“We’re hired by the hospital, but we work for the community”

Towards More Effective Hospital Involvement in Community Action

Can hospitals work in partnership with community groups to address the determinants of health?

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1. Community Partnerships

The health care system is under considerable pressure to reform how it does business, although critics and reformers sometimes differ sharply on the diagnosis of and proposed remedies for what ails the system. In this paper, we examine the nature of calls for health care providers and institutions to work more closely with other sectors to address disease prevention and health promotion in the community, and the implications for hospitals in Ontario and in Canada.

Current thinking on community and population health suggest a wide range of social and economic determinants of health that extend well beyond health care. Clinicians, frustrated by a growing tide of human misery 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 prevention measures in the community.

We would like to consider the role of hospitals that work in partnership with community groups to address the determinants of health. Our focus on hospital-community collaborations can be distinguished from previous work which examined:

(a) the responsiveness of hospital-based care providers to the unique health care needs of particular groups (e.g., gays/lesbians, the homeless, aboriginal groups);

(b) community involvement in hospital governance (community boards, community participation in health care 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).

What is the rationale for and what are the risks associated with this departure from the hospital’s traditional mandate of clinical care? What might these efforts reasonably be expected to achieve?
2. Making the case for hospital involvement in community action

It is clear that health care providers and institutions could be doing more to address community health determinants. Some commentators even suggest that health care institutions should be increasingly accountable for community and population health outcomes.

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 diversity of people affected and of groups and agencies already working to address community health issues. Promoting community health requires more active community participation in agenda-setting, intervention design, implementation, and evaluation than was characteristic of earlier disease prevention or health education initiatives. Intersectoral collaboration and community participation are increasingly considered essential in addressing the broad determinants of health.

Calls for reorienting health services along these lines have emanated from federal and provincial governments, hospital and public health associations, academics, health policy commentators, municipal health planning bodies, and health professionals. For example, Health and Welfare Canada describes health promotion as an opportunity for health care 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,” and asserts that health promotion activities are “joint ventures” that involve “individuals, institutions and communities working together to enable people to increase their potential for health.” (Health and Welfare Canada, A Guide for Health Promotion by Health Care Facilities, Ottawa, 1990).

Increasingly, standards for “community benefit” and responsiveness to local community health needs are being developed for inclusion into the hospital accreditation process. The W.K. Kellogg Foundation’s Hospital Community Benefit Standards Program in the U.S. stipulates four criteria: 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.

Examples of hospital involvement in community action include mental health promotion, school breakfast programs, community economic development projects, needle exchange programs for drug addicts, advocacy for the provision of housing for the homeless, and participation in coalitions for the prevention of low birth weights or spousal abuse. In each case, hospital-based health care providers work collaboratively with community groups. In some of these projects, hospitals or hospital-based personnel may play a leadership role. In projects that more closely resemble community development (as opposed to community-based programming), decision-making power is shared more equitably with community groups.

3. The benefits of community action

Hospitals participate in joint community health initiatives for a number of reasons: to improve the health of the community, learn about the specific health needs of minority and immigrant populations, enhance the image of the hospital, change the hospital’s service mix, reduce health care costs, or achieve specific financial gains. Creating goodwill between the hospital and the community is especially important. Strong community support can sometimes be mobilized to reverse decisions to close particular hospitals. In the U.S., significant tax-exemption benefits also encourage hospitals to meet Hospital Community Benefits Standards.

For community groups, hospitals represent significant concentrations of resources that communities can tap into. These include personnel, space and facilities, materials and equipment, expertise and economic power (e.g., bulk purchasing). 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, and ethnoracial associations).

4. Challenges

Hospitals, however, may have difficulty responding to community health needs. Traditionally, health care facilities were organized to care for sick patients or (in a few cases) enrolled populations rather than communities. Community health promotion demands new skills on the part of hospital staff. At the same time, hospitals must overcome the barriers of funding cuts and calls to focus on the hospital’s “core business” in order to work in collaboration with partners from diverse backgrounds. Community action is further challenged by broader political environment (not unique to Ontario) in which advocacy and community development appear more “risky” than before.
The organization of hospital care may also serve as a barrier to community action. A narrow focus on “curing patients,” a rigidly hierarchical administrative structure, or an organizational culture that values control over the participation of frontline staff and community groups may stifle attempts at community action. Hospital culture also tends to privilege professional expertise over lay knowledge. Hospital staff may be sceptical about the effectiveness of health promotion.

Community groups and agencies may also fear being overwhelmed, taken over, or supplanted by a hospital intent on duplicating what existing agencies may be trying to do in the community. In some jurisdictions, hospitals are spearheading “community initiatives” that directly compete with and undermine existing community projects. Community groups may also fear that hospital-community partnerships may mean avoiding patients or issues that the hospital does not want to deal with (e.g., marginalized populations) or the imposition of a medical perspective on community health promotion efforts. These experiences and concerns suggest that hospital involvement in community action is not inherently empowering for community groups.

Because many forms of collaboration are possible, from symbolic “consultation” to equal partnership to full community control, hospitals may co-opt community energies to serve institutional agendas in ways that do not improve community health. In the context of the sometimes strained relations between hospitals and their communities, seemingly minor faux pas caused by naïveté on the part of healthcare professionals about the community development process can derail community health initiatives. Hospital involvement in community action therefore remains controversial.

We make no a priori assumptions about the actual benefits (or harms) associated with hospital involvement in community action, because so much depends on how this work is carried out, and on the sensitivity, responsiveness, and ethical stance of those involved.

5. 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, but it is rarely defined. The U.S.-based Community-Campus Partnerships for Health project, which examines partnerships between campus hospitals and the surrounding community, is developing a set of guiding principles of community-campus partnerships. A critical issue 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.

Hospital staff engaged in collaborative initiatives must be prepared to contribute time and resources to projects in which community groups have a significant say in what issues are to be addressed, how these issues are defined, what activities will be undertaken, and how these activities will be evaluated. This commitment must also extend to seemingly mundane aspects of how an initiative is run, including where and when meetings take place, whether meetings are formally structured, whether hospital-based participants are micro-managed by management or allowed some flexibility, and who claims credit for the accomplishments (or is assigned blame for the failures) of the initiative.

The prospect of working collaboratively with community groups is a daunting one for many health care professionals. The community development literature offers limited assistance to well-intentioned hospital personnel on how to actively support and nurture community groups while strengthening hospital-community relations. However, there is growing anecdotal (and some published) evidence to suggest that many hospitals (though still a minority) are rising to the challenge, and even hiring experienced community development staff to help.

6. Results of a pilot study

In spring 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 consisting of 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 study results suggest, first, that a wide range of community projects undertaken with hospital participation are guided by community action principles. These include a focus on community capacity 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 the institution that employs them and to the community) sometimes creates difficulties, because each constituency has competing expectations about the nature and purpose of hospital-community collabora-
tion. Although 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 the implicit commitments that lie at the heart of a community development approach. They say a great deal about how the respondents conceptualized community, what they saw as the community capacity-building aspects of their collaborative work with community groups, and what they valued in the nature and quality of their relationships. They imply that communities have significant assets and skills, not just problems, that the hospital needs the community as much as the community needs the hospital, that the hospital needs to remain open to addressing issues identified by the community, and that community work demands sensitivity to one’s own power and ways of operating that might reinforce power imbalances between community groups and the hospital. This means avoiding tokenism, listening carefully and non-judgmentally, demonstrating a willingness to act as well as being up-front about one’s own limitations, valuing the experiential knowledge of community residents and not just the expertise of credentialed hospital personnel, yielding leadership to others at times, and not allowing concern about the public relations implications for the hospital to interfere with good community development practice.

Several respondents mentioned using community criticism of their hospital as a mechanism for bringing about changes within their institutions to improve hospital involvement in community action. They suggested that those who take leadership on community action within hospitals face the challenge of convincing hospital administrators of the importance and potential impact of their work. For many community development staff members, this means working to bring about organizational change within the hospital and educating others on the nature, scope, and potential of community action. Respondents also emphasized the importance of support from top hospital management and from community agencies. This finding is echoed in a similar study of the organizational context for the involvement in public health departments in community action. (B. Poland, M. Boutilier, et al., “The policy context for community development practice in Public Health: a Canadian case study,” Journal of Public Health Policy, 21(1), 2000, 5-19.)

Not surprisingly, our pilot study indicated that the hospital is generally viewed by the community as powerful and able to command extensive resources. 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 gives rise to concerns about unequal power in any partnership. Members of community groups are often concerned about the motives of hospitals who are seen as wishing to “take over,” “expand their turf,” or “shut us out.” Consequently, the issue of developing trust is one of the most crucial tasks faced by those seeking to do community action from a hospital base. When that trust is developed, respondents in our study indicated that it becomes a tremendous support base for future work.

7. Designing 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 local focus. Much more research needs to be carried out in Canada that systematically examines the nature and context of hospital involvement in community action and the lessons learned about what works and why. We need to know more about what factors influence success and even how “success” is to be defined, not only from the perspective of hospital staff, but also from that of community groups.

This kind of research could generate valuable insights for policy makers, hospital administrators, front-line practitioners, and community groups on how to make collaborative efforts more successful. The insights could be distilled into guiding principles, assessment criteria, and other policy and practice tools. This is precisely what the Social Sciences and Humanities Research Council of Canada has now funded our group 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 to develop, focus test, refine, and disseminate a variety of practical tools to guide policy and practice.

Above all, we hope to help hospitals and community groups work together productively on community action to improve population health, to the benefit of people throughout Canada.
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