RÉGIE RÉGIONALE
DE LA SANTÉ ET DES
SERVICES SOCIAUX
DE MONTRÉAL-CENTRE

*2000 Annual Report*
*on the Health of the Population*

# Transformation of the Montreal Network: Impact on Health

DIRECTION
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*Garder notre monde en santé*

*2000 Annual Report*
*on the Health of the Population*

# Transformation of the Montreal Network: Impact on Health

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# Foreword

Information is a critical component when decisions are made about what must be done. Action is essential if a society is to change and develop. However, action that fails to take full account of what works and what does not work may not be useful and, indeed, may even be harmful.

It is in this perspective that we have prepared this third annual report on the population's health. In the report, we take stock of five years of change* in the health care system in Montréal that has occurred against a backdrop of significant budget cutbacks. We have focused, in particular, on the impact that these changes have had on what, in our view, is the most basic factor in the health care system, i.e. Montrealers' health.

Our report centres on health policy throughout the region. The analyses undertaken focus on the network considered as a system and not on the specific organizations that it comprises and much less on the individual practitioners working in the system.

The report is aimed at everyone who helps to shape health policy: elected representatives, health care system administrators, various organizations and agencies in the system, health care professionals and individual Montrealers, who are both the system's shareholders and clients.

We hope that the publication of this report will have a positive effect on exchanges within the health care system with a view to consolidating what has been accomplished under the reform, reviewing the sensitive issues pinpointed and fostering services that are better matched to the needs of the population.

***Marx said that the important thing is not to understand the world but to change it. Poor man, he got it the wrong way round. The important thing is not to change the world too much until you understand it.***

Malcolm Bradbury [1]

Director of Public Health

Richard Lessard, M.D.

* The terms "reform," "reorganization", "transformation," and "restructuring" are used interchangeably in this report to reflect the same situation, i.e. the aftermath of the adoption, by the Board of Directors of the Régie régionale de la santé et des services sociaux de Montréal-Centre of two plans, i.e. "Achieving a New Balance" for the period 1995-1998 and "Accent on Access" for the period 1998-2002.

## Summary

The reform of the health care system has been the subject of public debate since the mid 1990s, when it was decided to close or merge various establishments in Québec. In Montréal, rapid, marked change caused concern among the public and the targeted sectors. What has been the veritable impact on health of the reorganization of the health care system in Montréal? The Director of Public Health's third annual report attempts to answer this question.

To this end, professionals in the Direction de la santé publique have elaborated, in collaboration with clinicians, a series of indicators in order to monitor a number of potentially problematical situations, pinpoint unexpected situations and ascertain which issues warrant more thorough assessment. In addition, independent research teams from the universities and the health care system undertook 17 research projects.

The report places in context the major changes that have occurred in the health and social services system in Montréal since 1995. As is to be expected in any project of this scope, several reorganization objectives have, by and large, been attained, others have been partially achieved, while others still remain to be put into concrete form.

Aside from the initial plan guiding the reform, the reorganization has highlighted the significant impact of the voluntary separation program or early retirement program, which has achieved "unexpected success." Among the reform's positive achievements, mention should be made of appreciable progress with respect to home care combined with marked progress as regards inter-institutional agreements covering post-hospitalization care. Access to residential services has also progressed notably.

However, not only has the number of hospitalizations declined but also, contrary to expectations, so has the number of procedures involving one-day care. The anticipated reduction in the number of patients on waiting lists and waiting periods have probably not achieved the hoped-for levels. From the standpoint of front-line services, the desired closer collaboration between private medical clinics and multidisciplinary teams in the CLSCs has lagged. As for preventive services, a clear decrease in the number of hours worked in health promotion and preventive services has been noted in the CLSCs.

The report also presents key research findings on system performance. The authors emphasize those observations that are good news, others that are, to the contrary, cause for concern, and still others that raise critical uncertainty

to which we must find a response in order to guide impending stages in the reorganization.

Among the good news, it should be noted that sweeping changes have occurred without any detectable effect on mortality. Moreover, when the shift to ambulatory care has been accompanied by the introduction of effective interventions, a reduction in mortality and morbidity has been noted. System performance has improved overall in respect of avoidable hospitalizations. Reorganization has led to broader recourse to appropriate or pertinent intervention and a concomitant reduction in discretionary intervention. In particular, the reform has fostered innovations such as Info-Santé CLSC and the SIPA program, which have already had a positive effect on system performance.

Among the areas for concern, monitoring has revealed a marked increase in readmission rates following birth. Furthermore, monitoring has highlighted a clear increase in admission rates pertaining to complications that arise following the delivery of one-day hospital care. Cutbacks have obviously reduced the ability of various establishments, especially hospitals, to absorb peak demand, above all in emergency departments.

Some issues warrant further examination, e.g. taking account in the decision-making process of the health and safety of health-care personnel. In order to pursue the reorganization, uncertainty must also be dispelled concerning the respective roles of various interveners with a view to more fully integrating the different components of the system. Surveys of the public and professionals suggest that the communications strategy has not allowed for sufficient penetration and understanding of the objectives of the reorganization advocated by the health care system's managers.

The report's authors are of the opinion that the reform is incomplete. In our 1999 annual report, we emphasized the importance of targeting the right objectives from the standpoint of : **prevention**, **cure** and **care**. Experience has shown that increased emphasis on results related to the objectives of curing and providing care can lead to a reduction in the intensity of prevention measures. Striking a balance between these three objectives will pose a challenge that is all the more demanding since we will have to deal, in the coming years, with major socio-demographic, epidemiological and technological changes. For this reason, the report's authors are submitting to decision-makers, whether they are practitioners, administrators, elected representatives or individual citizens, various issues pertaining to their interpretation of the findings of the evaluation. It is hoped that this analysis will be useful as the reform is pursued.

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# Overview

*It is a beautifully sunny fall morning in September 1997. Helen Slater, 68, is leaving the Queen Elizabeth Hospital, where she has just been treated for diabetes. As has been the case each time she has visited the hospital over the past 10 years, she is pleased and considers herself lucky to be able to receive quality health services free of charge a stone's throw from her home. Upon reaching her home, she hears on the radio that her hospital is going to close. Astounded by this decision that she deems as troubling as it is illogical, she calls Marcia, her friend and confidant, who does not know any more about the news than she does. Several telephone calls later, she is dismayed. Why has such a decision been made? Who has made the decision? What was going to happen?*

Public debate has focused on the reform of the health care system since the late 1990s, when the government decided to close or merge various establishments in Québec. While the reorganization of health services had begun several years earlier, substantial government budget cutbacks between 1995 and 1998 exacerbated the pace and scope of the closures and mergers. Advances in medical technologies and the new avenues they are opening gave considerable impetus to this change.

In Montréal, Québec and Canada, as in all industrialized nations, similar change is occurring. Recourse to hospitalization is declining, a shift is taking place to ambulatory care, new services are being implemented in the community closer to the living environment, administrative and support costs are being reduced, administrative decentralization is under way, and so on.

The change that has occurred in Montréal has been quick and pronounced for three reasons. First, institutional services predominate in Montréal because of a longstanding tradition in the community of charitable and church-based services. Second, we had a lot of catching up to do, as many other cities had already initiated the shift to ambulatory care. Third, a significant factor was the adoption at the economic summit conference held in 1996 of a zero deficit. The health and social services budget accounts for roughly one-third of the Québec government's spending and managers in the health care system would have to achieve a great deal in very little time.

Given the situation, the reform caused concern. A majority of Quebecers believed that the health care system required sweeping reorganization. Some observers worried about the morale of health care professionals and physicians and a possible demobilization. The enormous "success" of the voluntary retirement program, which exceeded by far initial forecasts, confirms the validity for a number of people of these concerns.

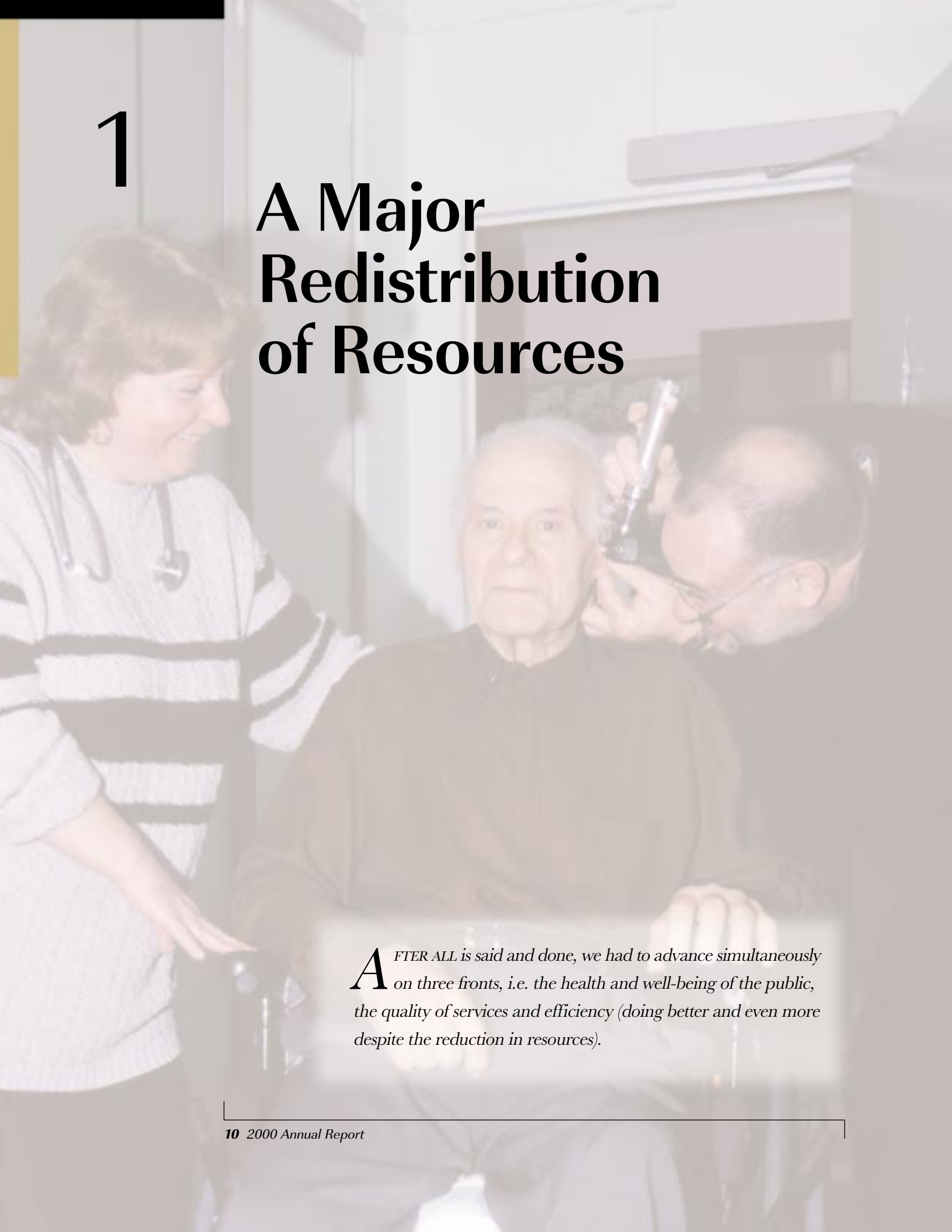
Are we to conclude that the reorganization has failed and that our public health and social services system, which, until recently, was regarded as one of our finest collective achievements, is in free-fall? What has been the true impact of the reform on the Montréal health care system? This is the question that this third annual report from the Director of Public Health seeks to answer, from the standpoint of the effect of change on health.

Given both the mandate assigned the Director of Public Health by legislation and the mandate received in 1995 from the Board of the Directors of the Régie régionale de la santé et des services sociaux de Montréal-Centre, we are making public our monitoring and research findings. We are especially grateful to researchers in the Montréal universities who agreed to share and discuss their research findings with us even though, in some instances, the research was not completed.

Chapter 1 examines the major changes that have occurred in the Montréal health and social services network since 1995. In Chapter 2, we focus on the key research findings on system performance. We emphasize observations that bode well for the future and others, which, to the contrary, are cause for concern. Still other observations raise critical uncertainty to which we must respond in order to properly direct the impending stages of the reorganization. Chapter 3 presents various issues pertaining to an interpretation of the findings of the evaluation, bearing in mind the issues facing the health care system in the coming years.

1

# A Major Redistribution of Resources



*AFTER ALL is said and done, we had to advance simultaneously on three fronts, i.e. the health and well-being of the public, the quality of services and efficiency (doing better and even more despite the reduction in resources).*

The Régie régionale de la santé et des services sociaux de Montréal-Centre was established in April 1994 pursuant to the *Act respecting health services and social services*. While the Régie is not authorized to determine the resources allocated to the Montréal area, it nonetheless has a duty to make the best possible use of such resources in order to serve the public. From the outset, the Régie has perceived its mission as follows: "To maintain balance between the public's changing needs and quality services while making the best possible use of the resources allocated by the Québec government."[2]

Barely a few months after the Régie was established, the Minister of Health and Social Services asked it to solve an equation involving several unknown components. First, the Minister asked the Régie to reduce the annual regional budget from $3.3 billion to $3.1 billion in three years and to strike a new balance in the health care system by pursuing innovative approaches to make available health and social services and adjust to rapidly changing needs.

In order to find the appropriate response to the numerous questions raised by these demands, the Régie régionale organized public hearings. Certain observations were clearly evident in the 223 briefs heard at that time. First, observers noted that the network was unbalanced as it was built around a hospital network that was more developed than in most cities of similar size and less and less suited to responding to the needs of an ageing population. The imbalance was apparent in other ways: many elderly people were awaiting care, insufficient resources were available in residential and extended (long-term) care facilities for the elderly, home-care services were barely developed, coordination was posing problems, and so on. These consultations once again revealed the frequently reiterated willingness to adopt vigorous upstream measures by engaging in preventive and community measures in light of the four regional health promotion and disease prevention priorities adopted in early 1995.

After all is said and done, we had to advance simultaneously on three fronts, i.e. the health and well-being of the public, the quality of services and efficiency (doing better and even more despite the reduction in resources).

*Helen Slater has just learned that the courts have dismissed the Queen Elizabeth Hospital's request to overrule the decision of the Régie régionale de la santé et des services sociaux de Montréal-Centre's Board of Directors. The hospital is to close shortly. It is said that the budgets thus obtained will be reinvested in home care services, residential housing for the elderly and preventive services for young people. Ms Slater clearly heard the news but her disappointment is preventing her from fully accepting it. The hospital services perfectly suited her needs and the staff were very caring.*

A final consensus was reached concerning how to reduce the budget. In order to absorb a net reduction of $190 million over three years, officials in the health care system strongly opted for targeted cutbacks in a limited number of institutions instead, as had been the case in the past, of identical parametric cutbacks in all institutions. In the wake of these consultations, the Board of Directors decided to cut the budget by $345.6 million, equivalent to over 10% of the total budget, in order to achieve the cutback requested by the government and to reinvest $155.6 million with a view to creating conditions suited to the shift to ambulatory care.[3]

### *A complex network*

The health and social services network in the Montréal area, which is Québec's biggest employer, can be broken down as follows: 96 public establishments with their own boards of directors, several of which are affiliated with universities and offer some supraregional services; 46 private establishments; 29 local territories served by as many local community service centres (CLSCs); two youth centres with a dozen service outlets; several hundred subsidized community organizations; over 400 private medical clinics; and 1 600 general practitioners and more than 2 000 specialists. All told, this represents an investment of just over $4 billion, equivalent to one-tenth of the Québec government's budget. It should also be noted that Montréal Island comprises 29 municipalities and 5 school boards, without which intersectoral initiatives would not be possible.

***For this reason, the health care system can be compared with a political system in which competing ideologies and interests clash, which the Rochon Commission in 1988 described as the "system taken hostage."***

The challenge of better coordinating such a system is a daunting one. This is especially true since each organization in the system is autonomous and, through its board of directors, members or owners, as the case may be, is empowered to manage its own affairs and, indeed, to compete with other organizations for increasingly scarce resources. For this reason, the health care system can be compared with a political system in which competing ideologies and interests clash, which the Rochon Commission in 1984 described as the "system taken hostage." This explains the inevitable ongoing tensions

that must be managed. It is the most demanding challenge of decentralization, since we must not, above all, jeopardize meeting the citizens' needs.

### *A commitment to monitor the reform*

*Officials at the Régie régionale adopted a stance centred on public accountability.*

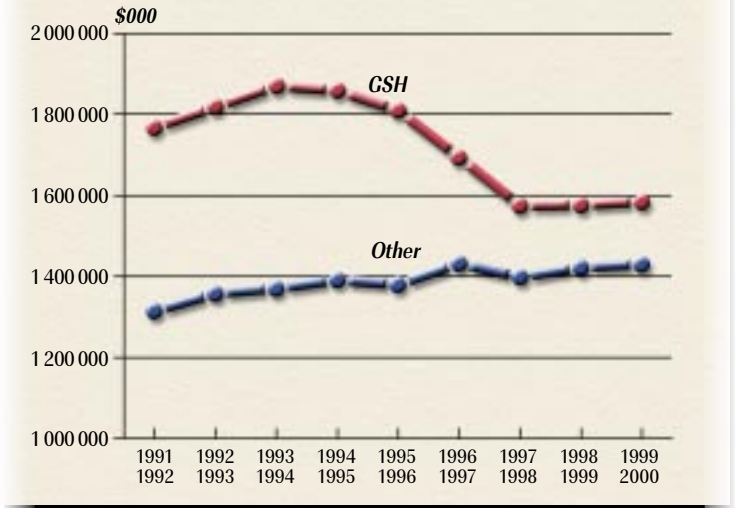
Decision-making must focus on the public's best interests, which must remain at the forefront of the concerns of an organization such as the Régie régionale. For this reason, from the outset, officials at the Régie régionale adopted a stance centred on public accountability. This policy direction led to a process aimed at developing indicators to ensure monitoring of the reform and to pinpoint potential risks and problematical situations. The Régie régionale's team of professionals committed itself to this task, one result of which is the performance indicators submitted periodically to the Board of Directors and which can be consulted on the Régie régionale's Web site.[5]

However, this undertaking is not confined to monitoring a limited number of indicators. As is the case with the Direction de la santé publique in the realm of health, each department of the Régie régionale has sought to systematize follow-up in respect of other facets of performance. The Direction de la programmation et de la coordination has assumed responsibility for the coordination and accessibility of services. The Direction des relations avec la communauté monitors public satisfaction in regard to health care, and other departments are responsible for follow-up pertaining to financial and human resources. Some of the information presented in this chapter has been drawn from the work of our colleagues in these various sectors, to whom we wish to express our thanks.

### Have the anticipated budget transfers been carried out?

fig. 1

**Change in the budgets of general and specialized hospitals (GSH) and other health and social services establishments, Montréal-Centre, 1991-1992 to 1999-2000**

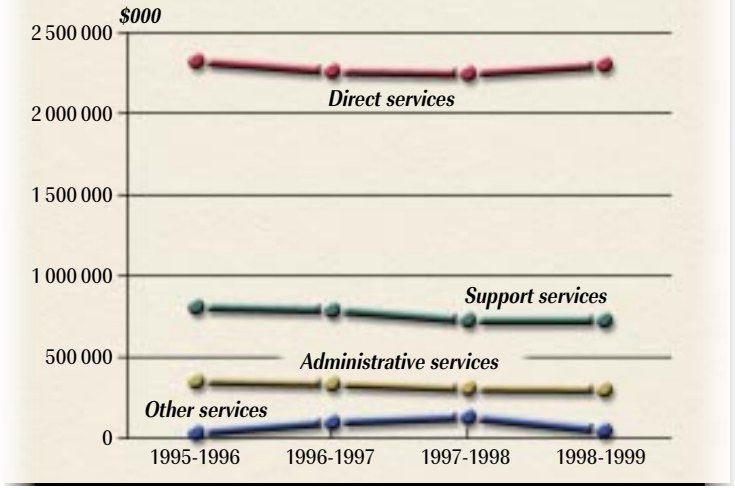



Targeted budget cutbacks in the hospitals have been substantial and have been accompanied by an increase of nearly 10% in the budget for other establishments and nearly 50% for community organizations (see Figure 1). However, in addition to these reductions planned at the outset, $86.6 million in cutbacks were effected in the wake of the government's decision to achieve a zero deficit.

An analysis of the expenditures of establishments since 1995 confirms that spending on direct services in the establishments overall has been maintained at essentially the same level (see Figure 2). It should be noted that the relative stability of such expenditures conceals increases in inherent or system costs, i.e. increases in salaries, operating costs and other expenses that cannot be pared down.

fig. 2

**Change in the direct costs of health and social services establishments, by category of service, Montréal-Centre, 1995-1996 to 1998-1999**




Between April 1995 and March 1998, expenditures in respect of short-term hospitals plummeted 16%. The reduction applied, above all, to administrative and support services.

### How have budget cutbacks affected hospital operations?

The reduction in services in short-term (acute-care) hospitals has been marked:

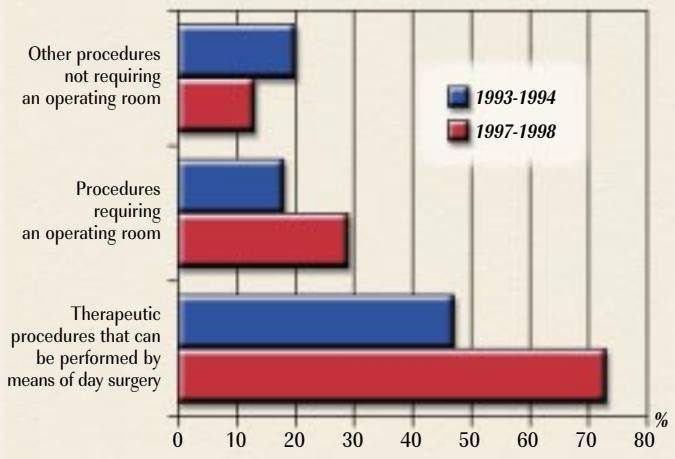
- reduction of 2 443 acute-care beds;[6]
- closing of nine surgery departments;
- closing of seven emergency departments;

- reduction in the average length of hospital stay, from 8.2 days in 1995-1996 to 7.3 days in 1998-1999 (the objective of 6.8 days in 1998 has been maintained for 2002).

Despite this reduction in hospital capacity, officials at the Régie régionale wished to maintain operating capacity and even to increase the day surgery rate. However, the data suggest that the results have been mitigated. The reform has been accompanied by a more favourable overall breakdown in diagnostic and therapeutic procedures effected through one-day hospital care (see Figure 3). As for therapeutic procedures that can be carried out by means of day surgery, the increase from 47% to 73% of the potential points to the intensification of pertinent, one-day clinical activities.

fig. 3

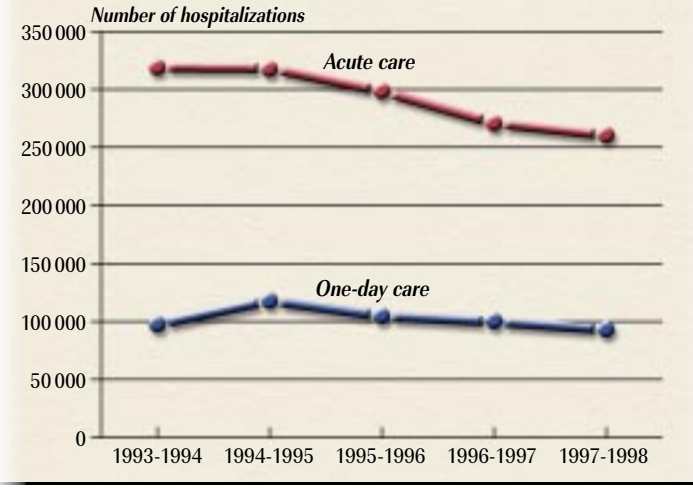
**Proportion of diagnostic and therapeutic services provided through one-day hospital care, by type of procedure, Montréal-Centre, 1993-1994 and 1997-1998**




The same is true of the gradual shift of other procedures that do not require an operating room. On the other hand, not only was a significant reduction in the number of hospitalizations noted, but also, contrary to expectations, a reduction in one-day hospital care (see Figure 4). Although the shift to ambulatory care has occurred, it must also be acknowledged that the intensity of hospital care has decreased.

fig. 4

**Number of hospitalizations by type of care, Montréal-Centre, 1993-1994 to 1997-1998**



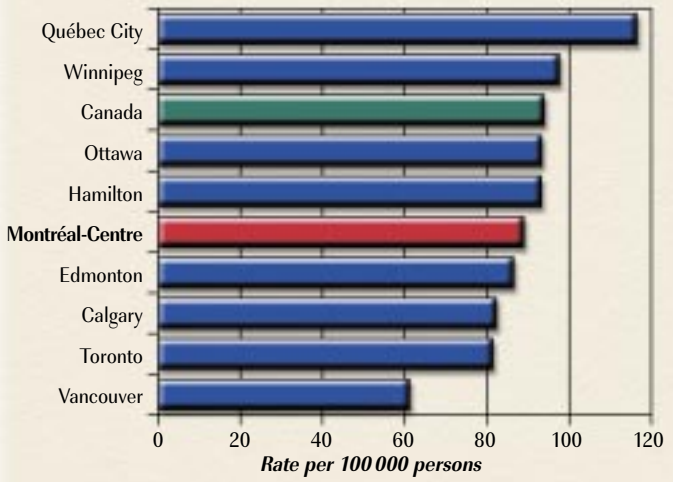

In addition, certain targeted specialized services have risen by 10% to 20%, especially as regards tertiary cardiology procedures, certain orthopaedic surgical procedures and cataract operations. Paradoxically, the desired reduction in the number of individuals on waiting lists and waiting time have not reached the expected level,

apparently because of an increase in demand that has coincided in an increase in supply.

According to the latest figures, from the standpoint of specialized services, the Montréal area, in relation to other urban centres in Canada, ranks in the middle with respect to coronary bypass (see Figure 5) but far behind as regards hip and knee arthroplasty, with rates below half the Canadian average (see Figure 6).

fig. 5

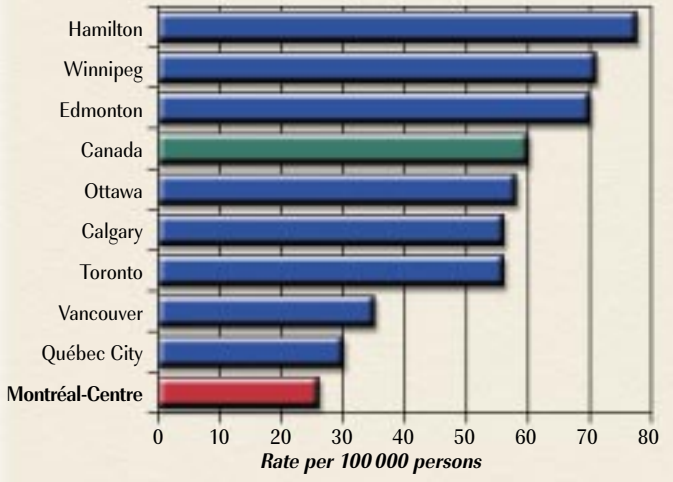
**Age-standardized rate of coronary bypass surgery for certain regions in Canada, 1997-1998**




Specialized medical staff, who work above all in hospitals, has also been reduced since 1994. However, the region has maintained an enviable position, ranking second after the Vancouver-Richmond area and ahead of Toronto and Québec City,[7] although the reduction, between 5% and 10% depending on the field of specialization, has generally been more pronounced in surgical specializations, i.e. nearly 25% in general surgery. Once again, the government's voluntary separation program had such an impact that it was necessary to negotiate the return of staff after retirement in scores of cases, despite the agreement initially concluded.

fig. 6

**Age-standardized rate of arthoplasty of the knee for certain regions in Canada, 1997-1998**




### Has there been a genuine increase in services for the elderly outside the hospitals?

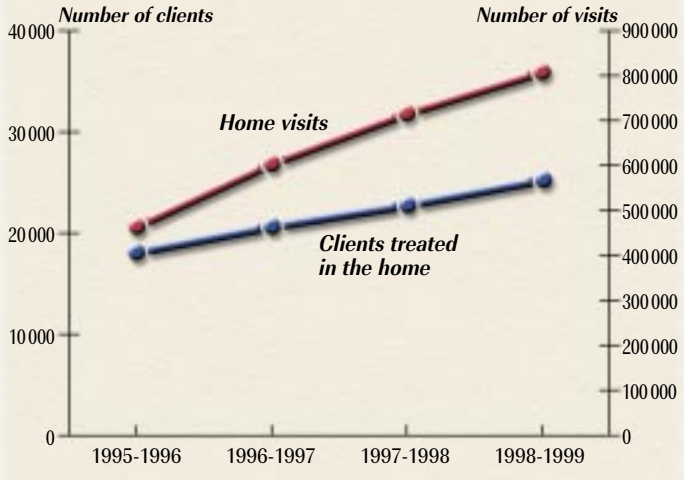
Budget cutbacks and the reorganization of hospital operations, while they are the most visible facets of the reform, are not its ultimate objective. Several indicators point to progress in achieving the new balance being sought.

### *Home care*

The per capita budget for CLSC-based home care services increased from $47 to $67 between 1995 and 1998. As Figure 7 indicates, budget reallocations made it possible to serve 40% more beneficiaries, while the number of visits almost doubled. This substantial increase suggests that CLSC-based services have made significant inroads in the community.

fig. 7

**Number of clients 65 years of age and over and home visits made by CLSCs, Montréal-Centre, 1995-1996 to 1998-1999**




However, have the needs of the elderly living in the community been satisfied? Not entirely, if we go by the level of per capita funding of such services. Despite the additional funding, Québec still ranks below the other provinces.[8] To our knowledge, no administrative data are available that would enable us to quantify the level of need for support care for the elderly in local communities, so that it is hard to estimate the suitability of services. According to a study that is evaluated in Chapter 2, it appears that a majority of elderly people experiencing a loss of autonomy is not known to their CLSC.[9]

Nevertheless, the results achieved with respect to home care combined with significant progress concerning inter-institutional agreements covering post-hospitalization care encouraged the Chairwoman of the Board of Directors to assert that the benefits engendered by liaison between hospitals, CLSCs and physicians in the realm of home care represent one of the most striking achievements of the reorganization in Montréal.[10]

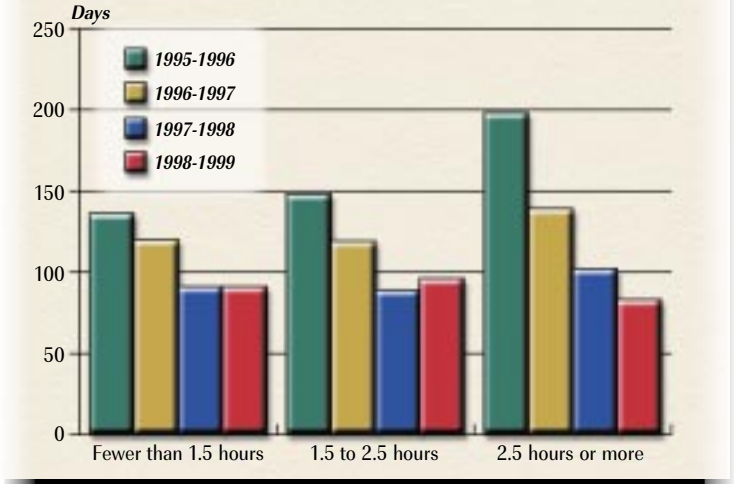
### *Residential services*

Access to residential services has also been broadened considerably. The first striking initiative is the establishment of a single outlet to examine cases and make decisions concerning residential services for

individuals experiencing a loss of autonomy. From the standpoint of regional coordination, the adoption of rules has been a significant achievement. Such rules stem from explicit clinical criteria and are managed by interdisciplinary committees. They could serve as the basis for the coordination of other types of services.

fig. 8

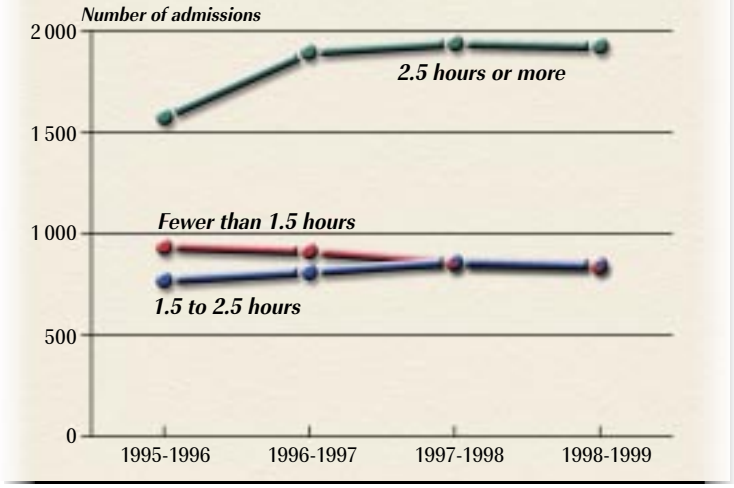
**Average waiting time (in days) for initial admission to a hospital centre for long-term care, by number of hours of care required, Montréal-Centre, 1995-1996 to 1998-1999**




With the addition of 2 108 residential beds, the number of individuals on waiting lists decreased from 1 954 to 1 583 and the average wait, from 168.2 days to 87.9 days, which still exceeds the provincial average of 47 days. The number of residential beds suited to the delivery of more complex services, i.e. demanding 2.5 or more hours of daily care, increased from 3 852 to 6 084, equivalent to over 40% of the regional total of 14 635 residential and long-term care beds. The reduction in average waiting times for initial admission is the most pronounced for these individuals with complex needs (see Figure 8).

fig. 9

**Number of admissions for long-term care, by category of hours of care, Montréal-Centre, 1995-1996 to 1998-1999**




The change in the number of admissions for residential placements convincingly illustrates the progress achieved (see Figure 9). The marked increase in capacity since 1995 affects individuals who require extensive services, to the detriment of other clienteles. The decision to serve individuals experiencing a loss of autonomy elsewhere than in hospitals has likely reduced pressure on the hospitals. Unfortunately, we do not have definitive data to back up this hypothesis.

**What has happened to front-line medical services**

As is the case in the other provinces, the organization of medical resources has not undergone any significant change during the reorganization of the health and social services system. Strategic decisions concerning medical services in Québec are centralized and are outside the purview of the Régie régionale. As for front-line services, closer cooperation between private medical clinics and multidisciplinary teams from the CLSCs has not advanced appreciably.

***As for front-line services, closer cooperation between private medical clinics and multidisciplinary teams from the CLSCs has not advanced appreciably.***

The proposal to establish interactive front-line service networks announced in the reorganization plan has not been carried out. The front-line integrated networks mentioned in *Accent on Access*, the 1998-2002 plan to improve services, have yet to be implemented. We are banking a great deal on the establishment of the Département regional de médecine générale to do so. However, those groups associated with this process will have to show a willingness to seek solutions if we are to fill the gaps, which, as we will see later, are not inconsequential.

Essentially, two front-line networks have continued to coexist almost unchanged. Some 400 private medical clinics are providing over 80% of general medical services in the area; multidisciplinary teams and most professionals other than physicians are working in 29 CLSCs. The Régie régionale's willingness has not made possible genuine progress in respect of the historic duality that characterizes access to our health care system. Contrary to the improvements noted since collaboration agreements have been reached between the hospitals and CLSCs, the coordination between establishments and private networks of general practitioners' offices is occurring, by and large, case by case and patient by patient.

Furthermore, we have no information that would enable us to quantify professional staff other than physicians providing services privately. Such services are deemed to be uninsured. The same is true of alternative front-line services in respect of which we do not collect data, even though, according to some research, such services account for a significant portion of demand for primary care.[11]

**Have preventive services improved?**

The desire to increase initiatives aimed at prevention and measures targeting the determinants of health has been reflected, first and foremost, in regional health and well-being priorities. Through a $2.7-million budget allocated by the Board of Directors, the priorities have led to 40 targeted community projects focusing on the most pressing needs and relying on collaboration between professionals in the Direction de la santé publique and local institutions and community organizations. From the outset, this close collaboration with the community has centred on a determination to reconcile research findings and community needs. The projects are implemented through contractual agreements that specify the anticipated results, about which the Auditor General commented favourably when he visited the Régie régionale in 1996.

***From the outset, this close collaboration with the community centred on a determination to reconcile research findings and community needs.***

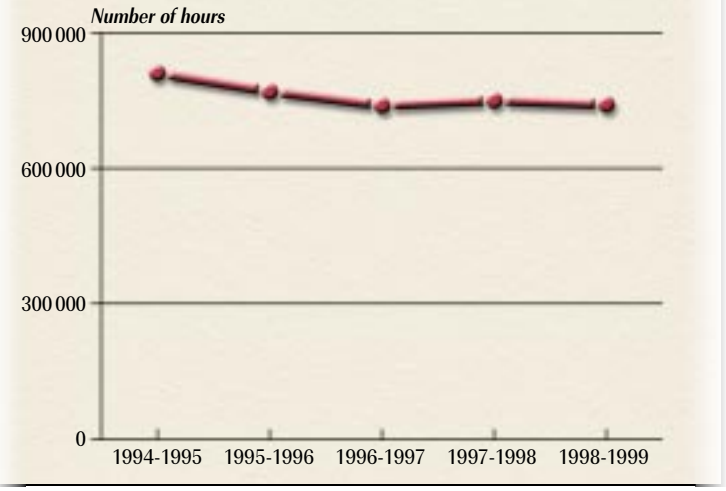
The first phase of the plan to reorganize services in Montréal (1995-1998) was intended to consolidate the financial capacity of CLSCs and community organizations in the fields of promotion and prevention. The reallocation of $12.2 million was intended to enable community organizations and CLSCs to undertake more concerted initiatives in the community. In addition to bolstering intervention in the community, the consolidation sought to foster dialogue between regional teams at the Régie régionale and local teams. Excellent results have been obtained, as confirmed by the first joint regional prevention-promotion conference[12] and the realization of a participatory evaluation of the priorities[13] involving several hundred interveners. The establishment of a $1.4-million intersectorial action support fund has made possible the implementation of projects in various neighbourhoods and municipalities on Montréal Island.

During the second phase of the reorganization (1998-2002), prevention has been integrated into each continuum of service. Essentially, this means ensuring closer collaboration and strengthening liaison between public health experts and the administrative heads of programs at the Régie régionale.

While participatory evaluation and the annual renewal of contractual agreements have enabled us to measure our efforts and continue in this direction, the reallocation of funding aimed at broadening preventive services in the CLSCs has not produced the anticipated results. As we will see in Chapter 2, several observations suggest that, in light of the shift to ambulatory care, the CLSCs' preventive mission has not measured up. Instead, since 1994-1995, a clear decrease has been noted in the number of working hours devoted to health promotion and disease prevention services in the CLSCs (see Figure 10). The available data on community organizations do not allow us to quantify their efforts with regard to prevention. However, widespread comments from community groups have highlighted the marked pressure exercised on them by the shift to ambulatory care.

fig. 10

**Number of hours devoted annually in CLSCs to promotion and prevention, Montréal-Centre, 1994-1995 to 1998-1999**




**Have services improved for young people?**

In conjunction with deliberations on young people in difficulty and social inequality, a one-day session was organized on the health of young people during public hearings on the Régie régionale's second plan in 1998.[14] There was a clear desire on the part of participants to have a significant impact on the lives of children and young people and the frustration expressed at the lack of coordination and, occasionally, the confusion reigning in the youth sector was striking.

Participants emphasized the limitations of the network, characterized by a sectorial, institutional and compartmentalized approach in which each group of agencies and establishments is demanding more resources in order to continue doing what it believes it is doing well.

This consultation was at the origin of the Projet jeunesse montréalais. To enable young people to develop on Montréal Island, the project has

***The Régie régionale undertook to:***

- bring together all sectorial and intersectorial partners in order to define ways of emphasizing collaboration within a complete continuum of youth services that integrates preventive and clinical services, youth protection and rehabilitation;
- systematically document the facilities and the entire range of service providers used by young people throughout local communities (the key findings of this research project intended to take stock of the situation of young people are discussed in Chapter 2).

adopted the objective of supporting all children, young people and parents. Through broad prevention initiatives, it proposes to act upstream in order to better equip young people and their families to overcome the challenges of everyday life. In particular, it seeks to strengthen and better coordinate measures dealing with problems of access by various clienteles to services, i.e. families experiencing major difficulties, single-parent families, individuals with mental impairments, 18- to 25-year-olds left to their own devices, young parents, young people with mental health problems and individuals dealing with drug and alcohol abuse. Research funds earmarked for evaluation have also been requested and granted.

The Projet jeunesse montréalais is, to some extent, a pact between numerous partners that have agreed to collaborate, although the temptation is sometimes strong to fall back on their individual interests and specific missions. The establishment of a regional coordinating committee and local committees headed by local project facilitators from the CLSCs, the production of guidelines and extensive deliberations aimed at clarifying the division of responsibilities are concrete illustrations of this initiative.[15] Despite these achievements and even if, as observers note, practices in the field are beginning to change, the Projet jeunesse montréalais has still not been fully implemented. Until very recently, the initiative has come up against the thorny question of the apportionment of resources between the CLSCs and youth centres. For the time being, the desired consensus has not been attained.

***The Projet jeunesse montréalais is, to some extent, a pact between numerous partners that have agreed to collaborate, although the temptation is sometimes strong to fall back on their individual interests and specific missions.***

**Have services improved for individuals suffering from mental impairment and mental disorders?**

Several measures were intended to enhance the suitability of services for individuals suffering from acute mental problems. An analysis of funding since 1995 reveals an overall reduction of 12% in the funds allocated to inpatient and outpatient services in the hospitals, offset by a 15% increase in community-based intervention. As we will see in Chapter 2, however, the hospitals continue to play an important role. The needs of individuals with mild mental health problems and experiencing psychological distress are not as well understood and constitute the focus of ongoing research in Montreal.

The study's findings with regard to individuals suffering from mental impairment reveal the difficulty of changing service delivery in the manner desired by planners, parents and community agencies. Despite the fairly modest targets adopted in the 1995 plan, progress in light of the objectives continues to be disappointing. Consequently, it is hardly surprising that indicators respecting access to services remain unchanged. According to information available as of March 31, 2000, both waiting time for access to programs (support: 482 days; socio-professional: 667 days; residential: 530 days) and the number of individuals waiting, ranging from 230 to 460 depending on the program, confirm that the system's performance has failed to meet expectations.[16]

***The study's findings with regard to individuals suffering from mental impairment reveal the difficulty of changing service delivery in the manner desired by planners, parents and community agencies.***

**Have the changes affected health professionals?**

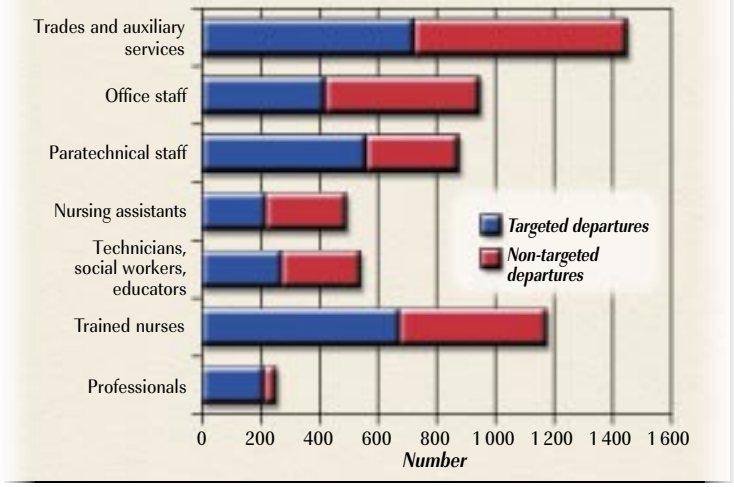
Since 80% of the Régie régionale's budgets are earmarked for salaries, cutbacks and reallocations have obviously significantly affected staff. For this reason, the Régie régionale has established a regional manpower service in order to coordinate the numerous changes to be made.

In 1998, in its review of operations related to human resources in conjunction with the implementation of the plan entitled Achieving a New Balance, the Direction des ressources humaines estimated that, of the 7 579 salaried workers laid off, 94.5% were able to find a job. In the case of managers, however, just over 60% had found a new position.

The most striking changes occurred under the government's voluntary separation program, which the Régie régionale had not anticipated and which was carried out over a few months in 1997. Figure 11 summarizes the results of this program, which largely exceeded its objectives and which placed health care system managers in a difficult position, the effects of which we are undoubtedly still feeling.

fig. 11

**Number of early retirements by category of salaried position, Montréal-Centre, October 1997**




For each of the professional and technical categories, the number of departures exceeded the targets set during the planning stage: of the 12 766 individuals 50 years and over eligible, 5 734 took advantage of the program, i.e. 45% of the potential total, as against 3 078 anticipated departures. The loss within several months of 1 176 qualified nurses, with their knowledge and practical understanding of the system, was a blow from which the system has yet to recover.

While the universal retirement program negotiated centrally between the government and the unions made possible an additional $86.6-million budget cutback, it left in its wake a ripple effect from the standpoint of human resources. At the time of writing this report, the shortage of nurses continues to be the most troubling result. As we will see in Chapter 2, the available research data suggest that nurses have experienced serious stress and have suffered from these changes.

**Interactive information systems to support an interactive network**

Another objective of the reorganization of the health care system in the Montréal area was to implement an information system capable of integrating all data on a given clientele and offering the partners access to this system in order to enhance clinical decision-making overall, reduce overlapping and avoid the duplication of services.

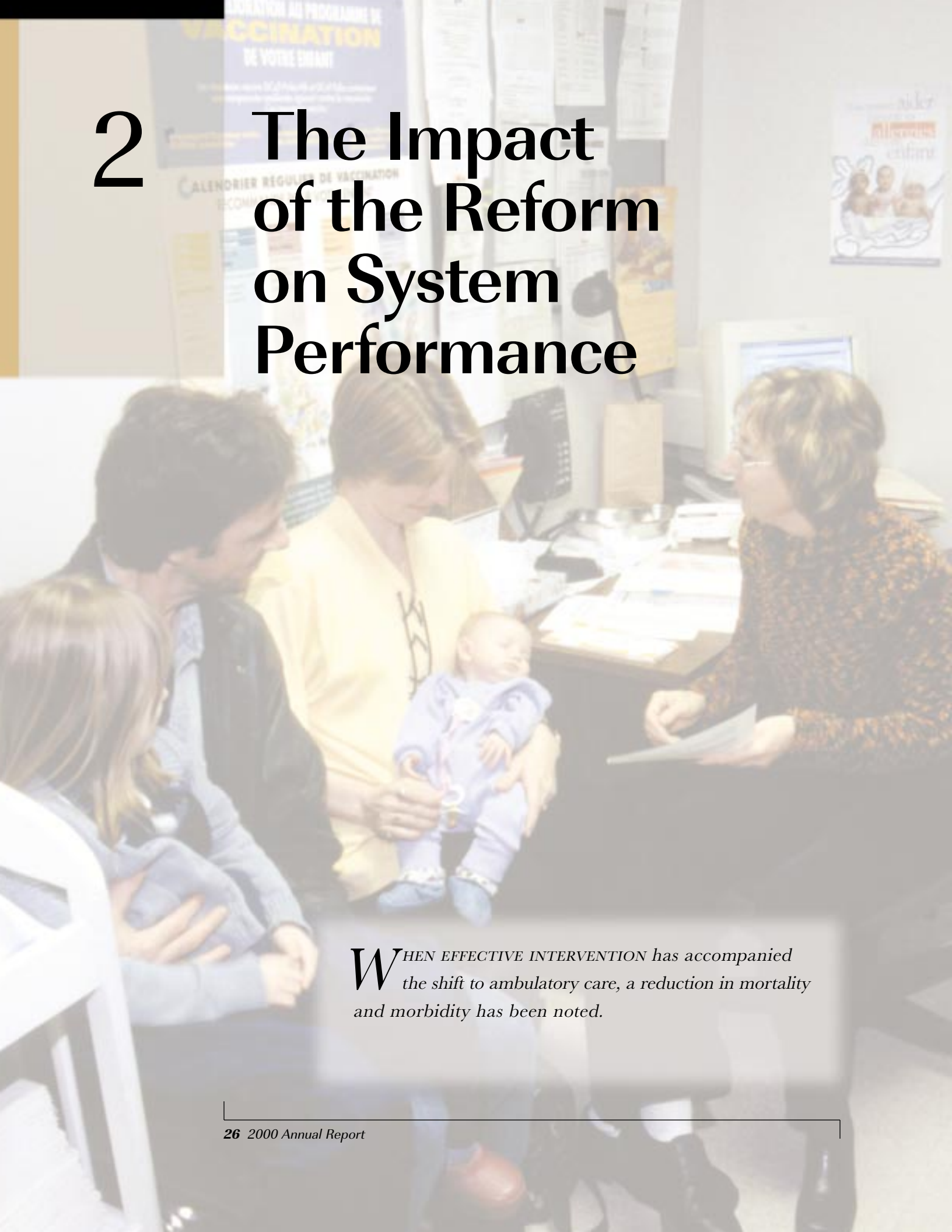
This project has not been brought to a successful conclusion but efforts to set up systems specific to each category of service provider, e.g. the CLSCs, have continued. Moreover, the health care system telecommunications network has been introduced in establishments but its use is confined, by and large, to administrative tasks. Since private clinics are, for the time being excluded, the network's usefulness for clinical purposes is, at least for now, negligible. To be of genuine use in supporting the reform, all interveners in the health care system, including private physicians' offices, should be able to use this tool for clinical purposes.

**Doing more with reduced resources**

As the foregoing observations clearly reveal, since 1995 Montréal's health and social services system has undergone rapid change. This reorganization has occurred against a backdrop of worldwide reform of health care and reductions in public spending on health care services. The reform has focused on the Montréal health care system overall, although several important factors related to change, especially decisions on the collective agreements of unionized staff and on medical resources, continue to be centralized at the provincial level.

In light of the policy directions put forward by the ministère de la Santé et des Services sociaux, the Régie régionale has reassessed the organization of services while attempting to do more with reduced resources. As is to be expected in any project of this scope, several objectives of the reform have been largely attained, others only partially, and others still not at all. Our review of the situation also reveals the impact of other, unexpected events. Let us now turn to their main impact on system performance, particularly as regards the health of the population.

# 2 The Impact of the Reform on System Performance



*WHEN EFFECTIVE INTERVENTION has accompanied the shift to ambulatory care, a reduction in mortality and morbidity has been noted.*

Starting in 1995, the Régie régionale undertook to document the impact on various facets of performance[17] of the reorganization of the Montréal health care system. The Direction de la santé publique was mandated to monitor the reform's impact on health and well-being. Below are the key observations that it has made.

This annual report is one of three interrelated publications. It is aimed at everyone who is involved in decision-making in the realm of health and social services from a policy, organizational and clinical perspective. It is also intended for Montrealers, who are simultaneously shareholders in and beneficiaries of our universal health and social services system.

A separate report presents detailed information on the monitoring of indicators developed in close collaboration with clinicians in order to pinpoint possible problems.[18] Given the repetitive, complex nature of the changes in health and social services, we have decided to focus on a number of indicators with a view to establishing a series of core criteria. These indicators are being used to monitor potentially problematical situations and to pinpoint unexpected situations and questions that warrant more thorough examination.

The third report, edited by Dr. Pineault and Dr. Tousignant, summarizes 17 research projects pertaining to the reorganization of the health care system.[19] The undertaking is unique in that the teams of researchers agreed to pool their observations and analyses, often even before publishing them and, in some instances, when data were still only fragmented or preliminary. This information, combined with the findings of the monitoring program, sheds light on a broad range of research issues and concerns raised by the reform.

### *What can we learn from the evaluation of the reform?*

Several evidenced-based observations stemming from Montréal's experience can serve as a guide to the ongoing reorganization of the health care system, both here and elsewhere.

### *Our findings are divided into three groups :*

- good news, which is extensive and which emphasizes that the reform has been accompanied by change that is, on balance, favourable;
- identifiable areas for concern, in respect of which our observations are sufficiently solid to conclude that we must rethink our strategies;
- areas of critical uncertainty concerning key issues, which must be clarified in order to guide decision-making.

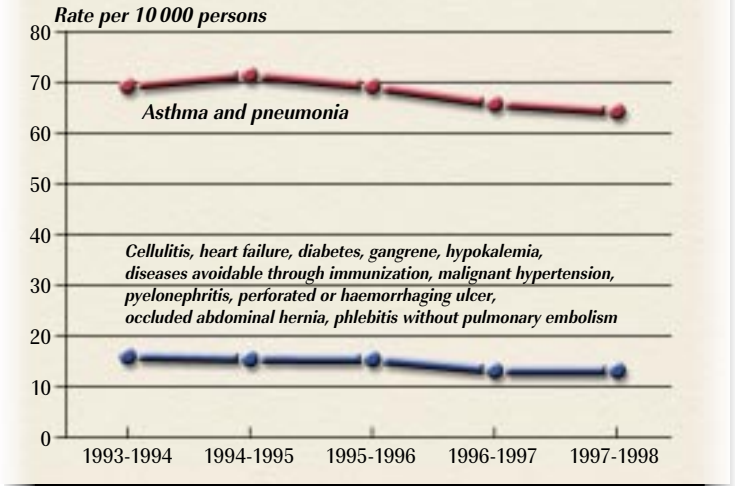
## *Good news*

The first piece of good news is that significant changes have been made without any discernible effect on general mortality, a noteworthy achievement. Although only major social upheavals, disasters or epidemics usually have a measurable impact on general mortality in a given population, the examination of mortality rates is reassuring. Whether we consider premature mortality, mortality among the elderly or even very old people, or differences related to type or social inequality among the least privileged members of society, there is every indication that no change associated with the reform has led to higher mortality rates.

In many instances, the opposite has been true. A reduction in mortality and morbidity throughout the population has been noted when the shift to ambulatory care has been accompanied by the introduction of effective intervention, as a number of examples clearly show.

fig. 12

**Rate of admissions deemed avoidable, by group of medical conditions, Montréal-Centre, 1993-1994 to 1997-1998**



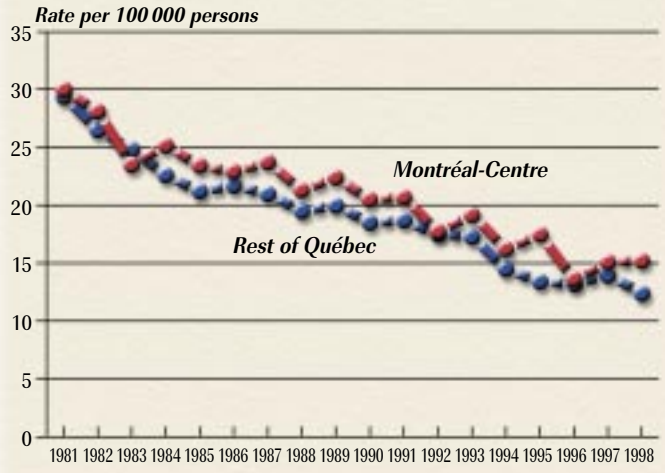

### Situations avoided through efficient services

The first example is the reduction in deaths or hospitalization avoidable through health care (see Figures 12 and 13). These indicators are reliable tools to gauge the health care system's ability to react appropriately to common, major health problems for which effective clinical intervention is available.

The system's overall performance improved with regard to avoidable hospitalization between 1994 and 1998. Despite the tension of which everyone is aware and about which everyone is concerned, the situation at present is better than it was initially. Mention should be made of the contribution made by various preventive or curative measures that allow health professionals to act upstream and thereby reduce pressure on the hospitals. The same is true of avoidable mortality rates recorded in situations that should not arise, given the effectiveness of the services available. Overall, we have noted a reduction in the avoidable mortality rate during the period, although the rate appears to have levelled off since 1997.

fig. 13

**Crude rate of death avoidable through care, Montréal-Centre and rest of Québec, 1981 to 1998**

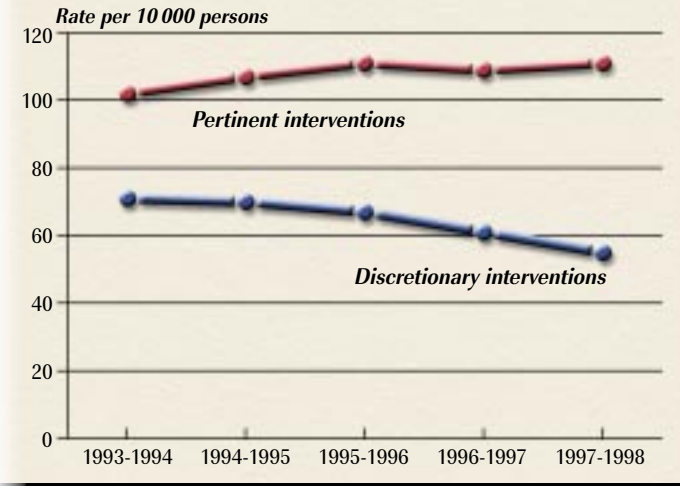



## A genuine shift to ambulatory care and more relevant choices

As we saw in Chapter 1, the shift to ambulatory care has occurred, although the shift followed, rather than preceded, the reduction in hospital services. Budget cutbacks have significantly curtailed the resources available for hospital services. All the same, the shift from hospital to ambulatory care has fallen short of initial targets.

fig. 14

**Hospitalization rate for pertinent and discretionary interventions, Montréal-Centre, 1993-1994 to 1997-1998**




It was important to ascertain to what extent the reduction in hospital funding would result in more judicious use of resources. Certain possibilities, some favourable, others unfavourable, were contemplated when the reorganization of hospital services was planned. In order to accurately document what actually happened, we monitored a number of

proven procedures.[20] We also documented recourse to other services whose effectiveness, while proven in certain clinical situations, raises controversy in medical publications.[21] The conclusions drawn from these analyses are unequivocal: the reorganization has led to more extensive recourse to the relevant procedures and a concomitant reduction in discretionary procedures (see Figure 14). Constraints appear to have led to more rational use of resources.

### Equitable streamlining overall

fig. 15

**Premature mortality rate, by income category, Montréal-Centre, 1986-1988 to 1995-1997**

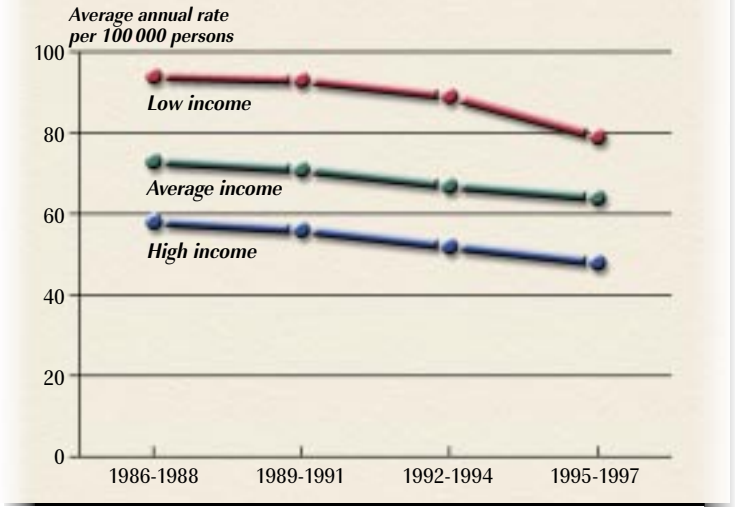
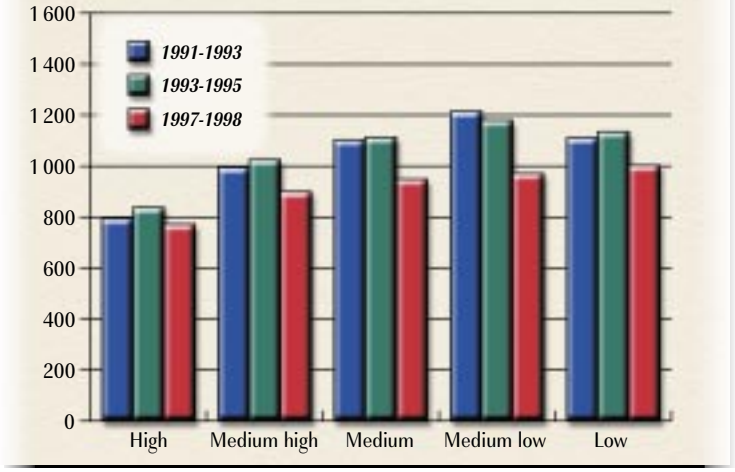



fig. 16

**Crude hospitalization rate, by income category, Montréal-Centre, 1991-1993 to 1997-1998**




Social inequality in health care is a key concern of the Régie régionale.[22] It is known that socially and economically disadvantaged individuals resort more frequently to health services, especially front-line and emergency services. For these reasons, close attention was paid to an examination of disparities between social groups in conjunction with the reform. We wanted to determine whether the reorganization process would affect various socio-economic groups differently. Several observations indicate that the reform has not exacerbated socio-economic discrepancies in the health care system.

While general mortality rates according to income were stable during the period, premature mortality fell slightly (see Figure 15). It should be noted that premature mortality declined more extensively in low-income groups, by just over 10%, a notable decrease.

An analysis of hospitalization rates according to socio-economic standing is also fairly revealing. The change in the crude rate shows that the reduction affected all groups (see Figure 16). However, the most striking reductions occurred among less privileged individuals; there was

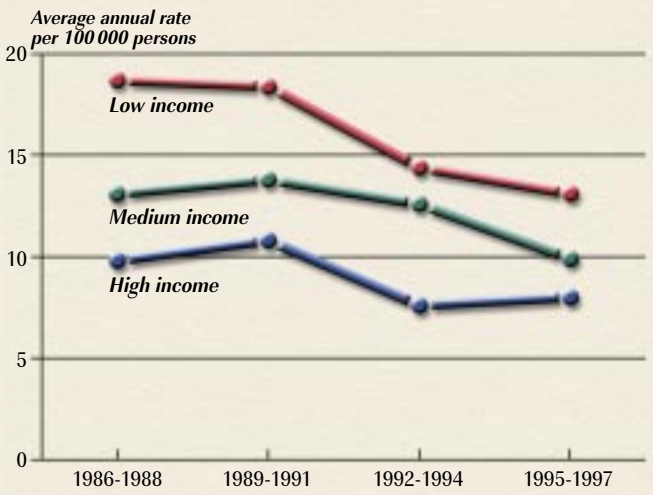
probably less potential in those groups whose initial use rates were the lowest. Nevertheless, a socio-economic gradient persists, although it is less pronounced than in the past. The same trends are apparent in the number of admissions or days of hospitalization. The average length of hospital stay is, by and large, similar for each socio-economic group.

In absolute terms, the shift toward ambulatory care seems to have been harder to negotiate among underprivileged groups but the relative discrepancies between social groups have remained appreciably the same.[23] The study by Pineault *et al*.[24] assessed perceived access to services from 1996 to 1998 and arrived at similar conclusions. It corroborates the reduction in recourse by low-income earners to hospital services and a concomitant reduction in recourse to the services of medical specialists.

Has this reduction been detrimental to health? The best indicator for this question, i.e. the mortality rate for certain causes avoidable through health care, suggests that such is not the case (see Figure 17). In fact, the downward trend noted since the mid-1980s has continued in the least privileged groups while the rate appears to have stabilized among the most privileged groups.

fig. 17

**Mortality rate for certain causes avoidable through care, Montréal-Centre, 1986-1988 to 1995-1997**




**Stable readmission rates and gains with respect to heart disease**

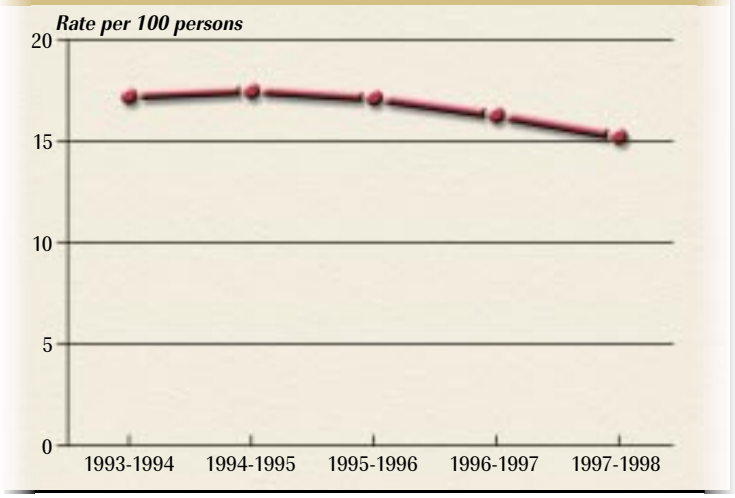
One of the most plausible hypotheses concerning the undesirable effects of the reform is that a reduction in the length of hospital stays combined with inadequate post-hospitalization services or limited access could lead to untimely readmissions. A readmission is defined as a first admission following a hospital stay in respect of a given condition. Such readmissions not only engender additional costs but would also appear to reflect health risks.

We therefore monitored readmissions in respect of five medical conditions identified in collaboration with clinicians, i.e. hip fractures, myocardial infarction, heart failure, colon and rectal cancer, and chronic obstructive

lung disease. We noted reductions in the length of hospital stays ranging from 10% to 35% between 1993 and 1998.[25] Moreover, an increase in the clinical severity of cases occurred, which coincided with the increasing complexity of cases admitted to hospitals. Despite these changes, no statistically significant change in readmission rates has been noted. Such results should reassure us concerning the ability of hospital teams to efficiently treat in less time than was previously the case individuals suffering from these five medical conditions and, in all likelihood, other similar conditions.

fig. 18

**Lethality rate during the 90 days following admission for myocardial infarction to a hospital, Montréal-Centre, 1993-1994 to 1997-1998**




Another observation that warrants mention is the reduction in the lethality of acute myocardial infarction, which suggests an improvement in the services offered individuals suffering from acute cardiac disorders (see Figure 18). The downward trend observed with regard to the mortality rate for cardiovascular disease is well known,[26] but only an improvement in clinical services can explain the reduction noted in the percentage of individuals who died within 90 days of a myocardial infarction.

### A reform fostering innovation

The reorganization has fostered innovations that have the potential to favourably affect the health care system's performance. Our list is hardly exhaustive, since it is, for the time being, impossible to fully take stock of the projects put forward in various sectors to bolster the efficiency of services. Several initiatives nonetheless warrant mention.

First, new programs have been set up in a number of priority fields. Numerous examples come to mind: prevention programs aimed at underprivileged children and young people (Naître égaux, grandir en santé),[27] integrated services for frail elderly people (SIPA),[28] innovative approaches to treating heart failure[29] or stroke,[30] and so on. Mention should also be made of the Info-Santé CLSC service, which the public uses extensively throughout Québec and whose relevance and efficiency have been demonstrated through a rigorous evaluation.[31]

The reform has given a boost to new methods of organization aimed at fuller integration of services, e.g. post-hospitalization services in the realm of physical health[32] or the delivery outside of institutions of mental health services.[33] The successful example of a properly planned transfer from one type of resource to another, carried out by trained, properly supervised staff, shows that it is possible to find solutions better adapted to the needs of individuals suffering from mental impairment or experiencing a loss of autonomy.[34] The unusual result obtained through a study of the preventive management of back pain clearly reveals that the health care system can remain receptive to relevant innovations despite the major changes now under way.

### *Efficient services to combat back pain*

According to the findings of the recently published Québec Health Survey, back pain continues to be a major health problem that appreciably undermines individual autonomy and the quality of life. Back pain is second only to respiratory problems among reasons for consulting general practitioners. International experts maintain that the principal objective of intervention should be to prevent chronic symptoms and relapses.

In Montréal, research conducted over the past five years in collaboration with the Direction de la santé publique de Montréal-Centre and the Institut de recherche en santé et sécurité du travail has led to significant advances. In 1999-2000, a major project applying these research findings was carried out by the Fédération des médecins omnipraticiens du Québec and the Commission de la santé et de la sécurité du travail and proposed clearly established diagnostic criteria and an audiovisual kit for patients to all general practitioners. These tools are designed to broaden access to quality information and foster communication between physicians and their patients, which is essential to combat back pain. The Régie de l'assurance-maladie du Québec has even contributed to this investment by adding a new remunerated procedure code for physicians that involves the patient in prevention measures.

The success of this collaboration illustrates the importance of implicating researchers and decision-makers at the outset of a process demanding changes in practices, while respecting their autonomy.

It is also worth noting that the reform has encouraged the development of new approaches to evaluation and monitoring. Evaluation in itself often leads to improvement. A growing concern for the quality of data and results means that the latter will have an increasingly positive effect, although indirectly.

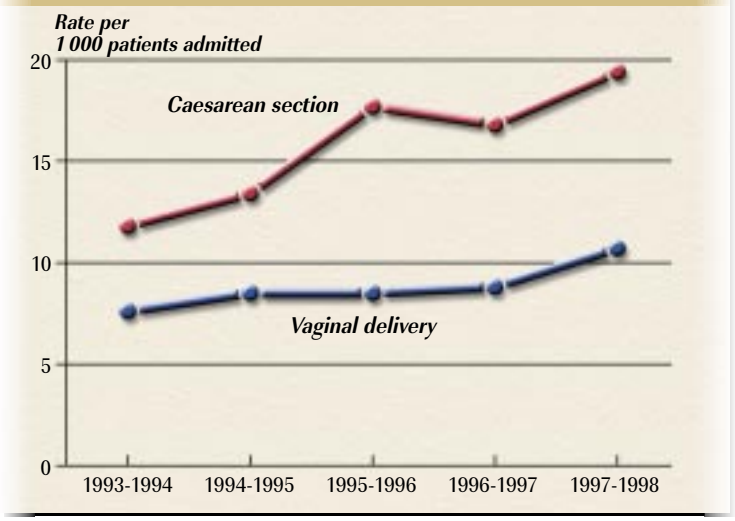
## *Areas for concern*

Certain observations focus on the potentially unfavourable impact of the reform or, at least, the persistence of shortcomings noted with respect to quality, which can put public health at risk. First, let us look at access to basic services, especially among certain vulnerable clienteles.

### Services for mothers and children

fig. 19

**Readmission rate following vaginal delivery and delivery by caesarean section, Montréal-Centre, 1993-1994 to 1997-1998**




Giving birth is the most common reason for being admitted to a hospital. The first days of life are decisive from the standpoint of the child's health and subsequent development. Monitoring has revealed a striking increase in the readmission rate following vaginal delivery and delivery by caesarean section, linked to a reduction in length of hospital stay of 21% and 17%, respectively, for these types of delivery (see Figure 19).[35]

Research has also highlighted delays in appropriate post-natal follow-up, which varies from one establishment to another, including hospitals and CLSCs. The delays are crucial since they are associated with a greater risk of post-partum depression, which has been confirmed by research.[36] Researchers have noted overlapping roles, a lack of trust between hospital and CLSC staff and frequent duplications of services. For example, 51% of mothers were called at home by both the hospital and the CLSC. It is to be hoped that the recent agreement between these establishments concerning perinatal services will facilitate better coordination and eliminate overlapping.[37]

### Inadequate access to basic services by elderly people experiencing a loss of autonomy

Care for elderly or very old people experiencing a loss of autonomy is a key challenge facing the reorganization of the health care system and research findings suggest that much remains to be done. The work of Cardin *et al.*[38] reflects the findings of Pineault *et al.*

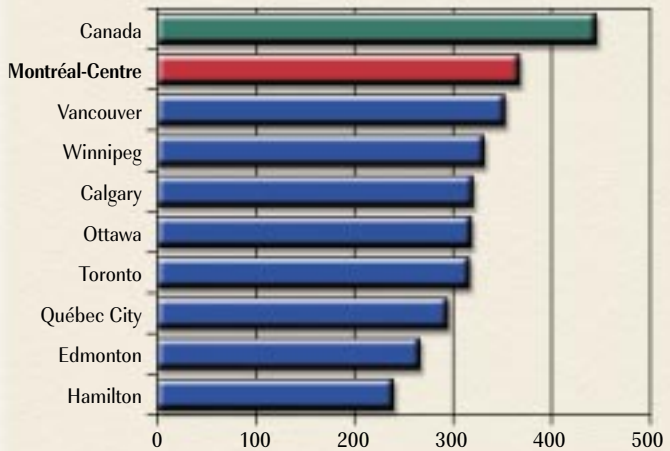
This study estimates that 40% of individuals 70 years or over released from emergency departments displayed to varying degrees a loss of autonomy and that only 42% were using CLSC home care services. An estimated 15% of elderly people experiencing a loss of autonomy once again urgently consulted a physician within two weeks of the initial visit to the emergency department and two-thirds of these visits occurred in the emergency service. However, the risk of returning to the hospital was considerably reduced when the individuals received information on the appointments to be made and the tests to be taken after discharge and a referral concerning home care services. It is disturbing to note that 37% of such individuals claimed that they did not have access to the services of a family physician.

### Gaps in front-line services

In addition to this study on visits to emergency departments, other observations corroborate the emerging consensus on problems in front-line service delivery, examined extensively during the hearings of the Clair Commission. As Figure 20 indicates, hospitalization rates for conditions that can be treated through ambulatory care remain higher in Montréal than in most Canadian urban centres. The high level of medical resources in the region[40] and the presence of 29 CLSCs suggest that we might expect better results. The opposite is true.

fig. 20

**Age-standardized hospitalization rate for conditions suited to ambulatory care in certain urban regions in Canada, 1997-1998**

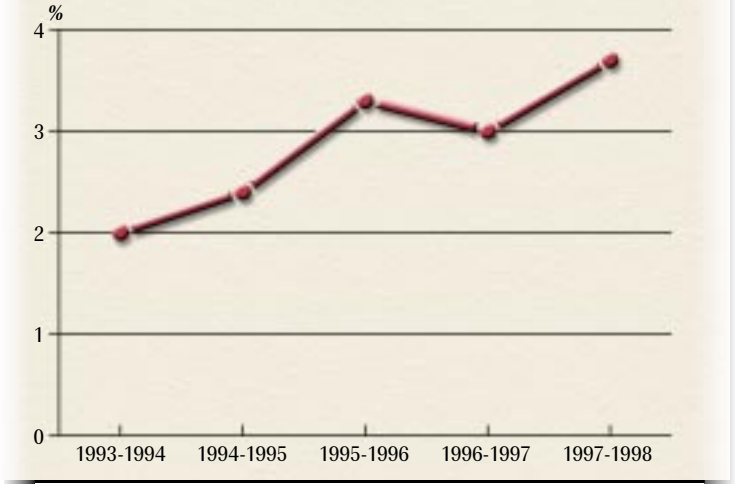


The foregoing observations should encourage us to give priority to a review of the organization of front-line services in Montréal. They strongly suggest that we should vigorously pursue efforts to better coordinate the activities of physicians in private practice and local CLSC teams in each community. A proactive approach in the realm of front-line services with respect to elderly people experiencing a loss of autonomy also seems important. Closer collaboration between front-line and second-line services would be advisable to ensure the delivery of ambulatory care services without which hospitalization would be necessary.

**Increase in complications arising after one day hospital care**

fig. 21

**Admission rate to general and specialized hospitals following a one-day hospital care, Montréal-Centre, 1993-1994 to 1997-1998**




Monitoring has revealed a clear increase in admission rates in respect of complications arising after one-day hospital care. As Figure 21 shows, the rate almost doubled, from 2.0% in 1993-1994 to 3.7% in 1997-1998. We can assume that such problems have affected, in particular, certain vulnerable clienteles, such as individuals suffering from chronic diseases and frail elderly people.

These observations may reflect new methods of practice. In some instances, admission may represent a judicious decision that normally follows one-day diagnostic or therapeutic hospital care. However, they more likely reflect the difficulty of safely making the shift from hospital services to ambulatory care, because of shortcomings in hospital services. Roberge *et al*. have shown that there are striking differences between hospitals in the number and nature of the measures implemented, the order of implementation and the intensity of effort.[41]

Another possible explanation is the problems that the CLSCs encounter in providing post-hospitalization home care services. While proof to support this hypothesis is not entirely conclusive, the assumption is plausible.

CLSC staff has had to learn about new technologies and professional practices imposed by the shift to ambulatory care. However, according to Lehoux *et al.*, only a minority of CLSCs has shown itself to be genuinely proactive in meeting this challenge.[42]

Another study focusing on the health risks posed by one-day hospital care[43] shows that the state of health of patients treated in day surgery is similar to that of patients who received treatment during hospitalization that could have been provided in day surgery. The same was true of caregivers: the number of caregivers that had to curtail their activities because of the care they provided did not differ significantly between the two groups of patients.

**Reduction in length of hospital stays: impact on patients, their families and friends**

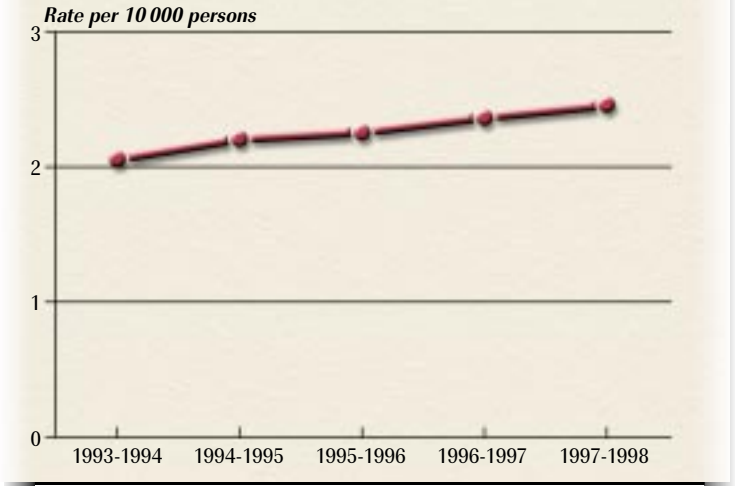
Have changes in hospital practice imposed a heavier burden on patients or on their families and friends? Research does not allow us to draw a firm conclusion.[44] Tousignant and his collaborators have examined the impact on patients of a reduction in the length of stay in respect of certain surgical and medical conditions. Analyses have revealed differences in state of health between groups of patients treated in 1996 and in 1999, although researchers were unable to attribute this difference to the reorganization of health services. However, the increase in clinical severity noted with respect to medical cases in 1999 encouraged the authors to recommend the cautious implementation of any additional measure aimed at reducing the length of hospital stay, depending on the severity of the patients' condition.

Moreover, the data that the research team collected did not reveal any discernible impact on the health and well-being of caregivers, although the limited number of observations precludes drawing firm conclusions. Other research suggests, to the contrary, that the growing complexity of the condition of elderly people cared for in the home appears to adversely affect the quality of life of informal caregivers.[45] Consequently, there is good reason to pursue research and exercise caution when dealing with this problem.

## Increase in ruptured appendicitis

fig. 22

**Ruptured appendix rate, Montréal-Centre, 1993-1994 to 1997-1998**

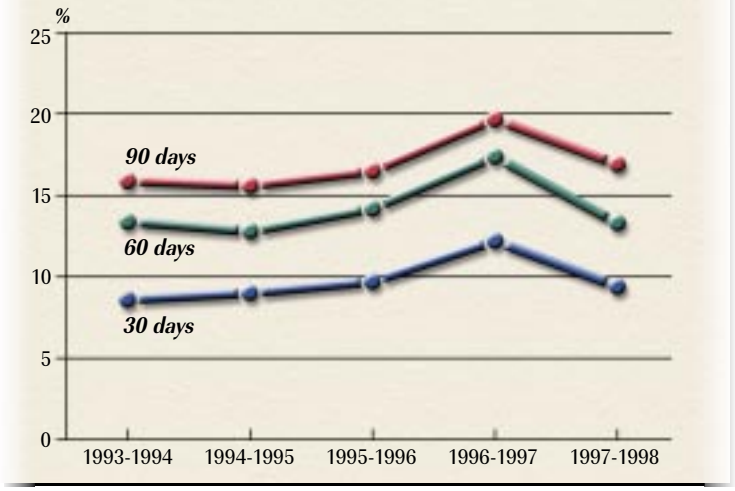



Monitoring data indicate an appreciable, although not statistically significant, increase in admission rates for ruptured appendicitis, which is a surgical emergency and an immediate threat to health (see Figure 22). This trend could reflect a delay in access to services, i.e. a delay by the patient in consulting a physician, a delay in diagnosing the patient, a delay in having an operation, and so on. The Direction de la santé publique is unable to immediately offer a conclusive response and is pursuing research on the matter, starting with the gathering of information out in the field.

## Respiratory diseases: optimum treatment?

fig. 23

**Lethality rate for obstructive lung diseases, three follow-up periods, Montréal-Centre, 1993-1994 to 1997-1998**



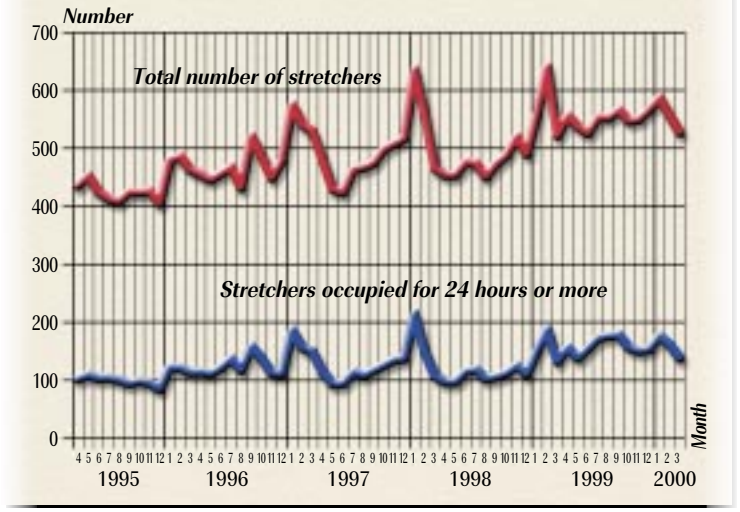

Monitoring has highlighted the burden represented by respiratory diseases, which is already greater in Québec and Montréal than in the rest of Canada and which has increased during the reorganization of the health care system. This situation is not well-understood. Of course, tobacco plays a major role in the incidence of respiratory diseases, which explains their rapid rise among women.[46] Other factors such as the virulence of viral and bacterial agents or resistance to antibiotics could also explain this situation. However, the increase in the lethality rate (see Figure 23), which reached a statistically significant level in 1996-1997, raises as yet unanswered questions concerning the delivery of suitable services pertaining to respiratory diseases, e.g. judicious use of available drugs, appropriate forms of care, and so on.

### Emergency rooms in a state of flux

More than any other indicator, the performance of emergency services clearly reveals the overall dynamic of the health care system and, to a certain extent, the social services available in the community. Ordinary Quebecers, as much as administrators and journalists, fully understand this situation. However, congestion in emergency departments, a rampant problem in most cities in Québec and elsewhere, reflects an extremely complex situation that no observer can claim to fully comprehend. What is happening in emergency rooms reflects what is happening — or not happening — before, during and after hospitalization. We cannot expect to find a simple, single, definitive solution to this important problem.

fig. 24

**Average daily number of stretchers occupied in emergency departments, Montréal-Centre, April 1995 to March 2000**




An analysis of the occupation of stretchers in emergency departments has been conducted since April 1995 (see Figure 24) and the figures clearly show a steady, gradual increase in patients on the order of 20% until late 1998, with winter peaks equivalent to an additional increase of 20%. One-third of cases are directly attributable to respiratory diseases and infections. In 1998, however, the situation deteriorated somewhat and the level of occupation rose and remained high throughout the 1999-2000 fiscal year. The relative stability of the occupancy rate of stretchers for more than 24 hours, observed until then also declined. A daily average of roughly 150 or more patients remaining on stretchers for over 24 hours was observed regularly.

The reduction in resources has obviously curtailed the ability of establishments, especially hospitals, to handle peak demand. As Roberge *et al.*[47] have shown, budget cutbacks in the hospitals combined with the growing complexity of patients' problems significantly diminished the leeway available until that time to cope with fluctuations.

### Prevention at risk

Growing demands engendered by the shift to ambulatory care have exacerbated tension between various missions in front-line establishments, to the detriment of their preventive and psychosocial roles. This observation was noted in Chapter 1 in the discussion of the reduction of the number of hours devoted in CLSCs to prevention-promotion measures and has been confirmed by other research.

Richard *et al.*, in their study of preventive services aimed at young people, have noted that the CLSCs scarcely deal with several issues deemed important in the realm of prevention, even though urban CLSCs generally seem more active in these sectors.[48] What is even more disturbing is that Poirier *et al*. have noted that shortcomings in funding, demands from the standpoint of supervision and the voluntary departure program have led to budget choices that are affecting CLSC prevention programs.[49]

A study conducted by a group of researchers headed by Dr. Jean-François René reveals that the CLSCs are not alone in this respect.[50] The research, focusing on over 1 000 Québec community organizations, noted significant changes in the practices of such organizations in conjunction with the shift to ambulatory care.

***The prevention mission of the CLSCs and community agencies has been undermined.***

These observations lead us to conclude that the prevention mission of the CLSCs and community organizations has been undermined. Despite additional funding, it would appear that broader delivery by the CLSCs of ambulatory services has been achieved, in part, to the detriment of individual and collective preventive services offered locally.

### Is collaboration happening among services for young people?

The question of the health and optimum development of young people has been a priority issue in respect of health services in the Montréal area, given their prominence in regional priorities and the pivotal nature of the Projet jeunesse montréalais in the 1998-2002 plan to improve services.

The findings of the participatory evaluation of regional priorities have shown the feasibility of and interest in partnerships negotiated in the field (see insert on page 42).[51] Moreover, the overview undertaken of

the situation of young people has provided an indication of needs based not on the situation of organizations offering services but on the situation of young people in the community.[52] The assessment has confirmed that the problems related to social adaptation among people under the age of 24 are frequent: every year, nearly one young person in six seeks a consultation for this reason in Montréal. Among underprivileged young people, the figure is as high as one in three. Problems of internalization, which are the least apparent, are the most frequent. The medical practitioners consulted vary from one community to the next, depending on the resources available. General practitioners are the health professionals most frequently consulted by young people.

Generally speaking, the needs of local communities are fairly closely aligned with the level of consultation by young people: the greater the need, the more young people tend to rely on facilities in the community. However, this is not true in all communities. Young people from the territories of CLSCs with the greatest numbers of recent immigrants consult health professionals less than anticipated. However, since these communities are over-represented in rehabilitation centres and correctional services, ethnocultural factors must strongly influence access to health services. Contrary to popular belief, a lack of resources does not appear to be the main obstacle to access by young people in Montréal-Centre to services but instead the ethnocultural traits of the community.

***A lack of resources does not appear to be the main obstacle to access by young people in Montréal-Centre to services but instead the ethnocultural traits of the community.***

This observation is all the more significant in that the advancement of initiatives under the Projet jeunesse montréalais stalled, until very recently, over the question of resources since stakeholders were reluctant to apportion responsibilities in the absence of a framework for sharing resources between the CLSCs and the Centres Jeunesse. The delays are such that there is a risk of demobilizing local and regional teams and the team of researchers that is to assess the project might have to postpone its work for want of anything to evaluate.[53]

The foregoing observations clearly reveal that changes in organizational methods seem to be hard to introduce when the structure of the system is not modified, especially from the viewpoint of control over resources. It would be distressing if qualified interveners, who believe in these

objectives and their ability to make a difference among young people, were unable to adopt the organizational methods that would enable them to satisfy the needs of young Montrealers. Given the recent completion of local community needs assessment and the Régie régionale's reiteration of its willingness to invest more energy upstream from various problems, it is to be hoped that the anticipated consolidation of preventive practices in the realm of services for young people will be achieved in the short term.[54]

### *An example of participatory evaluation*

In 1994, following extensive public consultation, the Régie régionale undertook a shift to disease prevention and health promotion and pinpointed its intervention priorities. The Direction de la santé publique was asked to develop and implement these priorities and, to this end, it sought the participation of a wide array of regional partners. Furthermore, the Direction was asked to evaluate the 13 programs arising from the priorities and it was logical to think of establishing a partnership associated with the evaluation. The participatory evaluation that was introduced sought to encourage actors connected with the programs, ranging from decision-makers to interveners in the field, to answer, in light of the data collected, two questions.

***Has progress been made in the implementation of the programs?***

***In light of the conditions surrounding the implementation, is the definition of each program still meaningful?***

In particular, the findings have made possible a number of worthwhile adjustments along the way. Moreover, they have shown that strategies for enhancing individual potential and enriching living environments are more likely to be carried out than those pertaining to the improvement of living conditions and political influence. We have also noted that, with the necessary technical support, interveners can jointly manage a process that ranges from the observation of a program's achievements to the judgment of its quality and recommendations on desirable changes.

An independent ethical review committee, which monitored the realization of the project, concluded that the program was empowering insofar as such an evaluation is of a public nature and leads to recommendations on the future of programs.

## *Areas of critical uncertainty*

This final section of the chapter focuses on issues for which we have some information but which, because of their importance or the ambiguity of the findings, warrant more thorough examination. Human resources, the most influential component of our sector of activity, will be examined first.

### Mistreated human resources

Health care workers are the key resource in the health care system. The reforms have significantly affected them, although there is little in the way of scientific research devoted to the question. In Montréal, the efforts of the advisory committee set up to oversee the elaboration of the impact assessment program failed to interest research groups in these issues. More recently — better late than never — university research projects have been launched.[55]

However, the results of a major study conducted in the Québec City area have just been published.[56] The study examines the impact of the reorganization of the health care system on the professional life, family life and health of nurses. Researchers documented the increase in the workload, the reduction in decision-making leeway and the decrease in social support at work, which have accompanied the destabilization of work teams. The intensity of successive changes, from the standpoint of colleagues, clienteles and work units, appears to have undermined the feeling of belonging, caused a lack of trust and led to withdrawal. Many nurses display high levels of psychological distress and increased consumption of alcohol and psychotropic drugs. An increase in the length of sick leave and the frequency and duration of absences due to diagnosed mental health problems have been well documented.

***The intensity of successive changes, from the standpoint of colleagues, clienteles and work units, appears to have undermined the feeling of belonging, caused a lack of trust and led to withdrawal.***

It is hard to put these findings into perspective. As certain observers have, ironically, suggested, studies devoted to human resources in the health sector often tend to show that worker morale has never been lower.[57] In addition, research does not examine the impact on the health of workers who have chosen to retire and leave the system. Have these other categories of workers been affected differently?

Although a number of questions remain unanswered, at least in the Montréal area, observations concerning nurses and issues pertaining to the health and safety of health-care personnel strike us as sufficiently convincing to warrant greater vigilance and broader recognition in the decision-making process, both by managers and professional associations.

**Integration of services, the crux of the reform**

Everyone agrees that services offered by various components of the system must be better integrated to allow the health and social services system to develop. This has been an explicit objective of the reform and a necessary avenue, which observers expected to have a positive impact on the organization of work and the quality of care offered various clienteles. Research has given rise to a number of observations, although uncertainty remains that must be overcome in order to pursue the reorganization of the health care system.

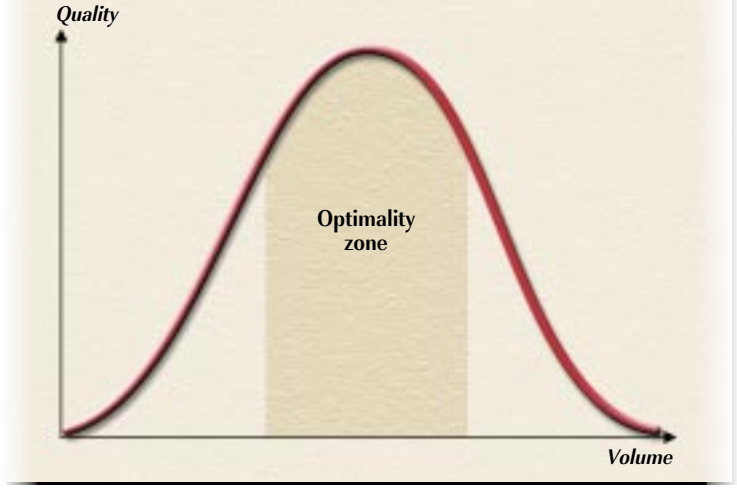
Two studies have shown that poorly defined roles and a lack of trust between hospital staff and front-line service providers is a major obstacle to the integration of services.[58, 59] The relationship of trust between primary, secondary and tertiary level professionals, based, by and large, on the perception of the competence and skill of these individuals, appears to be especially important. The quality of coordination depends on this level of trust and, in sectors where coordination is weak, overlapping has been noted, along with continuity problems, major conflicts over the sharing of responsibilities, and a lack of consistency in the care and information given to patients.[60] In a word, we are facing a genuine problem of quality.

***In sectors where coordination is weak, overlapping has been noted, along with continuity problems, major conflicts over the sharing of responsibilities, and a lack of consistency in the care and information given to patients.***

These observations highlight the relevance of continuing to question ourselves about the concept of the integration of services, a concept mentioned by several observers but that is not defined consistently.[61] Research reveals certain conditions for success, e.g. formalize agreements and establish a relationship of trust.[62] However, much remains to be done to ascertain the mechanisms that would enhance the quality of relationships between interdependent partners, as is the case in the health care system. Various structuring methods and the role played by financial and other incentives warrant special attention or rigorous testing.

## Relationship between volume and quality, an emerging issue

Diagram A
**Relationship between volume of activity and quality**




Scientific documentation proposes various examples that indicate a positive association between the volume of activities an organization carries out and the objective quality of such activities. This relationship has been clearly demonstrated in respect of certain specialized services, including heart surgery.[63] A number of analyses conducted by the Collectif de recherche appear to indicate that this relationship is not linear (see Diagram A). An overly low level of activity could compromise the maintenance of the appropriate expertise. A very high level of activity could, to a certain extent, harm the quality of service and increase the risk of error.[64] Between these two extremes appears to lie a zone or a certain volume of activity that corresponds to an optimum level of quality, a level that apparently varies from one type of service to another.

There is good reason to pinpoint an optimality zone with respect to each type of service and, if need be, to systematically take it into account in decision-making. The public will be properly served provided that the allocation of resources guarantees the delivery of services by establishments, professionals or physicians who produce adequate volumes of activity.

## Erosion of trust among the public and professionals

Throughout Canada, an erosion of public trust in the health care system has accompanied health care reform. Similarly, a survey conducted in 1998 in Australia, Canada, New Zealand, the United Kingdom and the United States reveals that fewer than one respondent in four felt that the health care system was working properly in its current form.[65] In Canada, the level of public trust stood at only 20%, a substantial drop in relation to the 1988 figure of 56%.

*Individuals who have used services have a more positive perception of the situation than those who have not.*

In Montréal, the public appears to believe that access to health care generally declined between 1996 and 1998.[66] It should be noted that individuals who have used services have a more positive perception of the situation than those who have not. Other surveys confirm this observation: respondents tend to display a higher level of satisfaction in respect of services received than with the health care system in general,[67] which suggests that the media have exaggerated public dissatisfaction.

Surveys of the public and professionals suggest that the communication strategy has not allowed for sufficient penetration and assimilation of the objectives of the reorganization advocated by officials in the health care system. According to the surveys conducted by the team headed by Dr. Pineault, 40% of respondents claimed that they were uninformed about the reform at all three stages of the study.[68] Following interviews with directors of professional services and nursing, Roberge *et al*. reported striking differences between various sectors in terms of the measures implemented and the intensity of the effort expended.[69] Under the circumstances, it would be surprising that information on the objectives of the reorganization circulated in an optimal manner. Apparently contradictory messages may also have created confusion, i.e. improve services, on the one hand, and engage in budget cuts, on the other.

*It would be desirable to improve communications between decision-makers and practitioners.*

To what extent could the erosion of public trust prove detrimental to decision-makers in the pursuit of the reform? We do not have any data on this question. However, we do have information that suggests that it would be desirable to improve communications between decision-makers and practitioners. These exchanges should take place in each organization, of course, but also between organizations in order to broaden acceptance of the reform, establish bonds of trust, foster a better understanding of policy directions, and ensure greater consistency with regard to ways of implementing policy.

The reform of the health care system in Montréal has sparked numerous mandatory changes that we have had to negotiate simultaneously. Efforts to curb spending have been more fruitful than those aimed at reorganizing services. Overall, the system has succeeded in dealing with sweeping, rapid organizational change. Certain measurable improvements have been recorded in system performance but areas of concern remain that must be closely examined in the coming months. Furthermore, uncertainty and anxiety persist, especially with regard to strategies to communicate the reform's objectives and from the standpoint of ensuring participation by professionals and the public. This is a prerequisite to fully understanding past and impending change and to accepting it.

3

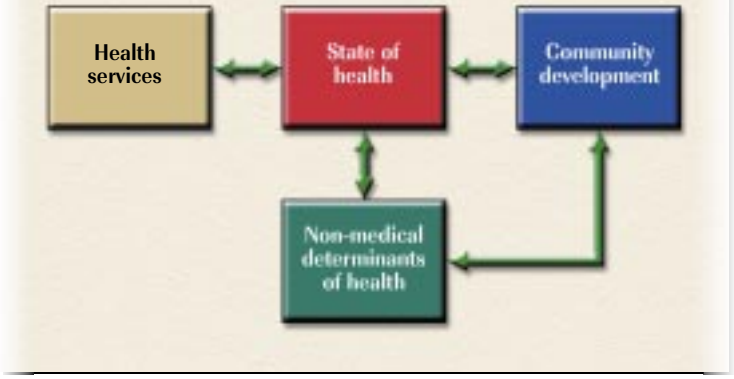
# An Unfinished Reform

*TO STRIKE A BALANCE between the three objectives of the health and social services system — prevention, cure and care — will be all the more demanding since major socio-demographic, epidemiological and technological change will have to be dealt in the coming decades.*

Increasingly, the World Bank and various international agencies are regarding health as one of the keys to collective development and the prosperity of nations. It is one of the reasons why investment is being promoted in health services; it can foster not only better health but encourage economic and social development as well.

While the delivery of health services is essential to ensure the health of the population, this contribution alone is insufficient. Several influential factors that affect health care lie outside the health care system, i.e. non-medical determinants such as lifestyle and living conditions, the psychosocial environment, the healthiness and conviviality of living environments, the natural or built eco-logical environment, and so on.

Diagram B
**Health services, health and development**




While the importance of these non-medical determinants is recognized by growing numbers of observers and experts, the public deems health care to be more important. Health care implies a moral dimension: the most serious questions, dealing with life and death, are often discussed in conjunction with the delivery of health care. At the same time, the potential of modern technology is growing markedly and is receiving extensive media coverage. The public's very high expectations in respect of the apparently boundless capacity of medicine are hardly surprising.

Québec is part of this worldwide trend, all the more so since it has substantially modified its health care system and cut budgets in a very short time.

### *Target the right objectives*

If we consider the health needs of the population overall, Montrealers can be divided into three groups. The majority are in very good or excellent health and rely to a limited extent on health care services and

at moderate cost. A second group, just over one-third of the population, perceives its health as good. These individuals usually suffer from acute conditions that may be reversible, or chronic conditions, risk factors or health problems for which effective treatment is available. This group more frequently requires ongoing care, which, of course, affects the attendant costs. The third group, which accounted for 11% of the population in 1998, perceives it health as average or poor and the care given such individuals accounts for the highest costs in the health care system.

Our previous annual report stressed the importance of targeting the right objectives in respect of each of the three groups, whose needs differ.[70] The key objective for the first group is prevention, i.e. to maintain or even enhance health potential with a view to ensuring that the individuals in question do not move up the pyramid to another category requiring additional care. Curing is the most pressing need in respect of the second group and assumes that individuals have access to the appropriate services in order to overcome risk factors and intervene promptly in dealing with disease, thus delaying its development and reducing the risk of complications. In the third group, located at the top of the pyramid, the key objective is to provide care because of average or poor health. For the individuals in this group, who suffer from an impairment or an often irreversible disability, therapeutic approaches are intended not to eliminate the problem but instead to enhance the individual's ability to deal with the problem and, despite everything, live a satisfying life.

Experience has shown that the health care system is having trouble maintaining the desirable balance between each of these three objectives. Research confirms that the prevention mission is especially vulnerable. Growing demands related to the other two objectives – cure and care – can lead to the curtailment of prevention activities. Furthermore, it may be hard to strike the proper balance between curing and care. The risk of underutilization, improper use or even the overuse of such services is genuine, which poses a daunting challenge for clinicians and the managers who administer services.

***Growing demands related to the other two objectives, cure and care, can lead to the curtailment of prevention activities.***

### *A System facing major transitions*

Striking a balance between the three objectives of the health and social services system — prevention, cure and care — will be all the more demanding since major socio-demographic, epidemiological and technical change will have to be dealt with in the coming decades.

The socio-demographic transition, already under way, will compel the health care system to adapt to rapid demographic change, which, in all likelihood, will have a genuine impact on demand for and the use of services. From a social and economic perspective, the persistence of social inequality and changing family and community dynamics will continue to significantly affect needs.

Diagram C
**Transitions to be negotiated in the health care system**


The epidemiological transition will alter the profile of problems pertaining to the health and well-being of the population. While infectious diseases used to be prevalent in Québec society, chronic diseases have now come to the fore, of which cancer, cardiovascular disease, diabetes and respiratory diseases are the most devastating. This burden will persist for some time to come given the disappointing trends in Québec society concerning smoking, diet and a sedentary lifestyle. Problems related to stress and precarious living conditions will also persist and manifest themselves through social adaptation difficulties, violent behaviour and psychological distress. The epidemiological transition will continue until 2020. Increasingly, health problems in an aging population will predominate. For example, mention should be made of osteo-articulatory and cognitive problems and the accumulation among frail elderly people of concomitant problems.

However, perhaps the most significant pressure will be exercised by the technological transition. Recent and impending technological breakthroughs undoubtedly offer considerable potential benefits as

*The technological explosion simultaneously risks compromising the government's ability to cover costs.*

regards public health, although the technological explosion simultaneously risks compromising the government's ability to cover costs. Consider, for example, the cost of drugs, which is now increasing by roughly 20% a year, costly medical imaging techniques, or anticipated innovations in the realm of genomics.

The combined effect of changing needs and broader diagnostic and therapeutic possibilities has already begun to make itself felt. Since resources are scarce and the capacity for intervention is growing constantly, we must, inevitably, make choices. Moreover, such choices must not only seek to maximize the impact on health, bearing in mind the resources available, but must also take into account the objective of fairness and the priorities that society adopts.

*Since resources are scarce and the capacity for intervention is growing constantly, we must, inevitably, make choices.*

The time has perhaps come to review the logic governing decision-making with respect to the allocation of resources. As is the case with cost-benefit analyses, we could adopt certain measuring methods or conventions that allow us to ascertain the usefulness of interventions according to a single standard. Following the example of the World Health Organization (WHO), if we adopt a common measurement unit based on life expectancy adjusted for the quality of life, it would be easier to make objective comparisons of options and support decision-making at different hierarchical levels. Let us now examine the discussion points suggested by the findings of the evaluation from the standpoint of the pursuit of the reform.

### *Discussion points for decision-makers*

Important decisions are being made constantly in our health care system at the clinical, administrative and political levels as well as that of the individual citizens. Our performance analysis suggests a number of discussion points for all decision-makers.

#### The clinical perspective

Research data confirm what some people know already from personal experience: increased demand and a reduction in room to manoeuvre have put the professions in the health sector at risk. Front-line

practitioners must regain some degree of control over their work environment, policy directions and organizational choices. Failure to ensure that all health professionals participate could compromise the health care system's mission.

The abundance and ready availability of scientific information should encourage practitioners to concern themselves, more than ever, with the optimum application of knowledge. While the evaluation program has not focused on this question as such, the discrepancy between knowledge and its application must not diverge significantly from what is indicated in the medical literature. Increasingly, the challenge posed by performance will demand adherence to conventions of practice based on advanced knowledge. It is incumbent upon practitioners to show the way and display leadership in this respect.

***The challenge posed by performance will demand adherence to conventions of practice based on advanced knowledge.***

Even if we apply all of the science available to us, we still must organize ourselves. Research indicates that we have some catching up to do. Overlapping, delays and excessive recourse to emergency services are all too common. We must also accept the rules that we have adopted.

One essential priority in this area is a fully understood, functional hierarchy that clarifies roles, responsibilities and interactions. Instead of thinking in terms of ad hoc visits we must think about care episodes and a continuum of services. We must also analyse in detail processes and design the course to be followed by the individual, always minimizing obstacles and ensuring the necessary supportive care and attention at all times in our labyrinthine health care system.

More than ever, it is essential to bring together the dynamic front-line forces, i.e. CLSCs, community organizations, physicians and practitioners from the private sector. The collaboration agreements tested in other situations warrant testing between CLSCs and physicians in private practice. A population-based approach, centred on age or sex to reflect different stages in people's lives, has already proven its usefulness and could be promising.

The coordination of front-line caregivers with specialized secondary and tertiary teams also needs to be perfected. We would be well advised to adopt a program-based approach accompanied by procedures for exchanges, collaboration and mutual referral, at least in respect of the most common problems such as chronic diseases instead of having to start from scratch every time. We must set up a team, similar to that put into operation by the Programme québécois de lutte contre le cancer.[71]

**The administrative perspective**

Administrators have also been affected in recent years by the process of change. There are now fewer of them to manage more complex situations, maintain sound organization and create an organizational framework that fosters teamwork. Managers must also understand how their roles fit in with the health care system and the intervention process. They must encourage their organizations to make their expected contribution to the system and draw from the system what is necessary to ensure organizational development. Moreover, they must play a pivotal, proactive role and be able to deal with values and emotions.

***The health care system will need administrators who apply a preventive management approach.***

Increasingly, the health care system will need administrators who apply a preventive management approach, who fully understand the continuum in which they are working and who know how to oversee the continuum in order to do better at less cost whenever possible. Such administrators will be able to document the internal and external performance of their teams, services and organizations.

Another challenge that arises in a system such as ours, in which there is considerable autonomy and where lines of authority are fairly weak, is to give a clearer sense of direction. Without descending to command-driven logic, the health care system probably needs better structured decision-making cores that possess clear levels of competence, a system head and a common game plan. Otherwise, the reorganization will be impossible. Only managers with vision and the appropriate skills and attitudes will be able to see the health care system through the reorganization.

### The political perspective

The challenge facing elected representatives and the administrative structures that support them is to maintain a sound, healthy system. To this end, as is true of any human endeavour, the system must pursue an ideal, strive to achieve an objective, be active, collaborate and receive recognition for its successes.

*It is up to the policy makers to specify choices with respect to the most strategic results*

It is incumbent upon policy makers to look ahead, suggest a vision and give meaning to collective action. They must steer a steady course, even in troubled times. It is up to the policy makers to specify choices with respect to the most strategic results because it is impossible to do everything, in addition to finding and allocating the resources necessary.

It is incumbent upon policy makers to promote a concern for performance so as to derive the maximum benefit from the resources available in order to ensure prevention, cure and care. Furthermore, they must adopt a broad framework within which performance can be managed. A renewed health policy, which clarifies obligations of means and objectives concerning results could prove a valuable tool to identify major targets and how to monitor them, in collaboration with professional and administrative staff.

### The peoples' perspective

When all is said and done, in the case of health and well-being, there is only one judge, i.e. the individual concerned. Montrealers are, for all intents and purposes, the key decision-makers. Until now, their judgment has centred on their perceptions, their assessment of the system's strengths and weaknesses and what it has to offer them.

*Individual Montrealers are, for all intents and purposes, the key decision-makers.*

The information revolution now under way is upsetting the inherently asymmetrical relationship between the individual and the professional. Montrealers have ready access to information on health and well-being. They are increasingly educated and many of them wish to make enlightened decisions with regard to their health. We are witnessing the emergence of a new therapeutic approach in the array of technologies at our disposal, a promising strategy that might be dubbed

"informaceutical." Informaceutics is the art and science of preventing, curing and providing care through information. Knowledge underpins everything, even health. Restoring to the individual control over health relies on a summary of information and the efficient transmission of knowledge.

***Informaceutics is the art and science of preventing, healing and providing care through information.***

We believe that the reorganization of the health care system cannot succeed unless the power of information is put to good use. Would it not be advisable to more actively promote the dissemination of knowledge, especially in French? This means taking full advantage of the potential of information resources and turning them into genuine working tools to be used by the health care system.

### *Progress toward an efficient system*

Everyone agrees in the clinical, administrative and political sectors that it is important to bolster the health care system's efficiency. The system must provide health care and good service at an acceptable cost both for users and service providers, whether in terms of direct costs in dollars or other financial and human costs.

***Everyone agrees in the clinical, administrative and political sectors that it is important to bolster the health care system's efficiency.***

Why not agree on a performance concept that is not only acceptable to but promising for the majority and which would make it possible to adopt criteria in order to assess and enhance our performance at each level, as practitioners, as an organization and as a system? The comprehensive framework for analysis put forward by WHO in its *2000 World Health Report* has been favourably received and offers worthwhile potential.

The framework would play an integrating role and accommodate several themes that are central to the mission of the health care system, e.g. efficacy, fairness, economic efficiency, responsiveness, satisfaction and so on. Such a framework would also allow for comparisons with other health care systems because it is important to learn from them. Furthermore, the framework would require that we document all relevant facets of system operations. From this viewpoint, the next shift could be electronic.

**Under this framework, the Québec health care system could be evaluated according to five basic objectives by comparing the attainment of these objectives and the resources invested. Specifically, the objectives are to:**

1. enhance Quebecers' health;
2. reduce health disparities;
3. satisfy the public's legitimate expectations concerning the quality of services;
4. meet these expectations without discriminating against vulnerable groups; and
5. fairly apportion the funding burden.

### Monitoring: A role for public health

As interveners in the realm of public health, we will maintain our commitment to monitor and assess the system's performance and to keep informed all decision-makers, i.e. elected representatives, managers, practitioners and ordinary Montrealers. We will continue to evaluate the impact of various changes on the health and well-being of Montrealers, especially vulnerable groups. We will closely monitor avoidable morbidity and mortality through the appropriate measures. We will pay special attention to access and recourse to services and procedures that are deemed to be effective, particularly with respect to vulnerable groups. We will continue to be concerned about social inequality in the health care sector as regards accessibility, the quality of services and the fair apportionment of funding.

## Afterword

It is the spring of 2005 and Helen Slater is leaving her neighbourhood health cooperative. For three years, she has regularly consulted this primary-care team set up by the CLSC, a group of physicians and a former physiotherapy centre. Helen has found a good family doctor there whom she consults periodically, since diabetes requires regular follow-up. The clinic is affiliated with several specialists whom she can consult by appointment, including the young nutritionist who introduced her to vegetarian cooking and the ophthalmologist who examines her eyes annually.

Helen Slater has chosen the cooperative, with which she has signed a three-year agreement, because of the friendliness and respect with which she is treated and the skill demonstrated by the team, not to mention its team of collaborators. The agreement determines the payment made to the team for accepting her in its practice. This is in keeping with the government policy that the Minister of Health adopted to resolve the health crisis in the early 2000s. Moreover, the agreement specifies the framework under which staff in the cooperative have access to relevant computerized information, regardless of where it is located in the databases of Québec health agencies. This electronic link is especially valuable for the pharmacist in simplifying follow-up, renewing prescriptions and reducing prescription errors.

The general practitioner and his team have undertaken to maintain regular contact with Helen Slater in order to keep her in good health. They occasionally write to her to provide information on health questions of concern to her. They also make home visits when it is preferable to do so. When she visits the cooperative's office, she can readily obtain in the waiting room useful information on health and community resources. A nurse deals with her, the same one who helps the physician coordinate health care. The nurse periodically administers short questionnaires to monitor Helen Slater's health, takes blood samples and sends out periodical reminders. The nurse-coordinator ensures follow-up in respect of specialized services or establishments for services that the cooperative does not offer directly in order to attain the objective of the patient's comprehensive health plan.

This is the array of services to which Helen Slater has access in the Montréal health care system in 2005. Some observers are saying that it is once again becoming one of the best systems in the world. It is also said that the reorganization of the system must continue and there is talk of a "genetic shift." If one thing is constant in the health care sector, it is change and perhaps the system is changing for the better.

## Projects and Researchers

Below is the list of research projects focusing on health services offered in Montréal that are related to various measures in the Régie régionale de la santé et des services sociaux de Montréal-Centre's reorganization plan. The researchers who agreed to collaborate in this collective undertaking are identified as such. Summaries of each project can be found in Collectif de recherche sur l'impact de la transformation du réseau montréalais sur la santé.

*Effects of the health services reorganization on emergency department overcrowding.* Danièle Roberge [1], Raynald Pineault [4], Pierre Tousignant [2-3], Sylvie Cardin [1].

*Transfer of dependent clients from CRPDIs to the Verdun Champlain-Manoir CHSLD (Centre hospitalier de soins longue durée: long-term-care hospital).* Militza Zencovich [5].

*Evaluation of the impact made on accessibility by the reconfiguration of Montreal-Centre's network of health services.* Raynald Pineault [4], Léo-Roch Poirier [2], Ronald Lebeau, Véronic Ouellette.

*Implementation and operational assessment: coordinating CHSCDs- CLSCs-attending physicians; post-hospital care and administration.* Carole Lécuyer [5].

*"User friendliness"and organizational framework of home technologies.* Pascale Lehoux [6], Raynald Pineault [4], Lucie Richard [7], Jocelyne St-Arnaud, Henk Rosendal.

*CLSC promotion and prevention (PP) services in the field of perinatality-childhood-youth: Profile and study of determinants.* Lucie Richard [7], Danielle D'Amour [7], Jean-Marc Brodeur [2], Raynald Pineault [4], Louise Séguin [4], Jean-François Labadie.

*Impact of health system's reconfiguration on the organization of preventive services offered by CLSCs in the Montreal-Centre region.* Léo-Roch Poirier [2], Patricia Goggin [2], Natalie Kishchuk [2].

*Evaluation of the impact of postnatal follow-up procedures on mother and newborn in the context of early obstetric discharge.* Lise Goulet [7], Danielle D'Amour [7], Raynald Pineault [4], Louise Séguin [7], Jocelyn Bisson.

*Strategic analysis of the implementation of a network of perinatal care.* Danielle D'Amour [7], Lise Goulet [7], Raynald Pineault [4], Karina Daigle.

*Diabetes project: Evaluation of the implementation of an integrated-services model for patients suffering from diabetes in the Côte-des-Neiges district.* André-Pierre Contandriopoulos [6], Danielle Larouche [1], Rosario Rodriguez [6], Raynald Pineault [4].

*Cost-effectiveness of early supported discharge for stroke.* Nancy Mayo [8], Josephine Teng, Sharon Wood-Dauphinee [13], Robert Côté [9], Eric Latimer [10], James Hanley [8].

*Procedures and perceived quality of care for the elderly in emergency departments: Impact on risk of return visit.* Sylvie Cardin [1], Raynald Pineault [4], Danièle Roberge [1], Eddy Lang, Michel Tétrault, Josée Verdon [11].

*Randomized study evaluating the effect of an inter-disciplinary program of ambulatory clinical follow-up on the rate of rehospitalization, quality of life, and use of hospital resources among patients with heart failure.* O. Doyon [12], J. Brophy [13], J.-L. Rouleau [14], A. Ducharme [15], F. Gauthier [15], M. Langlois [15], J. Loyer [15], S. Heppel [15].

*Evaluation of the effectiveness of the network of services offered to persons with mental problems who live in the community.* Léo-Roch Poirier [2], Louise Fournier [2], Deena White [16], Céline Mercier [17], Alain Lesage [18].

*Impact of day surgery on users and their families.* Pierre Tousignant [2-3], Lee Soderstrom [19], Jean-Pierre Lavoie [2], Terry Kaufman [20].

*Impact of reduced hospital stay on users and their families.* Pierre Tousignant [2-3], Lee Soderstrom [19], Jean-Pierre Lavoie [2], Terry Kaufman [20], Raynald Pineault [4].

*Evaluation of the SIPA (système de services intégrés pour les personnes âgées en perte d'autonomie: system of integrated services for dependent seniors) demonstration project, per capita simulation.* François Béland [4], Howard Bergman [13], Paule Lebel [14], André-Pierre Contandriopoulos [6], Jean-Louis Denis [6], Pierre Tousignant [2-3], Joanne Monette, Francine Ducharme, Anne Langley.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## Figures and Diagrams

## Footnotes

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