of corporatism (Montpetit, 2003), health services are systematically integrated at provincial, regional and local levels (Aslanyan et al., 2012), and government has strong ties to community organizations. Nevertheless, and this is what makes this a critical case for studying gaps, hierarchical modes of governance are poorly connected to network modes of governance. In practice, the ministry and the regions have a very limited ability to support network-based intersectoral coordination of public health services on the ground. The analysis of why this is the case suggests that governance capacity in (public) healthcare services in Québec has de facto been weakened over recent decades.

We begin with a critical review of recent literature on governance to help conceptualise gaps and governance capacity. We move on to outlining the research design of our study. We then present our two-part analysis. First, we systematically identify the governing arrangements in public health in schools and the specific gaps in the co-existence between hierarchy and network modes of governance. Second, we ask why these gaps exist by examining the governance capacity in (public) healthcare services in Québec. We conclude with a discussion of our overall findings.

Conceptualizing Gaps in Co-existence of Modes of Governance, and Governance Capacity

In the literature on governing public services the understanding of gaps is not well developed. Studies typically see different forms of co-existence as clashes and/or fits and Klijn and Skelcher's (2007) offer a more precise definition. Clashes can reflect fundamental tensions between different modes of governance ('incompatibility conjecture') or changes in the balance between modes of governance ('transitional conjecture'). Fits can be down to compensation where one mode of governance addresses the weaknesses of the other ('complementary conjecture') or steering where states actively shape network governance ('instrumental conjecture'). Clashes and fits have in common that they connect different modes of governance either negatively or positively.

In contrast, gaps are situations, where different modes of governance simply do not connect. In Tenbensel and colleagues' study of health reform in New Zealand (2011), the policy framework failed to connect to implementation detail; there was no earmarked funding or performance management to relate the two to each other. This is not an unusual situation, but we know little about gaps. Studies often seem to treat potential gaps as a stepping-stone for analysing how such gaps can be bridged. For example, governance failures offer the starting point for an extensive body of literature on meta governance (for example, Jessop, 2004; Klijn and Koppenjan, 2012; Sorensen and Torfing, 2009). From this, governments emerge as engineers of the co-existence of different modes of governance: they provide ground rules, ensure compatibility, mediate

conflicts and rebalance power differentials. The dominant, underlying focus is on how governments can connect different modes of governance.

How can we come closer to specifying the gaps that can exist between different modes of governance? The more formalised approach of social network analysis offers a useful starting point. With nodes (actors) and ties (links) as the basic unit, Nageswaran et al. (2012, similarly Jessani et al. 2016), for example, define gaps as a low density of relations among actor and more specifically as a high score of ideal ties that do not currently exist. The focus is on interpersonal relations between individuals, whereas the governance literature has a more functional approach (Lewis 2006); organizations connect to each other based on shared activities and resources. This requires that we identify functions of public management and then focus on the disconnects between the modes of governance used in each management function. We therefore suggest defining gaps as disconnects between different modes of governance in the management of public services. Bouckaert and colleagues (2010) identify different general functions of public management and for the purpose of our analysis, we distinguish between the following three. *Process management* concerns the organization of activities to support coordination. This relates to coordination agreements and broader support for coordination, for example, through specific training, schemes for job rotation and development of relevant competencies. Strategies of process management may be more or less strongly mandated. *Strategic management* concerns planning and evaluating public health initiatives (and how they are supported). This can occur in a top-down and unilateral manner or in a bottom-up and interactive fashion. *Financial management* relates to the budgets used and the auditing arrangements in place. An interesting issue is how explicit the focus on coordination is. Financial management can be input or results-

based and oriented towards information exchange or consolidation. Within each management function we focus on the relative disconnect between different modes of governance. The expectation is that gaps between modes of governance can weaken the functioning public management.

As regards why different modes of governance do not connect, Tenbensel and colleagues (2011: 252) tentatively indicate that this is the case, where policies are difficult to implement or where responsibilities are unclear. This suggests that gaps in the co-existence of governance modes are bounded. This echoes Pierre and Peters (2000) who argue that national contextual factors can account for differences in governance arrangements. The authors then discuss the different abilities of states to adapt to change (2000: 162ff) and suggest that this reflects a complex interplay between political, social and economic factors, including the international environment. Accounts of governance capacity often fall into two camps (Bell and Hindmoor 2012, Pierre and Peters 2005): the state-centric perspective focuses on institutional dimensions of capacity closely related to governments (for instance Jacobsen et al. 2015), whereas the society-centric perspective highlights those dimensions of capacity located in networks that may or may not include government (for instance, Torfing et al. 2012).

This is different in the state-centric relational approach to governance capacity developed by Bell and Hindmoor (2009a, b, 2012). The approach integrates the two perspectives and acknowledges the possibilities of a positive zero-sum game, whereby relations between state and non-state actors can enhance the governance capacity of both. This is well suited for the study of gaps, as a broader understanding of governance capacity may be better at accounting for the absence

(rather than varying degrees) of connections between modes of governance. Institutions matter because governance occurs through them. High governing capacity typically corresponds to centralised decision-making, strong administrative apparatus, fiscal resources, policy instruments and legitimacy (Bell and Hindmoor 2009a: 61ff). We understand institutional capacity as the elements that make the public health system in Québec distinct from other industrialised countries. Centralised decision-making helps to concentrate the political and administrative capacity in relation to public health and allows the state to support coordination in a coherent way. A strong administrative apparatus offers bureaucratic and administrative resources that allow the state to act effectively when supporting coordination in public health. Policy instruments describe the concrete means that states have at their disposal to implement policies of coordinating public health services. Governing capacity is also relational and depends on the relative closeness of relations to society. The closer the ties, the greater the infrastructural power of states and their ability to work with non-state actors. We understand relational capacity broadly as the ability to develop close relations with non-state actors in public health, such as community-based organizations. Overall, we see governance capacity as the ability to connect different modes of governance to each other. The expectation is that the weaker the governance capacity, the more likely it is there are gaps in the co-existence of different modes of governance.

Research design

The analysis is based on a critical single-case study of supporting coordination of public health services in schools in the Canadian province of Québec (Yin, 2014). This is a critical case because there is a gap in the co-existence between hierarchy and network modes of governance,

although the structures of the health system and its policies in Québec predict a high governance capacity as outlined above.

The findings of the case study are based on the analysis of grey literature; this includes: official program documents available from the programme website, provincial and regional coordination agreements between the health and education sectors, and public health policy documents. We also conducted 11 semi-structured expert interviews, which lasted around 40 minutes and were conducted in June 2014. The interviews included managers and professionals at the provincial level (Ministry of Health and Social Affairs, National Institute of Public Health, National Round Table on Health Promotion and Prevention), at an urban Regional Health Authority (RHA) as well as experts (programme managers, coordinator) at three Health and Social Care (HSC) centers within that region (renamed “Lake”, “Village” and “City” for the purpose of this article). The centers cover a broad range of contexts in terms of relative location and social economic status of the resident population.

All participants were thoroughly informed about the study before they gave their oral consent. All interviews were recorded and transcribed verbatim. Participants were given the possibility of adding to and deleting from the original transcript of the interview. Direct or indirect references to the specific RHA, the individual HSC centers and the individual participants were subsequently removed.

We conducted a two-part thematic analysis of the data. The first part followed Bouckaert and colleagues (2010) and as outlined above sought to systematically identify the governing

arrangements in public health in schools and the specific gaps in the co-existence between different support strategies related to the process, organizational and financial functions of governance (see Table 1 below). We focus on hierarchy and networks as these are most influential modes of governance/support strategies in the public healthcare system in Québec. The second part of the analysis applied Bell and Hindmoore's (2009: 61ff) concept of governance capacity to account for the relative ability of governments to connect different support strategies to each other.

TABLE 1 ABOUT HERE

The data analysis began by constructing and applying a set of codes derived from the operationalization of the conceptual framework to each interview transcript. Using NVivo 10 software, we analyzed the interview material based on a thematic analysis that combined deductive and inductive elements with the aim to identify common threads (Braun and Clarke, 2006). The resulting codes were then collated to create preliminary themes, which were subsequently reviewed and refined. We first conducted an analysis within each of the three local health services centers, followed by a cross-site analysis. We did this both individually and jointly, and the iterative nature of the work resulted in a truly joint analysis.

Identifying Different Support Strategies and How They Fail to Connect

Process Management – Organizing Support Activities in SchoolHealth

Formally, support of coordination is strongly mandated as SchoolHealth is part of provincial health policy. It is compulsory for regional health authorities and HSC centers to implement SchoolHealth by supporting local schools coordinating of public health services. The Ministry of Health and Social Affairs together with the National Institute of Public Health also very actively supported the initial introduction of SchoolHealth. The yearly healthcare agreements at regional and local levels complement the formal mandate and include targets for the implementation of SchoolHealth. However, only one indicator relates to SchoolHealth and competes with many others.

Coordination is also formally mandated across the health and education sectors. In 2003, the two ministries signed a formal agreement about the implementation of SchoolHealth. This was subsequently complemented by a regional agreement between the RHA and the relevant education authority. The regional committee of SchoolHealth partners is responsible for supporting the programme, but does not seem to be very active.

The mandate emerges as partly intersectoral and highly formal. In practice, it works as a framework for other forms of network-based support, but which are predominantly mono-sectoral apart from the local level. At the provincial level, the National Institute of Public Health focuses on supporting coordination across levels through different forms of knowledge production and knowledge translation. The institute is also involved in more direct implementation support of selected regional health authorities/HSC centers.

The same occurs at the regional level, and this concerns adapting best practice to specific local contexts:

> [W]e start with their [the professionals'] working practices […] and we weave relevant theoretical knowledge into these practices […]. But we do this as part of a [local] process, not based on a pre-defined process.
>
> (Respondent, RHA)

This network-based approach is also reflected in the specific support activities of the RHA, which appear more intersectoral than at the provincial level. The authority organizes and chairs two groups, bringing together programme managers and local coordinators, who work with SchoolHealth in the HSC centers/school boards.

The support activities of the HSC centers are also network-based and build on negotiation and persuasion. As one local coordinator explains in relation to local schools:

> I am a facilitator. I am here to inform and support, not to say "we will do this and that". […] My role is not to be very directive, but to advise, to facilitate […].
>
> (Local coordinator, HSC center, Village)

This also means working from the bottom-up and exploring how local school boards can make sense of the objectives identified by the RHA or the HSC center. The different local round tables offer platforms for sharing experiences and for defining joint objectives.

Organizing the support of coordination in SchoolHealth has a framework that is strongly mandated, whereas the practice of support activities mostly follows a network approach. Within

the health sector, the two strategies complement each other well. Yet, the mandate only weakly extends to the education sector. One respondent from the provincial round table reports that the main concern is the non-existence of indicators to audit the performance of the programme within the education sector. This can be interpreted as a lack of reciprocal engagement of the education sector to support the coordination of SchoolHealth. The following quote from a programme manager powerfully illustrates the challenges arising from this at the local level:

> Because they [the schools] don't have targets, there is no pressure to reach the target. […] [I]t is as if we gave one person the mandate to reach the target, and we gave another person the mandate to implement [what needs to be done to reach the target]. It does not work.
>
> (Program manager, HSC center, City)

The challenge is exacerbated as there are no inter-sectoral networks at the national level and as the inter-sectoral network at regional level seems to have little significance. The network-based support at the local level cannot easily connect to national/regional support strategies in the respective sectors. This is problematic as supporting coordination in SchoolHealth based on negotiation/persuasion is challenging. Such a process is typically nested, whereby the HSC center deals with the local school commission, which, in turn, deals with local schools. Yet, local schools enjoy considerable autonomy and even local school boards cannot necessarily make them commit to working with SchoolHealth, as the following quote illustrates.

> The toughest challenge is that the […] school boards do not have any authority over school directors. […] [T]he bottom line is that if the school director does not want to implement this programme [SchoolHealth] in the school, it does not get any further.

(Programme manager, HSC center, City)

At the same time, many local schools see teaching as their core responsibility, whereas they consider public health activities as peripheral. Other schools do not have sufficient resources to embark on implementing SchoolHealth or find that the approach too inflexible or time consuming.

Strategic Management – Planning and Evaluating Support Activities in SchoolHealth

Overall, the healthcare agreements at regional and local levels offer an important leverage for planning. Formally, this occurs in a top-down, unilateral fashion and is hierarchy-based. The regional agreements have to be in line with the national public health plan, while the local agreements have to reflect the regional public health plan. For example, in the most recent healthcare agreements between the Ministry and the RHA, SchoolHealth is one of the priorities for public health services (Ministère de la Santé et des Services Sociaux, 2014). This is complemented by specific objectives for each RHA formulated as the percentage of schools implementing SchoolHealth. This forms the basis for an end-of-year action plan.

Yet, there is a common understanding that healthcare agreements and public health plans need to acknowledge regional/local specificities (Trottier, 2010). For example, the specific thematic areas for SchoolHealth in the annual plan of the RHA reflect discussions with representatives from health and education sectors:

> We agree on a yearly work plan, including the objective and organizational conditions of [our cooperation]. This typically involves one representative from each

> local HSC center, school commission, [and] we need meetings and a participatory approach.
>
> (Respondent, RHA)

Other aspects of planning and evaluating the support of coordination in SchoolHealth follow a network logic even more strongly and occur in a bottom-up, interactive manner. An example is the regular meetings with the programme managers and local coordinators of the region responsible for SchoolHealth. Planning is based on negotiations and occurs as part of meetings when discussing the agenda for the next meeting. The same is true of the informal evaluations at the end of each meeting, in which the two groups also give feedback on the issues resolved and the next steps to be taken.

At the local level, the planning by the HSC centers directed at schools/school boards and community organizations is again strongly network-based, reflecting separate planning processes/priorities.

> I think that the great benefit [of SchoolHealth] is the planning process […] But everything depends also on the school boards, with whom we have to negotiate.
>
> (Local coordinator, HSC center, Village)

The overall picture for strategic management is similar to that of process management; within the health sector, the interplay between hierarchy and network-based strategies is complementary, but apart from the local level, there is little planning across sectors. The inter-sectoral, network-based planning at the local level therefore remains poorly supported. Again, this is problematic

as joint planning can also be difficult. Among schools, SchoolHealth enjoys low acceptance and a number of respondents suggest that flexibility rather than planning is required to engage and support front-line provider organizations:

> Montreal Public Health has formulated three main priorities at population level. It can occur that we are interested in building a partnership with a school, but that school is not interested in any of those priorities.
>
> (Programme manager, HSC center, Village)

Similarly, other respondents stress the importance of providing ad hoc support based on specific and concrete needs. With the cuts in funding over recent years, the individual HSC centers also have very limited resources for planning and evaluation.

Financial Management – Funding and Auditing Support Activities in SchoolHealth

The funding for supporting coordination in SchoolHealth is input-based and follows the principle of hierarchy. The RHA pays for one local coordinator in each HSC center. This is the only direct funding available. The HSC centers also offer ear-marked funding to private, non-profit community organizations, which can include activities to support coordination in SchoolHealth. All other front-line support activities have to be covered by existing staff. The level and scope of support through funding emerges as limited. There is too little hierarchy, and it does not extend to the education sector.

The same is true for auditing the support of coordination in SchoolHealth, which is output-based and network-oriented. The definition of output is the number of local schools working with the SchoolHealth approach. The underlying idea is that the ministry uses auditing as a lever for offering support to regional health authorities. The connection is rather weak in practice, and the indicators are used as a general assurance that funds are well spent:

> What happens is that when their indicator [target for number of schools in SchoolHealth] is green, I conclude that they strive to adopt [School Health]. […] Then we send them a [letter]: "Perfect, congratulations and keep up the good work. You succeed beyond what was expected" […].
>
> (Respondent, Ministry of Health and Social Affairs)

The network nature of auditing is underlined by the fact that even when there is no improvement, the discussions with the regional health authorities remain constructive.

Especially at the local level, the relative strength of the audit as a strategy to support HSC centers is rather week. This reflects a deep disconnect between the results audited and the actual support activities provided and also has potentially serious, unintended negative side effects.

With their focus on the number of schools and the process of implementation, the indicators fail to capture the actual services provided by the HSC center and the local schools. The indicators are also closely modeled on SchoolHealth as a specific approach and fail to capture other relevant activities. This extends to activities leading to procedural output, such as making contact and negotiating. These are crucial for SchoolHealth, which relies on inter-sectoral collaboration. Local schools and regional education authorities also do not follow the same indicators.

The engagement of HSC centers and local schools in SchoolHealth and in health promotion and prevention more broadly largely remains invisible. This is exacerbated as indicators do not come with any funding:

> If you do not build indicators protecting intersectoral action, then you can forget about SchoolHealth. We will not implement this programme.
>
> (Respondent, Roundtable on Health Promotion and Prevention)

In the context of tight financial and personnel resources, SchoolHealth and related activities can easily loose out in favor of clinical activities, which with their individual focus are more easily accounted for and where funding follows performance.

Summary

Québec's provinical administration uses traditional planning and evaluation instruments (hierarchy-based governance) to support the implementation of SchoolHealth, but these instruments are essentially mono-sectoral. The regional level uses the same instruments, but also offers some incentives to connect with actors from the education sector and with community organizations (network-based governance). The interviews highlighted the limited resources of local health actors to enroll schools in the program, and implementation ultimately depends on schools' willingness to engage in SchoolHealth. There is thus a gap between the hierarchy- and network-based governance, especially across regional and local levels and across the health and education sectors. The ability to connect different modes of governance appears weaker than expected and in the following we review broader, underlying changes in governance capacity.

Accounting for Weak Governance Capacity to Connect Different Support Strategies

Institutional Capacity

Centralized Administration. In Québec, support strategies for coordinating public health are embedded in a multi-level context where responsibilities are distributed among provincial, regional and local levels. The levels relate to each other through command and control, although the specific means and the degree of (de)centralization have changed (Gaumer and Fleury, 2007).

Writing about Canada, Raphael and Byant (2006: 42) state that historically, the responsibility for public health has first and foremost been with local and regional levels, whereas provincial legislation specifies mandatory responsibilities of the lower levels. This also applies to Québec. The tasks of regional health authorities include planning, allocating funding and supporting the local level, whereas implementation lies with the HSC centers. This includes coordinating public health services with local service providers, but there is considerable local leeway.

This form of centralized administration at regional levels has co-existed with the legacy of 1960s public administration based on concertation and consensus (Facal and Bernier, 2008: 502). For example, allocation of funding follows hierarchical lines from regional to local levels and also

draws on consultation of local actors. This is not a formal requirement, but is employed to strengthen the legitimacy of budgets (Arweiler and Contandriopoulos 2007).

The last decade has seen moves to further centralize administration by strengthening the provincial level. The 2003 reform created the HSC centers (*centres de santé et de services sociaux*) as larger administrative structures, coordinating primary care and public health services. It also reinforced regional administrative responsibilities in relation to coordination. Although this took place after we completed our research, the 2015 reform confirms this trend. It replaced local care centers with larger units, dismantled regional health authorities and granted the ministry greater responsibilities.

Strong Administrative Apparatus. In Québec, each of the three levels has historically been responsible for both health and social care services; especially at the local level, this was combined with a strong focus on population health. This is embodied by local community service centers (*centres local de services communautaires*), which emerged at the inception of the health system in the early 1970s (Gaumer and Fleury, 2008). This helps to institutionalize community-based primary care services, together with a political culture of state interventionism and a strong notion of solidarity (Facal and Bernier, 2008: 503ff).

Over recent decades, the administrative apparatus has been further strengthened. The public health focus has become more distinct at regional and provincial levels and public health has been more closely integrated into the mainstream healthcare system (Breton et al, 2008). The 1992 reform saw the creation of separate public health directorates at both provincial and

regional levels, required to produce regional public health plans. This was extended to the local level in 2003 (Breton et al, 2008), and the new HSC centers (CSSSs) have explicit responsibility for public health. At provincial level, government created the National Institute of Public Health in the late 1990s to support the ministry and the regional health authorities. The 2001 Public Health Act also defined the responsibilities of the latter two in a more explicit way. Indeed, Bernier (2005: 13) argues that compared to other provinces, Québec adopts a "strongly statist" approach.

In practice, the administrative apparatus also has weaknesses. Provincial and regional levels do not always support local implementation of public health programmes in a satisfactory way, and local actors lack clout vis-à-vis local counterparts. For example, a study of child healthcare services (AUTHOR et al, 2012) highlights that the ministry only outlines overall ideas and largely leaves implementation to individual HSC centers and their local partners. The formal requirements for inter-sectoral coordination also remain minimal, while regional and local levels do not always have the necessary resources to support coordination (Gaumer and Fleury, 2007: 15).

Policy Instruments. Historically, direct provision and coordination of public health services have been the main instruments located at local level. At present, this is the overall responsibility of the HSC centers together with local service providers and community organizations.

Over the last decades, a wider range of instruments has emerged (Bernier, 2006). Most prominent are three-year healthcare plans and closer steering of funding streams. They are

located at central levels and create tensions with decentralized policy instruments (Gaumer and Fleury, 2007).

Planning occurs through a centralized system of nested three-year plans. Besides local health plans, HSC centers also have had to write service agreements since 2001, which are approved and monitored by regional health authorities. In turn, they have to produce three-year plans and management agreements to be approved by the ministry. Policy instruments draw on both local decentralization and strong centralization to regional and especially provincial levels (Gaumer and Fleury, 2007: 12f, 18).

The policy instruments related to funding of public health services are also more centralized (Arweiler and Contandriopoulos, 2007: 105ff). Targets for budgets, results-oriented budgets and programme-specific funding are on the rise. The allocation of funding across regional health authorities is now based on a more detailed formula, which distinguishes between different programme areas and indicators of needs within each programme. Auditing procedures have become more formalized and form part of two layers of management agreements between the ministry, regional health authorities and HSC centers. This is in line with the emergence of more results-based management following the Public Administration Reform Act in 2002 (Rouillard et al, 2008: 25).

Relational Capacity

Historically, community-based, third-sector organizations have played an important role in public health activities, reflecting social mobilization in the 1960s and 1970s. The initial local community service centers had close ties to community organizations, and their remit included fostering community-based activities (Gaumer and Fleury, 2008). The importance of the third sector is a more general characteristic of Québec (LaForest, 2006; Orsini, 2006). Historically, non-profit organizations play on important role in providing welfare services, adopting a double position: They were social critics, making demands on the state to improve the socioeconomic conditions of the most vulnerable populations while receiving public funding for their activities. This unique position was first recognized in 1973, and the support programme gave non-profit organizations a lump sum to pursue their own strategic priorities (Jetté, 2008). Subsequent legislation confirmed and extended this support (White and Equipe d'évaluation de la politique, 2008).

Over recent decades, the ties to the community weakened. Local centres were more closely integrated into the healthcare system, offering a fixed set of services mainly within primary care. In the 1990s community organizations became a vehicle for the shift to primary care, although this occurred under extreme budget cuts. The ministry has also relied more heavily on project funding (White and Equipe d'évaluation de la politique, 2008). This typically occurs within a framework programme asking non-profit organizations for bids. Together, this forces non-profit organizations to adjust activities to be more in line with ministerial priorities.

Summary

Since the 1960s, Québec's public health services have relied on a balance between strong administration and strong ties with the community. Institutional reforms in the past decades have disrupted this balance. Increasing centralization has strengthened the vertical orientation of the health administration at regional and local levels, while the mainstreaming of community organizations has narrowed their focus on service delivery. The ties between the health administration and community organizations have thus become looser. This is significant in the relation to SchoolHealth, as the health administration at provincial and regional levels does not seem to employ its strengthened institutional capacity to reach out to the education sector and to employ intersectoral support strategies

Discussion

The article set out to account more systematically for the 'what' and 'why' of gaps in the co-existence between different modes of governance. Based on a case study of public health in schools in Québec, the answer is two-fold. First, gaps consist of a lack of connections between mono-sectoral hierarchy- and intra-sectoral network-based support strategies in the management of school health services. Second, this reflects a de facto weakened governance capacity, where provincial/regional government does not use its (strengthened) institutional capacity in an intersectoral manner, and where relational capacity is too weak to compensate.

Gaps between Support Strategies

Hierarchy-based support strategies are predominantly mono-sectoral and connect poorly to network-based support strategies that are cross-sectoral (see table 2 below).

TABLE 2 ABOUT HERE

SchoolHealth requires support strategies that focus directly on inter-sectoral coordination in a multilevel context; this echoes the literature on joined-up government (Pollitt, 2003). However, different clusters of governance do not always connect, as Haveri et al (2009) find in their study of governing collaboration in Finnish and Norwegian municipalities. This also applies to SchoolHealth; it includes three types of clusters of support, but hierarchy-based support strategies lack continuity across clusters:

(1) a provincial cluster, consisting of the Ministry of Health, the National Institute of Public Health, the regional health authorities and, through the initial joint agreement, the Ministry of Education;

(2) regional clusters, including the RHA, the HSC centers and, through a formal agreement, the regional administration of the Ministry of Education; and

(3) local clusters, with the HSC center, the local school commission(s), the local schools and the local community organizations.

The governance cluster at provincial level is de facto mono-sectoral and focuses on hierarchical support strategies. The governance clusters at regional level are formally inter-sectoral and engage in some network-based support strategies but, in practice, their activities are mostly mono-sectoral and focus on hierarchical support strategies. Only the local governance clusters actually engage in inter-sectoral and network-based support strategies.

The local governance clusters emerge as the primary arena for directly supporting inter-sectoral coordination, and network-based forms of support prevail. This reflects the complexity of the governance issue (Lægreid et al, 2015). Complexity also requires support; based on their analysis of the impact of network management of water supplies in Norway Hovik and Hanssen (2015, similarly Conrad, 2015) find that the more complex the coordination the more direct governance is required. This makes it potentially problematic that network-based support strategies are poorly connected to hierarchy-based support strategies, which are mono-sectoral. The only exception is the initial joint agreement between the two ministries and the corresponding agreement between their regional administrations. The clusters at provincial and regional levels also make very little use of support through financial management, and this exacerbates the situation. Kiland and Torjesen (2013) also identify lack of financial support as one of the major challenges for local public health partnerships in Norway.

Weakened Governance Capacity to Connect Support Strategies

The disconnect between hierarchy and network-based support strategies at provincial and regional levels has clear knock-on effects for local clusters of support. This results in conflicts over proper goals of schools (teaching subjects vs. fostering personal development) and makes organizing and planning the support of coordination difficult. Conflicts are multiplied as negotiations are highly nested.

This is at odds with the historically strong governance capacity in public health in Québec. combining strong institutional and strong relational capacity (see Table 3 below). The former

includes *centralized administration* at regional levels, a *strong administrative apparatus* in the form of combined responsibility for health and social care, and direct provision and coordination at decentral levels as *policy instruments*. Strong relational governance capacity means that local centers have close ties to their communities and that community organizations are important providers of public health services.

TABLE 3 ABOUT HERE

The disconnect between support strategies also seems at odds with the further strengthening of institutional governance capacity over the past 10-20 years. *Centralized administration* has been extended to the provincial level, and a clearer focus on population health at the regional and provincial levels and a greater integration of public health in the mainstream health system have considerably enhanced the *strong administrative apparatus*. *Policy instruments* have been extended in range and to central levels. Importantly, in the case of SchoolHealth the health administration did not seem to use its strengthened institutional capacity to reach out to the education sector and to enhance the inter-sectoral nature of their support strategies. This puts high expectations on relational capacity, but are hard to fulfil. By default rather than design, ties to civil society have weakened, whereby regional and local health administration has become more oriented towards the next level and whereby community organizations have become more focused on service delivery. For SchoolHealth, relational capacity lacks both depth and width to stretch across levels and to include the education sector.

Implications for understanding gaps in the co-existence of different modes of governance

What are the more general lessons about gaps we can draw from the critical case study of supporting public health services in schools in Québec? While gaps in the co-existence of different modes of governance lack detailed conceptualisation in the literature, they have become more common. The reason is two-fold: governance is an increasingly complex task and governance capacity is more fluid.

Governance is an increasingly complex task of coordination. For example, public health services pose "wicked problems" of coordination, as public health encompasses a broad range of functions spanning across different sectors of the health system and beyond (Fierlbeck, 2010). This also applies to public services more broadly (McGuire, 2006) and coordination across horizontal and vertical divides is high on political agendas. Yet this task has become more complex (Bryson et al, 2015; Lægreid et al, 2015); New Public Management reforms have fragmented public services with their double focus on including more non-public providers and on shifting responsibility to lower levels.

Contexts of governance are also highly complex (Hovik and Hanssen, 2015; Howlett, 2011; Voets et al, 2015); they are specific and vary across government levels, programmes and policy sectors. In relation to each specific dimension, governance will face different sets of challenges depending on the level of administrative resources, the state of cooperation among civil society organizations and politicians' conception of relational governance. Governance is not neutral either; it produces its own, often unintended effects and is interpreted differently depending on where it is applied (Lascoumes and Le Galès, 2007).

Another reason why gaps have become more common is that governance capacity is more fluid; it is not fixed in time but emerges as in perpetual, albeit slow, movement. The layering of policies and strategies across policy sectors affects how a specific set of strategies to support coordination operate. For example, governments cannot take for granted that more hierarchy at the center will translate into effective exercise of authority across levels. In the case of Québec, New Public Management reforms have unwittingly favored hard forms of institutional governance capacity, which poorly connect to existing relational governance capacity. Indeed, they have weakened state-civil society as the seat of legitimacy for many public actions in health and social services. Soft forms of institutional governance capacity might have been better able to maintain relational governance capacity (Martin and Guarneros-Meza, 2013; Vabo and Røiseland, 2012).

In short, the increasing complexity of the task of governance and the higher fluidity of governance capacity suggest that gaps in the co-existence of modes of governance have become more common. In terms of research, this calls for a more thorough conceptualisation of the nature of such gaps and why they occur. The present study has made some initial steps suggesting that gaps can be thought of as different types of disconnects underpinning the management of public services and that gaps reflect weak governance capacity. Future studies need to set focus on gaps across a wider range of policy areas and countries to test and refine relevant conceptualisations of gaps. In terms of policy practice, the increasing relevance of gaps requires first and foremost taking the existence of such disconnects seriously. If gaps can be overcome, is an open question. Reforms of public services often consider structural changes as a

magic bullet. As our study powerfully underlines, structures operate in time and place specific contexts and therefore require explicit attention understood as a type of mirco-steering (Jacobsson et al. 2015). However, the structures underpinning gaps may not be amenable to change and this calls for policy practitioners to have more realistic ambitions.

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Table 1: Functions of Public Management and Underlying Modes of Governance

Process management	Organizing public services • Strongly mandated (hierarchy) • Weakly mandated (network)
Strategic management	Planning and evaluating public services • Top-down, unilateral (hierarchy) • Bottom-up, interactive (network)
Financial management	Funding & auditing public services • Input-based (hierarchy) • Results-based (network)

Adapted from Bouckaert et al (2010).

Table 2: Overview of Different Strategies for Supporting Coordination in SchoolHealth and How They Connect

PROCESS MANGEMENT Organizing support	• Strong mandate for support through legislation, but highly formal and only partly inter-sectoral (hierarchy) • Many less mandated forms of support, but predominantly health sector based apart from local level (network)
STRATEGIC MANAGEMENT Planning and evaluating support	• Top-down, unilateral planning and evaluation through *healthcare* agreements (hierarchy) • Complemented by bottom-up, interactive planning and evaluations as part of regular, informal discussions, but only inter-sectoral at local level (network)
FINANCIAL MANAGEMENT Funding and auditing support	• Funding input-based (hierarchy), but limited and only health sector-based • Audit output-based through indicators (network), but weak as disconnect with (inter-sectoral) practice

Table 3: Overview of Governance Capacity to Connect Different Support Strategies in SchoolHealth

INSTITUTIONAL CAPACITY		RELATIONAL CAPACITY
Centralized administration	• Historically, located at regional levels and combined with local leeway for implementation and undercurrent of concertation and consensus • Recent moves to strengthen provincial level	• Historically strong ties with community and Community organizations important providers of public health services • Recently, ties to community weakened because of mainstreaming: HSC centers and community organizations more integrated in health system
Strong administrative apparatus	• Historically, combined responsibility for health and social care • Recently, stronger focus on population health at regional/provincial levels and Public health integrated into mainstream health system	
Policy instruments	• Historically, through direct provision and coordination at decentral levels • Recently, wider range of instruments and at central levels (health plans, steering funding streams)	