ABSTRACT

In 1995 the Montreal Regional Health and Social Services Board began a major process of change to its health care system. This transformation places particular emphasis on primary health care and increases the role of local community services centres (CLSCs) and community organizations (COs). In order to understand this process as experienced by COs, the present exploratory study was conducted during the summer and fall of 1996. We targeted 12 COs, 4 CLSCs, the Quebec Federation of CLSCs, and the Montreal CLSC Working Group. Semi-structured group interviews and CO documents were used as sources of information. Most participants believe in the need for change but feel that the strategies and implementation have been mismanaged. COs are feeling the pressure to professionalize and specialize current and future services. The "social economy" appears to be gaining momentum in the health sector.

ABRÉGÉ

En 1995, la Régie régionale de la Santé et des Services sociaux de Montréal-Centre amorçait une démarche de changement majeur du système de soins. Cette transformation met l'accent sur la première ligne et souligne l'importance des centres locaux des services communautaires (CLSC) et des organismes communautaires (OC). Une étude exploratoire a été développée, afin de comprendre ce processus de transformation tel qu'il est perçu par les OC. Douze OC, quatre CLSC, la Fédération de CLSC du Québec et le Regroupement de CLSC de Montréal ont été rencontrés. Les sources d'information ont été des entrevues semi-structurées de groupe et des documents des organismes interviewés. La plupart des participants sont de l'avis que la transformation était nécessaire mais que le processus d'implantation n'est pas adéquat. Les OC se sentent sous pression pour professionnaliser et spécialiser leurs services. L'«économie sociale» semble prendre la place dans le secteur de la santé.

The Role of Community Organizations in the Transformation of the Health Services Delivery System in the Montreal Metropolitan Area

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In its 1995 report *Un juste prix pour les services de santé*, the Quebec Council on Health and Well-Being recommended that "the money saved by health care organizations, due to rationalization of bed usage, must be invested in family support services, in the financing of community organizations, in the coordination of continuous services, and in the organization of primary health care services available around the clock."¹ Also in 1995, the Montreal Regional Health and Social Services Board began a major process of change to its health care system known as the *virage ambulatoire* (ambulatory shift). As part of this transformation the importance of community organizations will increase through an allocation, over three years, of \$14.9 million.²

Given that this decision follows the recommendations of both the Council on Health and Well-Being¹ and the Inquiry on Health and Social Services,³ there appears to be recognition of the contribution of community organizations to the health care system. Despite this support, many issues regarding the transformation remain unclear and there is a general sense of confusion among community organizations. The general goal of the present study

is to better understand the transformation process of the health care system in the Montreal area as experienced by community organizations. More specifically, this study attempts to (a) understand the attitudes and opinions of members of community organizations and CLSCs towards the *virage ambulatoire*, and (b) understand the role of community organizations in this *virage*.

METHODS

This study does not base itself on any existing theory and does not attempt to test any precise hypotheses. We therefore decided to use an exploratory research strategy using information gathering and inductive reasoning. A phenomenological approach was chosen given that we sought not to explain but to understand the ambulatory shift from the perspective of COs.⁴

Two sources of information were employed in our data collection: semi-structured group interviews^{5,6} (Table I), and documents obtained from community organizations concerning the transformation of the health care delivery system in the Montreal area.

Given the vast number of health-related community organizations on the Island of Montreal, we devised a flexible list of selection criteria (Table II). Using these criteria, 12 associations and community organizations were selected (Table III). Because COs and CLSCs in Montreal have a fairly long historical relationship,⁷⁻¹² and given that CLSCs are currently the principal partners of COs, we reasoned that the *virage ambulatoire*, as experienced by COs, would be best understood through discussions with both COs and CLSCs. This

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decision led us to contact four CLSCs using a snowball sampling method with the four community organizations chosen according to their location in Montreal (north, south, east, and west). These four organizations indicated the CLSC with which they have the most contact. We also interviewed representatives of the Quebec Federation of CLSCs and the Montreal CLSC Working Group.

During July of 1996 we contacted directors of COs and CLSCs by mail, followed up by telephone, in order to ensure the participation of their organization in the study and to arrange for appointments. All interviews took place at the organization itself between August and October of 1996. The duration of interviews ranged between one and one and a half hours, with the average number of participants being 4 (range from 1 to 8). In the case of interviews with COs, most often both the director and a representative of their membership were present.

Both of the researchers were present at most of the meetings. In addition to the note taking, the interviews were tape recorded. A log was kept by each of the researchers to note important themes, impressions and perceptions concerning each interview. After each encounter, each of the researchers wrote up a separate report using these sources of data. The reports were later cross-validated. Finally, by integrating information from COs' documents about the transformation, a preliminary document was written and sent to the participating organizations to receive their feedback. A final copy was then written taking participants' comments into consideration.

RESULTS

Community organizations

For the most part, COs' relationships with CLSCs are amicable and regular. Most COs engage in mutual referrals with CLSCs. Most of the respondents tend to qualify their relationship with CLSCs as being personal rather than institutional. There is, however, little notion of partnership.

All respondents agreed with the general spirit of the transformation: it was needed and it was time. Most of the discomfort

TABLE I Initial Semi-structured Interview	
1.	<i>Organization's history.</i> Year of foundation, nature of services delivered, type of clients targeted, financial support.
2.	<i>Current relationship with other health care organizations.</i> Type of relationship, frequency and intensity of contacts.
3.	<i>General opinions regarding the transformation of the health care system.</i>
4.	<i>Opinions about the consequences of the transformation for COs.</i> Regarding clients, activities, programming, mandates, volunteers, resources.
5.	<i>Position towards the changes.</i> Proactive, reactive, passive.
6.	<i>Relationship that should exist between health care actors.</i> Characteristics ensuring survival and success.

TABLE II Selection Criteria of COs	
1.	<i>Geographical scope.</i> Local, regional, provincial.
2.	<i>Activity in one of the following areas:</i> physical health, elderly population, mentally and physically handicapped individuals, mental health, social adaptation of youths and adults in difficulty, prevention and health promotion.
3.	<i>Linguistic-cultural dimension.</i> Francophone, anglophone, multi-ethnic.
4.	<i>Specialization.</i> Rights, services, both.
5.	<i>Financing.</i> Public, private, mixed.

TABLE III Community Organizations Selected					
Program	Community Organization	Geographic Scope (CO)	Linguistic Cultural Dimension	Specializing In:	Financing
Physical health	CO 1	Provincial	—	Rights Services	Private Private
	CO 2	Local (West)	Anglophone		
Elderly population	CO 3	Provincial	—	Rights Services	Mixed Public
	CO 4	Regional	—		
Physically and mentally handicapped individuals	CO 5	Regional	—	Rights & Services Rights & Services	Mixed Mixed
	CO 6	Regional	Anglophone		
Mental health	CO 7	Regional	Francophone Francophone	Rights & Services Services	Public Public
	CO 8	Local (East)			
Social adaptation of youth and adults in difficulty	CO 9	Regional	Anglophone Multi-ethnic	Services Services	Mixed Mixed
	CO 10	Local (South)			
Prevention and health promotion	CO 11	Regional	— Francophone	Services Services	Mixed Mixed
	CO 12	Local (North)			

concerning the transformation related to the strategies used in its implementation. Such concerns were often raised in terms of the speed and the improvised fashion with which it is taking place. Several respondents noted that the necessary conditions to make the ambulatory shift work were not put into place before it began, and furthermore, that it was not planned as a function of the needs of the popula-

tion. Most respondents also mentioned that the general public, as well as health professionals, lack the necessary information regarding the ambulatory shift to make informed decisions.

One indicator of the problems ensuing from poor strategic planning is the increased number of inappropriate referrals that COs have been receiving. Respondents attributed the increase in

these referrals to two factors: the inadequate training of CLSC workers in individual needs evaluation ("Too many CLSCs do not have the expertise to identify problems associated with blindness"); and/or increased workloads which may lead to decreased time devoted to such evaluations ("Waiting lists for evaluations at CLSCs can be as long as two months, and consequently, individuals are often referred to COs without having been adequately evaluated or evaluated at all"). As a result, COs are receiving heavier and heavier cases, many of which their volunteers should not be handling ("Our volunteers do not have the proper training to deal with heavy cases. They are not professionals. Volunteering must not become a full-time job"). A further consequence of inadequate evaluation and overburdened CLSCs is that families will become increasingly responsible for filling in the gaps created by these problems.

Several organizations mentioned that they are increasingly being forced to shift gears from solving basic health and psychosocial problems to becoming crisis managers, especially concerning the elderly and mentally ill. A combined effect of recent changes to the drug insurance plan, the closing of hospitals, and CLSCs' inability to deal with an increasing clientele has brought, and will bring, more people to the doors of COs in crisis. Consequently, COs fear that they will have less time to fulfill their original mandates and be forced to focus on crisis management.

As a result of some of the changes already experienced, some COs were questioning their original mandates. For example, one organization specializing in health services for youth and teenagers were considering widening their target population given increasing demands from elderly people as a result of recent hospital closures.

For COs that function with the assistance of volunteers, respondents also emphasized the importance of maintaining volunteers' interest and pleasure in the activities that they perform. While they do not want to overburden their volunteers, COs will do their utmost to render services to those in need: "COs have a responsibility to appreciate what volunteers can do, what they cannot do, and what they do not

want to do." Several respondents also suggested that organizations that will survive the transformation are those that have a stable base of volunteers, staff, and financial support.

In a paradoxical fashion, COs are feeling pressure to expand their services delivery in very specific areas. For example, given the increase in day surgery, several organizations predict a significant need for services such as Meals on Wheels. In tandem with this service, there was particular emphasis placed on the need for better and more comprehensive home-cleaning services. The increased need for transport services was also stressed.

Local Community Services Centres (CLSCs)

In general, the relationship CLSCs have with COs is described as constant, regular but very diverse. Despite the changes to the health system, the majority of participants stated that the working dynamics between CLSCs and COs have maintained their traditional form.

Opinions were unanimous regarding the transformation of the health care and social services delivery system: it is positive because it emphasizes primary care. However, it was pointed out that the ambulatory shift is nothing new: "The Castonguay-Nepveu reform [the health care reform in Quebec in the 70s] is now what we are really implementing." Concerning CLSCs, the strategy used to implement the transformation is largely viewed as "inadequate". Elements demonstrating its inadequacy are a lack of information and a deficient deployment of health professionals from hospitals to CLSCs.

Because CLSCs do not have enough money to make all of the appropriate changes, respondents think that the extra work will fall onto COs. As a result, COs should be prepared to deal with greater workloads, more complicated cases and increased professionalization. The risk is that eventually three forms of professionals will co-exist: "public", "private" and "community" professionals. As stated by one respondent: "This is the emergence of the social economy." Another respondent also exclaimed that: "The social economy slides

between the public and the private sectors." The social economy is distinct from the public sector in two ways. Its service providers are not professionals working through public institutions and its services are only partially, or not at all, paid for by the state. Participants speculated that the services most likely to be targets of the social economy will be transport and house-cleaning, given that they are outside of the mandates of most CLSCs.

DISCUSSION

Our results can be summarized into six categories: opinions and attitudes regarding the transformation, opinions and attitudes towards the role of COs in the future health care system, features of COs that will facilitate the transformation, characteristics of the context that will encourage collaboration between COs and their partners, professionalization and specialization and the emergence of the social economy.

There was general consensus among COs and CLSCs that the role of COs will increase in the future health care delivery system in Montreal. This reform is just one in a series of events in the redistribution process of responsibilities between public, private and community sectors.^{3,7,8,10} While CLSCs tended to be more optimistic and confident than COs regarding their present and future relationship, COs were more cautious. Their caution appears to be a function of two factors. First, the transformation demands a closer relationship between CLSCs and COs, a relationship that could jeopardize the autonomy of the latter. Second, COs lack confidence in the ability of CLSCs to accomplish their new roles. Consequently, COs fear that they will be expected to assume certain functions that should be undertaken by CLSCs.

Given the deinstitutionalization implicit in the transformation and the new needs that this will create (housecleaning, transport, services for the mentally ill, etc.), the COs that are most likely to survive the transformation are those whose services meet the new demands of the population. This situation creates a tension in the community world given that, on the one hand, COs will try to respond rapidly and effectively to these new and/or increased

demands, while on the other hand maintaining their original mandates. Many COs feel pressure from both their clientele and the health care network to provide increasingly "professionalized" services. For instance, respondents believe that they will need to offer services demanding a certain amount of training such as psychological services for the mentally ill and their families. Thus, the capacity of COs to attract volunteers and stable sources of financing were seen to be critical variables if COs are to survive the professionalization and the extra workload that will be demanded of them as a result of the ambulatory shift.

If the necessary financial resources are not provided to COs by the State, a new space called the social economy could develop (Figure 1). While COs are wary and reticent to demand payment for services, the current withdrawal of the State from the financing of health and social services may lead to this situation. CLSCs tended to be particularly aware of the impending development of the social economy, while the subject of the social economy rarely emerged from interviews with COs.

In a report published in 1991 regarding the role of COs in the health care reform begun in 1988,¹³ Proulx suggested that COs should play an increased role in the health care system, reflect on what this new role will entail, maintain a certain autonomy from health care institutions and define a new partnership with other health care actors. Although our findings are similar to those of Proulx, we add two further elements that COs must face: increased specialization and professionalization and the emergence of the social economy. These two issues should be explored in future studies.

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Figure 1. Health care system (A) before and (B) as a result of ambulatory shift.

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