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

# Transformation of the Montreal Network: Impact on Health

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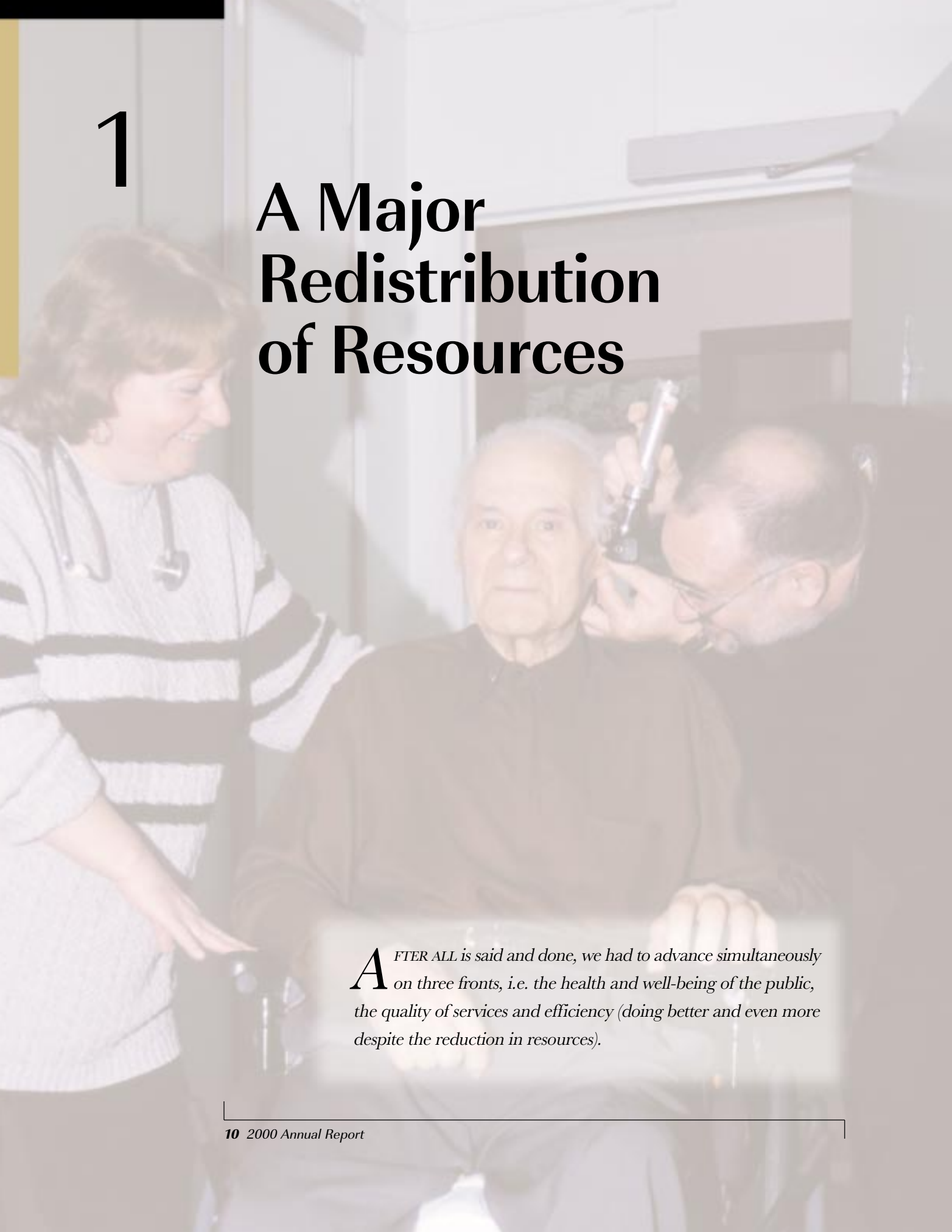
# A Major Redistribution of Resources



*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.*

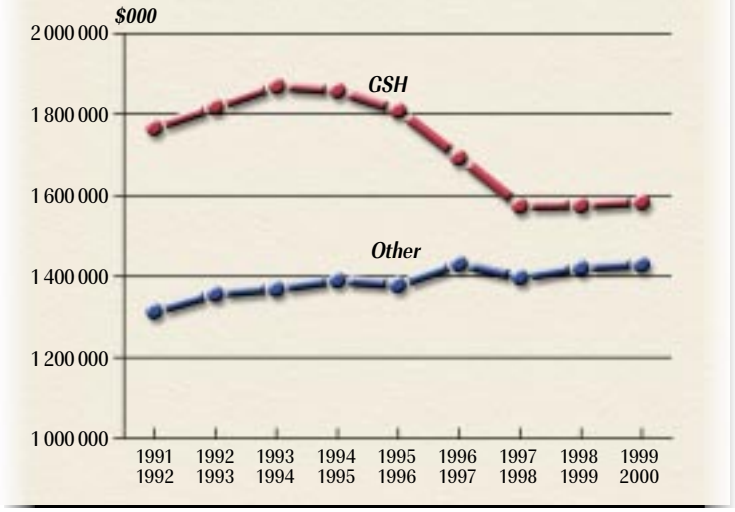
Decision-making must focus on the public's best interests, which must remain at the forefront of the concerns of an organization such as the Régie régionale. For this reason, from the outset, officials at the Régie régionale adopted a stance centred on public accountability. This policy direction led 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**

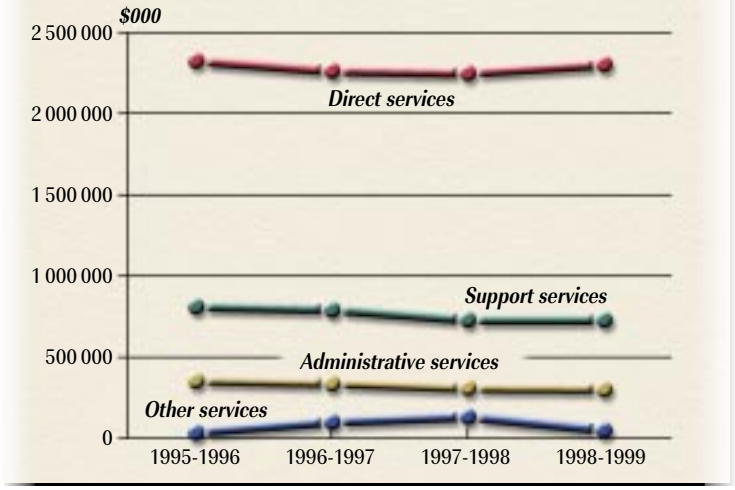



Targeted budget cutbacks in the hospitals have been substantial and have been accompanied by an increase of nearly 10% in the budget for other establishments and nearly 50% for community organizations (see Figure 1). However, in addition to these reductions planned at the outset, $86.6 million in cutbacks 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:

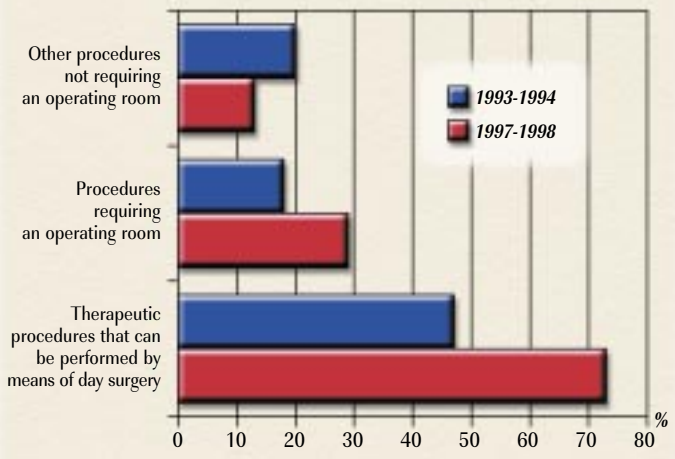
- reduction of 2 443 acute-care beds;[6]
- closing of nine surgery departments;
- closing of seven emergency departments;

- 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

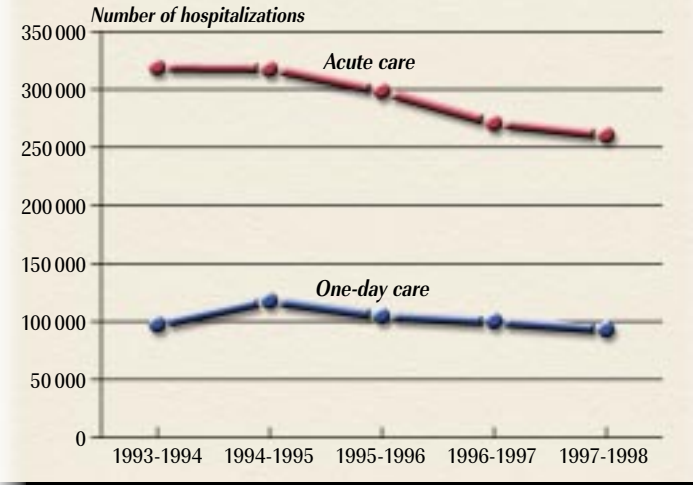
**Proportion of diagnostic and therapeutic services provided through one-day hospital care, by type of procedure, Montréal-Centre, 1993-1994 and 1997-1998**




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**



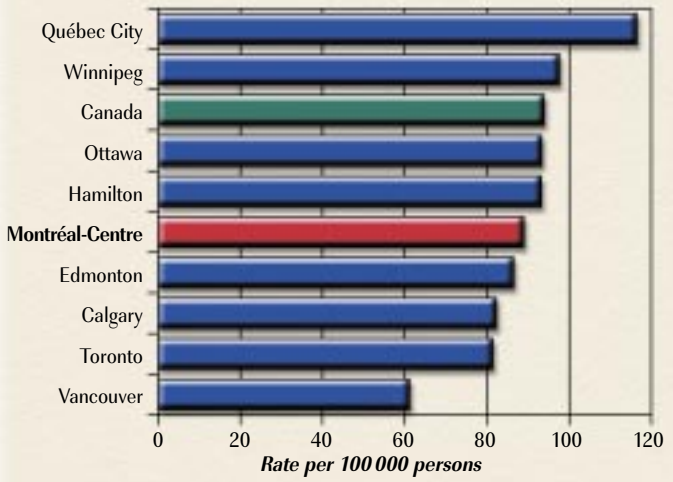

In addition, certain targeted specialized services have risen by 10% to 20%, especially as regards tertiary cardiology procedures, certain orthopaedic surgical procedures and cataract operations. Paradoxically, the desired reduction in the number of individuals on waiting lists and waiting time have 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

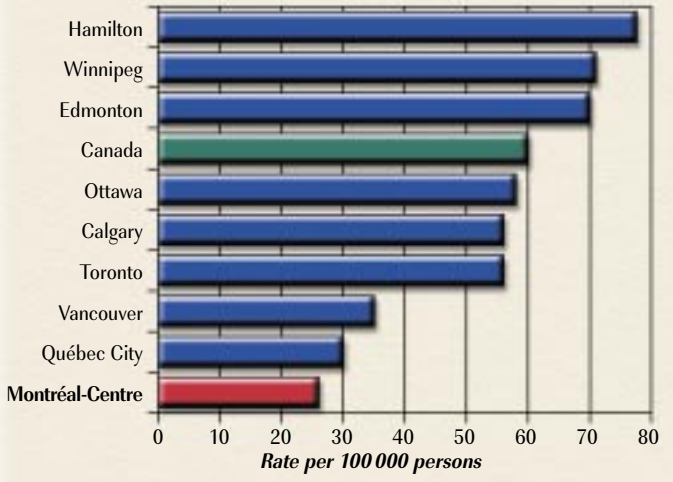
**Age-standardized rate of coronary bypass surgery for certain regions in Canada, 1997-1998**




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?

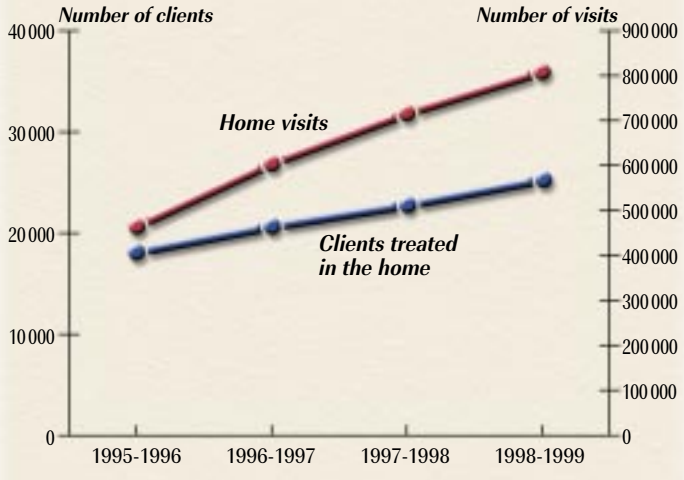
Budget cutbacks and the reorganization of hospital operations, while they are the most visible facets of the reform, are not its ultimate objective. Several indicators point to progress in achieving the new balance being sought.

### *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]

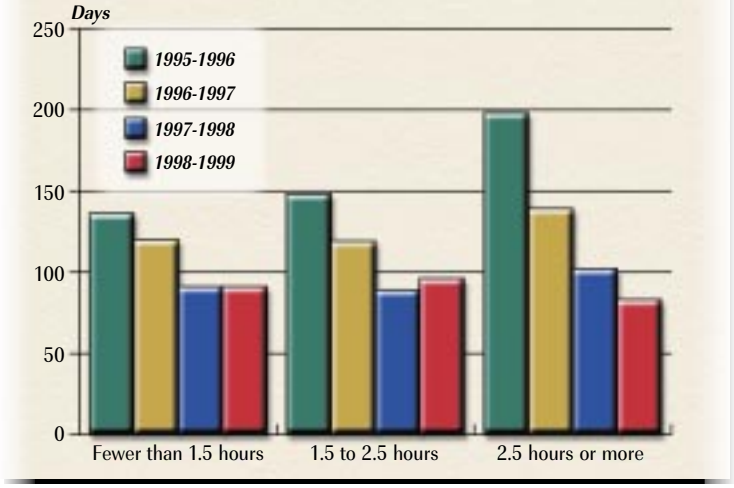
### *Residential services*

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

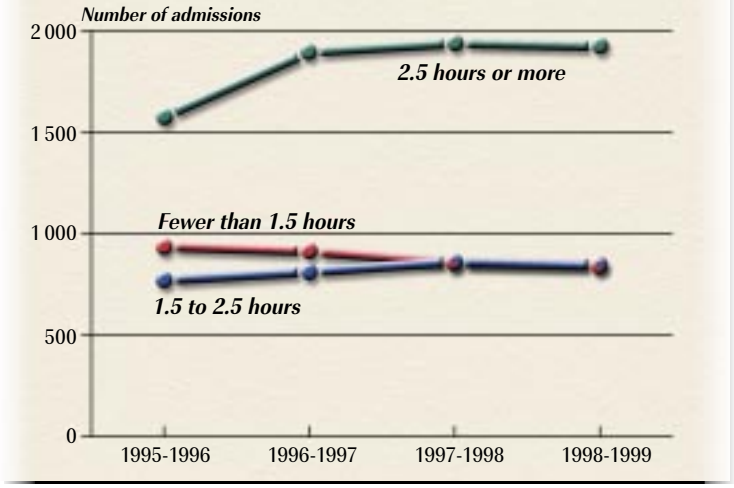
**Average waiting time (in days) for initial admission to a hospital centre for long-term care, by number of hours of care required, Montréal-Centre, 1995-1996 to 1998-1999**




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.

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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.

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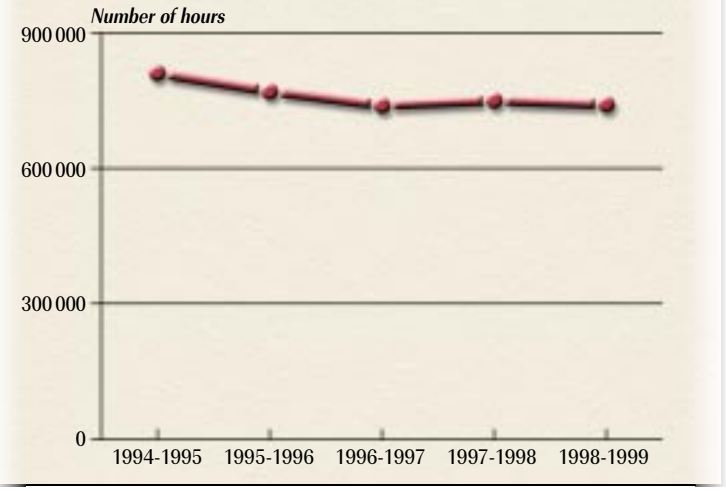
The first phase of the plan to reorganize services in Montréal (1995-1998) was intended to consolidate the financial capacity of CLSCs and community organizations in the fields of promotion and prevention. The reallocation of $12.2 million was intended to enable community organizations and CLSCs to undertake 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.

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**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]

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**Have the changes affected health professionals?**

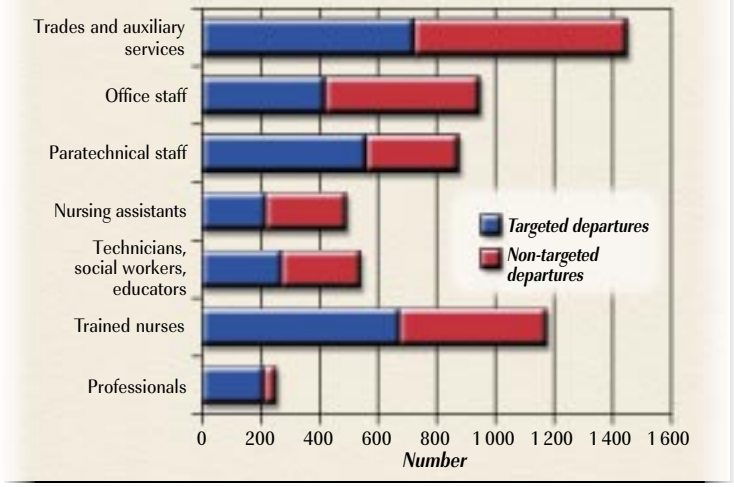
Since 80% of the Régie régionale's budgets are earmarked for salaries, cutbacks and reallocations have obviously significantly affected staff. For this reason, the Régie régionale has established a regional manpower service in order to coordinate the numerous changes to be made.

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.