EVALUATION OF THE IMPACT OF DEPARTMENTS OF COMMUNITY HEALTH IN THE PROVINCE OF QUEBEC

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Introduction

The concept of the Department of Community Health (usually referred to as DSC the initials of "Département de Santé Communataire") is an extremely interesting one; it locates within an acute general hospital not only in-patient and out-patient services but also the headquarters of the staff whose task it is to study health problems within the catchment population, design appropriate health promotion programmes for that population and evaluate the impact of both health promotion and health care provision on that population.

At the moment in Coventry we are looking at ways in which eg: a particular hospital might include within its facilities health promotion, preventive medicine, health screening and evaluation. It was felt that the experienced gained in the Province of Quebec would be of considerable value to us at this particular point. Accordingly it was considered that a study visit would have the following two benefits:-

1. Involvement with Canadian colleagues in the evaluation of the degree of success of these developments now that a decade has passed since their introduction.

2. More specifically, identification of the potential for translating the most successful aspects of these developments into the local scene in Coventry (and, to the extent to which others might be interested, into the wider NHS).

Method

I flew to Montreal on 16th March 1987 and returned to England on 28th March 1987. Between these dates I followed a programme of visits, meetings and discussions, kindly arranged for me in advance by the Quebec Provincial Government Department of International Co-operation. Although I visited Quebec City and the City of Sherbrooke as part of this programme, I was based in Montreal, travelling by bus or aircraft as appropriate. Details of the programme are set out in Appendix 1.

My initial sessions were with academic staff of the Department of Social and Preventive Medicine and the Department of Health Service Administration at the University of Montreal. Thereafter I visited four DSCs, three in Montreal and one in Sherbrooke but my detailed study focused on two of these - that associated with the Montreal General Hospital (the teaching hospital attached to McGill University) and the one associated with the University Hospital at Sherbrooke. My visit to Quebec City was for the purpose of attending a Conference on "Health Profile and Monitoring" organised jointly by all thirty two DSC's in the Province.

Findings

1. HISTORICAL BACKGROUND

In 1933 a Provincial law was passed setting up a network of public health units which, apart from in Montreal and Quebec City, replaced the existing Municipal Public Health Departments throughout the Province. These new units and the existing Departments together provided all the

traditional public health services such as infectious disease control, maternal and child health, the school health service etc.[1]

However, in the early 1970s, a major reform of Health and Social Services was launched in the Province as a result of the Castonguay-Nepveu Report.[2] The main concern of this report was to develop the existing system of medical care and to link it with the existing Public Health and Social Welfare Services. The ultimate objective of these radical proposals was to improve the health of the population;[3] in spite of this, and although the intention had been to include health promotion and preventive medicine as integral parts of the medical care system, the report did not really focus sufficiently sharply on the means of achieving this in practice and, as a result, the Quebec Government created a task force in 1971 to make recommendations with regard to the detailed organisation of the public health sector. The outcome was the Law Respecting Health and Social Services (1971),[4] the enactment of which created the framework for the organisation of the public health function - now referred to as "Community Health" (not simply a change in title but a substantially changed orientation, as will be demonstrated).

The result of the legislation of the early 1970s was the creation of three new structures below the Ministry of Health and Social Affairs as shown in the table:-[5]

PUBLIC AGENCIES RESPONSIBLE FOR PUBLIC HEALTH IN QUEBEC

Agency	No	Territorial Jurisdiction	Population	Public Health Functions
Ministry of Health and Social Affairs	1	Province	6.5 millions	To establish Public Health Policies and Regulations.
Regional Council	12	Region	200,000 - 2 millions	To allocate resources according to needs and Regional Priorities.
Department of Community Health (DSC)	32	Sub-Region	50,000 - 400,000	To identify health needs of population, to develop and implement health programes, to co-ordinate community's efforts aimed at achieving health objectives, to evaluate the impact of programmes.
Local community service centres (CLSC)	140	Local	20,000 - 70,000	To provide health and social services to individuals in the local population.

One of the major objectives of setting up the twelve Regions was to render more effective the functions of planning, organising, co-ordinating and evaluating health and social service programmes in each Region. However, it was felt appropriate to further divide each

Region into Sub-Regions and to establish, in each of the latter, a DSC within the most appropriate acute general hospital. Thirty two DSCs were rapidly established and each was assigned the tasks of:-

1. Analysing health problems within the catchment population of the hospital (its "territory").

2. Developing and implementing appropriate health promotion programmes.

3. Co-ordinating the existing resources within its territory, including community efforts, aimed at achieving health objectives.

4. Assessing the impact of the programmes on the health of the catchment population.[6]

The CLSCs (Centres Locaux de Services Communataires) were established at neighbourhood level, each to provide Primary Health and Social Services for its local population. It was intended that there should be a comprehensive network of 166 CLSCs developed throughout the Province to work closely with the DSCs within whose territory they lay, together creating the organisation for the promotion of community health at Sub-Regional level.[5]

2. BRIEF OUTLINE OF DEVELOPMENTS SINCE THE EARLY 1970s

The network of DSCs was quickly developed as most of the personnel required to staff them were available for transfer from the Municipal Public Health Departments of Montreal and Quebec City and from the

Public Health Units throughout the remainder of the Province. Furthermore DSCs were grafted onto already existing and functioning organisations, namely the thirty two acute general hospitals selected for this pupose. Thus, there were no significant economic implications in setting up the new structure at this level.

The development of the network of CLSCs has been much slower as these have required additional resources. Whereas it took less than a year for the thirty two DSCs to be completely established, the full network of 166 CLSCs, as initially planned, is still not yet complete; at the present time there are currently 140 CLSCs in operation.[5]

The Director of each DSC is a Board-certified Specialist in Community Health who enjoys the same status as the head of any of the Clinical Departments in the hospital such as Surgery, Paediatrics etc. He or she also enjoys a "protected budget" which ensures that the money which the Government has earmarked for the promotion of community health is really spent for that purpose.[5] At the local level the CLSCs integrate Health and Social Services and are responsible for the direct provision of these to their local populations. However, each CLSC is an autonymous body with no formal obligation to accept the health promotion programmes developed by the DSC within whose territory it lies; only by consensus committees can the influence of DSCs be exercised over CLSCs.[1]

3. EXPERIENCE GAINED IN THE PROVINCE OF QUEBEC SINCE THE INTRODUCTION OF THE NEW STRUCTURE (BASED ON VERBAL COMMENTS OF DRS RAYNALD PINEAULT, GEORGES DESROSIERS, JOHN HOEY, ROGER GOSSELIN, ROBERTO IGLESIAS, PIERRE DUPLESSIS AND WILLIAM SHANNON, UNLESS REFERENCES INDICATE OTHERWISE)

3.1 Integration of the DSC within an acute general hospital.

It has not proved a uniformly smooth task to integrate a department geared to the promotion and evaluation of community health within an establishment with a traditional curative role. Although the DSC was to become the "community conscience" of the hospital[7] this has been considered somewhat ambitious and perhaps unrealistic.[1] Where integration has gone ahead smoothly this has tended to be within the administrative structure of the hospital, rather than within the professional structure.[5]

The Directors of DSCs themselves are not in total agreement on this issue. Of the three whom I met personally, two (Drs Iglesias and Duplessis) felt very strongly that having their DSCs located within prestigious hospitals gave status to the specialty of Community Health and offered the opportunity of involving clinical specialists in health promotion activities. On the other hand, the third (Dr Hoey) felt that his "protected budget" was at such risk of being eroded by the demands of his clinical colleagues that he recently moved his DSC "off site" from his - equally prestigious - hospital and now feels that his community health programmes are likely to be more robust and to have greater impact. An interesting observation was made to me on this issue by a Radiologist working at the Montreal Institute of Cardiology to the effect that "unless a Director of a DSC works from within a hospital, the clinical specialists will never get to know him personally and will therefore be totally uninterested in what Community Health is all about".[8]

3.2 Relationships between DSCs and CLSCs within their territories.

Although it had been the original intention that the DSCs should co-ordinate the community health promotion activities of the CLSCs,[6] since the network of CLSCs developed much more slowly many DSCs initially found themselves having to assume temporarily the responsibility of providing direct Health and Social Services within the community. Furthermore such services were delivered according to those traditional public health programmes which were familiar to the staff (mostly public health nurses) which the DSCs had inherited from the Municipal Public Health Departments of Montreal and Quebec City and the Public Health Units throughout the rest of the Province. This direct service provision militated against the planning, programming, co-ordinating and evaluating roles intended for the DSCs and latter campaigned vigorously for the further transfer of these staff to the emerging CLSCs so that both organisations could get on with the tasks intended.[9] When this transfer actually took place, the DSCs found themselves almost totally without fieldwork staff who could implement the community health promotion policies drawn up as a result of their epidemiological surveys. This paradoxical situation was described as the DSC being "like a brain with no hands" (Raynald Pineault) or "a penguin without flippers" (Pierre Duplessis). On the other hand the view was expressed that too much could be made of such analogies and that a DSC could work towards establishing a high profile in community health promotion within its territory (John Hoey).

With the aquisition of new staff however, from other disciplines such

as epidemiology, biostatistics and the social sciences, the DSCs are now well placed to influence the CLSCs and other community agencies in health promotion issues but, as has been mentioned before, only by collaboration, persuasion and careful use of such local media as the press, radio and television.

3.3 Relationships between DSCs and General Practioners practising in their territories.

Apart from those working on a sessional basis in CLSCs, General Pracitioners are totally professionally independent and are remunerated on a fee for service basis, within the Province's health insurance scheme. Those working within CLSCs relate well to the DSCs but it appears that the remainder have little contact with the DSCs. This is considered not only disappointing but also potentially damaging to the cause of community health promotion as 80 - 90% of the population receive primary health care from such independent General Practitioners and only 10 - 20% from those working at CLSCs. This has lead to a realization that actively seeking consultation with local General Practitioners is likely to be the only way to establish dialogue, let only partnership.

3.4 Relationships between DSCs and the Regional level.

Although the Regional Councils' role focussed initially on facilitating co-ordination and consolidation it gradually encompased the responsibility of financing programmes.[6] Moreover it has not been easy to determine respective planning roles for the Regions and the DSCs at Sub-Regional level. Theoretically the Region has the

responsibility of allocating resources according to its own perceived needs and priorities; accordingly there has been an identified overlap in the assessment of needs and priorities between the Region and its constituent DSCs.

Interestingly enough, this does not constitue a problem in the Region of Estrie, where the territory covered by the DSC based in the teaching hospital in the City of Sherbrooke is coterminous with the Region itself (a relatively compact one with a population of around 240,000); here a consensus approach reflecting the shared views of the Region, the DSC and the CLSCs has resulted in agreed planning objectives. The problem has also been solved in the two northern Regions of Nouveau Québec and Côte Nord where the existing single DSC in each case has been merged with the relevant Regional Council.

Such developments, taken along with the identified planning overlap, are currently matters of considerable concern to staff of DSCs who feel that their very existence is threatened before they have had the opportunity of demonstrating their impact on the health of the communities which they serve.

4. EVALUATION OF THE SYSTEM SO FAR, AS PERCIEVED BY PROFESSIONALS WITHIN THE PROVINCE

The Provincial Government's reasoning behind the major reforms of the early 1970s was that one might acheive a kind of "global medicine" in which one would find health and social services integrated so as to provide a comprehensive spectrum of activities such as education, advice, prevention, diagnosis, treatment and rehabilitation, with the

public participating in the running of all services.[10] The last mentioned certainly seems to have been achieved at both Regional and local levels by the active involvement of the consumer by membership of both the Regional Councils and the Management Committees of CLSCs; between these two levels, the DSCs are perceived as essentially professional entities, orignally considered rather technocratic but no longer so because of their latter tendency to recruit social scientists in addition to epidemiologists and biostatiticians.

The integration of diagnosis, treatment and rehabilitation also seems to have been well established, but as far as the promotion of community health is concerned - with its elements of education, advice, prevention and screening - the main obstruction would appear to be, regrettably, the extent to which General Practitioners clearly wish to stay "outside the system". For example, once he or she has satisfied the various professional bodies, a General Practitioner can set up in practice within the territory of a DSC without informing the latter of his or her existence, except fortuitously for example by notifying a case of infectious disease. Bearing in mind that 80 - 90% of the population receive their primary health care from such General Practitioners, it is virtually impossible for the DSC to assess for example, the take-up of immunisation within its territory as General Practitioners are remunerated directly by the health insurance organisation for such activities, as part of the total fee-for-service method of payment, and are in no way obliged to inform the DSC. The advantages of the relatively close links between General Practitioners and District Health Authorities in England are much envied by the staff of Quebec DSCs.

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Having dealt with issues of structure and process it is necessary to comment on outcome evaluation. Here particularly there is evidence of candidness and critical appraisal and DSCs appear at this stage to be more confident about "intermediate outcome" than "final outcome" for the following three reasons:-

1. The network of Regional Councils, DSCs and CLSCs is barely completed and the DSCs in particular for some years initially have had to devote many of their energies to administrative matters such as staff transfer and re-transfer rather than to their primary functions.

2. Debate is still active on those health indicators which measure the success or otherwise of health promotion programmes.

3. There is an acknowledgement that assessment of improvement or otherwise in the health status of a population is a relatively long-term issue.

Excellent examples nevertheless of "intermediate outcome" can be demonstrated as outlined below:-

1. The DSC associated with Montreal General Hospital (a map of territory set out in Appendix 2) has produced and distributed widely a publication entitled "Health Priorities - 1985 - 1987",[11] setting out health problems identified by survey methods along with suggested courses of intervention. The topics include not only such predictable issues as cardiovascular disease and cancer but also the consequences of the loss of independence and

social isolation of Senior Citizens.

It is significant that the publication is addressed to "organisations, professionals and residents of the territory". Furthermore it draws attention to the differential importance of the various health problems in each of the four CLSC sectors within the territory as a basis for local action by professionals, organisations and consumers. It is also significant that active - and successful - attempts were made to consult with local General Practitioners, amongst others, when the document was still at the preliminary draft stage.

The DSC has also published documents relating to health expectancy in the territory,[12] and sociodemographic, health and lifestyle characteristics of the residents,[13] the latter representing the findings of the detailed surveys referred to earlier.

A further interesting initiative taken by this DSC is that in 1983 it established a Regional infectious disease control unit to co-ordinate communicable disease control activities covering not only its own territory but also those of the other seven DSCs which, in total, cover the greater Montreal area. This appears to be a lively and extremely effective unit.

It would appear that this DSC is making a considerable impact on community health in "intermediate outcome" terms and one can understand the wish of its Director to take every possible precaution to secure his "protected budget", even at the expense

of relocating his headquarters separately from the hospital!

2. Quite a different approach has been adopted by the DSC attached to the Teaching Hospital in the City of Sherbrooke (map of territory set out in Appendix 3). Here, the two striking features are the position of the Director within the hospital and the particular emphasis on occupational health.

The Director is not only clearly perceived as a senior member of the hospital medical staff, he also teaches Community Health at both undergraduate and postgraduate levels as a senior member of the university staff. This arrangement gives him the opportunity of interesting clinicians in the promotion of community health and of involving them publicly in relevant programmes. To what extent these factors play a part one can only guess but certainly the DSC's community health programmes appear to be well received by both CLSCs and the general public. A particularly interesting initiative has been the creation of a "health boutique", in the heart of a busy city supermarket, where health promotion and screening are "marketed" in an attractive and interesting manner which clearly appeals to the public.

The emphasis on occupational health clearly reflects the importance of mining and quarrying (including asbetos), timber-felling, metal-working, chemical engineering and textile mills which form the economy of the territory (which, interestingly enough, holiday visitors from the USA tend to see only as a

Region of lakes, mountains and forests, suitable for camping, fishing and skiing).

The DSC, being in contract with the provincial committee for health and safety at work, employs a Senior Medical Specialist who directs a team of doctors, nurses, hygienists and researchers to oversee the relevant activities (which are prescribed by law) covering safety at work, control of risk factors in the work environment and health screening of employees; health education in the work place is also a prominent feature of the set up. The DSC further "sub-contracts" some of the responsibilities to the CLSCs within the territory but retains the accountability for the standard of service provided. (This represents an atypical relationship between a DSC and the CLSCs, the reason being that the provisions and standards of the service are governed by statute).

Personal Impressions and Summing Up

The establishment of the DSC, with its defined functions in relation to the assessment, promotion and evaluation of community health, within an acute general hospital represents an interesting initiative, providing an innovative approach and allowing traditional structures and procedures to be challenged.

Leaving aside the impressive achievements of the DSC associated with Montreal General Hospital, which say much more about the staff of that organisation than the framework within which they work, there is a clear

and unambiguous message to the effect that programmes for the promotion of community health which radiate outwards from a busy general hospital to its catchment population carry considerable credibility. The fact that this is largely based on a (probably universal) public myth - namely that doctors are experts in health - is irrelevant if the results are positive. Most professionals would agree that hospital clinicians are primarily interested in the diagnosis and treatment of disease (and the clinicians themselves would argue that this is what they have been trained to do). But if eg: a white coated Cardiologist, stethoscope around neck, can be both visibly and audibly associated with a local campaign to reduce the incidence of coronary heart disease, and it is shown that this increases public interest and response, then the location of the DSC within the hospital would appear to have many advantages.

Furthermore we must not behave as if the situation was static. Many newer approaches to undergraduate medical training in both Canada and the United Kingdom include relevant aspects of the behavioural sciences from the begining of the curriculum and the gradual development of the epidemiological approach in clinical teaching inevitably brings in the "missing denominator", ie: the population from which the cases arise.

Lastly, an increasing number of hospital clinicians may see more clearly the merit of contributing to the reduction of the potential acute in-patient case load, especially as hospitals, in Canada as in England, learn that their resources are not infinite. Accordingly it would not be unreasonable to suppose that, for example, the clinician responsible for the trauma service could become interested in, and

actively associated with, local accident prevention educational programmes and Paediatricians with efforts to secure the maximum take-up of routine childhood immunisation.

The question of the involvement of General Practitioners in community health promotion would appear to require addressing as a matter of urgency. Apart from those working within CLSCs, the very excellence of the Quebec Health Insurance Plan from the medical care point of view would seem to militate against motivating the General Practitioner to become involved in local health promotion activities. However, the DSC associated with Montreal General Hospital has shown that this can be done and others could with benefit follow that example.

Now that the majority of DSCs have settled down to a mutually satifactory interactive relationship with the CLSCs within their territories, what is perhaps now needed is a period of organisational stability which would allow the DSCs to demonstrate their capacity to tackle their original mandate. If the Regional Councils were to absorb them there would inevitably be a loss of the sense of corporate identity which exists at Sub-Regional level and the planning and evaluation of programmes would be moved one step further away from the population served (which is, in fact, contrary to the decentralisation philosophy which underpinned the original ideology). Perhaps there may be scope for compromise, eg: by the DSCs remaining responsible for the functions within their territories but being made directly accountable - in a managerial sense - to the Regional Councils so that planning objectives, with associated resource allocation, might be agreed as a result of interactive discussion between the two levels, and perhaps a performance

review process built into the system.

Further developments within the Province will clearly merit continuing interest.

Possible Implications for Coventry Health Authority

It is frequently a valid criticism that study visits to North America by United Kingdom health professionals are of little practical value to the NHS because the resources of the latter rarely allow the costly developments in the prestigious "show places" which tend to be on the visiting circuit. This study deliberately avoided this pitfall in that its purpose was to determine to what extent one health care establishment, namely a hospital, could take on additional responsibilties over and above its traditional role and to what extent such an arrangement might render more effective and efficient the new activities.

Although the model would probably work most smoothly in England where a medium-sized District was served by one all-purpose general hospital, Coventry is nevertheless well placed to consider, at least, some aspects of the Quebec experience:-

Firstly, as a result of both the introduction of General Management and subsequent rationalisation of facilities, there is a very real opportunity to take a critical look at how we utilise all the facilities and services which we control.

Secondly, we have a city centre acute hospital, readily accessible from all parts of the District, which currently houses the city's

Accident Department, the great majority of the various specialty out-patient clinics and a wide range of diagnostic laboratories; a major consequence of this is that a highly significant proportion of the population of the District "pass through the doors of the hospital" in any given year.

Thirdly, there are already tentative plans to relocate the Health Education Division within that hospital, from its present highly unsatisfactory position at District Headquarters.

Fourthly, it is almost certain that, witin a year, the first routine mammographic screening facility in the West Midlands Region will be based at this hospital, offering a service to women aged 50 - 64 years.

Fifthly, the Department of Traumatic and Orthopaedic Surgery at the hospital has expressed keen interest in being involved in accident prevention educational programmes (the Consultants concerned were actively involved, along with the City's MPs, in pressing for seat belt legislation).

Sixthly, the hospital also houses the Genito-Urinary Medical Clinic which, of course, deals with by far the greatest volume of counselling and testing for HIV infection.

Lastly, the General Manager of the hospital has expressed interest in developing health promotion activities <u>within</u> the hospital in accordance with the Health Authority's Timed and Costed Programme for health promotion and preventive medicine.

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All these factors would appear to suggest that this particular hospital could readily take on a role which would allow it to be perceived by the District population as a centre of health promotion, preventive medicine and screening.

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PROGRAMME OF VISITS, MEETINGS AND DISCUSSIONS

17th March	Ministry of Health and Social Affairs, Montreal, (Mme Monique-Isabelle Fortier, Programme Co-ordinator).
18th March	Department of Social and Preventive Medicine, (Drs Raynald Pineault and Georges Desrosiers), Department of Health Service Administration, (Dr Roger Gosselin), University of Montreal. DSC Montreal General Hospital, (Dr John Hoey).
19th - 20th March	Colloquium "Health Profile and Monitoring", Quebec City.
23rd March	DSC Sherbrooke University Hospital, City of Sherbrooke, (Dr Roberto Iglesias, Robert Pronovost and Marie Dorval).
24th March	DSC Maisonneuve-Rosemont Hospital, Montreal, (Dr Serge Marquis).
25th March	DSC Sainte-Justine Hospital, Montreal, (Dr Pierre Duplessis).
26th March	DSC Montreal General Hospital, (Dr William Shannon).

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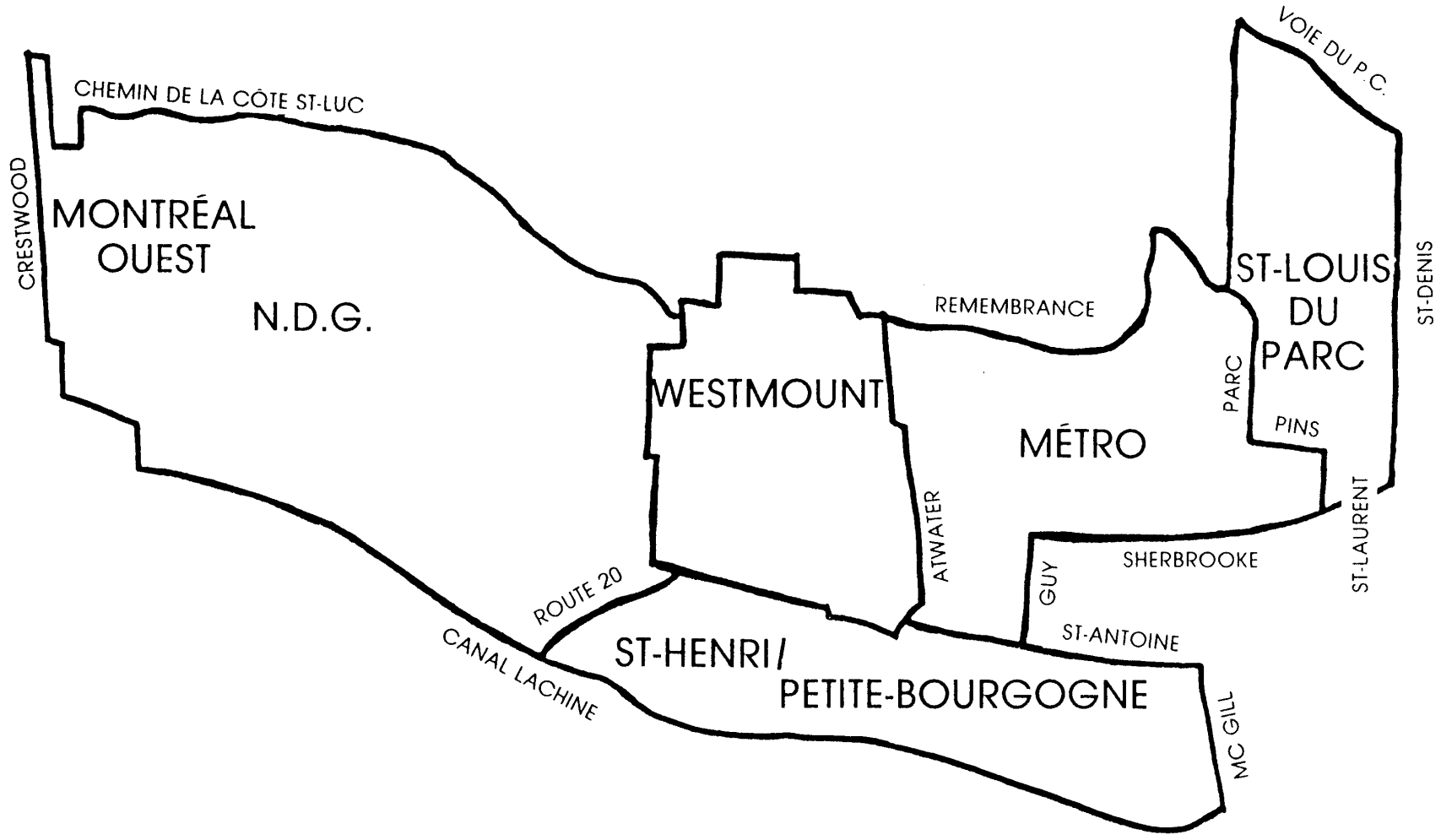

Territoire du Département de santé communautaire — Hôpital général de Montréal (territoire reconnu jusqu'en novembre 1984)

APPENDIX III