

Ideas at Work

We're Hired by the Hospital, but We Work for the Community: Examining Hospital Involvement in Community Action

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It is no secret that healthcare is under considerable pressure to reform its scope, mandate and how it does business, although critics and reformers sometimes differ sharply on both the diagnosis and proposed remedies for what ails the system. In this article, we examine the nature of long-standing calls for healthcare providers and institutions to work more closely with other sectors and players to address disease prevention and health promotion in the community, and specifically the implications for hospitals in Ontario and in Canada.

Current thinking on the broad determinants of community/population health, reflected in the discourses of population health (Evans and Stoddart 1990; Evans, Barer et al. 1994) and health promotion (Pederson, O'Neill et al. 1994; Raeburn and Rootman 1998; Robertson 1998), emphasizes a wide range of social and economic determinants that extend well beyond healthcare. From these perspectives the contributions of healthcare to population health often appear at best uncertain (McKeown 1979). It has been noted that those who claim a broader understanding of the determinants of health have sometimes sought to use these arguments to argue for (or to justify) cuts to healthcare funding in the name of deficit reduction – with or without the often unrealized promise of “reinvestment” in prevention, health promotion or community care (Stevenson and Burke

1992; Poland, Coburn et al. 1998). Clinicians too, frustrated by a seemingly growing tide of human misery whose antecedents are not easily tackled at the individual level (e.g., the health consequences of homelessness that some inner-city clinicians see daily), are becoming increasingly interested in looking beyond the institutional walls to prevention in the community.

Truth be told, the healthcare versus determinants of health debate strikes us as being cast in too narrowly polarized “either-or” terms. Granted, much more could be done to prevent illness and premature mortality, and in times of fiscal austerity this may require judicial reallocation of resources from curative care to disease prevention and health promotion. But the need for healthcare is unlikely to “dry up” anytime soon. Further, it can be argued that universal access to healthcare, as part of the broader social safety net of the welfare state, helps mitigate what would otherwise be an even more rapidly escalating gap between rich and poor (Poland, Coburn et al. 1998), which has itself been shown to be a potent predictor of population health (Wilkinson 1996, 1997a, 1997b.) Recent pre-election debates illustrate the importance Canadians put on accessible and high quality healthcare, as well as the willingness of governments and political parties to promise reinvestment in healthcare (for politically expedient, as well as a genuinely important, reasons).

This being said, it is equally evident that reforms are needed beyond simply “throwing money” at the system. Most of these are dealt with eloquently, and in depth, elsewhere (Rachlis and Kushner 1989; Armstrong, Armstrong et al. 1994; Armstrong and Armstrong 1996).

In this commentary, we specifically address the role that hospitals could play (and increasingly are playing) in working in partnership with community groups to address the determinants of health. Our focus on hospital-community collaborations that address the broad determinants of health beyond the hospital walls can be distinguished from previous work that examines (a) the responsiveness of hospital-based care providers to the unique healthcare needs of particular groups (e.g., gays/lesbians, the homeless, aboriginal groups); (b) community involvement in hospital governance (community boards, community participation in healthcare decision-making); (c) the extension of hospital services into the community (e.g., efforts at more comprehensive case management, seamless transition from institutional to home-based care as result of early discharge, etc.); or (d) health promotion within the hospital (making the hospital setting more health promoting for patients and staff). We briefly examine the rationale, as well as the risks, associated with this “departure” from the hospital’s traditional mandate of patient-focused clinical care, arguing that much more needs to be learned about when such collaborations are warranted, how they are to be best undertaken, and what they might reasonably be expected to achieve.

MAKING THE CASE FOR HOSPITAL INVOLVEMENT IN COMMUNITY ACTION

It is clear that healthcare providers and healthcare institutions can (and, many assert, ought to) be doing more to proactively address community/population health determinants. After all, hospitals are significant publicly funded institutions in their community, with a mandate to improve the health status of residents in their designated communities. Some commentators go further, suggesting that providers and healthcare institutions should be made increasingly accountable in terms of community/population health outcomes (Sigmond 1995, 1997).

It is also clear that if hospitals are to take a more proactive role in addressing the determinants of health, they cannot do so single-handedly. Nor should they, given the range of players affected, and the diversity of groups and agencies already working on many fronts to address community health issues, locally and in broader contexts. It’s increasingly recognized that promoting community health requires more active community participation in agenda-setting, intervention design, implementation and evaluation than was characteristic of many earlier disease prevention/health education initiatives (Raeburn and Rootman 1998; Fisher, Neve et al. 1999). For

these and other reasons, intersectoral collaboration and community participation are increasingly considered essential to meaningfully address the broad determinants of health.

Calls for reorienting health services along these lines have emanated from governments at the federal level (Epp 1986; Health and Welfare Canada 1986, 1990) and at the provincial level (Ontario Ministry of Health 1989, 1992a 1992b, 1993; Premier’s Council on Health Strategy 1989; Health Services Restructuring Commission 1997), from provincial and national hospital and public health associations (Canadian Hospital Association 1987; Baskerville 1988; Fyke 1989; Ontario Hospital Association 1994; CPHA 1996), from academics and health policy commentators (Rifkin 1985; Milz and Vang 1989; Johnson 2000), from municipal health planning bodies (Metropolitan Toronto District Health Council 1996) and from hospital-based health professionals (Searle, Boreskie et al. ; Farley 1993, 1994; Beddoe-Stephens 1996; Graham 1996; Poland, Graham et al. 1997). These sentiments have also been echoed by hospital associations and healthcare systems/health policy analysts and commentators in the United States and overseas. (Melum 1980; Kernaghan and Giloth 1983; Longe and Wolf 1984; Nutbeam 1991; Kretzman and McKnight 1993; McClain and Stratton 1994; Tones 1995; Vetter 1995; Shi, Samuels et al. 1996). For example, the Canadian Hospital Association (1987) recommends that the scope of hospitals’ roles in health promotion encompass supporting initiatives for creating healthy communities at the local level, while Health and Welfare Canada (1990) describes health promotion as an opportunity for healthcare facilities “to become partners in health with the community, to develop new and expanded partnerships of individuals, families and communities, and to enable them to identify and meet their own health needs.” It asserts that by their very nature health promotion activities are “joint ventures” that involve “individuals, institutions and communities working together to enable people to increase their potential for health.” It is stated that “health promotion in the context of health care institutions is a philosophy that advocates co-operation, collaboration and action between a facility and the larger community it serves.”

Increasingly, standards regarding “community benefit,” defined as “community service with an outcome orientation” (JHAE 1994), and responsiveness to local community health needs are being developed for inclusion into the hospital accreditation process (e.g., the CCHSA’s AIM project). The W.K. Kellogg Foundation’s *Hospital Community Benefit Standards Program* in the United States stipulates four standards regarding evidence of formal commitment to community benefit, the carrying out of projects to improve health status in the target community, partnering with other organizations and individuals to this end, and fostering an

internal environment that encourages hospital-wide involvement in these activities (HCBS n.d.).

This presents both a challenge and an opportunity for healthcare facilities, which are used to organizing care around sick patients or (in a few cases) enrolled populations rather than communities (JHAE 1994). Challenges associated with the need for new skills sets on the part of hospital staff, and those arising in the process of making collaboration work across sectors with participants from diverse disciplinary, organizational, socio-economic and ethno-racial backgrounds, are compounded by system-level challenges (funding cuts, renewed emphasis on the hospital's "core business") that provide few incentives for this work, as well as a sea change in the broader political environment (not unique to Ontario) in which advocacy and community development appear more "risky" than before (Poland, Boutilier et al. 2000).

The remainder of this article briefly examines the pros and cons of hospital involvement in community action, drawing on an extensive review of the literature, as well as qualitative pilot research undertaken with personnel in several hospitals in the metro Toronto region. By "community action" we mean partnerships between hospitals and community groups or agencies that focus on factors other than clinical medicine that affect community health. In other words, the focus is on hospital participation in collaborative efforts that address broader determinants of health, since most health problems have their roots in complex "social, physical, economic and other circumstances that affect entire populations and the communities in which they live" and over which clinical care alone cannot be expected to have substantial impact (Boex, Cooksey et al. 1998: p.543). These include not only individual health-related behaviour (diet, exercise, smoking, substance abuse, self-care) or uptake of preventive health services such as breast cancer screening (Taylor and et al. 1996), but also a wide range of factors in the social, economic and natural environment, such as homelessness, income inequality, systemic discrimination, domestic violence, food security, social and economic policies, exposure to industrial and environmental toxins, to name but a few.

Examples of hospital involvement in community action include coalitions for the prevention of low birth weights, advocacy around the provision of housing for the homeless, the development and implementation of a needle exchange program for drug addicts, school breakfast programs, community economic development projects, participation in local coalitions addressing spousal abuse, mental health promotion and other community health issues. In each case, hospital-based healthcare providers see the health consequences of these broader determinants of health, and work collaboratively with community groups to address them. In some of these projects, hospitals (or hospital-based personnel) may play a leadership

role. In other cases they do not. Those that more closely resemble community development (as opposed to community-based programming) are initiatives in which decision-making power is shared more equitably with community groups and attention is paid to capacity building and community empowerment (Labonte 1987, 1993, 1994, 1996; Boutilier, Cleverly et al. 2000). Here, distinctions in the literature on community development between social planning, locality development and social action models (Rothman and Tropman 1987; Rothman, Erlich et al. 1995; Boutilier, Cleverly et al. 2000) are pertinent insofar as they sensitize us to the fact that many calls for hospital involvement in community action frame it in terms of social planning approaches that emphasize formal needs assessment, linear planning models and formal evaluation, in contrast to more grassroots, bottom-up locality development processes that are less bureaucratically controlled, more emergent and fluid in design and more radically oriented to capacity building in the broadest sense of the term.

AN ISSUE OF SELF-INTEREST AS WELL

There are many reasons for hospitals to take an interest in joint community health initiatives: improving the health of the community, enhancing awareness of the specific health needs of minority and immigrant populations, improving the image of the hospital, changing the hospital's service mix, reducing healthcare costs and achieving specific financial gains (Longe and Wolf 1984; Graham 1996). It is also argued that hospital participation in community health initiatives will ultimately "enhance goodwill and cooperation between the hospital and the community" by demonstrating that the institution is "concerned about the health of the community" (Longe and Wolf 1984). In instances where strong community support can be mobilized to successfully reverse decisions to close particular hospitals, the importance of this goodwill to hospital administrations cannot be overestimated. In the United States, there are also significant tax exemption issues that drive hospital interest in seeking to meet Hospital Community Benefits Standards (Sigmond 1997; Gamm and Benson 1998). Speaking again from a U.S. perspective (but perhaps foreshadowing future developments north of the border), Boex, Cooksey et al. (1998: 532) go further still, arguing that "the core business of hospitals now requires, for both competitiveness and quality improvement reasons, that hospitals move beyond their physical and conceptual walls to form community partnerships."

WHAT DO HOSPITALS HAVE TO OFFER?

As relative heavyweights in the healthcare system, hospitals have much to contribute to community health initiatives. Writing from a community empowerment perspective, Kretzman and McKnight (1993) argue that hospitals represent

significant concentrations of resources that communities can tap into, including: personnel (in both paid and volunteer capacities); space and facilities (places to meet, or to incubate community initiatives; meeting rooms, but also kitchens, cafeterias, gyms, auditoriums); materials and equipment (computer, photocopier, fax, audio-visual and medical equipment, books); expertise (in health promotion, grant writing, project administration, evaluation); and economic power (bulk purchasing power, purchasing policies re buying local; employment practices). Hospitals can partner with other public institutions (community colleges and universities, libraries, parks, police, schools, community health centres), individuals (youth, artists, seniors), the private sector (local businesses, banks, corporations), and community associations (churches, voluntary organizations, immigrant support services, ethno-racial associations), they argue. Successful partnerships “benefit both the local hospital and the community because ... each of the partners magnifies the resources and, therefore, the effectiveness of the other” (Kretzman and McKnight 1993).

CHALLENGES

While the potential for hospital involvement in community action is considerable, so too are the challenges posed by aspects of hospital culture and the organization of hospital care that can mitigate against the involvement of hospitals in community action to address the broader determinants of health. To varying degrees in each site, these may include a narrow (curative) institutional mandate, hierarchical administrative structures and organizational culture that (in practice, despite rhetoric to the contrary) values profile and control over the relinquishment of control to frontline staff and community groups, troubled local history of hospital-community relations, reimbursement schedules (which, for example, favour curative over preventive care), biomedical orientation and training of hospital staff, privileging of professional expertise over lay knowledgeability, and scepticism regarding the effectiveness of health promotion, to name but a few (Tones 1995; Graham 1996; Johnson 2000). As Nutbeam (1991) and others have noted, historically “hospital-based medicine has been least accessible and amenable to introducing the concept and principles of health promotion.”

Community groups and agencies may also have concerns about being overwhelmed, taken over or supplanted by a hospital intent on “reinventing the wheel” and duplicating what existing agencies may be trying to do in the community, and which may unwittingly foist a medicalized perspective on community health promotion interventions (Beddoe-Stephens 1996). There is some anecdotal evidence that in some jurisdictions in the United States, and perhaps elsewhere, several hospitals are “spearheading” community initiatives that

directly compete with and undermine existing community projects (Randy Stoecker, University of Toledo, personal communication), something that Tones, (1995) Ashdown (1990) and others warn against. Community groups may also fear that hospital-community “partnerships” may mean the dumping of patients and/or issues that the hospital does not want to deal with (i.e., marginalized populations), and/or as part of an exercise in reducing costs. These experiences and cautionary voices suggest that hospital involvement in community action is not inherently empowering for community groups.

Because many forms of collaboration are possible, from largely symbolic consultation to equal partnership to full community control (Arnstein 1969; Rifkin 1985; Charles and DeMaio 1993; Labonte 1993), hospitals may (often inadvertently) co-opt community energies to serve institutional agendas in ways that do not fundamentally improve community health. In the context of the sometimes strained relations between hospitals and their communities, seemingly small faux pas borne of naivety on the part of healthcare professionals about the community development process can sometimes have disproportionately unfortunate consequences. For these and other reasons, hospital involvement in community action remains controversial. Thus, we make no a priori assumptions about the actual benefits (or harms) associated with hospital involvement in community action, because much depends on how this work is carried out, and on the sensitivity, reflexivity and ethical stance of those involved.

MAKING PARTNERSHIPS AND COLLABORATION WORK

The term “partnership” is frequently employed to characterize the ideal relationship between hospital and community with respect to community action initiatives (Farley 1993, 1994; Goeppinger 1993; Kretzman and McKnight 1993; Labonte 1993; Lumsdon 1993; Levine, Becker et al. 1994; McClain and Stratton 1994; Shi, Samuels et al. 1996), though the term is rarely well defined. Gray (1985, 1991) has written extensively on conditions facilitative of inter-agency collaboration. The US-based Community-Campus Partnerships for Health project, which examines partnerships between campus hospitals and the surrounding community, is also developing a set of guiding principles of community-campus partnerships (S. Seifer, personal communication, August 1997). A critical issue to be addressed, we feel, is the extent to which decision-making power is shared in these partnerships. When decision-making power is retained by the hospital, attempts to involve community members in health “partnerships” may rightly be seen as mere window dressing. We contend that hospital administrators (and other hospital staff engaged in these collaborative initiatives) must be prepared to contribute time and resources to projects in which community groups have a significant say in what issues are addressed, how these

issues are defined, how they will be addressed within the context of the proposed partnership initiative, and how these activities will be evaluated. This commitment must also extend to, and is reflected in, many seemingly mundane aspects of how an initiative is run, including where and when meetings take place, under what conditions of formality, the degree to which the involvement of hospital staff is micro managed by supervisors and administrators (i.e., the flexibility afforded to hospital-based participants by management), and who claims credit (or is assigned blame) for the accomplishments (or failures) of (or controversies surrounding) the initiative.

But the prospect of working collaboratively with lay community groups to address the broad determinants of health is a daunting one for many healthcare professionals. The challenges are perhaps greatest for hospitals and hospital personnel, for whom community action is often a radical new proposition and a *modus operandi* that requires a whole different skill set (and mind set). Unfortunately, without wading deeply into the vast literature on community development in health, there is very little tailor-made assistance available to well-intentioned hospital personnel about how to engage productively in community action in ways that actively support and nurture community groups, while strengthening hospital-community relations as a foundation for subsequent collaborative work. (Nor do such resources typically exist for community groups on the other side of the equation contemplating collaborative work with hospitals.) Meanwhile, there is growing anecdotal (and some published) evidence to suggest that many hospitals, though perhaps still a minority, are rising to the challenge and even hiring community developers on staff to assist with this work (Longe and Wolf 1984; Rifkin 1985; Milz and Vang 1989; Farley 1993, 1994; Lumsdon 1993; Bushy 1995; Tones 1995; Vetter 1995; Metropolitan Toronto District Health Council 1996).

RESULTS OF A PILOT STUDY

In the Spring of 1997, under the auspices of the Hospital Network in Support of Community Action (<http://www.utoronto.ca/chp/hospital.htm>), we completed a small qualitative pilot study comprising interviews with seven individuals in the greater Toronto area who are active in community action on behalf of their hospitals, and who have been specifically hired to do this sort of work. The pilot study results suggest, first, that a wide range of projects undertaken in the community with hospital participation are guided by community action principles. These include a focus on community capacity(ies) and meaningful community-hospital partnership, as well as a broader definition and vision of health and its determinants. Second, respondents indicated that their dual accountability (to their employer/institution and to the community) sometimes creates difficulties and dilemmas when each

constituency has competing expectations regarding the nature and purpose of hospital-community collaboration. While they recognized the need to respond to institutional imperatives, all were clear about their own allegiances. As one respondent put it, "I'm hired by the hospital, but I work for the community."

Such declarations reveal implicit and explicit value commitments that are at the heart of a community development approach. These appeared to constitute a shared world view or perspective in terms of how they conceptualized community, what they saw as the community capacity-building aspects of their collaborative work with community groups, and what they valued in terms of the nature and quality of their relationships. This perspective recognizes that communities have significant assets and skills, and not just problems; that the hospital needs the community just as the community needs the hospital (mutual interdependence); that the hospital needs to remain flexible and open to addressing issues identified by the community; and that an appreciation of power relations in community work implies the need to be sensitive to one's own power and ways of operating that might reinforce power imbalances between community groups and the hospital (e.g., avoid tokenism, really listen, demonstrate willingness to act as well as being up-front about one's own limitations or the limitations imposed by the organization, showing that one values the experiential knowledge of community residents and not just the expertise of credentialed hospital personnel, not always taking leadership, not allowing concern about the public relations implications for the hospital to interfere with good practice).

Several respondents mentioned using community criticisms of their hospital as a lever and mechanism for bringing about changes within their institutions that would be enabling of hospital involvement in community action, suggesting that those who take leadership on community action within hospitals face challenges in convincing hospital administrators and management about the importance and potential impact of their work. For many, this signals the need for organizational change and education within the hospital regarding the nature, scope and potential of community action. Indeed, support from top hospital management and from community agencies was seen as important to collaborative work. This has been echoed in a similar study of the organizational context for the involvement in public health departments in community action (Poland, Boutilier et al. 2000).


Not surprisingly, our pilot study indicated that the hospital is generally viewed by the community as well resourced and powerful. On the one hand, this gives hospitals tremendous clout and credibility, and creates interest within the community in closer partnerships. On the other hand, it also gives rise to concerns within the community about implications of this unequal power in community-hospital partnerships, and some concern about the motives of hospitals that are seen as wishing

to “take over,” “expand their turf,” or “shut us out.” Consequently, the issue of developing trust with community participants is one of the key challenges (and most crucial tasks) reportedly faced by those seeking to do community action from a hospital base. And when that trust is developed, respondents indicated that it becomes a tremendous supportive base for future work.

FASHIONING A RESEARCH AGENDA

Interesting as these pilot study results may be, they can hardly be construed as the basis for widespread policy and practice reform, given the small sample size and localized focus. We included a précis of our results because, despite the need for explicit guidance and resources tailored to hospitals and community groups seeking to work collaboratively on the determinants of health, so little research has been done in Canada or elsewhere that systematically documents the nature of hospital involvement in community action, the unique challenges posed for hospital-based personnel of undertaking this work within this particular institutional context, and the lessons learned about what works and what doesn't work, and what factors influence success (indeed, how success is defined), not only from the perspective of hospital staff, but also from the perspective of community groups.

This kind of research could generate valuable insights for policy makers, hospital administrators, frontline practitioners and community groups about how to make such collaborative efforts more successful, and perhaps even when not to undertake such initiatives. These insights could be distilled into relatively accessible guiding principles, assessment criteria and other policy and practice tools that many hospitals and hospital personnel, but also community groups, would surely welcome. This is precisely what the Social Sciences and Humanities Research Council of Canada has now funded us to undertake. Using a combination of qualitative (in-depth case studies and focus groups) and quantitative (survey) research methods in Ontario, and regional workshops across the country, we are examining hospital involvement in community action so as to develop, focus-test, refine and disseminate a variety of practical tools to guide policy and practice. Recognizing that, outside Ontario, hospitals are part of Regional Health Authorities, and that this organization of care may have important implications for hospital involvement in community action, we have also planned for a series of regional workshops across the country to assess the transferability of our findings and to make appropriate modifications to our proposed policy and practice tools. Partner organizations in this research include the Canadian Healthcare Association, the Canadian Council on Health Service Accreditation, CERIS (the Joint Centre of Excellence for Research on Immigration and Settlement), Collaboration in Community Development (an Ontario network of community

workers), the National Capital Alliance on Race Relations, the Ontario Hospital Association and SETO (the South East Toronto Organization). The investigator team, itself a partnership between three departments in two academic institutions and investigators from several hospitals in the GTA, is joined by an advisory group of well-known scholars, health professionals and community activists from across Canada and the United States. We look forward to sharing the results with you in a future issue of *Hospital Quarterly*. 

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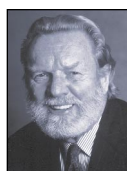
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Commentary: A Health System Approach to Population Health

GERRY PREDY AND PENNY LIGHTFOOT

Poland et al.'s paper raises the premise that there are calls for "healthcare providers and institutions to work closely with other sectors and players." They then go on to explore how hospitals can answer these calls. However, based upon the experience in Alberta, a more appropriate question is how can the health system respond? The differences in these underlying premises have important implications for understanding how the health system (not individual providers or institutions) can best effect change that will lead to healthier people in healthy communities.

Hospitals are only one component of the system, albeit a major one. Other components include continuing care, rehabilitation, community and primary care, and public health. The system has both the provision of high quality care and the improvement of population health as its goals.

In order to maximize the effectiveness of interventions, it is important to build upon the strength of each sector. While each sector has a contribution to make to community action, Poland et al. admit that the typical skill set of hospital staff does not support a comprehensive approach to health and its determinants.

In our experience, the leadership and expertise in population health comes from the public health sector. Addressing the determinants requires strong leadership with a broad knowledge of the community in order to develop an approach which encompasses all sectors in the health system, as well as community partners, and also establishes priorities for action. There is a need for expertise in assessing and synthesizing information on health status and health service utilization data, in identifying desired outcomes and developing evidence-based strategies to reach these outcomes.

For example, in our region, smoking behavior was identified as a priority. A coordinated response was developed with the support and involvement of all providers. It included advocacy for policies to reduce smoking (e.g., legislation to create more smoke-free spaces), school-based programs aimed at preventing the uptake of smoking by adolescents and enhanced opportunities for cessation programs for smokers, especially targeted at low-income smokers. Such a comprehensive approach would not have been feasible for an individual institution to undertake.

Poland suggests that hospitals and communities link in small units for the betterment of both. While such linkages may be useful for addressing issues like the responsiveness of hospital programs to the unique healthcare needs of their communities, our experience suggests that in a regionalized system, building upon the expertise of its public health/community health component, can best deal with the macro issues associated with determinants of health. It can do so in a comprehensive way across multiple provider and community partners.

Although it would be more challenging in a non-regionalized system, we suggest that a similar approach including the public health sector would optimize the effectiveness of interventions to address the determinants. **KQ**

Gerry Predy is the Medical Officer of Health for the Capital Health Region in Alberta, the largest integrated academic health region in Canada. He has over 25 years experience in Family Medicine and Public Health and has major responsibilities for health protection programs and monitoring and reporting on the health status of the population.

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