



HEALTH CARE: A COMMUNITY CONCERN?

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CHAPTER 26

A New Look at Community Inputs

At the provincial inquiries some members of the public had expressed concerns about lack of involvement of community members in policy development, other than as taxpayers providing revenues for social redistribution. These concerns had been there from the 1960s onwards. But as was pointed out earlier, power in organizations tends to be associated with formal authority or technical expertise. There are, of course, some community members who can use the informal and non-formal systems of power (i.e., knowing how to get the system to respond to their demands or getting their ideas across through social networking). The collectivist welfare state and its health care system are organizations where such power struggles go on.¹

The focus of the Canadian federal welfare state in the 1940s was financial redistribution, and so community involvement was not a special issue for that government until after the Organization for Economic Cooperation and Development (OECD) conference in 1980 on *The Welfare State in Crisis* (1981), which suggested that the Westminster parliamentary countries could profit by broadening their discussions with economic policy makers. Concurrently Canada was working on its human rights policies (1968–83). These challenged the idea that income support and expert service delivery were all that was necessary for a satisfactory collectivist social organization. Acceptance of all other citizens as equals was as important as providing a social minimum and funding universal social programs. The concept of partnerships at a number of different levels became a new issue. And one issue in partnerships was community involvement.

1 As Alford (1975) demonstrated, the power of the health planners in New York was divided between professionals and administrators. They might from time to time co-opt consumers to their cause if they thought it to be useful.

The Response of Formal Authorities to the Concept of Consumer Involvement

The insecurities of politicians and bureaucrats who were learning how to set up and work the formal system were discussed in Chapter 16. Politicians were not anxious to have a third power group of consumers working alongside them (as the reception in Saskatchewan of the McLeod [Saskatchewan 1973] study of community participation showed clearly).

And in the early years of the collectivist system the bureaucrats were clerks without much power themselves, until the Established Programs Financing Act (EPF) legislation in 1977 forced the provincial governments to appoint professionally trained administrators. Then both politicians and bureaucrats had to learn how to cope more effectively with their jobs, and they did not want consumer interventions.

Writing about bureaucratic developments in Ontario, a more populous and advanced province, Vernon Lang said in 1974:

Administrative evolution during the past three decades has built some monster-sized enterprises like OHIP (Ontario Health Insurance Plan) designed to relate to the citizen directly. It has also tried to work on more human scales. The province has enlarged the political size of communities, while simultaneously decentralizing the public service. These two trends, upward and downward, have for the most part not collided yet, but sooner or later they will. When that happens will they merge, coexist or back off? There has been a tendency to see the newer units — larger than before from the local viewpoint, smaller from the provincial — as being in some sense the citizen's future 'community'. The evolutionary process has led to some erratic shifting of the citizen's community, causing him bafflement. People in general have become more dependent on the state than they used to be. (p. 67)

Lang predicted that there would need to be more opportunities created for citizen involvement in social policy development, for people wanted more than work opportunities, and: "The kind of massive changes on which [social policy development depends] can be achieved only if we carry the citizens with us by organizing far more widespread citizen participation than we have today, in considering the options available and in reaching consensus on directions for social policy" (p. 69).

Lang's critique was published in the same year as the Mustard report (Ontario 1974) which presented a new plan for service development in the province. Ontario, responding to the pressures for change, had begun to set up new structures known as District Health Councils (DHC) in 1973 (Ontario 1975a). These were not management boards, as in Quebec, but advisory

bodies reporting to the minister on local health priorities planning.² Nevertheless they were seen as a threat both by bureaucrats and professional experts and were not allowed much power. It was not until 1990 that Quigley and Kealey (1990) proposed a coordinating body so that they could work together to develop more effective planning. And it was in the 1990s that the DHCs were given some authority to comment on the operational budgets of hospitals.

A Democratic Socialist Plan for Consumer Involvement: British Columbia 1972-75

At about this time Canada's socialist governments were trying to involve consumers in policy making, and British Columbia endeavoured to set up a community participant social welfare program. Clague et al. (1984) have made a detailed examination of the establishment of community resource boards (CRBs) in the heady three years of the New Democratic Party (NDP) government in British Columbia from 1972 and have reviewed their rapid demise when the Socreds returned to office in 1975.

The analysis is detailed and provides a number of clues about the difficulties being encountered then and today in efforts to coordinate and integrate health and social services. Vancouver was chosen as the trial area — it was to be a region with a two-tier system of elected community boards.³ This was a city in which the United Way had already done a good deal of preliminary work in planning the future development of voluntary social services (Canadian Council on Social Development 1972) and there were experiments involving community health centre development, multiservice centre activity, job training for women on assistance, development of the Greater Vancouver Mental Health Service, citizen involvement in economic development policy in the city council and regional district, and plans for decentralization of municipal service activity (p. 70).

Clague et al. (1984) identified many difficulties involved in setting up the Vancouver CRBs, one of which was hasty decision making. Focussing

2 British Columbia had set up regional hospital districts in 1966 for institutional facility planning but these advisory bodies, composed of appointed representatives of health boards, were buffer groups against back-bench pressures rather than true advisory bodies (Detwiller 1972).

3 Local communities outside Vancouver were advised to form community resource societies as a preliminary to the establishment of CRBs in their areas. Guldmond (1977) has reviewed an experiment (funded as a federal demonstration project) in which the Social Planning and Research Council of British Columbia assisted eight non-metropolitan communities with health planning between 1973 and 1976.

more directly on the coordination and integration issues they identified the following problems:

1. There was no overall grand plan. The minister said he wanted to get community groups involved in the process of decentralizing and integrating services. "All action stemmed from this assumption" (p. 35).
2. The Community Resource Boards Act defined "social services" very broadly. In addition to the usual statutory and non-statutory services the term could mean "any services, either social action or preventive" that could help people "develop their full potential and well being." Also included were "services designed to encourage and assist residents of a community to participate in improving the social and economic conditions of their community." The government might delegate additional services to a CRB on recommendation from the Minister concerned, including public health services, mental retardation services, mental health services, correctional services and manpower and employment services of the provincial government" (p. 41).
3. The experiment brought the main private social welfare agencies under government control, a beginning attempt at provincial rationalization of the social welfare system.
4. "The two most contentious features of the act were control and accountability. ... The funding process was intended to be the principal means by which the minister would retain control. Some community and consumer groups felt the bill did not go far enough in decentralizing authority. They saw the minister's desire to retain residual responsibility as a means of transferring heat from the government to the CRBs without relinquishing authority" (p. 45).
5. The relationship of the CRBs to existing municipalities had not been worked out. The municipalities saw them as the creation of another level of government (p. 78).
6. The relationship of the CRBs to the minister was advisory; they did not have the power to change provincial policies (p. 90).
7. The Vancouver Resources Board (VRB) used the mechanism of grant aiding local communities to redistribute resources to more needy areas (p. 111); and discretionary grants were used to help needy people (p. 195).
8. The composition of the boards was expected to vary but the top tier in Vancouver was to include representatives from the park and school boards and the city council as well as members appointed by the minister (p. 80).
9. The bottom tier was to be elected, but in the first election, voter partici-

pation was low⁴ and the elected community representatives tended to be professionals and human care workers (p. 60).

10. At the ministry level, the Department of Human Resources was put under greater pressure by the changes going on below. Communication between the minister with his special project team and the regular civil servants was inadequate. The minister may have wanted to assure accountability but he did not have an adequate database on the costs of his projects, so they got out of control (p. 50).
11. There were no experienced staff at the CRBs. All had to learn on the job about the concept of community participation, about how the model should work, about team work and about basic procedural techniques (such as needs assessment) (pp. 54, 94).

In terms of structural issues Clague et al. identify these negatives in the CRB experiment:

1. The concept of elections to CRBs was a very unpopular issue.
2. CRBs were outside the traditional structuring of government (a legislative anomaly).
3. There was a lack of a command structure within the Department of Human Resources to coordinate the changes and a lack of consistency in informing staff about decisions coming down from headquarters.
4. The use of service contracts to voluntary agencies was very controversial (p. 15).

In fact the Minister of Human Resources was challenging the established social service structures in much the same way as the Saskatchewan government had challenged the established medical structures and with much the same results.

Why have we discussed this experiment within the Ministry of Human Resources? Because, as was indicated above, the intention was to set up community health (CHC) and human resources centres modelled on Quebec's Centres locaux des services communautaires (CLSCs) in which medical and social service resources were to be provided together under the governance of a local community board which bridged the present service divisions. But this experiment came long before the British Columbia voters were ready to move to this form of organization.

When the Socreds returned to power in 1975 their first targets were the CRB and CHCs' experiment.⁵ The minister based his arguments for their

4 Only eight percent.

5 British Columbia had set up a special division to develop CHCs under the guidance of Dr. Foulkes (see Chapter 11). Five centres were opened up. Four

demise on reinstating central accountability and control but, as Clague et al. (1984) have pointed out, there were other factors, many of them ideological (p. 15). Jones (1977) has also studied the short-lived existence of CRBs.

The Socreds were supported mainly by angry rural voters who pursued rural/urban rivalries. They had strongly resented the concept of providing better service levels in the cities and use of discretion by VRB employees to treat some clients better than the general guidelines suggested.

Quebec's Interest in Community Involvement

The plan proposed for Quebec in the Castonguay-Nepveu committee's recommendations (Quebec 1970-72) was to establish CLSCs, districts and regions under the provincial government of Quebec to deliver health and social services to the people of the province. The government, of course, would consist of elected representatives working with professional bureaucrats. Lower down, the subsectors of the organization would be governed jointly by consumer representatives and professionals working together on management issues. Brunet and Vinet (1979) showed how the service providers were able to dominate the discussions because of their inside knowledge but Godbout (1983) was less pessimistic about consumer inputs having an influence over practice.

There were a number of unresolved issues in addition to the governance questions (which were resolved in favour of total consumer control over policy making in 1990). The CLSCs employed community developers (*animateurs sociaux*) as well as professional service givers, and for many years it was uncertain whether their advocacy activities were useful and appropriate. The Rochon committee (Quebec 1988) recommended that their positions be eliminated. The government had stopped helping voluntary organizations. Rochon proposed this be reconsidered, thus ensuring that advocacy could continue but outside the CLSC service delivery structures.

It took twenty years for CLSCs to be set up all across the province because of medical resistance to the concept. The Brunet report (1987) recommended that when choices had to be made, CLSCs should be set up in high risk areas. And in 1990 it was at last accepted by the government that there was a parallel subsidized medical care organization.

The Issue of Medical Dominance

The issue of medical dominance has already been discussed in earlier chapters but it is necessary to restate the doctors' power position here. The first

survived the scrutiny of an audit committee set up by the successor government (British Columbia 1977) and were retained. Otherwise the idea was killed.

confrontation on the matter of consumer involvement on boards of governance came in Saskatchewan in the early 1950s when the government proposed to set up more regional health boards after trying out pilot schemes in Swift Current and Weyburn. The government had built on the experience of the municipalities, which had developed boards to manage public hospitals, and the municipal doctor programs, which combined personal care and public health services in one salaried position.

Despite the pilot regions' evident success (Canada Hall 1964) in bringing together all the elements of medical care, public health and mental health under one authority, the government's plan to introduce further regionalization met with resistance from the medical profession. In 1951 two communities voted down proposals for introducing regionalization into their areas as a result of persuasion by the College of Physicians and Surgeons. This ended the Saskatchewan government's efforts to establish that model of organization.

Medical hostility to community boards was shown again later when the Saskatchewan doctors were unwilling to settle their strike over the introduction of provincial Medicare, 1962, until community clinic boards were reconstructed to a landlord-tenant relationship only (Badgley and Wolfe 1967).⁶

By the end of the 1960s some Canadians were becoming angry with the way in which they were being treated by doctors. Although the radical challenges to the professionals had begun in the United States (Illich 1974), both Ontario and Quebec decided to investigate whether professionals were sufficiently concerned with consumers' interests. (Ontario Krever 1970; Quebec Castonguay-Nepveu 1970-72). Both provinces set up new machinery for professional regulation.

Following the publication of the Krever committee's report, the Ontario Medical Association appointed its own investigating committee (OMA 1973) which recommended appointment of lay persons to its council. Other professional associations in that province followed. Quebec set up a new Office of the Professions in 1971 to look into the matter of protecting consumer interest, for the investigation of the Castonguay-Nepveu commission's subcommittee had shown that professional interests took precedence. To correct the worst abuses of power this Office of the Professions conducted consumer surveys and received complaints from dissatisfied clients (Quebec Office of the Professions Annual Reports). However, in a review conducted some years later, Slayton and Trebilcock (1978) thought that the changes introduced were

6 Nevertheless, although the government had to back off on this issue at this time, Coburn, Torrance and Kaufert (1983) thought that this strike negotiation signalled the beginning of the end of medical dominance.

not very effective in increasing professionals' concern because it soon became clear that it was not easy to change the attitudes of self regulating professionals whose licensing bodies held the monopoly position.

In 1990 Ontario passed a new act to regulate the professions, taking an entirely different approach. Under this act it is professional activities which are regulated, not professional persons. It remains to be seen whether this change will be effective.

Lower Level Boards in English-Speaking Provinces

There were, of course, some subsectors of the system of care where community members had been able to make their inputs — in municipalities, particularly in the prairie provinces, and on hospital boards, union boards of health, and voluntary organizations involved in social planning or service provision. Why were these regarded as insufficient for making community inputs into the collectivist model of care?

With the introduction of the Canada Assistance Plan some provinces removed much of the responsibility from the municipalities, though in other provinces they retained their powers. (Manga and Muckle [1987] have reviewed the situation as it was at that date.)

Hospital boards are long established foundations in which the roles of community representatives *vis-à-vis* medical staff and administrators have been clearly worked out (Perrow 1965). The community representatives most desired by these two other powers in the hospitals were local businessmen who could help to raise and decide on the use of funds. Board members were quickly made to realize that they must keep out of medical decision making territory.

Union boards of health which supervised public health services were made up of elected municipal politicians who were also well aware of the limits of the policy making role. Board members' interventions into medical health officers' professional decision making, common in the nineteenth century, were no longer possible.

So far as the voluntary organizations were concerned, Govan's study (1966) of developments up to that time have already been described. She discussed the changes brought about by the war (mutual aid organizations grew in numbers) and by the coming of the welfare state (charities got together to form United Ways to prioritize the allocation of contributions to their member agencies). Rekart (1994) and the Korbin report (British Columbia 1993b) have shown that in one province, British Columbia, there have continued to be large numbers of voluntary agencies that have been undertaking contract work for governments, but that this has been poorly administered and coordinated.

These last two investigators raised questions about the continued existence of these services. Should they be taken over, or at least better coordinated by government, or should they continue to be subsidized and allowed to "do their own thing"? There are arguments on both sides. Governments may be better at gap filling, particularly in rural areas, but voluntary organizations may see problems earlier and respond more quickly and flexibly to them. However, there seems to be the need to sort out the issues of gaps in service and overlapping provisions and who should be responsible.

The Impact of Three New Pressures

The health promotion and human rights movements made it clear that the welfare state approach to financial redistribution had its limitations. Unless there were attitude changes among individuals and changes in society's approaches to problem solving, Canada would not be able to deal with its social problems. A third pressure was the necessity of reducing the cost of social programs. One way of tackling this matter was to involve consumers in taking more responsibility for making claims upon resources and in setting priorities on how to deploy these resources.

The Health Promotion Movement in English Speaking Provinces

As planners began to work on health promotion matters they could see that progress could not be made without involving both individuals and communities in improving their lifestyles and environment. The Canadian Public Health Association (CPHA) was active in educating its professional members in this new approach. It was not easy for public health nurses to shift from having been health educators, deploying their professional expertise on a one-to-one basis, to becoming community development specialists, but the CPHA worked hard on the matter and so did a number of the senior nursing administrators.

The CPHA also gave its support to the concept of setting up healthy community groups at the local level and developing provincial networks of these groups (e.g., British Columbia Healthy Communities 1989). Many provinces also support seniors' wellness groups.

The Institute of Health Promotion Research at the University of British Columbia and the British Columbia Consortium of Health Promotion Research have been developing projects in participatory action research (Green et al. 1995).

The Human Rights Movement

Even before the International Year of Disabled Persons (IYDP), 1981, advocates for change in disability policy had protested against medical and

bureaucratic dominance and the assumption that the persons with disabilities must adapt to deal with the barriers in society. They had argued that some barriers could be eliminated and that the persons with disabilities could become much more independent (Hahn 1985). These arguments were accepted by the Special Committee of the House of Commons which investigated their problems for IYDP (Canada 1981b). Since then a number of steps have been taken to improve communications, open up work opportunities, restructure housing and transportation to enable those who wish, and who are able, to live independently in the community (d'Aubin 1986). This is one example of a disadvantaged group which has taken action to bring in major policy changes through community advocacy.

In Chapter 25 we have also described new policies which have been developed for transferring control over health services to native boards, and what has been done to help multicultural groups.

Networking

So far this discussion has been concerned with the establishment of formal structures for consumer/community involvement in health service policy making, planning and management, but in the last six years attention has turned to the combination of formal and informal participation. Particularly in the development of mental health services the idea of partnerships or networking has been pursued (Boudreau 1991; Gottlieb 1983; Gottlieb and Selby 1989). Gottlieb (1983) has proposed five levels of community networking involvement from one-to-one supportive relationships to working with the local media on community issues.

Regionalization

The financial inquiries into health services had begun to put forward regionalization as a solution to many structural problems of the Canadian health services. It was thought that by breaking the provincial structures down into smaller units it would be possible to solve a number of problems of coordination and integration of service provision and to bring consumer representatives into policy making. This will be discussed in Chapter 29.

Summary

This chapter has discussed two factors which led to the exclusion of consumers/community members from policy making for many years. The first of these was the emphasis in the welfare state on financial redistribution. However, in the 1980s the need for governments to work in partnership with others began to be recognized.

The second was insecurity on the part of politicians and bureaucrats and the traditional dominant stance of the doctors. Power is associated with formal authority and technical knowledge, and the power holders were not willing to let community members share this power except in the human resource boards experiment in British Columbia and in the limited number of CLSCs in Quebec. But in both of these, there were difficulties in getting consumer involvement established because of inadequate planning and/or unwillingness to let power go.

The medical profession was very resistant to consumer involvement and the provincial governments were unsuccessful in finding how to improve professional regulation when they tried to do so.

Traditional lower level boards in hospitals and public health services were usually permitted to continue after the introduction of welfare state legislation but these were very limited in what they could do.

However, times have changed under the influence of the health promotion movement and human rights movements and the need to find new ways to control the cost of services. Regionalization has been recommended as the best mechanism for addressing these issues, and it will be discussed in Chapter 29.

