



## Perspective

# Stories of institutional and local policy change from Harvard's Cambridge Health Alliance

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Social Accountability has been defined by the World Health Organization as “the obligation [of health professionals and institutions] to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve.” (World Health Organization’s World Health Report, 1995). I was privileged to attend an inspiring lecture on social accountability in the context of community health delivered by Dr. David Bor, Associate Dean for Undergraduate Medical Education, Head of the Department of Medicine, and Charles S. Davidson

Professor of Medicine at the Cambridge Health Alliance (CHA) in May of 2017 during a medical-student exchange between McGill and Harvard Universities. His lecture was titled, “Cambridge Health Alliance: A Public, Academic Community-Responsive Health Care System.” I found Dr. Bor’s recounting of his years with the Cambridge Health Alliance fascinating, highly educational, and above all, inspiring. In this piece I will be reflecting on concepts such as possible approaches to responding to the needs of a changing population, holding institutions and governing bodies responsible, and building support for social projects,

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all through examples given by Dr. Bor from his personal experiences.

The first example of social accountability presented was the history of the development of the Cambridge City Hospital as it grew and evolved to become a part of the multicentered Cambridge Health Alliance. The CHA is a multicentered integrated health care system with a focus on primary care. The rise of the institution occurred as a response to the needs of the vulnerable population in Cambridge city, and later its surrounding areas. Originally, Cambridge was inhabited by an immigrant population who were labourers within the community. The hospital was founded with a charitable mandate: to keep these workers healthy. Over time, Cambridge grew in population, and soon the City Hospital became over capacitated with patients. This overburden leading to limited resources left the poor, uninsured population behind, both in terms of hospital services and their place in the growing, thriving community. As a result, this vulnerable population became marginalized, and were pushed out of Cambridge to the surrounding areas. The Cambridge City Hospital saw the opportunity to fulfill their mandate to serve the population by expanding their reach beyond Cambridge. They accomplished this by collaborating with other hospitals in the surrounding areas, creating the CHA.

These individual centres were originally culturally oriented to serve the population who lived in their respective local areas. This focus evolved in response to the social need for cultural understanding with regards to how health care is approached. For example, a large Portuguese population was in the area served and thus one of the Hospitals was largely staffed by individuals from within the Portuguese community. This meant patients could be served in their mother tongue and receive care from individuals who were more likely to understand their cultural values. The cultural specificity served the community in some ways, however soon anonymity became an issue as the patients would be recognized by their neighbors and peers when seeking care.

The story of the evolution of the Cambridge Health Alliance and the challenges faced along the way provide an excellent illustration of similar challenges Montrealers, and more broadly, Canadians, are facing still today in our own communities. The combined priorities of cultural understanding, a sense of community, and the need for anonymity create a complex issue not easily managed. This

is especially true in small communities. There is also the issue of alienating individuals from other cultures when institutions are geared toward one specific cultural group. To deal with these challenge of providing both inclusive and culturally sensitive care to all and to better serve the multicultural populations in our communities today, I think that what is needed are multicultural centres (i.e. centres open to all cultures with clearly identified and accessible resources for those desiring more cultural or linguistic specificity in their care) with healthcare professionals and support staff who excel in their cultural competency. This should go hand in hand with in-place institutional policies that promote access to cultural and language interpreters in order to ensure that patients feel heard. Though training in cultural awareness and sensitivity is already integrated in the undergraduate medical curriculum, as we see in our first-year courses in at McGill, institutional changes, including access to interpreters, is still lacking. Specialized community centres exist, such as the CLSC Parc-Extension in Montreal, which is catered toward specific populations, such as asylum seekers, for primary care delivery. An example of analogous programs offered at the CHA include culturally specific mental health programs for the Asian, Haitian, Latino and Portuguese communities respectively. At the CLSC, some of the specialized services offered include health assessments for asylum seekers newly arrived to Canada, Punjabi interpreters available on site, as well as interpretation services readily available at any time for any language via telephone. Despite the availability of such specialized resources on a primary care level, for higher levels of care in hospitals, these efforts need to be improved upon - especially as the populations of Montreal and Quebec grow more multicultural and diverse. For example, interpretation services are not standard in Quebec Hospitals.

The Cambridge Health Alliance's history is an excellent example of how a public institution recognized the needs of the population and took action on their own to achieve a healthier, better served population, as well as a working toward improving the effective running of an institution/set of institutions. Other examples of social accountability Dr. Bor discussed involved instances when the public sector was not taking the actions required to best serve the public, and physician-led advocacy projects were undertaken in order to make the desired changes happen. These examples will be discussed next.

How does one make change in a community? According to Dr. Bor, change in a community is accomplished by forming a constituency that will demand the services they want. For example, during the AIDS epidemic in the 1980's, physicians struggled to help their AIDS inflicted patients given the lack of an effective treatment, and as a result they sought opportunity to help by other means. In order to have the greatest impact, the physicians made effort to find out the needs of this population of patients, and what community services would most contribute to their health and wellbeing. To discover the priorities of the population, Dr. Bor turned to the constituency and asked them. This particular constituency group decided that availability of housing during times of illness was the biggest issue they faced. With the collective voice of this group, Dr. Bor and his colleagues were able to change policy, which gave those affected by AIDS top priority for publicly available housing.

Amongst those presented by Dr. Bor, I found this story particularly inspiring. Not only was an important change effected to improve the wellbeing of a vulnerable group, but this group was able to prioritize and voice the changes they wanted to see. This story demonstrates that one voice can grow louder through the building of a community of like-minded individuals, and that once the collective voice is loud enough, change can and will be made. That being said, I would like to acknowledge that my recounting of the story may misleadingly suggest that making such impact is simply a matter of asking. In many cases, I'm certain that enacting such change is not so simple. In this case, Dr. Bor was well placed with the right connections to bring his project in front of those in a position of power more readily than the average person. Physicians, as highly respected members of the community, are privileged to have a powerful voice with respect to influencing health policy. It is my hope that as a medical student, while I progress in my career, that I may expand my own network of allies and be well placed to enact change on behalf of the groups I serve.

A final story from Dr. Bor I would like to share is a beautiful illustration of how one can successfully overcome obstacles to make change in a community. In this story, Dr. Bor struggled to get the patient population in need to become engaged in demanding social accountability from the governing institutions to provide the care they needed. The population in question were the African-American men in the area around Cambridge

- a group which had been under-reached through the medical strategies in place. Not only were these men seeking care less frequently, they were also among those who were less healthy. Dr. Bor sought to create a task force of African-American men to once again understand their priorities and advocate with them their needs to the city for change of policy and program implementation. Unfortunately, this population was not drawn to being engaged in this discussion, which was incidentally at the root of the problem being addressed. In order to inspire participation in the community, the task force reached out to the grandmothers of the African-American community - a group who were thought to have the time for and interest in protecting and improving the health of their families. This strategy indeed proved effective, as in the African-American community the grandmothers were valued and respected by their sons and grandsons. Thus, through this creative seeding, the men's health was prioritized in the community.

It is my hope that these three stories might illustrate how social accountability is an important concept to bear in mind - not only from the point of view of public institutions, but also from the point of view of members of the general public. Institutions should be seeking ways to better serve and reach the communities that utilize their services in order to continue growing and evolving along-side the changing needs of the diversifying population. When the institutions are unable to identify the needs of the population on their own, it is important for the public to become involved in voicing their needs and priorities to those who can enact change. Finally, obstacles are plentiful in the course of striving for social accountability, whether in the form of addressing challenging issues or in garnering support to present the importance of an issue. In the face of these obstacles, one must be creative, and seek collaboration. The louder the voice behind a project, the broader the potential reach.

A quote from Dr. Bor in response to this article: *"Social accountability is not just an ideal. It's a necessary component of successful democracy. The beauty of democracy's potential is that resulting policies and initiatives should be unique to a particular place and moment, and should mature with time. Sadly, our national democratic institutions are too susceptible to corruption and influence by moneyed interests. However, at the local level, the ideal can work well. Health professionals have surprising influence, partly by our*

*status in society, but mainly through our ability to listen and explain. You've got those skills. Use them well."*

## References

1. Bor D. Cambridge Health Alliance: A Public, Academic Community-Responsive Health Care System. Oral Presentation presented at McGill->Harvard Medical Student Exchange; 2017; Harvard University, Cambridge USA.