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THEORIES OF PARTICIPATION IN HEALTH CARE DECISION MAKING: CASE STUDIES OF FOUR COMMUNITIES IN ONTARIO, CANADA

Submitted by
Julia Abelson
For the degree of PhD
University of Bath

1998

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Summary

The thesis explores the complexity surrounding theories of participation as applied to local decision-making in the health care arena. The field of education, although subjected to a less detailed analysis, was used as a comparator to determine whether lessons learned in the health care arena have wider application. Four communities in Ontario, Canada were chosen for in-depth study to recount their "participation stories" and to describe and explain the factors that shaped the observed participation. The thesis was organized around three principal foci. The first establishes the concepts and methods underlying the analysis (Chapters 2 through 4). In Chapter 2 the participation literature was reviewed from various disciplines and fields of study to distil a broad base of knowledge on the subject of what influences participation generally and in the fields of health care and education.

An analytic model used to guide the analysis was developed and presented in Chapter 3. It portrays the multiple influences on participation (i.e., predisposing, enabling and precipitating). A research strategy is presented in Chapter 4 that describes the process of inquiry and explains the decision to employ case studies based on the diversity, gaps in understanding, and strengths and weaknesses of prior participation research.

Chapters 5 through 7 present and analyze the results of the case studies. Participation profiles are presented for each of the four study communities in Chapter 5. Through these profiles, the heterogeneity of participation is illustrated with parallels and contrasts highlighted among case study areas. Chapter 6 applies the model outlined in chapter 3 focusing on the independent role played by each set of influences. The heterogeneity described in Chapter 5 is explained in this chapter through the analysis of census data and community informant interviews. Chapter 7

addresses the interaction between model elements and the combined influence they exert on the participation process. Chapter 8 shifts the focus of analysis to a comparison of participation in health care and education highlighting their similarities and differences with respect to participation and how it is shaped. The concluding chapter reflects on the methodology, contributions to the literature, the utility of the model, policy implications of the research and recommendations for future research.

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CHAPTER 1

INTRODUCTION

The central aim of this thesis is to explore the complexity surrounding theories of participation as they apply to local decision-making in the health care arena. Four communities in Ontario, Canada have been chosen for in-depth study to recount their "participation stories". More specifically, it is concerned with the participation of communities in local decision-making processes and the factors that shape their participation. The health policy arena has been chosen as a "tracer" for the analysis and will be compared to the field of education to determine whether lessons learned in this policy area have wider application.

Participation and Democracy

Political theorists and practitioners have been fascinated with participation in the affairs of government since Athenian times and the origins of classical "face-to-face" democracy. Inextricably linked to the democratic principles of 'government for the people' is the involvement of the citizenry, either directly or indirectly in government decisions. To participate is to "take part" or "share in common with others". Democratic participation, therefore, implies a sharing of power over government decision-making. The extent to which this power should be shared lies at the heart of debates over the merits and deficiencies of democratic models arguing for more or less citizen control. Representative (or indirect) democracy advocates believe that decision-making power should lie with those elected by the populous to govern while supporters of participatory (or direct) democracy tend to align themselves with the Athenians and later theorists such as Rousseau, J.S. Mill and Cole.[1]

[1] For a detailed discussion of their theories see Pateman (1970).

A detailed chronology of the roots of participation theory is both beyond the scope of this thesis and unnecessary given the numerous and thorough accounts provided elsewhere. Nevertheless, some key "events" in the history of participation are worth chronicling to provide some context for this analysis. Derived from the democratic model of the Greek city-state, the New England town meeting conjures up similarly romantic notions of small face-to-face gatherings where all citizens participate in the decisions affecting them. Although appropriate for the small and predominantly rural communities of the day, the effectiveness of this form of participatory democracy quickly diminished as populations grew and modern government became too complex to be handled through an annual town meeting. The town meeting continues to be used as a decision-making forum in three New England states and as a medium for information exchange in many others. It has all but been replaced, however, by representative government where citizens elect their governors and find ways to influence the decision-making process through these representatives.

With expanding bureaucracies and the evolution of public administration as the dominant model for public service provision government policy-making has become a highly technical and expert-driven process with little role for the citizen. The long period of prosperity following the Second World War has also been suggested as a reason for relatively low levels of political participation. Parry (1992) chronicles the reflections of one British politician on the subject who concluded that

Material contentment would permit ordinary persons to devote greater attention to their growing leisure interests and be, quite properly, less concerned with interfering with the lives of others through political participation (Crosland,1975 in Parry et al, p.89)

The 1960s marked an unprecedented period of participatory activity, often in the form of political demonstrations. The proliferation of consumer groups, the establishment of women's and civil rights movements and massive protests against the Vietnam War in the United States heralded a new era of participatory democracy. Morone (1990), in his account of citizen participation in the United States describes the times in the following manner:

It demanded participation, celebrated grass-roots community, proclaimed the consensus of the people, mobilized previously oppressed Americans, and won new political rules and institutions. (p. 141)

Operating in parallel was a move during the 1970s toward the establishment of representative government structures as a means for establishing greater local control over decision-making in the human service arenas. Health planning agencies sprung up in the United States and Canada with the objectives of serving local needs and preferences. The participation of community representatives on decision-making boards was an essential feature of these structures - a phenomenon that would repeat itself in the 1990s. The origins of this movement were attributable, in part, to World Health Organization doctrine that emphasized the importance of community participation in local planning and resource allocation.

The Policy and Political Context of Participation

From the brief account presented above, 'participation' seems to have been firmly planted on the political agendas of many Western nations since the 1960s. More recently, calls for a more active, involved citizenry have intensified throughout Western societies as governments attempt to restore public confidence in the democratic process. Public distrust and dissatisfaction with government performance have led to demands for more direct accountable democracy but this explains only part of the enthusiasm for introducing new methods of public participation. At least as much, if not more of the impetus has come from government itself in its efforts to achieve (or create the impression of achieving) greater accountabilities to the public. Government slogans claiming to "put government closer to the people" and to "make government more responsive to the needs of the people" exemplify these attitudes. In Britain, citizens' charters have been introduced into almost every arena of public service. Citizen panels are being used in Germany and the United States to advise government policy in a number of areas and "public consultation" has become the buzzword of the late 80s and 90s throughout the Western world (Kathlene and Martin, 1991; Renn et al, 1993).

Renewed interest in direct democracy has been greatly facilitated by advances in communications and information technology which allow the face-to-face meetings of Athenian society to be simulated through electronic town halls, referenda, voter juries and deliberative polling (Fishkin, 1992; Adonis and Mulgan, 1994; Coote, 1994; Goar, 1994). As with the diffusion of many new technologies, the proliferation of the means for facilitating direct involvement has convinced at least some of the

public that they can and should take part in decision-making forcing politicians and bureaucrats to respond to these pressures.

Coincident with these trends is the changing context of public involvement where the focus of decision-making has shifted from sharing abundant to rationing scarce resources. Many governments have chosen to involve the public in these difficult decisions to increase legitimacy and diffuse opposition to unpopular program cuts. At the same time, however, these decisions have spurred existing pressure groups into action and led to the creation of new ones in order to save valued programs and services. The threat of losing services has been shown to be a highly effective mobilizer.

One of the more interesting phenomena to emerge in the participation discourse is the call for a shift away from the individualism of the 1980s to viewing the "community" as the cornerstone to improvements in social and economic conditions through concepts like capacity-building, civic duty, mutual assistance and healthy communities (Morone, 1997; McNight, 1990; Putnam, 1993; Bellah, 1985; Sandel, 1982).

Those charged with finding solutions to long-standing problems of unemployment and violence have found the remedy for society's ills by harkening back to a mythical "golden age" of altruistic, civic-minded, and self-sustaining communities able to solve their own problems and take responsibility for themselves. Calls for a return to the "good old days" and a greater sense of community (although pursuing different objectives) have been made by groups as ideologically opposed to one another as the Labour Party in Britain and the Republican right in the United States. Much of this political rhetoric is rooted in the re-emergence of the political

philosophy of communitarianism (Etzioni, 1993). Whatever the political motive, this resurgence of interest in "community" has taken both policy and research communities by storm as the following reviews illustrate:

> *The policy-making community has been particularly energized by the findings of Making Democracy Work. From the World Bank to city hall, the creation of social capital has been embraced as a solution for social problems as diverse as promoting economic development in Africa and stemming urban decay in Los Angeles.*
> (Boix and Posner, 1996, p.2)

> *The communal story has mushroomed into a minor academic movement. Here, argue proponents, is firm cultural ground for invigorating public life and initiating political reforms. The idea attracts intellectuals from across the political spectrum. Progressives stress mutual obligation and the communal limits to market capitalism; conservatives emphasize the responsibilities individuals owe society.* (Morone, 1997, p.996)

The Canadian Context

As in other Western democracies, Canadian politicians and governing institutions have increasingly been criticized by, and lost the confidence of, the public. Opinion polls, election results and the emergence of new political parties demonstrate a growing distaste for self-interested, unaccountable politicians and the loss of faith in government as "the people's protector". In contrast to their southern neighbours, Canadians do not necessarily advocate a drastic reduction in government but would like to see an improvement in its overall performance.[2] A related phenomenon is the growing realization of the limitations of the rational policy-making process and an acceptance by the public and government of a role for societal values into decision-

[2] A recent study of Canadian public opinion towards government concluded that there is basic approval for what government does but there is widespread opinion that it costs too much and is ineffective. The study, *Rethinking Government*, was sponsored by a consortium of 10 federal departments and agencies, 2 provincial governments and 2 private-sector companies and involved detailed surveys of elite and public opinion as well as focus groups.

making. This has been demonstrated in Canada recently through debates over euthanasia and assisted suicide, priority setting in the public services and the siting of hazardous environmental facilities. Canadian governments at all levels are seeing the advantages of legitimizing and even evading tough decisions by involving the public. Recent examples include the Province of Ontario's announcement of plans to use the referendum as a tool of "direct democracy"(Globe and Mail, August 28, 1996, p.A1); Alberta's Growth Summit which gave citizens across the province the opportunity to provide input into government's reinvestment decisions in areas such as government-funded institutions (i.e., schools and hospitals) which have been the target of massive spending cuts in recent years (Globe and Mail, Aug. 25, 1997, A6); and local government initiatives such as Vision 2020 Community Futures exercises and constituent assemblies[3].

Participation and Canadian Health Care Policy

Provincial governments in Canada have responded to shrinking revenues and increasing expenditures by introducing major reforms to their health care systems which account for approximately one-third of every provincial budget. These reforms have emphasized changes to the structures governing health care decision-making. Governments of all political stripes are devolving decision-making from the centre to some form of regional or local decision-making structure. Although devolution models differ from one province to the other the general trend has been to transfer the planning and priority-setting, management and resource allocation decisions to a local

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[3] Vision 2020 exercises have been conducted in several Ontario communities in the late 1980s and early 1990s as a method to facilitate community economic development processes. The constituent assembly model was adopted by one Ontario community to inform its municipal government reform process.

board made up of a combination of elected and appointed officials who are representative of their community (Lomas, Woods and Veenstra, 1996).

The "official" motivation behind these decisions, according to government documents and royal commission reports, has been to improve the overall efficiency and effectiveness of the health care system by pursuing objectives of increased accountability and responsiveness to the needs and preferences of individuals and communities. The instrument called on to achieve these objectives is the *participation* of citizens, communities and the public in health care decision-making (Hurley, Lomas and Bhatia, 1994; Rasmussen, 1996). The concept of devolution and community-based decision-making as instruments of health care reform, and governments' certainty that this is a "good thing" is based on little or no empirical evidence. An international review of devolution initiatives found few studies of its impact on government performance with equivocal results about its merits or weaknesses (Canadian Medical Association, 1993). Enthusiasm for these initiatives is more likely due to governments' rejection of centralized technocratic policy development in favour of a return to the community control era of the 1970s. As Rasmussen (1996) observes:

> *Arguments about community control in the 1970s were initially advanced both as a means of providing input into the policy process from the dis-advantaged and the disaffected, as well as to counteract and overcome the privileged relationship between bureaucracy and certain vested interests.* (p.5)

A more cynical view of these policy proposals, alluded to earlier, is that they have little to do with involving citizens and communities in decision-making and much more to do with "diffusing the blame" for unpopular government decisions. Rasmussen continues:

> *It would seem that most provinces are more interested in the latter benefit, rather than possessing any strong commitment to the disadvantaged and dispossessed.* (pp.5-6)

Although efforts to involve the public and communities in newly-established governance structures have been front and centre in the health care participation debate, the proliferation of "consultation exercises" in the health care arena has brought the debate closer to the public.[4] Until recently[5], provincial governments in Ontario and across the country as well as the federal government have seemingly been unable to make a decision without consulting the public or at least groups with an interest in the policy area. Although earnest attempts have been made to listen to and incorporate the views of the public into the policy-making process, evidence is mounting that consultation is being conducted as a means for legitimizing government decisions with little commitment to incorporating the public's views. The result, at least in some health care policy arenas such as long-term care for the elderly, has been a severe loss of public confidence in the consultation process and their potential to influence the policy process (Aronson, 1993; Abelson et al, 1995).

Even the most well intentioned attempts to involve the public in decision-making, however, have produced unsatisfactory results. Since the early 1970s the general participation literature has provided consistent evidence to indicate the propensity for the affluent and highly educated to participate in public affairs over

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[4] The reader may have already noted the use of various terms related to participation such as "involvement" and "consultation". These terms and their relationship to participation are discussed later in this chapter and again in the literature review chapter.

[5] The election of the Conservative Party in Ontario in June, 1995 heralded a new era of politics which has focussed on marginalizing all "special interests" from policy debate. The introduction and passing of Bill 26 is perhaps the best example of the Conservative government's philosophy toward public consultation. This omnibus legislation which granted new and unprecedented powers to the government across all ministries was passed in only a few short weeks in January 1996 and would not have involved any public consultation had it not been forced to by opposition filibustering in the legislature.

those with comparatively fewer resources.[6] Recent examples of attempts to involve the public in health care decision-making have provided support for the generalizability of these findings to the health care sector (Lomas, 1997). The "participating public", it has been argued, is highly unrepresentative of the community and only those with vested interests in the health care system make the investment in participating.[7]

If the above is true, then how is the widespread community mobilization that has been exhibited in response to proposed hospital closures to be explained? Are the same unrepresentative, vested interests at work or do hospitals represent symbols of our communities which must be protected at all costs? Highly visible public demonstrations held to protest proposed hospital closures in communities across the country are one form of community participation just as the regular attendance of a group of volunteers at meetings to discuss the health care priorities of the community is another. Understanding these complexities and the context within which participation occurs in communities is what lies at the heart of this inquiry.

Concepts, Definitions and Terminology: Unpacking the Concepts of 'Community' and 'Participation'

References have been made in the preceding sections to the challenges involved in bringing together two complex notions such as 'community' and 'participation'. Before embarking on a study of community participation some

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[6] see literature review chapter for an extensive discussion of this subject

[7] Evidence to support this argument can be found in the attendance documented for the public meetings to discuss the Oregon Medicaid proposals which was dominated by health care professionals and others with a vested interest in health care (see Office of Technology Assessment. *Evaluation of the Oregon Medicaid Proposal.* Washington, D.C.:U.S. Congress, 1992). A recent study of community preferences for local health care decision-making in Ontario found public meetings to be similarly dominated by those with an interest in the health care system (see Abelson, J. et al. 1995. *Canadian Medical Association Journal* 153:403-12)

unpacking of each concept is required. With respect to participation, a variety of objectives and dimensions may be considered.[8] Acts of participation, for example, may be undertaken for instrumental or expressive purposes. In the case of the former, participation is typically undertaken to achieve a specific objective, often to influence the outcome of a decision-making process. Taking part in a demonstration to exercise a person's rights as a citizen or just for the sake of "being there" are examples of the latter. The act of participating may come in the form of direct involvement in the decision-making process (i.e., direct democracy) or through the provision of input into the process (i.e., consultation). As depicted in accounts of community mobilization in response to proposed hospital closures, participation may be *initiated* by individuals and groups within a community, or *solicited* (through consultation exercises) by decision-making bodies interested in hearing the community's views on a particular matter (i.e., health services restructuring). Although very different in character, each of these activities will be considered in the analysis of "participation". The consideration of participation in fairly broad terms is one aspect of this investigation that departs from other research in the field. Previous studies have tended to define participation in the strictest terms (typically aligned to a single discipline) such as "political participation" (i.e., voting, campaigning, contacting public officials and demonstrating); "organizational membership"; or "mobilization". In this analysis, all aspects of community participation that have an instrumental objective will be considered. Participation, in this study then, will be defined as:

> All activities undertaken by members of the public with the specific objective of influencing the outcome of a public policy decision. Public policy refers to those

[8] Each of these will be discussed in greater detail in subsequent chapters.

> policies that are made by government or quasi-government institutions.[9]

The implication of considering a broad spectrum of participation activities is that this study will consider some aspects of participation such as 'consultation', for example, where others have not. The approach also increases the complexity of the analysis but permits a more realistic exploration of community participation.

The meaning of community, like participation, has preoccupied social scientists for centuries producing vast and discrete literatures and little consensus over its definition (Jewkes and Murcott, 1996). A major point of departure exists, however, between definitions that tie people to a geographic locality as compared to a set of shared needs or characteristics. Still others combine both these aspects in their definitions of community.[10] Although communities may be defined by different sets of shared characteristics such as religion, ethnicity and social class, geography has always been a strong defining characteristic of community in health policy matters. Schlesinger (1997) writes on the subject:

> *In the past, when community has been used in the context of health policy, it has consistently been linked to particular localities, whether embodied as community health centres, as community mental health centres, or as community coalitions for cost containment.* (p. 941).

A geopolitical perspective of community based on geographic, administrative and political units has been adopted in my analysis that also provides the opportunity to examine other dimensions of community (e.g., religion, ethnic, health needs, etc.) within these boundaries. The use of administrative and political units are essential to

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[9] This definition is an adaptation of other definitions used by others in the political participation literature (see Parry, G., Moyser, G. and Day, N. 1992. *Political Participation and Democracy in Britain.* Cambridge: Cambridge University Press.)

defining community in this study since participation is often geared toward local institutions such as health facilities and involves local decision-making bodies that have jurisdiction over health care matters such as district health councils. Although I am primarily interested in the participation of the public within these communities, an understanding of the different potential definitions of the 'public' and 'community' and their respective roles and influences on the participation process is essential. Some of these have been defined elsewhere (Abelson et al, 1995) to include:

- random citizens with no particular interest in the health care system
- interested members of the community
- appointees to a health care decision-making body (e.g. DHC members)
- experts (mainly providers and administrators working in the health care system)
- elected officials

Other concepts of community often referred to in health policy analyses are communities of shared health needs and the health care provider community although the latter would perhaps more appropriately fall into the category of interest group.

The word "consumer" is often used to identify community members who are not employed in or benefit financially from the health care system but who are recipients or potential recipients of health services. It is related to the terms 'public' and 'citizen' but implies a beneficiary relationship between individuals and their health care system. While it is not the preferred term for use in this analysis, it will be employed to the extent that it is used by others to identify a group of participants. In such instances consumer will be defined as "an individual who may receive or is receiving health services. A consumer does not directly or indirectly earn her/his living from the provision of health or health related services." (Association of District Health Councils of Ontario, 1994). Provider will be defined as "an individual who is

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[10] For a detailed discussion of the different meanings of community in the social sciences literature

involved in the management or the provision of a health service, or is a member of a regulated health profession or is/was educated as a professional in health services." (Association of District Health Councils of Ontario, 1994).

The use of the phrase "community participation" also deserves special attention. Within the community development literature, "community participation" is associated with the process of empowering communities to assume greater control over their decision-making processes, whether this occurs in the health field or elsewhere.[11] In the health promotion and education fields more specifically, "community participation" is a basic tenet of World Health Organization policy and programmes. The most widely- referenced statement declaring the centrality of "community participation" to the WHO is the Alma- Ata declaration of September 1978 where the effective participation of the community in policy and planning was considered "indispensible to guarantee the development of health activities and the prevention and control of disease" (World Health Organization, 1978; Green, 1986). While these notions of community participation are not at odds with that of this thesis, my interpretation of the phrase is much broader than that of either WHO policies or health promotion and community development academicians.

Purpose and Objectives of the Study

We are a long way from understanding the circumstances in which individuals and groups attempt to influence the policy process (particularly in the health care field) in their communities. As stated earlier, this study seeks to identify factors that

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and the health literatures more specifically see Jewkes, R. and Murcott, A. 1996. Meanings of Community. *Social Science and Medicine*, 43(4):555-563.

[11] Abbott (1995) discusses the relationship between community participation and community development tracing its history from the 1950s where community development and community participation were considered synonymous to more modern conceptions of community development as a form of participation.

promote and inhibit participation. What are the factors that shape a community's ability to try to influence the outcome of policy decisions? What are the precipitants to community mobilization? What, if anything, is unique about participation and its influences in the health care sector as compared to other policy sectors? How do various social science theories of participation apply to the health care sector?

Overall, it seeks to *observe the participation process in selected communities and to develop an explanatory model of community participation in health care decision-making.* More specific objectives of the research are:

1. To explore the relationship between various community characteristics and participation, to determine whether theories about the influences of community characteristics on local participation can be applied to participation in health care decision-making.

2. To compare the relative importance of community and issue characteristics in influencing the style and magnitude of participation in communities.

3. To assess the "uniqueness" of participation in health care decision-making versus other policy sectors using the field of education as a comparator.

4. To determine the feasibility of collecting participation data at the aggregate- versus the individual-level using secondary data sources in each community.

Numerous theories have been asserted to answer these questions and empirical studies have tested various hypotheses. These are the subject of a literature review in Chatper 2. An analytic framework has been developed to examine the various influences on participation in four Ontario communities. Participation in the health care arena has been chosen as the principal field of study although the field of education will be used as a comparator to assess the uniqueness of participation in health care decision-making. Given the inquiry's primary focus on the health care arena, however, a less comprehensive analysis has been conducted in the education sector.

Education as a Comparator

Education serves as an ideal comparator to health care for a variety of reasons. Easily identifiable local decision-making bodies exist for both health care and education although their responsibilities and governance structures vary considerably.[12] For the purposes of this study, therefore, there are comparable targets for public influence. Both policy sectors are highly professionalized although the number of professional groups is much smaller in education. Although their constituencies differ the general public attaches a high degree of importance to both health care and education and seeks the highest quality in service delivery. This provides a breeding ground for pressure groups seeking to influence policies in both sectors although the types of policies over which influence is sought may differ. Health care and education, therefore, are similar on enough basic characteristics to ensure their strength in comparability while allowing the effects of a few key differences in characteristics to be observed.

With the introduction to the subject matter of this inquiry now complete, let us turn to an examination of the literature on the subject which is the focus of the next chapter.

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[12] The Province of Ontario is divided into 33 health planning districts. District health councils are bodies appointed by the provincial government to plan for the health care needs of their district. When this study began there were 166 elected school boards in Ontario with operational management and resource allocation responsibilities for their jurisdictions. The number and responsibilities of school boards has changed since 1995 and will be discussed separately in Chapter 8.

References to Chapter 1

Abbott, J. (1995). Community Participation and its relationship to Community Development. *Community Development Journal*, 30, 158-68.

Abelson, J., Lomas, J., Eyles, J., Birch, S. and Veenstra, G. (1995). Does the Community Want Devolved Authority? Results of Deliberative Polling in Ontario. *Canadian Medical Association Journal*, 153(4), 403-12.

Adonis, A. and Mulgan, G. (1994). Back to Greece: the scope for direct democracy. *Demos*, 3, 2-9.

Aronson, J. (1993). Giving Consumers a Say in Policy Development: Influencing Policy or Just Being Heard? *Canadian Public Policy*, XIX:4:367-78.

Association of District Health Councils of Ontario. (1994). *Citizen Participation in the Local Planning Process: Broadening the Spectrum.* Toronto: ADHCO.

Bellah, R., Masden, R., Sullivan, W., Swidler, A. and Tipton, S. (1985). *Habits of the Heart.* Berkeley: University of California Press.

Boix, C. and Posner, D. (1996). Making Social Capital Work: A Review of Robert Putnam's *Making Democracy Work: Civic Traditions in Modern Italy.* Working paper No. 96-4, Centre for International Affairs, Harvard University.

Canadian Medical Association. (1993). *The Language of Health System Reform: Report of the Working Group on Regionalization and Decentralization.* Ottawa: Canadian Medical Association.

Coote, A. 1994. Citizen, your country needs you. *The Independent.* November 10. London. 10, p.16.

Etzioni, A. (1993). *The Spirit of Community: Rights, Responsibilities, and the Communitarian Agenda.* Crown Publishers, Inc.

Fishkin, J. (1991). *Democracy and Deliberation.* New Haven: Yale University Press.

Goar, C. 1994. In search of a better way to take the public's pulse. *The Toronto Star.* Februrary 1, p.A17.

Green, L. (1986). The Theory of Participation: A Qualitative Analysis of its Expression in National and International Health Policies. *Advances in Health Education and Promotion*, 1, 211-36.

Hurley, J., Lomas, J. and Bhatia, V. (1994). When tinkering is not enough: provincial reform to manage health-care resources. *Canadian Public Administration*, 37, 490-514.

Jewkes, R. and Murcott, A. (1996). Meanings of Community. *Social Science and Medicine*. 43 (4), 555-63.

Kathlene, L. and Martin, J. (1991). Enhancing Citizen Participation: Panel Designs, Perspectives and Policy Formation, *Journal of Policy Analysis and Management*, 10 (1), 46-63.

Klein taps Albertan expertise. *The Toronto Globe and Mail*. August 25, 1997, p.A6.

Lomas, J., Woods, J. and Veenstra, G. (1997). Devolving authority for health care in Canada's provinces: 1. An introduction to the issues. *Canadian Medical Association Journal*, 156 (3), 371-77.

Lomas, J. (1997). Devolving authority for health care in Canada's provinces: 4. Emerging issues and prospects. *Canadian Medical Association Journal*, 156 (6), 817-23.

McKnight, J. (1990). Mapping community capacity. Evanston, Illinois: Center for Urban Affairs and Policy Research Report, Northwestern University.

Morone, J. (1990). *The Democratic Wish*. United States: Basic Books.

Morone, J. (1997). Enemies of the People: The Moral Dimension to Public Health. *Journal of Health Politics, Policy and Law*, 22 (4), 993-1020.

Ontario plans use of referendums. *The Toronto Globe and Mail.* August 28, 1996, p.A1.

Parry, G., Moyser, G. and Day, N. (1992). *Political Participation and Democracy in Britain*. Cambridge: Cambridge University Press.

Pateman, C. (1970). *Participation and Democratic Theory*. Cambridge: Cambridge University Press.

Putnam, R. (1993). *Making Democracy Work: Civic Traditions in Modern Italy.* Princeton: Princeton University Press.

Rasmussen, K. Institutional Change and Policy Outcomes: District Health Boards in Saskatchewan. Paper presented to the Canadian Political Science Association Annual Meeting, June 2-4, 1996. St. Catharines, Ontario.

Renn, O., Webler, T., Rakel, H., Dienel, P. and Johnson, B. (1993). Public Participation in Decision-Making: A Three-Step Procedure. *Policy Sciences*, 26, 189-214.

Sandel, M. (1996). *Democracy's Discontent: America in Search of a Public Philosophy*. Cambridge, Mass.: Harvard University Press.

Schlesinger, M. (1997). Paradigms Lost: The Persisting Search for Community in U.S. Health Policy. *Journal of Health Politics, Policy and Law*, 22 (4), 937-992.

World Health Organization. (1978). Primary Health Care Report of the International Conference on Primary Care, Alma Ata, USSR. September 6-12. Geneva: Health for All Series, No. 1.

CHAPTER 2

LITERATURE REVIEW

INTRODUCTION

Few concepts in the social sciences literature have received as much attention from as many different disciplines and fields of study as the concept of "participation". Its close association to another favourite subject of social scientists - democracy – undoubtedly explains such widespread interest. As noted in the introductory chapter, the importance of a highly participatory citizenry to successful democracies has been a pervasive theme in Western political thought and the subject of long-standing debate among democratic theorists since the Athenians developed the classic model of direct democracy 2500 years ago.[1]

For many others, participation has little to do with theoretical debates about its role in democratic societies; it represents an intrinsic value which holds the optimistic promise of change and improved decision-making which has led to an abundance of writing on the subject. Finally, it is the elusiveness of a concept like "participation" that has sparked the interest of others still (this author in particular), who have spent much time and energy searching for clarification of the meaning of participation and a greater understanding of the factors that influence it.

Political scientists represent only element one of a large group of social scientists interested in participation. Sociologists have long been concerned with the erosion of participatory community structures in favour of increased centralization

[1] The debate has focussed largely on the merits of representative vs. participatory democracy. For a detailed account of this debate, see Pateman (1970).

and bureaucratic institutions while public administration theorists have placed emphasis on devising optimal bureaucratic decision-making processes which incorporate both elite and lay opinions. Economists have explored the costs and benefits of participation stressing the logical inconsistencies of collective action while psychologists have developed long lists of conditions thought to foster or inhibit the likelihood of an individual taking part in the activities of his or her community. These disciplines have developed the solid foundation on which much of the participation literature rests. Less theoretical contributions to the participation literature have resulted from interest in documenting experiences with participation initiatives in a variety of public policy sectors such as the environment, education and health care. Many of these public participation initiatives were introduced by governments in response to wider social movements dating back to the late 1960s and early 70s such as the women's, consumer and environmental movements. The participation literature has also been characterized by the contributions it has received from scholars, bureaucrats and participants alike who typically fall into one of two camps: the analysts or the advocates of participation.

In the sections below, a critical examination of the literature is presented that addresses the question of what drives public participation. A specific emphasis of the review is to highlight the literature's multi-disciplinary character with the aim of promoting learning across both academic disciplines and fields of study (especially health care and education). Before proceeding with the review, a brief discussion of the meaning of participation is undertaken.

Definitions and Terminology

"Participation" is a concept that most people, whether academic or not, can easily relate to. For many, the word conjures an image of being involved in some

activity, either as an individual or group member, for the purpose of meeting some personal or group objective. Once you scratch the surface, however, participation becomes an ambiguous word raising innumerable questions such as: Participation by whom? Participation for what purpose? Participation in what form? The elusiveness of the word has driven well-intentioned, if overzealous, typologists to unravel its meaning, resulting in even greater confusion on the subject. Participatory activities, for example, have been described by different analysts as "levels", "modes", "types", "forms" and "categories". A more general weakness of the literature, however, has been the lack of precision used in defining terms and the context within which they have been used. Several general statements can be made in summarizing this aspect of the literature:

1. Participation may be initiated for different reasons

Commonly cited purposes for participating are:

a) for the educational or developmental benefit of the citizen.
The importance of citizen participation as a means of self-fulfillment and of carrying out citizen duties was the subject of the writings of Aristotle, Rousseau and J.S. Mill.[2] More recently, these goals have pervaded the community development, health promotion and local government literatures.

b) for the instrumental purpose of achieving a desired policy decision or outcome (out of self-interest or altruism)
Political scientists and public administration scholars have tended to emphasize citizen interests over fulfillment, concerning themselves more with the direct influence on policy decisions.

c) to improve the quality of public policy-making

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[2] See Pateman (1970) for a more detailed discussion.

Public administration and planning literatures emphasize the importance of involving the public in various stages of the decision-making process using a variety of mechanisms such as information provision, citizen surveys, consultation and public meetings.

2. Participation may occur in many different forms

The most widely referenced typology of participation activities is Arnstein's "ladder of participation" (1969). Framing participation in a power-sharing context with "citizen control" at the top of the ladder and "manipulation" at the bottom, Arnstein presents a highly normative description of activities that involve the redistribution of power from those with it to those without.

Political participation has been used primarily by political scientists to capture those activities designed to achieve instrumental objectives. These include voting, the most common form of political activity, and associated activities such as canvassing for a political candidate, attending campaign meetings, contacting political officials regarding an issue of concern; and communal activities designed to solve a local problem (Verba and Nie, 1972). Another illustrative typology makes the distinction between direct (face-to-face) or indirect (non-face-to-face) participation (Richardson, 1983).

3. Participation may occur at different levels

The locus of participatory activity may be demonstrated at a variety of organizational levels ranging from neighbourhoods, municipalities and larger regional governance structures to provincial and national government levels.

4. All Participators are not alike

The notion of who is or should be participating has evolved over time adding some confusion to our understanding of the concept. The Athenians along with modern-day scholars of democracy invariably refer to the "citizen" (with his associated rights and responsibilities) as participant in the political decision-making process. The "public", while often used interchangeably with citizen, is a slightly broader depiction of the citizenry without the obligations often ascribed to citizenship. Community development and health promotion specialists are most comfortable discussing the participation of the "community" and the associated image of people working together to achieve some collective objective. Participation in the health and social services fields has led to the identification a whole new set of participants that includes consumers, users, service recipients, service providers, or stakeholders which combines all of these.

THE INFLUENCES ON PARTICIPATION

With public participation continuing to figure prominently in debates about improving government performance and accountability, and being seen as a popular tool for legitimizing government decision-making, then it is reasonable to ask the question: What influences participation? Attempts to answer this question comprise a large portion of the participation literature and have been undertaken from numerous professional and academic disciplines and fields of study.

Organization of the Literature Review

As would be expected for a multi-disciplinary literature review, multiple databases were used to search the literature (e.g., Social Sciences Index, Social Sciences Citation Index, Medline, Health Administration, Educational Resources

Information Centre (ERIC), Education Index, and Dissertation Abstracts). In the early stages of the review, general search terms such as *community participation*[3], *citizen participation, political participation, public participation* and *community mobilization* were used.[4] These were combined with others such as *local decision-making, health care, education,* and *influences.* As the literature review progressed more specific searches were initiated to obtain references pertaining to selected independent variables. These included terms like community cohesion, interest groups, altruism, issues, and community development. An interesting outcome of this process was that the combination of search terms used became an important determinant of the discipline within which literature was identified.

As the process of reviewing and categorizing the literature unfolded three broad categories emerged providing the basis for organizing the review. Each category included both theoretical and empirical literature pertaining to a different source of influence exerted on participation. The first category includes all literature pertaining to *community* influences on participation; the second category addresses the *institutional* influences on participation; and the third category deals with the influence exerted by *issues and interests* on participation. These sources of influence provide the basic elements of the conceptual model of participation presented in Chapter 3. With respect to the organization of the review, the first section deals with the content of the participation literature and is followed by a separate discussion of methodological approaches.

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[3] The reader should note that a large component of the community participation literature comes from developing countries where community participation is a basic tenet of the World Health Organization's health promotion doctrine (as discussed in the previous chapter). The development literature has been excluded from my review of the literature due to the vastly different institutional and community contexts within which participation occurs in developing countries as compared to the four Ontario communities that are the subject of this study.

COMMUNITY INFLUENCES

The literature reviewed within the category of community influences deals with a variety of community characteristics thought to shape participation. Some of these characteristics are *structural* and pertain to personal and population characteristics such as income and education levels, residential stability and size while others are more *socially* driven such as the extent to which there are easily identifiable values or social networks present in the community.

Structural characteristics

If the participation literature provides us with any consensus at all, it is about who participates. Summarizing accumulated evidence from hundreds of studies of political participation, Milbrath and Goel (1977) state unequivocally that "persons of higher socioeconomic status, especially higher education, are more likely to become highly involved psychologically in politics than persons of lower status" (p. 47). Similar conclusions have been reached in a broader review conducted several years later prompting the authors to state that "there remains agreement that the most active participants are few in number and unrepresentative of the population overall" (Checkoway and Van Til, 1978, p. 28). Studies conducted since then have continued to report similar trends (Parry, Moyser and Day, 1992).

Other characteristics such as age and sex have also been analyzed to determine their relationship to participation activities. Men have been found to participate more than women and participation has been found to peak in the middle ages then taper off during the years of retirement and beyond (Verba and Nie, 1972; Milbrath and Goel, 1977; Parry, Moyser and Day, 1992). Neither of these factors, however, exerts the

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[4] As with the development literature, an explicit decision was made early on to exclude the workplace participation literature in an effort to narrow the scope of the review and to focus only on those literatures of greatest relevance to the subject of the inquiry.

same magnitude of independent influence over participation as do education and income.

Despite the general trends described above, certain characteristics have been found to exert a different influence on voting than on other forms of participation. For example, the influence of education on voting is weak as compared to its influence on other forms of participation. A slightly negative linear relationship was found by Parry et al. (p. 75-76), i.e., those with graduate education report lower voting levels; this is also supported by Verba & Nie and Milbrath & Goel. Reasons for this finding include i) the traditional argument that lower costs of voting mean that minimal resources such as education are required; and ii) those with higher education levels are driven more by issues than by politics therefore voting is not considered as important as other forms of participation. When the influence of age is examined, voting follows the same general pattern of other forms of participation; however, it is more strongly related to age than is any other form of political participation (Verba & Nie, 1972).

Aside from the purely socioeconomic variables, studies of political participation have also found organizational involvement (which commonly involves but is not restricted to political activity) to be a major independent predictor of participation. Dating back to Tocqueville's early observations about Americans' propensity to join clubs and associations, numerous studies since then have confirmed this phenomenon (Tocqueville, 1835; Almond and Verba, 1965; Verba and Nie, 1972). This combination of individual and group resources, when considered together, accounts for the majority of influence on participation (Parry et al, 1992). Labeled the 'standard socioeconomic status model', it is used in the majority of empirical studies of political participation and assumes that participation is

> *primarily driven by individuals' resources (i.e. time, money, skills) and civic orientations ([i.e.] attitudes which individuals hold toward themselves or the political system which predispose them toward political action).*
> (Leighley, 1995, p.183)

While the findings described above provide only general trends about the nature of participation (confined largely to the general political arena) they have served as reference points for participation research in virtually every field of study. Studies in the fields of health care and education, for example, have identified the overrepresentation of well-resourced individuals and groups (Lomas, 1997; Abelson et al, 1995; Office of Technology Assessment, 1992; Salisbury, 1980) spurring participation scholars and practitioners to devise innovative methods for involving "marginalized", "hard-to-reach" and "underrepresented" populations.

The political participation literature has been uniquely successful in its ability to influence researchers across disciplinary and field boundaries through studies of the various individual characteristics that influence participation. This strength may also be seen as a weakness, however, given the narrow definition of political participation employed in these studies and the focus on participation in 'mass politics' rather than sector-specific participation. Leighley (1995) writes on the subject:

> *Hence, in examining individuals' participation as decisions to engage in one political activity rather than another, we might exploit various institutional contexts (e.g., interest group politics, local school politics, party politics) as alternatives to the study of "mass" participatory politics.*
> (p.198)

A greater concern felt toward health care and education issues, for example, may prompt women and the elderly to participate more vigorously in the education and health care fields respectively than in the general political arena. Women with school-aged children would seem to be logical candidates for active participation in the education sector while the elderly, who rely more heavily on the health care

system than other cohorts might feel a more immediate need to influence health care policies.

In reviewing the literature that has addressed the community influences on participation, one is immediately faced with the task of considering the role played by individual-level versus aggregate- or community-level data. As described above, there is a large literature that has found a positive relationship between personal resources such as income and education and participation. But does this well-documented evidence allow us to make the same conclusions at the aggregate-level, i.e., that a community of higher average income and education levels is more participatory than one with lower average levels? This issue will be discussed in greater detail in a subsequent section of the chapter.

Size has also been identified as an important community variable. Aristotle described his affection for smaller democracies that would enhance citizen participation in and control of government:

> *Most persons think that a state in order to be happy ought to be large; but even if they are right, they have no idea what is a large and what is a small state. For they judge the size of the city by the number of the inhabitants; whereas they ought to regard, not their numbers, but their power. ... experience shows that a very populous city can rarely, if ever, be well governed; since all cities which have a reputation for good government have a limit of population. (p.162, 1326a5-15)*
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> *... A state, then, only begins to exist when it has attained a population sufficient for a good life in the political community: it may indeed, if it somewhat exceeds this number, be a greater state. But, as I was saying, there must be a limit. What the limit should be will be easily ascertained by experience. ... if the citizens of a state are to judge and to distribute offices according to merit, then they must know each other's characters; where they do not possess this knowledge, both the election to offices and the decision of lawsuits will go wrong. (p.163, 1326b5-25)*

Dahl and Tufte (1973) identify the optimal size for an effective democracy as somewhere "between a population so small that the polis [can] not be self-sufficient and so large that citizens could no longer know one another's character" (p. 5). While

no conclusive evidence exists to support the "smaller is better" theory (Newton, 1982), there may be reason to believe in an indirect link between size and the community's ability to foster participation. A survey of local government efforts to encourage citizen participation found a significant relationship between the city's overall participation index and city population (i.e., larger cities tended to use more mechanisms to encourage participation than small cities). Government attempts to overcome the "alienation" effect of larger cities and economies of scale that may exist in establishing participation mechanisms in larger cities with larger resource bases to draw from were reasons cited for these findings (Scavo, 1993).

Other structural variables thought to influence participation include the mobility of the population, proportion of home ownership, stage of family lifecycle and the proportion of old housing stock in a community (Haeberle, 1987). These are often identified as structural characteristics that will contribute to the social solidarity or sense of community that exists and that will inevitably influence participation. The links, therefore, between the structural and social characteristics discussed below are evident in much of the research conducted in this area.

Social characteristics

A variety of concepts have been used to describe the influence that social characteristics of communities exert on various forms of participation. These include terms such as *social solidarity, community cohesion, sense of community* and *civic virtue*, all of which describe some aspect of the social context in which participation takes place.

Some of the earliest work on *social solidarity* was conducted by members of the University of Chicago's school of urban sociology who were interested in testing theories about the relationship between the social solidarity of a community and the

propensity for its residents to become members of neighbourhood associations. Social solidarity was believed to result in strong psychological attachments to an area and an awareness of common interests through the informal interactions between neighbours (also referred to as the natural community model). Residential stability and population homogeneity were thought to be necessary elements in the psychological attachment process (Park, 1952; Zorbaugh, 1929).

These theories have been supported, challenged and expanded upon through empirical investigation since the 1920s. Among successful challenges to the social solidarity theory has been the empirically supported argument, related to collective action theory[5] and the free rider problem, that participation may in fact be lower among those who identify most strongly with their community and assume that problems will be dealt with by others in the community. A related argument, also supported by empirical evidence, is that participation will be higher among those who do not identify with their community who are afraid that if they do not take action themselves, then no one else will (Oliver, 1984).

Others have been more concerned with expanding the theory to include consideration of participation in local associations being driven by location-specific socioeconomic interests that will have a direct benefit on their well-being such as threats to property values (Oropesa, 1992). The notion of self-interest[6] playing a role in influencing participation has been acknowledged in earlier work (Zorbaugh, 1929). More recent work by Lee et al (1984), casts doubts on prior studies. Their longitudinal study of neighbourhood associations in Seattle, Washington presents a revised version of the "natural community" theory suggesting that "local social

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[5] Collective action theory and the free rider problem will be discussed in greater detail later on in this chapter (see "Issue and Interest-Related Influences").

[6] This concept will also be discussed further in a subsequent section.

relations may have grown out of, rather than fostered, political actions" (Lee et al, p. 1185).

The notion of residential stability links *social solidarity* with another social characteristic of communities, *community cohesion.* Based on the notion that community cohesion is fostered in neighbourhoods where individuals work and live in together or in close proximity to each other, the theory asserts that high levels of community cohesion will translate into pressures for forms of political participation such as voting. The traditional, working-class community epitomizes this theory and voter participation statistics for the United Kingdom have documented high voter turn out in such communities (Eagles and Erfle, 1989; Parry et al, 1992). The integration into the residential community through long-term residence is considered to be an attribute of community cohesion while socioeconomic homogeneity is considered a pre-requisite for it. Research testing this theory demonstrated a positive relationship between two different measures of community cohesion and voter participation in three British general elections (Eagles and Erfle, 1989).

Still another characteristic related to *social solidarity* and *cohesion* is *sense of community.* Rooted in the community psychology literature of the mid-1970s, sense of community identifies the perceptions that individuals hold about their communities (Sarason, 1974). A definition widely accepted and supported through recent empirical investigation, it includes four elements tied to perceptions of (i) membership or belonging; (ii) influence or mattering; (iii) reinforcement of shared needs; and (iv) shared emotional connection (McMillan and Chavis, 1986). Sense of community scales have been used to measure the relationship between sense of community and common forms of political participation (i.e., voting, campaigning, contacting political officials and communal activities). A self-reported sense of

community was found to exert a positive influence on all forms of self-reported political participation among a group of randomly selected individuals who took part in a telephone survey in a large American city (Davidson and Cotter, 1989).

The notions of *civic virtue*, *community capacity* and *communitarian* ideals are embodied in a social theory that has received much attention in recent years. In critiquing the individualism of liberal doctrine, theorists have turned to a concept of community that is oriented toward shared public life and promoting the common good rather than the pursuit of private interests (Bellah, 1985; Putnam, 1993; Sandel, 1996; Etzioni, 1993)[7]. Morone (1997) writes on the subject:

> *In the past two decades, critics have attacked liberalism for sanctioning rampant individualism and neglecting the common good. Back to Tocqueville and early America went contemporary social theorists. What they were looking for was an alternative foundation for American public life. What they found was the celebration of community. ... The upshot was a communitarian rewriting of the political culture. In this view, Americans are not just individualists but also communitarians, not just celebrants of self, but participants in a shared public life.* (p.996)

Putnam's evaluation of the institutional performance of Italian regional government (based on a 20-year longitudinal study) has been the focus of most of the attention in this area since the publication, in 1993, of *Making Democracy Work: Civic Traditions in Modern Italy*. The central thesis of the book is that government performance is tied to the "vibrancy of associational life" in each region. In areas where there are dense networks of associations, Putnam argues, governments operate more efficiently, creatively and effectively. The explanation for this relationship is based on the presence of "social capital" or "civicness" (as it is referred to in the book) in communities produced by the networks, norms of reciprocity and trust that

[7] Although the literature on this subject has been dominated by American social and political theorists drawing on American history, Canadian scholars have embraced the basic principles of civic engagement and collective decision-making while applying them in the context of Canadian communities.

are fostered between members of community associations through their social interaction and co-operation.

When one considers the relevance of social capital to the study of community participation in health care, it appears that there is some relationship between the two but just what kind of relationship and its direction is not at all clear. The notion of community members possessing a civic virtue exhibited through associational membership and civic participation, for example, overlaps with and is embedded in the concept of political participation. Organizational involvement is both a predictor of political participation and a measure of social capital. The term "civic participation" often refers to citizen participation in politics. In this way then, civic participation, as a measure of social capital is synonymous with political participation. Putnam makes the following distinction between civic participation and political participation:

> *Participation in a civic community is more public-spirited ..., more oriented to shared interests.*
>
> (p. 88)

Barber (1984) describes the relationship differently in his discussion of civil society and political participation. He sees high levels of political participation providing the seeds for civic participation. As citizens engage in political acts, the narrow interests that may have initially motivated them to participate will be gradually overtaken by the pursuit of a common good provided there are genuine arenas for deliberation and the exchange of ideas.

Despite the compelling results and widespread enthusiasm for Putnam's findings, we are at an early stage in our understanding of the relationships between social networks, civic participation and institutional performance. The section above highlighted the uncertainty surrounding conceptual definitions and directional

relationships. In addition, as subsequent chapters will demonstrate, the operationalization of concepts such as associationalism and civic participation is fraught with problems leading one to either marvel at (or be skeptical of) the availability and precision of Italian data for various civicness measures. Finally, the generalizability of Putnam's work beyond Italy to younger countries, like Canada, with less developed social networks deserves careful scrutiny.

The concept of *community capacity* is related to the above, although its currency appears to be restricted to the health promotion and public health arenas. Community capacity is about "building healthy, sustainable or caring communities" through the mobilization of resources to meet the needs of community members and by building networks and associations to bring people together. McNight's work[8] in the United States has driven much of the current fascination with capacity building in Canadian communities. Activities typically associated with capacity building include encouraging philanthropy and voluntarism, fostering partnership across sectors and building networks for social and economic support. Associations are seen as a key element in building successful communities. In this way, community capacity draws heavily on Tocqueville's depictions of American life and the propensity for citizens to join as a model for democracy. Community capacity, like social capital, is seen as a panacea for many of society's ills. This has occurred, despite any empirical evidence to support its theoretical assumptions.

Methodological issues have plagued community studies. Most studies have analyzed relationships at the individual-level using cross-sectional survey data. While these studies often provide useful insights into the influence that certain characteristics have on participation (at the individual level) they do not tell us

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[8] See McKnight, J. and Kretzmann, J. 1990.

anything about whether the same relationship will be found for aggregate-level community characteristics. Indeed, for some social characteristic measures such as sense of community and social solidarity it is unclear whether aggregate-level data could even be collected to examine these relationships. A related problem is the common mismatch found between the level at which aggregate data is collected for participation measures and corresponding community characteristics. This is often due to the lack of available data at common levels of aggregation and results in an inability to observe variations that may occur within a region. Putnam's civicness study illustrates this problem although it is not clear that he attempted to overcome it. Measures of civicness (described as being rooted in the small communes of medieval Italy) were aggregated across large populations despite the almost certain existence of within-region variations in civicness.

Finally, the strong correlation that exists between participation and many of the factors thought to influence it present considerable challenges in identifying the precise relationships between dependent and independent variables under study. The sense of community literature, for example, identifies perceptions such as belonging, self-efficacy, and shared emotional connection as factors likely to influence an individual's decision to participate. These same attributes of "empowerment" are often considered to be those that result from participatory activities themselves, making it difficult to pinpoint precisely where the relationship begins. The same pattern has been found in the social solidarity literature where conflicting evidence exists regarding the nature of the relationship between the development of social networks and the formation of neighbourhood associations to resolve local problems.

INSTITUTIONAL INFLUENCES

If community influences provide the seeds for participation to grow then institutional influences provide a source of nourishment along the way. As citizen participation became fashionable in the 1960s, the actions of governments and administrative agencies of various levels were perceived as important "enablers" of participatory efforts. While advocates of participation welcomed any form of institutional activity designed to encourage participation, analysts of participatory programs soon began to expose the conflicting objectives and unsatisfactory results of many institutional actions.

Actions taken to facilitate participation are numerous and wide-ranging but are typically designed to achieve one or more of the following objectives:

i) to offer actual opportunities for face-to-face participation through the designation of citizen membership on decision-making bodies or the establishment of citizen-run decision-making bodies themselves;

ii) to encourage participation indirectly by reducing the costs involved in participating through information dissemination, offering flexible meeting times and locations with incentives such as covering transportation or parking costs, and comprehensive advertising of various participation methods.

The literature that has examined the influence of enabling factors on participation does not rest on the same theoretical foundations as does the community characteristics literature. In contrast, this literature is more descriptive and focuses almost exclusively on efforts made to involve the public in decision-making and the identification of barriers to its successful achievement.

The fields of health care and education policy as well as local government studies have provided many illustrative accounts of experiences with government-mandated citizen participation programs. A wave of participation initiatives were introduced in the United States beginning in the 1960s with the Community Action

Program (CAP) in 1964 and the Model Cities Program in 1966. Each of these programs were designed to involve citizen participation in local initiatives to meet local needs and both these programs have been heavily criticized for their failure to adequately involve citizens from the outset. Community action programs have been described as merely "restrained exercises in representative democracy" (Berry et al, 1993, p. 34) and case studies of the Model Cities program have concluded that "as organized systems of citizen participation become institutionalized, they tend to become less democratic" (McNamee and Swisher, 1985, p.311).

In 1974, on the heels of the CAP and Model Cities programs, the U.S. government unleashed yet another program to involve citizens, this time in health care decision-making. Aimed at improving the health of local residents, a network of health planning agencies were established throughout the country with responsibility for local health planning and development and were to be governed by majority consumer boards (Checkoway, 1981). Accounts of the Health Systems Agencies' experiences with involving consumers in the planning process are unanimous in reporting the HSAs' failed efforts (Marmor and Morone, 1980; Checkoway, 1981). Citing the lack of guidance provided by the federal government in their definition of consumer and in requirements for board composition, accounts relate the ease with which the medical profession and hospital officials were able to dominate the planning agency activities.

Strikingly similar experiences are described in a comprehensive account of a Canadian province's (Quebec) efforts, between the 1970s and 1990s, to institutionalize community participation within its health and social services system. Reforms implemented in the 1970s included the granting of a minority number of citizen seats on the boards of a number of decision-making bodies. Citing

conclusions drawn from empirical work conducted by others in the area, O'Neill (1992) comments that "consciously or not, citizen participation usually ends up as consolidating the power of professionals or bureaucrats and not as a way to empower the community" (p. 297). More recent reforms of the systems have responded positively to earlier Commission recommendations to "pull the power out of the hands of professionals, bureaucrats, and administrators ... in order to make them accountable to the general public through electoral mechanisms"(p. 296). It remains to be seen what the impact of these institutional actions will be on actual and perceived participation.

Institutional actions designed to promote participation in the field of education have also met with poor results. Results from a study of community organizations' influence on educational policy in three American cities indicate that citizens have little influence on the educational decision-making process (Gittell, 1980). Reasons given for the lack of citizen influence are based on a systematic lack of support or encouragement for citizen participation in major school policy issues. Targets for blame include federal, state and local policies that mandated the creation of community-based service delivery and advisory organizations. These organizations "effectively diffused the energies of independently based and self-initiated citizen organizations" and gave these "new-style organizations ... the most direct access to the system but the least influence on school policy "(p. 242).

The overall picture that has emerged from these experiences is of failed attempts to adequately involve the public in decision-making and consolidation of power into the hands of a few with strong vested interests[9]. Numerous reasons have been cited for these failures including government manipulation of citizen

[9] This subject will be addressed in detail in the section dealing with "Issue and Interest-Related Influences"

participation through mandated participation and the failure of institutional actions to overcome the costs of participation, identified earlier as a major disincentive to participation. Robertson and Minkler (1994) summarize the phenomenon of citizen manipulation by governments in their critical analysis of the health promotion movement:

> *It could be argued that much of current health promotion practice, although using the rhetoric of community participation, in fact operates at these levels when professionals attempt to get people in the community to take ownership of a professionally defined health agenda. ... Community participation in these instances often consists of the professionals convincing the community to take responsibility for and to carry out activities to address these issues, without ever having decided whether these issues are of interest to them.* (p. 305)

The local government studies literature illustrates the case of institutional inability or lack of commitment to reduce the costs of participation. A survey of strategies to encourage citizen participation conducted in over 150 U.S. cities' (all with populations over 100,000) found few exemplary cases of government efforts to reduce obstacles to participation (Scavo, 1993). While all cities reported the use of public hearings to gather input on policies, only 21% of cities reported experimenting with meeting locations outside city hall and less than 10% reported any experience with mechanisms to encourage the public to attend or participate in public meetings. Neighbourhood councils were the most common method reported (60% had them) for involving residents in decision-making although the resources devoted to supporting these councils varied considerably.

Similar results have been found in the health care field with most health planning agencies opting for traditional methods of participation such as community meetings held in public buildings (with little effort to reduce the costs of participation). Survey results demonstrated little variation among planning agencies

in their efforts to induce public participation with most opting for "safe" methods mandated by government (Checkoway, 1982; ADHCO, 1994).

Institutional actions that are considered most frequently in the participation literature are those initiated by government or quasi-government institutions. While its existence as an institution may be worthy of debate, the media constitute a set of actors who have been largely ignored in discussions about the influences on participation. The media plays a major role in disseminating information to the public on a variety of local and national issues. Inadequate information provision is invariably identified as a major deterrent to participation, therefore, it would appear that the media could be used as an enabling force in this area. There are few studies of the relationship between media actions and participation efforts despite consistent themes being reported of an important media role in the journalism literature. A study of nine news organizations' coverage of national issues in the United States found coverage to be inadequate in providing citizens with information about policy issues and how they might get involved (Keefer, 1993). The importance of the media has also been recognized in the health promotion literature where “supportive media” and “media problems" were identified as facilitators and inhibitors respectively for community change to occur (Thompson et al, 1991).

Of course the potential negative impact of the media cannot be overlooked. The media often go beyond the mere provision of information to influence and shape the attitudes of the public. This can have an equal, if not greater, impact on the extent and nature of participation that occurs than the mere provision of information about how to participate.

The widely reported failures of institutional actions to encourage participation have prompted analysts and advocates alike to identify the conditions required for

successful participation. One of the comprehensive attempts to identify critical success factors has been undertaken by Berry et al (1993). Using in-depth surveys and interviews to identify five U.S. cities with the most exemplary participation records, they proceeded to examine these cities to understand the reasons for their success. A common factor identified in all but one city was the establishment of an effective, well-resourced city-wide network of neighbourhood associations that brought issues and concerns raised by neighbourhood residents to the attention of local government. The study considered the socioeconomic characteristics of the cities as a potential influence on participation and found a high degree of variability across cities. Less attention was given, however, to the relationship between the cities' social characteristics such as social solidarity and sense of community and whether these characteristics may have played some complementary role in fostering the social networks that increased their receptivity to government actions.

Efforts to involve the public in decision-making, whether legitimate or not, have been the subject of intense scrutiny from all fields of study, usually with the goal of offering insights into what works and what does not. If any conclusions can be made about this aspect of the literature it is that institutional actions have had consistently poor results in each of the fields covered by this review. What is striking about this body of literature is the absence, with few exceptions, of analysis that considers the possibility that reasons for successive failures may lie beyond simply ensuring that the costs of participation are reduced or that the appropriate mechanisms for participation are in place. Even under ideal conditions, it may be that there are only exceptional circumstances in which citizens may choose to get involved in public affairs. These circumstances are the subject of the next section of the review.

ISSUE AND INTEREST-RELATED INFLUENCES

The third and final category of influence does not lend itself to the same simplicity in labeling as "community" or "institutional" influences. The subject of this section is the influence exerted over participation by the interests of individuals and groups. Notions of power will also be included in this discussion although not explicitly in the context of influence exerted over the political process (i.e., outcomes of participation).

One of the first distinctions to be made in this discussion is between interests and interest groups. In his introduction to a collection of writings on power, Lukes (1986) defines interests as "falling into two categories: a person's 'more ultimate goals and aspirations'; and his interests 'in the necessary means to his more ultimate goals ...'" (p.6). Interest (or pressure) groups are organized to pursue the common interests of their members in influencing government policy. For many groups, the interests pursued are commonly referred to as 'self-interests' typically consisting of two dimensions: one economic and the other relating to the achievement of power or control over people or processes. These self-interested groups are to be contrasted with another set of groups referred to as public interest groups who pursue a set of collective interests (Jordan and Richardson, 1987).

A fundamental perspective on the role of interest groups is that of 'pluralism' based on the supposition that policy formulation occurs as a result of the clash between and weighing of interests held by different groups in society (Truman, 1951; Dahl, 1956). Although initially criticized as antithetical to the democratic process, pluralism was soon regarded as the essence of democracy since individual citizens could, in theory, join any group they wished to advance a particular agenda.

Petracca (1991) cites the 1950s as a turning point in thinking about democratic participation and pluralism:

> *Since the 1950s democratic theory in America has been dominated by a rejection of classical democratic theories on the grounds that they 'were normative and value-laden'. . . . Revisionist theories struggled to minimize the activities and responsibilities of citizens in order to reconcile normative theory with empirical political reality. ... Rational choice theory, with its assumptions of economic man and its minimal expectations for political participation, flourished as a product of democratic revisionism.* (p.308)

Rational choice theory and political participation

A major theme in the interest group literature has been the motives underlying individual and group behaviour. As the preceding passage highlights, the establishment of rational choice theory has shifted our thinking about the motives for participation. Rational choice theorists assert that there are economic, not sociological explanations for political participation. Individuals', as rational, economic beings, participate out of self-interest[10] to maximize their utility, not for the benefit of any greater good.

Despite the important role that it has played in improving our understanding of political participation, rational choice theory has received its share of criticism. Mancur Olson is best known for his seminal analysis of the paradox of participation based on the proposition that rational actors do not participate in collective action in pursuit of common goals. Uncovering the tension that exists between the interests of the individual and those of the group, Olson argues in his classic study *The Logic of Collective Action* (1965), that individual members of large organizations will allow others to accept the associated costs of participation while they reap the benefits. The

[10] The notion of self-interest was first juxtaposed against the more traditional motives of civic virtue by Hobbes and then further reflected in the writings of Locke and Smith who emphasized the importance of pursuing individual interests. Since then, theories of self-interest have greatly influenced thinking in economics and psychology and have stirred much debate over their normative value. See Mansbridge (1990) for a full discussion.

application of his analysis to political participation reveals the following paradox: Why would individual rational actors choose to participate in activities such as voting where they have little or no influence over the outcomes of the decisions? Proponents of rational choice theory have attempted to overcome this paradox by offering various explanations for these contradictory findings. One might argue, for example, that self-interest in maintaining a democratic society would lead one to vote even though the act of voting would not influence the outcome of the election. More severe critics, however, have rejected rational choice arguments outright arguing that "public good cannot be based solely on the motive of self-interest" and that "[h]igher motives are essential for the development and creation of a democratic republic" (Petracca, 306). Others such as Sen (1987) consider other elements in addition to self-interest such as the values of commitment and sense of moral obligation. Phillips (1993) summarizes recent thinking on this issue:

> *Thus, the self is not conceived to be unidimensional, as a bundle of stable and unambiguous preferences that are simply 'followed' according to a single utility function. Rather, most people have a complex set of values, intentions, and demands upon them and, consequently, frequently face an inner tension between conflicting goals and commitments.* (p.614)

Critiques of self-interest theory have been empirically as well as normatively driven. Sears and Funk (1991) examined the empirical evidence on the role of self-interest in forming and maintaining sociopolitical attitudes. After reviewing 25 studies of the effects of self-interest on public opinion, they concluded that self-interest did not explain social and political attitudes. In their conclusions, however, they identified several exceptions to the general rule including the strong influence exerted by self-interest on local issues that threaten the community and the powerful role played by elite interests as compared to the interests of the general public (p.79). To summarize

the critics, then, it is rational choice theory's failure to account for the complexities of human nature and behaviour that have weakened it as an explanatory and predictive model of political participation.

Rational choice supporters loath to abandon the model have adopted various approaches for evading the paradox of participation. Whiteley (1995), in summarizing these approaches, favours the "selective incentives" approach as the most plausible alternative. The selective incentives argument suggests that people participate for the self-interested satisfaction of taking part in a political process and, in keeping with Olson's collective action theory, reap these (in contrast to influencing the outcome of a decision) as benefits of their participation. As Whiteley suggests, however, this argument appears to contradict the empirical findings of studies of high cost participation activities such as political activism which demonstrate expressive and policy concerns as the motivations for participation, not simply an interest in political demonstration.

The discussion above has demonstrated the important role that incentives play in influencing an individual to participate. Although the model's ability to account for these incentives is considered to represent an important improvement over the standard socioeconomic model, the rational choice approach also has its limitations in explaining all aspects of participation. In the context of this study of participation, it is also worth noting that while much of the rational choice literature discusses the underlying motivations for individual behaviour, motivations are not of central concern to this investigation. It is the role that self-interested behaviour plays in shaping participation that is pertinent to this analysis rather than the reasons why each individual chooses to become involved. A further distinction to be made between prior research and the research undertaken in this study is that while much of the

political science literature has dealt with individuals the focus of this study is the community.

Interests, Power and Participation

> *Perhaps the most important long-range task of a theory of community power is to distinguish among communities on the basis of their patterns of decision-making. Such a theory would hopefully provide clues as to the characteristics of communities which are critically significant in determining the kinds of decision-making taking place.* (Polsby, 1963, 138)

Another perspective on the relationship between interests and participation pertinent to this inquiry has its roots in social and political theory. While material or economic dimension of interests dominated discussion in the preceding section, this section deals with the dimension of interests pertaining to power. Lukes (1974) presents a conceptual analysis of power based on three dimensions. The first deals with the notion of power being distributed pluralistically as argued by Dahl, Polsby and Wolfinger in their early pluralist writings.[11] It focuses on "behaviour in the making of decisions on issues over which there is an observable conflict of (subjective) interests, seen as express policy preferences, revealed by political participants" (p.15). The second dimension involves a critique of the pluralist view in its consideration of the ways that decisions are prevented from being taken on potential issues. Bachrach and Baratz are the initiators of this critique which argues that power is not always about making decisions but may also be about agenda-setting: "... power may be, and often is, exercised by confining the scope of decision-

[11] For example, see Dahl, R. 1961. *Who Governs? Democracy and Power in an American City*. New Haven and London: Yale University Press; Polsby, N. 1963. *Community Power and Political Theory*. New Haven and London: Yale University Press.

[12] The professions have been the subject of study by sociologists since the establishment of the modern-day professions in the late 19th and early 20th century. For references to this literature see Carr-Saunders and Wilson (1933); Freidson (1970); and Abbott (1988).

making to relatively "safe" issues" (Lukes quoting Bachrach and Baratz, p.18). In his third dimension, Lukes critiques the preceding views suggesting that power may be exercised "in the absence of actual, observable conflict, which may have been successfully averted" (p. 24) and that there may be "latent conflict which consists in a contradiction between the interests of those exercising power and the real interests of those they exclude" (p.25). Although much has been written on the subject, the salient points to be made about power and its relationship to participation is that it is about controlling the outcome of decisions or the processes through which these decisions are reached (Lukes, 1986). The concern of this thesis is with the latter, not the former.

Polsby's (1963) seminal study of community power, referred to above, is particularly relevant to the study of community-level participation in health care decision-making. Polsby's analysis tested two competing theories of community power: pluralist and social stratification theory. Prior to the writings of pluralist scholars like Polsby, social stratification theory dominated, asserting that the pattern of social stratification was the principal determinant of power in a community and that the pattern of social stratification was based on the domination of a single (upper class) power elite over the lower classes. Pluralist theory challenged these assertions by suggesting that a single group may not dominate, that no assumptions should be made about the pattern of power exhibited in a community and that power may be tied to issues and interests that change over time.

Also pertinent to this analysis is the notion that there are different types of power and power relationships. Of relevance to the study of participation in the health care and education sectors are the concepts of professional and structural

power. Professional power[12] deals with the asymmetry of information that exists due to the possession of expertise in a particular area (i.e. medicine, health planning or education) and structural power is vested in institutions by virtue of their existence. Alford (1975), in his study of the politics of health care, offers a conceptual framework of structural power that contrasts with the traditional pluralist view. He writes:

> *The distinction must be made between the organized action of a group to represent its interests (an 'interest group') and those interests served or not served by the way they 'fit' into the basic logic and principles by which the institutions of a society operate. For want of a better or more conventional term, I shall call the latter structural interests. These are interests which are more than potential interest groups ... Rather, structural interests either do not have to be organized in order to have their interests served or cannot be organized without great difficulty.* (pp.13-14)

Alford classifies these structural interests as either 'dominant', 'challenging' or 'repressed' based on their ability to be served by existing social, economic and political structures. Professional monopolies such as medicine are examples of dominant structural interests whereby the existing institutional structures favour medicine's domination over other groups. Challenging interests are present when institutional structures are in transition, perhaps during major reform for example. Finally, repressed structural interests typically remain 'unserved' within existing institutional structures unless major political mobilization occurs.

Analysts of organizational engagement in political action describe a related phenomenon in terms of concentrated and diffuse interests. Marmor and Morone (1980) provide a thorough analysis of this subject in their study of consumer representation on American health planning boards in the 1970s.[13] Summarizing earlier critiques of pluralism they refer to the propensity for groups engaging in

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political action to form a highly biased sample of affected interests as "imbalanced political markets" (p.127). Imbalanced political markets, they argue, result from the significant costs incurred in organizing for political action so that only those groups with "concentrated interests"[14] (i.e., those groups with the most to gain by organizing or the most to lose by not organizing, are likely to bear the costs of participation). Associated with concentrated interests are the availability of resources and expertise that act to reduce the marginal cost of participation. "Diffuse interests", the category that consumer groups often fall into, can also come together for political action but they tend to be "loosely organized" and "characterized by a grass-roots style of politics" (p.129). Political markets become imbalanced, then, when interests are unequal and resources are disproportionate.

Tuohy and Evans (1984) consider the notion of imbalanced political markets in the Canadian context in their analysis of decentralized health planning in the Province of Ontario. The organizational structure of consumer interest groups, they argue, poses significant obstacles to their ability to exert any influence at the local level:

> *In Canada, to the extent that groups promoting the consumer interests are organized at all, it is ... at the provincial and federal levels, not the local level. As Marmor has pointed out, the marginal cost of political action is greatly reduced where ongoing organizations promote groups interests; hence the marginal cost of mobilizing the consumer interest in Ontario is likely to be greater to the extent that the decision-making process is decentralized. ... Notably, the same cannot be said of provider groups, which, by and large, are organized both provincially and locally -- a difference that contributes to the political imbalance ... noted earlier.* (p. 92)

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[13] The reader may recall that this study was referred to in the previous section on "Enabling Influences"

[14] Although Marmor and Morone (1980) provide one of the more in-depth analyses of this subject, these ideas have been discussed elsewhere and are referred to in their article. For other references on this subject, see Wilson (1973); Schattschneider (1960); and Marmor and Wittman (1976).

Tuohy and Evans identify additional problems in organizing consumer interests. Consumers are easily prone to the free rider problem described earlier due to a less well defined and consistent community of interest. In addition to being diffuse, health care consumer interests were also described as "fragmented" into "benefit-receiving" and "cost-bearing" components. This fragmentation highlights a tension between the interests of consumers as residents of local communities and actual or potential service recipients (i.e., benefit receiving) and the interests of consumers as provincial taxpayers (i.e., cost bearing):

> *As benefit receivers, people may press for more health care resources available to them locally. It is as provincial taxpayers that they have an interest in getting 'more bang for the buck'.* (p. 103)

Issues, Interests and Participation

As discussed in previous sections, interest in explaining individual voting behaviour has been a major preoccupation of political participation researchers but the participation literature also has much to offer by way of analysis of other forms of participation, among these, issue-oriented participation. While interests play a key role in motivating participation, it is their relationship to specific issues that appears to exert a particular type of influence over the participation process. Land use, abortion and environmental concerns are examples of issues that mobilize individuals and communities to participate.

The community of limited liability theory[15] epitomizes the notion of issues providing the impetus for participation. Although rooted in urban sociology theory, it

[15] The community of limited liability theory developed as a critical response to the natural area theory proposed by Robert Park, one of the founders of the Chicago School of Urban Sociology, which emphasized the natural area as a source of social integration and solidarity which fostered involvement in local affairs. The community of limited liability, espoused by Janowitz (1967) and Greer (1962), in contrast, claimed that the establishment of social ties through voluntary associations served only as a functional vehicle for pursuing common interests. For a more detailed discussion of both theories, see Guest, A. 1984. "Robert Park and the Natural Area: A Sentimental Review". *Sociology and Social Research*, 69:1-21.

resonates with political science theories of interest groups and collective action. Embedded in any discussion of what precipitates participation is the link that exists between the issue and the interests held by an individual or group. Carrying the argument further, an issue will only spur groups into action when the interests of a group are served by doing so. One is able to predict, therefore, based on the characteristics of an issue what interest groups will have an interest in responding through mobilization. The fact that the limited liability theory has been referred to as "a problem encountered in the study of neighbourhood participation" (Cook, 1983, p.463) is a testament to its importance as an alternative and direct competitor to the social network theories described earlier.[16] First described by Janowitz (1952) and elaborated upon by Hunter and Suttles (1972), the theory is based on the notion of communities operating as political rather than social units. Lee et al (1984) describe the theory's basic suppositions:

> *Proponents of the limited-community model contend that when a household's own interests or stakes are secure, little motivation exists for devoting time to neighbourhood affairs. Only when one or more of these interests are threatened will residents become involved actively, and even then the unaffected segments of the local population are likely to remain aloof.* (p.1163)

There have been few studies which have attempted to test this theory directly although the descriptive literature is replete with examples of narrowly-defined issues that have led to concentrated participation efforts (Henig, 1982; Hutcheson and Prather, 1988; Massey, 1994). The NIMBY phenomenon is the classic example of community mobilization in response to direct threats to property values and public safety. As described in Kraft and Clary (1990):

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[16] Citing the discovery of an alternative theory as "a problem" also illustrates the normative perspective often adopted in this type of research.

> *NIMBY refers to intense, sometimes emotional, and often adamant local opposition to siting proposals that residents believe will result in adverse impacts. Project costs and risks, such as effects on human health, environmental quality, or property values, are geographically concentrated while the benefits accrue to a larger, more dispersed population.* (p. 300)

The longitudinal study of an American city's neighbourhood associations represents one the most compelling accounts of the role that issues have played in mobilizing activity (Lee et al, 1984). In setting out to test the accuracy of the theory of transition from the natural to the limited community, not only was the presence of the modern-day limited community confirmed but it was suggested that elements of the limited community may have been present all along and that the natural community theory required revision (see discussion in earlier section). Support for this finding can be traced back to some of the earliest neighbourhood studies. Documenting the experiences of a community council in a deprived area of Chicago, Zorbaugh (1929) accounted for the failed attempts at community organization:

> *It demonstrates beyond the shadow of doubt the impossibility of converting local areas of the city into 'villages' with the neighbourliness, face-to-face contacts, and emotional attitudes of the village a generation ago ..... The only issue that can bring out a ... gathering is an issue affecting property values ... and these issues bring out only people from the Gold Coast*
>
> (p. 216)

Analysts of community mobilization have examined the conditions required for neighbourhood mobilization. Henig (1982) presents one of the more comprehensive analyses of the relationship between the type of issue or 'condition' presented and behaviour likely to result. He describes seven characteristics thought to increase awareness and promote action (pp.60-61):

- visibility (influences awareness)
- suddenness (an abrupt change can be perceived and responded to more readily)
- geographic specificity (geographically specific threats mobilize more intense action)
- clarity of responsibility (importance of a clear target for action)

- complexity (complexity of issue will deter mobilization)
- veto-ability (i.e. easier to rally opposition against to block an impending threat than to organise around long-standing conditions that require positive action)
- institutionalized procedures (mobilization is facilitated through clear channels of communication)

Studies documenting the absence of "positive participation" by supporters of a proposal demonstrate the converse argument to Henig's 'veto-ability' characteristic. In a study of political participation in the U.S. health care reform debate, for example, Brodie found that Liberal *supporters* of the Clinton administration's health care reform proposals stayed out of the debate while Conservative *opponents* of the proposals were actively involved. The absence of the elderly from the debate was also striking because, although considered friendly to the proposals, they had no stake in the outcome since little would have changed for them (Brodie, 1996).

Attempts have also been made in the literature to assess the independent influences of issue-specific and community structure variables (e.g., income, education) on community mobilization. Bridgeland and Sofranco (1975), in a study of community mobilization around environmental quality hypothesized that community mobilization was a function of community resources (i.e. structural features) and issue characteristics. Although findings failed to support the primacy of one set of variables over the other, the study raised the question of the direction of the relationship, in particular, whether incidents themselves produce mobilization or a mobilized citizenry generated incidents.

The notion of issues and the threat they may pose to a group of citizens acting as an influence on participation has significant intuitive appeal. As discussed earlier, much has been written about the significant and immediate costs incurred by participants with benefits rarely being realized, if at all, until well into the future (Kweit and Kweit, 1981; Bryden, 1982; DeSario and Langton, 1987; Parry et al,

1992). It would seem highly plausible, then, that individuals would only decide to participate when they might be seriously affected by the outcome of a decision. As discussed earlier, however, Olson's collective action theory suggests that another pattern of behaviour is more likely to emerge. Within the context of a group of people sharing a common interest in a collective good, Olson argues, the group will be prevented from achieving that good because each member has a greater incentive for inaction (i.e. to wait for someone else to procure the good). This logic is applied to large groups only as Olson argues that smaller groups, subjected to personal interactions, will overcome the free rider problem. The relevance of Olson's theory to this discussion is that it provides insights into the behaviour expected of groups with shared interests seeking to achieve a common goal. Following Olson's argument, larger groups may have more difficulty achieving their collective good than smaller groups. With respect to the issues that mobilize collective action, one could argue that the behaviour expected might depend on the nature of the collective good.

Participation for the purposes of resource procurement can also be a strong community mobilizer. This has been demonstrated in the health care domain in a case study of an Australian community's campaign to raise funds to purchase radiotherapy equipment (Short, 1989). Alford's structural interests framework (discussed in the preceding section) is used to analyze the role played by three separate interest groups. The first group, the 'professional monopolists', represent the dominant interests of the medical profession's monopoly over health care. 'Corporate rationalizers' represent the second group and their interests lie with the achievement of efficiency and effectiveness within the health care system and thus represent the challenging interests. Finally, the 'community' represents the third group whose interests in pursuing improved health for the population, for example, are referred to as repressed

structural interests. The important role played by structural interests was highlighted in Short's study which demonstrated the influence of the medical community in convincing the public of its "need" for additional resources.

A DISCUSSION OF METHODS USED IN PARTICIPATION STUDIES

The preceding sections have reviewed studies analyzing the relationships between participation and numerous independent variables thought to influence its magnitude or form as well as studies concerned with disentangling the more complex aspects of the participation process. In this section the methods employed in these studies will be reviewed emphasizing their strengths and limitations with a view to informing the methodological approach that will be described in Chapter 4.

The collection of primary data using survey or interview methods characterizes much of the literature described above while a smaller number of studies used secondary data often previously collected by an organization for administrative or evaluative purposes. In a few cases, researchers have employed a combination of methods including broad-based and in-depth surveys and interviews, in addition to the analysis of secondary data for both a sampling of the population and in the context of selected case studies. In general, study methods also tend to fall within the categories of individual- or aggregate-level analyses. Population surveys such as those undertaken by Verba & Nie (1972) and Parry et al (1992) were the most common method used to analyze individual-level participation while a combination of primary and secondary data collection and analysis were used in aggregate-level studies such as Haeberle's study of neighbourhood identity and citizen participation (1987). Studies of voting behaviour illustrate the characteristics of each method. Individual-level analyses of voting behaviour involve surveys of a sample of individual voters to identify their self-reported behaviour. Using this type of analysis, self-reported voting

behaviour can be linked to demographic or socioeconomic characteristics. In contrast, aggregate-level studies focus on the actual voting behaviour of the population using electoral data. While aggregate-level studies do not allow relationships between personal characteristics and individual voting behaviour to be explored, they do allow for the analysis of relationships between aggregate community characteristics and aggregate voting behaviour. These types of analyses (i.e. aggregate) are also dependent on the availability of aggregate data for the variables under study.

Drawing conclusions from research conducted using different methods driven by different research questions is complicated even further by the diversity of measures used. As discussed earlier in the chapter, different conceptualisations of participation have led to researchers' interest in analysing different participation data. The lack of consensus on the definition of independent variable measures such as "sense of community" have also presented challenges in comparing study results.

Table 2-1 presents a categorization of the participation measures used in the empirical studies reviewed in this chapter. The majority of studies fall into the broad participation categories of organizational activity and political action. Urban sociologists have contributed most of the studies of organizational activity while a range of disciplines including political science, sociology and community psychology have been interested in the influences on political action defined by a number of activities.

Table 2-1

Categorization of Participation Measures used in Empirical Studies

Study	*Voting*	*Contacting*[17]	*Organizational activity*[18]	*Political action*[19]	*Institutionally-initiated participation*[20]
Checkoway (1982)					X
Cook (1983)				X	
Davidson & Cotter (1989)				X	
Eagles & Erfle (1987)	X				
Gittell (1980)			X		
Guest & Oropesa (1986)				X	
Haeberle (1987)			X		
Henig (1982)				X	
Hunter & Staggenborg (1986)				X	
Hutcheson & Prather (1988)				X	
Kathlene & Martin (1991)					X
Lee et al (1984)			X		
Oliver (1984)			X		
Oropesa (1992)			X		
Parry et al (1992)			X	X	
Putnam (1993)			X	X	
Renn et al (1993)					X
Salisbury (1980)			X	X	
Scavo (1993)					X
Sharp (1982)		X			
Short (1989)				X	X
Thomas (1982)		X			
Vedlitz, Dyer & Durand (1980)		X			
Vedlitz & Veblen (1980)	X	X			
Verba & Nie (1972)			X	X	
Wandersman & Gianmartino (1980)			X		
Wandersman et al (1987)			X		
Zorbaugh (1929)			X		

[17] Refers to contacts made by members of the public with government officials by telephone or through face-to-face meetings

[18] Refers primarily to membership in local organizations although some studies have distinguished between membership, active and token participation

[19] Refers to some combination of activities which may include any or all of: letter-writing, meeting with public officials, petitions, campaigning, attending a public meeting, demonstrating, meeting informally with neighbours or active involvement in an organization

[20] Refers to opportunities provided by institutions for citizen participation such as committee membership, public meetings, citizen surveys and information provision

Various methodological problems encountered in participation studies have also placed limitations on the conclusions that can be drawn from the literature. Early studies that examined only one dimension of participation, such as voting, are notable examples. More recent research, spurred by the work of Verba and Nie, has acknowledged the multi-dimensional nature of participation and developed more comprehensive measures.[21] These studies are also limited, however, in their emphasis on the presence or absence of a participation measure with little consideration given to the degree of intensity of participation or the conditions under which one form of participation might be selected over another. For example, surveys demonstrating that a certain proportion of the population chose to write letters to their local politician over the past year (e.g., Verba & Nie, 1972; Sharp, 1982; Vedlitz & Veblen, 1980) provide some baseline information about the population's participatory activities, but they tell us nothing about the context in which the letter writing took place, what factors led to the decisions to write the letters and whether the same number of people would write letters again over the next year. This is not a criticism of the cross-sectional survey method but an indication of its limitations. What is absent from these studies is the observation of participation over time.

Leighley's (1995) field essay on political participation supports this view. In her overview of the major theoretical models and empirical findings of the literature she identifies the strengths and weaknesses of various models as predictors of participation

[21] Studies listed under the political action category in Table 2-1 exemplify the use of multi-dimensional measures of participation. Political action, as defined in the footnote to the table, may represent a combination of participatory acts such as letter-writing, contacting public officials, attending public meetings, etc.

and concludes that more attention needs to be given to identifying the relative importance of each model as a predictor rather than trying to prove or disprove one theory in favour of another. Calling for future studies to improve our understanding of the complexity of participation she refers to similar observations made more than 20 years ago by Salisbury (1975, p.336):

> *The focus has too often been simply on whether there was more or less participation. It must instead be directed toward what kinds of actions, in what institutional contexts, over what periods of time, with what kinds of objectives, and with what constraints in the environment* (emphasis added).

Those studies that have succeeded in providing more contextual detail about the factors influencing participation, however, are often criticized for their lack of generalizability beyond the case studied (e.g., single participation programme, participation in a single neighbourhood) and for their inability to separate the independent effects of different influences on the participation process.

The complex nature of participation also presents methodological challenges to the quantitative analyst seeking to establish the relationships between participation (however defined) and its influences. Few researchers, if any, have been successful in establishing causation but a more significant challenge to overcome has been the establishment of the direction of the relationship since participation is so strongly correlated with many of the factors thought to influence it. A classic example of this problem is the long-standing debate over the direction of the relationship between social networks and participation in neighbourhood associations. Does the presence of social networks lead to participation in neighbourhood associations, does participation in neighbourhood associations provide the catalyst for the establishment of social networks

or is there a third factor that simultaneously "causes" both? Short of a longitudinal study, we may never know the answer to this question and it may be a different one depending on the type of community one is examining. The point to be made is that these dilemmas are not recognized often enough in the empirical literature on participation and, whenever possible, efforts should be made to untangle the relationships between independent and dependent variables.

Conducting Aggregate-Level Participation Studies

Some of the more specific methodological problems encountered in participation studies are those encountered in conducting aggregate-level analyses.[22] Despite the merits of individual-level participation analyses cited earlier, they fall short in providing insights into the factors that influence participation at the community level (the subject of this inquiry). In contrast, aggregate studies allow for the relationships between participation and community characteristics such as size, residential stability and the proximity of a community to large urban centres to be explored. As discussed earlier in this chapter, however, the number and quality of these studies have been severely limited by the lack of aggregate participation data. With the exception of voting data which is only a one-dimensional measure of participation, very little participation data is collected at the aggregate level and, if collected at all, it is done so unsystematically.[23]

Government institutions are the organizations most likely to collect data for measures such as contacts with public officials, letters and petitions. Lack of consistent

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[22] Similar problems have been encountered by health economists in conducting economic evaluations of community-level health promotion programmes. Shiell and Hawe (1996) discuss the limitations of applying individual-based microeconomic methods to the evaluation of community development programmes where empowerment and collective health are identifies as successful outcomes.

[23] This finding is supported by the review of empirical studies in the earlier sections of this chapter.

recording methods among these organizations presents challenges in using this data. In contrast, the task of collecting aggregate data for community characteristics of interest is made much simpler with the aid of census data.

In general, the absence of readily available 'hard' quantitative data for multiple participation measures and the variables thought to influence participation necessitates the use of more innovative and flexible approaches to conduct studies in this area. One such approach is to devise methods for collecting 'soft' quantitative data based on the identification of 'proxy' indicators for variables under study. A prime example of this approach is in the measurement of concepts described earlier as "sense of community", "community cohesiveness" or "civicness". In the absence of clear and easily measurable definitions, several indicators have been identified as proxy measures. Residential stability is a common proxy for community cohesion and sense of community while the civic community has been identified using proxies such as newspaper readership and organizational density. Participation measures may also require the use of proxy indicators. Measuring the mobilization of a community over an issue, for example, may necessitate the use of interviews with key informants in the community who are knowledgeable in the area being studied in addition to the monitoring of newspaper coverage of the issue and associated events[24].

A second formidable problem in conducting aggregate-level studies is the mismatch that commonly exists between the level at which participation data is collected (if collected at all) and the level at which community characteristic data are collected. This mismatch of data collection levels often results in the selection of a larger unit of

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[24] A more detailed discussion of proxy measures is presented in chapter 4.

analysis than desired and the inability to observe variations within geographic boundaries. As discussed in an earlier section, Putnam's study of Italian regional government illustrates this problem. Measures of civicness were aggregated for populations of several hundred thousand people without considering the variations that might exist within these large regions.

CONCLUSIONS

This chapter has reviewed the relevant academic literature concerning participation and its contextual influences. Numerous theories, from a variety of disciplines, have been applied to the study of this phenomenon. Those considered of greatest relevance to this review include social network theories, drawn largely from the sociological literature, which include the concepts of "social solidarity", "community cohesion" and "civic virtue". A converse theory to that of social solidarity (rooted in the natural community theory) is the community of limited liability theory. Related to these but of a distinct theoretical nature is the construct of "sense of community" derived from the social and community psychology literatures. Collective action (or rational choice) and theories of interests and interest groups are also highly relevant to an analysis of the contextual influences on participation. With such a wide range of theories to choose from, it is not surprising that the literature is both vast and inconclusive. There are several areas for which the literature provides either compelling evidence or a body of knowledge that all points in the same direction:

1. Personal resources such as income and education have a significant influence over individual decisions to participate, especially in political activities

2. Residential stability appears to be a structural characteristic of communities that positively influences social networks. These networks are, in turn, associated with neighbourhood-level participation.

3. The presence of social networks in communities is associated with instrumental participation although there is uncertainty about the precise nature and direction of this relationship.

4. Issue-linked interests (whether individual or communal) play an important role in influencing and precipitating participation.

Unanswered Questions

There are many unanswered questions remaining from this review. Those of particular relevance to the focus of this study are discussed below.

What is the nature of the relationships between different influences on participation and the nature and intensity of participation?

Despite detailed analyses of the relationship between personal characteristics and various forms of political participation, we know very little about which forms of participation will be influenced by the presence or absence of different influences on participation (e.g., community, institutional and issue) in a given community. The only study that attempted to relate some of these issues examined the relationship between different types participation and individual characteristics in a community threatened by a proposed hazardous waste treatment plant. Results demonstrated that forms of participation requiring only minimal commitment of time and resources were found to be a function of emotional attachment to the neighbourhood whereas more intense participation was found to be a function of the residents' resources and financial investment in the neighbourhood (Cook, 1983). More studies, such as the one undertaken here, are needed to disentangle the complexity of participation.

What are the relationships between individual- and aggregate-level analyses?

This methodological issue has been referred to several times throughout the chapter. Most participation studies collect individual-level survey data and are unable to account for aggregate-level community characteristics in their analyses. As a result, there is much less information about the way in which structural or social characteristics of communities influence participation or about the links that may exist between individual-level and community-level characteristics. Sampson (1991) describes the limitations of community studies to date which have relied almost exclusively on the individual as the unit of analysis and the limitations of using aggregate-level census data which may not include adequate measures of theoretical interest. Advocating the need for greater emphasis on community-level measures and more studies which link individual- and aggregate-level data Sampson presents and tests a model for bridging this gap in a study of social bonds and community cohesion. The need for richer sources of community-level data on characteristics, however, addresses only one side of the equation. Equal emphasis should be given to identifying sources of community-level participation data that can be used in longitudinal participation studies of which there are only a few scattered in the literature. Richer sources of aggregate-level data would reduce reliance on less robust individual-level analyses conducted with cross-sectional survey data.

What is the relevance of theories of participation for participation in specific institutional contexts such as health care and education?

With a few exceptions, participation studies in the fields of health care and education have been restricted to analyses of efforts to increase consumer and parent involvement in decision-making respectively. The assessment of institutional actions' ability to facilitate or "enable" participation have provided valuable insights into the role played by dominant, powerful interest groups, especially in health care. A major

weakness of these studies, however, has been the absence of any underlying theoretical or conceptual frameworks for analysis.[25] As a result, we know very little about the applicability or relevance of theories such as the standard socioeconomic model, rational choice or social capital theories to specific institutional contexts such as health care or education. Furthermore, participation studies have tended to fall into one of two categories. They have either been general studies of participation (e.g., national surveys of mass participation or studies of citizen participation in local "affairs") or studies confined to a particular policy area (e.g., environment, health planning, education). Not a single comparative analysis of participation in more than one institutional context was found thus identifying a significant hole to be filled by this study.

SUMMARY

The literature reviewed in this chapter has been drawn from various disciplines and fields of study to distil a broad base of knowledge on the subject of what influences participation. Despite a vast literature, rich in theoretical and empirical research, our understanding of the complexity of participation and its contextual influences (both geographic and policy-specific) remains superficial. In chapter 3, an analytic model is developed that builds on the literature reviewed in this chapter and portrays the multiple influences on participation. This is followed by a research strategy presented in Chapter 4 that accounts for the diversity of prior participation research, the research gaps identified in this chapter, and the strengths and weaknesses of methods employed in prior studies.

[25] Alford's (1975) structural interest analysis in the health care domain and Salisbury's (1980) analysis of citizen participation in the public school system are notable exceptions to this rule.

References to Chapter 2

Abbott, A. (1988). *The System of Professions*. Chicago: University of Chicago Press.

Abelson, J., Lomas, J., Eyles, J., Birch, S. and Veenstra, G. (1995). Does the Community Want Devolved Authority? Results of Deliberative Polling in Ontario. *Canadian Medical Association Journal*, 153(4), 403-12.

Alford, R. (1975). *Health Care Politics: Ideological and Interest Group Barriers to Reform*. Chicago: University of Chicago Press.

Almond, G.A. and Verba, S. (1965). *The Civic Culture: Political attitudes and democarcy in 5 nations*. Boston: Little Brown & Co. 379 pp.

Aristotle. (1988). *The Politics*. Edited by S. Everson. Cambridge: Cambridge University Press.

Arnstein, S. (1969). A Ladder of Citizen Participation. *Journal of the American Institute of Planners*. 35, 216-24.

Association of District Health Councils of Ontario. (1994). *Citizen Participation in the Local Planning Process: Broadening the Spectrum*. Toronto: ADHCO.

Bachrach, K. and Zautra, A. (1985). Coping with a Community Stressor: The Threat of a Hazardous Waste Facility. *Journal of Health and Social Behaviour*, 26, 127-41.

Barber, B. (1984). *Strong Democracy*. Berkeley: University of California Press.

Bellah, R., Masden, R., Sullivan, W., Swidler, A. and Tipton, S. (1985). *Habits of the Heart*. Berkeley: University of California Press.

Berry, J., Portney, K. and Thomson, K. (1993). *The Rebirth of Urban Democracy*. Washington: Brookings Institution.

Bridgeland, W. and Sofranko, A. (1975). Community Structure and Issue-Specific Influences: Community Mobilization over Environmental Quality. *Urban Affairs Quarterly*, 11, 186-214.

Brodie, M. (1996). Americans' Political Participation in the 1993-94 National Health Care Reform Debate. *Journal of Health Politics, Policy and Law*, 21, 99-128.

Bryden, K. (1982). Public input into policy-making and administration: the present situation and some requirements for the future. *Canadian Public Administration*, 25, 81-107.

Carr-Saunders, A.M. and Wilson, P.A. (1933). *The Professions.* Oxford: Clarendon Press.

Checkoway, B. and Van Til, J. (1978). What do we know about Citizen Participation? In: *Citizen Participation in America* (S. Langton, ed.), pp. 25-42. Lexington: Lexington Books.

Checkoway, B. (1981). Innovative Citizen Participation in Health Planning Agencies. In: *Citizens and Health Care.* Elmsford, New York: Pergamon Press, pp. 118-138.

Checkoway, B. and Doyle, M. (1980). Community Organizing Lessons for Health Care Consumers, *Journal of Health Politics, Policy and Law*, 5 (2), 13-26.

Checkoway, B. (1982). Public Participation in Health Planning Agencies: Promise and Practice, *Journal of Health Politics, Policy and Law*, 7 (3), 723-33.

Cook, J. (1983). Citizen Response in a Neighborhood Under Threat. *American Journal of Community Psychology*, 11, 459-71.

Dahl, R. (1956). *A Preface to Democratic Theory.* Chicago, Ill.: University of Chicago Press.

Dahl, R. (1961). *Who Governs? Democracy and Power in an American City.* New Haven and London: Yale University Press.

Dahl, R. and Tufte, E. (1973). *Size and Democracy.* Stanford, California: Stanford University Press.

Davidson, W. and Cotter, P. (1989). Sense of Community and Political Participation. *Journal of Community Psychology*, 17, 119-25.

DeSario, J. and Langton, S. eds. (1987). *Citizen Participation in Public Decision-Making.* New York: Greenwood Press.

de Tocqueville, A. (1839). *Democracy in America*

Eagles, M. and Erfle, S. (1989). Community Cohesion and Voter Turnout in English Parliamentary Constitutencies, *British Journal of Political Science*, 19, 115-25.

Etzioni, A. (1993). *The Spirit of Community: Rights, Responsibilities, and the Communitarian Agenda.* Crown Publishers, Inc.

Freidson, E. (1970). *Profession of Medicine: A Study of the Sociology of Applied Knowledge.* New York: Dodd & Mead.

Gittell, M. (1980). Limits to Citizen Participation: The Decline of Community Organization. Beverly Hills, California: Sage.

Guest, A. (1984). Robert Park and the Natural Area: A Sentimental Review. *Sociology and Social Research*, 69, 1-21.

Haeberle, S. (1987). Neighborhood Identity and Citizen Participation. *Administration and Society*, Vol. 19, No. 2, 178-96.

Henig, J.R. (1982). *Neighborhood Mobilization.* New Brunswick, New Jersey: Rutgers University Press.

Hunter, A. and Suttles, G. (1972). The Expanding Community of Limited Liability, pp.44-81. In: *The Social Construction of Communities.* Chicago: University of Chicago Press.

Hutcheson, J. and Prather, J. (1988). Community Mobilization and Participation in the Zoning Process. *Urban Affairs Quarterly*, 23 (3), 346-68.

Janowitz, M. (1967). *The Community Press in an Urban Setting: The Social Elements of Urbanism.* Chicago: University of Chicago Press.

Jordan, A.G. and Richardson, J.J. (1987). *Government and Pressure Groups in Britain.* Oxford: Clarendon Press.

Keefer, J. (1993). The News Media's Failure to Facilitate Citizen Participation in the Congressional Policy-Making Process, *Journalism Quarterly*, 70 (2), 412-24.

Kraft, M. and Clary, B. (1990). Citizen Participation and the NIMBY Syndrome: Public Response to Radioactive Waste Disposal. *The Western Political Quarterly*, 299-328.

Kweit, M. and Kweit, R. (1981). *Implementing Citizen Participation in a Bureaucratic Society.* New York: Praeger Publishers.

Lee, B., Oropesa, R., Metch, B., Guest, A. (1984). Testing the Decline-of-Community Thesis: Neighborhood Organizations in Seattle, 1929 and 1979. *American Journal of Sociology*, 90 (5), 1161-88.

Leighley, J. (1995). Attitudes, Opportunities and Incentives: A Field Essay on Political Participation. *Political Research Quarterly*, 48, 181-209.

Lomas, J. (1997). Devolving authority for health care in Canada's provinces: 4. Emerging issues and prospects. *Canadian Medical Association Journal*, 156 (6), 817-23.

Lukes, S. (1974). The one-dimensional view. The two-dimensional view. The three-dimensional view. (Chapters 2-4). In: *Power: A Radical View.* Oxford: Macmillan, pp.11-25.

Lukes, S. (1986). Introduction. Chapter 1. In: *Power*. New York: New York University Press.

Mansbridge, J. (1990). *Beyond Self-Interest.* Chicago: University of Chicago Press.

Marmor, T. and Morone, J. (1980). Representing Consumer Interests: Imbalanced Markets, Health Planning and the HSAs, *Milbank Memorial Fund Quarterly/Health and Society*, 58(1), 125-165.

Marmor, T. and Wittman, D. (1976). Politics of Medical Inflation. *Journal of Health Politics, Policy and Law*, 1 (Spring), 69-83.

Massey, I. (1994). Impediments to Collective Action in a Small Community. *Politics and Society*, 22(3), 421-34.

McKnight, J. (1990). Mapping community capacity. Evanston, Illinois: Center for Urban Affairs and Policy Research Report, Northwestern University.

McMillan, D. and Chavis, D. (1986). Sense of Community: A Definition and Theory. *Journal of Community Psychology*, 14, 6-23.

McNamee, S. and Swisher, K. (1985). Neighborhood Decentralization and Organized Citizen Participation, *Sociological Focus* 18, 4, 301-12.

Milbrath, L. and Goel, M. (1977). *Political Participation.* Chicago: Rand McNally Publishing Company.

Morone, J. (1997). Enemies of the People: The Moral Dimension to Public Health. *Journal of Health Politics, Policy and Law*, 22 (4), 993-1020.

Newton, K. (1982). Is Small Really so Beautiful? Is Big Really so Ugly? Size, Effectiveness, and Democracy in Local Government. *Political Studies*, 30 (2), 190-206.

Office of Technology Assessment. (1992). Evaluation of the Oregon Medicaid Proposal. Washington: United State Congress.

Oliver, P. (1984). If you don't do it, nobody else will: Active and Token Contributors to Local Collective Action. *American Sociological Review*, 49, 601-10.

Olson, M. (1965). *The Logic of Collective Action.* London: Oxford University Press.

O'Neill, M. (1992). Community Participation in Quebec's Health System: A Strategy to Curtail Community Empowerment? *International Journal of Health Services*, 22 (2), 287-301.

Oropesa, R. (1992). Social Structure, Social Solidarity and Involvement in Neighborhood Improvement Associations. *Sociological Inquiry*, 62, 107-18.

Oropesa, R. (1992). Social Structure, Social Solidarity and Involvement in Neighborhood Improvement Associations. *Sociological Inquiry*, 62, 107-18.

Park, R. (1952). *Human Communities: The City and Human Ecology*. Glencoe, Ill.: Free Press.

Parry, G., Moyser, G. and Day, N. (1992). *Political Participation and Democracy in Britain*. Cambridge: Cambridge University Press.

Petracca, M. (1991). The Rational Choice Approach to Politics: A Challenge to Democratic Theory. *The Review of Politics*, 53, 289-319.

Petracca, M. (1993). Tilling the Field of Interest Group Research: An Overview of New Insights. *Perspectives on Political Science* 22 (2), 61-9.

Phillips, S. (1993). Of Public Interest Groups and Sceptics: A Realists' Reply to Professor Stanbury. *Canadian Public Administration*, 36, 606-616.

Polsby, N. (1963). *Community Power and Political Theory*. New Haven and London: Yale University Press.

Putnam, R. (1993). *Making Democracy Work: Civic Traditions in Modern Italy*. Princeton: Princeton University Press.

Richardson, A. (1983). *Participation*. London: Routledge & Kegan Paul.

Rasmussen, K. Institutional Change and Policy Outcomes: District Health Boards in Saskatchewan. Paper presented at the Canadian Political Science Association Annual Meeting, June 1996.

Renn, O., Webler, T., Rakel, H., Dienel, P. and Johnson, B. (1993). Public Participation in Decision-Making: A Three-Step Procedure. *Policy Sciences*, 26, 189-214.

Robertson, A. and Minkler, M. (1994). New Health Promotion Movement: A Critical Examination. *Health Education Quarterly*, Vol. 21 (3), 295-312.

Salisbury, R. (1975). Research on Political Participation. *American Journal of Political Science*. 19:323-41.

Salisbury, R. (1980). Modes of Participation and Policy Impact in American Education. In: Foster, C. (ed.) *Comparative Public Policy and Citizen Participation*. Oxford: Pergammon Press. 99-116.

Salisbury, R. (1980). *Citizen Participation in the Public Schools*. Lexington, Mass.:D.C. Heath and Company.

Sampson, R. (1991). Linking the Micro- and Macrolevel Dimensions of Community Social Organization. *Social Forces*, 70, 43-64.

Sandel, M. (1996). *Democracy's Discontent: America in Search of a Public Philosophy*. Cambridge, Mass.: Harvard University Press.

Sarason, S.B. (1974). *The Psychological Sense of Community: Perspectives for Community Psychology*. San Francisco: Jossey-Bass.

Scavo, C. (1993). The Use of Participative Mechanisms by Large U.S. Cities. *Journal of Urban Affairs*, 15 (1), 93-109.

Schattschneider, E.E. (1960). *The Semisovereign People*. Hinsdale, Ill.: Dryden Press

Sears, D. and Funk, C. (1991). The Role of Self-Interest in Social and Political Attitudes. In: Zanna, M. ed. *Advances in Experimental Social Psychology*, 2-80. San Diego, California: Academic Press, Inc.

Sen, A. (1987). *On Ethics and Economics*. Oxford; New York, NY, USA: B. Blackwell.

Sharp, E. (1982). Citizen-Initiated Contacting of Government Officials and Socioeconomic Status: Determining the Relationship and Accounting for it. *The American Political Science Review*, 76, 109-115.

Shiell, A. and Hawe, P. (1996). Health Promotion, Community Development and the Tyranny of Individualism. *Health Economics*, 5, 241-7.

Short, S. (1989). Community Participation or Community Manipulation? A Case Study of the Illawarra Cancer Appeal-A-Thon. *Community Health Studies*, Vol XIII (1), 34-38.

Thompson, B., Wallack, L., Lichtenstein, E. and Pechacek, T. (1991). Principles of Community Organization and Partnership for Smoking Cessation in the Community Intervention Trial for Smoking Cessation. *International Quarterly of Community Health Education*, 11, 187-203.

Truman, D. (1951). *The Governmental Process*. New York: Knopf.

Tuohy, C. and Evans, R.G. (1984). Pushing on a String: The Decentralization of Health Planning in Ontario. In: *The Costs of Federalism*. Golembiewski, R. and Widawsky, A. eds. New Brunswick, N.J.:Transaction Books, 89-116.

Vedlitz, A. and Veblen, E. (1980). Voting and Contacting: Two Forms of Political Participation in a Suburban Community. *Urban Affairs Quarterly*, 16, 31-48.

Verba, S. and Nie, N. (1972). *Participation in America: Political Democracy and Social Equality*. New York: Harper and Row Publishers.

Wandersman, A. and Hallman, W. (1993). Are People Acting Irrationally? Understanding Public Concerns about Environmental Threats. *American Psychologist*, 48(6), 681-6.

Whiteley, P. (1995). Rational Choice and Political Participation -- Evaluating the Debate. *Political Research Quarterly*, 48(1), 211-33.

Wilson, J.Q. (1973). *Political Organizations*. New York: Basic Books.

Zorbaugh, H. (1929). *The Gold Coast and the Slum*. Chicago: University of Chicago Press.

CHAPTER 3

DEVELOPING A MODEL FOR ANALYZING THE INFLUENCES ON PARTICIPATION

The previous chapter's literature review highlighted various theoretical and empirical models that have been used to study participation and its influences. In this chapter, the literature review is used to develop a framework for analyzing community participation that accounts for the independent and combined influences that shape it.

The first step in the process of developing the analytic framework is to situate the subjects under investigation. More specifically, the process begins by broadly identifying the independent and dependent variables. In conducting this inquiry into community participation and its influences, participation fulfils the role of dependent variable. That is, we are interested in looking at what influences, shapes and drives participation. The independent variables, therefore, are all those things that exert an influence on participation.

Conceptualizing Participation

Participation was defined in Chapter 1 as *"an instrumental act with the purpose of influencing policy decisions and achieving specified objectives"*. Acquiring a thorough understanding of community-level participation requires the analyst to consider its multiple dimensions. The literature reviewed in the previous chapter described the numerous participation typologies that have been conceived as well as quantitative analyses of participation using measures such as the number of "contacts made", petition signatures obtained or meeting attendees. This study moves beyond these approaches by considering the contextual aspects of participation (i.e., both quantitative and qualitative dimensions). A typology is presented in Table 3-1. Its application will be discussed in a subsequent section of the chapter.

Table 3-1
Typology of Participation

Typology of Participation
Form Form refers to the overall approach taken to participation. For example, it may take the form of routine and on-going involvement through committee membership in contrast to issue-driven participation through meeting attendance, petitions, letter-writing campaigns and other mobilizing activities.
Initiator The initiator refers to who initiates the participation and whether it is *solicited* or *unsolicited*. For example, a local decision-making body such as the district health council may solicit a community's involvement in a particular health planning exercise while the community may organize in response to a particular issue.
Method Method is related to form but refers to the specific participation activity employed (e.g., attendance at meetings, committee membership, letter writing, contacts with public officials, etc.).
Quantity Quantity refers to the magnitude of community participation (e.g., number of people who attended a meeting, wrote letters, applied for committee membership, etc.)
Intensity Intensity refers to the amount of participation confined to a particular issue over a defined period of time (e.g., how many people attended meetings held over two-day period on the subject of hospital closures).
Texture Texture is a qualitative measure referring to the breadth or depth of community involvement (e.g., a few key individuals or organizations vs. grass-roots participation).
Tone Tone refers to the degree of emotion underlying the community's involvement (e.g., sophisticated, business-like approach to participation or one that is aggressive and emotional).

Conceptualizing the Influences on Participation

An important result of the literature review was the categorization of theoretical and empirical research under the following three theme areas:

I. Studies examining the relationships between individual and community characteristics and participation (from political science and sociology literatures)

II. Studies examining the relationships between institutional actions and participation (from public administration, community development and health promotion literatures)

III. Studies examining the relationships between interests, interest groups and participation (from political science and community mobilization literatures).

1. Identifying the Potential Sources of Influence on Participation

Each research theme listed above identifies a potential source of influence on participation. Theme I addresses the role played by a community's population characteristics. Theme II deals with the characteristics of institutions operating within the community and theme III addresses the role of issues and interests in the community. As the previous chapter concluded, much of the prior participation research has emphasised the role played by only one of these sources of influence, neglecting the potential for a combination of influences to shape participation. In conducting this analysis of community-level participation, therefore, each of these potential sources of influence will be considered recognizing their potential to influence participation independently, or in combination with each other.

2. Identifying the Type of Influence Exerted by the Source

Moving to the next stage of the model development process, it is evident that the three categories of research not only assist in the identification of different sources

of influence (i.e., populations, institutions and issues) but provide insights into the type of influence each exerts on participation. Each of the three "sources" of influence described above exerts a specific "type" of influence over participation and, as such, constitutes a separate element of the model. The first source (i.e., community or population characteristics) exerts a ***pre-disposing*** influence on participation; the second (i.e., characteristics of and actions taken by institutions) exerts an ***enabling*** influence; and the third (i.e., issues and interests) a ***precipitating*** influence. Table 3-2 relates each of the newly constructed model elements to its corresponding research theme. A discussion of each model element follows.

Table 3-2

Research Themes and Model Elements

Research Theme	Model Element
I. Studies examining the relationships between individual and community characteristics and participation	Pre-disposing influence
II. Studies examining the relationships between institutional actions and participation	Enabling influence
III. Studies examining the relationships between individual and group interests and participation	Precipitating influence

Pre-disposing influences

Predispose v.r. To incline beforehand; to give a previous disposition or tendency to; to fit or adapt previously.
Predisposition n. The state of being previously disposed toward something.

Pre-disposing influences account for the first element of the model and are defined as *"those characteristics of a community or population that provide the basic building blocks for participation"*. Underlying this term is the notion that certain communities have an inherent predisposition to participatory activity based on the fundamental characteristics of the community's population and geography.

The characteristics that may pre-dispose a community toward participation may be *social* or *structural* but refer specifically to the population of the community, in contrast to the institutions operating within it. Political science and sociology studies identify *structural* characteristics to include socio-economic status variables (typically income and education levels), the residential stability of the population, population size and homogeneity. Sociological and political theory suggest that the presence of certain *social* characteristics in a community can influence its propensity toward participation. Examples include the extent to which individuals join and form local clubs and organizations, the extent to which residents read a local newspaper and voluntary activity. As discussed in the literature review, the relationships between participation and social characteristics such as "associationalism" "civic engagement" and "social cohesion" are less well understood than are relationships between structural characteristics and participation. In the context of this study, however, these characteristics (both structural and social) will be considered to be the basic building blocks for participation. Their presence in a community, therefore, is hypothesized, to pre-dispose them to participatory activity.

Studies of political participation have established the relationship between an individual's personal characteristics (i.e., wealth, education and political affiliations) and participation in various political activities[1]. Where this research fails to guide us, however, is with respect to the generalizability of individual-level survey research to: i) the health care policy field; and ii) the aggregate level of communities (i.e., are communities with higher overall education levels, on average, more participatory than those with lower education levels?).

Aggregate-level studies are limited too, in their tendency to focus on testing relationships between either social or structural characteristics of communities and various forms of participation while offering few insights into the combined and interactive effects of structural and social characteristics on participation (again, the focus of this inquiry).

This research departs from prior studies in its focus on exploring the relationships between community characteristics and various qualitative aspects of participation identified earlier in this chapter (e.g., tone, intensity, texture). This contrasts with prior studies that have focussed on establishing whether participation has occurred or not rather than with exploring its contextual influences.

Variables of interest

As described earlier in this chapter, the influences on participation will be viewed as independent variables. Within the category of pre-disposing influences,

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[1] The resource-based model of political participation is based on numerous empirical studies and argues that the individual's possession of the necessary personal (wealth and education) and group (organizational affiliations) resources is the major influence on participation in the political arena. According to the model, the possession of these resources, enhanced or diminished by certain background characteristics such as occupational position, individual and communal values and personal and situational factors, combined with some trigger for involvement, explain the conditions for participation. See Parry et al (1992) for a more detailed description of the model.

then, the potential influence exerted by the following community characteristics on participation will be explored:

1. <u>Structural characteristics</u>

Income
Education
Size
Residential stability (and its links to social solidarity and social cohesion)
Proximity between workplace and residence (and its link to social cohesion)
Population homogeneity (socio-economic and cultural - and its link to social cohesion)

2. <u>Social characteristics</u>

Civic participation
- newspaper readership
- referendum voting
- blood donation
- voluntarism

Associationalism
- density of voluntary associations
- organizational membership

Social cohesion
- fostered by residential stability, population homogeneity and proximity between workplace and residence (listed under structural characteristics)

The relationship between each of these characteristics and participation was discussed in the literature review (See "Community Influences"). Table 3-3 summarizes the relationships between each of the variables and participation as described in the literature. These concepts will be operationalized in Chapter 4. In general, though, the relationship between the structural variables and participation has been documented in the literature and, therefore, falls into the category of hypothesis-testing variables. In contrast, the relationships between social characteristics and participation are less well understood and fall into the category of hypothesis-generating or "emerging" variables (see discussion in Chapter 4).

Table 3-3

Relationships between Pre-Disposing Influences and Participation

Community characteristic	***Relationship to other Variables***	***Relationship to Participation***
Education		- positively associated with participation
Income		- positively associated with participation
Size		- positive link between community size and ability to foster participation
Residential Stability	- precondition to *social solidarity* - fosters *social cohesion*	
Population homogeneity	- precondition to *social cohesion*	
Proximity between work and residence	- fosters *social cohesion*	
Social solidarity		- social relations foster political actions through psychological attachment to an area and the awareness of common interests through informal interactions
Social cohesion		- associated with high levels of political participation
Civic engagement/ Social capital		- associated with high levels of political participation

Enabling influences

Enable, enabled, enabling v.t. To make able; to supply with power, physical, moral or legal; to furnish with sufficient power, ability or authority; to render fit or competent; to authorize.

The research that falls under the second theme area in Table 3-1 emphasizes the role played by ***enabling influences***, the second element of the analytic model. Enabling influences refer to those actions taken by institutions to enhance the ability of individuals and groups to participate in a decision-making process. As the dictionary definition suggests, the enabling process often deals with a power relationship with one group "empowering" another to participate. Institutions, in the context of this study, may be specific to a geographic community such as local government structures or the media, or to a policy arena such as the local district health council or school board.

While advocates of participation have welcomed any form of institutional activity designed to encourage participation, analysts of participatory programs have exposed conflicting objectives and unsatisfactory results of many institutional actions.[2] Chapter 2 offered several explanations for the failed attempts on the part of institutions at enabling participation. Institutional desire to manipulate the community participation process (i.e., community participation for the purposes of achieving the objectives or outcomes sought by decision-makers) along with institutions' failure to overcome the significant costs of participation were cited as reasons for these failures. The notion of an institution manipulating the participation process appears to indicate a lack of organizational commitment to encouraging and fostering community participation. For enabling influences to be present in a

community, therefore, one might look for evidence of institutional commitment to participation and the presence of a "culture of participation". Employing creative methods for reducing the costs of participation would also indicate institutional commitment to promoting participation. Finally, the media's role in information dissemination in their coverage of local policy issues would also demonstrate institutional commitment to enabling participation if we consider the provision of information as a form of empowerment.

Variables of interest

Based on the evidence from the literature and the discussion above, the following list of indicators was generated to examine the presence and role of participation enablers in a community:

1. Presence of a participatory culture within the institution
2. Institutional commitment to encouraging or reducing impediments to participation
3. Media culture that promotes participation

The first indicator addresses the extent to which an institution demonstrates its commitment to enabling participation at the corporate level and fosters the establishment of a culture of participation throughout the organization that extends into the community. This may be exhibited through a corporate mission statement, through terms and references of committees or through the actions taken by the leaders within the organization. The second indicator follows directly on the first providing explicit examples of actions taken. The third acknowledges the important role played by the media in dissemination information to the community pertaining to

[2] A detailed discussion of this topic was provided in the literature review chapter under the institutional influences section.

local affairs. Each of these will be described in more detail and operationalized in Chapter 4.

Disabling influences

Although enabling influences are the principal foci of this aspect of the model, the role of *disabling* influences must also be mentioned as institutional actions can just as easily be taken for the purposes of disabling participation. Disabling influences will not be explicitly incorporated into the model; however, evidence of their influence over the policy process will be reported and included as a secondary aspect of the analysis.

Interest groups

The role of interests and interests groups will be discussed in greater detail in the next section. Some groups, however, such as consumer alliances and professional organizations may also be seen as enablers of participation with an infrastructure in place and the ability to reduce the costs to participation for their members and the general public.

Precipitating influences

Precipitate, precipitated, precipitating v.t. To throw headlong; to cast down from a precipice or height; to urge or press with eagerness or violence; to hasten; to hurry blindly or rashly.

Outside of any pre-disposing and enabling influences that may be present in a community from time to time a set of circumstances will act as a "catalyst" to participation. These catalysts are referred to in the model as ***precipitating*** influences. The literature review helped to disentangle the concept of "precipitants" to participation by considering two separate elements -- issues and interests -- and their relationship to each other. The community mobilization literature clearly

demonstrates that issues play an integral role in providing the impetus to participate. But this is only part of the explanation. One must look more closely at whom or what is mobilized by an issue to fully understand the process. More specifically, an issue may act as a precipitant to participation by mobilizing the interests of individuals or groups in a community. In this way, the issue and the interests of those individuals and groups affected by the issue are inextricably linked.

Literature reviewed in the previous chapter illustrated this relationship. The importance of "threatened interests" in the limited-community model was described, for example, as they related to the issue of property values by Lee et al (1984) and Zorbaugh (1929). Studies of community mobilization in response to environmental concerns (i.e., the NIMBY phenomenon) and the threats they pose to the interests of property values and public safety provided additional examples (Wandersman and Hallman, 1993; Henig, 1982; Kraft and Clary, 1990). Emotional reactions to threats imposed on a community are empirically supported (Bachrach and Zautra, 1985). Within the health care domain, the specific role of interests and interest groups in the health care decision-making process has been observed in several empirical studies (Alford, 1975; Marmor and Morone, 1980; Checkoway and Doyle, 1980; Short, 1989). The emphasis of this research has been on the dominant role that health care providers (with concentrated interests) have played in influencing the decision-making process in communities in the United States and Australia. Comparable empirical research is lacking for Canadian communities. In this study, proposed hospital closures and the threat (whether real or perceived) that this issue presents to the economic and health interests of a community was closely examined (see Chapter 5 for more discussion on this subject).

Another precipitant to participation in the health care domain is the perceived need for additional resources in the form of programs, services, equipment, facilities or human resources. Participation for the purposes of resource procurement can be a strong community mobilizer in the health care domain. In a case study of an Australian community's campaign to raise funds to purchase radiotherapy equipment, Short (1989) highlights the important role played by structural interests in demonstrating the influence of the medical community in convincing the public of its "need" for additional resources.

Precipitating influences, then, constitutes the third "independent" variable in the analytic model. The presence of issues and the interests exhibited by communities around these issues provides the basis for examining the type of influence these precipitants exert on participation.

Applying the Model

The model serves several purposes in this inquiry. First and foremost, it provides a template for examining the role played by each set of "influences" in shaping participation. It is used as a tool for collecting, analyzing and interpreting data obtained during the various fieldwork stages (described in detail in Chapter 4). More specifically, the model will be used to answer the following questions:

1.How does the presence (or absence) of each set of "influential factors" shape the quality and quantity of participation in a community?
i.e. what is different about participation in communities that have:
pre-disposing vs. no pre-disposing factors
enabling vs. no enabling factors
precipitating vs. no precipitating factors

2. What is the relationship between each set of factors and their combined influence on participation?
i.e. how is participation shaped by a combination of pre-disposing and enabling factors vs. a combination of pre-disposing and precipitating vs. a combination of enabling and precipitating factors vs. a combination of all three factors?

In the concluding chapter the model's utility as a tool for explaining and predicting community-level participation will be evaluated with recommendations made for further refinements to the model.

Developing Profiles of Participation

The first step in applying the model is the compilation of community profiles of participation using the typology of participation described in Table 3-1. A detailed discussion of data, data sources and the data collection process is provided in Chapter 4.

Developing Profiles of Pre-Disposing, Enabling and Precipitating Influences

The second step in the analytic process involves explaining the participation observed in each community by developing profiles for each set of influence (i.e., pre-disposing, enabling and precipitating). The model assumes that each of the influential elements may be present in a given community, either alone or in combination with the others, and may exert a different type of influence over the participation process. The influence exerted over participation may also depend on the combination of elements present in the community. Considering the potential presence of each set of influences, alone or in some combination with each other in a community, then, there are seven potential options for their presence. For illustrative purposes, consider seven different communities exerting a different combination of influences:

Community A -- pre-disposing factors only (PD)

Community B -- pre-disposing and enabling factors (PDE)

Community C -- pre-disposing and precipitating factors (PDP)

Community D -- pre-disposing, enabling and precipitating factors (PDEP)

Community E -- enabling factors only (E)

Community F -- enabling and precipitating factors (EP)

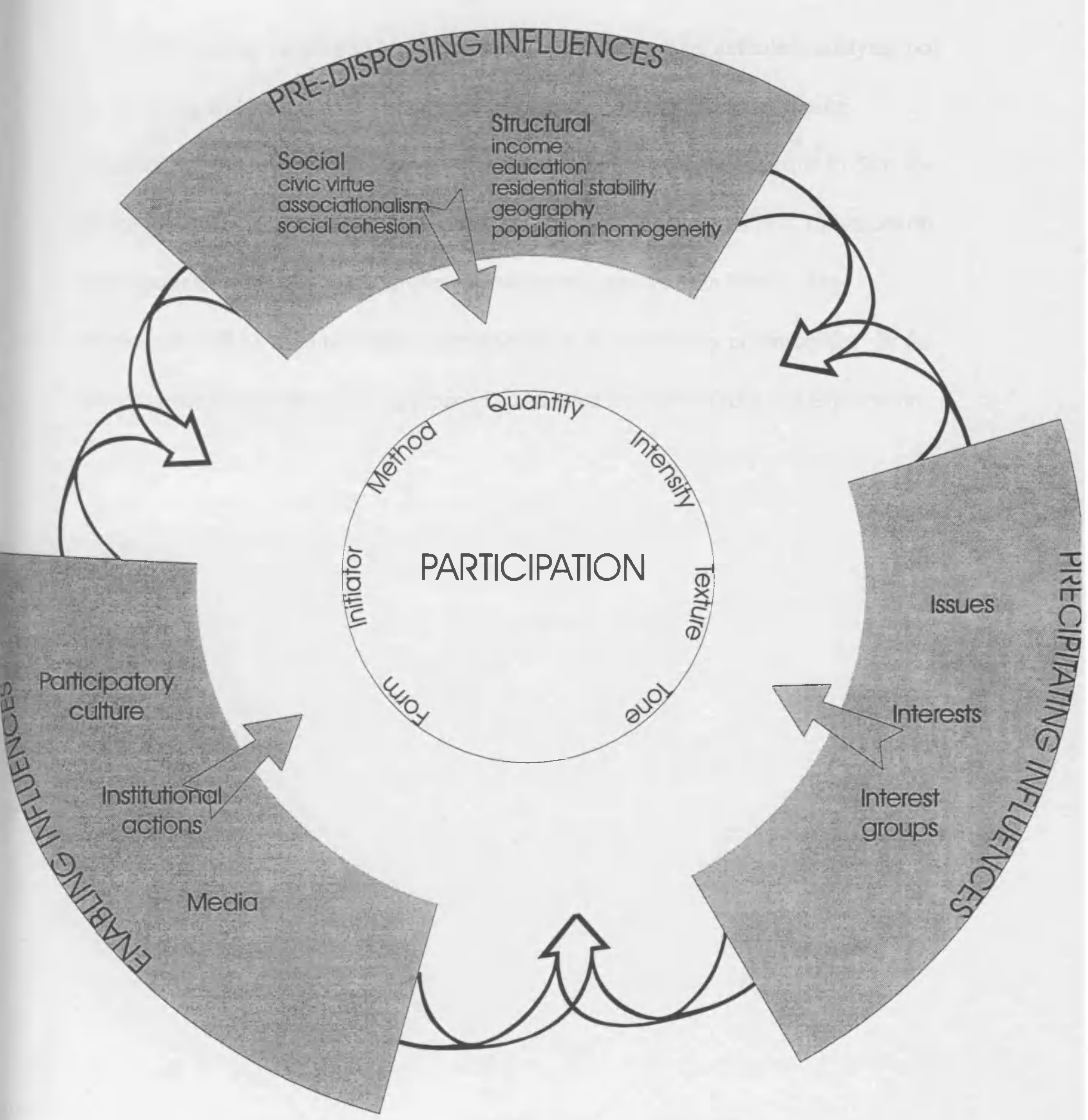
Community G -- precipitating factors only (P)

Given the diversity of the pre-disposing influences described earlier in the chapter there are a variety of combinations of influences that might be observed in Communities A-D. For example, a community may possess only one pre-disposing influence (e.g., high education level) while another may possess several of these factors (e.g., high education levels, residential stability, and social cohesion). Socio-economic characteristics and residential stability represent two pre-disposing characteristics with the greatest likelihood of influencing participation based on the evidence presented in the literature review. Other characteristics such as the presence of social networks, high néwspaper readership or community cohesion (measured by the tendency for the population to live and work in the same community) may also exert some influence over participation. The nature of these relationships, however, is uncertain and will hopefully be elucidated through the inquiry process.

The final stage of the analytic process involves the establishment of a chain of evidence linking those characteristics observed to influence participation (i.e., profiles of pre-disposing, enabling and precipitating influences) to participation itself (i.e., profiles of participation). As the process unfolds different sets of influences may be found to be more closely associated with different dimensions of participation. For example, if education level is associated with a more or less emotional *tone* of participation, the model will account for this within each respective element. Figure 3-1 is a schematic representation of the model. Participation is represented in the centre of the diagram with each of its dimensions identified. The three shaded areas

represent the three sets of influences on participation and their composition as described in the literature. The diagram demonstrates using different arrows that there may be independent influences exerted on participation (i.e., arrows originating from the shaded areas) as well as combined influences (arrows coming together from each of the shaded areas). This second set of arrows is intended to illustrate the less clearly understood relationships between the model elements and their combined influence on participation.

Figure 3-1



A Framework for Analyzing Participation and its Influences

SUMMARY

The model developed here should not be considered the definitive analytic tool for studying and understanding participation. It is an attempt, rather, to bring coherence to the literature that has analyzed the influences on participation to date and to provide a framework that will systematically account for the multiple influences on participation (as well as the multiple dimensions of participation itself). The framework will be used to explore participation in the case study communities. In the next chapter a methodological approach is presented for undertaking this exploration.

References to Chapter 3

Alford, R. (1975). *Health Care Politics: Ideological and Interest Group Barriers to Reform*. Chicago: University of Chicago Press.

Bachrach, K. and Zautra, A. (1985). Coping with a Community Stressor: The Threat of a Hazardous Waste Facility. *Journal of Health and Social Behaviour*, 26, 127-41.

Checkoway, B. and Doyle, M. (1980). Community Organizing Lessons for Health Care Consumers, *Journal of Health Politics, Policy and Law*, 5 (2), 13-26.

Henig, J.R. (1982). *Neighborhood Mobilization*. New Brunswick, New Jersey: Rutgers University Press.

Kraft, M. and Clary, B. (1990). Citizen Participation and the NIMBY Syndrome: Public Response to Radioactive Waste Disposal. *The Western Political Quarterly*, 299-328.

Lee, B., Oropesa, R., Metch, B., Guest, A. (1984). Testing the Decline-of-Community Thesis: Neighborhood Organizations in Seattle, 1929 and 1979. *American Journal of Sociology*, 90 (5), 1161-88.

Marmor, T. and Morone, J. (1980). Representing Consumer Interests: Imbalanced Markets, Health Planning and the HSAs, *Milbank Memorial Fund Quarterly/Health and Society*, 58(1), 125-165.

Parry, G., Moyser, G. and Day, N. (1992). *Political Participation and Democracy in Britain*. Cambridge: Cambridge University Press.

Short, S. (1989). Community Participation or Community Manipulation? A Case Study of the Illawarra Cancer Appeal-A-Thon. *Community Health Studies*, Vol XIII (1), 34-38.

Wandersman, A. and Hallman, W. (1993). Are People Acting Irrationally? Understanding Public Concerns about Environmental Threats. *American Psychologist*, 48(6), 681-6.

Zorbaugh, H. (1929). *The Gold Coast and the Slum*. Chicago: University of Chicago Press.

CHAPTER 4

METHODOLOGY

One becomes fastidious about method only when one has no story to tell.

(Postman, 1988:16)

Research Questions and Statement of Methodological Approach

The model presented in the previous chapter identified three sets of "influential factors" which were posited, based on evidence from the literature, to shape the quality and quantity of community participation. As discussed in the preceding chapter this model was developed as an analytic tool to answer two principal research questions:

1. How does the presence or absence of each set of "influential factors" shape participation?
2. What is the relationship between each set of factors and their combined influence on participation?

The methodological approach used to operationalize the model is described below.

Selecting a Research Design and Methods

Traditional approaches to selecting a research design typically involve choosing between a qualitative and quantitative research paradigm which are distinguished from one another on the basis of their ontological (i.e., what is real) and epistemological (i.e., the relationship between the researcher and that being researched) assumptions. In general, quantitative research paradigms involve the use of deductive forms of logic with pre-selected theories and hypotheses being tested for cause-and-effect relationships between pre-determined variables. Qualitative studies, in contrast, use inductive logic allowing information to emerge throughout the process

of data collection which is then used to develop models and theories to explain the phenomena of interest (Creswell, 1994). Fierce debates are waged over the strengths and limitations of each paradigm while others argue the merits of combining aspects of both approaches in certain situations.[1] The methodological approach taken to this inquiry involved such a combination of "interpretative" (associated with qualitative design) and "hypothesis-testing" (associated with quantitative design) elements to answer the research questions posed above.

Breaking it down into its component parts, this inquiry is about gaining a better understanding of i) participation (the dependent variable) and ii) its multiple influences (the independent variables). Chapter 3 identified three broad sets of "influences" over the participation process drawn from the theoretical and empirical literature. Within each of these sets of influences (i.e., *predisposing*, *enabling* and *precipitating*) are different variables of interest. Again, from the literature reviewed in Chapter 2, there is compelling evidence regarding the relationships between some of these variables and participation but for many other variables we are at an early stage in our understanding of their relationships to participation. In the category of pre-disposing characteristics, for example, the evidence is reasonably conclusive regarding the influence of *structural* variables such as income and education over the individual *decision* to participate. But this evidence tells us very little about *how* this participation is demonstrated in the context of communities or the health care arena. Structural variables, therefore, were used both to test hypotheses and to provide a

[1] This subject has received much attention recently in academic circles. For example, the June 1995 issue of the American Political Science Review dedicated a lengthy section to "The Qualitative-Quantitative Disputation" (Vol. 89, No.2: 454-481). The debate focussed on the review, by a variety of scholars who mix both qualitative and quantitative data and methods, of a provocative new book *Designing Social Inquiry: Scientific Inference in Qualitative Research*, by Gary King, Robert Keohane,

more in-depth understanding of these relationships. As chapters 2 and 3 revealed, the relationships between participation and *social* variables such as social capital and community cohesion were less well understood and were, therefore, categorized as variables to explore through an interpretative rather than hypothesis-testing process.

Although enabling influences were generally considered, a priori, to exert a relatively weak influence over the participation process the exact nature of this relationship was unclear. Some enabling influences were identified for exploration at the outset of the study period (e.g., actions taken by local decision-making bodies to encourage participation) while others were generated through the interviewing process.

Relationships between participation and precipitating influences were also identified through this interpretative process. Table 4-1 describes the general methodological approach taken by listing for each category of influence, the variables of interest and the approach taken to examining their relationship to participation.

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and Sidney Verba which argues that the logic of good qualitative and quantitative research is essentially the same.

Table 4-1
Methodological Approach

Category of Influence	*Variables of interest*	*Method of inquiry*
Predisposing	Structural	
	- income	hypothesis-testing
	- education	hypothesis-testing
	- residential stability	interpretative/exploratory
	- geography (e.g., size)	interpretative/exploratory
	- population homogeneity	interpretative/exploratory
	Social	
	- civic participation	interpretative/exploratory
	- associationalism	interpretative/exploratory
	- social cohesion	interpretative/exploratory
Enabling	Culture of participation	Interpretative/exploratory
	institutional commitment	Interpretative/exploratory
	role of media	Interpretative/exploratory
Precipitating	issues, interests (e.g., as threats)	Interpretative/exploratory

Bridging the Quantitative/Qualitative Divide: Selecting the Case Study as a Research Strategy

An aggregate-level analysis using the case study method was selected to explore both the structural and contextual influences on participation in health care and education in selected Ontario communities. Case studies are typically categorized as qualitative research methods although they may employ both quantitative and qualitative data collection methods. This method was chosen for the following reasons:

1. Case studies allow hypotheses to be tested about the relationships between independent and dependent variables while investigating the phenomenon of interest within its real-life context (Yin, 1994; King, Keohane and Verba, 1994). This is

consistent with my interest in testing hypotheses about the relationships between various factors that influence participation in the context of communities and over a specified time period.

2. Participation has often been studied as a narrowly defined activity with little consideration given to the context within which the activity is occurring. As will be argued throughout this inquiry, the boundaries between participation and its context are not always clearly defined, lending further support for its amenability to case study. The literature points to the need for more attention to the examination of the multiple dimensions of participation and tone and its contextual influences. This can only be done using a qualitative approach that emphasizes the exploration and generation of new variables and relationships between participation and its influences.

3. Interest in exploring the complex relationships between different sets of influences and the resulting participation is more amenable to a qualitative than a quantitative research design. A qualitative approach is also necessary to capture certain features of participation such as its tone and intensity.

4. Few studies have employed aggregate-level analysis to answer questions about the influences on participation. This study will contribute, therefore, to our understanding of participation in the context of communities in contrast to individual-level participation, which has been the focus of much prior participation research.

5. Using the community as the unit of analysis requires a broader scope of data collection employing a variety of qualitative and quantitative methods.

Defining the Case

Each case was identified broadly as *"a community defined according to existing geographic boundaries for health and school board districts"*[2] and specifically as *"the participation of the public in the decisions affecting health care and education in their community"*. The use of administrative and political units was essential to defining community in this study since participation was often geared toward local institutions such as health facilities and involved local decision-making bodies that have jurisdiction over health care matters such as district health councils.

County delineations used to identify both health planning and school board districts or regions determined study community boundaries. These county delineations were also used to form the electoral districts for municipal, provincial

and federal elections although different configurations may be used at different levels. For example, one health district may cover two counties, which may, in turn, cover three electoral districts. The district health council boundary was used to determine which schools and electoral districts would be included in each study community.

Selecting the Cases

The guiding principle used to select the study communities was interest in exploring relationships between numerous community influences (drawn from the literature) and participation. The case selection process evolved considerably and although some may find an account of intended actions and aborted efforts tangential to a discussion of methods, the account offers some insights into the complexities of conducting research in this area.

From ideal to actual

The initial approach to case selection was to conceive a multiple case study design that would systematically control for a set of variables while testing the relationship between each characteristic of interest (i.e., independent variable) and participation (i.e., dependent variable). From data collected for a previously specified set of variables for all health districts within the province of Ontario, a smaller subset of cases would be selected. These pre-specified variables included community characteristics (average household income, education level and residential stability); institutional actions thought to have an enabling influence on participation; and the presence of issues thought to evoke participation. Communities would then be selected based on simple ratings (high or low) for each of the three categories of

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[2] Definitional issues pertaining to community were discussed in detail in Chapters 1 and 2.

variables while controlling the other two variables. Diagrams of the proposed community selection strategy are depicted below.

Community Characteristics

Institutional actions & Issues

	High	Low
High	Case 1	Case 3
Low	Case 2	Case 4

Institutional Actions

Community characteristics & Issues

	High	Low
High	Case 1	Case 3
Low	Case 2	Case 4

Issues

		High	Low
Community characteristics & Institutional actions	High	Case 1	Case 3
	Low	Case 2	Case 4

Adopting such a strategy (i.e., that would systematically control for all variables of interest) would have necessitated the selection of 12 different cases. This strategy was abandoned for several reasons:

1. The ability to conduct an in-depth exploration of participation and its contextual influences would have been severely limited under this strategy.

2. There was no obvious source of data for collecting information about the presence of issues across communities in Ontario and no prior research was identified which had attempted to address this question. An extensive process of surveying each community in Ontario would have been required to identify communities where issues have provoked participation. This process highlights the paradox that arises so often in conducting research when an additional study is needed to generate the data needed to meet the requirements for the optimal research design.

3. A survey of all district health councils in Ontario was conducted to identify the various mechanisms used to facilitate public participation in health council activities (Association of District Health Councils of Ontario, 1994). Survey results supported prior research conducted in the United States which found few differences between health system agencies (similar to the Ontario health councils) in their approaches to enabling participation (Checkoway, 1982). These findings provided a rationale for excluding institutional actions as a criterion for selecting cases although any pre-existing knowledge about institutional actions would be considered in the final selection of cases.

How the cases were actually selected

Given the limitations described above, the case selection process was modified to select communities based only on the presence (or absence) of characteristics thought to pre-dispose them to participation. Two principal categories of community characteristics were used in the selection process: socio-economic characteristics (i.e.,

income and education) and community cohesion (i.e., residential stability and proximity between workplace and residence). In addition to these basic measures, two other factors were considered in the selection process: the presence of 'social capital'[3] in the community (measured by newspaper readership and referendum voting[4]) and voter participation[5] data for the last federal, provincial and municipal elections.

Canadian census reports[6] were used as the primary source of data for both socio-economic and community cohesion data. Data for the following measures were aggregated to census division[7] and census sub-division[8] levels:

- average household income
- highest education level attained
- proportion of population residing in community 5 years ago
- proportion of employed whose place of work is in their census sub-division of residence

Table 4-2 provides a list of each of the community variables and the indicator used to measure them.

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[3] Social capital or civic engagement (as described in Chapter 3) was identified as a variable of interest to be explored through the case study process. Some baseline information about civic engagement was collected (using the crude measures identified above) to guide the case selection process. For example, I was interested in communities that demonstrated high or low newspaper readership and referendum voting.

[4] These two measures were used in a recent study of civic communities in Italy (discussed in Chapter 2). See Putnam (1993).

[5] Once again, voter participation data was intended to guide the case selection process. In a sense, this constituted a 'fishing expedition' to identify communities that appeared to demonstrate high or low levels of participation (understanding of course that voter participation is only one form of participation and may or may not be associated with other forms of participation).

[6] Statistics Canada. 1994. Profile of Census Divisions and Subdivisions in Ontario - Part B. Ottawa: Minister of Industry, Science and Technology.

[7] the census division represent all counties, districts and regional municipalities

[8] the census subdivision represents areas within the census division (e.g., cities, towns and villages)

Table 4-2

Variables and Indicators used to Measure Community Characteristics in the Case Selection Process

Variable	*Indicator*
Socio-economic status (e.g., income and education)	1. Average household income 2. Percentage of population with university degree
Residential Stability	Percentage of population that moved out of census area in the last five years (lower number indicates higher stability)
Community cohesion - proximity between workplace and residence	Percentage of employed population whose place of work is located in their census sub-division of residence
Social capital[9] - civic participation	1. Newspaper readership 2. Percentage of population who voted in 1992 federal referendum
Voter turn-out	Percentage of population who voted in: - 1993 federal election - 1990 provincial election - 1991 municipal election

As described in an earlier section, the District Health Council boundary was used as the unit for selecting study communities. There are thirty-three health councils in Ontario. Census data were used to cluster communities on the basis of population size (a variable of interest), location in rural and urban settings (known to share different community values) and northern and southern regions of the province (also known to share different histories and community values). Within each of these categories, communities were further clustered on the basis of similarity in community characteristics (e.g., education, income, and residential stability). Seven communities were selected from this initial categorization process for more detailed

[9] Newspaper readership and referendum voting are the social capital measures that were used in Putnam (1993). Data were collected for additional measures such as blood donation, the density of voluntary organizations and levels of community volunteer activity. These will be defined and operationalized in the "Data" section of this chapter.

analysis. Table 4-3 provides the results from the preliminary analysis of these seven communities. Three communities (Ottawa-Carleton, Hamilton-Wentworth and Simcoe County) represented large populations (i.e. over 250,000), two of which were predominantly urban (Ottawa and Hamilton) and located in the southern region of the province. The remaining four communities were small (less than 200,000 population), predominantly rural and three of them were located in northern regions of the province (Cochrane, Nipissing, and Renfrew).

Few differences were found in voting behaviour, which led to its elimination as a selection criterion from the final community selection process. Oxford County was eliminated after further analysis because its health council boundary is subsumed under a larger region preventing the collection of data specific to the area. Of the six remaining communities, four were selected that would allow comparisons to be made for the following variables thought to influence participation:

1. Socio-economic characteristics (1 community with high income and education levels; 1 with moderate levels and 2 with low levels)

2. Population size (2 large and 2 small communities)

3. Population density and community cohesion (2 southern urban communities with dense populations; 1 northern community with a single town supporting a large remote area; and 1 northern, remote and sparsely-populated community)

Figures 4-1 through 4-5 include a map of Ontario identifying the location of each study community as well as individual maps of each community. Tables 4-4a and 4-4b compare each of the selected communities on social and structural characteristics.

Table 4-3
Community Profiles

Geographic Area	Population	Average household income ($)	University degree (%)[1]	Mobility (5 yr.)[2]	Place of work[3]		News readers[4]	Ref. voting[5] (1992)	Federal voting (1993)	Prov. voting (1990)	Mun. voting (1991)
					M	F					
Cochrane District	93,000	44,386	5.7	.15	.84	.89	.13	66%	64%	62%	57%
Hamilton-Wentworth	445,000	46,415	9.8	.18	.52	.62	.24	71%	67%	64%	41%
Nipissing District	84,000	41,342	7.6	.24	.74	.79	.27	71%	67%	70%	47%
Ottawa-Carleton	678,000	56,554	23.0	.29	.44	.49	.26	78%	67%	63%	41%
Oxford County	93,000	46,789	5.8	.24	.50	.54	n/a	70%	68%	68%	42%
Renfrew County	91,000	40,904	7.0	.26	.34	.40	.09	76%	73%	66%	50%
Simcoe County	288,000	49,503	7.6	.35	.38	.46	.04	71%	69%	64%	33%

[1] indicates percentage with university degree
[2] indicates movement out of area since last census
[3] indicates place of work in the same census sub-division as residence for males and females
[4] indicates paid newspaper circulation per capita per county
[5] voter turn-out in 1992 federal referendum on the Canadian constitution

Table 4-4a
Case Study Comparisons

	Hamilton-Wentworth	**Ottawa-Carleton**
Population	445,000	678,000
Rural/Urban	urban/suburban	Urban/suburban
% population in single city	72%	46%
Income	46,415	56,554
Education (% with university degree)	9.8%	23%
Mobility	18%	29%
Workplace/residence proximity	52%	44%
Newspaper readership	24%	26%
Referendum voting	71%	78%

Table 4-4b

	Nipissing	**Renfrew**
Population	84,000	91,000
Rural/Urban	rural/urban	Rural
% population in single city	65% (dense)	15% (sparse)
Income	41,342	40,904
Education (% with university degree)	7.6%	7%
Mobility	24%	26%
Workplace/residence proximity	74%	34%
Newspaper readership	27%	9%
Referendum voting	71%	76%

* Shaded areas depict variables upon which communities differ

A comparison of the communities of Ottawa-Carleton and Hamilton-Wentworth illustrates similarities across the structural characteristics of size and urban/suburban status and on the social characteristics of civicness as measured by newspaper readership and referendum voting. These communities differ considerably, however, on the two indicators of socio-economic status (income and education) considered to exert a strong predisposing influence over participation although these

differences are offset by the higher levels of residential stability and workplace/residence proximity in Hamilton-Wentworth. It should be noted that these two communities have very large populations, each possessing large municipalities (and several cities in the case of Ottawa-Carleton) within their regional boundaries. As a result, considerable variation in the characteristics under study was expected within these regions (addressed in the next section).

The communities of Nipissing and Renfrew offered a better overall match differing only on community characteristics for which there was weaker evidence of influence on participation (i.e., proximity between workplace and residence, population density, newspaper readership as a proxy for civicness).

Studying Variations within Communities

Some heterogeneity was expected within each geographic community, especially those with larger populations. To the extent that these variations, in either socio-economic characteristics or other community characteristics, were thought to have influence on the participation process, they were examined in a sub-area analysis. Analysis was restricted to the larger-sized communities for which there was greater a priori evidence of the existence of within-region variation analysis (see Table 4-5).

For example, where large variations in education or voter participation levels were found, efforts were made to link these variations with corresponding patterns of participation.[10]

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[10] As discussed in Chapter 2, the issue of aggregating data collected across heterogeneous populations has not been adequately addressed in the participation literature. In Putnam's analysis of the relationship between the degree of civic engagement in a community and institutional performance in Italian regions, for example, measures of civicness (described as being rooted in the small communes

Table 4-5

Within-region Variations (Hamilton and Ottawa)

	Population	Average Household Income ($)	Education[11] (% with degree)	Mobility[12] (% moved)	Place of work (%)[13]
Hamilton-Wentworth	**445,000**	**46,415**	**9.8**	**18**	**52**
Ancaster	21,988	78,413	22	26	11
Dundas	21,868	58,073	19	25	19
Flamborough	29,616	65,195	12	26	14
Hamilton	318,499	35,905	9	16	65
Stoney Creek	49,968	50,922	7	22	17
Ottawa-Carleton	**678,000**	**56,554**	**23**	**29**	**41**
Gloucester	101,677	64,254	20	33	18
Kanata	37,344	71,969	26	37	18
Nepean	107,627	65,802	24	27	24
Ottawa	313,987	40,036	25	25	72
Vanier	18,150	30,010	11	32	11

[11] indicates percentage of population over 15 years of age with university degree
[12] indicates percentage of population over 5 years of age who have moved out of census area since last census
[13] indicates percentage of male population in workforce who work in the same census sub-division as they reside

DATA

In keeping with the overall approach to the inquiry, data was collected in each community for both participation (dependent variable) and its influences (independent variables).

I. Participation Data

Participation data was collected from as many secondary sources as possible with the objective of developing a "participation profile" for each community. Primary participation data was also collected during the interviewing process.[14] Table 4-6 lists and describes the participation indicators and sources for which data were sought. Each indicator is briefly described below.

a) Contacting political officials

"Contacting" is a well-documented form of political participation. As Table 4-6 illustrates, local constituency offices for members of provincial parliament (M.P.P.) were the principal data source used. The decision was made to obtain contact data from provincial, rather than regional and municipal level politicians, because both health care and education are under provincial jurisdiction and it was felt, therefore, that attempts to influence policy decisions in these areas would likely be targeted at the provincial-level politicians.[15]

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[14] The interviewing process will be discussed in the next section on Data Sources (see Key informants and interviewing, p. 116).

[15] In some instances, as will be described in Chapter 5, both regional and provincial politicians were targets of intense lobbying efforts from their communities.

Table 4-6

Participation Data and Sources

Participation Indicator	*Data Source*
contacts made with political officials • written correspondence • phone calls	Members of provincial parliament constituency offices
Petitions • number initiated • number signed • range of issues	provincial legislative library documents
applications received to sit on local decision-making bodies • number received • nature of applicant, e.g., health care provider, consumer, etc.	health councils, municipal electoral offices
• attendance at public meetings (organized by institutions or community group) - number in attendance	newspapers, health councils, school boards
• issue-driven community mobilization - documentation of meeting attendance, letters, petitions and submissions received; organizations established to address specific issues	DHCs, school boards, newspaper coverage

b) Petitions

Petitioning is a form of *issue-driven* participation that has the intended goal of influencing a decision-making process through the accumulation of signatures from groups and individuals who either support or oppose the decision under consideration. Petitions are generally considered to be a poor measure of the level of support or opposition for a decision largely due to the circumstances under which signatures are obtained. Individuals who sign petitions often know little about the issue on which the petition has been initiated and have no reason to become informed or to carefully consider their decision to sign because there are rarely any repercussions arising from signing. Unlike other forms of participation such as attending a meeting, contacting a

public official or even voting which is considered a low cost activity, the costs of signing a petition are almost non-existent. Despite these limitations, petitions will be taken as a form of instrumental participation as they demonstrate considerable effort taken on the part of petition initiators to influence a policy process. Petition data was obtained from the Ontario Legislative Assembly's Hansard Reporting Service between September, 1994 and June 1996.[16] Additional petition data pertaining to a specific community decision-making process (discussed in detail in Chapter 5) was obtained from district health council offices.

c) Applications received by the District Health Council

Applying for membership on a local district health council is a form of *routine* as compared to *issue-driven* participation. As positions open up on council, the DHC's nominating committee seeks applications through advertisements in the local newspaper for "community" or "provider" representatives. DHC files were reviewed to obtain the number and source (i.e., community, provider) of applications received each year.

d) Attendance at public meetings

Attending a public meeting is one of the more traditional demonstrations of democratic participation. Attendance figures were sought for all types of public meetings initiated by community groups, individuals and/or decision-making bodies. As the discussion of participation dimensions in Chapter 3 noted, attendance figures provide only a "quantitative" view of participation but provide some indication of the baseline level of involvement in a community. In addition to the number of attendees, information was obtained through the interviewing process regarding the subject,

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[16] Petitions recorded in Hansard have been submitted to provincial members of parliament and then

location and tone of the meetings as well as the characteristics of attendees (where available).

e) Community mobilization

Community mobilization involves a range of participatory acts, all pertaining to the issue of concern to community groups and individuals. It is more than holding a single meeting to discuss an issue and more than initiating a single petition to oppose something. It represents all of the participatory acts taken over a relatively short period of time to influence a decision-making process and is typically characterized by its *initiator* (i.e. the community as opposed to decision-makers). Meeting attendance, petitions and the establishment of organizations around a particular issue were all included as participatory acts that, taken together, constitute community mobilization.

II. Data for Pre-disposing Influences

As described in Table 4-2, structural and social characteristic data obtained from census reports and voting records were used in the community selection process. During the case study process, however, additional data were collected for each of these categories. Secondary data was collected for three indicators of social capital: blood donation; density of associations; and voluntarism. Each of these is described below.

a) Blood donation

Blood donation was introduced to the study as a new indicator of social capital. This indicator has not previously been used in this field and therefore represents a new contribution to the literature. A voluntary act taken by a group of

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read by that member in the legislative assembly.

individuals for the benefit of other members of the community, blood donation was thought to be a strong indicator of social capital. The motivation underlying the act of donating blood in Canada falls under Titmuss' description of the "voluntary community donor":

> *This type is the closest approximation in social reality to the abstract concept of a 'free human gift'. The primary characteristics of such donations are: the absence of tangible immediate rewards in monetary or non-monetary forms; the absence of penalties, financial or otherwise; and the knowledge among donors that their donations are for unnamed strangers without distinction of age, sex, medical condition, income, class, religion or ethnic group. ... They are acts of free will; of the exercise of choice; of conscience without shame.*
>
> (Titmuss, 1971:88-89)

The Red Cross of Canada manages the blood donation system in Canada. Until recently, it had not allowed blood donors to engage in direct donation[16] (a practice that would allow individuals to donate to relatives, friends or other specified parties) thus reinforcing the concept of blood donation as a community-centred act. The civic-mindedness demonstrated through blood donation is illustrated in references made by Red Cross officials in discussing the location of blood donation facilities in Canada. For example, the decision to locate a new plasma-collection facility in one Ontario community sparked the following comment from a Red Cross director:

> *The challenge now is to find other locations with the same community spirit.* (Picard, 1996,Globe and Mail,A1)

Blood donation data were collected from local Red Cross offices where detailed monthly reports are produced summarizing donor attendance (including new and repeat donors) as well as the number and location of blood donation clinics held in each community.

b) Density of associations

Putnam (1993) identified the "vibrancy of associational life" as a key indicator of civic engagement and, using a census of all local and national associations in Italy, reported on the density of associations across Italian regions. This type of census data does not exist for communities across Canada or Ontario although inventories of community organizations are available in some communities. The high degree of variability in collecting, organizing and presenting this inventory data seriously limited inter-case comparisons. The approach taken to collecting and analyzing this information, however, is reported in Appendix 4-1 and its utility as a resource for future studies in this area will be discussed in the concluding chapter. In Hamilton-Wentworth, an independent study of community associations provided a rich source of data regarding the associational life of the community. The results of this study will be discussed in greater detail in Chapter 6.

c) Voluntarism

Voluntarism was selected as another indicator of social capital. Although the underlying motivations for volunteering may be selfish, when considered in aggregate, volunteer activity provides some insights into the collective "face of a community". More specifically, it is an example of the community engaging in acts of civic participation that generate and reinforce the networks that offer opportunities for collaborative problem-solving. Voluntarism was measured for two of the study communities where volunteer centres were established. In these communities, detailed statistical reports were collected to track the number of contacts made with the volunteer centre by prospective volunteers.

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[16] The practice of direct donation has recently been the subject of public debate in Canada as part of a

III. Data for Enabling Influences

Table 4-7 lists "institutional actions" thought to enable participation for which data were collected. Other enablers were generated through the interviewing process.

a) Presence of a participatory culture

Several methods were used to assess the "participatory culture" in each community. First, municipal government, district health council and school board documents were reviewed to determine whether explicit mandates for community participation existed. These included references to promoting community participation as an organizational objective, guidelines for meeting attendance and community involvement on committees and other representative bodies. The internet was used as an additional source to assess the approaches taken by regional and municipal governments to communicate with the public and solicit community participation. The extent to which a participatory culture existed in each community was also discussed with community informants during the interviewing process.

b) Institutional acts taken to encourage or reduce impediments to participation

Moving beyond organizational culture, local institutions were assessed as "enablers" based on the specific acts taken to promote or reduce the costs of participation. This data was collected through written "requests for information" from local governments, district health councils and school boards. In particular, each organization was asked to provide information concerning "mechanisms the council/board provides for the public to raise issues of concern to them or to participate in various decision-making processes of the council/board" and how these mechanisms are publicized.

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royal commission that has been established to study the circumstances surrounding the contamination of blood products within the Canadian Red Cross.

c) Media culture

The presence of a media culture that promotes participation through information dissemination was determined by analyzing the content of newspaper coverage of local issues. In particular, information was sought about the extent to which an article provided information about how community members might participate, e.g., date, time and place of a public meeting.

Table 4-7

Institutional Actions
presence of a participatory culture (e.g. mandate of local government or health care/educational decision making body)
demonstrated commitment of local institutions to encourage participation through actions designed to reduce impediments to and promote participation (e.g. percentage of budget allocated to communications through media, etc.)
presence of a media culture that promotes participation through information dissemination

IV. Data for Precipitating Influences

Precipitants to participation were described in Chapter 3 as "issues that mobilize interests" exhibited, for example, in the form of perceived threats to the safety, health or economic stability of individual or community interests. Although some general hypotheses were developed regarding the role of precipitants in the participation process, specific examples of precipitating influences were generated through the interviewing process and analysis of local media coverage.

DATA SOURCES

A fundamental principle of the case study research strategy is "the opportunity to use many different sources of evidence" (Yin, 1994, p.91). Interviews, documentation and archival records were identified as the principal sources of evidence given the characteristics of the data described in the preceding section. Direct and participant observation was used in a complementary manner.

a) Key Informants and Interviewing

One of the positive attributes of community-level studies is the ability to use secondary data to examine various structural and contextual characteristics of the

community. Interest in explaining community behaviour such as the influences on participation in the context of health care decision-making necessitate more in-depth analysis of a community's social processes such as its power structures and approaches to mobilizing resources which secondary data cannot provide (Krannich and Humphrey, 1986). Community informants became, therefore, an essential source of primary data for the study. Interviews with community informants were used as the principal data collection tool in each community.

Selection of Community Informants

The approach taken to selecting community informants was based on the principle of obtaining a variety of perspectives on the subject of participation in health care and education in each community from participants themselves and from those who manage, observe and enable the participation process. In particular, the perspectives of elected officials, senior management, community appointees and citizen participants were obtained using the sampling strategy described below.

Two general selection criteria were used:

i) representatives from similar organizations in each study community
ii)referral from previously-identified informants

Representatives were selected from the following positions within organizations:

a) senior administrative officials or chief executives for the local district health councils, school boards and regional or municipal government

b) senior elected or appointed official (i.e., chairperson) for the local district health council, school board and regional or municipal government

c) consumer or parent representatives to the local district health council or school board

d) representatives of the local media (e.g., health, education or local affairs reporter for the local newspaper

In some communities, additional administrative, elected or appointed officials were interviewed to obtain more in-depth information about a particular topic or to corroborate other sources. Another method employed to select informants was to ask informants (either at the beginning or end of the interview) to identify anyone else in their organization or in the community more broadly whom they felt should be interviewed. Appendix 4-2 presents a list of informants (by position and organizational designation) in each community. Over 80 interviews were conducted between October 1995 and August 1996. Appendix 4-3 summarizes the number of informants by community and policy sector. Fewer interviews were conducted in Nipissing District and Renfrew County than in Hamilton-Wentworth and Ottawa-Carleton due to their smaller size and lower level of complexity (i.e., smaller number of school boards). Each interview lasted approximately one hour and was conducted either in person or by telephone.[17]

Development of an Interview Guide

Appendix 4-4 presents the interview guide developed to structure open-ended interviews. A brief introduction to the study was provided which often involved briefly describing the research being conducted. The operational definition of "participation" being used in the study was provided to ensure consistency in question interpretation and responses. Interviews were conducted using the format of "a discussion about participation and its influences" rather than a structured question and answer format. This is consistent with descriptions of qualitative case study interviewing techniques where "the purpose for the most part is not to get simple yes

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[17] Attempts were made to interview everyone in person but scheduling difficulties and long distances between the research base and study communities made telephone interviews an appropriate alternative.

and no answers but description of an episode, a linkage, an explanation" (Stake, 1995, p. 65). Discussion topics included:

- a general description of participation in the community
- a more specific description of participation in the context of health care or education (depending on the informant)
- opinions regarding the various influences on participation (usually prompted by the question: "What do you think influences participation in health care or in education?)
- examples of issues that have arisen in the community that have influenced participation and a description of the way in which participation was influenced
- the philosophy of the organization or group regarding the enabling of participation

Recording the Interviews

A decision was made at the outset of the interviewing process to employ detailed note taking as the principal recording technique. A detailed summary was prepared following each interview, usually within twenty-four hours of the interview being conducted. This was found to be an excellent method for capturing the essence of the interview and minimizing the loss of any valuable information. Tape recording was used in a few interviews where it was known in advance that the interview would be long, where absolute precision was required or when a considerable amount of historical information or context was to be provided.

b) Documentation

A broad range of documents were used to collect data for various community participation measures as well as for pre-disposing, enabling and precipitating influences (i.e., DHC and school board documents describing the organization's philosophy with respect to enabling participation). Evidence obtained from these documents was also used to corroborate material obtained from key informants. These included:

- District Health Council files containing applications for Council membership
- District Health Council documents outlining attendance at meetings

- District Health Council reports, e.g., annual reports, community profiles, and consultation exercise reports
- Letters, petitions and organizational submissions to the District Health Council
- School Board reports, e.g., annual reports, organizational charts, and budgets
- Municipal government records of school board election results
- Regional and municipal government planning department reports
- Telephone and mail logs from local politicians' offices
- Newspaper clippings - collected for each community over the one-year data collection period
- Letters to the editor of local newspaper
- Summary documents from volunteer offices
- Red Cross blood donation summary reports

c) Archival Records

Profile data from the 1991 census for each census division and subdivision (i.e., all counties, districts, municipalities, cities, towns and villages) covered by the four study communities were used to construct profiles of the structural characteristics thought to influence participation (e.g., education, household income, residential mobility, etc.).

d) Direct Observation

Visits were scheduled in each community during which time interviews were conducted and time was spent reviewing local documents. The time and duration of each visit is provided in Appendix 4-5. In addition to providing the opportunity to conduct face-to-face interviews, site visits were used to obtain relevant background material and to observe the participation process in each community. Attending community meetings, reading the local newspaper and talking to individuals in their "natural habitat" provided insights into the communities that could not be gleaned through telephone interviews.

e) Participant Observation

The opportunity for participant observation was provided in Hamilton-Wentworth (researcher's home base). A close working relationship with the District Health

Council in this community permitted access to the organization's design and implementation of a community consultation exercise on the issue of health care restructuring. Insights were obtained into the health council's motivations for inviting public participation through a variety of mechanisms.

DATA COLLECTION

The process of data collection can be most appropriately described as iterative. The same steps were taken in each community although the order in which they were followed may have differed slightly from one to the next. In general, data was collected using the following process:

Step 1 - Site visits to each community to conduct the first round of interviews with key informants (i.e., those identified by position and organization), to study and obtain documents relevant to the analysis

Step 2 - Analysis of documents obtained during site visits to identify the data collected and remaining gaps
- completion of first round of interviews by telephone (i.e., those that could not be arranged during the site visit period)

Step 3 - Return visits to two communities to conduct a second round of interviews (based on referrals from informants previously interviewed)

Step 4 - Additional telephone interviews conducted

ANALYSIS

Analysis focussed primarily on developing participation profiles for each community and on explaining the independent and combined influences exerted by predisposing, enabling and precipitating influences on participation. Interspersed between each of these data collection steps described above, the analysis also reflected an iterative process of reviewing data, categorizing information, and preparing preliminary briefs to summarize the information collected along the way. Although a discussion of the approaches to interpreting and analyzing the data is included as an

introductory section to Chapter 5, in general, the following steps were taken in the analysis process as preliminary steps to writing up the cases:

Phase 1 - Profiles of Participation (from documents and interviews)

Documents obtained from all relevant organizations were used to extract participation data. In addition, all descriptive information about participation was extracted from interview summaries.

Phase 2 - Profiles of Community Characteristics as Influences on Participation (from census data and other sources of quantitative data)

This phase expanded on the preliminary work conducted during the case selection process described earlier. Information for each community was compiled into summary tables to be used to compare the relative role played by community characteristics as influences on participation.

Phase 3 - Profiles of Community Characteristics as Influences on Participation (from interviews)

Interview material was analyzed to extract all characteristics identified by informants as exerting an influence on participation.

Phase 4 - Profiles of Institutional Actions (from documents and interviews)

Documents obtained from DHCs and school boards were analyzed to extract information pertaining to the organization's position or philosophy regarding community participation. In the case of school boards, organizational charts were examined to assess the level of parent involvement on board committees and the official relationship between the board and parent groups.

Phase 5 - Profiles of Issues as Precipitants of Participation (from documents and interviews)

Analysis of newspaper clippings identified issues that had arisen in each community before and during the study period.

DATA VALIDITY

> *Triangulation uses up resources ... so only the important data and claims will be deliberately triangulated. Importance depends on our intent to bring understanding about the case and on the degree to which this statement helps clarify the story or differentiate between conflicting meanings. If it is central to making the "the case", then we will want to be extra sure that "we have it right."* (Stake, 1995, p. 112)

A unique feature of case study research, and one of the principal reasons for employing this research strategy, is the use of multiple sources of evidence to generate a set of facts or findings. As Yin (1994) discusses: "the most important advantage presented by using multiple sources of evidence is the development of converging lines of inquiry, [known as] ... triangulation ... " (p.92). The principle underlying the concept of triangulation is that case study findings or conclusions, if they are based on several different sources of information that corroborate each other, will be more accurate and convincing. Different types of triangulation may be used in case study research (Stake, 1995). Those used in this study include:

Data Source Triangulation - gathering data from more than one individual or organization representing a particular perspective. Applying this to the study of participation in health care, for example, data source triangulation would (and did) involve interviewing more than one person from a DHC or school board and interviewing individuals in the same position or organization but within different communities.

Investigator Triangulation - several investigators gathering the same data or making the same interpretations based on the data. This triangulation method was not used due to the independent nature of this study.

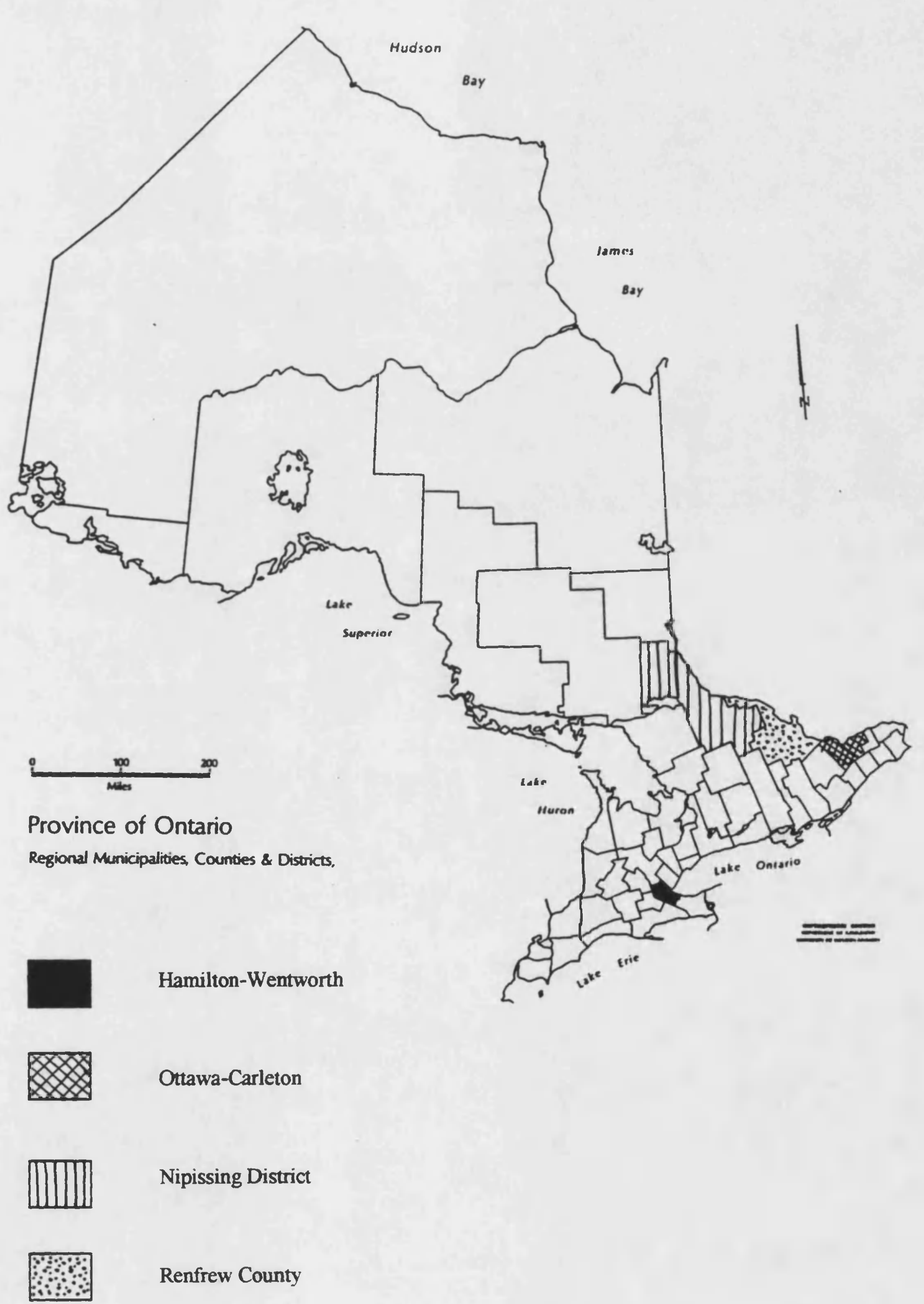
Theory Triangulation - reaching the same findings or conclusions from different theoretical perspectives or different behavioural models. Although this method is most suitable for studies where there are multiple investigators from different disciplinary backgrounds, an interdisciplinary approach to studying participation was adopted at the outset of the study enabling limited use of theory triangulation by a single investigator.

Methodological Triangulation - obtaining the same results or reaching the same conclusions using different data collection methods (e.g., interviews and documentary evidence). This triangulation method was used extensively throughout the analysis and was a secondary objective of the research study.

SUMMARY

Before turning to the presentation of findings and analyses that follow in the next four chapters it may be worth reflecting on the implications of embarking on an exploration of participation's complexities. The model presented in the previous chapter, and the methods described here have articulated the need and mapped a course for such an inquiry. It focuses on tracking the multiple dimensions of participation within its multiple contexts (e.g., geographic and policy) and endeavours to accomplish this using both qualitative and quantitative methods. There is a trade-off in using this type of research design to study a complex subject. Although a rich body of knowledge may be produced on the subject there may be a narrow scope for drawing clear conclusions. In light of this trade-off, then, it may be useful to consider this a pilot study in assessing the costs and benefits of approaching the study of participation this way.

Figure 4-1



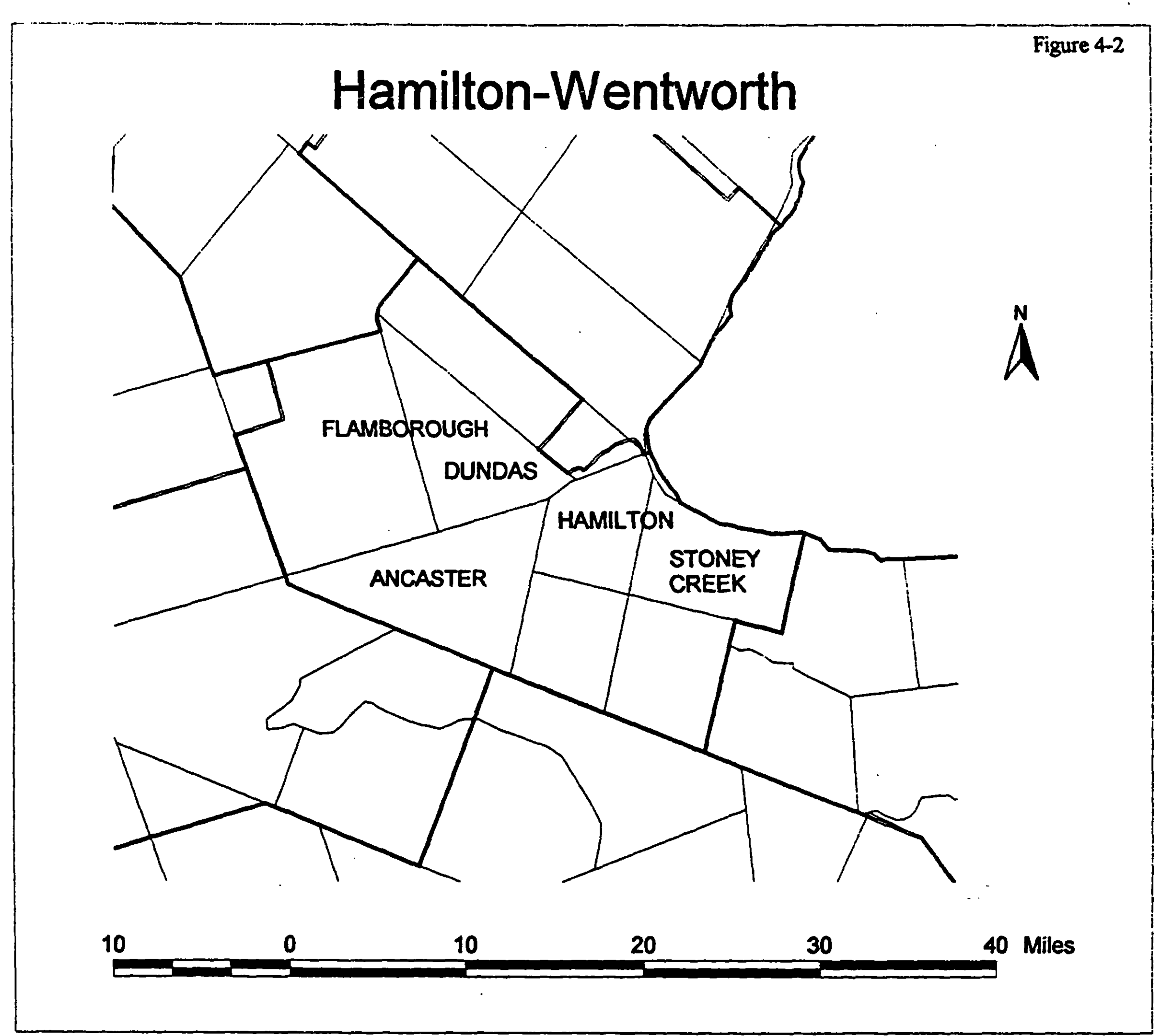
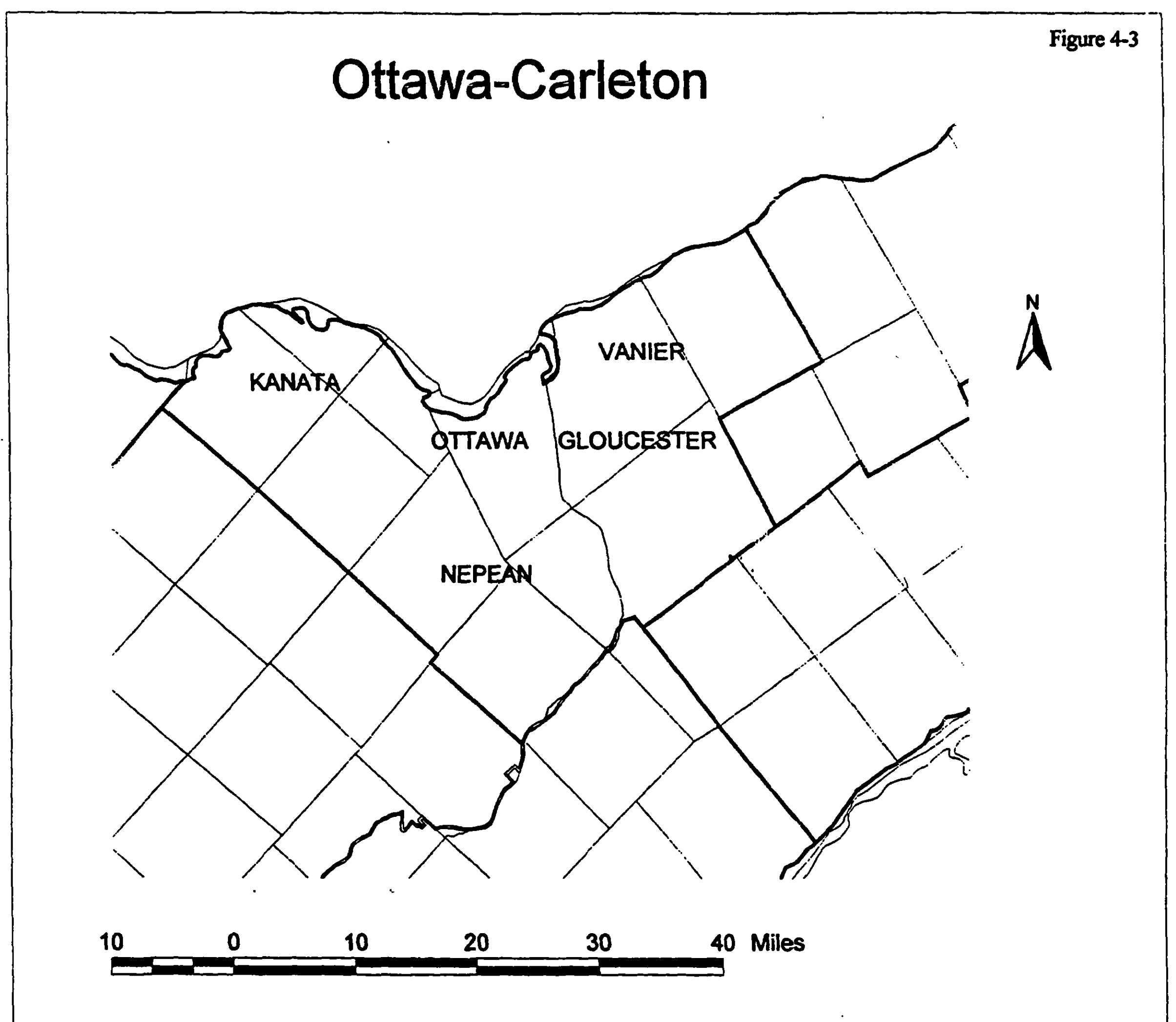


Figure 4-2
Hamilton-Wentworth
N
FLAMBOROUGH
DUNDAS
HAMILTON
STONEY
CREEK
ANCASTER
10
0
10
20
30
40 Miles

Figure 4-3



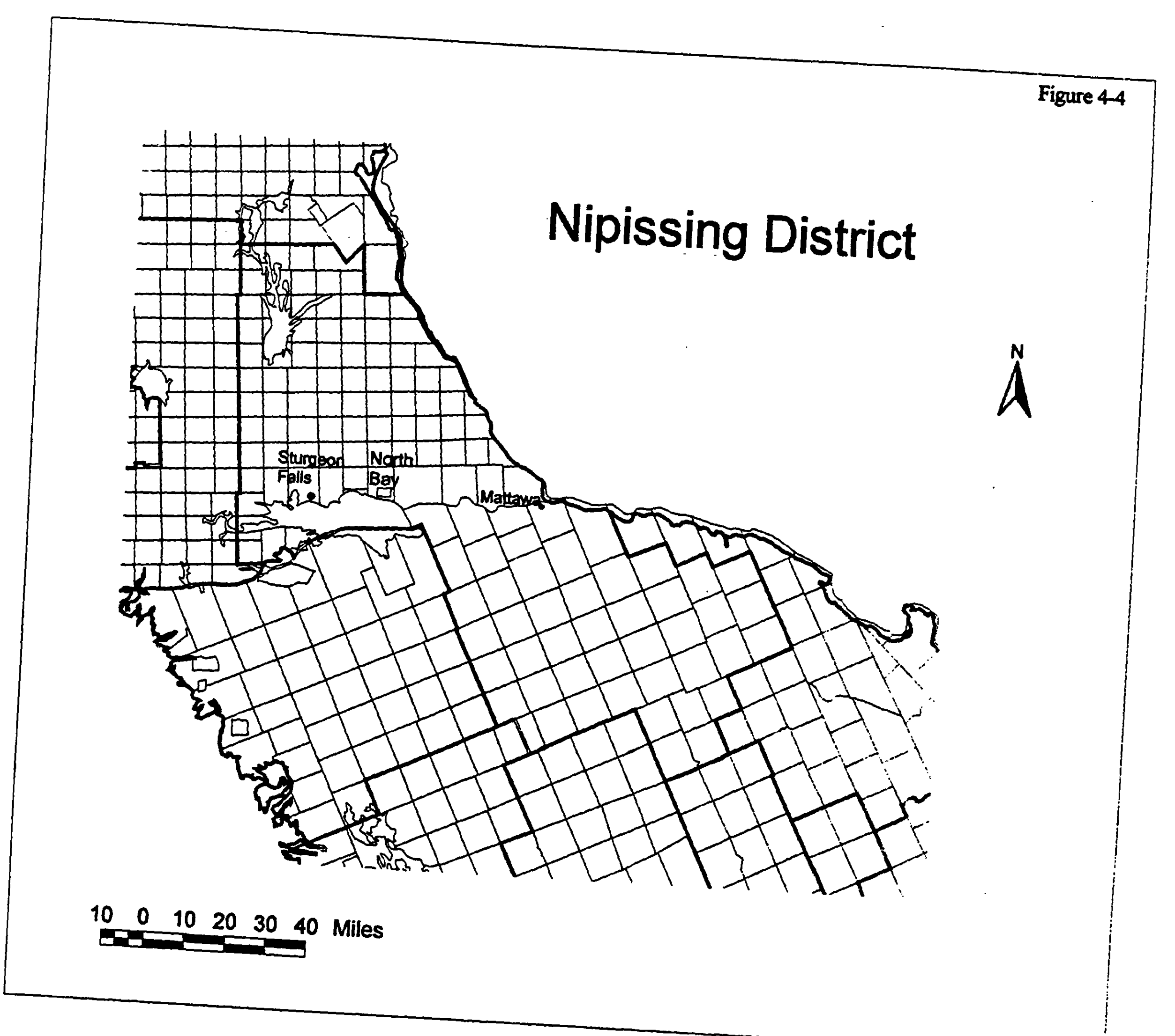


Figure 4-4
Nipissing District
N
Sturgeon Falls
North Bay
Mattawa
10 0 10 20 30 40 Miles

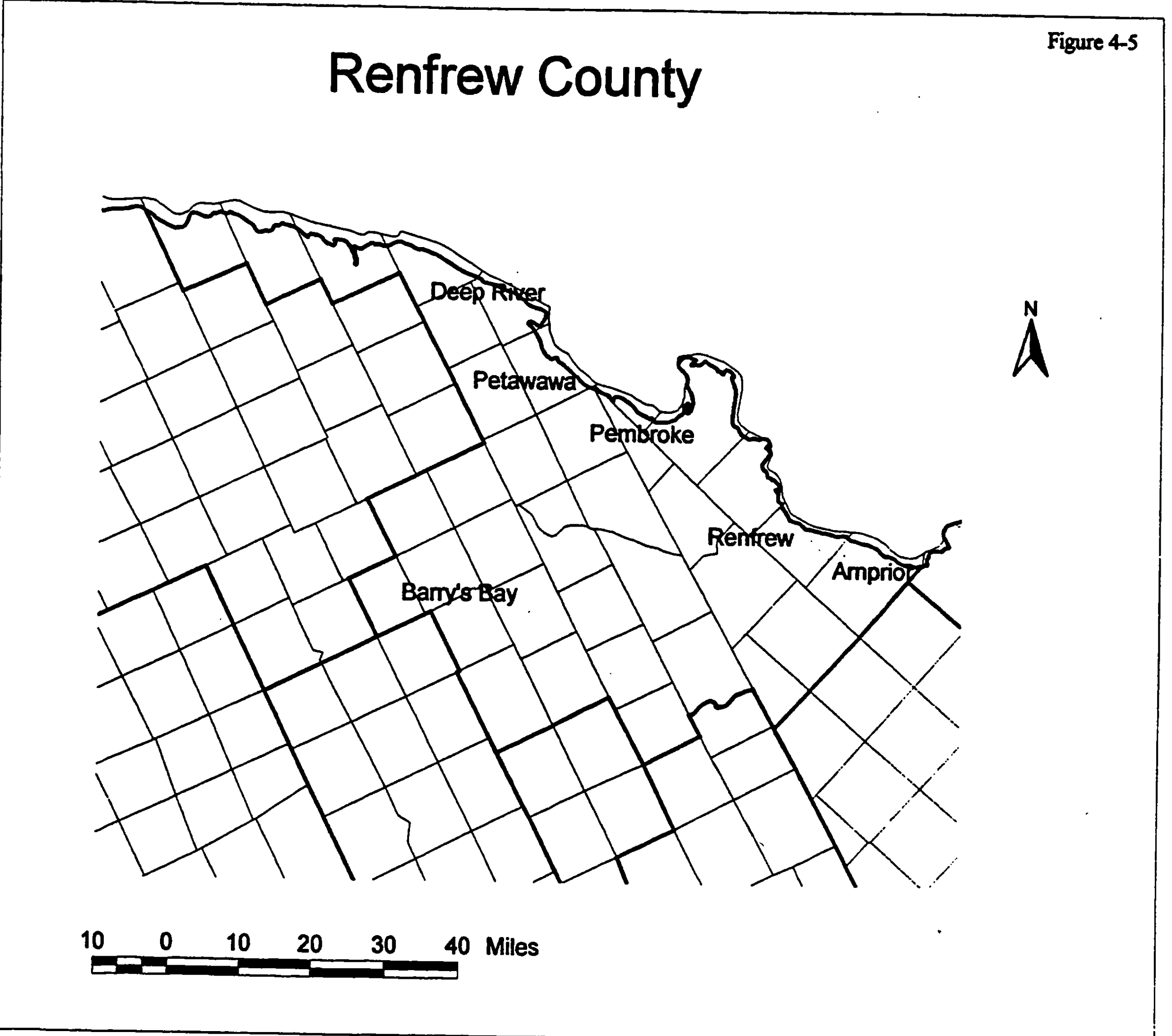


Figure 4-5
Renfrew County
Deep River
Petawawa
Pembroke
Renfrew
Arnprior
Barry's Bay
N
10 0 10 20 30 40 Miles

Appendix 4-1

Collecting Associational Density Data

1. Contact was made with public libraries, planning departments and community information centres (where available) in each municipality under study to obtain lists of community organizations

2. Organizations were broken down into the following categories:

a) organizations representing the interests of residents of defined geographic communities
e.g. community/neighbourhood associations, citizens' groups, etc.

b) organizations representing educational interests e.g. parents associations

c) organizations representing health care interests e.g. citizens for the local hospitals

d) each of the above organizations were further broken down by municipality

3. "Associationalism" (i.e. the tendency towards organizing) was measured by:

a) total number of organizations listed for each municipality divided by the total population for that municipality (to obtain an aggregate per capita measure)

b) total number of each category of organization (e.g. community, education, health) for
each municipality divided by the total population for that municipality

c) proportion of "communities/neighbourhoods" with a community/neighbourhood association - using a map of community/neighbourhood boundaries with listing of associations plotted on map to identify which neighbourhoods have associations

Appendix 4-2

List of Interviewees by Position and Organization for each Community

Hamilton-Wentworth

Health Care	Education	Other
Hamilton-Wentworth DHC Executive Director Chairperson Long-term care planners (2) Council member (regional government representative) Council member (consumer representative) Department of Public Health Medical Officer of Health Former Medical Officer of Health	City of Hamilton Board of Education Chairman of the Board Director of Education Board trustee President, Home and School Association Wentworth County Board of Education Chairman of the Board Assistant to the Director of Education President of the Council of Home and School Associations Hamilton-Wentworth Roman Catholic Separate School Board Chairman of the Board Director of Education Superintendant of Education President of Joint Elementary Parents Advisory Group	Government Chairman of Regional government Chief Executive Officer of regional government Chairman, Regional Health and Social Services Committee Director of Environmental Services, Regional Public Health Department Community Executive Director, Social Planning and Research Council Retired Director of Social Services for the Region and long-time community volunteer

Ottawa-Carleton

Health Care	Education	Other
Ottawa-Carleton Regional DHC Executive Director Former executive director Chairperson Project Coordinator, Health System Reconfiguration Project Communications consultant Senior health planner Long-term care planner Associate Medical Officer of Health Community Leader re: community-based health care (former health council member) Community Leader re: long-term care Local health policy analyst	Ottawa Board of Education Chairman of the Board Director of Education Past Chair, Joint Council of Elementary and Secondary Advisory Committees Carleton Board of Education Chairman of the Board Assistant Secretary to the Board Director of Research and Planning Director of Communications President, Carleton Council of Parents' Associations Ottawa Roman Catholic Separate School Board Chairman of the Board Superintendant of Education President, Board Parent Advisory Committee Carleton Roman Catholic Separate School Board Chairman of the Board Director of Education Chair, Parent Communications Committee	Regional Government Academic expert on regional government Retired member of regional planning department

Nipissing District

Health Care	Education	Other
<u>Nipissing-Temiskaming DHC</u> Executive Director Chairperson Planning staff (3) <u>Department of Public Health</u> Medical Officer of Health	<u>Nipissing District Board of Education</u> Chairman of the Board Director of Education Parent representative <u>Nipissing District Roman Catholic Separate School Board</u> Chairman of the Board Director of Education Board trustee and chairman of the Special Education Advisory Committee	<u>Municipal/Provincial Government</u> Mayor of North Bay Assistant to provincial member of parliament Director of Social Services, municipal government <u>Media</u> Health reporter for local newspaper <u>Community</u> Director of child care council and community activist Sociologist and community representative on various decision-making bodies

Renfrew County

Health Care	Education	Other
<u>Renfrew County DHC</u> Executive Director Chairperson Planning staff (2) Council member Health care interest group leader Community leader re: long-term care	<u>Renfrew County School Board</u> Board Chairperson Parent representative <u>Renfrew County Roman Catholic Separate School Board</u> Board Chairperson Director of Education Parent representative on school board committees	<u>Media</u> Health reporter for local newspaper <u>Government</u> Member of provincial parliament for Renfrew County

Appendix 4-3

Number of Interviews Conducted in each Community

	Hamilton-Wentworth	*Ottawa-Carleton*	*Nipissing District*	*Renfrew County*
Health Care	8	11	6	7
Education	11	13	6	5
Other	6	2	6	2
Total	**25**	**26**	**18**	**14**

Profile of Community Informants

	Health Care	Education	Other	Total
Male	10	17	11	36
Female	21	19	4	45
Total	**31**	**36**	**15**	**82**
Volunteers	9[18]	9	2	20
Elected official	1	13	4	18
Paid staff	21	14	9	43
Total	**31**	**36**	**15**	**82**

[18] Four of these 9 health care volunteers were elected to the position of district health council chairperson.

Appendix 4-4

Draft Interview Instrument

Introduction

1. Briefly describe research objectives and purpose of interviews (i.e. to obtain background information about participation in health care/education for each community). "The interview should take no more than 40 minutes ..."

2. Provide them with definition of participation that I am using for my research and ask that they respond to the questions using this definition.

3. Ask if there is anyone else who they think should be interviewed to obtain this information (e.g. former staff or chairperson, leader of community organization, etc.)

Section A – How participatory is this community?

In your position as ________________________, what have you observed about the participatory nature of ________________________?

For example, would you say that it is a highly participatory community?
Are certain groups more active than others?
Do certain geographic areas tend to be the source of more participation than others?
Would you characterize the participation that occurs as being broad-based (i.e. widespread participation on a variety of issues) or narrow and issue-specific (i.e. smaller number of groups participating in response to specific issues)?

What are the various ways in which individuals and groups participate?

Are certain methods used more frequently than others?

Does the method of participation used depend on the nature of the issue?

To what extent does participation depend on the actions taken by organizations such as the health council/school board to invite participation or is it driven more by grass-roots organizations?

What is your estimate of the percentage of participation that is institutionally driven vs. initiated by individuals and organizations themselves?

Section B - Issues and Participation

To what extent do you think participation is purely reactive (i.e. it occurs in response to an issue that arises in the community)?

Are there other things that influence participation besides an issue?

What are the 1 or 2 issues that have arisen over the past couple of years that have generated the most significant and intense levels of participation in ____________________? Describe the participation that took place, over what period of time, etc?

What are the current issues that the DHC/school board is facing which are likely to stir activity within this community over the next year?

Section C – Enabling Factors

What is the philosophy of the DHC/school board with regard to enabling participation in decision-making?

What is your best estimate of the percentage of the DHC/school board budget that is allocated to enabling participation?

Do you ever evaluate any of these enabling mechanisms? If so, how and how often?

Appendix 4-5

Community Visit Schedule

Nipissing
October 16 - 20, 1995

Ottawa-Carleton
November 13 - 17, 1995
February 19 - 23, 1996
May 15 - 16, 1996

Renfrew County
February 21, 1996
May 17, 1996

Hamilton-Wentworth
Researcher's home base - no travel required

References to Chapter 4

Association of District Health Councils of Ontario. (1994). *Citizen Participation in the Local Planning Process: Broadening the Spectrum.* Toronto: ADHCO.

Checkoway, B., O'Rourke, T. and Bull, D. (1984). Correlates of Consumer Participation in Health Planning Agencies: Findings and Implications from a National Survey. *Policy Studies Review*, 3, 296-310.

Creswell, J. (1994). *Research Design: Qualitative and Quantitative Approaches.* Thousand Oaks, California: Sage Publications.

King, G., Keohane, R. and Verba, S. (1994). *Designing Social Inquiry: Scientific Inference in Qualitative_Research.* Princeton: Princeton University Press.

Krannich, R. and Humphrey, C. (1986). Using Key Informant Data in Comparative Community Research. *Sociological Methods and Research.* 14 (4), 473-93.

McKnight, J. and Kretzmann, J. (1990). *Mapping Community Capacity.* Evanston, Ill.: Centre for Urban Affairs and Policy Research Report, Northwestern University.

Picard, A. (1996). Plasma facility a first in Canada. *Toronto Globe and Mail*, 1 Jan. 1996, A1.

Postman, N. (1988). Social Science as Moral Theology. In: *Conscientious Objections*, pp.3-19. New York: Knopf, Inc.

Putnam, R. (1993). *Making Democracy Work: Civic Traditions in Modern Italy.* Princeton: Princeton University Press.

Sharp, E. (1982). Citizen-Initiated Contacting of Government Officials and Socioeconomic Status: Determining the Relationship and Accounting for it. *The American Political Science Review*, 76, 109-115.

Stake, R. (1995). *The Art of Case Study Research.* London: Sage Publications.

Statistics Canada. 1994. Profile of Census Divisions and Subdivisions in Ontario – Part B. Ottawa: Minister of Industry, Science and Technology.

Titmuss, R. (1971). The Gift. In: *The Gift Relationship: From Human Blood to Social Policy.* pp. 70-89. New York: Pantheon Books.

Yin, Robert. (1993). *Applications of Case Study Research.* London: Sage Publications.

Yin, Robert. (1994). *Case Study Research: Design and Methods.* London: Sage Publications.

CHAPTER 5

PARTICIPATION PROFILES

The Organization of Research Findings

The characteristics that give multiple case studies their value as a research design pose considerable challenges for the researcher when it comes to presenting and interpreting the research findings. In an exploratory study such as this one, choosing a reporting format results from the process of organizing and analyzing the material collected throughout the study and engaging in the writing process itself. With so many relationships being explored, in the context of four communities and in two policy sectors, a systematic approach to presenting and analyzing the research findings is needed. Although the material could have been organized in any number of ways, the following method was chosen:

Individual profiles of participation and its influences on health care are presented for each community in this chapter. Within each profile a separate discussion is devoted to the subject of issue-driven participation and the case of hospital closures which arose in three of the four study areas. A cross-case analysis of pre-disposing, enabling and precipitating factors and their <u>independent</u> influence on participation in health care is the focus of Chapter 6 to be followed by a cross-case analysis of the <u>combined</u> influence of pre-disposing, enabling and precipitating influences on participation in health care in Chapter 7. Finally, Chapter 8 compares the case of health care participation with that of education

COMMUNITY PROFILES

To provide some context for the presentation of participation profiles, a brief description of each community is presented in Appendix 5-1

I. Community Profiles of Participation - A Case-by-Case Narrative

The profiles presented below were compiled using qualitative data generated through the interviewing process (i.e., answers to the question: "What are your observations about participation in Hamilton-Wentworth, Ottawa-Carleton, etc.?") and quantitative data (e.g., applications for membership on the district health council, attendance at community meetings, contacts with members of provincial parliament and petitions) collected from secondary sources identified in Chapter 4. While the primary objective of this chapter is to describe the participation observed in each community, there will be some preliminary discussion of the influences that shape the observed participation that will be elaborated on in Chapter 6.

A. Hamilton-Wentworth

> *Hamilton-Wentworth is typical of many other communities -- until an issue affects them directly you don't see people getting involved.*
>
> *... there is nothing unusual about Hamilton-Wentworth as compared to other communities.*
>
> *[Hamilton-Wentworth is] a pretty active community with regard to input into decision-making.*

Participation in local affairs was depicted as "typical of the participation demonstrated in most communities" although some consensus emerged that the community was more active in providing input into local decision-making. Several informants used the words "combative and unpretentious" to describe the community's approach to participation. Feelings of neglect and a sense of impoverishment and inferiority due to its "steel town" image and close proximity to

Toronto were also attributed to the community and thought to spur an "aggressiveness" in the community's demand for ownership of local government and involvement early on in a decision-making process. Institutions such as school boards, district health councils and regional government respond to these demands by offering opportunities for widespread community involvement such as public consultation exercises in health care planning, visioning exercises to establish priorities for regional government and constituent assemblies to provide input into local government restructuring (see detailed discussion of "enablers" in Chapter 6). These mechanisms, in turn, had the effect of sustaining the public's expectations for involvement. Size was often used to explain the accessibility demanded of its local decision-makers and the ease with which the community communicates its dissent or approval of local decision-making. Informants frequently stated that the community "is large but not too large". One local politician recounted being told, upon moving to the area, that Hamilton is "Canada's biggest small town or smallest big city". Linked to its manageable size was a degree of informality that characterized the community that provided the public with the perception that they can influence their decision-makers with relative ease.

> *Everyone knows everyone and all the players. ... There is easy access to all the players ... and people expect to have this easy access.*
>
> (Municipal politician)

A relatively stable population creates an atmosphere of people having grown up with each other, providing the roots for the establishment of informal networks and a civic-minded community. Hamilton-Wentworth has a well-established voluntary sector and

a vibrant associational life that provides an infrastructure for participation.[1] It was also described as having "a strong network of interest groups" to facilitate community outreach.

Community informants repeatedly spoke of a strong culture of partnership and co-ordination that has developed in the human services arena over the last two decades. The university's vision, strong leadership from the medical community as well as a "labour mentality" and the history of meeting and organizing that goes along with a strong union presence in a blue collar town were reasons cited for this strong partnership orientation.

The culture of this town is that we work together.

(District Health Council executive director)

Examples include the joint hospital council made up of chief executives of the area hospitals, the Social Planning and Research Council and the Coalition of Community Health and Support Service, a service provider network linking health and social services agencies in the community which began as a sub-committee of the District Health Council.

With respect to the context within which participation occurs, Hamilton-Wentworth was described as:

> *... a medium-sized community with stable power structures and a large group running things, not an internal clique.*
>
> (Former health council chairperson)

[1] The role of Hamilton's voluntary sector and associational presence will be described in more detail in chapter 6.

Participation in Health Care

Observations of participation in the health care sector were consistent with those of participation in local affairs more generally. Referring to the dimensions of participation described in Chapter 3, the *texture* (i.e.,breadth vs. depth) of participation was characterized by a high degree of co-ordinated participation from the "stakeholder community" accompanied by the expectation of being consulted in the decision-making process. Partnerships common to this sector are facilitated by the community's manageable size. As one health official noted: "Hamilton-Wentworth is small enough for people to know each other but big enough for there to be expertise." A former hospital executive described the culture in this way:

> *A 20-year tradition of collaborative work toward building and maintaining the Faculty of Health Sciences. Each hospital had equal membership in the network and there was a strong expectation of commitment to the network.*

Partnership and co-operation were not always cast in a positive light though. One municipal councillor, with minimal involvement in local health care issues, observed that the "health care lobby is very organized" and hospitals and the district health council wield considerable influence and power in the community. Another informant suggested that co-operation does not necessarily lead to better outcomes:

> *In communities where there is no culture of co-operation, the partnerships that are formed may be more successful.*

There were mixed views regarding the general public's participation in health care decision-making. While some acknowledged that everyone in the community had a stake or an interest to pursue (therefore contributing to widespread community involvement), most expressed the opinion that the community held an elitist view of who should be involved in health care decisions, a view thought to be driven by the

health care elite itself. One senior regional politician identified a "lack of sophistication and feeling of intimidation" among the public with respect to its involvement in health care decision-making. A review of applications received for membership on the local district health council provides some empirical support for these observations. Of the 51 applications received in 1995 for membership on the district health council, two-thirds (34) were submitted by providers as compared to one-third (17) from consumers.[2]

Several informants suggested that the public were more comfortable discussing and participating in general municipal affairs such as transportation or broader health issues such as the environment than getting involved in health care. The *tone* of participation in health care was thought to be more polite due to the respect felt towards physicians and hospital administrators. This intimidation and deference to the community's health care elite was believed to perpetuate the local hospitals' ability to persuade local decision-makers to support them leaving the public prone to manipulation. The following comments support this view:

> *We're just little Hamiltonians, what do we know about health care?*
>
> (Former medical officer of health)

> *The broader community leaders like the chamber of commerce and regional government had tremendous blinding respect for hospitals.*
>
> (Former hospital president)

References to the power exerted by the university and health care elite over the health care decision-making process were also made:

> *[The] [h]ealth sciences and the university has an infrastructure of its own and can inhibit community involvement because of its power.*

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[2] A description of the application data was provided in Chapter 4.

(Former health council chairperson)

Referring to the *form* of participation, the ease with which participation could be obtained for short-term, narrow and well-defined issues was compared to the challenges inherent in initiating and sustaining longer-term routine participation. As indicated by the quotation at the beginning of this section, Hamilton-Wentworth was viewed similarly to other communities in its propensity for widespread participation to be driven by issues directly affecting them.

Petition data obtained for Hamilton-Wentworth support informants' observations of issue-driven participation. Table 5-1 presents health care petition data obtained from the Ontario Legislative Assembly's Hansard Reporting Service between September, 1994 and June 1996.[3] During this period 13 petitions were submitted pertaining to health care matters. The table provides a comprehensive summary of the petitions including the subject, number of signatures, source and where it was submitted.

[3] Petitions recorded in Hansard have been submitted to provincial members of parliament and then read by that member in the legislative assembly. A detailed description of this data was provided in Chapter 4.

Table 5-1

Health Care Petition Data for Hamilton-Wentworth
September 1994 - June 1996

Subject	Number of petitions	Source	Signatures	Submitted to (e.g., location and member of parliament
Opposition to cuts to French Language Services[4]	3		2000 200	Hamilton (opposition member)
Opposition to cuts to single health care organization[5]	1	Leadership of health care organization	1300	Hamilton (opposition member)
Opposition to proposed closure of Catholic hospital[6]	8			Hamilton (all petitions filed with the only 2 opposition members in community)
Opposition to health care funding cuts[7]	1			Hamilton (opposition member)

The table illustrates that all 13 petitions dealt with community opposition to funding cuts most notably pertaining to a single health care facility slated for closure.[8] The data are also noteworthy in that all petitions were submitted to City of Hamilton constituency offices of opposition rather than governing members of parliament. This may represent a bias toward the overreporting of petition data in constituency offices where members of parliament are keen on demonstrating opposition to government

[4] Legislative Assembly of Ontario. Official Report of Debates (Hansard). 1st Session, 36th parliament. November 2, 28 and December 13, 1995. Toronto: Queen's Printer.
[5] Legislative Assembly of Ontario. Official Report of Debates (Hansard). 1st Session, 36th parliament. December 12, 1995. Toronto: Queen's Printer.
[6] Legislative Assembly of Ontario. Official Report of Debates (Hansard). 1st Session, 36th parliament. March 19, 20, 21, 25, 26,27 and April 3, 1996. Toronto: Queen's Printer.
[7] Legislative Assembly of Ontario. Official Report of Debates (Hansard). 1st Session, 36th parliament. December 11, 1995. Toronto: Queen's Printer.
[8] The subject of hospital closures is discussed in greater detail later on in this chapter - see "The Case within a Case - Health Care Restructuring and Issue-driven Participation"

policy. One might also expect there to be a bias toward underreporting petition data from governing member constituency offices where there is less enthusiasm for demonstrating community opposition to government policies.[9]

Intra-case Variations

The most outstanding aspect of the participation observed in Hamilton-Wentworth was the degree of heterogeneity observed within the region. Community informants made frequent references to variations in the participation exhibited throughout the region:

> *Hamilton-Wentworth municipalities are much less homogeneous than those in Ottawa-Carleton.*
>
> (Regional politician)
>
> *Local identities are very strong across municipalities.*
>
> (Social planner)
>
> *Pockets within Hamilton-Wentworth have shown involvement.*
>
> (Former DHC executive director)
>
> *There is a high degree of variation across communities within Hamilton-Wentworth. Dundas has a small town feel but the City of Hamilton does not. You need a sense of community to get involved therefore you would expect Dundas to have greater community involvement than Hamilton.*
>
> (Former DHC chair)

Numerous examples of these variations were generated through the interviewing process. Reactions to public health hazards in two communities illustrate these variations. In 1994, a group of children from a low-income neighbourhood in the north end of Hamilton were exposed to mercury in an abandoned warehouse. In the words of a former regional government official responsible for handling this situation:

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[9] Although no one would confirm that over- and underreporting goes on, a staff member from one opposition member's constituency office did acknowledge that they had received petitions from groups

"We thought the community would go wild over this". A telephone hotline was set up for concerned community residents to obtain information but no one called. In striking contrast to the lack of involvement described in this deprived north end neighbourhood, community concerns over an abandoned facility located in the more affluent west end of the city led to "many community meetings".

The secondary participation data collected for the region revealed striking variations. Dundas residents exhibited high levels of both *routine* and *issue-driven* forms of participation. They applied for membership on the district health council and attended community consultation meetings around issues such as hospital restructuring and long-term care in disproportionately higher numbers than did residents of other municipalities in the region.

Table 5-2 presents attendance figures for two community meetings held on the subjects of planning for long-term health care specifically (middle column) and for the health services system more generally (right hand column). Each of these meetings was held during a period of community consultation (i.e. participation was *solicited* by the local district health council). Of the total number of participants in each of the consultations, 18% attended the meetings held in Dundas despite Dundas accounting for only 5% of the region's total population. The table also shows that Dundas recorded the second highest attendance ratings in the region for both consultations. The DHC application data presented in Table 5-2a indicate similarly high levels of participation as compared to the rest of the region with Dundas recording the second highest number of applications, second only to the City of Hamilton, with 15 times the population.

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outside of their constituency who did not feel that their voice was being heard through their own

Table 5-2

Participation Patterns for 2 Different Consultation Exercises in Hamilton-Wentworth

Municipality (proportion of regional population)	LTC Consultation Attendance[10] (April - June 1994)	Health Services Restructuring Consultation Attendance[11] (January 1996)
Ancaster (5%)	41 (16%)*	77 (14%)**
Dundas (5%)	47 (18%)	99 (18%)
Flamborough (7%)	24 (9%)	49 (9%)
Glanbrook (2%)	104 (40%)	25 (4%)
Stoney Creek (11%)	18 (7%)	61 (11%)
Hamilton (71%)	29 (11%)	245 (44%)
Total	263	556

* percentage of total attendance for long-term care consultation
** percentage of total attendance for health services restructuring consultation

Table 5-2a
Applications for DHC Positions
***Hamilton-Wentworth* (applications received in 1995)**

	Consumer	Provider	Total
Hamilton	11	24	35
Ancaster	1	2	3
Dundas	4	4	8
Flamborough	0	1	1
Stoney Creek	0	0	0
Other	1	3	4
Total	**17**	**34**	**51**

Note: Hamilton-Wentworth DHC does not retain applications dating back more than one year

governing member of parliament.
[10] Source: Hamilton-Wentworth District Health Council. Long Term Care Consultation Files.
[11] Source: Hamilton-Wentworth District Health Council. Health Action Task Force Working Paper on Open Consultation. February 23, 1996.

The tiny township of Glanbrook (population 9800) should also be noted for its demonstration of high participation levels. Meetings to discuss the issue of long-term health care planning were held throughout the region between April and June 1994. Out of 263 total attendees, 104 attendees were from Glanbrook, a disproportionately high turn out for its small population. Explanations for these findings are discussed in Chapters 6 and 7 in the cross-case analysis of the influences on participation.

The secondary data presented above should be considered in light of certain limitations. The reader is reminded that these results reflect participation observed over a one-year period and as such, their ability to represent more general participation trends is limited.

Issue-Driven Participation - The Case of Health Care Restructuring

As discussed in chapter 1, health care restructuring and its underlying objective of health care expenditure reduction, has been a dominant health care issue in Canada for the past number of years. Hospital closures, the focal point for achieving health care savings, have emerged as the most visible and contentious aspect of the restructuring process. In Ontario communities, district health councils have been assigned the task of leading local health care restructuring processes and providing recommendations to the provincial government regarding the reallocation and reconfiguration of health care services in their communities. As the fieldwork portion of this inquiry began, health care restructuring processes were being initiated in Hamilton-Wentworth and Ottawa-Carleton, providing an excellent opportunity to conduct an in-depth study (i.e., "a case within a case") of issue-driven participation in these two communities. Renfrew County had already begun its hospital restructuring process before it became the centrepiece of the newly elected Conservative

government's deficit-reduction platform in the spring of 1995. As my fieldwork began, Renfrew County was immersed in an acrimonious debate about the future of one of its two hospitals. As such a retrospective approach was taken to observing the restructuring process in this community.

The restructuring events observed in the above communities did not take place in Nipissing District. Prior to the beginning of the study period, North Bay's two hospitals had merged under a single administration, the outcome of a 10-year process involving the senior medical and administrative personnel of the two hospitals with no community involvement. The absence of community involvement in this restructuring process is noteworthy and will be discussed in greater detail in Chapters 6 and 7.

A brief chronology and description of each community's involvement in the restructuring process is presented in each of the participation profiles. A detailed analysis of this process, guided by the analytic model developed in Chapter 3, follows in Chapters 6 and 7.

Health Care Restructuring in Hamilton-Wentworth

<u>The Role of the DHC - Soliciting Participation</u>

The DHC launched its restructuring process with the establishment of a Health Action Task Force in January 1995 which had the mandate to "study the region's network of programs, services, institutions and care providers with a view to preparing a Comprehensive Health Care Plan" (Hamilton-Wentworth DHC, 1995). A testament to the community's tradition of demanding input into local decision-making processes (and decision-makers' response to this demand) was the District Health Council's decision to establish the Health Action Task Force comprised of "ten

members with broad-based experience and commitments to the community" rather than representing any particular health care interest (Hamilton-Wentworth DHC, 1995).

Following four months of study and consultation with health care providers, the Task Force released a set of preliminary ideas for public discussion on January 4, 1996. The ideas were distributed in a tabloid that accompanied the local newspaper and through public institutions such as libraries, hospitals, community centres, etc. This was followed by four days of open houses (2 held concurrently on each day) in different parts of the region. The public was also invited to submit responses in writing, by fax or through a 24-hour "1-800" (i.e., no charge) telephone line. Open house participants were encouraged to complete an exit questionnaire that solicited their views on the concepts outlined in the tabloid.

The Community's Response

In contrast to public consultation processes carried out in other communities during this period, residents of Hamilton-Wentworth were asked to respond to general principles for restructuring rather than specific options or proposals. The lack of concrete proposals provoked some in the community to criticize the Task Force and the DHC for creating a sham out of the public consultation process. Others found it difficult to respond to the exit questionnaire because they felt they knew too little about the concepts to comment. A sample of community reactions follows:

> *Proper timing and clarity are essential if serious consultation is to take place. ... A time frame of four days is grossly unsuitable for any sort of preparation. ... Clearer recommendations and perhaps alternative measures ought to have been at the forefront.*
>
> (Health care consumer, *The Hamilton Spectator*, Jan. 18, 1996, p.A7)

> *In the local process, the Task Force has not yet provided clear recommendations, so it is difficult for the public to respond. ... The Health Action Task Force has allowed only one week for public input. One wonders how meaningful input can be obtained in such a short time.*
>
> (Senior hospital official, *The Hamilton Spectator*, Jan.11, 1996)

Despite concerns about lack of time and clarity of issues, the community's response to the open house invitations was enthusiastic. With only four days notice, close to 550 people attended one of eight open house sessions held during the week of Jan. 8-12, 1996. Of those attending, 369 questionnaires were completed for a response rate of 66%.

Socio-economic characteristics appear to have influenced the degree of participation at the open houses[12]. Although 44% of participants resided in the City of Hamilton, the smaller municipalities were well represented when compared to their share of the region's total population. Dundas and Ancaster (the two most affluent municipalities in the region) comprised 18% and 14% respectively of total participants while each account for only 5% of the region's population.

The low level of general public involvement in health care issues described by Hamilton-Wentworth interviewees was also confirmed by the breakdown of provider vs. non-provider participants. Fifty-one per cent of participants were providers or had a family member who was a provider.[13]

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[12] The specific role played by socioeconomic characteristics will be discussed in greater detail in Chapter 6 in the section on "Pre-disposing Influences".

[13] This 50% split between providers and non-providers is more public involvement than has been recorded in other studies The experience of the Oregon State Legislature and its attempts to involve the public in its reforms to Medicaid offer some comparative data. In 47 town halls that were held throughout the state, 69% of the one thousand participants were directly employed in the health care system.

On March 4, 1996 the Health Action Task Force released its preliminary report to the public. Although the report was over 100 pages long with discussion and recommendations for comprehensive changes to the region's health care system, the media focussed on the most contentious aspects of the report – the identification of potential hospital closures. In particular, the recommendation to close the site of the region's only Catholic hospital became headline material. This occurred, despite a separate recommendation to relocate the same hospital, including its governing board, to another site within the city.

Close St. Joe's. That's what health task force recommends.

(Hamilton Spectator headline, March 4, 1996, p.A1)

The recommendation to close the only Catholic hospital in the city (despite the proposed recommendation to move it to another site) sparked an intense period of community mobilization.

The initial deadline for receiving comments on the proposals was March 18, however, this timeline was extended to the middle of April to allow more time for input. Responses came in a variety of forms including individual letters, faxes and calls, formal submissions (mostly from health care providers or organizations), petitions, and cards and flyers. Table 5-3 summarizes the community response.

Table 5-3

Community Response to Health Care Restructuring Proposals in Hamilton-Wentworth

Response Categories	***Hamilton-Wentworth*** (March 4 - April 15, 1996)
Individual letters[14]	1334
Faxes/Calls	1742
Submissions[15]	606
Petition signatures[16]	84,668
Cards/Flyers[17]	46,578
Total	134,928

Source: Hamilton-Wentworth District Health Council, May 1996

Dozens of letters to the editor were also received during this period. In addition to the responses received by the district health council, local members of parliament received calls and letters (often duplicates of letters sent to the health council). Table 5-4 summarizes the contacts made with each provincial members of parliament for Hamilton-Wentworth between June 1995 and April 1996. Although originally sought as a source of participation data for health care issues more generally, the contact data allow comparisons between the number of contacts made concerning broader health care issues and those concerning hospital closures more specifically. The total number of contacts reported for each member of parliament, therefore, is less important than the relative number of "general health care" vs. "hospital closure" contacts.

[14] Letters written and signed by individuals in contrast to form letters that were mass-distributed

[15] These were distinguished from individual letters based on their content regarding proposals for restructuring. Submissions tended to come from individuals and organizations with a high level of involvement in the health care system although some submissions did come from members of the general public.

[16] Multiple petitions were received in each community primarily organized around a specific hospital

[17] Cards and flyers were produced and distributed by various hospitals for individuals to sign and mail in to the DHC

Table 5-4

**Contacts re: Health Care in Hamilton-Wentworth
(between June 1995 and April 1996)**

Constituency Office	**Total Contacts (letters and calls)**[18]
Hamilton East M.P.P.	2400 + 4500 re: hospital closure
Hamilton Centre M.P.P.	50+ 650 re:hospital closure
✓Stoney Creek M.P.P.	80 + 300 re: hospital closure
✓Hamilton West M.P.P.	165 + 437 re:HATF
✓Hamilton Mountain M.P.P.	no data collected
✓Dundas M.P.P.	44 + 446 re: hospital closure

✓ government member of parliament

What transpired was a mass mailing campaign orchestrated by the Catholic Hospital and supported by the Bishop's office. Cards were distributed through the hospital and Catholic parishes throughout the region indicating opposition to the hospital closure. Individuals simply had to sign the card and return it to the health council. Petitions were circulated in the same manner.

> *Thousands of Roman Catholic worshippers heard yesterday that the mission and future of Hamilton's St. Joseph's Hospital are threatened ... In a pastoral letter read to congregations throughout the region, Bishop Anthony Tonnos expressed concern that the proposal 'will erode the ability of St. Joseph's Hospital to continue its healing mission in the tradition of the Catholic Church and the Sisters of St. Joseph.' He urged church members to voice their opinions to the task force through a card inserted in yesterday's church bulletins.*
>
> (Morrison, March 11, 1996, A1)

Petitions were employed several times as a method of *unsolicited* participation to oppose hospital closures. The provincial legislative assembly reporting service was

[18] Absolute contact numbers should not be compared among members of parliament due to variability in recording techniques employed. This will be discussed in greater detail in the summary section of this chapter and again in Chapter 8.

used to identify the number, subject and source of petitions reported in the legislature dealing with the issue of hospital closures. Between March 19 and April 3, 1996 seven petitions were read in the legislature by members of parliament for Hamilton-Wentworth (Hansard, 1996).

At the political level, regional council demonstrated unwavering support for, and arguably, blind deference to the local hospitals in their immediate and unanimous vote to oppose the closure of any hospital, acute care or urgent care. Only one voice spoke out in favour of a more reasoned approach, urging his colleagues to wait for all the information to be received before taking a vote on the issue.

> *'How foolish would it be to respond to a 76-page report that we have not even read yet?' said Mr. Caplan, who left the council chambers before the vote on the resolution, then returned.*
>
> (Peters, March 6, 1996, B3)

The Response of the Health Care Elite

The extended period for receiving input into the final decision-making process had the effect of giving the local health care elite time to organise and propose more palatable alternatives. The long history of co-operation and collaboration among area hospitals facilitated this process. By the middle of April an alternative proposal was presented by a network of local health care leaders (calling themselves the Academic Health Care Network) representing area hospitals, the university's health sciences faculty and the region's major community nursing organization. The proposal agreed with many of the recommendations put forward by the Health Action Task Force but took exception with Task Force proposals for reducing the size of the acute care sector suggesting that their targets were too aggressive. The Academic Health Care Network's proposal aimed to achieve similar savings without necessitating any

hospital closures through a vast array of reconfigured services among the area hospitals.

Media Response

The proposed alternative was immediately embraced by the local newspaper which had voiced opposition to the proposed hospital closures and the work of the Health Action Task Force through editorials such as this one:

> *The leaders of Hamilton's medical community have unveiled a hospital blueprint which represents a major improvement over the drastic surgery recommended by the Health Action Task Force. ... To the relief of many people, the new proposals would ensure that St. Joseph's Hospital would continue to serve from its strategic location in downtown Hamilton, as overwhelmingly supported by the citizens of this community. ... The cost estimates in this plan, in our view, are more closely grounded to experience than those in the task force. Knowledgeable critics suggested that the task force had relied on inaccurate and incomplete information and the doubts were amplified when the task force didn't properly explain its findings to the public. ... The report builds on the demonstrated ability of Hamilton's hospitals to work together in achieving necessary efficiencies.*
>
> (Editorial, April 16, 1996, A8)

The Final Decision

In the end, the weight of the local health care elite carried the day. The Health Action Task Force revised its recommendations maintaining that one acute care hospital should still close while failing to name which one it should be. The District Health Council had the final say in the matter and in a packed meeting room with over 400 attendees it voted to leave all sites open and supported much of the Academic Health Care Network's proposal.

B. Ottawa-Carleton

If you have letterhead people will listen to you.

(Former health council member)

The classic resource-based model of participation epitomizes participation in Ottawa-Carleton. High education and income levels translate into high levels of political participation predominantly through membership in groups and associations. Perhaps the most distinguishing feature of Ottawa-Carleton's participation profile is the propensity for participation to occur through formal groups and associations reflecting the region's position and image as a government town. As one volunteer stated, "people are used to functioning this way." A myriad of government and quasi-government institutions are located in the region including federal, regional and municipal governments, a single regional district health council and six school boards attracting hundreds of national, regional and local associations to the region, all contributing to a sophisticated, bureaucratic *tone* of participation. This concentration of government and non-government organizations creates the demand for a large volunteer base and accompanying expectations for a high degree of involvement in decision-making.

In addition to the structural elements described above the Ottawa-Carleton region is also described as a highly politicized community. The public is, on average, well educated and the extensive media coverage of political issues gives the public a high level of awareness of local issues. The tendency for local politicians to "drum up business" by raising issues directly with the public and press was also described in the context of scores of full-time politicians (under increasing public scrutiny) needing to justify their existence and salaries. One interviewee observed the phenomenon of the

professional politician taking on the role of public participation advocate that has led to a misperception of active and widespread public involvement. "Once you scratch the surface", she observed, you find the "same [small number of] people involved".

Participation in Health Care

Community involvement in health care decision-making also operates at a fairly sophisticated level, again, in an organized and structured manner. Established 20 years ago, the Ottawa-Carleton DHC is the oldest health council in Ontario, and has a long history of involving the community in the health planning process. The elaborate and decentralized committee structure of the health council involves a minimum of 300-400 community representatives at any one time. Only loose ties exist between committee representation and representation to the health council resulting in a greater allegiance to community constituencies than to the interests of the health council.

Applications received for district health council membership provide documentary evidence to support the observations made by community informants. Out of 60 applications received in 1994, two-thirds (i.e., 40) were consumers. This contrasts with the provider-dominated (i.e., two-third provider to one-third consumer) application process described in Hamilton-Wentworth. A former health council executive director made the following observations about how participation in health care decision-making has evolved and the composition of council membership:

> *[Our] aim was to search out highly motivated people with active involvement in the voluntary sector, not necessarily in health care.*
>
> *About 3000 people make up the voluntary sector who are 'generalists' who do a stint in health and social services and then move on to another area.*
>
> *There is a long-standing tradition of public service in Ottawa-Carleton*

especially from the legal profession which encourages voluntary participation.

Civil service representatives tended to serve on committees but not on council due to time demands.

A different kind of person participates now than in the past. ... People who participate now are sparked by a particular issue and are very divisive.

In its first 10-12 years of operation [the DHC] had virtually no political interference regarding membership. ... As more and more DHCs were established and the types of decisions changed there was more political interference from the province.

Another illustration of the community's interest in, demand for and commitment to involvement is exhibited through the long-term care planning process. A planner with the Ottawa-Carleton DHC spoke of a highly active long-term care committee: "The DHC has always had the major players in continuing care around the table". In the first two years of the committee's establishment there was very little turnover in membership. Between 30 and 40 applications were received for consumer representatives and it is estimated that over 2000 people have been involved over a 5-6 year period. Extensive informal networks and coalitions have developed as a result of the planning process in the form of at least 25 community agencies and 5000 volunteers (personal communication, Ottawa DHC long-term care planner). Table 5-5 summarizes attendance figures for community information meetings regarding long-term health care planning between September, 1993 and June 1995 (a similar set of results was presented for Hamilton-Wentworth in Table 5-2). Over 2,000 individuals attended 55 meetings held throughout the region.

Table 5-5

Participation in Long-term Care Community Meetings Ottawa-Carleton (September 1993 - June 1995)

Meeting Audience	*Attendance*
Community	96
Consumers	887
Providers	540
Combination (e.g., community/provider or consumer/provider)	488
Total	**2011**

Despite the perception of a broad base of community involvement in health planning, some expressed the view that there still remains only a small, core group of active participants. This was accompanied by a concern that those who have participated in the past may not be participating to the same extent now due to time pressures. Others expressed concerns about the political nature of appointments to the health council and the difficulty encountered in finding people who will "champion the cause of the community" (Former district health council chair).[19]

At the elite decision-maker level, the environment was described as "highly competitive and divisive". This contrasts once again with the collaborative history that has characterized health care decision-making in Hamilton-Wentworth. According to one community informant familiar with both communities: "Hamilton-Wentworth has had a long history of collaboration while Ottawa-Carleton has worked

[19] District health councils solicit applications from the community for council membership and submit nominations to the provincial government. The final decision, however, is made by the provincial government's appointments office.

painstakingly towards collaboration." An historical linguistic and religious split in the community explained the competitive environment, in part. Two large teaching hospitals, one predominantly English (Ottawa Civic Hospital), the other predominantly French (Ottawa General Hospital), have had a long rivalry and an acrimonious relationship fuelled in recent years by the construction of a new site for the Ottawa General.[20]

Despite a sophisticated populace the power wielded by the health care elite was also used to characterize community participation in health care decision-making. One informant described the difficulty in achieving a balance between academic centres and the community when "hospitals and physicians have tremendous power over the community [and] fuel perceptions that more services are better."

The absence of any health care petition data[21] for Ottawa-Carleton represents a striking contrast to the 13 petitions submitted in Hamilton-Wentworth during the same period. As will be discussed in the section on issue-driven participation, hospital closures were being discussed in Ottawa-Carleton at the same time as in Hamilton-Wentworth yet there were no attempts made to influence local constituency offices using the petition as a *method* of participation. By way of explanation, it may be that the petition is a method of participation that reflects the characteristics of some communities and not others. I will return to this point later on.

Intra-case variations

Few, if any, distinctions were made regarding different municipalities' approaches to participation. In contrast to Hamilton-Wentworth where vastly

[20] This is described in more detail in the hospital restructuring section and again in Chapter 6.
[21] This petition data is to be considered independently of petition data that will be discussed later on in this chapter. The distinction lies in the source of the data. In this section, petition data refers to those

different patterns of participation were observed, secondary participation data obtained failed to reveal any striking within-region variations. Community informants did, however, acknowledge the different approaches taken to community participation by two groups in suburban communities to the east (Orleans) and west (Kanata) of the City of Ottawa in their bids for new health care facility funding. Informants knowledgeable of both participation initiatives described the approaches taken by each group in the following series of quotes:

> *The Kanata process was much slower than in Orleans due in part to geographic differences. The Kanata population was more spread out than in Orleans.*
>
> *Orleans had strong leadership and excellent staffing.*
>
> *No service providers were involved [in Kanata]. [They were] more interested in social justice and health promotion issues.*
>
> *The approach in the West was more community development-focussed emphasizing the development of partnerships in the community and with politicians. ... The east end approach was more rational, technical and medically-oriented. ... [The East] planning group wanted a building. [The West] wanted services.*
>
> *Orleans wanted to fill a hole, Kanata wanted to fill gaps.*
>
> *The approach to involving communities differed. The West used focus groups, the East used surveys.*
>
> (Associate medical officer of health, Ottawa-Carleton; Senior health planner, Ottawa-Carleton DHC)

Issue-Driven Participation – The Case of Health Care Restructuring

In the spring of 1995, the Ottawa-Carleton District Health Council established a Health Services Reconfiguration Project to review and present recommendations for broader health services restructuring in the region. The DHC began its

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petitions submitted to local members of provincial parliament and read out in the provincial legislature.

reconfiguration process by seeking community involvement on 13 program panels defined by disease or burden of illness categories (e.g., ageing, cancer, cardiovascular health, etc). Over 1000 people submitted applications for panel membership. The reconfiguration process was to take at least a year to complete but in September 1995 timelines were shortened to March 1996 forcing any DHC wanting the opportunity to provide input into the government's budget-setting decisions for the next fiscal year to accelerate their process. An intense process of review and community consultation ensued. On December 11, 1995, the DHC released three options for hospital restructuring, all involving the closure of at least one hospital, with one option proposing the closure of one of the city's oldest and largest tertiary care facilities, the Ottawa Civic Hospital (see Appendix 5-2 for details about options presented).

The Community's Response - December 12-15, 1995

The public was given four days to respond to the proposals. The DHC received over 30,000 responses in the form of letters, faxes and phone calls with the majority opposing any hospital closures. Table 5-6 presents a summary of the community's response.

Additional petition data submitted to local district health councils will be discussed separately.

Table 5-6

Community Response to Health Care Restructuring Proposals in Ottawa-Carleton

Response Categories	***Ottawa-Carleton*** (Dec. 12-15, 1995)
Individual letters[22]	1250
Faxes/Calls	1400
Submissions[23]	9250
Petition signatures[24]	10,175
Cards/Flyers[25]	6420
Total	28,495

Each of the hospitals threatened under the DHC proposals mounted organized responses by providing individuals with prepared letters. The local newspaper printed numerous letters to the editor each day in support of various hospitals under threat. Many of these came from hospital staff or volunteers but community members and patients were also among the authors (Messner, 1995; Gibson, 1995; Esmonde-White, 1995). Editorials criticized the limited time period provided for public response to the options and the lack of financial information provided for each of the proposals (Denley, 1995; Ottawa Citizen, 1995). An article was also written by the chairman of the DHC defending the process being used to arrive at decisions (Soucie, 1995). The media was even criticized for indirectly supporting the Ottawa General Hospital with the inflammatory headline "Sleek General pulls ahead in Hospital Race"(Medline and Brethour, 1995).

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[22] Letters written and signed by individuals in contrast to form letters that were mass-distributed

[23] These were distinguished from individual letters based on their content regarding proposals for restructuring. Submissions tended to come from individuals and organizations with a high level of involvement in the health care system although some submissions did come from the general public.

[24] Multiple petitions were received in each community primarily organized around a specific hospital

[25] Cards and flyers were produced and distributed by various hospitals for individuals to sign and mail in to the DHC

The contacting[26] and petitioning of members of parliament did not appear to figure as prominently in the community's response as it did in Hamilton-Wentworth. The petition data reviewed did not identify any petitions from the Ottawa-Carleton region on the issue of hospital closures or health care restructuring more broadly.

Revised Options - December 20, 1995

The three original options were revised based on input received from the community. The closure of the Children's Hospital of Eastern Ontario and the Civic Hospital was eliminated from the new set of options and a proposal (developed by a group of hospital board chairs and CEOs) for the merger of the Ottawa Civic and General hospitals was added (see Appendix 5-3 for revised options). The revised options were released on December 20 and DHC approval was expected at a December 21 meeting. Instead, the provincial government announced its intention to delay the process while it reviewed the work of the Reconfiguration Project.

The government's intervention into Ottawa-Carleton's reconfiguration process was criticized by some for its lack of commitment to community consultation (Ottawa Citizen, 1995; Denley, 1995; Medline, 1995) and praised by others who were anxious for the restructuring process to continue. Among the strongest proponents for government intervention was the president of the Ottawa General Hospital who was likely to gain under any restructuring plan:

> *We always felt the government wanted bold measures in Ottawa ... There was always this fear that as the scenarios are made public and opposition to the scenarios becomes vociferous, then the district health council would perhaps back down.*
>
> (Labelle, Ottawa Citizen, Dec. 23, 1995, p.A1)

[26] Problems were encountered in collecting contact data from members of parliament in this community. This will be discussed in more detail in the chapter summary and again in Chapter 8.

Following an intense period of community outrage and political jockeying among hospital administrators, the DHC and the provincial government, the health council announced its decision to extend the deadline for submitting its recommendations to the government by more than two months, until early June 1996 (Kirkey, 1996). Part of the rationale for extending the deadline was to allow for more community input into the restructuring proposals through vehicles such as "open house information sessions", 24-hour phone lines and opportunities for written feedback on proposals. (Kirkey, 1996)

Response of the Health Care Elite

Much of the work went on behind the scenes with a bloody battle ensuing among hospital administrators trying to save their respective institutions. Executives from 8 of the region's 10 hospitals drafted a plan to save $100 million over three years by merging the two largest health care facilities (Ottawa Civic and Ottawa General) and closing a smaller community hospital (Salvation Army Grace). The plan did not achieve consensus among hospital executives, however, with both the General and the Grace rejecting the plan. The General's Chief Executive argued the need for hospital closures favouring a plan that would make the General the centre of high technology care for the region while the Grace won concessions from the health council to study the cost implications of keeping it open.

Back to the Community

A second round of community consultations held in May 1996 invited the public to respond to the health council's plan to merge the Civic and the General and to close the Grace (the DHC adopted the plan proposed by the hospital executives).

The Final Decision

On May 29, 1996, the DHC voted to approve the proposed merger but voted against the proposal to close the Grace Hospital. In the end the DHC "bowed to intense public pressure and voted not only to keep the Grace Hospital open but to give it more responsibility" (Medline and Kirkey, 1996).

C. Renfrew County

In contrast to the relative ease of involving the community in Hamilton-Wentworth and Ottawa-Carleton, participation in Renfrew County was described as being dominated by a vocal few. A volunteer member who has served on the DHC since its establishment in 1992 described the approach to community involvement in the following manner:

> *People who are vocal are a real minority. You never know if people are with you or not because the vast majority are silent. People like to let their politicians do the work for them.*

Those who do get involved, however, make up for their small numbers in ferocity:

> *You would have thought that all of Renfrew County was concerned about this issue the way people were talking but when we held a meeting on it, only 40 people showed up.* (DHC volunteer)

Participation was described as only occurring when proposals were provided to the public and that it is "difficult to get people involved early on in the decision-making process" (DHC executive director). Local variations in participation patterns were identified with better participation cited in larger towns where there is a concentration of interest groups and media. Inaccessibility to cable television in rural areas was seen as an impediment to providing opportunities for active involvement. Instead, rural communities must rely exclusively on print media that serves only a limited communication function. As a result, word of mouth is a much more influential vehicle in rural communities. A notable exception was the community of Deep River, which was described as highly participatory despite its comparatively small population.

The characteristics of being small and rural appear to influence many dimensions of participation in Renfrew County.[27] The community often feels threatened by the presence and powerful influence of larger neighbouring communities (e.g. Ottawa-Carleton, see map in Figure 4-1), particularly the "urban assault on rural values". It is these threats that the community tends to respond to most vociferously.

Participation in Health Care

The Renfrew County DHC was one of the last councils to be established in the province in December 1992. Community resistance to its establishment and the DHC's low community profile help to explain the minimal role it plays in enabling participation in health care decision-making. Difficulties were encountered in obtaining community representation on the district health council and its committees. Since 1992, approximately 107[28] applications were received for council membership with over two-thirds of these coming in first year. Twenty-nine applications were received in 1994 and 8 applications were received in 1995.

Of the 75 applications received for membership on the long-term care task force in 1993, 70 were received from providers. A long-serving member of provincial parliament for the area reinforced depictions of a low level of routine community involvement observing that:

> *People are more likely to volunteer to obtain benefits that affect them directly. They are not as interested in government-related voluntarism [e.g., DHC].*

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[27] this relationship will be discussed in more detail in the cross-case analysis in Chapter 6.
[28] This number represents an estimate provided by the health council's administrative assistant. Application files were discarded prior to my initial visit to the DHC.

Emphasis was given to the community's propensity for issue-driven participation by an informant who observed that "people tend to stick to single issue causes".

Although petitioning was only used on one occasion in Renfrew County during the period for which data was collected, it was given much attention due to the number of signatures obtained. More than 16,000 signatures were obtained for a petition opposing the closure of a local hospital, the most signatures ever obtained on a petition submitted to the provincial legislature (see "Health Care Restructuring in Renfrew County" for more discussion on this subject).

Intra-case variations

Although strong local identities are characteristic of many Renfrew County communities, Deep River was depicted as an anomaly with respect to its participation in health care decision-making. A single industry town, Deep River was described as a close-knit community that organizes itself quickly and easily to respond to issues that arise while exhibiting a high degree of involvement in routine activities. Table 5-7 presents meeting attendance figures for a community consultation on long-term care planning in 1994. Ten meetings were held in different locations throughout Renfrew County. The breakdown of attendance figures for the county indicates a disproportionately high number of people (30%) attended the Chalk River meeting.

Table 5-7

Participation in Long-term Care Consultation Meetings Renfrew County (September to December, 1994)

Municipality (population as a proportion of the total county population)	Participation (number of attendees as a percentage of total participants)
Arnprior (14%)	27 (9%)
Barry's Bay (9%)	60* (20%)
Chalk River** (8%)	90 (30%)
Eganville (8%)	29* (10%)
Pembroke (46%)	41 (14%)
Renfrew (15%)	50 (17%)
Total	297***

Source: Renfrew County DHC
* two meetings held in this community
** population of North Renfrew area used (includes Deep River)
*** attendance figures do not include 24 people who attended a "Francophone" meeting at an unidentified location

Despite its decreasing and ageing population, Deep River was described as "still very vocal and well-organized with about 60 local groups functioning in [the] community". An example of this high level of organization was provided by a former district health council planner who, in describing community involvement in long-term care planning, reported that Deep River had disproportionately high attendance at meetings and organized their own transportation to meetings.[29]

Issue-Driven Participation – The Case of Health Care Restructuring

Discussions about participation in health care decision-making in Renfrew County focussed almost exclusively on the hospital restructuring process in the City

of Pembroke. It is important to understand the political context within which Renfrew County's restructuring process took place. Prior to the election of the Conservative government in June 1995 there had been little political will to close hospitals although major rationalization exercises involving substantial bed closures had become routine throughout the province. Despite weak attempts by the previous socialist government to engage the public in debates about broad determinants of health and the need to shift resources from hospital care to community care the general population continued to hold strong emotional attachments to their hospitals. It was against this political backdrop that the newly formed Renfrew County District Health Council (DHC) established the Pembroke Hospital Services Review Committee to make recommendations to the provincial government for hospital restructuring within the City of Pembroke. Like many other small communities in Ontario, Pembroke had two hospitals, the Civic (a Protestant institution opened in 1902) and the General (a Catholic institution opened in the 1870s by the Grey Sisters of the Immaculate Conception). In November 1994, the DHC's restructuring committee presented three options for the community to consider:

i) the closure of the (Protestant) Civic Hospital;
ii) the closure of the (Catholic) General Hospital; and
iii) the rationalization of services between the two hospitals to eliminate duplication.

The Community's Response

Three public meetings were held in late November 1994 to discuss the options. Attendance at each meeting was over 1000 and a petition with over 15,885 signatures (one of the largest petitions ever submitted to the Ontario Legislature) was presented by an organization called the Friends of the Pembroke Hospitals led by an employee

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[29] Long-term care meeting attendance data was not available for this community.

of the Civic Hospital. This group was formed with the specific objective of opposing the Review Committee's two hospital closure options. A second group - the Committee for Option 4 Health Care - submitted its own proposal recommending the amalgamation of the two hospitals into one called "The Pembroke Health Care Centre".

Enormous opposition pressure was mounted against the health council's option to close a hospital. Three hundred letters opposing closure were submitted to the health council and all levels of politicians were lobbied to oppose any closure including 4 provincial candidates, Pembroke City Council and Renfrew County Council. In May 1995 the Hospital Services Review Committee voted 13 to 2 to recommend to the DHC the closure of the Pembroke Civic Hospital. According to the founder of the Friends of the Pembroke Hospitals, the "public went wild". The only two members who voted against the closure were the nursing union representatives who were concerned about job losses. The Civic hospital representative on the committee voted to close his own hospital and was branded a "traitor". The Chair and CEO of the Civic withdrew from the committee before the final vote expressing their concerns regarding the "biased process". Hundreds of people attended a public meeting in May 1995 to express their opposition to the decision and no further decisions were made until October 1995 when the DHC voted on the recommendations of the committee. Five hundred people attended the meeting with pickets. In 2 hours the decision was made to recommend to the provincial government that the hospital be closed. The vote was 14 in favour and 3 opposed. Several stipulations were made to the recommendation for closure:

i) that the issue of governance was to be resolved;

ii) that the savings achieved through the closure be reinvested into the community; and
iii) that the community receive money to cover capital costs of building on the site of the General hospital.

Response of the Health Care Elite

Between May and October 1995 the board of the Civic Hospital voted to take legal action against the health council. The decision was based on the identification of more than 30 flaws in the council's final report including the report's acknowledgement that it obtained public input into the process which the board believed had not been sought. In November 1995 the chairman of the DHC resigned over the controversy. A lawsuit was filed against the health council which, along with the DHC's recommendations for the closure of the Civic Hospital, was left for the provincial government to deal with.

D. Nipissing District

As with the other study communities public participation in local decision-making was described by the majority of interviewees as being limited to very narrow issues that affect people directly. In contrast to the other 3 communities, however, views regarding the general public's approach to involvement in local issues ranged from "complacent" and "reticent" to "apathetic", "selfish" and "afraid of change". The "conservativeness" and "don't rock the boat" philosophy of North Bay and its surrounding community helps to explain part of this phenomenon but North Bay also has an ageing population and functions as a modest retirement community which may explain the quiet, reticent label its population has received. The ease of access to elected officials afforded by the community's small size was also identified as a reason for not getting involved.

North Bay was described as being run by an elite group of small business leaders. A number of interviewees described North Bay as a community that seems to wait until a crisis erupts or until a decision is made before getting involved. According to one community informant, "mobilization occurs around problems but not around solutions or about how to build capacity in the community". An example given was the efforts made to establish a Social Planning Council that involved only a small, elite group of providers.

The tiny community of Sturgeon Falls (pop. 6,000) provided a striking contrast to North Bay in its active participation in all aspects of local decision-making. A stable, homogeneous and primarily francophone population, Sturgeon Falls was depicted as mobilizing around its francophone interests. It was described as having a very active municipal council felt to be responsible for mobilizing the population around various issues. The town of Mattawa (pop. 2,500) was also described as a "beehive" of activity although it was not considered to be as vocal in pursuing its interests as Sturgeon Falls.

Participation in Health Care

Consistent with the depictions of general involvement described above, Nipissing was described as exhibiting a low level of involvement in health care matters. As with Renfrew County, the community's lack of interest in policy matters was described by the mayor of North Bay who observed that "people get more involved through voluntarism than by influencing policy decisions". A related observation was the absence of any "professional community activism with only a core group of people who cross over between sectors" (former district health board member).

The absence of participation "enablers" was frequently cited as a reason for the low levels of participation[30]. The Nipissing DHC is a new entity in the community and is seeking a broader representation of the community in health care decision-making. Like the Renfrew County DHC, it was one of the last health councils to be established in the province, overcoming strong community resistance in the process.

It is perhaps not surprising, given the profile presented so far, that there were no petitions submitted from this community during the period for which petition data was collected.

Intra-case Variations

As was the case in Hamilton-Wentworth, depictions of participation in health care in Nipissing District were based on describing the heterogeneity among communities. North Bay's participation in health care decision-making was compared to that in the smaller communities of Sturgeon Falls and Mattawa. Like Deep River in Renfrew County, Sturgeon Falls and Mattawa were described as communities able to mobilize when necessary. Participation results for long-term care consultation exercises supported the observations of community informants. In June 1995 three public meetings were held on the subject of long-term care planning in three different locations throughout Nipissing district. Table 5-8 provides a breakdown of meeting attendance. Of the 141 people who attended the meetings almost 60% of the attendance originated from the tiny community of Sturgeon Falls accounting for only 7% of the district's population.

[30] This will be discussed in detail in Chapter 6 (see section on Enabling Influences).

Table 5-8

Participation in Long-term Care Consultation Exercises Nipissing District (June 1995)

Municipality (Population as a proportion of the total district population)	Participation (number and percentage of total participants)
North Bay (65%)	40 (28%)
Mattawa (3%)	17 (12%)
Sturgeon Falls (7%)	80 (57%)
Total	**141 (100%)**

One informant registered some concern about the outcome of such strong mobilization efforts observing that despite Sturgeon Falls' admirable record of community mobilization, it had procured resources in the form of specialized health care technology that could not be supported by the community (i.e., it had the potential for resulting in quality of care problems) due to its infrequent use.

Data Limitations

The limitations of the secondary participation data have been referred to throughout the chapter and deserve special attention here.[31] DHC *application data* could not be compared among communities for two reasons: i) comparative application data was only available for the same year for two communities (Ottawa-Carleton and Hamilton-Wentworth) and ii) Nipissing application data was not compiled on a yearly basis but collapsed for all years since the DHC's establishment in 1992. The data are further limited by the reliance on estimates rather than accurate

figures provided by the Renfrew County DHC. Potential bias in the reporting of *petition data* was identified earlier as a validity threat in communities dominated by members of parliament from governing parties. Despite Hamilton-Wentworth's history as a labour union town and left-of-centre political leanings, all but two of its provincial members of parliament are Progressive Conservatives. This may have resulted in more pressure being placed on the two opposition members to mount attacks (through petitions) against government policies regarding hospital closures. Finally, lack of uniform recording methods for *contact data* prevented any comparisons from being made either within or among communities. A wide range of methods were used to record contacts made with local members of parliament ranging from manual note-taking by the receptionist to sophisticated computerized telephone and mail logs. Some offices recorded all mail and telephone contacts, some recorded only mail contacts, and still others had no formal recording mechanism at all. A further problem encountered was the overlap between contact data collected in the local constituency and parliamentary offices.

SUMMARY

Table 5-9 summarizes the participation observed and reported in each community and is guided by the participation dimensions defined in Chapter 3. Several themes emerge from these profiles. First, the communities of Hamilton-Wentworth and Ottawa-Carleton appear to exhibit a high degree of enthusiasm for community involvement in health care decision-making although their approaches differ considerably. Both communities have an expectation of being involved in decision-making but the aggressive and emotional *tone* of participation demonstrated

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[31] A more general discussion of methodological limitations is presented in Chapter 9 which identifies

Table 5-9

Comparative Profiles of Participation

Participation Dimension	*Hamilton-Wentworth*	*Ottawa-Carleton*	*Nipissing District*	*Renfrew County*
Form	-short-term issue-driven participation -moderate level of routine participation	- balance between routine and issue-driven participation	- largely issue-driven	- largely issue-driven
Initiator(s)	- solicited by well-established DHC - controlled input solicited by DHC in health care restructuring - elite-driven	- solicited by well-established DHC - threatened interest groups	- threatened interest groups	- threatened interest groups
Method(s)	- petitions - meeting attendance - informal contacts	- committee representation - formal approaches	- through members of parliament	- through members of parliament
Quantity	- high levels re: issues - low-moderate levels re: routine	- moderate-high levels re: issues - moderate levels re: routine	- low levels of routine participation	- low levels of routine participation
Intensity	High	Moderate	Low	High
Texture	- co-ordinated, co-operative and collaborative at elite level	- core group of active community volunteers	- core group of (50) active, elite community members	- small number of vocal community members - vast silent majority
Tone	- friendly, informal aggressive	- polite, formal, bureaucratic, sophisticated - competitive at elite level	-conservative, complacent	- aggressive, acrimonious

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the challenges faced in collecting secondary participation data and offers some recommendations for improving the quality of this data.

in Hamilton-Wentworth is sharply contrasted with the highly sophisticated and organized approach taken in Ottawa-Carleton. Another striking contrast between the two communities is the heterogeneity observed in Hamilton-Wentworth patterns of participation as compared to the uniformity observed in Ottawa-Carleton. Table 5-9 does not illustrate this heterogeneity as it does not include within-region variations but these variations suggest that, in reality, there were more than 4 communities under investigation. Finally, the dominance of and deference to the provider elite that characterized much of the health care participation in Hamilton-Wentworth (particularly around the issue of health care restructuring) did not emerge in descriptions of health care participation in Ottawa-Carleton. Frequent references made to community characteristics in depictions of participation suggest the important role played by predisposing influences in shaping the observed participation. These will be further analysed in Chapter 6.

Renfrew County and Nipissing District offered very different profiles from those described above. Very little community involvement was described in Nipissing and issue-driven participation was given great emphasis in Renfrew County. The absence of community enablers and an infrastructure for participation offer some clues to explaining these findings but community perceptions of the respective roles of government and the voluntary sector in local decision-making also seem to play an important role. As with Hamilton-Wentworth, a striking degree of heterogeneity was also observed in the Nipissing and Renfrew County.

A comparison of the petition data among communities affords the opportunity to generate the early hypothesis that there may indeed be a relationship between the characteristics of communities and the propensity toward certain methods of

participation. Evidence to support this hypothesis is found in the high number of petitions initiated in Hamilton-Wentworth (and read in the provincial legislature) as compared to other communities on the issue of hospital closures. There may be something about Hamilton-Wentworth that predisposes it to initiating petitions. A more general finding as illustrated in Table 5-9, however, is the different "styles" of participation demonstrated among communities. Explaining this heterogeneity, as well as other findings, will be the task of the ensuing chapters.

Appendix 5-1

COMMUNITY PROFILES

Hamilton-Wentworth

Hamilton-Wentworth is located in the southwestern part of Ontario approximately 65 kilometres from metropolitan Toronto, Canada's largest city (population approx. 3 million). It is a regional municipality consisting of a regional tier of government along with municipal tiers for each of 6 distinct municipalities. The City of Hamilton is the largest municipality (population 318,499) located in the geographic centre of the region with the suburban and rural municipalities of Dundas, Ancaster, Flamborough and Stoney Creek and Glanbrook forming an outer ring around the city. Each of these municipalities has strong local identities shaped by unique historical developments.

In keeping with its "steel town" image, manufacturing represents the largest source of employment in the region although the percentage of people employed in this sector has decreased steadily from 33.9% in 1981 to 22.7% in 1991. Health care is the largest non-manufacturing employment sector followed by the boards of education and the university.

Education levels for the region's population are comparable to the provincial average for all but university education levels where they fall below the provincial average. The region also has a higher than average percentage of low-income families and individuals. Hamilton-Wentworth has a large immigrant population with a large Italian-Canadian population.

Governance Structures in Health and Education

One District Health Council and three school boards serve the region. One public school board serves the city of Hamilton, a second public board serves the peripheral municipalities of Dundas, Ancaster, Flamborough, Stoney Creek and Glanbrook and a single Roman Catholic Separate school board serves the entire region.

There are two hospital corporations in the region: i) the Hamilton Health Sciences Corporation is the product of a recent merger of the Hamilton Civic Hospitals (which operates the Hamilton General Hospital and the Henderson Hospital) with the Chedoke-McMaster Hospital; and ii) St. Joseph's Hospital.

OTTAWA-CARLETON

The Regional Municipality of Ottawa-Carleton is located in the National Capital Region (Ottawa) in southeastern Ontario. The Region covers an area of 2,767 square kilometres (1,064 square miles).

The Region was created in 1969 by the Provincial Government of Ontario to help deal more effectively with common objectives shared by the region's 11 municipalities. It acts as a regional governmental body with powers exercised by a Regional Council of 18 elected councillors and a directly elected Chair. Initially, the Region brought together sixteen municipalities: the City of Ottawa, all the municipalities of the former County of Carleton, and the Township of Cumberland. That number has since been reduced to eleven by amalgamations and boundary adjustments. Geographically, the Region centres on the City of Ottawa, which accounts for approximately 46.3% of the Region's population.

The federal government, until recently, was the largest employer in the region. Since 1981, however, the federal government's share of the employment sector has decreased from 32% to 20% with Community and Health Services taking over as the largest employment sector at 26%.

The region has a highly educated population and an average household income well above the provincial average.

Governance structures for Health and Education

The region is served by one DHC and 6 school boards: 4 English-speaking boards, 2 French-speaking boards and 3 each of Roman Catholic and public school boards.

There are 10 hospitals in the region: 5 general acute care hospitals, 3 chronic care facilities, 1 hospital specializing in maternity and eye care and 1 provincial psychiatric hospital.

NIPISSING DISTRICT

Nipissing District is located in Northeastern Ontario and covers an area of 18,000 square kilometres (11,250 square miles). The City of North Bay is the largest urban centre in the District, situated on Lake Nipissing.

Since its beginnings as a settlement for the Nipissing Indians, North Bay has always been known as a transportation centre. The building of the Canadian Pacific and Canadian National Railways, and then the Ontario Northland Railway, established North Bay as the major transportation centre for the region. The arrival of the railways opened new markets for both lumber and the other natural resource activities in the area. Easy access to primary resources (nickel, iron, copper, gold, platinum, silver and cobalt) drew a wide range of light and heavy industry to the area. As mining and lumber developed in regions to the north and east, North Bay became a supply centre, and a secondary manufacturing base grew to service these industries. North Bay also developed as a regional centre for education, health care, retail and other personal and professional services.

North Bay is critically situated at the junctions of Highway 11 and the Trans Canada Highway 17 and remains a major transportation centre for Northern Ontario.

Fewer residents of Nipissing District hold a university degree than the provincial average and the average income for the area is also lower than the provincial average. Twenty per cent of Nipissing residents reported French as the language spoken at home.

Governance Structures for Health and Education

One District Health Council serves Nipissing District (which also covers the Temiskaming area). The City of North Bay has one full-service general hospital with two sites (the result of a merger of the city's two hospitals in 1994). There is also a psychiatric hospital. There are two school boards: one public and one Roman Catholic.

RENFREW COUNTY

Renfrew County is located in eastern Ontario in the heart of the "Ottawa Valley", the watershed of the Ottawa River. The County stretches from the outskirts of Canada's Capital, the City of Ottawa, in the east and along the shores of the historic Ottawa River to the northern tip of Algonquin Park's wilderness in the west.

Renfrew County (pop. 91,000) is organized by a county system of local government[32] encompassing 37 municipalities. It is made up of mostly rural communities with a low population density covering approximately 7,500 square kilometres (4500 square miles). The City of Pembroke (pop. 14000) is the county's major urban centre.

Compared to the provincial average, the population of Renfrew County is less formally educated, less likely to have moved and growing at a slower rate. Its unemployment rate is higher than the provincial average and has a slightly higher proportion of elderly residents. English is the mother tongue of 90% of residents (much higher than for its surrounding communities and the province) and religious affiliations are evenly split between Protestants (48%) and Catholics (44%), similar to the provincial situation.

A Canadian Forces military base, Petawawa, and the Atomic Energy Corporation Ltd. (AECL), located in Chalk River, are the major employers in the northern part of the county. The two boards of education are the largest employers in the remaining part of the County (both are located in the City of Pembroke).

Governance Structures in Health and Education

One District Health Council serves the county. There are two school boards (one public and one Roman Catholic board).

[32] The county system was established in Ontario in 1849 under the Baldwin Act to organize and deliver basic services such as seniors' citizens homes, roads, social assistance, economic development and libraries that were beyond the scope of individual municipalities (D. Siegel, "Local Government in Ontario", in The Government and Politics of Ontario, fifth edition. G. White (ed.). 1997, 134-5.)

Appendix 5-2
Health Care Restructuring Options for Ottawa-Carleton

The Options - December 11, 1995

Option A

Keep Ottawa Civic, Ottawa General Hospital as tertiary teaching hospitals.
Close Riverside and Grace hospitals (both community hospitals)
Close Children's Hospital of Eastern Ontario building and move it to the General Hospital
Strengthen roles of the Queensway-Carleton and Monfort hospitals.
Develop two ambulatory care centres in east and west ends of the region.

Option B

Change Ottawa Civic Hospital into a community teaching hospital
Consolidate adult tertiary services at the Ottawa General and University of Ottawa Heart Institute
Close Riverside and Grace hospitals

Option C

Close Civic Hospital and transfer its programs to the Ottawa General
Transfer Heart Institute from the Civic to the General Hospital
Strengthen the roles of the four existing community hospitals
Develop two ambulatory care centres in the east and west.

Source: Ottawa-Carleton District Health Council

Appendix 5-3

Revised Options for Restructuring in Ottawa-Carleton

Revised Option A
Close Riverside and Grace hospitals.
Keep Ottawa Civic and Ottawa General as tertiary centres
Keep CHEO and expand its services
Develop two out-patient centres in east and west of region

Revised Option B
Close Grace and Riverside hospitals.
Change Civic Hospital into a community teaching hospital.
Consolidate all adult tertiary care at Ottawa General and Heart Institute with back-up specialty services to remain at Civic to support Heart Institute.

Revised Option C
Merge the Civic and General hospitals.
Convert Grace Hospital into an out-patient hospital and Riverside into a short-stay hospital.

Source: Ottawa-Carleton District Health Council

References to Chapter 5

Documents

Legislative Assembly of Ontario. Official Report of Debates (Hansard) - Petitions. 1st Session, 36th parliament. Toronto: Queen's Printer, 1996.

Hamilton-Wentworth District Health Council. (1995). *The Health Action Task Force: An Overview*. Hamilton. HWDHC.

Hamilton-Wentworth District Health Council. *Health Action Task Force Working Paper on Open Consultation.* Hamilton: HWDHC, 23 February 1996.

Ottawa-Carleton District Health Council. (1995). *Directions for Change: Position Paper on Reconfiguration Scenarios*. Ottawa: OCRDHC, 11 December 1995.

Renfrew County District Health Council. *Pembroke Hospital Services Review Committee – Final Report*. Pembroke: RCDHC, August 1995.

Newspaper articles

Close St. Joe's. That's what health task force recommends. *The Hamilton Spectator*, March 4, 1996, p.A1

Denley, R. "Health council lacks ability to manage the challenge of hospital restructuring." *Ottawa Citizen*, December 14, 1995, p.E1 (cols 1-5)

Denley, R. "Ontario's scheming destroys credibility of hospital studies." *Ottawa Citizen*, December 23, 1995, p.D1 (cols 1-4).

Editorial. A Better Plan. *The Hamilton Spectator*, April 16, 1996, A8.

Editorial. Hospital emergency. *The Ottawa Citizen*, December 13, 1995, p. A10 (cols 1-2).

Editorial. An Unhealthy Sham. *The Ottawa Citizen,* December 22, 1995, p.A14 (cols 1-2).

Esmonde-White, H. and P. A gift from CHEO - the life of our daughter. *The Ottawa Citizen*, December 19, 1995, p.A14 (col 2-3).

Gibson, K. Grace a leader. *The Ottawa Citizen*, December 18, 1995, p.A8 (col 2).

Kirkey, S. Health council extends deadline on hospital plans. *The Ottawa Citizen*, February 9, 1996, p.C1 (cols 1-5).

Levine, M. Getting Informed Public Input. *The Hamilton Spectator*, January 11, 1996.

Medline, E. and P. Brethour. Sleek General pulls ahead in hospital race. *Ottawa Citizen,* December 13, 1995, p.A1.

Medline, E. and Kirkey, S. 1996. Health Council votes to keep all hospitals. *The Ottawa Citizen,* May 30, 1996, p.A1 (cols 1-2).

Medline, E. Provincial actions outrage council chair. *The Ottawa Citizen,* December 23, 1995, p.A1-A2 (cols 1-2).

Messner, P. Fan of Riverside. *The Ottawa Citizen,* December 18, 1995, p.A8 (col 2).

Morrison, S. Bishop urges worshippers to speak out on St. Joe's. *Hamilton Spectator,* March 11, 1996, p.A1.

Peters, K. Regional council opposes 'closure of any hospital'. *The Hamilton Spectator,* March 6, 1996, B3.

Pirocchi, I. The viewpoint of patients has to be heard. *The Hamilton Spectator,* January 18, 1996, p.A7.

Soucie, P. "Take a Valium". *Ottawa Citizen.* December 15, 1995, p.A15 (cols 1-3).

<u>Community Informants</u>

Hamilton-Wentworth

Caplan, M. Personal interview. 4 June, 1996. Hamilton, Ontario.
Hamilton City Councillor, District Health Council Member

Clark, K. and Poushinsky, P. Personal interview. 9 April, 1996. Hamilton, Ontario.
Long-term Care Planners, Hamilton-Wentworth District Health Council

Cook, T. Personal interview. 23 November, 1995. Hamilton, Ontario.
Regional Chairman, Hamilton-Wentworth

Eyles, J. Personal interview. 12 July, 1996. Hamilton, Ontario.
Consumer Representative, Hamilton-Wentworth District Health Council

Fenn, M. Personal interview. 22 November, 1995. Hamilton, Ontario.
Chief Administrative Officer, Regional Municipality of Hamilton-Wentworth

Goodman, S. Personal interview. 1 November, 1995. Hamilton, Ontario.
Executive Director, Hamilton-Wentworth DHC

Hunter, B. Personal interview. 1 January, 1996. Hamilton, Ontario.
Director of Environmental Services, Department of Public Health, Hamilton-Wentworth

Jaffray, D. Personal interview. 12 December, 1995. Hamilton, Ontario.
Executive Director, Hamilton-Wentworth Social Planning and Research Council

James, M. Personal interview. 13 December, 1995. Hamilton, Ontario.
Medical Officer of Health, Hamilton-Wentworth Department of Public Health

McMekum, T. Telephone interview. 23 November, 1995. Hamilton, Ontario.
Mayor of Flamborough and Chair, Health and Social Services Committee, Hamilton-Wentworth Region

Meyer, M. Personal interview. 5 June, 1996. Hamilton, Ontario.
Chair, Coalition of Community Health and Support Services

Scott, F. Personal interview. 20 December, 1995. Hamilton, Ontario.
Former Medical Officer of Health, Hamilton-Wentworth Department of Public Health

Walsh, N. Personal interview. 6 June, 1996. Hamilton, Ontario.
Retired Director of Social Services, Planning Department, Regional Municipality of Hamilton-Wentworth

Watt, S. Personal interview. 9 November, 1995. Hamilton, Ontario.
Chair, Hamilton-Wentworth District Health Council

Ottawa-Carleton

Albrecht, D. Personal interview. 16 May, 1996. Ottawa, Ontario.
Executive Director, Sandy Hill Community Health Centre

Angus, D. Telephone interview. 20 February, 1996. Ottawa, Ontario.
Former Director of Reconfiguration Project, Ottawa-Carleton District Health Council

Bourgault, L. Personal interview. 14 November, 1995. Ottawa, Ontario.
Executive Director, Ottawa-Carleton District Health Council

Bradshaw, C. Personal interview. 20 February, 1996. Ottawa, Ontario.
Former Member, Planning Department, Regional Municipality of Ottawa-Carleton

Chapman, M. Telephone interview. 2 August, 1996. Ottawa, Ontario.
Chair, Council on Aging, Ottawa-Carleton

Graham, K. Telephone interview. 15 February, 1996. Ottawa, Ontario.
Carleton University

Martell, C. Personal interview. 16 May, 1996. Ottawa, Ontario.
Long-term Care Planner, Ottawa-Carleton District Health Council

McCormack, H. Personal interview. 22 February, 1996. Ottawa, Ontario.

Senior Health Planner, Ottawa-Carleton District Health Council

Robinson, K. Personal interview. 20 February, 1996. Ottawa, Ontario.
Consultant to Health Services Reconfiguration Project, Ottawa-Carleton District Health Council

Soucie, P. Personal interview. 16 November, 1995. Ottawa, Ontario.
Chair, Ottawa-Carleton District Health Council

Stewart, P. Telephone interview. 15 January, 1996. Ottawa, Ontario.
Associate Medical Officer of Health, Ottawa-Carleton

Warren, A. Telephone interview. 29 July, 1996. Ottawa, Ontario.
Former Executive Director, Ottawa-Carleton District Health Council

Nipissing District

Burrows, M. Personal interview. 18 October, 1995. North Bay, Ontario.
Mayor, City of North Bay

Cowan, B. Personal interview. 17 October, 1995. North Bay, Ontario.
City Editor, The Nugget

Hill, D. Personal interview. 19 October, 1995. North Bay, Ontario.
Director of Social Services, City of North Bay

Howe, J. Telephone interview. 19 October, 1995. North Bay, Ontario.
The Neighbourhood Centre, Nipissing Child Care Council

Sparks, A. Telephone interview. 28 June, 1996. North Bay, Ontario.
Sociologist, Nipissing University

Staff of Nipissing-Temiskaming District Health Council. Group interview. 16 October, 1995.

Whiting, C. Personal interview. 18 October, 1995. North Bay, Ontario.
Chair, District Health Council

Renfrew County

Bonert, K. Telephone interview. 16 November, 1995. Pembroke, Ontario.
Reporter, Pembroke Observer.

Bowering, L. Personal interview. 14 November, 1995. Pembroke, Ontario
Executive Director, Renfrew County District Health Council

Bowering, L. and McSheffrey, S. Personal interview. 21 February, 1996. Pembroke, Ontario. Executive Director and Chair, Renfrew County District Health Council

Carruthers, M.J. Telephone interview. 8 January, 1998. Pettawawa, Ontario. Consumer Member, Renfrew Count District Health Council

Conway, S. Telephone interview. 12 June, 1996. Toronto, Ontario. Member of Provincial Parliament, Renfrew North

O'Brien, T. Telephone interview. 22 August, 1996. Pembroke, Ontario. Former Consumer Representative on Long-term Care Committee

O'Hearn, K. and Peacock, C. Personal interview. 17 May, 1996. Pembroke, Ontario. Long-term Care Planners, Renfrew County District Health Council

Wong, G. Telephone interview. 16 November, 1995. Pembroke, Ontario. Chair, Friends of the Pembroke Hospitals

Other

Fyfe, W. Telephone interview. 10 March, 1998. Mississauga, Ontario. President, Credit Valley Hospital, Mississauga, Ontario. (Past president of hospitals in Hamilton and Ottawa).

CHAPTER 6

APPLYING THE ANALYTIC MODEL: CROSS-CASE ANALYSIS OF THE INFLUENCES ON PARTICIPATION

The profiles presented in the previous chapter provide the description and context necessary to conduct more in-depth analysis of community-level participation and its influences. The preceding chapter's recounting of each community's participation stories leaves the reader with many unanswered questions about *how* and *why* participation unfolded the way it did in these communities and whether there are any consistent explanatory themes that cut across the case studies. For example, why is it that Dundas, Deep River and Sturgeon Falls emerge as such highly participatory communities within their larger geographic entities? Are similar forces at work in these communities to produce such a highly participatory citizenry? Does the threat of hospital closures evoke similar responses from all communities or are there other influences shaping the dimensions of participation. What differential influence, if any, do the well-established DHCs in Hamilton-Wentworth and Ottawa-Carleton have in shaping participation as compared to the newly-established DHCs in Renfrew County and Nipissing district?

The purpose of this chapter is to explore the independent role of various influences in shaping community-level participation. Chapter 7 will explore the interaction between these influences and their combined effect on participation. The analytic model introduced in Chapter 3 will be used as a guide for the analysis.

THE INDEPENDENT INFLUENCE OF PRE-DISPOSING, ENABLING AND PRECIPITATING INFLUENCES ON PARTICIPATION

Each element of the model (i.e., pre-disposing, enabling and precipitating influences) will be addressed separately in the sections below.

PRE-DISPOSING INFLUENCES

Pre-disposing influences were defined in Chapter 3 as *"those characteristics of a community or population that provide the basic building blocks for participation"*. The literature review revealed numerous studies that have examined the relationships between community characteristics and participation. As described in the methodology chapter, data was collected for a number of these characteristics to inform the community selection process. Once study communities were chosen, however, more detailed analysis of these characteristics was undertaken and a comprehensive set of community characteristics was compiled for each area. These characteristics have been summarized in a set of appendices that will be referred to throughout this chapter. Community influences were also identified through interviews with informants in each community. The results of this data collection process are discussed in the second half of this section (see "What Community Informants Revealed")

Description of the Secondary Data

As discussed in previous chapters, the literature documenting the various community influences on participation was used as a guide for collecting the data presented in this section. Data were separated into two categories: i) those describing the structural characteristics of the communities; and ii) those describing the social characteristics of the communities. Table 6-1 presents each community characteristic with its corresponding data source. Data presented on the structural characteristics of each community elaborate upon those used in the case selection process described in Chapter 4.

Table 6-1

Community Characteristics and Data Sources

Structural characteristics	Description and Data Source
Education	attainment for all levels (1991 census)
Household Income	average and median household incomes for each community (1991 census)
Residential Stability (indicator of social cohesion)	Movement within and outside census sub-division area (1991 census)
Proximity between workplace and residence (indicator of social cohesion)	% employed males whose usual place of work is within census sub-division area (1991 census)
Social characteristics	
Newspaper readership	Newspaper readership surveys (1995) (Ottawa, Hamilton and North Bay only)
Blood donation	number of repeat and new donors across and within each community (Canadian Red Cross - local office reports, 1995)
Voluntarism	Number of contacts with community volunteer centres (available for Hamilton-Wentworth and Ottawa-Carleton only, 1995)
Density of Associations	number of citizens' groups, service clubs per capita (inventories produced by local government offices and public libraries)
Referendum Voting	Voter turnout in 1992 federal referendum (Elections Canada, 1994)

What the Secondary Data Revealed

Education and income

Given the strong and positive relationship documented in the literature between *socio-economic* status and participation it would seem reasonable to examine the education and income levels in each community to assess their *expected* influence over participation. Appendices 6-1 through 6-3b provide comparative data for education and income levels. Ottawa-Carleton stands out among the four communities with the highest overall income and education levels. The other three communities have similar education levels with minor exceptions: Renfrew County has the highest percentage of residents with the lowest level of education and Hamilton-Wentworth has a higher percentage of residents with a university degree than either Renfrew County or Nipissing district. Comparing income levels, Hamilton-Wentworth is more similar to Ottawa-Carleton than to Renfrew or Nipissing.

Using overall education and income levels as a *predictor* of participation, then, one would *expect* Ottawa-Carleton to be *more* participatory than Hamilton-Wentworth, followed by Nipissing and Renfrew County. Comparing aggregate levels, however, can be somewhat misleading. Large variations in education levels are found within Hamilton-Wentworth, for example, with two municipalities (Ancaster and Dundas) exhibiting disproportionately higher education levels than the rest of the region (Appendix 6-2a). In contrast, little variation exists within Ottawa-Carleton with the exception of a small low-income pocket in one municipality (Appendix 6-2b). Income levels are also more variable in Hamilton-Wentworth than in Ottawa-Carleton. In summary, then, Ottawa-Carleton would be expected, based on income and education levels alone, to demonstrate higher overall levels of

participation followed by Hamilton-Wentworth with some within-region variations expected for Hamilton-Wentworth. Having reviewed this census data, how well do they explain the participation profiles presented in the previous chapter? On the whole, reasonably well it seems. Ottawa-Carleton and Hamilton-Wentworth were both described as highly participatory communities compared to Nipissing and Renfrew although the profiles do not illustrate the magnitude of difference between Ottawa-Carleton and Hamilton-Wentworth that the census data would suggest. Dundas and Ancaster were singled out as "more participatory" (see Chapter 5, Table 5-2) than the rest of Hamilton-Wentworth which corresponds to their higher income and education levels. In contrast, more uniform descriptions of participation were presented for Ottawa-Carleton (see Chapter 5, Ottawa-Carleton profile intra-case variations), also consistent with the census data. The census data for education and income, therefore, provide some clues to understanding the overall levels (i.e., *quantity*) of participation observed in the study communities. They do not, however, provide any information regarding the qualitative aspects of participation.

Residential stability and social cohesion

The empirical literature is less definitive regarding the role that *residential stability* and *population homogeneity* play in influencing participation. As discussed in the literature review chapter, urban sociological theory has long held that residential stability and population homogeneity are necessary structural characteristics for fostering social solidarity in a community leading to the pursuit of common interests through informal interactions between neighbours (i.e. a form of participation). The argument, in essence, is that participation is greater in communities where long-term residence and population homogeneity facilitate the psychological attachment process.

Challenges to social solidarity theory, however, suggest that participation will be lower among those identify most strongly with their community and assume that collective problems will be dealt with by others (commonly referred to as the "free rider" problem). Conversely, participation is expected to be higher among those who do not identify with their community and do not, therefore, have the confidence and trust in their neighbours to address the problem. Still other (related) studies examining the influence of community cohesion (considered to incorporate the attributes of long-term residence and population homogeneity) on participation have demonstrated a positive relationship between community cohesion and voter participation[1].

While their precise relationships to participation are unclear, residential stability, population homogeneity and the proximity between workplace and residence appear to exert some influence over participation. What insights do the census data provide regarding these potential influences? Appendix 6-4 compares *residential stability* (or population mobility) patterns among the four study communities. Overall, Hamilton-Wentworth and Renfrew County have stabler populations than the other two communities, tempting one to expect more participatory communities. Hamilton-Wentworth "movers" tend to move within their municipality rather than to a different one within the region. Although Renfrew County has the highest percentage of non-movers (indicative of a stable population), movers tend to leave the region entirely. Ottawa-Carleton movers are just as likely to move within the same municipality as to another one within the region and Nipissing has equal numbers of movers within as outside the municipality. Population mobility patterns within communities (see Appendix 6-4a) demonstrate the tendency for rural municipalities to

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[1] see literature review chapter for specific references

have stabler populations compared to their more mobile urban counterparts suggesting, based on the hypothesis that population stability is positively associated with participation, differences between rural and urban communities in their approach to participation.

A review of census data for *proximity between workplace and residence* paints a more confusing picture. Nipissing has the highest proportion of males who work and reside in the same municipality (69%) while Renfrew County has the lowest of the four study communities (29%) (see Appendix 6-5). This finding is explained, in part, by the geography of the areas. The population of Nipissing is concentrated in either North Bay or its two neighbouring towns (Sturgeon Falls and Mattawa). In contrast, Renfrew County is much more sparsely populated with no dominant city or town. The "dominant centre" phenomenon is demonstrated to a lesser degree when comparing Hamilton-Wentworth (49%) to Ottawa-Carleton (41%). Relating these findings to the predicted propensity for participation, census data for *residential stability* and *proximity between workplace and residence* appear to present contradictory findings. Renfrew County's stable population (and the predicted positive association with participation) must be balanced against its sparse population and lack of geographic centre (and the predicted negative association with participation). Nipissing, while exhibiting some attributes of cohesion (and therefore a predicted positive association with participation), does not have a particularly stable population thus making it difficult to draw any links between social solidarity measures and participation. Ottawa-Carleton and Hamilton-Wentworth are large urban centres for which notions of solidarity and community cohesion are less meaningful. These data are of limited use and much less powerful than the education

and socioeconomic characteristic data, therefore, in predicting aggregate participation levels.

Social characteristics

Other characteristics thought to influence participation include a series of proxy measures that have been used to predict the stock of social capital (or civic engagement) present in a community[2]. Measures such as *newspaper readership*, the *propensity for joing local clubs and associations*, and *referendum voting* were used in Putnam's analysis to measure participation in civic affairs, with strong associations demonstrating highly civic-minded communities.

What does a civic-minded community tell us about its propensity for participation in health care decision-making? While it is not clear that a highly civic-minded community is a necessary pre-requisite for more instrumental forms of participation it may provide some clues to the quality of participation that is expected. One might predict, for example, that in communities where there is a large stock of social capital, participation may be more cooperative and constructive than self-centred and destructive.

As described in Chapter 4, data was collected for a number of "civicness" indicators: associational density, newspaper readership, blood donation, voluntarism and referendum voting. In one community (Hamilton-Wentworth) an independent study of community associations was conducted providing a rich source of data (Abelson and Veenstra, 1996).

a) Newspaper readership

North Bay reported a higher level of interest in civic affairs based on results from a random telephone survey of local newspaper readership conducted in the

[2] see references to Putnam (1993) in the literature review

spring of 1995 (Appendix 6-6). Approximately 1000 people were surveyed in each of Ottawa and Hamilton and 500 people were surveyed in North Bay (Renfrew County was not included in the survey). North Bay respondents demonstrated higher readership than in Ottawa or Hamilton in all age, income and education categories with the following exceptions:

i) 18-24 year olds
ii) $30,000 - $50,000 income earners
iii) respondents with some post-secondary education

b) Blood donation

Appendix 6-7 presents a summary of blood donation results for each community in 1995. The highest number of donors per capita (including repeat donors) was reported in Ottawa-Carleton (7.5%) followed closely by Nipissing (6.6%), Hamilton-Wentworth (6.4%) and then Renfrew County (4.5%). A different set of results shows Renfrew County to have the highest mean number of donors attending each clinic (213) as compared to Nipissing (183), Ottawa-Carleton (154) and Hamilton-Wentworth (82). This result is most likely due to the smaller number of clinics offered in Renfrew and Nipissing as compared to the larger centres of Hamilton and Ottawa.

Intra-case variations

A within-community comparison of blood donation provides variable results. Within Hamilton-Wentworth, the Town of Dundas reported the highest mean number of donors per clinic and the second highest donor to population ratio (Appendix 6-8a). The City of Hamilton reported the highest donor/population ratio with a permanent clinic open every day for people throughout the region to attend.

The City of Gloucester reported the highest mean number of donors per clinic followed by Kanata and Ottawa (Appendix 6-8b). The City of Ottawa, however,

reports an overwhelmingly high donor/population ratio compared to the rest of the region due to the use of office buildings (located predominantly in Ottawa) for mobile blood donor clinic locations.

Clinic locations

The locations chosen for mobile blood donor clinics provide some insights into patterns of civic participation. Close to a third (29%) of mobile clinics in Hamilton-Wentworth were evenly distributed throughout the municipalities surrounding the City of Hamilton (Appendix 6-9) while only 8% of mobile clinics in Ottawa-Carleton were located outside the City of Ottawa (Appendix 6-10). Clinic sites also differed between Hamilton-Wentworth and Ottawa-Carleton: Hamilton-Wentworth clinics were distributed evenly throughout educational institutions, hospitals, community centres and places of work (Appendix 6-9) while Ottawa-Carleton clinics were located predominantly at places of work, most notably, federal government offices (Appendix 6-10). These different patterns and locations of blood donation indicate more of a civic focus on blood donation in Hamilton-Wentworth (i.e., community centres, universities, colleges) as compared to the corporate or workplace focus of blood donation in Ottawa-Carleton.

The blood donation data presented above must be cautiously interpreted. In October 1993 a Royal Commission[3] was established in Canada to investigate the national blood system following deaths and infection resulting from the receipt of tainted blood. During the period for which blood donation data were collected, confidence in the blood collection system was extremely low. Although the "tainted blood scandal" is likely to have affected absolute blood donation statistics reported

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[3] The Commission of Inquiry on the Blood System in Canada (commonly referred to as the Krever Commission) was established on October 4, 1993 and ended in February, 1995. The report was not delivered until November, 1997.

here, there is no reason to believe that donations would decrease disproportionately across communities, therefore, supporting relative rather than absolute comparisons.

c) Voluntarism

Both Hamilton-Wentworth and Ottawa-Carleton have Volunteer Centres which provide opportunities for community volunteers to be matched with organizations seeking volunteers. Both centres track the number of prospective volunteers who contact them each year providing a source of data (albeit crude) on the potential volunteer pool in the community. While the volunteer centre provides only one of many statistical sources on voluntarism it provides a useful "snapshot" of comparative voluntarism for the two communities. Appendix 6-11 provides a summary of contacts with volunteer centres in Hamilton-Wentworth and Ottawa-Carleton for 1995. Contacts per 1000 population demonstrate a higher concentration of voluntarism in Ottawa-Carleton compared to Hamilton-Wentworth.

The presence of local United Way offices is another indicator of community voluntarism (although it will also be discussed as an "enabler" in a subsequent section). The United Way movement had its roots in Canada in the early part of the 20th century when local charities were beginning to raise funds to strengthen their communities. Over the years, other community groups like the Red Cross, the Red Feather, the Community Chest and the United Appeals banded together to raise funds and share resources. In the 1970s, these organizations adopted the name of United Way. The goal of each local United Way office is to increase the organized capacity of people to care for one another and to create a common ground where labour, business, community leaders, and government come to the table to solve problems. United Way activities include assessing the community's human services needs and establishing priorities for meeting those needs; raising funds to meet the needs

through campaign contributions; and distributing resources to local programs. Each United Way is created in and by their local community so a "community has to want to create a United Way office" (Personal communication, President of United Way Canada). There are 121 local United Way offices across Canada with 44 located in the Province of Ontario. Of relevance to this study is the location of United Way offices in Ottawa, Hamilton and Deep River (Renfrew County) and the absence of a United Way office in Nipissing district.[4]

d) Associational density

The high degree of voluntarism demonstrated in Hamilton-Wentworth was explored in greater detail in a survey conducted of 900 community organizations[5] in the Hamilton-Wentworth region between July and October 1996. Results suggest that a vibrant associational life exists in Hamilton-Wentworth with members of many groups interacting with each other in a variety of settings (e.g., work, socially, other groups) and collaborating with other organizations on priority issues (Abelson and Veenstra, 1996).

As described in Chapter 4 (See Data – Section II.b), attempts were made to replicate the associational density data generated by Putnam (1993). Inventories of community organizations were obtained for each community. However, concerns about their comprehensiveness (particularly those produced for Nipissing and Renfrew County); the variable methods used to produce these inventories (e.g., different inclusion and exclusion criteria); and differing organizational objectives (e.g., planning, economic development, community resources) underlying their compilation, prohibited their inclusion in the analysis. While summary figures could

[4] This point will be discussed again under the community informant section of this chapter

[5] Organizations included in the survey included citizens, seniors, women's, multicultural, sports, recreation, hobby and arts groups from across the region.

be produced for each community the number of caveats needed to explain the data would render them meaningless.

e) Referendum voting

Referendum voting contributed little to explaining patterns of civic participation. Referenda are held very rarely in Canada as compared to Italy (where it was used as a proxy for civic participation). In 1992 a national referendum was held on the future of Canada's constitution. Unlike traditional elections that are held for the purposes of choosing local, provincial and federal government representatives, the 1992 referendum sought the electorate's opinion regarding a national issue. Voter turnout was highest in Ottawa-Carleton (78%) and Renfrew County (76%), followed by Nipissing (71%) and Hamilton-Wentworth (71%). The higher turn-out in Ottawa and Renfrew is as likely, if not more likely, to be explained by the proximity of these communities to the province of Quebec (the jurisdiction the referendum was designed to accommodate) and the high degree of relevance of the issue in these communities, than by any fundamental differences in the communities' stock of social capital.

Summary

As with the residential stability and social cohesion data presented earlier, it is difficult to extract any clear messages from the social characteristics data presented here. Based on newspaper readership and blood donation data, Nipissing appears to exhibit a high degree of interest in civic affairs and voluntarism although Ottawa-Carleton has the highest overall blood donor per capita ratio. A strong spirit of voluntarism and associationalism is also demonstrated in Hamilton-Wentworth. Within-region variations are also noteworthy with the Town of Dundas demonstrating higher levels of blood donation when compared to its neighbours. While Dundas' high levels of voluntarism correspond to high levels of participation depicted in the

previous chapter's participation profiles, the same patterns of association do not appear to hold for other communities. Nipissing, for example, did not emerge as a highly participatory community (with the exception of Sturgeon Falls) with respect to instrumental participation yet it exhibits at least some qualities of a civic-minded community. The positive relationship between civic and instrumental participation, based on the findings of this study has yet to be proven.

As was the case for the participation data summarized at the end of Chapter 5 some coherence must also be brought to the secondary data presented for pre-disposing influences. Table 6-2 presents community rankings for each of the community characteristics discussed in this section. Each characteristic has been given a ranking between 1 and 4 based on the data presented in the appendices (i.e., Ottawa-Carleton had the highest income and education levels and therefore received a ranking of 1 for education and income). The rankings also reflect the assumption that each characteristic exerts a positive influence over participation. Summary scores for each community were generated using a mean ranking. Each characteristic was weighted equally although an argument could be made for giving greater weight to some characteristics over others (e.g., education over newspaper readership).[6] Comparing community scores demonstrates a slightly higher mean ranking for pre-disposing influences in Ottawa-Carleton (1.8) although Hamilton-Wentworth and Nipissing District demonstrate similar rankings (2.3 and 2.5 respectively). Only Renfrew County demonstrates an overall ranking well below the others (3.2). The rankings must be taken in the context of standard deviation scores that illustrate larger deviations from the mean for Ottawa and Renfrew indicating more variation within these communities than in either Hamilton or Nipissing.

[6] This type of analysis could be conducted in a more in-depth quantitative study of the role of community characteristics.

Table 6-2

Community Rankings for Pre-Disposing Influences

Characteristics	*Hamilton-Wentworth*	*Ottawa-Carleton*	*Nipissing District*	*Renfrew County*
Education	2	1	3	4
Income	2	1	3	4
Residential Stability	2	4	3	1
Proximity between workplace and residence	2	3	1	4
Newspaper readership	2	3	1	n/a
Blood donation	3	1	2	4
Voluntarism	2	1	n/a	n/a
Associational density	N/a	n/a	n/a	n/a
Referendum voting	3	1	3	2
Mean ranking[7] (Standard deviation)	**2.3 (1.2)**	**1.8 (3.0)**	**2.5 (1.9)**	**3.2 (3.0)**

N.B. 1 = highest ranking, 4 = lowest ranking

In summary, then, taken on their own, the quantitative collected for various structural and social characteristics of communities data (with the exception of income and education data) give us little to go on with respect to explaining the participation described in the previous chapter. While some preliminary clues are provided regarding the degree or *quantity* of participation that might be expected in a community, the census and other quantitative data presented here are of limited utility in explaining the *quality* of participation.[8] We must turn, therefore, to the community

[7] Mean ranking calculations exclude data for characteristics where there is missing data (i.e., newspaper readership, voluntarism and associational density)

[8] Support for this claim is found in the community research literature which has discussed the limited utility of secondary data in explaining community events and highlighted the benefits of using community informants as primary data sources. See Krannich and Humphrey (1986) for a detailed discussion of this topic.

informants for an additional source of explanation for the findings presented in Chapter 5.

What Community Informants Revealed

Emphasis was given in the sections above to the quantitative evidence gathered in the form of census data, newspaper readership, blood donation data, referenda voting and voluntarism data. In this section, emphasis is given to the qualitative evidence gathered through the interviewing of informants in each community who were asked to identify the influences on participation and how these influences shaped participation. A cumulative process was undertaken to generate a comprehensive list of community characteristics (i.e., "predisposing influences") summarized in Table 6-3. As no attempt was made to reach consensus on the list, it cannot be interpreted as an indication of complete agreement among informants. Most, if not all characteristics were mentioned by at least one informant though, and by several in many cases (see methodology chapter for more details about the interviewing process). The characteristics are discussed separately in the sections below.

Table 6-3
Characteristics Pre-Disposing a Community to Participate

Hamilton-Wentworth	*Ottawa-Carleton*	*Nipissing District*	*Renfrew County*
<u>Structural</u> Sense of community vs. Physical isolation University presence Workplace/Residence proximity Population size Education Income Geography Ethnicity <u>Social</u> Strong commitment to collaboration and coordination Desire to preserve local identities Resistance to change Elite dominance over health care	<u>Structural</u> Sophisticated, well-informed community Linguistic divisions Ethnicity <u>Social</u> Large volunteer base with strong commitment to public service Government town with high level of interest in politics and policy Emphasis on community development	<u>Structural</u> Population size <u>Social</u> Preservation of cultural identity Conservative, traditional community values Lack of interest in collective problem-solving/decision-making Elite dominance of local decision-making	<u>Structural</u> Education Income Single company town Religious divisions Cultural homogeneity Residential stability Sparse population/distance between communities Population size <u>Social</u> Rural community values, e.g., resistance to change Resentment felt toward provincial government Desire to preserve local identities Community values

Education and Income

The role played by education and income in influencing participation in health care decision-making emerged as a major theme from the interviews. *Ottawa-Carleton* was described as a sophisticated, well-informed community that instills confidence to participate. One informant described the relationship in the following way:

> *It is the "middle classness" of the community that is the big variable in Ottawa-Carleton. This is played out through higher education levels, the confidence that comes with education, the feeling that you have the right*

to be involved ... and having sufficient income to be able to devote time to this. These characteristics are what pre-dispose people to join organizations, volunteer their time on health boards in the same way that they would get involved in community garage sales.

(Community Health Centre administrator and former District Health Council member, Ottawa-Carleton)

In addition to providing the resources to participate, education and socioeconomic influences appear to create high expectations for being involved in decision-making as well as a natural affinity for certain types of involvement. Associated with this is the influence that the federal government as the region's major employer exerts over the form of participation selected by participants. Several informants described the tendency for people to form groups and associations in order to influence decision-makers:

Participation in health care usually occurs through groups and associations. For example, a new organization formed this past week - Physicians for Quality Health Care for Ottawa-Carleton. Many groups will be organizing this week to prepare for options that will be announced at the end of the month.

(Former District Health Council executive director, Ottawa-Carleton)

Ottawa-Carleton is a government town so people are used to committees.

(Long-term care consumer, Ottawa-Carleton)

Education and income were reported to exert the same influence in other communities, however, the more modest education level of the *Hamilton-Wentworth* population as compared to *Ottawa-Carleton* was felt to instill a greater sense of intimidation with respect to participation in health care decision-making. As discussed in Chapter 5, several informants acknowledged the deference of the Hamilton-Wentworth community (including local politicians and the media) to the health care elite (e.g., hospital CEOs and physician leaders).

> *Participation in health care is different. There is more of an elitist view of who should be involved in health care decisions. There is a perception (even among local politicians) that 'we're just little Hamiltonians, what do we know about health care'.*
>
> (Former medical officer of health, Hamilton-Wentworth)

The implications of such deference has been a high level of participation from the Hamilton-Wentworth stakeholder community (i.e., those with direct interests in the health care sector) along with "elitist voluntarism", according to a former chairperson of the District Health Council. The community's high concentration of university professors with time to participate was also identified as an important contextual influence.

Education was identified as exerting a strong influence on participation in one municipality within *Renfrew County*. The town of Deep River (site of the Atomic Energy Company Limited) has a highly educated population that is reported to exert considerable influence over the acquisition of resources for the community. This is in stark contrast to lower education levels that correspond to lower participation levels elsewhere in the County.

Neither education nor income was mentioned as important influences over participation in health care decision-making in *Nipissing District.*

Residential Stability

Residential stability was neither identified as having a positive or negative influence on participation in *Ottawa-Carleton*, *Hamilton-Wentworth* or *Nipissing District* although it was considered to be attributable to high levels of involvement in parts of *Renfrew County*, particularly those communities with homogeneous and stable populations. Also associated with the stability of the population in these communities was a culturally homogeneous population thus making it difficult to

separate the independent influence of a stable versus a culturally homogeneous population on participation.

Cultural and Religious Characteristics

Cultural and/or linguistic characteristics were identified in Chapter 5 as exerting significant influences over the context in which health care decisions are made in both *Ottawa-Carleton* (p.159) and *Nipissing District* (p.173). In *Ottawa-Carleton,* a long history of linguistic (and religious) divisions between French Catholic and English Protestant residents has led to the development of parallel health care systems. The two major teaching hospitals in the region have French-Catholic and English-Protestant roots and failed attempts to identify a single principal teaching hospital has perpetuated a long-standing rivalry between the two hospitals for decades. In an era of abundant resources, each has been able to build its own empire with relative ease. In the more recent environment of budget cutbacks, however, a more pronounced rift has appeared between the English and French-speaking communities although this rift simmers beneath the surface of public debate:

> *The language division in Ottawa-Carleton is one of the characteristics that has pre-disposed the community to participation although I was surprised that hospitals didn't use it more as a weapon to fight for survival.*
>
> (Consultant to District Health Council, Ottawa-Carleton)

Cultural and linguistic characteristics have also fuelled participation in the community of Sturgeon Falls within *Nipissing District.* In the interests of preserving its cultural identity, the predominantly francophone community has participated in a manner disproportionate to its population size of 5000 and has been highly successful in mobilizing to procure health care resources for its tiny community.[9]

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[9] The issue of cultural preservation is discussed in greater detail in Chapter 7.

While cultural and linguistic characteristics played only a modest role in influencing health care participation in Hamilton-Wenworth and Renfrew County, religious characteristics were much more visible. Several informants cited religious divisions between supporters of the local Protestant and Catholic hospitals as the fuel for much of the opposition to the proposed closure of the Protestant hospital in Pembroke (*Renfrew County*) (DHC staff, local newspaper reporter). Similarly, the proposed closure of the only Catholic hospital in *Hamilton-Wentworth* led to an emotional outcry as well as a sophisticated, highly-organized response from the Catholic community (Morrison, 1996) although the same religious split that fuelled participation in the debate in Renfrew County was not in evidence in Hamilton-Wentworth.

Geography and Social Cohesion

Geography emerged only as an influence on participation in *Renfrew County* and was discussed in two different contexts. In the first instance, long travel distances and sparse populations within the County were thought to impose barriers to participation.

> *There is better participation in larger towns where there is a concentration of interest groups and where there is media. ... Rural people rely more on print media and these are very helpful tools for communication but problematic for other aspects of involvement.*
>
> (District Health Council executive director, Renfrew County)

Geography was also indirectly referred to in the context of population size and the difficulty in achieving high levels of participation when there is only a "small pool of potential participants" (Local member of parliament).

Social cohesion was equated with "feelings of strong local identity" by numerous informants and was discussed almost exclusively in geographic terms. In

Hamilton-Wentworth, strong local identity was used to explain high participation rates in health care decision-making from two specific communities within the region, i.e., Glanbrook and Dundas, as compared to other municipalities.

In *Renfrew County*, the town of Deep River was also thought to have a strong sense of community (owing in large part to the "company town" phenomenon) which was observed to exert an important influence over health care participation (See Chapter 5, Renfrew County profile). The strong local identity depicted in *Nipissing*'s Sturgeon Falls was closely tied to its francophone roots and the associated desire to perserve its cultural identity.

Community Values

In all but one community, great emphasis was placed on the influence of community values over participation generally, and in the health care sector more specifically. For example, *Nipissing District* was identified as having conservative, traditional values that emphasize elite decision-making over grass-roots involvement. A general distaste for collective problem solving (e.g., involvement in public affairs and policy-making) was also identified despite a strong spirit of voluntarism (e.g., local fundraising efforts, and blood donation).

For *Renfrew County*, a long tradition of doing battle with and feeling resentment toward the provincial government was thought to translate into widespread skepticism and distrust of many provincial government initiatives (including the local District Health Council, an arm of the provincial government).

In *Hamilton-Wentworth*, several informants identified the sense of inferiority to Toronto and general "underdog" mentality as a unifying force for the community that has helped to promote a strong tradition of collaborative problem-solving among agencies and institutions. The presence of informal networks, organized labour and a

general ease of association have also been identified as important elements in shaping the community's collaborative approach to decision-making.

A commonly held value in rural and smaller communities is the general resistance to change of any kind. This value was believed to underlie community opposition to hospital closure proposals in *Renfrew County.*

Summary

There are several conclusions worth noting about the exposition of pre-disposing influences and their relationship to participation. First, there is a broad range of community characteristics that contribute to shaping both the quality and quantity of participation, from structural characteristics such as education and income to the presence of a network of community associations. Evidence from census data, corroborated by informant interviews demonstrates the important roles played by education and socioeconomic characteristics in pre-disposing communities such as Ottawa-Carleton, Dundas and Deep River to higher baseline levels of participation. Other structural characteristics such as population stability and homogeneity appear to provide the seeds for instilling social solidarity in a community although their precise influence on participation remains unclear. This raises a second point relating to the complex interrelationships that exist between community characteristics. The combination of a stable, homogeneous population with a strong sense of community, for example, appears to exert an important pre-disposing influence over participation. The Town of Dundas, for example, stood out as highly participatory among the smaller municipalities demonstrating participation rates out of proportion to its size. While the population's high socioeconomic status relative to other parts of the region likely accounts for part of this trend there are other characteristics that are also influential. Educational levels, and in particular, the concentration of university

professors in Dundas sheds further light on the story but the presence of a strong local identity and sense of community also appears to be at work. A drive through Dundas recalls images of the quintessential New England town with the Town Hall in the centre of town, a single main street of shops and banking facilities and a palpable small town atmosphere. The characteristics of small size, a strong attachment to their community combined with a relatively high education level have instilled a strong commitment to participation in this community. The presence of the same combination of characteristics in another community, however, does not always shape participation in the same way. In Renfrew County the presence of a close-knit, homogeneous community was identified as a pre-disposing factor to community opposition to the closure of a local hospital. A similar combination of characteristics, in contrast, pre-disposed the Town of Dundas to a less *issue-driven* form of participation in favour of a more *routine* level of participation. This leads one to consider the potential for a combined influence exerted by i) socioeconomic characteristics and ii) social cohesion over the dimensions of participation, and the possibility that some community characteristics exert less independent influence over participation than others or that they are only influential when combined with other community characteristics or other influences on participation such as enabling or precipitating influences. A third observation regarding pre-disposing influences is their differential influence on participation. Socioeconomic characteristics, for example, pre-disposed communities to higher levels of routine participation whereas cultural characteristics such as language and religion appeared to exert more influence over issue-driven participation (e.g., participation driven by desire to preserve cultural identity in Sturgeon Falls, mobilization driven by threats to language- and religion-

specific service delivery in Ottawa-Carleton, Renfrew County and Hamilton-Wentworth).

A final point worth noting is the limited utility of census and other quantitative measures presented in the first part of this section as compared to the comprehensiveness provided by community informants. While some agreement was found between the characteristics identified using each data collection method, the interviews were found to be a much more powerful tool for comprehensively examining the influences of pre-disposing influences on the various dimensions of participation. Table 6-4 illustrates this point by comparing the results obtained from secondary sources (i.e. census data) with those obtained during the interviews. The census data were only found to resonate with community informants' observations for education and income. Data for residential stability and social cohesion, in contrast, did not match up to informant observations and the material obtained during the interviewing process provided many more examples of community characteristics that influence participation (e.g., culture, religion, community values).

Table 6-4

Expected and Observed Influences of Community Characteristics on Participation in Health Care Decision-Making

	Hamilton-Wentworth	*Ottawa-Carleton*	*Nipissing District*	*Renfrew County*
Education Census (E) Interview (O)	 ✓✓ ✓✓	 ✓✓✓ ✓✓✓	 ✓ ---	 ✓ ✓ (✓✓✓ for Deep River)
Income Census (E) Interview (O)	 ✓✓ ✓✓	 ✓✓✓ ✓✓✓	 ✓ ---	 ✓ (✓✓✓ for Deep River) ---
Residential Stability Census (E) Interview (O)	 ✓✓ ---	 ✓ ---	 ✓ ---	 ✓✓ ✓✓✓ (selected areas)
Social Cohesion Census (E) Interview (O)	 ✓✓ ✓✓ (selected areas)	 ✓✓ ---	 ✓✓✓ ---	 ✓ ✓✓✓ (Deep River)
Cultural (O)	---	✓✓✓	✓✓✓ (Sturgeon Falls only)	---
Religious (O)	✓✓	✓✓	---	✓✓✓
Geography (O)	✓	---	---	✓✓
Community Values (O)	✓✓✓	---	✓✓✓	✓✓✓

(E) expected influence over participation based on census data collected for each community
(O) observed influence over participation based on interviews with community informants

✓ low level of expected or observed influence over participation
✓✓ medium level of expected or observed influence over participation
✓✓✓ high level of expected or observed influence over participation
--- not mentioned as an influence over participation and could be interpreted as low or non-existent influence

ENABLING INFLUENCES

Enabling influences, as defined in Chapter 3, refer to *the presence or absence of institutional actions that influence the ability for individuals and groups to participate in a decision-making process*. In contrast to pre-disposing influences which capture the characteristics of the population and community itself, enabling influences emphasise the role of institutions in fostering participation. Institutions may be specific to a policy area such as a district health council (in the health care arena) or school board (in the education arena) or they may play an enabling role across a wide range of policy issues (e.g., regional or municipal government or the media). Table 4-7 (Chapter 4) provided a list of institutional actions that were to be explored. These included the mandate of local government or a health care decision-making body to involve the public in their decision-making processes; the reduction of impediments to participation through information provision, accessibility to decision-makers, etc. or the presence of a media culture that promotes participation. The participation literature is replete with accounts of institutional efforts to enable citizen, consumer or community participation in decision-making processes (see section on "institutional influences" in literature review). These efforts have often been viewed as failures with respect to the achievement of broad-based community involvement or viewed cynically as exercises in manipulation to achieve a pre-determined outcome or to put off making a decision. The data describing "enabling influences" and their sources are provided in Chapter 4, sections IIIa-c.

1. The District Health Council as an Enabler of Participation

District Health Councils (DHCs) in Ontario play a pivotal role in seeking community input on all aspects of health care decision-making that fall under their mandate. DHCs are intended to reflect and incorporate the views of their community through membership on council, committees of council and through community involvement in health council activities. Historically, this has been restricted to the area of health planning but over the past few years DHCs have been given increased responsibilities in the areas of priority setting and resource allocation (although they do not have responsibility for decision-making in these areas, only advisory powers).

DHCs are all "enablers" of participation in that they are required to "develop strategies to assure and enhance public participation in all parts of the planning process" (Association of District Health Councils of Ontario, 1993, p. 59). Community informants were asked to express their views regarding the philosophy of the DHC with regard to enabling participation:

> *The DHC helps to create the expectation of participation. Even if no one attends a meeting or participates, providing the opportunity is what is important.*
>
> (DHC executive director, Hamilton-Wentworth)

> *We try to be as inclusive as humanly possible, e.g. times of meetings, child care, seniors' care, and public transportation.*
>
> (Former DHC chair, Hamilton-Wentworth)

> *The DHC's philosophy is to receive and seek input from the community. We have insisted on public involvement despite the short timeline for decision making.*
>
> (Former DHC executive director, Ottawa-Carleton)

> *Communities and people should be involved in decision-making.*
>
> (DHC executive director, Renfrew County)

Despite their universal commitment to enabling participation, DHCs were perceived differently by their respective communities. The Ottawa-Carleton and Hamilton-Wentworth DHCs are among the oldest in the province having been established in the early 1970s. In contrast, DHCs in Renfrew County and Nipissing District are two of a newer crop of DHCs established only a few years ago in spite of much community resistance. Both staff and volunteers of the Renfrew County DHC explained that the DHC was forced on the community by government threats to withhold funds if a DHC was not established. Community opposition to the DHC's establishment was explained in the following manner:

> *Renfrew County has historically been very isolated from the provincial government and has resisted interference in local affairs. There was a perception that the DHC was a tool of the government.*
>
> (DHC chairperson)

Underlying this resistance to provincial government interference is a history of local politicians successfully fighting for community resources from a distance.[10] The prospect of letting the government into the community might threaten a beneficial arrangement.

While the Hamilton and Ottawa DHCs have had over 20 years to establish a presence in and cultivate strong ties to their community, Renfrew and Nipissing are only beginning this process. A telling example of their fledgling status was the keen interest displayed by staff of the Nipissing DHC in having their community selected for this study. During a week-long visit to the community (during which the DHC was used as a base) it became apparent that the DHC was interested in using me to raise their profile in the community and to develop links between themselves and

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[10] Renfrew County boasts the highest per capita spending in the province on long-term health care services despite population demographics that are not out of line with the provincial average.

other institutions in the community (using me as the conduit). It was even suggested that the local newspaper write a story about my research with the objective of enhancing the DHC's presence in the community.

A testament to the role of the DHC as enabler was the view expressed by the chairperson of the Nipissing DHC that "[since] the community doesn't enable participation ... [she] sees the role of the DHC as [an] enabler of participation". This opinion suggests that the establishment of the DHC in this community has the potential for shaping participation. This opinion was shared in Renfrew County where the absence of any DHC profile in the community was felt to be detrimental to the outcome of the community consultation process on hospital restructuring. During this process, the DHC was heavily criticized for failing to adequately involve the community. According to one community informant "the process was closed despite the DHC's repeated commitment to a 'Made in Pembroke solution'. Concerns were also raised about a hidden agenda being carried out by a new executive director who was not from the Pembroke area[11]. Resistance to the DHC's establishment also played a role in deterring it from carrying out its enabling function. The view expressed by the executive director of the DHC was that "the people who resisted hospital restructuring were also resistant to the establishment of the DHC".

The actions taken by DHCs to enable participation in health care decision-making were observed during the health care restructuring process in three of four communities (only Nipissing did not engage in this process). An analysis of the different approaches taken has been published elsewhere and is attached as an appendix to this chapter (Appendix 6-12) (Abelson and Lomas, 1996). The article presents a systematic approach to involving communities in decision-making that

identified the various elements to be considered in designing an institutionally driven public participation exercise. These include:

i) the purpose and context of participation;
ii) who will be selected for participation;
iii) what and how information will be presented;
iv) how the public will be asked to participate and over what time period;
v) what input the public will be asked to provide.

Examples drawn from *Hamilton-Wentworth, Ottawa-Carleton and Renfrew County* illustrate the different approaches taken to enabling participation.

In *Hamilton-Wentworth* and *Ottawa-Carleton,* participation was enabled through the design of sophisticated public input processes involving the hiring of communications consultants. A variety of mechanisms were made available to the community for obtaining information or voicing their opinions about health care restructuring proposals. A major difference between the Hamilton and Ottawa approaches, however, was the strategy employed for disseminating information about the proposals to the public. *In Hamilton-Wentworth* an insert describing the work of the DHC and its preliminary ideas for restructuring was disseminated through the local newspaper and to all public facilities (e.g., libraries, hospitals, etc.). The public was invited to attend an open house in their area to find out more about the proposals and to provide their input to the DHC. Other participation methods included writing, calling or faxing the DHC with their ideas and reactions. In contrast to this broad-based dissemination strategy, the *Ottawa-Carleton* DHC prepared a detailed report outlining the content and rationale for their proposals but only made it available through the DHC office. This minimal dissemination strategy left much of the responsibility for communicating the report's contents to the local media and those whose interests were threatened by the proposals (i.e. those hospitals threatened with

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[11] The executive director of the Renfrew County DHC was newly-appointed and had moved to the area from another DHC position in the central west region of the province. She was an outsider and

closure). Only months later during an extended period of public consultation did the Ottawa DHC hold 'open houses' similar to those held in Hamilton-Wentworth (Abelson and Lomas, 1996).

A more traditional approach to enabling participation was adopted by the Renfrew County DHC. Only after all the information was collected, analyzed and options were formulated did the DHC present its comprehensive plan to the public for discussion and response. Confrontational public meetings, pitting the community on one side against decision-makers on the other, were held to discuss the options. This contrasts with a less confrontational 'open house' format that diffuses any outrage that may be present in the community (Abelson and Lomas, 1996). In the case of Renfrew County, the community's perception was that they were not involved in the process and according to a local reporter "the DHC handled it poorly by announcing their decision and then providing reasons later".

Summary of DHC as Enabler

The DHC's tenure in the community and perceptions held toward the DHC appear to play an important role in enhancing or deterring the DHC's role as an enabler. The long history of DHC presence in Hamilton-Wentworth and Ottawa-Carleton has provided these communities with a stable infrastructure and culture of participation. In contrast, Nipissing and Renfrew County have only a marginal presence in their communities and have not yet established themselves as community players. In the latter case, however, there is some indication that the DHC's profile was heightened (for better or worse) during its restructuring process.

Another point worth noting from the discussion is that while the DHC's unwavering commitment to involving the community in its decision-making

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considered to be a government representative carrying out the government's agenda

processes is not under debate, the motivations underlying the elaborate design of some consultation exercises deserve careful scrutiny. After close examination of three communities' health care restructuring processes (and the opportunity to be a participant observer in the Hamilton-Wentworth process) one is struck by a fine line that appears to exist between the DHC as an enabler and a manipulator. The hiring of high-priced communications consultants in Hamilton-Wentworth and Ottawa-Carleton, for example, suggest the importance attached to communicating the 'right' message to the public. Hamilton-Wentworth's carefully crafted consultation process involving informal and innocuous 'open houses' is another demonstration of the DHC's balancing act as enabler/manipulator. As described earlier, the open house format was deliberately chosen over the more traditional "community meeting" where confrontations between the "community" and the "experts" can erupt more easily over contentious issues such as hospital closures.[12] Other examples of manipulative actions include the provision of short time frames in both Ottawa-Carleton and Hamilton-Wentworth for community response to proposals. Short timeframes prevent any widespread community mobilization from developing. In this way, community decision-making exercises such as health care restructuring are increasingly about 'managing controversy'[13] rather than legitimately seeking the community's views. Public relations and communications consultants are routinely hired to ensure that the desired results are achieved from the public participation exercise. In fairness, as will be illustrated in an upcoming section, much of the impetus for these actions is driven by the DHC's desire to reform the health care system and the need to counter the attack of those with vested interests in preserving the status quo.

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[12] The reader will recall the description of the community meetings in Renfrew County where an angry group of 500 protestors raised pickets and shouted down speakers.

2. <u>Local Government as an Enabler of Participation</u>

As with DHCs, the institutional presence of local government differs markedly between communities, particularly between those with large and small populations. Local governments in both Hamilton and Ottawa were described as "strong enablers of participation". A long history of community development and neighborhood-based service delivery can be traced in *Ottawa-Carleton*, for example, facilitated in part by the establishment of 13 community resource centres between 1970 and 1980 by the regional government's Social Services Department with the goal of "strengthening communities". According to one community informant, the strong commitment to community development, nurtured by local government, has been responsible for the creation of a "culture of participation" which is believed to support the broad base of community involvement that exists in the long-term care area of local health care decision-making. Reports of approximately 25 community agencies, 5000 volunteers and extensive informal networks and coalitions in the long-term care area support these claims (Ottawa-Carleton DHC staff).

The role of local government as an enabler in *Hamilton-Wentworth* was summarized succintly by one informant:

> *Hamilton-Wentworth institutions are better than most communities in terms of involving the public in visioning and forming policies but, like other communities, it does a poor job of involving communities in policy implementation.*
>
> (DHC consumer representative, Hamilton-Wentworth)

Like Ottawa-Carleton, Hamilton-Wentworth regional government has historically been supportive of broad-based community participation and has enabled participation in various ways. The Social Services Department of regional

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[13] This term was used to describe such community consultation exercises in MacDonald, L and Mondel, M. Managing Public Conflict: How to involve citizens in making the hard choices. *The Ottawa Citizen*, February 4, 1996, p.A9 (cols 1-5).

government has been instrumental in supporting coordination and collaboration between various community agencies through organizations such as the Social Planning and Research Council (SPRC).

> *The Region took over [the] coordination function from SPRC over time and had higher profile and more resources to bring people together.*
>
> (Former director, Department of Social Services, Hamilton-Wentworth Region)

> *Leadership at the region is grass-roots minded.*
>
> (Former director, Department of Social Services, Hamilton-Wentworth Region)

Other views of local government commitment to enabling participation in Hamilton-Wentworth included its "strong support of transparent, public decision-making" and an increasingly active role taken by the Department of Public Health in community development over the past 5 years.

A frequently mentioned example of local government enabling participation was a recent community-wide "visioning" exercise (referred to as Vision 2020) described by informants as:

> *an excellent process created by the region which had political leadership but lots of opportunities for public involvement*
>
> (Consumer representative, Hamilton-Wentworth DHC)

> *ha[ving] kept community groups interested and coordinated all along*
>
> (Senior official, Hamilton-Wentworth regional government)

A second enabling example, for which the regional government received an "Excellence in Citizen Involvement" award[14], was the establishment of the Constituent Assembly project which brought 23 citizens from across the region together to discuss the restructuring of regional government. The award "recognizes

innovative strategies designed to inform citizens about local government services and to include them in the process of community decision-making." The ICMA stated that "the Constituent Assembly process of community consultation for reviewing municipal government in Hamilton-Wentworth was unique to Ontario, Canada and abroad" (Hamilton-Wentworth Regional Government, July 3,1997).

Despite the generally positive opinions expressed by community informants regarding local government's enabling influence in both Hamilton and Ottawa, a caveat was introduced in these communities regarding the role of the "full-time politician" as an enabler of participation. Community-level participation was felt to be shaped differently in the City of Ottawa and the City of Hamilton as compared to smaller municipalities due to the presence of full-time politicians. One informant suggested that:

> *Having full-time politicians as advocates tends to syphon off community participation because there is someone there to take care of the problem.*
>
> (Senior regional government official, Hamilton-Wentworth)

This view was tied to the belief that as government becomes more institutionalized voluntarism drops off and that grass-roots voluntarism will be higher when you don't have professional politicians. A different slant on the influence of professional politicians was taken in Ottawa where an informant observed the enabling role of politicians by their mere presence in the community (and the need to be seen to be doing something).

> *The presence of many layers of government and politicians looking for business enables participation. The scale of this is unique to this area.*
>
> (Former DHC executive director, Ottawa-Carleton)

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[14] The awards are presented to local governments around the world each year by the International City/County Management Association (ICMA) in recognition of creative programming.

The classic tension between direct and representative democracy was also highlighted:

> *Local councillors don't all want empowerment. Some believe that they were voted in to represent their constituents and they don't need to listen to them beyond that.*
>
> (Former medical officer of health, Hamilton-Wentworth)

Another informant questioned the motivation underlying local government's interest in enabling participation suggesting that facilitating broad-based community participation is merely used as a tactic for government to defer decision-making.

A different view of local government was presented in Nipissing although the distinction must be made between the City of North Bay (the dominant centre) and smaller municipalities such as Sturgeon Falls. In general, the North Bay municipal government was viewed as an elite decision-making body with little interest in or commitment to enabling participation. Although a former mayor of North Bay was described as "open and inclusive" the general view of local decision-making was that it was run by a small group of businessmen who were long-term residents of the community. The current mayor stated that "council tries to get public input when they see that an issue affects a large group of people" but suggested that people are more interested in voluntarism than in influencing policy decisions. One gets the distinct impression that North Bay almost prides itself on its lack of infrastructure (i.e., absence of government enabling mechanisms) in favour of a low tax base and the reliance on charity when money is needed to purchase something.

> *Charity is a big motivator ... If money is needed the community will raise it but they don't want services in place.*
>
> (Former health board member and university professor, North Bay)

A related example is the absence of a United Way office in North Bay discussed in the previous section on "Predisposing Influences". In communities where there is interest in establishing a United Way, key leaders from business, labour and community sectors come together. The absence of a United Way provides another sign that "enablers" are missing from this community. A community informant who wondered, upon moving into the community, why there was no United Way reinforced this point.

3. Role of the local media as an enabler

> *The mass media serve as a system for communicating messages and symbols to the general populace. It is their function to amuse, entertain, and inform, and to inculcate individuals with the values, beliefs, and codes of behaviour that will integrate them into the institutional structures of the larger society. In a world of concentrated wealth and major conflicts of class interest, to fulfil this role requires systematic propaganda.*
>
> (Herman and Chomsky, 1988, p.1).

The literature that has examined the role of the media as enabler has documented differential approaches taken by the media to the provision of enabling information. Examples include facts surrounding a local issue, whether a decision is going to be taken on the issue and how the public can participate in the decision-making process (i.e., location of public meetings, contact information, etc.). Informants in each community recognized the powerful role played by the media in enabling participation through information provision.

> *The presence of a local newspaper and cable television enables participation.*
>
> (Social planning agency director, Hamilton-Wentworth)

> *There is better participation in larger towns where there is a concentration of interest groups and where there is media.*
>
> (Executive director, Renfrew County DHC)

DHCs in all communities reported routine use of the media to advertise public meetings, seek committee and council membership and public input on various decisions. Challenges were identified in using the media to enable participation in rural communities where traditional communication vehicles such as cable television are non-existent. Print media was considered a necessity in rural areas but its associated costs were identified as a potential deterrent to providing enabling information. While there was unanimous agreement about the media's potential role in enabling participation, concern was expressed about the media adequately fulfilling this role in some communities and assuming an even greater role in others.

In Nipissing District, North Bay's local newspaper (The Nugget) was criticized for failing to provide adequate coverage of local issues and opportunities for community involvement. A local child care advocate observed, upon moving to North Bay 6 years ago, that there are few communication channels for providing enabling information:

> *The local newspaper often provides information about what is going on the day of an event which makes it difficult for people to organise their time to participate.*

DHC staff were also critical of the newspaper for their poor coverage of health issues generally and DHC activities in particular. In response to these criticisms a reporter for The Nugget claimed that "the newspaper is trying to focus more on local community issues to raise awareness".

In the three other study communities, views centred on the media's sensational approach to enabling participation.

> *The media's role is more than enabling, it's more enflaming.*
>
> (Medical Officer of Health, Hamilton-Wentworth)

The media may seek public involvement as a ruse for stirring up trouble.

(Former DHC executive director, Ottawa-Carleton)

The health care restructuring processes in Ottawa-Carleton, Hamilton-Wentworth and Renfrew County provided a unique opportunity to observe the media's role in providing information on a high profile community issue and is discussed in greater detail in Chapter 7.

4. Health Care Consumer Groups as Enablers

Consumer groups, as long-term stable and organized interests, would appear to natural enablers of community-level participation. The organization of consumer groups in Canada, however, presents significant barriers to playing an enabling role in the participation process. Consumer interest groups tend to be organized at the federal and provincial levels (mirroring the levels of government responsible for health and social policy decisions) with few resources available at the local level (Tuohy and Evans, 1984; Jones, 1997). This represents a great imbalance against professional interests which are more likely to be organized at the provincial and local levels.

As discussed in the previous section (see "Predisposing Influences" -- density of associations), attempts to gather associational density data were largely unsuccessful due to variable inclusion criteria, data collection methods and sources. In addition, few community informants spoke of the role played by consumer groups in their local participation processes other than consumer representation on committees. The paucity of information about the role played by consumer groups in local health care participation is striking. Or is it? If resources are not available at the local level then efforts to influence the participation process will be severely curtailed. This was the situation described by the Chair of the Health Council for the

Consumers' Association of Canada. Several reasons were given for the weak role played by consumer groups in the local health care decision-making arena. Principal among these was lack of resources:

> *If you want consumer participation you've got to pay for it. If you don't [pay for it] it's simply rhetoric. Voluntary groups just can't do anything.*
>
> (Chair, Consumers' Association of Canada Health Council)

Although the reduction in local organization resources resulting from government cutbacks was a major reason cited for their diminished role, the diversity (and fragmentation) of interests within the consumer sector was also given. An exception to this phenomenon of weak local consumer presence, however, emerged in the long-term health care arena. Consumer involvement in long-term care was unusually high during the early 1990s in Ontario due to a substantial commitment of resources by the previous New Democratic Party government. In particular, the establishment of a Seniors Alliance representing over one million seniors in Ontario received substantial funding from the provincial government enabling it to apply pressure locally. This would also explain the availability and precision of participation data for long term care planning presented in Chapter 5.

Summary

Several themes emerge regarding the observed relationship between enabling influences and participation in the study communities. First, the long-established presence of the DHC in Ottawa-Carleton and Hamilton-Wentworth suggests a stronger enabling influence over participation in these communities than in Nipissing District or Renfrew County. Second, the enabling role played by the DHC as well as local government is found to exert a specific influence over the *form* and *initiator* of

participation. More specifically, the actions taken by these institutions are primarily concerned with enabling routine, solicited participation versus unsolicited, issue-driven participation. Third, the culture of participation described in Ottawa-Carleton (i.e. history of encouraging community-based service delivery and decision-making) matches the "expectation of participation" described in its participation profile in Chapter 5. Similarly, the local government's commitment to community involvement through visioning exercises in Hamilton-Wentworth matches the participation profile depicted. The lack of infrastructure or culture of participation in Nipissing also provides a plausible explanation for the "apathetic" participation profile depicted in Nipissing. Fourth, enabling influences fail to explain differential participation observed within communities since the institutional actions designed to facilitate participation are applied across an entire region. In other words, enabling influences alone do not explain the highly participatory communities of Dundas in Hamilton-Wentworth, Sturgeon Falls in Nipissing or Deep River in Renfrew County. Fifth, although not specifically mentioned by community informants, community size and the concentration of resources that accompanies large regions governed by two tiers of government, full-time politicians and a sizeable bureaucracy must surely account for the presence of well-established infrastructures in Hamilton-Wentworth and Ottawa-Carleton as compared to Renfrew County and Nipissing District. Sixth, the absence of an enabling role for consumer groups was striking and represents an important explanator of low levels of routine involvement. Finally, the absence of enabling influences does not explain high levels of participation in response to issues, the subject of the next section.

PRECIPITATING INFLUENCES

As discussed in Chapter 3, there may be forces at work in a community, that, regardless of the presence or absence of pre-disposing or enabling influences, act as a "catalyst" of participation. These catalysts or mobilizers are defined, in the context of the analytic model, as *precipitating influences*. Underlying many precipitants to participation is a strong link between an *issue* that has arisen in a given community and the *interests* of parties affected by the issue. The location of a waste disposal site in close proximity to a residential neighborhood is an example of an issue (the siting of a waste disposal facility) that is strongly linked to the interests (health, property values, etc.) of a community. Precipitants are likely to influence various dimensions of participation including its *intensity, tone, texture and quantity*. With respect to form, precipitating influences are almost always associated with issue-driven participation although it may be solicited or unsolicited. Examples of the types of issues likely to precipitate participation include:

- perceived threat to the safety, health or economic stability of individuals or communities
- perceived need for some additional program or service
- maintenance or preservation of property value
- desired improvements to the quality of service
- pursuit of specific interest for personal or community gain

The participation literature provides strong support for the association described above between precipitating influences and participation.[15] Many empirical studies of participation in the environmental and health promotion arenas have examined how communities mobilize in response to local issues. The political science literature offers some insights into the role played by interests in the health care arena. Studies of participation in health care decision-making have looked

[15] For a discussion of this topic refer to the 'community of limited liability theory' in literature review chapter.

primarily at the dominant role played by the "concentrated" interests of the health care elite as compared to the "diffuse" interests of health care consumers and the public more generally.[16] The case studies conducted here provide the opportunity to observe the influence exerted by precipitating influences over community-level participation. Community informant interviews were used as the primary method for collecting information about the presence and role of precipitating influences.

The most commonly reported factor to exert an influence over participation was the single issue. Informants in each study community repeated phrases such as "when an issue affects them directly, people get involved" or "you get involved in the issue that affects you most directly". Implied in these statements is the link between the issue and the participant. Interest in the issue does not appear to be enough to spark participation - the issue must have some palpable effect on the potential participant. Some informants provided insights into this relationship and its influence on participation (i.e., the characteristic of the issue):

> *Proposed changes to [long-term care] service provision provoked controversy.*
>
> (DHC staff, Renfrew County)
>
> *More mobilization is expected in times of cutbacks.*
>
> (Medical Officer of Health, H-W)
>
> *The community seems to be able to mobilize itself to procure facilities.*
>
> (DHC staff, Nipissing)

In each of these examples, participation is precipitated or "mobilized" for the purposes of achieving a specific objective: to oppose service provision changes, to protect against service reductions or to acquire more services, all of which have tangible effects on the community.

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[16] This literature was reviewed in Chapter 2 in the section on "Interest and Interest group Influences"

1. Quality and Quantity of Participation

Informants also referred to the different dimensions of participation in the community's response to an issue. References to the *form*, *quantity*, *texture*, *tone* and *intensity* of participation are found in the following quotes:

> *When people feel it directly impacts them the community can turn out in full force and it does.*
>
> (DHC executive director, Hamilton-Wentworth)

> *There is not a lot of regular participation but participation is issue-driven.*
>
> (Former DHC executive director, Ottawa-Carleton)

> *There is no problem getting people to participate on a short-term, narrow, well-defined issue.*
>
> (Former DHC chair, Hamilton-Wentworth)

> *If something is taken away, involvement intensifies.*
>
> (Former DHC executive director, Ottawa-Carleton)

Views were mixed on the subject of single-issue groups versus groups moving between different issues. Some believed that while organizations may initially form around a specific issue they often carry on to other issues while others believed that health care groups tended to stick to the same issue.

Organizations form around an issue and then take on a life of their own and then may be carry on to other issues.

(former DHC executive director, O-C)

Those who get involved stick to their own areas.

(DHC member, H-W)

People tend to stick to single issue causes. This is what citizens feel their role is.

(DHC executive director, Renfrew)

Few differences were found among study communities in the reported presence, and influence, of precipitating influences with the exception of Nipissing District, which presented an interesting contrast to the normal pattern of issue-driven participation. According to several informants, community mobilization around issues is a non-issue for the City of North Bay with the exception of groups trying to raise funds for a particular cause. One informant observed that:

People don't even consider mobilizing around issues so decision-makers have no concerns about mobilizing.

(former member of district health board)

Nipissing also stood out from the rest because it was not engaged in the health care restructuring exercises that other communities were involved in which may have biased community informant views of the role of precipitating influences (i.e., threat of hospital closures) in these communities. This bias appears unlikely, however, given the number of examples of precipitating issues provided in Ottawa, Hamilton and Renfrew as compared to Nipissing.

2. Types of issues

It is perhaps worth noting that although the issue of resource allocation was implicitly tangled up in community discussions regarding hospital closures,

"rationing" per se was not part of the discourse in these debates as it is for example in many communities in Britain. The reason for this is due to the fact that district health councils have traditionally functioned as planning bodies and have only recently become involved in resource allocation decisions (and even then only in an advisory capacity). Rationing issues tend to be debated at the provincial and federal levels in Canada although their effects are obviously demonstrated at the individual patient and community level.

Informants gave numerous examples of issues that have precipitated widespread community involvement. Most of these issues dealt with proposals to "take something away" from the community although informants in Nipissing District referred more often to community mobilization for the purpose of obtaining services or equipment. Closure of hospital departments and, within the study period, the closure of hospitals were the dominant health care issues around which communities mobilized. Although the cost-cutting environment within which health care decisions are currently being made was responsible for the unprecedented levels of community mobilization observed during the study period, informants referred to other issues that have sparked similar community reactions over the years. In Renfrew County, for example, informants described similar mobilization efforts in response to hospital closure proposals, the location of waste disposal site and proposals for the amalgamation of the Catholic school board with a neighboring community's school board. For the other communities, however, the hospital closure threat was the most controversial issue that had come along in many years.

There was not a single health care issue reported by any informant that had mobilized the community to the same degree. Many of the issues that had arisen in the past concerned only a small group of people who would be directly affected by the

decision (e.g., long-term care) in contrast to the hospital closures that affected the entire community. In Chapter 5, participation profiles for three of four study communities depicted widespread community mobilization in response to proposed hospital closures (see discussions of health care restructuring in Hamilton-Wentworth, Ottawa-Carleton and Renfrew County participation profiles). Examining the *quantity* and *texture* of participation one may be inclined to conclude that broad-based community participation took place in these communities with thousands of letters being written, thousands of petition signatures, hundreds in attendance at community meetings, etc. As has been alluded to in previous sections (e.g., role of cultural and religious characteristics, p. 210) and, as will be further illustrated in the next chapter, much of this "broad-based" community participation was either initiated, orchestrated or carried out by those whose interests would be best served by achieving a particular outcome (i.e., preventing the closure of a particular hospital), most notably concentrated health care interests, in contrast to the diffuse and heterogeneous interests of the community. This is not to say that the general public in each of these communities was not affected by the proposed hospital closures but that the magnitude and style of participation were strongly associated with the interests held on the issue. In general, those threatened most severely by the proposed closures participated with a level of intensity and fierceness (i.e. *tone*) that went unmatched by the community at large who responded primarily through solicitations for community input by the local DHC or hospital.[17]

The information presented in this section permits the following observations to be made about the relationship between precipitating influences and participation. First, the role of precipitating influences in influencing participation is unquestionably

[17] These issues are discussed in greater detail in Chapter 7.

strong given the emphasis placed on issue-driven participation and its dimensions by community informants. Second, precipitants influence the *tone*, *intensity* and *texture* dimensions of participation. They evoke intense, short-term participation around narrow well-defined issues. Third, it is not clear what the absence of precipitating influences in Nipissing District tells us about participation in this community. Does it mean that with no precipitating influences there is no participation as one might conclude from the participation profile depicted in Chapter 5, or are there other influences that also contribute to explaining these findings? An answer to this question will be sought in the next chapter where the combined influences of pre-disposing, enabling and precipitating influences on participation are examined.

SUMMARY

The cross-case analysis undertaken in this chapter highlights the following themes regarding the independent influences on participation. Education and income were clearly identified as key influences, both quantitatively (from census data) and qualitatively (from interviews), playing an important role in shaping routine participation. Residential stability did not play much of a role at the aggregate community level (although it was found to play a minor role within study communities). This was not a surprising finding given the high degree of mobility that characterizes modern communities. The role of culture and religion in shaping local health care participation was an unexpected finding and represents a potentially new contribution to the literature. The role played by social cleavages in producing social cohesion will be explored in the next chapter. Social cohesion, population homogeneity and community values also played an important role in shaping participation although the outcomes of their influence (i.e., participation dimension)

were not at all predictable. Dundas, Deep River and Sturgeon Falls, for example, represent three socially cohesive, homogeneous communities with strong community values. Each community, however, exhibited a different style of participation: routine, co-operative involvement in Dundas, emotional, issue-driven involvement in Sturgeon Falls, and some combination of both in Deep River. These findings suggest that independent influences, alone, do not tell the whole story and will be subjected to further scrutiny in the next chapter.

Enablers were found to play a more important role than was expected based on the minimal role suggested in the literature. Long-established DHCs and supportive local governments in Ottawa-Carleton and Hamilton-Wentworth were found to play a significant role in creating a culture of participation and providing the necessary infrastructure for participation. In contrast, the same "culture" of participation was not found in Nipissing and Renfrew County and both communities were found to harbour resistance to government infrastructure. The marginal presence and role for consumer groups in local health participation was a surprising finding although this was explained by the organizational hierarchy of consumer groups in Canada and their concentrated representation at the federal and provincial levels of government.

With this part of the analysis complete, the complexity of participation has been partially explored and, it is hoped, partially unravelled. An important part of the story, however, is still to come. In the next chapter, the relationships between each of the influences and their combined role in shaping participation will be explored.

Appendix 6-1

Educational Attainment for Residents 15 years of age and older for Hamilton-Wentworth, Ottawa-Carleton, Nipissing District and Renfrew County, 1991 (Counts and Percentages)

Education Level	*Hamilton-Wentworth*	*Ottawa-Carleton*	*Nipissing District*	*Renfrew County*	*Ontario*
Total population 15+	358045	540595	65340	71230	7922920
less than grade 9	48690 (13.6%)	35230 (6.5%)	8950 (13.7%)	11085 (16%)	911960 (12%)
grades 9-13 without certificate	96235 (26.9%)	100115 (18.5%)	17650 (27.0%)	19810 (28%)	1971565 (25%)
grades 9-13 with secondary certificate	55070 (15.4%)	80105 (14.8%)	10015 (15.3%)	12755 (18%)	1228255 (16%)
trades certificate or diploma	13425 (3.7%)	13585 (2.5%)	3005 (4.6%)	3310 (5.0%)	272470 (3%)
other non-university without certificate	24905 (7.0%)	34235 (6.3%)	4445 (6.8%)	3750 (5.0%)	515480 (7%)
other non-university with certificate	57570 (16.1%)	82235 (15.2%)	11295 (17.3%)	11325 (16%)	1263030 (16%)
university without degree	26965 (7.5%)	70895 (13%)	5010 (7.7%)	4175 (6.0%)	732570 (9%)
university with degree	35190 (9.8%)	124200 (23%)	4965 (7.6%)	5015 (7%)	1027590 (13%)

Source: Statistics Canada. 1991 Profile of Census Divisions and Subdivisions - Part B.

Appendix 6-2a
Educational Attainment for Residents 15 years of age and older for within Hamilton-Wentworth, 1991 (Counts and Percentages)

Education Level	*Hamilton-Wentworth*	*Ancaster*	*Dundas*	*Flamborough*	*Glanbrook*	*Hamilton*	*Stoney Creek*
Total population 15+	358045	16605	16815	22655	7515	256080	38370
less than grade 9	48690 (13.6%)	850 (5.1%)	1035 (6.2%)	1840 (8.1%)	695 (9.2%)	39270 (15.3%)	5010 (13.1%)
grades 9-13 without certificate	96235 (26.9%)	3415 (20.6%)	3800 (22.6%)	5650 (24.9%)	2275 (30.3%)	71185 (27.8%)	9910 (25.8%)
grades 9-13 with secondary certificate	55070 (15.4%)	2440 (14.7%)	2320 (13.8%)	3640 (16.1%)	1370 (18.2%)	38490 (15%)	6815 (17.8%)
trades certificate or diploma	13425 (3.7%)	590 (3.6%)	540 (3.2%)	975 (4.3%)	410 (5.5%)	9025 (3.5%)	1890 (4.9%)
other non-university without certificate	24905 (7.0%)	940 (5.7%)	1015 (6.1%)	1500 (6.6%)	415 (5.5%)	18320 (7.2%)	2710 (7.1%)
other non-university with certificate	57570 (16.1%)	2685 (16.2%)	3105 (18.5%)	4220 (18.6%)	1510 (20.1%)	39690 (15.5%)	6355 (16.6%)
university without degree	26965 (7.5%)	1985 (12%)	1865 (11.1%)	2100 (9.3%)	480 (6.4%)	17700 (6.9%)	2830 (7.4%)
university with	35190 (9.8%)	3705 (22.3%)	3135 (18.6%)	2740 (12.1%)	355 (4.7%)	22390 (8.7%)	2855 (7.4%)

Appendix 6-2b
Educational Attainment for Residents 15 years of age and older for within Ottawa-Carleton, 1991 (Counts and Percentages)

Education Level	*Ottawa-Carleton*	*Gloucester*	*Kanata*	*Nepean*	*Ottawa*	*Vanier*
Total population 15+	540595	76545	27465	85015	262400	15330
less than grade 9	35230 (6.5%)	4035 (5.3%)	610 (2.2%)	3600 (4.2%)	21230 (8.1%)	2325 (15.2%)
grades 9-13 without certificate	100115 (18.5%)	14675 (19.2%)	4520 (16.5%)	14880 (17.5%)	47575 (18.1%)	3905 (25.5%)
grades 9-13 with secondary certificate	80105 (14.8%)	12870 (16.8%)	4055 (14.8%)	11980 (14.1%)	35540 (13.5%)	2575 (16.8%)
trades certificate or diploma	13585 (2.5%)	2190 (2.9%)	565 (2.1%)	2145 (2.5%)	5965 (2.3%)	345 (2.3%)
other non-university without certificate	34235 (6.3%)	4710 (6.2%)	1860 (6.8%)	5555 (6.5%)	16465 (6.3%)	1130 (7.4%)
other non-university with certificate	82235 (15.2%)	11815 (15.4%)	4920 (17.9%)	14875 (17.5%)	34695 (13.2%)	1955 (12.8%)
university without degree	70895 (13%)	10560 (13.8%)	3870 (14.1%)	11870 (14.0%)	34770 (13.3%)	1390 (9.1%)
university with degree	124200 (23%)	15685 (20.5%)	7055 (25.7%)	20105 (23.6%)	66150 (25.2%)	1700 (11.1%)

Appendix 6-3

Average and Household Income and Percentage of Low Income Families and Individuals for Hamilton-Wentworth, Ottawa-Carleton, Nipissing District and Renfrew County, 1991 (Dollars and Percentages)

	Hamilton-Wentworth	*Ottawa-Carleton*	*Nipissing District*	*Renfrew County*	*Ontario*
Average Household Income ($)	46,415	56,554	41,342	40,904	52,225
Median Household Income ($)	40,249	49,407	35,380	35,474	44,432
% Low Income Families [1]	14.8	10.9	13.5	9.0	11.0
% Low Income Individuals[2]	41.3	32.0	38.0	27.5	31.0

[1] Proportion of Families living under the Statistics Canada Low-Income Cut-off
[2] Proportion of Individuals living under the Statistics Canada Low-Income Cut-off

Appendix 6-3a

Average and Household Income and Percentage of Low Income Families and Individuals for Hamilton-Wentworth, 1991

	Hamilton-Wentworth	*Ancaster*	*Dundas*	*Flamborough*	*Glanbrook*	*Hamilton*	*Stoney Creek*
Average Household Income ($)	46,415	78,413	58,073	65,195	54,601	41,232	54,619
Median Household Income ($)	40,249	67,133	50,789	56,842	50,096	35,905	50,922
% Low Income Families [3]	14.8	3.5	7.8	4.6	5.2	18.2	9.5
% Low Income Individuals[4]	41.3	27.7	32.9	20.2	21.7	43.4	34.0

[3] Proportion of Families living under the Statistics Canada Low-Income Cut-off
[4] Proportion of Individuals living under the Statistics Canada Low-Income Cut-off

Appendix 6-3b

Average and Household Income and Percentage of Low Income Families and Individuals for Ottawa-Carleton, 1991

	Ottawa-Carleton	*Gloucester*	*Kanata*	*Nepean*	*Ottawa*	*Vanier*
Average Household Income ($)	56,554	64,254	71,969	65,802	49,192	36,177
Median Household Income ($)	49,407	60,142	67,167	59,779	40,036	30,010
% Low Income Families [5]	10.9	8.4	2.9	7.2	15.9	27.7
% Low Income Individuals[6]	32.0	27.9	14.2	22.8	34.5	38.1

[5] Proportion of Families living under the Statistics Canada Low-Income Cut-off
[6] Proportion of Individuals living under the Statistics Canada Low-Income Cut-off

Appendix 6-4

Residential Stability for Hamilton-Wentworth, Ottawa-Carleton, Nipissing District and Renfrew County (counts and percents)

	Hamilton-Wentworth	*Ottawa-Carleton*	*Nipissing District*	*Renfrew County*	*Ontario*
Total population age 5+	413790	618925	76765	82590	9225700
Not moved within five years	231030 (55.8%)	277310 (44.8%)	39655 (51.7%)	48850 (59.1%)	4797795 (52.0%)
Moved within 5 years	182765 (44.2%)	341615 (55.2%)	37115 (48.3%)	33740 (40.9%)	4427905 (48.0%)
Moved within CSD*	107360 (58.7%)	163480 (47.9%)	18795 (50.6%)	12580 (37.3%)	2098400 (47.4%)
Moved outside CSD	75395 (41.3%)	178135 (52.1%)	18315 (49.3%)	21160 (62.7%)	2329505 (52.6%)

* Census Sub-Division or township or municipality

Source: Statistics Canada. 1991 Profile of Census Divisions and Subdivisions - Part B.

Appendix 6-4a
Residential Stability within the Region of Hamilton-Wentworth

Mobility	*Hamilton Wentworth*	*Ancaster*	*Dundas*	*Flamborough*	*Glanbrook*	*Hamilton*	*Stoney Creek*
Total population age 5+	413790	20180	19550	27160	8965	292050	45880
Not moved within five years	231030 (55.8%)	12200 (60.5%)	11160 (57.1%)	16335 (60.1%)	6495 (72.4%)	158640 (54.3%)	26195 (57.1%)
Moved within 5 years	182765 (44.2%)	7980 (39.5%)	8390 (42.9%)	10825 (39.9%)	2470 (27.6%)	133410 (45.7%)	19685 (42.9%)
Moved within CSD*	107360 (58.7%)	2775 (34.8%)	3525 (42.0%)	3715 (34.3%)	830 (33.6%)	87070 (65.3%)	9450 (48.0%)
Moved outside CSD	75395 (41.3%)	5200 (65.2%)	4870 (58.0%)	7110 (65.7%)	1645 (66.6%)	46340 (34.7%)	10235 (52.0%)

Residential Stability within the Region of Ottawa-Carleton

Mobility	*Ottawa-Carleton*	*Gloucester*	*Kanata*	*Nepean*	*Ottawa*	*Vanier*
Total population age 5+	618925	91345	33825	98625	288410	16750
Not moved within five years	277310 (44.8%)	38800 (42.5%)	12455 (36.8%)	45970 (46.6%)	130810 (45.4%)	6655 (39.7%)
Moved within 5 years	341615 (55.2%)	52540 (57.5%)	21365 (63.2%)	52660 (53.4%)	157600 (54.6%)	10100 (60.3%)
Moved within CSD*	163480 (47.9%)	22770 (43.3%)	8720 (40.8%)	26145 (49.6%)	84225 (53.4%)	4685 (46.4%)
Moved outside CSD	178135 (52.1%)	29765 (56.7%)	12645 (59.2%)	26510 (50.3%)	73370 (46.6%)	5420 (53.7%)

Source: Statistics Canada. 1991 Profile of Census Divisions and Subdivisions - Part B.

Appendix 6-5

Usual Place of Work for Male Employees (as a proxy for worplace/residence proximity)

	Hamilton-Wentworth	*Ottawa-Carleton*	*Nipissing District*	*Renfrew County*	*Ontario*
Employed Males	115205	195970	20405	24325	2730290
Usual workplace[7]	107870	181465	18845	21740	2493070
Employed in same CSD as residence[8]	56290 **(49%)**	80315 **(41%)**	14030 **(69%)**	7110 **(29%)**	1119885 **(41%)**

Source: 1991 Census

[7] denotes number of male employees with a usual workplace

[8] denotes number and percentage of male employees who work and reside in the same census subdivision (e.g. municipality)

Appendix 6-6

Newspaper Readership as a Measure of Civic Engagement (Percentage of adults who reported reading a local daily newspaper yesterday)

	Ottawa-Hull (%)	*Hamilton (%)*	*North Bay (%)*
Adults 18+	67	58	71
18-24	66	49	55
25-34	57	52	62
35-49	67	58	77
50-64	74	62	76
65+	74	70	80
<$30,000	53	54	61
$30,000-$50,000	74	61	73
$50,000-$75,000	65	61	80
$75,000+	71	55	82
Manager/prof	70	55	73
Primary (blue collar)	62	65	78
Clerical/sales/service	69	55	81
Working women	67	58	75
< high school	60	53	67
high school	67	63	70
some post-secondary	64	58	57
university grad+	70	56	83

Source: Canadian Facts. 1995. Newspaper Audience Databank Study (NADbank).
NADbank is a major research study that is updated every year in 32 markets across Canada. The study consists of telephone interviews of randomly selected adults 18 years of age and over living in each of the defined Census Metropolitan Area (CMA). Numbers of interviews conducted in each of the above communities were: Ottawa-Hull (1,020); Hamilton (1,234); and North Bay (488).

Appendix 6-7

Blood Donorship as a Measure of Civic Engagement (January - December 1995)

	Hamilton-Wentworth	*Ottawa-Carleton*	*Nipissing District*	*Renfrew County*
Mean # of donors/clinic	82	154	183	213
Donors/population (%)	6.4	7.5	6.6	4.5

Source: The Canadian Red Cross, Blood donor recruitment reports for Hamilton, Ottawa, Nipissing and Renfrew County offices.

Appendix 6-8a

Analysis of Blood Donorship as a Measure of Social Capital/Volunteerism (January - December 1995)

Hamilton-Wentworth

	Hamilton	Ancaster	Dundas	Flamborough	Stoney Creek	Total (Hamilton-Wentworth)
Donors attending clinic	19992 (2576)[9]	795 (133)	1122 (129)	628 (44)	544 (14)	23081 (2896)
New donors/total donors (%)	13%	17%	11%	7%	3%	13%
Mean # of donors/clinic	77	114	187	157	136	82
Population 15+	256080	16605	16815	22655	38370	358045
Donors/population 15+ (%)	7.8%	4.8%	6.7%	2.8%	1.4%	6.4%

[9] Numbers in parentheses represent number of new as compared to repeat donors

Appendix 6-8b

Analysis of Blood Donorship as a Measure of Social Capital/Volunteerism (January - December 1995)

Ottawa-Carleton

	Ottawa	Gloucester	Kanata	Nepean	Total (Ottawa-Carleton)
Donors attending clinic	39579	501 (122)	365 (96)	283 (79)	40728
New donors/total donors (%)		24%	26%	28%	
Mean # of donors/clinic	112	167	122	94	154
Population 15+	262400	76545	27465	85015	540595
Donors/population 15+ (%)	15%	0.7%	1.3%	0.3%	7.5%

Appendix 6-9a
Number of clinics by geography and location for Hamilton-Wentworth Region

Clinic location	Hamilton (excluding permanent clinic)	Ancaster	Dundas	Flamborough	Stoney Creek
University/college	11	3			
Workplace	13				
Hospital	11				
High school	14	3	2		
Community Centre		1	4	4 (Legion Hall)	
Church hall					4 (United Church hall)
Shopping malls	6				
Total	55	7	6	4	6

Appendix 6-9b
Analysis of blood donor clinic locations (City of Hamilton only)

Clinic Location	*Number of clinics*	*Number of donors*	*Number of new donors*	*Donors/clinic*
Permanent clinic	206	13303	1597	65
University/college	11	1747	217	159
Workplaces	13	1588	76	122
Area hospitals	11	1327	110	121
Shopping malls	6	630	73	105
Area high schools	14	1397	475	100
Totals	**261**	**19992**	**2548**	77

Appendix 6-10a
Number of clinics by geography and location for Ottawa-Carleton Region

Clinic location	Ottawa (excluding permanent clinic)	Gloucester	Kanata	Nepean
University/college	7			
Workplace	96		1	
Hospital	1			
High school				
Community Centre	2			2
Fire hall			2	
Shopping malls		3		1
Total	106	3	3	3

Appendix 6-10b

Analysis of blood donor clinic locations (Ottawa only)

Clinic Location	*Number of clinics*	*Number of donors*	*Number of new donors*	*Donors/clinic*
Permanent clinic	246	26517	4014	108
University/college	7	1099	566	157
Workplaces	96	11400		119
Area hospitals	1 (health sciences centre)	99	44	99
Shopping malls	0	0	0	0
Area high schools	0	0	0	0
Community centre	2	464	116	232
Totals	**352**	**39579**		**112**

Appendix 6-11

Contacts with Volunteer Centres
Comparison between Hamilton-Wentworth and Ottawa-Carleton
(1995)

	Hamilton-Wentworth	*Ottawa-Carleton*
Total Registrants/Referrals (1995)	2625	5552
Total Population (1991)	452,000	678,000
Registrants/Referrals per 1000 residents	5.8	8.1
Male	739	890
Female	1899	1662
Age range		
18 and under	817 (29%)	150 (5.8%)
19-24	721 (26%)	683 (26.7%)
25-34	618 (22%)	851 (33.3%)
35-44	316 (11%)	468 (18.3%)
45-54	155 (5.6%)	248 (9.7%)
55-64	86 (3.1%)	100 (3.9%)
65+	59 (2.1%)	52 (2.0%)
Total	2772	2552[10]

Sources: Volunteer Centre registration reports for Hamilton and Ottawa

[10] Demographic information was available for only 2552 registrants despite an additional 3000 (250 per month) referrals received by telephone and computer.

Brief Report

In Search of Informed Input: A Systematic Approach to Involving the Public in Community Decision Making

by Julia Abelson and Jonathan Lomas

Given the task of distributing scarce resources, decision makers are faced with the question of how to involve an increasingly threatened and disenfranchised public in decisions affecting their communities. This article introduces a systematic approach to public involvement in community decision-making and identifies key elements in the design of institutionally driven public participation exercises. Examples are drawn from the health care system restructuring experiences of three Ontario communities.

Étant donné la tâche de dispenser des ressources réduites, les décideurs font face à la question de la participation d'un public de plus en plus menacé et dépossédé des décisions touchant sa communauté. Cet article présente une approche systématique à la participation du public à la prise de décision communautaire et identifie les éléments importants dans la conception d'exercices de participation du public menés par les organismes. Des exemples sont tirés des expériences de restructuration du système de santé de trois communautés ontariennes.

Despite a longstanding debate over the merits of "participatory" versus "representative" democracy, decision makers have become preoccupied with the issue of how (not whether) to involve the public directly in community decision-making. Decision makers increasingly feel the need to involve the public in decisions as varied as waste disposal siting, school closures or land development, either in a consultative or a decisive role.

The context of public involvement has changed as the focus of decision-making shifts from sharing abundant resources to sharing scarce resources. Spending reductions are affecting every community, requiring decision makers to carefully consider the views of an increasingly threatened and disenfranchised public.

In this article, we introduce a systematic approach to involving the public in community decision-making. We identify the various elements that should be considered in designing an institutionally driven, as opposed to a community-mobilized public participation exercise. The proposed approach is not a prescription for success but rather a checklist for comprehensiveness.

The systematic approach

We developed our approach by analysing the health care restructuring processes that occurred between 1994 and 1996 in three Ontario communities — Ottawa-Carleton, Hamilton-Wentworth and Renfrew County — using interviews, document review and newspaper content analysis.

The task of health care system restructuring in Ontario has fallen to District Health Councils (DHCs), which are responsible for making health planning recommendations to the provincial government on behalf of geographically defined populations. DHCs are pivotal to obtaining public input and are required to "develop strategies to assure and enhance public participation in all parts of the planning process..."[1(p.59)]

Our analysis of DHC efforts to involve the public (and the results of these attempts) led us to propose the systematic approach outlined in Table 1.

The objective and context of participation

A first step in any public participation exercise is to identify the *objective(s)* for involving the public. Participation can occur in many forms and at many levels. Arnstein's famous "ladder of citizen participation" assigns each of eight rungs a different level of participation, from manipulation (on the bottom) to citizen control (at the top).[2] Framing participation in a power-sharing context, Arnstein's normative depiction is as much about the goals of participation as the activities involved.

Table 1: A Systematic Approach to Public Participation

Objective(s)
What is the objective of the public participation exercise?
* "voice"
* "choice"

Context
What is the context in which public participation is taking place?
* forward planning
* crisis management

Selection
* random
* targeted
* volunteer

Information
* presentation
* comprehensive/minimal
* controlled/phased
* Availability
* widespread
* selective (targets)
* restricted to requests
* "come and get it"

Participation Medium
* telephone
* mail/fax
* internet
* face-to-face
* public meeting
* open house

Participation Timeline
* short (days)
* medium (weeks)
* long (months)

Content
* single/multiple domains
* technical vs. non-technical
* assumed resource constraint

A simpler way of characterizing the public's role is to ask whether the intent is to give members of the public "voice" or "choice" in the decision-making process.[3] Giving them "voice" is synonymous with consultation exercises where the public's input is advisory (the focus of this paper). In contrast, giving the public "choice" means its role is decisive and it takes responsibility for the final decision(s). The general public, at least in Ontario, seems largely content to have voice while leaving the final choice to others.[4]

The *context* within which the community is being asked to participate often drives other elements of the process such as the *participation medium, timeline* and *content*. Forward planning, with a timeframe of perhaps years, can involve the public very early on as well as at regular intervals during the process, often using multiple methods of consultation. Although welcomed by most decision makers, the luxury of time afforded by long-range planning exercises is increasingly rare.

Public input is more often sought under "crisis management" conditions. DHCs in Ottawa-Carleton and Hamilton-Wentworth have had timelines curtailed for their restructuring exercises from two years to under a year. They have also had to confront stringent budgetary situations. Not only are the options for public involvement limited under these conditions but the public's level of anxiety and potential mistrust of the process is heightened considerably due to shortened timelines and threatened services.

Selection of participants

Who will represent "the public" is determined by the processes used to *select* participants. Once an umbrella decision-making group is established, it can involve members of the broader public in one or more of the following ways:

- planned random selection for telephone or mail surveys of representative views in defined areas;
- targeted participation in surveys or discussion groups for those with specific characteristics (e.g., ethnicity, gender, age, illness / disease, occupation);
- open invitation to volunteers to attend a meeting, complete a questionnaire, write a letter or telephone in.

The more compressed the timeline for decision makers, the greater the tendency to exploit the convenience of voluntary participation. Unfortunately, this biases attendance in favour of those whose interests are most threatened, e.g., employees in the health care sector. Even attempts to target participation by "average" members of the public are likely to fall short of truly representative views, but they do lessen the obvious bias of relying purely on responses to open invitation.[5]

Information for participation

The presentation and dissemination of *information* is the principal vehicle used to both encourage public participation and elicit *informed* input.[6]

Information presentation

The information presented to the public relates both to the *objective* of the participation exercise and the task being given to the public. Either comprehensive or minimal information is presented in a controlled or phased manner. The sponsor of the consultation exercise may choose to collect and analyse information (some of which may be from the public through surveys), formulate options, and then present a comprehensive plan to the public for discussion and response. This was the approach taken by the Renfrew County DHC.[7]

In contrast, Hamilton-Wentworth used a phased approach by presenting minimal information at the outset (to elicit broad-based public input) and releasing a detailed report thereafter with further opportunity for public input.[8] In Ottawa-Carleton, public input concerned three options for hospital closures with accompanying information provided about options development but not costs.

Considerable variation exists in both *what* and *how* information is presented to the public. No obvious advantages to any of the chosen approaches are evident although public dissatisfaction is characteristic of most. If minimal information is presented, the authors are accused of not providing enough detail to allow informed response. If detailed information is provided, the process is critiqued for being closed to public input and already decided. If detailed information is accompanied by a rationale for arriving at recommendations, the methodology underlying the rationale is criticized and used by opponents to discredit the restructuring process and proposals. The following quotes from the public exemplify the dilemma facing decision makers who have the task of presenting information to the public:

- "In the local process, the Task Force has not yet provided clear recommendations, so it is difficult for the public to respond."[9]
- "...it's clear the task force won't change its recommendations... Instead...the public must put pressure on the health council to justify and then change those recommendations if necessary. It's essential the council avoid the appearance of ramming through changes without discussion."[10]
- "Allan Greave, president of St. Joseph's Hospital, said he's not debating the data in the report...But he says their "logic is flawed" when it comes to analysing the data."[11]
- "A majority of those who spoke said they didn't want either hospital closed. Others knocked the study process for using inaccurate data or not giving the public enough information."[12]

Information availability

Strategies for making information available include: (1) mass dissemination through newspaper inserts, press releases and television; (2) selective dissemination to specific individuals and organizations; (3) restricted dissemination to those requesting it; and (4) minimal dissemination that requires people to obtain information by travelling to an office.

Once again, the dissemination approach is contingent upon the type of information presented and input sought from the public. In the early stages of the decision-making process, especially when broad public input is being encouraged, it may be reasonable to adopt a broad dissemination strategy using all media. At later stages in the process, however, more selective dissemination of reports may be all that is required.

The approach taken by Ottawa-Carleton illustrates the importance of matching the presentation and dissemination strategy to the task expected of the public. That DHC's task group prepared a detailed report outlining the content and rationale for each of three reconfiguration scenarios and made it available through the DHC office.[13]

This minimal dissemination strategy left much of the responsibility for communicating the report's contents to the local media and those whose interests were threatened enough to motivate them to obtain details, i.e., those hospitals threatened with closure. Members of the public were easily manipulated by emotional attachments to hospitals as the war waged between hospitals through the media. Any information that may have informed public input was lost at the outset of the process due to the way information was disseminated.

The how, when and what of public participation

The *participation medium* typically used to obtain public participation is the telephone, mail, faxes and the internet, as well as some form of public gathering. Tear-off forms for comments are routinely incorporated into any written material disseminated, along with telephone, fax and mailing information.

The traditional consultation mechanisms of public or "town hall" meetings often suffer from being confrontational, pitting the public against the decision makers. This has led some to prefer "open houses" where people can drop in at their convenience to obtain information, express their concerns, or seek clarification from a resource person and even give written input. This format reduces confrontation and prevents any one person or group from dominating. Ultimately, the decision over which medium to use may be as much about "managing controversy" as it is about seeking the community's views.[14]

The *participation timeline* is an often criticized element of the decision-making process, obviously related to the forward planning versus crisis management context. Most recent efforts in Ontario have been criticized for spending months preparing the information for dissemination and then giving the public only days to respond. The following views on this subject were expressed in two communities:

- "Proper timing and clarity are essential if serious consultation is to take place...A timeframe of four days is grossly unsuitable for any sort of preparation..."[15]
- "Instead of offering untenable deadlines on such significant public policy issues, the task force...should instead go an extra mile to explain the...proposals and heed the concerns and suggestions of regional health care consumers and providers."[16]
- "Considering the report was a year in the making, that [four-day] deadline is unrealistic."[17]

Despite routine complaints about the short timelines, the public appears well able to mobilize at short notice. In Hamilton-Wentworth, members of the public were given approximately one week's notice of eight open houses scheduled over a week-long midwinter period. Announcements soliciting public feedback appeared in a supplement to the regional newspaper. Over 500 people attended the eight open houses and, of these, over two-thirds completed a questionnaire soliciting open-ended views on a variety of topics.[18]

In the Ottawa-Carleton region, over 30,000 letters, tear-off forms, calls, petitions and flyers were received (between December 11 and December 15, 1995) in response to the options proposed by the DHC task group for health system reconfiguration.[19] Short timelines do not appear to limit the amount of participation. Long timelines, however, give concentrated interests the time to mobilize their often significant resources to sustain prolonged input.[20]

The *content* area in which participation is being sought can influence the participation process. Does it deal strictly with hospital restructuring, and more specifically, hospital closures (single domain), or does it deal with the restructuring of the health care *system* (multiple domains)? Is the decision largely technical (e.g., facility assessments for upgrading costs) or non-technical (e.g., which site to close) and are resource constraints assumed?

Efforts to obtain public input on single domain decisions such as hospital restructuring are predictably overshadowed by efforts to mobilize communities in opposition to the closure of those hospitals under threat. Studies conducted on the precipitants of community mobilization identify the influence of such things as: (1) the abruptness of the proposed change; (2) the ease with which people can unite; (3) a clear target for mobilization; and (4) the ability to "veto" the proposal.[21]

In both Renfrew County and Ottawa-Carleton, presenting the public with specific hospital closure options gave the community a sudden, specific target for mobilizing interests in opposition to direct threats. Although mobilization also occurred in opposition to the hospital closure recommendations in Hamilton-Wentworth, the public was asked early on in the decision-making process to participate in a much broader exercise of health care system restructuring. Consequently, input was obtained on a broad set of concepts, only one of which was hospital restructuring.

Conclusions and caveats

In this article, we have outlined a way to facilitate public input to community decision-making. This involves systematically identifying:

- the objective and context of participation;
- which publics are to be selected for participation and how they will be selected;
- what information will be presented and how;
- how the public will be asked to participate and over what time period; and
- what input the public will be asked to provide.

Our analysis demonstrates that for each element identified in the process, there are numerous decision options and no single best way to proceed. Being clear about the objectives for involving the public at the outset, and paying careful attention to the compatibility of different elements in the process, are two important considerations.

If the objective is to give the public "voice" in the decision-making process, for example, then this objective should be incorporated into the consultation design. In Ottawa-Carleton and Renfrew County, the public was given mixed messages about its role. On the one hand, the public was presented with options for restructuring which implied that there was a *choice* among options (i.e., what do you think about option A, B or C?).

Providing the public with this choice when, in fact, it had no responsibility for the final decision, imparted a false sense of influence over the process and created divisiveness within the community. These DHCs may have done better to involve the public earlier on in the process, as was the case in Hamilton-Wentworth, where there was criticism for presenting "vague ideas" but a greater ability to incorporate public input into final recommendations.

While it is impossible to accurately predict the public's reaction to proposals for community change, there are a handful of certainties in any public participation process. For example:

- Expect the design of the participation exercise to be criticized at various stages, especially by those most threatened by the outcome. The information presented and the time given for obtaining public input are likely to be targets of criticism. Members of the public have become increasingly cynical about consultation exercises, in part due to a growing belief (real or perceived) that their input makes no difference.[22,23]
- Expect the media to focus on the most explosive aspects of the decision and fuel the public's dissatisfaction with the decision-making process.
- Do not expect to hear the views of the general public. Volunteer participants are far more likely to represent individuals with an interest in health care decision-making. Even public opinion surveys suffer from low response rates (in the range of 25% to 35%).[24]
- Expect extensive community mobilization around narrow, clearly defined issues with clear targets for mobilization (e.g., hospital restructuring).

There is no magic formula for involving the public in community decisions, especially those requiring difficult choices in the allocation of scarce health care resources. Public participation, however, is increasingly sold as a technical exercise with highly paid consultants hired to "manage public controversy" through the provision of controlled opportunities for public input into decision-making.[25,14] We believe the systematic approach described here will help decision makers design public input processes that meet their needs without necessarily falling prey to the growing legions of public consultation consultants.

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References and notes

1. The Association of District Health Councils of Ontario and The Ontario Ministry of Health. *Moving Forward: Strengthening Health Planning in Ontario. A Report by the Joint Task Force to the Minister of Health.* Toronto, ADHCO and OMOH, 1993.
2. Arnstein S. A Ladder of Citizen Participation. *Journal of the American Institute of Planners* 1969; 35: 216-24.
3. Hughes T, Larson L. Patient Involvement in Health Care: A Procedural Justice Viewpoint. *Medical Care* 1991; 29(3): 297-303.
4. Abelson J, Lomas J, Eyles J, Birch S and Veenstra G. Does the Community Want Devolved Authority? Results of Deliberative Polling in Ontario. *Canadian Medical Association Journal* 1995; 153(4): 403-12.
5. Lomas J, Veenstra G. If You Build it Who Will Come? *Policy Options* November 1995: 37-40.

6. Fishkin J. *Democracy and Deliberation*. New Haven, Yale University Press, 1991.
7. Renfrew County District Health Council. *Pembroke Hospital Services Review Committee — Final Report*. Pembroke, RCDHC, August 1995.
8. Hamilton-Wentworth District Health Council. *Our Health, Our Future: A Comprehensive Health Care Plan for Hamilton-Wentworth*. Report of the Health Action Task Force to the Hamilton-Wentworth DHC. Hamilton, HWDHC, 4 March 1996.
9. Levine M. Getting informed public input. *The Hamilton Spectator* 11 January 1996. Sect A: 7 (cols 1-3).
10. Herron S. Explain plan, task force told. *The Hamilton Spectator* 8 March 1996. Sect C: 7 (col 5).
11. Davy D. Proposal to close St. Joe's met with anger. *The Hamilton Spectator* 9 March 1996. Sect B: 4 (cols 4-5).
12. Plath R. Benchmark for beds attacked by public. *Pembroke Observer* 22 November 1994. 3 (cols 1-2).
13. Ottawa-Carleton District Health Council. *Directions for Change: Position Paper on Reconfiguration Scenarios*. Position paper prepared by the Options Development Task Group, Health Services Reconfiguration Project. Ottawa, OCRDHC, 11 December 1995.
14. MacDonald L, Mondel M. Managing Public Conflict: How to involve citizens in making the hard choices. *The Ottawa Citizen* 4 February 1996. Sect A: 9 (cols 1-5).
15. Pirocchi I. The viewpoint of patients has to be heard. *The Hamilton Spectator* 18 January 1996. Sect A: 7 (cols 1-4).
16. Editorial. Out of Touch. *The Hamilton Spectator* 1 April 1996. Sect A: 8 (col 1).
17. Editorial. Hospital emergency. *The Ottawa Citizen* 13 December 1995. Sect A: 10 (cols 1-2).
18. Hamilton-Wentworth District Health Council. *Health Action Task Force Working Paper on Open Consultation*. Hamilton, HWDHC, 23 February 1996.
19. Ottawa-Carleton Regional District Health Council. *Overview of Response to Options Development Task Group Scenarios*. Ottawa, OCRDHC, 18-19 December 1995.
20. Checkoway B. The Empire Strikes Back: More Lessons for Health Care Consumers. *Journal of Health Politics, Policy and Law* 1982; 7(1): 111-124.
21. Henig J. *Neighborhood Mobilization: Redevelopment and Response*. New Brunswick, New Jersey, Rutgers University Press, 1982.
22. Aronson, J. Giving Consumers a Say in Policy Development: Influencing Policy or Just Being Heard? *Canadian Public Policy* 1993; 19(4): 367-78.
23. EKOS Research Associates Inc. Constituent Assembly Survey of Residents of the Regional Municipality of Hamilton-Wentworth, Final Report. In Building Better Government: Interim Report from the Constituent Assembly. Hamilton: Constituent Assembly on the Municipal Government System in Hamilton-Wentworth, 23 November 1995.
24. Canadian Facts. Personal correspondence. August 1995.
25. Connor DM. *A Generic Design for Public Involvement Programs*. Paper presented to the Annual Conference of the National Association of Environmental Professionals. Raleigh, NC, 26 May 1993.

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References to Chapter 6

Abelson, J. and Veenstra, G. (1996). *Describing the Associational Life of a Community: A Survey of Community Organizations in Hamilton-Wentworth.* Hamilton, Ontario.

Abelson, J. and Lomas, J. (1996). In Search of Informed Input: A Systematic Approach to Involving the Public in Community Decision-Making. *Health Care Management Forum.* 9 (4), 48-52.

Association of District Health Councils of Ontario and the Ontario Ministry of Health. (1993). *Moving Forward: Strengthening Health Planning in Ontario. A Report by the Joint Task Force to the Minister of Health.* Toronto: ADHCO and OMOH.

Canadian Facts. (1995). Newspaper Audience Databank Study (NADbank).

Hamilton-Wentworth Regional Government. Hamilton-Wentworth receives 'Excellence in Citizen Involvement' Award. Press release. Hamilton: HWRG, 3 July, 1997.

Herman, E. and Chomsky, N. (1988). *Manufacturing Consent.* New York: Pantheon Books.

Krannich, R. and Humphrey, C. (1986). Using Key Informant Data in Comparative Community Research. *Sociological Methods and* Research, 14 (4), 473-93.

Putnam, R. (1993). *Making Democracy Work: Civic Traditions in Modern Italy.* Princeton: Princeton University Press.

Regional Municipality of Hamilton-Wentworth. (1997). Hamilton-Wentworth Receives Excellence in Citizen Involvement Award. Press Release.

Statistics Canada. *Profile of Census Divisions and Subdivisions - Part B.* Ottawa, 1994 (1991 Census of Canada).

Tuohy, C. and Evans, R.G. (1984). Pushing on a String: The Decentralization of Health Planning in Ontario. In: *The Costs of Federalism.* Golembiewski, R. and Widawsky, A. eds. New Brunswick, N.J.:Transaction Books, 89-116.

<u>Informants</u>

Hamilton-Wentworth

Caplan, M. Personal interview. 4 June, 1996. Hamilton, Ontario.
Hamilton City Councillor, District Health Council Member

Clark, K. and Poushinsky, P. Personal interview. 9 April, 1996. Hamilton, Ontario.
Long-term Care Planners, Hamilton-Wentworth District Health Council

Cook, T. Personal interview. 23 November, 1995. Hamilton, Ontario.
Regional Chairman, Hamilton-Wentworth

Eyles, J. Personal interview. 12 July, 1996. Hamilton, Ontario.
Consumer Representative, Hamilton-Wentworth District Health Council

Fenn, M. Personal interview. 22 November, 1995. Hamilton, Ontario.
Chief Administrative Officer, Regional Municipality of Hamilton-Wentworth

Goodman, S. Personal interview. 1 November, 1995. Hamilton, Ontario.
Executive Director, Hamilton-Wentworth DHC

Hunter, B. Personal interview. 1 January, 1996. Hamilton, Ontario.
Director of Environmental Services, Department of Public Health, Hamilton-Wentworth

Jaffray, D. Personal interview. 12 December, 1995. Hamilton, Ontario.
Executive Director, Hamilton-Wentworth Social Planning and Research Council

James, M. Personal interview. 13 December, 1995. Hamilton, Ontario.
Medical Officer of Health, Hamilton-Wentworth Department of Public Health

Jones, J. Telephone interview. 16 September, 1997. Hamilton, Ontario.
Chair, Health Council, Consumers' Association of Canada.

McMekum, T. Telephone interview. 23 November, 1995. Hamilton, Ontario.
Mayor of Flamborough and Chair, Health and Social Services Committee, Hamilton-Wentworth Region

Meyer, M. Personal interview. 5 June, 1996. Hamilton, Ontario.
Chair, Coalition of Community Health and Support Services

Scott, F. Personal interview. 20 December, 1995. Hamilton, Ontario.
Former Medical Officer of Health, Hamilton-Wentworth Department of Public Health

Walsh, N. Personal interview. 6 June, 1996. Hamilton, Ontario.
Retired Director of Social Services, Planning Department, Regional Municipality of Hamilton-Wentworth

Watt, S. Personal interview. 9 November, 1995. Hamilton, Ontario.
Chair, Hamilton-Wentworth District Health Council

Ottawa-Carleton

Albrecht, D. Personal interview. 16 May, 1996. Ottawa, Ontario.
Executive Director, Sandy Hill Community Health Centre

Angus, D. Telephone interview. 20 February, 1996. Ottawa, Ontario.
Former Director of Reconfiguration Project, Ottawa-Carleton District Health Council

Armour, D. Telephone interview. 26 June, 1996. Ottawa, Ontario.
President, United Way of Canada

Bourgault, L. Personal interview. 14 November, 1995. Ottawa, Ontario.
Executive Director, Ottawa-Carleton District Health Council

Bradshaw, C. Personal interview. 20 February, 1996. Ottawa, Ontario.
Former Member, Planning Department, Regional Municipality of Ottawa-Carleton

Chapman, M. Telephone interview. 2 August, 1996. Ottawa, Ontario.
Chair, Council on Aging, Ottawa-Carleton

Graham, K. Telephone interview. 15 February, 1996. Ottawa, Ontario.
Carleton University

Martell, C. Personal interview. 16 May, 1996. Ottawa, Ontario.
Long-term Care Planner, Ottawa-Carleton District Health Council

McCormack, H. Personal interview. 22 February, 1996. Ottawa, Ontario.
Senior Health Planner, Ottawa-Carleton District Health Council

Robinson, K. Personal interview. 20 February, 1996. Ottawa, Ontario.
Consultant to Health Services Reconfiguration Project, Ottawa-Carleton District Health Council

Soucie, P. Personal interview. 16 November, 1995. Ottawa, Ontario.
Chair, Ottawa-Carleton District Health Council

Stewart, P. Telephone interview. 15 January, 1996. Ottawa, Ontario.
Associate Medical Officer of Health, Ottawa-Carleton

Warren, A. Telephone interview. 29 July, 1996. Ottawa, Ontario.
Former Executive Director, Ottawa-Carleton District Health Council

Nipissing District

Burrows, M. Personal interview. 18 October, 1995. North Bay, Ontario.
Mayor, City of North Bay

Cowan, B. Personal interview. 17 October, 1995. North Bay, Ontario.
City Editor, The Nugget

Hill, D. Personal interview. 19 October, 1995. North Bay, Ontario.
Director of Social Services, City of North Bay

Howe, J. Telephone interview. 19 October, 1995. North Bay, Ontario.
The Neighbourhood Centre, Nipissing Child Care Council

Sparks, A. Telephone interview. 28 June, 1996. North Bay, Ontario.
Sociologist, Nipissing University

Staff of Nipissing-Temiskaming District Health Council. Personal interview. 16 October, 1995.

Whiting, C. Personal interview. 18 October, 1995. North Bay, Ontario.
Chair, District Health Council

Renfrew County

Bonert, K. Telephone interview. 16 November, 1995. Pembroke, Ontario.
Reporter, Pembroke Observer.

Bowering, L. Personal interview. 14 November, 1995. Pembroke, Ontario
Executive Director, Renfrew County District Health Council

Bowering, L. and McSheffrey, S. Personal interview. 21 February, 1996. Pembroke, Ontario. Executive Director and Chair, Renfrew County District Health Council

Carruthers, M.J. Telephone interview. 8 January, 1998. Pettawawa, Ontario.
Consumer Member, Renfrew Count District Health Council

Conway, S. Telephone interview. 12 June, 1996. Toronto, Ontario.
Member of Provincial Parliament, Renfrew North
O'Brien, T. Telephone interview. 22 August, 1996. Pembroke, Ontario.
Former Consumer Reprepsentative on Long-term Care Committee

O'Hearn, K. and Peacock, C. Personal interview. 17 May, 1996. Pembroke, Ontario.
Long-term Care Planners, Renfrew County District Health Council

Wong, G. Telephone interview. 16 November, 1995. Pembroke, Ontario.
Chair, Friends of the Pembroke Hospitals

CHAPTER 7

PRE-DISPOSING, ENABLING AND PRECIPITATING INFLUENCES ON PARTICIPATION: THE COMBINED EFFECT

In the previous chapter the emphasis was placed on explaining the independent role of each set of influences on participation. Each element of the model was applied separately to elucidate the participation profiles depicted in Chapter 5. While this approach begins to unravel the mysteries of how participation is shaped by a community, it goes only part of the way in telling the story. By independently applying each element of the model, a somewhat sterile picture emerges suggesting the presence or absence of each set of influences in isolation of the other. A more realistic application of the model considers the presence of each set of influences in the context of the other two and their potential for exerting a combined influence on participation. The focus of this chapter, then, will be to apply the model while considering the effect of a combination of influences on participation.

A. The Case of Health Care Restructuring Revisited

In the preceding chapter, health care restructuring, and the threat of hospital closures more specifically, was identified as a strong *precipitant* to community participation in three of four study communities (Hamilton-Wentworth, Ottawa-Carleton and Renfrew County). In this section the precipitant of proposed hospital closures is examined in the context of *pre-disposing* and *enabling* influences to understand more fully how participation was shaped in these three communities. Table 7-1 identifies the pre-disposing and enabling influences present in each community in conjunction with the precipitant of hospital closures. A third column describes the participation observed in each community. Before examining this table

any further, however, a brief discussion of hospital closures as precipitants will be undertaken.

1. Hospital Closures as Precipitants to Participation

As described in Chapter 5, (see sections on issue-driven participation within each participation profile) participation began as a fairly routine exercise in each community's health care restructuring process. DHCs took the lead in establishing committees to gather the information necessary to propose options for decision-making and demonstrated their usual commitment to involving the public in the process. Once preliminary restructuring recommendations were made public, however, and hospital closures emerged as a potential threat to the community, participation took the form of mobilization in response to a *precipitant*. The hospital closure threat has all the conditions required for mobilization as discussed by Henig (1982) in his multiple-case study of neighbourhood mobilization. Conditions cited in his study included: i) the abruptness of the change; ii) the ease with which people can unite; iii) a clear target for mobilization; and iv) the ability to 'veto' the proposal, all of which can be applied to the hospital closure scenarios in the study communities. First, with the exception of Renfrew County which undertook its review over a slightly longer period of time, initial proposals were announced within a few months of the restructuring process' establishment (i.e., abrupt change). Second, a unifying force was easily identifiable in each community (i.e., those who stood to lose the most under the proposal such as a hospital targeted for closure and the communities served by it). Third, the DHC or its restructuring committee was a clear target for mobilization in each community and fourth, there was the opportunity to veto proposals because the community was asked to respond to them.

a) *Links between the Issue, Interests and Participation*

> *So many people are fighting for their own empires and their own visions of health care. But few among them are willing to say: This game of marbles must end.* (Kirkey and Medline, 1996, p.B1-2)

As discussed in Chapters 2 and 3, a strong link between issues and interests lies at the root of our understanding of the influence that precipitants wield over participation. The case of health care restructuring provides important insights into the range of interests affected by the outcome of such a decision-making process and how these interests were channelled into participation. First, it is helpful to identify whose interests were affected by the proposals. These include:

i) the community whose interests are to ensure that they have access to high quality health care services when needed. These are the potential users of the health care system who may in fact be disinterested members of the public who become interested only when it affects them

ii) health care recipients and their families who are regular users of the health care system and have an interest in seeing that a particular service continues to be provided in its current form or location

iii) health care providers typically divided between unionized and non-unionized workers whose interests relate to keeping their jobs or to continuing to work in the facility they're currently working in (family members of health care providers also fall into this category)

iv) hospital leadership whose interests have historically been associated with preserving the status quo (i.e. keeping hospitals open) and protecting their institutional presence in the community while securing their own individual positions

v) District Health Council whose interests are to serve the community through their health planning mandate

Each of these sets of interests can be considered under the general heading of structural interests as they relate to the health care system. Alford's (1975) typology of structural interests as dominant, challenging and repressed is particularly relevant to the case study of health care restructuring as is the notion of concentrated and diffuse interests (Marmor and Morone, 1980).[1] The interests of hospital chief

[1] Both of these concepts were discussed at length in Chapter 2.

executives are closely matched to Alford's 'dominant' and largely status quo interests. In all three study communities, executives demonstrated an ability to mobilize easily and effectively to control the restructuring process. In contrast, there appeared to be no one representing the interests of the community-at-large.

> *The problem with health care is that communities of interest don't have a shared agenda ... No one is looking at the system, everyone is looking at a piece of the system. ... No one worked for the community. Where were the people who supported the [task force] proposal?*
>
> (Local politician and health council member, Hamilton-Wentworth)

This is because the community's interests were highly diffuse as compared to the concentrated interests of the hospital establishment. That is, when it comes to health care most people want to ensure that it will be there for them when they need it. They do not derive the same benefits, however, from participating in order to preserve the status quo nor do they have as much to lose from not participating as those working in the health care system. The fact that no sizeable community group formed around the health care restructuring issue is evidence to support the claim of heterogeneous and diffuse community interests and the phenomenon, in Canada, of nationally and provincially-organized, as compared to locally organized, consumer representation (Tuohy and Evans, 1984; Jones, 1997). One exception to this rule was the Friends of the Pembroke Hospitals that was touted as a group of "concerned citizens" interested in ensuring accessible, high quality care for residents of the City of Pembroke. The leader of this alleged citizens' group, however, was an employee of the hospital slated for closure and was supported in his campaign by more prominent residents of the community including a local politician who was a physician employed by the threatened hospital.

2. Adding fuel to the fire: Community characteristics working in combination with a precipitant

The participation profiles presented in Chapter 5 provided strong evidence to support the claim that precipitants such as hospital closures exert a powerful influence over certain dimensions of participation. In this section the analysis is taken one step further to ask what, if any, additional influence did the presence of community characteristics have in shaping these dimensions. The reader is referred to Table 7-1 to examine the pre-disposing influences present in each study community observed to act in combination with the precipitant.

Table 7-1

Pre-Disposing and Enabling Influences on Participation in Health Care Restructuring[2]

	Pre-Disposing	*Enabling*	Participation
Hamilton-Wentworth	- deference to health care elite - Catholic presence - education and income (for Dundas and Ancaster)	- DHC commitment to community involvement - extensive media coverage	- some community input but participation process was dominated by health care elite
Ottawa-Carleton	- sophisticated, highly politicized community - linguistic and religious divisions	- DHC commitment to community involvement - extensive media coverage - acrimonious battle between hosital leaders fuelled community outrage and orchestrated response	- community rallied around "favourite hospital" tied to historical split between Civic and General
Renfrew County	- religious divisions - community resistance to change	- public distrust of DHC and DHC leadership	- intense, emotional response to hospital closure recommendation led by employees of threatened hospital

a) *Cultural characteristics*

The presence of cultural characteristics in Ottawa-Carleton and Renfrew County exerted similar influences in intensifying the community's reaction to proposed hospital closures. As described in Chapter 5, the initial proposal to close the Ottawa Civic Hospital (the city's oldest, English Protestant hospital) in favour of leaving the Ottawa General (the city's oldest, French Catholic hospital) open fuelled an emotional, culturally based response from supporters of the Civic Hospital (see Issue-Driven Participation, Ottawa-Carleton profile). An historical analysis published in *The Ottawa Citizen* highlighted the powerful influence exerted by the linguistic and religious divisions that have dominated health care decision-making in this community for over a century:

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[2] Nipissing District is excluded from this table due to the absence of a restructuring process in this community.

> *The evolution of Ottawa's hospitals snags on the intense sectarian rivalry that splits the city* (Gray, 1995, p.E3)

Battle lines were drawn back in the 1800s between the French-speaking Catholics in Lowertown (supported and cared for by the Grey Nuns) and the English-speaking Protestants in Uppertown whose disdain for Catholic nurses, thought to be proselytizing patients, led to the establishment of an Anglo-Protestant Hospital. According to the article's author this rift between Catholic and Protestant, French and English "brings screaming to a halt any hope of rational planning for the national capital" and underlies the community's response to the proposals for hospital budget cuts. Excerpts from *The Ottawa Citizen* describe the motivations underlying the community's response:

> *Some saw a francophone plot since both the General and Montfort hospitals, which offer mostly French-language services, were left virtually untouched. Dozens of Civic supporters, upset with media coverage, threatened to cancel newspaper subscriptions.*
> (Kirkey and Medline, March 30, 1996, p.B2)

> *... the bureaucrats were vague about the reasons for their visit, but seemed upset that numerous Ottawa-Carleton residents were phoning Toronto [provincial government capital] with complaints about francophone hospitals receiving preferential treatment.*
> (Kirkey and Medline, March 30, 1996, p.B3)

The religious split between supporters of the Catholic and Protestant hospitals played a similar role in intensifying the community's involvement in Renfrew County's decision-making process. DHC staff identified religious bigotry as a major influence over participation and spoke of the "quiet scrutiny" of council members' religious affiliation to assess the likely outcome of a council vote. The following quotes capture the essence of the divisions within the community.

> *There have been two hospitals in Pembroke since 1902 and people have*

their preferences for one or the other.

(Chair, Friends of the Pembroke Hospitals)

The underlying problem with hospital restructuring is over governance and the fact that one hospital is Protestant while the other is Catholic. If the Civic is closed there will only be a Catholic hospital ... people could handle the General being closed but not the Civic.

(Reporter for *The Pembroke Observer*)

A slightly different view of the role played by religious divisions suggests that they were deliberately used to mount opposition to the closure of the Civic hospital.

Religious divisions were used to stir up trouble. You go to the hospital that your doctor sends you to. There was no opposition to either hospital until people made it an issue.

(DHC member and hospital restructuring committee member)

Religious characteristics played a different, albeit equally powerful, role in the Hamilton-Wentworth process. A strong and well-organized Catholic presence in the community played an influential role in mobilizing resistance to the proposed closure of the city's only Catholic hospital.[3] Although resistance to the closure of a hospital is a given in any community, attempts to close a Catholic hospital are met with even stronger opposition due to the presence of a strong, easily identifiable group that can be effectively mobilized. The following excerpt from *The Hamilton Spectator* provides evidence in support of this point:

Thousands of Roman Catholic worshippers heard yesterday that the mission and future of Hamilton's St. Joseph's Hospital are threatened ... In a pastoral letter read to congregations throughout the region, Bishop Anthony Tonnos expressed concern that the proposal 'will erode the ability of St. Joseph's Hospital to continue its healing mission in the tradition of the Catholic Church and the Sisters of St. Joseph.' He urged church members to voice their opinions to the task force through a card inserted in yesterday's church bulletins. (Morrison, March 11, 1996, A1)

[3] It should be noted that opposition to the closure of the Catholic hospital was not restricted to the Catholic community but came from many individuals and groups from a variety of sectors within Hamilton-Wentworth.

b) *Socio-economic characteristics*

As depicted in the census data presented earlier in this chapter, Hamilton-Wentworth and Ottawa-Carleton differ fundamentally with respect to socio-economic characteristics. Hamilton-Wentworth, a predominantly industrial, blue-collar town contrasts with Ottawa-Carleton, a white collar, government town with a highly educated population. These socio-economic differences translate into different levels of sophistication in understanding and participating in the health care restructuring process. [4] As described in Chapters 5 and 6, the Hamilton-Wentworth community exhibited considerable deference to its health care leaders and put great trust in the hands of the medical establishment to do what was best for the community. This deference was strongly reinforced by local politicians and the media who routinely stepped aside to let the "experts" have their say (see Hamilton-Wentworth participation profile, Issue-Driven participation). In Ottawa-Carleton, there appeared to be a greater degree of sophistication among the general public and certainly within the media in health care restructuring matters. *The Ottawa Citizen* was highly critical of the restructuring process (and the DHC's role in particular) and ran sensational headlines about hospital closures. It covered the issues in a more analytic fashion, however, than did *The Hamilton Spectator*, expressing many different viewpoints on a single issue including lengthy descriptions of the historical rivalry between the city's two largest hospitals and the bitter feud waged between its current leaders. Excerpts from editorials appearing in each newspaper revealed a more sophisticated level of analysis of the complex issues involved in health care restructuring and the provision of more detailed information to the public in Ottawa-Carleton than in Hamilton-Wentworth:

[Excerpts from *The Ottawa Citizen*]

> *Today, the administrators in charge of the Civic and General hospitals aren't talking. The community volunteers in charge of reorganizing the way our hospitals work have lost credibility with the public. And hospital bureaucrats, fighting for their jobs and their turf, are threatening to hijack the future of Ottawa-Carleton's health care system.*
> (Kirkey and Medline, March 30, 1996, p.B1, underline added for emphasis)

> *The region's district health council gave Ottawa-Carleton residents what they wanted - no hospitals will close. But by saving hospitals, the health council has jeopardized health care.*
> (Medline, May 31, 1996, p.A1, underline added for emphasis)

> *A little trimming around the edges won't do it. What's needed is an approach to thinking about the system that sets aside the turf of individual hospital administrators and makes it as easy as possible for patients to find the help they need in the most cost-efficient way. Closing hospitals can save money. Building the most responsive system possible can save lives. The two don't have to be incompatible.*
> (Editorial, September 17, 1996, p.A10, underline added for emphasis)

[Excerpts from *The Hamilton Spectator*]

> *The Hamilton-Wentworth District Health Council finally showed that it was listening to the community by voting to maintain four acute-care hospitals with full emergency services. It could hardly have done otherwise. ... The council had the sense to borrow heavily from the constructive, made-in-Hamilton restructuring proposals of the health care network, representing the area hospital chief administrators and the medical community. ... This community has endured too much turmoil to go through another battle with Queen's Park* [the provincial government]. *The government should go an extra mile to co-operate with the health network and the health council. It should ensure that savings achieved by Hamilton hospitals are reinvested in this community... The health care network achieved a remarkable feat in reaching a consensus on complex health care issues. It is time to heal the wounds and implement the network plan.*
> (Editorial, May 28, 1996, p.A8, underline added for emphasis)

> *Many people are angered and frustrated that the health council, in its convoluted meeting, didn't send as clear a message of support for Hamilton's hospitals as the vast majority of the public fully expected. It's questionable if the provincial government will understand the depth of feeling if it relies on the health council alone.* (Editorial, May 30, 1996, p. A6)

The influence wielded by socio-economic characteristics (in combination with the precipitant of health care restructuring) is less tangible than that exerted by the

linguistic and religious characteristics described in the previous section. Based on evidence gathered from interviews, newspaper clippings and field observations, however, residents of Ottawa-Carleton appeared to be better informed of the intricacies and highly politicized aspects of the restructuring process than were residents of Hamilton-Wentworth. As a result, they were less prone to manipulation by the media, hospital administrators or local politicians pursuing their self-interested objectives although, as described by a former hospital executive in Ottawa-Carleton, this resulted in "complete distrust of all hospital CEOs [who were] all tarred with the same brush".

In Renfrew County's restructuring process influential community characteristics included: i) the community's strong resistance to change; and ii) a stable, homogeneous population. Hospital closures are a difficult pill for any community to swallow but when the preservation of the status quo becomes deeply rooted in a community such as Renfrew County, the prospect of closing a 100-year old hospital is highly unpalatable. Combined with this general fear of change is a stable population in a small community where everyone has some connection to their local hospital. These characteristics, combined with the religious split discussed earlier, produced emotional responses from the community in the form of angry protests, petitions and the ugly accusations directed at decision-makers (see Chapter 5, Health Care Restructuring in Renfrew County). The intimate relationship between strong community values and a homogeneous population, as discussed in the "Predisposing Influences" section, acting in combination with the precipitant of hospital closure, exerts a strong influence on participation.

3. DHCs, Hospitals and the Media: Enabling, Manipulating and Orchestrating Participation

References have already been made in Chapter 6 to DHCs walking the line between enabling and manipulating participation in pursuit of desired outcomes and to counter the actions of concentrated health care interests. In the health care restructuring accounts presented in Chapter 5, numerous references were made to the tactics employed by hospital administrators and provider groups in orchestrating participation to oppose threats to their institutions. In this section the notion is explored in greater detail emphasizing the role played by each of the major actors.

a) *DHCs*

DHC commitment to and support for community participation in Hamilton-Wentworth and Ottawa-Carleton was identified in Chapter 6 (see section on "Enabling Influences"). The following excerpt from *The Ottawa Citizen* [quoting the chair of the DHC's hospital restructuring committee] describes the DHC's philosophy regarding its role as enabler in the health care restructuring process:

> *... McGee has shared every detail of the local hospital reorganization with the people of Ottawa-Carleton ... She says health ministry bureaucrats, ..., have told her to be less open with the public, to avoid upsetting people. She ignores them. People need all the information, McGee says. They need it presented in an honest manner. Yes, they get uncomfortable with the bits and pieces and yes it's hard to put together. But they can do it. They're not stupid. I just believe we are a rational society on the whole.*
> (Kirkey and Medline, March 30, 1996, p.B2)

This open, consultative approach, although well intentioned, had the effect of *enabling* and, more importantly, *precipitating* an overwhelming and highly emotional response from the community and significantly altering the decisions of the committee:

> *An astounding 30,000 letters, petitions and forms from hospital workers and local residents poured into the health council's offices. McGee says she wanted the public to know what was being considered before any proposals were researched further. But the emotional outpouring from the public was so great, it sent her committee scurrying for cover. In the end, most of the tough decisions were taken off the table.*
> (Kirkey and Medline, March 30, 1996, p.B1-2)

The Hamilton-Wentworth DHC took a much more cautious approach to its enabling role (see Chapter 6, "Enabling Influences"). In contrast to the Ottawa DHC's bold announcement of specific options for hospital closures, the Hamilton DHC's first contact with the public was for the purpose of seeking their ideas about a variety of restructuring issues, only one of which focussed on hospital closures. The DHC was clever in its approach to this issue by asking the community whether they would support the closing a hospital as part of a larger restructuring plan. The DHC was then able to use the generally positive response (66% supported the principle of hospital closure[5]) obtained to support their subsequent proposals for hospital closures. Although it could be argued that the same commitment to enabling community participation was demonstrated by the Hamilton DHC as in Ottawa, the elements of manipulation and orchestration built into Hamilton's enabling role is worth noting. An excerpt from *The Hamilton Spectator* highlights this point:

> *There is a measure of meaningless, bordering on political fraud, in the debate over the closure of a Hamilton acute-care hospital. After months of 'public' consultation, the Health Action Task Force recommended closing St. Joseph's Hospital ... The vast majority of the citizenry responded with hostility. The hospital community's elite and some politicians responded with a scheme to keep all four hospitals open. The HATF countered by moving away from a decision in the direction of dither -- one hospital had to close, but it didn't have to be St. Joe's. ... it could appear that Hamilton is by open process making a tough choice in the face of reality. I think this is not the case. I think the provincial ministry of health internally decided to shut a Hamilton hospital for budgetary reasons before the process even commenced. I think the provincial government wants local, rather than Queen's Park, finger prints on the murder weapon. The ordinary citizen is an audience member, not a player in this game. ... If the argument for a closure is indeed compelling, why is it not being put to the people by way of a binding municipal referendum? ... At the bottom, the ordinary Hamiltonian just can't be trusted to cut her own throat.* (Davison, May 17, 1996)

[5] Source: Hamilton-Wentworth District Health Council. Health Action Task Force Working Paper on Open Consultation. February 23, 1996.

In Renfrew County, the DHC was criticized for not being inclusive enough in its deliberations over hospital restructuring. Despite repeated attempts by the DHC to craft a "Made in Pembroke" solution, opponents of the proposal to close the Civic Hospital argued that the process for arriving at this decision was a closed one. The board of the Civic Hospital even used the claim that the DHC failed to provide adequate opportunity for community input as the basis for filing a lawsuit against the DHC. Much of the basis for these accusations lies in the community's paranoia and distrust of a recently-established DHC that did not give itself adequate time to establish a presence in the community before plunging into a heated battle over hospital closures. In this instance, the DHC's role is perhaps more appropriately cast as *precipitant* to rather than *enabler* of participation. This suggests that attempts to "disable", deter or control participation can result in greater or more intense participatory efforts.

The casting of DHC's as manipulators of the participation process is antithetical to their perceived and assigned role as "community voice" in health planning matters. As discussed in the previous chapter[6], however, the context within which the manipulation occurs explains their seemingly contradictory behaviour. Applying Alford's (1975) model of dominant, challenging and repressed interests, the DHC, in the case of health care restructuring, represented the challenging interests (i.e., those interests present when institutional structures are in transition such as periods of reform) and was, arguably, acting on behalf of the broader community's interests. Given the diffuse and heterogeneous nature of community interests as compared to the concentrated interests of the medical establishment, then, attempts to

[6] See "Summary of DHC as an enabler"

manipulate the community in pursuit of reform objectives might be considered in a more positive light.

b) *Hospitals*

The accounts of participation in health care restructuring presented in Chapter 5 depicted hospitals threatened with closure mounting elaborate campaigns of "orchestrated participation". Not only did hospitals provide opportunities for individuals to respond to DHC proposals, they engineered much of the response through the circulation of petitions, flyers, form letters, response cards and placards which only required the individual to produce a signature or drop a postage paid letter in the mail. The Ottawa-Carleton DHC filled an entire office with boxes of submissions received from each of the threatened hospitals most of them form letters reproduced thousands of times. One of the smaller hospitals threatened with extinction produced election-style placards and automobile bumper stickers. All of this contributed to a highly competitive, confrontational style of participation that had everything to do with illustrating the *quantity* of community support that a particular hospital had garnered which would omit it from the chopping block. The public was clearly mobilized in support of provider interests.

The orchestration tactic used by the Pembroke Civic Hospital in Renfrew County was to establish a "community" front for hospital supporters in the form of the Friends of the Pembroke Hospitals. Hailed as a group of concerned citizens, the group was described as "coming together to oppose the closing of either of the city's hospitals in favour of rationalizing and eliminating duplication of services while ensuring the continued provision of accessible, high quality care". Several physicians opposed to the closure of the Civic Hospital organized this group. A community representative on the DHC described the tactics of the Civic Hospital as "manipulated

emotion" and observed that senior members of the hospital board behaved in a "divisive and sarcastic" manner throughout the restructuring process.

Local hospital leaders amplified the linguistic and religious rifts that pre-disposed Ottawa-Carleton to mobilize in opposition to any hospital closures, in particular, the two tertiary care hospital CEOs. As discussed in Chapter 5 (see Health Care Restructuring in Ottawa-Carleton), the community's hospital restructuring process was tainted by an acrimonious relationship between hospital CEOs which contributed to a sense of fear and outrage in the community. This atmosphere was fuelled by a media that monitored, as a spectator would at a tennis match, the trading of insults between senior hospital officials:

The Ottawa General Hospital, which stands to gain if the Civic closes, says such a move would be drastic and a major disruption to patients and staff. But Civic supporters are leery of the support. 'This is not the public position of someone who is interested in co-operation and collaboration,' Civic president Ambrose Hearn said Thursday. 'This is the position of someone who is interested in growth and dominance.'

(Kirkey, Dec. 15, 1995, p.C1)

And Gary Cardiff, spokesman for a group of hospital board chairs and CEOs, criticized Labelle for suggesting hospitals and the health council 'betray our community' by giving responsibility for the hospital overhaul to ministry bureaucrats. Labelle speculated that it might be necessary for 'three or four' hospitals in the region to close, 'if they're going to be small ones'. ... When asked if he would accept the closure of the Ottawa General instead of the Civic, Labelle replied, 'It's not for me to decide which institutions should close. I can only tell you that we are the most modern teaching hospital in Ontario.' The Civic's Hearn criticized the General's go-it-along approach. 'In the best interests of this community, we need co-operation, not competition', he said.

(Ibbitson, January 12, 1996, p.A1)

In Hamilton-Wentworth, the health care elite exerted their influence over the decision-making process from behind closed doors. The Academic Health Care Network, made up of the leadership from the community's hospitals, health sciences faculty and community agencies proposed an alternative to the DHC that, not surprisingly, kept all hospitals open. The Network was praised for working collaboratively toward a solution for the entire region that met the public's interest of not closing any hospitals.[7] In keeping with the community's history of partnership and collaboration, the hospital elite's orchestration preyed more on the trust and deference exhibited toward the health care elite than on the tension and conflict exhibited in Ottawa-Carleton.

c) *The Media*

[7] See *Hamilton Spectator* editorial excerpt (Chapter 5 – Health Care Restructuring in Hamilton-Wentworth)

Health care restructuring was front and centre in the media in all three communities. Local newspapers were the principal purveyors of information about the decisions being taken, the decision-makers, and key decision points in the process. Community informants had different views on the extent to which the media exerted an enabling or precipitating influence over participation. While local newspapers routinely disseminated information about the date, time and location of public meetings, the angle taken on stories often focussed on the most sensational aspects of the decision-making process often failing to give a full picture of the complexity of the health care restructuring process. By focussing on the contentious issue of hospital closures, the media, it was argued, contributed its share to *precipitating* the highly emotional community responses. Examples are provided in the following newspaper headlines:

'Close St. Joe's'. That's what health taskforce recommends.

(Hamilton Spectator, March 4, 1996, p.A1)

Proposal to close St. Joe's met with anger.

(Hamilton Spectator, March 9, 1996, p.B4)

Hospital overhaul plan pits big against small.

(Ottawa Citizen, December 12, 1996, p.A1)

Sleek General pulls ahead in hospital race.

(Ottawa Citizen, December 13, 1996, p.A1)

B. *Other combined influences on Participation*

The case of health care restructuring provides an excellent tool for analyzing the combined influences on participation. Another case which presented itself in several of the smaller communities was that of ensuring access to services. The

communities of Sturgeon Falls (Nipissing), Glanbrook (Hamilton-Wentworth) and Deep River (Renfrew County) were all observed to mount significant participation efforts for the purposes of protecting existing services or procuring new ones. In the discussion of precipitating influences in Chapter 3, an example of a precipitant to participation was to obtain services.

The reason why this issue is of particular concern to small and rural communities is that these communities perceive themselves as not receiving their fair share of services as compared to the larger cities. But, as the examples below will illustrate, the desire to ensure access to services is not always enough to mobilize the participation necessary in these communities.

In Sturgeon Falls, for example, a combination of pre-disposing, enabling and precipitating influences appears to be associated with high levels of participation. A close-knit, francophone community, its desire to preserve its cultural identity pre-disposes it to participate actively to obtain services for its community. A strong municipal government enables a process of political participation to achieve the desired outcome. One Nipissing community informant considered the cultural composition of the Sturgeon Falls to operate more as a precipitant to participation than as a *pre-disposing* factor remarking that:

> *Sturgeon Falls has the French language issue to rally people around ... Their mobilization of resources has led to the procurement of technology ....*
> (District Health Council chair, Nipissing)

The community of Deep River can also be used to illustrate a combination of influences on participation. Like Sturgeon Falls, Deep River was also identified as a highly participatory community that is able to ensure access to services for its population. The pre-disposing and enabling influences operating in this community are: the company town phenomenon in the form of Atomic Energy of Canada Limited

(AECL) which has attracted a highly educated workforce and created a homogeneous, close-knit community. The employer has had a strong enabling influence over community participation to obtain and provide high quality health care services to its residents.

An interesting comparator within Renfrew County is the community of Barry's Bay which shares a similarly strong sense of community with Deep River. Its cultural homogeneity and concerns regarding access to services, however, have not translated into the same organized approach to participation that is found in Deep River. It may be that community cohesion is not enough of an influence over participation and that other influences such as education and a strong enabling influence (i.e., company presence) are also necessary.

Finally, the community of Glanbrook in Hamilton-Wentworth presents an interesting example of a tiny, rural community exhibiting high levels of participation in response to access issues such as long-term care services for its ageing population. From the participation profile depicted in Chapter 5, Glanbrook demonstrated high levels of community participation in the long-term care planning area (Table 5-2, p. 145) and was singled out by community informants as having a strong voice on long-term care issues. What lies behind Glanbrook's active participation in this area, combined with its concerns regarding access to services, is the powerful enabling influence of a local volunteer agency and its committed leadership. When the subject of long-term care is discussed in the context of Glanbrook, only one person's name is ever mentioned and, as leader of the community's seniors volunteer agency she is able to mobilize "the seniors community" easily and effectively.

The sections above have concentrated on using the interactions between model elements to explaing the participation observed in Chapter 5. Can this same approach

be used to explain that absence of participation observed in Nipissing and the City of North Bay in particular? The analysis of the independent influences in Chapter 6 identified the relative absence of precipitants in North Bay as compared to the other study areas. In addition, Nipissing was also noted for its lack of infrastructure for participation. There was little support for the establishement of the DHC, the community has never established a United Way office and there is strong resistance to the creation of any "government" infrastructure although there is a strong volunteer base in the community. With no enablers or precipitants to participation, all that is left to consider is the potential for pre-disposing elements. Here too there are few likely candidates. The population is fairly homogeneous (i.e. no social cleavages), education and income levels are below the provincial average. It does have a relatively stable population with close proximity between work and residence but these are only partial contributors to the production of social cohesion. On the whole, it appears that North Bay provides the perfect example of a community lacking in many of the elements thought to be associated with participation and, as a result, exhibiting negligible instrumental participation.

SUMMARY

The objective of this chapter was to illustrate the combined influence of model elements on the quality and quantity of participation. In this regard, the analysis offers the following conclusions. First, while precipitants alone may determine much of the participation that occurs, underlying the precipitants are certain pre-disposing and enabling forces that shape the observed participation. Cultural characteristics and community values played a powerful role in combination with precipitants to mobilize participation. Pre-disposing factors also combined with precipitants in communities with strong local identities where mobilization occurred either to protect existing services or to procure new ones. Examples included Sturgeon Falls in Nipissing and Glanbrook in Hamilton-Wentworth. The combination of small, close-knit communities and concerns regarding access to services produced a strong mobilizing influence over participation.

Socio-economic characteristics were not found to exert a strong a role in conjunction with issue-driven participation although the cases of Hamilton and Ottawa illustrated a more sophisticated and less deferential view of the hospital elite in Ottawa-Carleton than in Hamilton-Wentworth.

The analysis illustrated the ability for enablers to become precipitants to participation around contentious issues. Actions taken by DHCs in more than one community fuelled perceptions of closed decision-making processes. These perceptions, in turn, sparked intense, emotional reactions. Finally, the case of Nipisssing (and North Bay more specifically) demonstrates the model's capacity for explaining the absence, as well as the presence, of participation.

References to Chapter 7

Alford, R. (1975). *Health Care Politics: Ideological and Interest Group Barriers to Reform*. Chicago: University of Chicago Press.

Henig, J.R. (1982). *Neighborhood Mobilization.* New Brunswick, New Jersey: Rutgers University Press.

Newspaper articles

Davison, M. (1996). The hospital closure debate borders on fraud. *The Hamilton Spectator.* May 17: cols (1-3).

Editorial. (1996). Health under the knife. *The Ottawa Citizen.* September 17: A10(cols1-2).

Editorial. (1996). Sell the decision to the province. *The Hamilton Spectator.* May 28 (col 1).

Editorial. (1996). Put our needs on the right track. *The Hamilton Spectator.* May 30 (col 1).

Gray, C. (1995). Body and Soul. *TheOttawa Citizen.* December 14: E3 (cols 1-5).

Ibbitson, J. (1996). Settle our fate, hospitals tell Ontario. *The Ottawa Citizen,* January 12, 1996, p.A1.

Kirkey, S. (1995). Civic Hospital gains unlikely ally in bid to remain open under health care restructuring. *The Ottawa Citizen.* December 15, 1995, p.C1.

Kirkey, S. Public input unlikely to have much impact. *The Ottawa Citizen.* May 15, 1996, p.C1.

Kirkey, S. and Medline, E. 1996. Bad Medicine. *The Ottawa Citizen.* March 30: B1-3.

Medline, E. 1996. Hospitals are saved, but health care hurting. *The Ottawa Citizen.* May 31: A1(cols 4-5).

Morrison, S. Bishop urges worshippers to speak out on St. Joe's. *Hamilton Spectator.* March 11, 1996, p.A1.

Community Informants

Caplan, M. Personal interview. 4 June, 1996. Hamilton, Ontario.
Hamilton City Councillor, District Health Council Member

Bonert, K. Telephone interview. 16 November, 1995. Pembroke, Ontario.
Reporter, Pembroke Observer.

Carruthers, M.J. Telephone interview. 8 January, 1998. Pettawawa, Ontario.
Consumer Member, Renfrew Count District Health Council

Wong, G. Telephone interview. 16 November, 1995. Pembroke, Ontario.
Chair, Friends of the Pembroke Hospitals

CHAPTER 8

COMPARING PARTICIPATION IN HEALTH CARE AND EDUCATION: IS THERE ANYTHING UNIQUE ABOUT HEALTH CARE PARTICIPATION?

The case studies of health care participation have contributed to our understanding of the independent and combined influences of various factors on community-level participation. But what conclusions, if any, can be drawn from the findings in the health care domain and applied to other policy sectors? Is there something unique about the way in which local participation in health care decision-making is shaped as compared to local participation in other policy areas? As stated in the introductory chapter, the field of education was chosen as a comparator for health care. The inquiry's principal focus remains within the health care sector and, as such, a less comprehensive analysis has been conducted of participation in the education sector.

A brief discussion of the political and policy context within which the study of the education sector was conducted will serve as a preamble to the analysis. The local decision-making structures for education will also be described to highlight the differences between the two policy sectors.

The Policy and Political Context of Participation in Education

Education, like most publicly funded programs, has come under increasing scrutiny in recent years. A combination of cost-control imperatives, concerns about the quality of education and growing dissatisfaction with the performance of elected officials at all decision-making levels has put education at the top of provincial governments' reform agendas along with health care and social assistance. In Ontario, two major studies have been commissioned to seek solutions to perceived

problems with the education system. In January 1995, the Royal Commission on Learning released its report calling for comprehensive change to the province's educational system. The Commission made 167 recommendations and identified early childhood education, community education, information technology, and teachers as key areas for intervention (Royal Commission on Learning, 1995). A second study, the Ontario School Board Reduction Task Force was established in February 1995 to advise the government on the reduction of school boards and trustees in the province. A shrinking education budget combined with public demands for improved education quality led the government to seek ways to "reduce duplication of services and use scarce resources more efficiently" (Ontario School Board Reduction Task Force, 1995). The task force's interim report presented options for the reduction of the number of school boards in the province by 40 to 50% and for a reduction in the number of trustees elected to each school board.[1] As of January 1, 1998 the number of school boards in Ontario dropped from 166 to 109[2] (Ontario Regulation 460/97, 1997) and the number of trustees was reduced from 1992 to 813.

Of the two reports, the community education section of the Royal Commission report presented the most significant implications for participation in educational decision-making. With respect to community involvement in school-based decision-making it recommended:

> *That the Ministry of Education and Training mandate that each school in Ontario establish a school-community council, with membership drawn from the following: parents, students, (from Grade 7 on) teachers, representatives from local and ethnic communities, service providers, municipal government, service clubs and organizations, business sectors.*
> (Royal Commission on Learning, p.44)

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[1] School boards are the oldest form of publicly elected government in Ontario.

[2] The number of major school boards dropped from 129 to 72 (now called district school boards) while the number of isolates (now called school authorities) has remained the same at 37.

Following the report's release, the Ministry of Education announced its "School Board Policies on School Councils" in April, 1995 which outlined the requirements for each school in Ontario to establish a school council by June 1996. Since then, school boards and parents have been digesting this proposed new structure and have developed different approaches to their establishment. There are differing views held on the desirability of school councils. Parents are split in their support of the councils with some keen to accept an expanded role in school-based decision-making and others concerned about the shift in parent roles from volunteer to decision-maker and the increased responsibilities that would ensue:

> *This all seems to bury the volunteer spirit that used to light up the old Parent Advisory Committees or PTAs. There doesn't seem to much room left for the parent who wants to simply volunteer an hour a week to go on a school outing or make hot dogs as a lunch-time treat.* (Plante-Perkins, 1995, p.30)

For their part, teachers and school board administrators feel threatened by any parent involvement that would allow parent input into the hiring and evaluation of teachers. Some school board trustees are worried that school councils have the potential to usurp the power of the school board while others welcome the provision of increased autonomy to individual schools.

School councils were being hotly debated during the interview period of this study. Its emergence as a major theme in the study of participation in education is reflected in material summarized in Tables 8-3 through 8-6 (discussed later in the chapter). School board amalgamation generated varied responses across school boards and parents' groups in the four study communities. As we shall see later on this chapter, with one exception, the public was involved only minimally in this issue.

Renfrew County is the exception where a community-wide response to the proposal for the Catholic School Board to amalgamate with both Ottawa and Carleton Catholic school boards was organized by the Renfrew County Separate School Board.

The Institutional Structures for Decision-Making: Health Care vs. Education

The major difference between local decision-making in health care and education lies in the extent to which decision-making in each sector is decentralized (i.e., from the provincial government to the local level). In health care, local District Health Councils have the mandate to plan for the health service needs of their communities and advise the provincial government on the allocation of resources within their regions. They do not, however, have any decision-making authority over revenue raising, resource allocation or reallocation, which rests with central government. Governance structures for District Health Councils consist of an appointed council made up of local health care providers, consumers and elected officials with each group representing one third of the council. So, while there is an 'elected' component to the health council, members are not directly elected to the DHC. Following an application and nomination process managed by the DHC, Council members are appointed by the provincial government for a three-year term and may be re-appointed for a subsequent three-year term. School boards, in contrast, are directly accountable to their communities for all decision-making functions. In addition to receiving an annual budget from the provincial government, school boards in Ontario raise additional revenues through municipal taxes.[3] They make all planning and allocation decisions for their jurisdiction and oversee the operation of all

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[3] A fundamental change to this arrangement has been proposed by the Conservative government in Ontario. Under newly-tabled legislation (January 1997), local school boards would lose control over revenue-raising in favour of complete provincial funding of the educational system. This represents a

schools through a board administration. The school board is an elected, special purpose body comprised of trustees who run for election or re-election every three years as part of the municipal election process. Their relationship to central government is similar to that of DHCs in that both decision-making structures are responsible for implementing provincially determined government policy.

An important distinction to be made between local decision-making in each sector is the asymmetry between DHCs and school boards. Whereas there is only one DHC in each of the four study communities, there are two school boards in each of Nipissing District and Renfrew County, three school boards in Hamilton-Wentworth and six school boards in Ottawa-Carleton. Table 8-1 presents the school board jurisdictions for each study community.

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major shift in favour of greater centralization of government control over education financing in Ontario.

Table 8-1
School board jurisdictions

School board	*Jurisdiction*
Hamilton public	City of Hamilton only
Hamilton-Wentworth Roman Catholic	Hamilton-Wentworth (all municipalities)
Wentworth public	Dundas, Ancaster, Flamborough, Stoney Creek
Carleton public	Gloucester, Nepean, Kanata
Carleton Roman Catholic	Gloucester, Nepean, Kanata
Ottawa public	City of Ottawa
Ottawa Roman Catholic	Ottawa, Vanier
French public	Ottawa-Carleton
French Roman Catholic	Ottawa-Carleton
Nipissing public	Nipissing District
Nipissing Roman Catholic	Nipissing District
Renfrew public	Renfrew County
Renfrew Roman Catholic	Renfrew County

The implications of this asymmetrical relationship for conducting research in this area were that participation and its influences in the education sector were examined for two or more populations within each community (in contrast to looking at community participation as a whole in the health care sector). This was found to be of great benefit in producing comprehensive profiles of participation in each community although it presented certain challenges when comparing participation between the two policy sectors[4]. The multiple board phenomenon is an artefact of the development in Ontario, and several other Canadian provinces, of parallel systems of education. By guaranteeing certain religious education rights in the Canadian

[4] These challenges will discussed in the concluding chapter.

Constitution, Ontario has two publicly funded systems of education: a Catholic and a secular system. In Ontario, both systems are publicly funded. In addition to the public and Catholic boards, Ottawa-Carleton has the added complexity of having two French-language school boards (1 public and 1 Catholic) in addition to its four English-language boards (2 public and 2 Catholic).

PART I - PROFILES OF PARTICIPATION IN EDUCATION

There appear to be at least two distinct levels at which participation occurs in the education sector. The first is at the level of the individual school; the second at the school board level. A third level at which participation occurs less frequently is the provincial level. Parents with the interests of their children at stake dominate community participation in educational decision-making at all three levels. As consumers of education on behalf of their children "parents" are a relatively homogeneous group. They contrast with consumers of health care who are a much more diverse group pursuing different objectives within the realm of health care decision-making. Although parents may also pursue different educational objectives depending on their children's needs (e.g., special education) discussions about public participation in education tend to focus on the involvement of parents as a uniform entity. Despite the emphasis on parents, taxpayers were also mentioned as important participants and identified by some as having an increasingly important voice in the decision-making process as funds for public education are reduced and the public expresses its growing intolerance for tax increases. Teachers, of course, are the other major participant group.

General Description of Participation at the School and Board Level

Interviews with community informants in the education sector described parent involvement at the individual school level by breaking it down into the following categories:

1. The largest group of parents is that with minimal or no involvement in any school activities but who attend meetings and interviews with teachers.

2. The second largest group of parents is that with no involvement at all in the school.

3. There is a large group of volunteers (smaller than either of the two groups described above) who help out at the school in a variety of ways including fund-raising activities, accompanying class field trips and providing administrative support in the school.

4. The parent organization (i.e., home and school association or school council) is typically the most active group in the school but also represents the smallest group of parents.

Table 8-2 presents data on the concentration of parent groups in school boards within each community. Participation at the school board level came primarily in the form of parent representation on board committees, attendance at school board meetings and the organization of parent groups on ad-hoc issues.

Table 8-2
Concentration of Parent Groups

	Hamilton-Wentworth	*Ottawa-Carleton*	*Nipissing District*	*Renfrew County*
Number and percentage of schools with parent groups[5]	Hamilton public 31 of 95(33%) Wentworth public 13 of 41 (32%) H-W Catholic all schools have parent group but only 54% attend umbrella organization meetings regularly	Ottawa public - all schools have some form of parent group - 60-70% of schools have a representative attend umbrella organization meetings regularly Carleton public 98% Ottawa Catholic 100% Carleton Catholic 100%	Nipissing public 98% of schools have some form of parent or community association	Renfrew County public 8 of 31 (26%) Renfrew County Catholic - all schools have a parent group

Sources: Ontario Home and School Association; interviews with parent association leadership
Notes: The Catholic school boards included in this analysis have a board requirement for each school to have a Catholic parent school community association. Although statistical information regarding the level of activity generated from these groups was not available, interviews conducted with parent representatives indicated varying levels of activity among them.

Community Profiles

A. Hamilton-Wentworth

Depictions of the *quantity* of participation in the education sector follow the traditional resource-based model of participation in each community (i.e., persons in higher socio-economic groups participate more actively than those in lower socio-economic groups). Informants also described the combined influence of geography and socio-economic characteristics on the different *methods* and *tone* of participation. For example, the more affluent and educated communities of Ancaster, Dundas and

[5] This data was collected prior to the compulsory establishment of school councils across the province of Ontario in June 1996. Every school is now required to have a school council in place.

west Hamilton were described as exhibiting a more articulate, professional tone of participation as compared to older parts of the city where participation tends to be "rowdy". Informants described these variations in different ways:

> *Letter-writing campaigns and presentations to the Board are more characteristic of Ancaster, Dundas and Westdale. ... In older parts of the city the tendency is to call local people and attend meetings*
>
> (School board chair, Hamilton-Wentworth)
>
> *The west end of the city has the strongest parent groups with the most active members.*
>
> (Parent representative, Hamilton-Wentworth)
>
> *The people of Ancaster take a rational approach to participation.*
>
> (School board official, Hamilton-Wentworth)

With respect to the *form* of participation exhibited in Hamilton-Wentworth, informants described varying degrees of routine involvement through parent organizations (i.e. home and school associations), parent representation on school board committees and more widespread participation around specific issues. In contrast to participation in the health care arena, there appears to be a greater infrastructure for participation in the education sector. Each school board had a network of parent groups established at each school. Additional structures have been established to represent each school at a higher level (e.g. Council of Home and School Associations) for the purposes of sharing information, organizing and communicating more effectively with the school board.

A senior administration official for the Roman Catholic board observed that the board has to do more to keep parents happy due to parents' threat of exit to the public school system. The Catholic board feels pressured to provide a wide array of

programs and services; if they don't provide the programs that parents can get in the public school system they will opt out. An example of this arose when the board planned to transfer a principal to another school. Parents objected to the transfer and presented a petition with 300 names opposing the move.

> *One parent ... told The Spectator she plans to redirect her taxes to the public school board if the decision is not retracted.*
>
> (Cox, April 13, 1995, p. C2)

A different view of participation was depicted in Wentworth County. As an amalgamated board covering several municipalities, each with strong local identities, attempts to influence decision-making at the board level are diffused by the geographic-specific concerns that rarely cross over into other municipalities. This phenomenon was described in the following manner:

> *Wentworth County is made up of 5 distinct communities so there is little infrastructure for participation.*
>
> (School board chairman, Wentworth County)

For the community to mobilize there must be an issue that cuts across all boundaries within Wentworth County. Despite this characteristic of the board, emphasis was given to the statements that the "board is not parochial" and that "trustees are not politicians" but interested in children and schools.

B. Ottawa-Carleton

Ottawa-Carleton parents were described by educators, school board trustees and parents themselves as extremely active and becoming more active over time in all aspects of education, due in part, to increased public scrutiny of the education system. A number of informants suggested that the days of parents leaving all educational

matters to the teachers and school principals are long gone. One informant observed that "*you used to have to pull teeth to get parents out - now parents are interested in system-wide issues*". Despite perceptions of an overall increase in parent involvement, the notion of a core group of active parents who participate all the time was a predominant theme. In addition, a high degree of variability in patterns of participation was observed found to be strongly associated with socio-economic status. Communities with high concentrations of immigrant and transient populations were singled out as demonstrating the lowest levels of participation. Despite Ottawa-Carleton's high overall socio-economic levels, therefore, the concentration of immigrant and transient populations in the highly urbanized city of Ottawa produced pockets of minimal or non-existent participation. Rural and urban areas were also reported to participate differentially.

With respect to the presence of home and school associations and other parent organizations, all boards in the Ottawa-Carleton region were reported to have highly organized parent groups. The relationships between parent groups and the board differed between boards[6] (i.e., whether the parent group is a committee of the board or an independent organization) but the propensity for organizing and a high degree of committee representation mirrors the routine level of participation observed in the health care sector.

The Ottawa Board of Education was described as unique in the province regarding its approach to community involvement. The board seeks both parent and community involvement on a range of advisory and administration committees to ensure a broad range of views and expertise on all matters.

C. Nipissing District

There was little that was unique in the accounts of participation provided by community informants in Nipissing. Higher levels of observed parent involvement were believed to be associated with higher education levels among parents in general and a higher level of participation among younger families. Participation was identified as being primarily driven by issues and crises such as school closures, boundary changes or class sizes. One school board executive suggested that this form of participation was undesirable stating that "if political participation occurs we haven't done our jobs."

The Special Education Advisory Committee (SEAC) of the Nipissing District Roman Catholic Separate School Board was described as a highly active group in the education arena. This group was singled out by a school board official as having a "strong, stable leadership over time that has provided the infrastructure for sustained active and influential involvement". An elected official with the same school board reiterated this comment stating that "special education parents are the most active and have been the most influential over the past few years". Letters, meeting attendance and presentations to the Board were cited as examples of the form of participation engaged in by this group.

D. Renfrew County

"More grass-roots involvement in Catholic boards than in public boards" was a characteristic used to describe participation in Renfrew County. According to this informant Catholic boards are able to define their school communities more easily with parents, the clergy and teachers. Non-parents were also identified as maintaining

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[6] These relationships will be discussed in more detail later in this chapter (see "Enabling influences at

a high degree of interest in education matters since the Catholic school board is the fourth largest employer in the area.

The community's participation in response to the proposed amalgamation of the Renfrew County Roman Catholic School Board with the Catholic school boards was a dominant theme among community informants in Ottawa-Carleton. Staunchly opposed to the proposed amalgamation, the school board organized an elaborate campaign to present its views to the Ontario School Board Reduction Task Force.[7] The response to the recommendation came in the form of thousands of letters, petitions, calls, editorials and submissions from local politicians, municipal governments, public agencies, members of the community-at-large, individual school communities, parent groups and the media.[8] Evidence of the magnitude of the community's response was found in comments made by the Chair of the Task Force at a public meeting. Speaking to a Renfrew County parent who attended the meeting, the Chair stated:

> *I have received more letters and phone calls from Renfrew County than from any other part of the province.*
>
> (Editorial, October 24, 1995)

Several informants observed highly varied participation patterns and within the Renfrew County School Board (public board) only 8 out of 31 (26%) schools were reported to have formally organized parent groups (see Table 8-2).

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the school board level")

[7] The task force's interim report presented options for the reduction of school boards in the province by 40 to 50%. Included in its interim report was the recommendation that the Renfrew County Roman Catholic Separate School Board amalgamate with the Ottawa and Carleton Roman Catholic Separate School Boards.

[8] A detailed summary of the community's response to the interim recommendation is contained in the school board's official response to the Interim Report, a document of several hundred pages published in October 1995.

PART II - FACTORS INFLUENCING PARTICIPATION IN EDUCATION

PRE-DISPOSING INFLUENCES

Many of the pre-disposing influences mentioned by health care informants were also identified by education informants although the degree of influence exerted over participation varied in some instances.

Education and Socio-economic Status

The most striking difference observed between reported influences in health care and education was the emphasis given to socio-economic characteristics as a pre-disposing factor to participate in the education sector as compared to that in the health care sector. Numerous informants in each study community identified the significant role that socio-economic characteristics play in influencing participation. The following quotes support this point:

> *If you looked at parent involvement in education you would find it was correlated with socio-economic characteristics.*
>
> (Board chair, Hamilton-Wentworth)

> *The wealthy and politically astute get their way.*
>
> (Education director, Ottawa-Carleton)

Education was also considered to wield an important influence over participation in education as was reported in the health care sector.

> *Economics has some effect but parents who are well-educated and keen on education are more likely to get involved.*
>
> (Parent representative, Renfrew County)

A number of informants also observed that an overall increase in the education level of parents has contributed to greater parental involvement in education.

Parents are more educated and therefore more likely to want to take a more active role in their children's education.

(Director of education, Nipissing)

Parents are more informed than they were 10 years ago and not easily fooled.

(Board chair, Ottawa-Carleton)

In *Hamilton-Wentworth*, socio-economic characteristics were reported to exert a strong influence over the type of parental involvement observed. As discussed earlier (see Hamilton-Wentworth profile), the more affluent and educated communities in the West end of the region were found to take a very articulate, professional approach to participation compared to the northern and central communities where a more informal approach is taken. The more affluent and educated part of the region was also reported to have the strongest parent groups with the most active members (Home and school association president, Hamilton board of education, School board administrator, Wentworth County board of education).

Some exceptions to this rule were inner-city schools in Hamilton-Wentworth, Ottawa-Carleton, and Nipissing district that were described as having a high degree of parent involvement in their schools despite the lower socio-economic characteristics of their school population. These deviations, such as the strong group of dedicated parents at a large inner-city school in North Bay, for example, were accounted for in the role played by exceptionally strong principals.[9]

Population Stability

Lack of population stability was mentioned by informants in *Hamilton-Wentworth* and *Ottawa-Carleton* as exerting a negative influence on participation in

[9] For a separate discussion of this subject see "School-level Enablers" later on in this chapter.

the education sector. Urban communities with highly transient populations were reported to have difficulty maintaining any regular parent involvement in the schools.

> *Inner city schools have the hardest time due to the high turnover of kids.*
>
> (Parent representative, Ottawa Board of Education)

As with participation in health care, however, communities with stabler and more homogeneous populations were reported to be more active in education issues.

Cultural Characteristics

Cultural characteristics were reported to play an important and very different role in influencing participation in education as compared to health care. Informants from predominantly urban school boards in *Ottawa-Carleton* and *Hamilton-Wentworth* identified cultural differences to be at least as influential over participation as socio-economic differences. In particular, school communities with high concentrations of certain ethnic populations were found to exhibit unusually high or low participation levels. High concentrations of recent immigrants were also identified as low to non-existent participation levels.

> *There is little involvement from Hispanic, Portuguese and Philipino parents but Ukrainian parents are very involved in school activities. ... The Portuguese culture has not exhibited any link between family and school. Philipinos are similar but they tend to be more educated so there is a greater baseline involvement in schools. Croatians, Serbs and Polish all have strong links to schools and lots of involvement in school activities.*
>
> (Education superintendant, H-W Roman Catholic Separate School Board)

Some cultures do not support parents getting involved in schools and meeting with teachers therefore we must involve them in activities which make them feel part of this community.

(Education director, French Language School Board of Ottawa-Carleton)

Religious Characteristics

The presence of a parallel Catholic education system in Ontario provides Catholic educators and parents with the opportunity to maintain a close relationship between the Catholic school system and the broader Catholic community. Informants spoke of the ability for Catholic boards to "rally the community" because the Catholic community is so easily defined as compared to the public school board community (Board chair, Ottawa Roman Catholic Separate School Board).[10] The tendency for more "grass-roots involvement" in Catholic boards with school communities composed of parents, clergy and teachers was also described (Education director, Renfrew County Separate School Board).

Geography

Geography was thought to influence participation in the communities of *Hamilton-Wentworth, Ottawa-Carleton* and *Renfrew County*. In Hamilton-Wentworth, the Wentworth County school board covers an area that includes 5 municipalities each with differing characteristics and issues of concern. There is great variation throughout the board in levels of parent involvement and few opportunities for any organized approach to participation due to the "distinct society" phenomenon (Board chair, Wentworth County Board of Education).

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[10] Catholicity, and religion more generally, appears to act as both a pre-disposing as well as a precipitating factor as was discussed in the preceding chapter in the health care context.

In *Ottawa-Carleton,* informants from the Carleton board of education (which covers suburban and rural communities) described the different approaches taken to participation by rural versus urban or suburban communities. Urban communities were generally considered to be more active than rural communities and rural communities were thought to respond to different types of issues (e.g., transportation) and in different ways than their urban counterparts (Board chair, Carleton Board of Education).

In Renfrew County, the problem of long distances between communities was thought to greatly inhibit participation in education as was reported for participation in health care (Parent representative, Renfrew County).

Sense of Community and Community Values

Neither of these influences figured prominently in informants' comments although *Renfrew County* informants made some reference to these factors.

> *Involvement depends on the values of the community. In some communities you can't keep parents out of the schools, for example, where schools and the community are closely linked.*
>
> (Board chair, Renfrew County school board)
>
> *Wilno is very active due to the culture of the community.*
>
> (Education director, Renfrew County Separate school board)

ENABLING INFLUENCES

Enabling influences were more of a dominant theme in the education sector than the health care sector. Educators, elected officials and parent volunteers all emphasized the role that enabling influences play in shaping both the quality and

quantity of participation. In general, enabling influences were seen to play a role at both the individual school and school board levels.

1. The Role of School-Level Enablers

The school principal was identified in all communities as the single most important enabler or detractor of school-level participation.

> *Resistance from schools can deter involvement ... The openness of the principal is also important. Some appear to be open but are not or are very controlling.*
>
> (Parent representative, Hamilton-Wentworth)

> *If the principal believes in something it will happen. Resistance from the principal can hijack the process.*
>
> (Parent representative, Hamilton-Wentworth)

> *There is resistance to [parent] council involvement in schools. The principal feels he/she is forced to form a group but will not support it.*
>
> (Parent representative, Ottawa-Carleton)

> *The principal has a lot to do with parent involvement*
>
> (Education director, Ottawa-Carleton)

> *The atmosphere and attitude of staff and principal is an important enabler of participation.*
>
> (Board chair, Renfrew County)

In Nipissing District, this influence was directly tested when an "exceptionally strong" principal who was committed to involving parents in all aspects of school activities transferred to another board and was replaced by a principal who did not possess the same commitment to parent involvement.[11]

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[11] The argument could be made that parent involvement did not actually change much as a result of the change in principals. A group of parents went to the board to complain about the new principal which effected another change of principals. As an epilogue to this story, the parents are very happy with their new principal who is very supportive of parent involvement.

We noticed a big change when this new principal came on. We were not receiving information the way we used to and parents were not involved the way they used to be.

(Parent representative, Nipissing District)

Parent and community leadership was also mentioned as an enabler of participation generally but also as an important influence in shaping the style of involvement. Informants spoke of the importance of identifying community leaders in the early stages of a parent group's formation.

2. School Boards as Enablers

At the outset of the study, each school board was asked to provide information about the mechanisms provided for involving the public in school board decisions (see Appendix 8-1). In addition, community informants were asked to describe the various mechanisms provided by their respective school boards to enable participation. Mechanisms for involving the public in school board matters include (with varying degrees of commitment): i) receiving submissions or delegations to the board; ii) public consultations or surveys to elicit views on specific issues; iii) parent/community representation on board committees. The costs of participating via submission or delegation to the board are high. An excerpt of board by-laws regarding delegations and submissions illustrates this point:

A person or delegation shall be required to submit, to the Secretary, a written application to appear before the Board, Section or a Committee, stating the matter on which a submission is to be made, the organization or interested parties to be represented, and the authority of the spokesperson; and shall also be required to submit a written brief to the Secretary before 12:00 noon on the fourth day before the meeting (excluding Saturdays, Sundays and holidays) for inclusion on the agenda.

(By-laws and Regulations, 21.01, Hamilton-Wentworth Roman Catholic Separate School Board, November 1994)

School board officials gave varying levels of attention to the public and to parents in particular with respect to the provision of information. Many school board officials stated the board's commitment to communicating with parents and the public and to providing them with as much information as possible while parents were both complimentary and disparaging in their comments about their board's commitment to fostering community participation. Tables 8-3 through 8-6 summarize the information gathered on the subject of the school board as an enabler of participation. The material presented in the tables was obtained from board reports and from interviews with board officials (including administrative and elected officials) and parent representatives. For each school board, the predominant parent organization and its relationship to the board is described followed by views regarding the parents rapport with the board and vice versa. Finally, parent and board views on the subject of school councils, which were being implemented during the study period, are presented.

The principal theme emerging from the material presented in these tables is the tension underlying the relationships between parent groups and school boards. School boards that appear to be encouraging participation by establishing parent advisory committees of the board are seen by some as "capturing" the interests of parents by controlling and co-opting their involvement. Several community informants acknowledged the dangers of this approach. One suggested that the existence of the committee might reduce parent involvement stating that "it's great to have BPAC but it may be too easy". Another suggested that "you can feel too comfortable". The most legitimate forum for parent participation seemed to come from groups that organized independently of the school board and, as such, were not at risk of being

manipulated or controlled by the board. Only one board in the four case study communities had this form of independent parent organization. The Parent Communication Committee of the Carleton Roman Catholic Separate School Board in Ottawa-Carleton was established 15 years ago and was described as "one of the best in terms of parent involvement". Because of its independence from the Board it has credibility at the Board level. There was some indication that other groups were moving in this direction. In Hamilton-Wentworth, for example, parents in the Roman Catholic school board have recently formed the Joint Elementary Parents Advisory Group (JEPAG) which is independent of the board and was formed as a grass-roots movement in response to the issue of school closures throughout the board. A notable exception to the observations made above is the Ottawa Board of Education where there is a strong culture of parent and community involvement in all board activities and corporate support demonstrated through separate budget allocations.

Table 8-3
School Board-Parent Organizational Structures
Hamilton-Wentworth

School Board	*Parent Organization*	*Relationship to Board*	*Parent Rapport with Board*	*Board Rapport with Parents*	*Parent views re: School Councils*	*Board views re: School Councils*
City of Hamilton Board of Education	Home and School Associations	- independent of Board	- perception of good rapport between parent and Board level - lots of parental involvement on board committees	- "token, not serious commitment to parent involvement" - "Council of Home and School Associations is not taken seriously"	- doesn't allow for broad base of parent involvement - would like school council to report to home and school	- Board document produced outlining implementation strategy - some trustees are opposed to councils
Wentworth County Board of Education	Council of Home and School Associations	- autonomous	- "evolutionary, positive and lots of potential" - good relationship but could be better - no formal parent representation on committees (only at request of Board)	- board has open process - people can come to meetings as individuals or as part of a delegation - board tries to inform community as much as possible	- home and school wants to retain its independence - home and school association and school council will operate at different levels - councils may be difficult to implement in some schools	- waiting for provincial guidelines - board would like to maintain same interaction with school councils as with home and school associations - "parents don't want to run schools"
Hamilton-Wentworth R.C. Separate School Board	- board established Catholic parent school community association (in each school) - parents have formed Joint Elementary Parents Advisory Group (JEPAG)	- independent of Board		- "if Board recognized parents groups things would work better"	- parents are not interested in hiring and firing - supportive of school councils but concerned about the skills needed to be on council	- "parents don't want to get involved in decision-making at school level" (Board chair) - trustees are already in place to make decisions; school councils would usurp trustee role

Table 8-4
School Board-Parent Organizational Structures
Ottawa-Carleton

School Board	*Parent Organization*	*Relationship to Board*	*Parent Rapport with Board*	*Board Rapport with Parents*	*Parent views re: School Councils*	*Board views re: School Councils*
Ottawa Board of Education	Joint Council of Elementary and Secondary Advisory Committee	Avisory committee of the Board (receives budget for meetings, etc.) - senior admin. person attends each meeting - merger of several committees 3 years ago	- high level of parent involvement but "you can feel too comfortable" - good to keep some distance - feels listened to	- long tradition of involving parents on advisory committees	- there is already so much involvement that provincial policy won't add much - problems will still be greatest for schools with minimal parent involvement - concern re: 2-tier system being created and ability to sustain support for two structures in each school	- no board position yet - concerns re: establishment in every school (i.e. where no parent involvement exists)
Carleton Board of Education	Carleton Council of Parents' Associations	- independent of Board (but requires principal support to establish in each school)	- Board pays lip service to parental involvement and refers to parents as "special interests" - resistance to council involvement in schools - structures in place for involvement but little support for	- feels it needs a more balanced view from parents and non-parents - frustrated with public meetings dominated by parents		- concerned about lack of defined accountabilities and if and how councils will represent communities - asking schools to begin with a community profile

			them			
Ottawa Roman Catholic Separate School Board	- Board Parent Advisory Committee	- established and structured by Board and subject to Board by-laws - established 10 years ago	- great to have BPAC but "it may be too easy" (i.e. I know it's there so I don't have to do anything)	- collaborative relationship between board and parents	- some resistance among parents and PAC members - volunteers don't want to be mandated"	- concern re: variation in parent involvement across schools
Carleton Roman Catholic Separate School Board	Parent Communications Committee	- independent of Board - formed over 15 years ago	- excellent relationship between parents and Board - best in Ottawa-Carleton - PCC has credibility at Board level	- "one of the best in terms of parent involvement" - board, administration and parent commitment to working together is essential to success	- most involved parents don't want to be involved in school councils - concerns re: "mandating volunteerism" and accountability, liability	- board committee developing framework for councils - wants PCC to remain active or be used as model for councils

Table 8-5
School Board-Parent Organizational Structures
Nipissing District

School Board	*Parent Organization*	*Relationship to Board*	*Parent Rapport with Board*	*Board Rapport with Parents*	*Parent views re: School Councils*	*Board views re: School Councils*
Nipissing Board of Education	Community Associations; Parent Advisory Committees (different names given to parent organizations throughout the board) - no umbrella group for parent organizations	- very loose relationship between parent groups and board	- "if there is political participation then we haven't done our jobs"	- very little parent involvement unless an issue affects them	- some concerns among parents about having to change their role from volunteers in schools to "political animals"	
Nipissing District Roman Catholic Separate School Board	No information obtained	No information obtained	No information obtained	No information obtained	- mixed reactions to school councils among parents - parents in one community wrote letter to oppose school councils - other parents are supportive of school councils	- a big part of the Catholic school board mission is to involve the community so school councils make sense - concerned that school councils will make more work for principals

Table 8-6
School Board-Parent Organizational Structures
Renfrew County

School Board	*Parent Organization*	*Relationship to Board*	*Parent Rapport with Board*	*Board Rapport with Parents*	*Parent views re: School Councils*	*Board views re: School Councils*
Renfrew County School Board	Parent Advisory Committee	- established three years ago by the board - meets every 2 months - used as vehicle to get information into the schools - no formal application process	- "Parent Advisory Committee is not useful at all" - no systematic process for appointing committee membership - "there is a need for a network of parent organizations"		- poor communication between board and parents on this - "school councils may attract a different type of person ... more administrative-minded and more interested in paperwork"	- concerns about the process - few guidelines in place and concerns re: single issue parents but many parents are glad to be taking on more than fundraising
Renfrew County Separate School Board	- no formal umbrella group for parent organizations	- no formal relationship	- board has involved parents in various committees including 3 parent members on the principals redeployment, selection and recruitment committee		- mixed reactions to school councils among parents - parents in one community wrote letter to oppose school councils - other parents are supportive of school councils	- a big part of the Catholic school board mission is to involve the community so school councils make sense - concerned that school councils will make more work for principals

PRECIPITATING INFLUENCES

Education informants made strikingly similar observations to those from the health care sector about the precipitants to participation. Numerous informants emphasized the importance of the issue and the requirement for a direct affect on the participant. The notion of something being taken away or the imposition of a direct threat were also identified as important precipitants or mobilizers of participation.

> *Any time a program is threatened there will be lots of involvement because parents are fearful it will affect children's livelihood.*
>
> (School board chair, Hamilton-Wentworth)
>
> *The reaction of parents has to do with the nature of the issue and the general feeling of being assaulted.*
>
> (School board chair, Hamilton-Wentworth)
>
> *Parents are apathetic about school issues unless it affects their child.*
>
> (School board chair, Nipissing)
>
> *There is lots more being done to take things away from people therefore more involvement to protect against this.*
>
> (School board chair, Ottawa-Careleton)

The type of involvement that occurs in response to a particular issue was described as follows:

> *The participation of non-parents (i.e. taxpayers without children in school) is not as intense or emotional a style of involvement as when you have kids in school and something affects you directly.*
>
> (School board chair, Hamilton-Wentworth)

Types of issues that precipitate participation

Table 8-7 presents a list of education issues cited by informants as precipitating participation in *Hamilton-Wentworth* and *Ottawa-Carleton*. As with health care decision-making, any attempt to significantly reduce or eliminate the provision of services results in widespread community mobilization. School closures are the most similar issue to hospital closures although they differ in the extent of community involvement evoked. As compared to hospitals, schools serve only a fraction of the community so while the reaction to a proposed school closure may be as intense as the reaction to a hospital closure it is likely to occur on a much smaller scale due to the size of the affected community.

Lobbying with the objective of getting a new school or school renovations also parallels the issue of resource procurement (discussed in the health care context). This issue is more prevalent in rural or suburban communities where rapid population expansion has occurred.

Most of the other issues highlighted in Table 8-7 relate to cuts or changes to service provision, also common to the health care sector. Two related issues unique to the education sector are transportation and school boundary changes, both of which evoke widespread parental involvement.

In addition to the service-related issues described above, several informants identified school-related issues or problems that are guaranteed to precipitate parent involvement. Parents made the general point that "if things are not going well in the school parents will get involved" and suggested more specifically that "if there is resistance from the principal in responding to parents' concerns, they will get involved".

Perceived inequities between schools were also identified as a precipitant to action in at least one school board. In the broader context of school board cuts the establishment of a board-wide parent advisory group was attributed to concerns about inequities between schools in more and less affluent areas in the city (Chair, joint elementary parent advisory group, Hamilton-Wentworth).

Informants from Nipissing described participation patterns in education similarly to those described for health care.

> *There is little participation unless a crisis erupts.*
>
> (Catholic school board director, Nipissing)

> *Unless you're closing a school, changing a boundary or taking something away there is no public involvement.*
>
> (Public school board chair, Nipissing)

In Renfrew County, the issue of the proposed amalgamation of the Catholic school board with the Catholic school board in a neighbouring urban community (Ottawa-Carleton) sparked widespread community mobilization:

> *The community felt threatened [by amalgamation] and responded to this threat.*
>
> (Catholic school board chair, Renfrew County)

School board amalgamation posed a variety of threats to the community. It threatened the viability of small rural schools, many of which would close due to small enrolment. It also threatened employment, given that the Catholic school board is the fourth largest employer in Renfrew County, and represented an "assault on rural values" (Catholic school board chair, director of education and provincial member of parliament).

Table 8-7
EDUCATION ISSUES THAT HAVE PRECIPITATED PARTICIPATION

Hamilton-Wentworth	*Ottawa-Carleton*
1. Proposal for small school closures (Hamilton Board, Hamilton-Wentworth Roman Catholic Board) - strong, organized lobby against closures in West end of city (Hamilton board) - led to strong lobby from parents and Roman Catholic community and to the formation of a group representing the 12 schools on the chopping block 2. Staff reductions (Hamilton-Wentworth Roman Catholic board) - e.g. teachers, principals, librarian - decreased support for education assistants - aide for special needs students - parents in Roman Catholic board organized around this issue 3. Changes to bus routes or school boundaries (Hamilton-Wentworth Roman Catholic board, Wentworth County board) - this was a general issue mentioned by the Roman Catholic board but a specific issue mentioned by the Wentworth County board which has had strong opposition from parents in Flamborough (a rural municipality) who have had transportation to schools in neighbouring school boards eliminated in favour of longer transportation routes within school board boundary - community used very sophisticated but unsuccessful strategies to influence board decisions (board admin) - boundary changes also change the social structure of children's education (board admin) 4. Accommodation (Hamilton-Wentworth Roman Catholic board, Wentworth County board) - need for more space (either new schools or more space on existing sites) - team of people got together to work on this and got 12 new classrooms (parent) - getting a new school can mobilize a community (board admin.) - parents have been very effective in lobbying the government for grants for new schools (board admin)	1. Threat of school closures (Ottawa Board, Carleton Roman Catholic Board) - various points in time over the years - this is mostly an issue at the elementary level (ages 4-13) because of the strong parental preference for children to attend neighbourhood schools which are often small and therefore targets for school board cuts based on a rationale of non-viability - one of the strongest lobbies against a school closure, however, was in opposition to a secondary school closure which was a bitter dispute between the school community and the board resulting in lawsuits and threats to the school board director 2. Cancellation of junior kindergarten 5 years ago (Carleton Board and Roman Catholic Board) - provoked incredible turnout to board meetings, record calls, delegation process - "random participation, not well-organized" Kanata was very well-organized – mobilization started in day care; Barrhaven also well-organized through community association and its special education committee (board chair) 3. Transportation (Carleton Board, Carleton Roman Catholic Board, Ottawa Roman Catholic board) - always an issue when routes are changed - perceived as inconvenience to and increase in responsibility for parents 4. Work-to-rule (Carleton Board) - school board received delegations, public question period - small group of parents took issue to provincial government and resolved it 5. Amalgamation of school boards (Carleton Roman Catholic Board)

5. Changes to junior kindergarten (Hamilton-Wentworth Roman Catholic board, Wentworth County board) - instead of children going to school for a half day each day the program would be operated on a full-day alternate day basis which would reduce busing costs - parents came together as a group around this narrow issue (board chair) - example of people getting involved when something is being taken away (board chair) - junior kindergarten decision made very quickly with little time for parents to respond (board chair) 6. French immersion (City of Hamilton board) - any time program is threatened there will be lots of involvement because parents are fearful it will affect children's livelihood 7. Taxes (Wentworth County board) - 2 groups have mobilized on this issue: i) group that wants to keep taxes low and ii) parents who want best education possible for their children (board chair)	6. Social contract days (Carleton Roman Catholic Board) - cuts to teachers salaries resulted in longer holiday period and parents concerned about how holidays should be spread out over the school year and wanted input into decision (parent) - board surveyed all parents against teachers wishes who felt parents should stay out of what they perceived to be union issues 7. French immersion (Ottawa Board) - when money is short why offer 3 levels of Fr. immersion? - board interested in cutting 2 levels but research is equivocal on outcomes for each entry level therefore no cuts made - there is always intense lobbying at the board re: French immersion (board admin) 8. Funding for Roman Catholic high schools (Ottawa Roman Catholic Board)

PART III - COMPARATIVE ANALYSIS OF HEALTH CARE AND EDUCATION

The profiles presented in the preceding sections provide the necessary elements for comparing health care and education at both micro- and macro- decision-making levels. At the micro-level, findings in the education sector can be compared with those for health care within each of the four case study communities while macro-level comparisons allow for broader analysis of the common and unique features of participation and its influences across the two policy sectors. The discussion below highlights the principal themes emerging from this cross-sectoral analysis.

The first theme to cut across both sectors is that of religious characteristics exerting a similar combination of pre-disposing, enabling and precipitating influences in the health care and education domains. Hamilton-Wentworth and Renfrew County provide examples of the Catholic community easily mobilizing itself to support a Catholic hospital (in the Hamilton-Wentworth case) and a Catholic school board (in Renfrew County). As has been noted in each case, although the community response was not restricted to the Catholic Church and its parishioners, it provided a convenient and supportive infrastructure for mounting an effective opposition to threatening proposals. The combination of a strong Catholic community identity (pre-disposing), the actions of various Catholic institutions such as the Church, hospital and school board (enabling) and the imposed threats to the future of these institutions (precipitating) exerted a powerful and arguably unrivalled influence over participation in the respective decision-making processes (i.e., health care and education) for each of these communities.

A second theme that arises from the comparison is the similar role played by community values as both pre-disposing and precipitating influences over participation in

health care and education. The values of "resisting change", "protecting what little you have" and "maintaining a strong local identity" that are characteristic of rural and smaller communities fuelled the fierce opposition that was mounted against both hospital closure and school board amalgamation proposals in Renfrew County. The motivations behind the well-organized responses to concerns about access to health care services and bus transportation in Glanbrook and Flamborough (in Hamilton-Wentworth) provide an additional example.

Socio-economic characteristics appeared to exert a more significant influence over routine participation in the education than the health care sector. Community informants from the education sector consistently reported the high degree of variation in participation among school communities of different socio-economic levels. In contrast, socio-economic characteristics were only observed to be important baseline predictors of participation in health care in Ottawa-Carleton where the overall community was felt to be highly participatory due to its affluent and highly educated population.

The cultural differences associated with different participation levels in the education sector were not identified in the health care sector. This finding is difficult to interpret. Since health care informants were not probed about this particular influence, one cannot conclude that cultural differences do not exert any influence over participation in health care decision-making. It may be that they do not exert the same degree of influence as in the education sector.

Precipitants were found to be the most powerful single influence over participation in both health care and education sectors. Identification with a single issue,

particularly one that presents a tangible threat to the community (i.e., something being taken away), is an extremely effective mobilizer of community participation.

> *Whether it's health care or education you get involved in the issue that affects you most directly.*
>
> (Former DHC member, Ottawa-Carleton)

The motives underlying institutional attempts to enable participation (i.e. through DHCs and school boards) in health care and education deserve careful scrutiny. Despite the structures that exist to involve the community in educational decision-making, there are strong deterrents to participation at both the school and board level. On the health care side, DHCs are strong advocates of community participation but seek a highly controlled approach to involving communities in their decision-making process. Manipulation under the guise of participation is a common strategy employed in both sectors. Although the dominant interests of the health care and education elite wield tremendous power in both sectors, an emerging role for challenging and repressed interests appears to be more evident in the education than in the health care sector.

Let me return, then, to the question posed at the beginning of this chapter: Can we generalize from health care to other policy sectors regarding the influences on community involvement in local decision-making or is the health care case unique? The themes highlighted above suggest that the answer to this question is yes and no. With respect to participation itself, there seems to be more routine participation in the education sector than in health care, likely due to the ease with which people identify with their children's schools and classrooms. When it comes to issue-driven participation though, participation in health care is much more evident. Considering the various influences on

participation, some pre-disposing influences such as culture, religion and community values were found to shape participation similarly in both sectors while others such as socio-economic characteristics exerted differential influences. The role of enablers as manipulators of participation, while more striking in health care, was also visible in education. Precipitants were also emphasized to the same degree in each sector although precipitants operating in the health care sector were associated with more vociferous and emotional participation than in the education sector.

A fundamental difference underlies the analysis of participation in the health care sector as compared to education. Interviews conducted in the education sector, for example, focussed on participation targeted at a specific decision-making level such as the school, school board or province primarily concerning parental participation. These were contrasted with interviews in the health care sector which were much less specific about participation levels and where the health care constituency was less clearly defined. The following quotations provide some insights into the different approaches taken to participation in each sector:

> *Few people have strong views regarding the structure of the education system as compared to health care - parents are more concerned with their own children than the system as a whole but education is more understandable to the man on the street ... health care is much more complex. The participation of each member is roughly equal on a school board but 1 articulate physician on a DHC is worth 5 members of the public.*
>
> (Former DHC executive director, Ottawa-Carleton)

> *Everyone pays school taxes and elects school trustees therefore people think they know more about it.*
>
> (Provincial Member of Parliament, Renfrew County)

Concern about health is more irrational ... The hospital is the personification of people's lives.

(Provincial Member of Parliament, Renfrew County)

SUMMARY

The comparative analysis presented in this chapter has revealed striking similarities between participation in health care and education. Both sectors feature the dominance of issues as drivers of participation. Both highlight the role of community values (particularly those of small, rural communities) in combination with precipitants such as hospital closures and school board amalgamation in producing fierce and organized opposition to perceived inequities in service access. The Catholic Church provided identical enabling and mobilizing infrastructures in both sectors to counter threats to Catholic health care and education.

Areas of divergence between the two sectors were also found, particularly in the differential influences exerted by structural characteristics over participation. Socio-economic and cultural characteristics, for example, exerted a more dominant influence over routine participation in the education sector than in health care.

The role played by institutions as enablers (i.e., DHCs and school boards) offers another area for comparison. Despite the structural differences identified between these institutions in earlier chapters, both have an explicit commitment to involve their "communities" in decision-making processes. Enabling factors appeared to play a more significant role in education than in health care with the school principal identified as the most important enabler or deterrent of parent participation. The case studies also

revealed stronger deterrents to participation in education than in health care. There are several plausible explanations for this. As discussed earlier, the education sector is subject to less interest fragmentation than is the health care sector. Parents, as active participants in the education arena, present a cohesive, powerful force and pose a greater threat to traditional decision-makers resulting in their attempts to derail participatory efforts. This is sharply contrasted with the health care sector where a fragmented community presents a much weaker threat to the status quo thus minimizing the need for the health care elite to deter participation. The divergent findings may also be explained by the different contexts within which participation was being debated in each sector at the time of the study. In the education sector, the provincial government was unveiling its plan for school councils as a method for increasing the involvement of parents and community members in the decisions affecting their schools. Despite opposing views regarding the benefits and pitfalls of school councils this policy environment had the effect of bringing the issue to the fore and crystallizing opinions on the subject of community participation in the education sector. Community participation in the health care sector, in contrast, has been under debate for a number of years both provincially and nationally and did not, therefore, evoke the same intensity of response from community informants.

The target of participation is another distinguishing feature between the two sectors. As described earlier in the chapter, participation in the education sector is targeted at one of two decision-making levels: the individual school or school board. The target of health care participation, in contrast, was discussed with much less specificity. District health councils obviously played an integral role in enabling routine and

precipitating issue-driven participation. But no school equivalent emerged in the health care arena. Although treated as symbols of their communities to be saved at all costs, hospitals, unlike schools, were never identified as targets for community participation efforts. The extent to which size, social solidarity and "constituency" account for these differences will be explored in the concluding chapter.

Appendix 8-1

Sample letter requesting school board "enabling" information

May 9, 1995

«Title» «FirstName» «LastName»
«JobTitle»,
«Company»
«Address1»
«Address2»
«City», «Province»
«PostalCode»

Dear «Title» «LastName»:

My name is Julia Abelson and I am a Canadian researcher enrolled in the University of Bath's Ph.D. programme in social policy. I am conducting research on public participation in decision-making, in the fields of education and health care, and will be returning to Ontario in September 1995 to conduct fieldwork in selected Ontario communities.

I have selected Ottawa-Carleton as one of my study communities and am writing at this time to inform you of my research and to request your school board's assistance in providing me with some background information. In particular I am interested in:

1. The names and addresses of any parent/community organizations in the area that have been formed to address school issues

2. Whether the board collects information about the nature of public attendance (i.e. who and how many?) at board and committee meetings as well as attendance at specially convened public meetings.

3a. What mechanisms the board provides for the public to raise issues of concern to them or to participate in various decision-making processes of the Board

3b. How these mechanisms are publicized.

3b. Whether the board keeps track of the number of people who become involved in this way and what the nature of the issues are.

4. What methods are used to keep track of letters and phone calls that are received from the public and directed to either the Board or one of its trustees.

In addition to the information requested above, I would also like to know who I should contact in the future to request interviews to discuss these issues in greater detail. Any names you could provide me with would be greatly appreciated.

I am hoping to collect the requested background information by June 9. I look forward to hearing from you soon. Please send any correspondence by mail or fax to:

Julia Abelson, M.Sc.
School of Social Sciences
University of Bath
Claverton Down
Bath BA2 7AY
United Kingdom

Fax: 011 44 1225 826 381

Sincerely,

Julia Abelson

References to Chapter 8

Hamilton-Wentworth Roman Catholic Separate School Board. By-laws and Regulations. Hamilton: HWRCSSB, November 1994.

Plante-Perkins, A. (1995). "Parent Council, School Council, Parent Advisory Council- What's in a Name? Plenty! *Parents Magazine.*

Renfrew County Roman Catholic Separate School Board. Renfrew County Catholic Schools: Response to the Interim Report of the Ontario School Board Reduction Task Force. October 1995.

Royal Commission on Learning. (1995). *For the Love of Learning.* Report of the Royal Commission on Learning. Toronto.

Government of Ontario. (1995). *Interim Report of the Ontario School Board Reduction Task Force.* Toronto.

Newspaper articles

Cox, C. Parents protesting transfer of principal. *The Hamilton Spectator*, April 13, 1995, p.C2.

Editorial. Renfrew County message is getting through against Separate school board amalgamation. *Barry's Bay This Week*, October 24, 1995.

Community Informants

Hamilton-Wentworth

Bishop, J. Personal interview. 15 February, 1996. Hamilton, Ontario.
School Board Trustee, City of Hamilton Board of Education

Costie, I. Personal interview. 13 December, 1995. Hamilton, Ontario.
Chair, Joint Elementary Parent Advisory Group (JEPAG), Hamilton-Wentworth Roman Catholic Separate School Board

Daly, J. Personal interview. 24 November, 1995. Hamilton, Ontario.
Director of Education, Hamilton-Wentworth Roman Catholic Separate School Board

Daly, P. Personal interview. 11 December, 1995. Hamilton, Ontario.
Chair, Hamilton-Wentworth Roman Catholic Separate School Board

Dowling, W. Personal interview. 2 November, 1995. Hamilton, Ontario.
Asistant to Allan Greenleaf, Director of Education, Wentworth County Board of Education

Edwards, S. Telephone interview. 29 November, 1995. Hamilton, Ontario.
President, Council of Home and School Associations, Wentworth County Board of Education

Gibson, M. Personal interview. 9 November, 1995. Hamilton, Ontario.
President, Home and School Association, City of Hamilton

Goodridge, D. Personal interview. 8 November, 1995. Hamilton, Ontario.
Director of Education, Hamilton Board of Education

Matier, M. Telephone interview. 8 July, 1996. Hamilton, Ontario.
Superintendant, City of Hamilton Board of Education

Pitt, C. Personal interview. 4 December, 1995. Hamilton, Ontario.
Superintendant of Education, Hamilton-Wentworth Roman Catholic Separate School Board

Stewart, B. Personal interview. 8 November, 1995. Hamilton, Ontario.
Chair, Hamilton Board of Education

Wallace, B. Personal interview. 9 November, 1995. Hamilton, Ontario.
Chairman, Wentworth County Board of Education

Ottawa-Carleton

Albrecht, D. Personal interview. 16 May, 1996. Ottawa, Ontario.
Executive Director, Sandy Hill Community Health Centre

Barton, C. Personal interview. 15 November, 1995. Ottawa, Ontario.
President, Carleton Council of Parents Association

Bottiglia, M. and Larkin, R. Personal interview. 16 November, 1995. Ottawa, Ontario. Administrative Assistant and Director of Education, Carleton Roman Catholic Separate School Board

Gillett, B. Personal interview. 15 November, 1995. Ottawa, Ontario.
Director of Education, Ottawa Board of Education.

Gowling, B. Personal interview. 14 November, 1995. Ottawa, Ontario.
Chair, Ottawa Board of Education

Kenelly, J. Personal interview. 17 January, 1996. Ottawa, Ontario.
Chair, Ottawa Roman Catholic Separate School Board

Parker, C. Personal interview. 15 November, 1995. Ottawa, Ontario.
Chair, Carleton Board of Education

Plante-Perkins, A. Personal interview. 17 November, 1995. Ottawa, Ontario.
Chair, BPAC Ottawa Roman Catholic Separate School Board

Pilon, R. Personal interview, 17 November, 1995. Ottawa, Ontario.
Director of Education, French Language Public School Board of Ottawa-Carleton

Shea, J. Personal interview. 15 November, 1995. Ottawa, Ontario.
Superintendant of Education, Ottawa Roman Catholic Separate School Board

Smith, H. Personal interview. 17 January, 1996. Ottawa, Ontario.
Immediate Past Chair, Joint Council of the OBE Elementary and Secondary Advisory Committee

Staff of Carleton Board of Education. Personal interview. 13 November, 1995. Ottawa, Ontario.

Flynn-Turner, J. Personal interview. 16 January, 1996. Ottawa, Ontario.
Chair, Carleton Roman Catholic Separate School Board (elected in Nov. 1991, chair in Sept. 1994, was PCC chair before that)

Urban, C. Personal interview. 6 December, 1995. Ottawa, Ontario.
Chairperson, Parent Communications Committee, Carleton Roman Catholic Separate School Board

Warren, A. Telephone interview. 29 July, 1996. Ottawa, Ontario.
Former Executive Director, Ottawa-Carleton District Health Council

Nipissing District

Church, S. Telephone interview. 21 January, 1998. North Bay, Ontario.
Parent Representative, Nipissing District Board of Education

Giroux, B. Personal interview. 17 October, 1995. North Bay, Ontario.
Director of Education, Nipissing District Roman Catholic School Board

Hewitt, K. Personal interview. 18 October, 1995. North Bay, Ontario.
Chair, Nipissing District Board of Education

Kennedy, B. Personal interview. 18 October, 1995. North Bay, Ontario.
Director of Education, Nipissing District Board of Education

Lucenti, B. Personal interview. 19 October, 1995. North Bay, Ontario.
Chair, Nipissing District Roman Catholic School Board

McCool, B. Personal interview. 19 October, 1995. North Bay, Ontario.
Chair, Special Education Advisory Committee, Nipissing District Roman Catholic School Board

Renfrew County

Belanger, T. Personal interview. 21 February, 1996. Pembroke, Ontario.
Parent Representative, Renfrew County Roman Catholic Separate School Board

Conway, S. Telephone interview. 12 June, 1996. Toronto, Ontario.
Member of Provincial Parliament, Renfrew North

Kelly, T. Personal interview. 17 May, 1996. Pembroke, Ontario.
President, Home and School Association, Renfrew County Board of Education

Marion, K. Personal interview. 17 May, 1996. Pembroke, Ontario.
Chair, Renfrew County Board of Education

Schreader, B. Personal interview. 21 February, 1996. Pembroke, Ontario.
Chair, Renfrew County Roman Catholic Separate School Board

Stunt, J. Personal interview. 17 November, 1995. Pembroke, Ontario.
Director of Education, Renfrew County Roman Catholic Separate School Board

CHAPTER 9

CONCLUSIONS

> *The words 'true' and 'false' do not apply here in the sense that they are used in mathematics or science. For there is nothing universally and irrevocably true or false about these interpretations. There are no critical tests to confirm or falsify them. There are no postulates in which they are embedded. They are bound by time, by situation, and above all by the cultural prejudices of the researcher. Quite like a piece of fiction.* (Postman, 1988:13)

A rich body of material concerning participation and its influences has been presented in the preceding chapters. As with any study of this magnitude, the process of analyzing and interpreting the data is rarely if ever exhausted. There is always more that could be done to describe and explain the study's findings. At some point, however, the researcher needs to stand back from the specifics of the data and reflect on the lessons to be drawn from the research. For example, where does the research confirm and bolster prior research? Where does the research make an original contribution to the literature and what does the research imply for policy? This exercise is particularly important in case study research where the particularities of the local context are often used to prohibit any generalizations from being made. This is not to say that we should not be concerned about the limitations of local context but that, with careful examination, broad themes can be extracted from these case studies. It is the objective of this concluding chapter, then, to reflect on the findings of the case studies presented to identify themes relevant to the participation literature and to the policy areas of health care and education. A discussion of these themes follows some initial reflections on the study's methodology identifying both its weaknesses and its strengths.

Reflections on the Methodology

The most significant methodological contribution of the study, the use of a multiple method case study design to explore aggregate-level participation, was also the source of the study's most significant methodological challenges. Although a small number of prior studies have employed both qualitative and quantitative methods to examine participation (Parry et al, 1992; Berry et al, 1993), few have explicitly set out to unravel the complexity of participation the way this study has. Meeting this objective has produced a rich body of material on the subject and identified a number of methodological problems in conducting exploratory research of this kind.

The aggregation problem

A key element of the inquiry was the collection of aggregate participation data from all available sources with the objective of developing participation profiles for each case study area. By incorporating both qualitative and quantitative dimensions of participation into the profiles (see Chapter 3, Table 3-1) no aggregate measure or index of participation for each case study area could be produced. Table 5-9 presents a systematic comparison of participation profiles but there is no way to aggregate the various dimensions of participation to produce a single representative "measure" of participation that could be used to facilitate the exploration of contextual influences in Chapters 6 and 7. In addition, efforts to aggregate the quantitative participation data alone (without considering the qualitative dimensions) were complicated by the lack of comparability both among and within communities due to the presence of different issues, timeframes and general approaches to involving the community.

The problem of relying on secondary data

Despite the rigorous approach taken to defining terms and setting parameters for the study, the use of secondary participation data necessitated reliance on data collection procedures established by local institutions (often found to vary considerably). At times this also involved conforming to others' definitions of "community" and "participation". As discussed in the introductory chapter, there are many different meanings of "community" as well as different operational definitions of "participation". Considering the potential for definitions of community to incorporate one or a combination of the list below the complexity involved in developing a profile of community participation is soon realized.

- community defined as representative volunteers (e.g. DHC members)
- community defined as experts/elite
- community defined as health care employees
- community defined as local elected officials
- community defined as health care consumers
- community defined as general public
- community defined along cultural/religious lines

Despite attempts made to devise innovative participation measures, the data collection process was fraught with problems. Lack of uniformity (both within and among communities) in data collection was the most serious problem encountered. While DHCs have a mandate to engage in community participation initiatives and are frequently asked to report on their consultations with the community, there are no guidelines in place for the collection of participation data. Applications received for membership on the district health council were filed and organized differently in each of the four DHCs with no apparent guidelines for retaining applications over a certain period of time (see Chapter 5, DHC application data).

Similar problems were encountered in collecting constituent contact data for local members of provincial parliament (M.P.P.s) regarding health and education matters. As discussed in Chapter 5, a variety of methods were used to record contacts

with M.P.P.s ranging from manual note-taking by the receptionist to sophisticated computerized telephone and mail logs. Some offices recorded all mail and telephone contacts, some recorded only mail contacts, and still others (usually those who were not members of the governing party and had substantially lower office budgets) had no formal recording mechanism at all. Where contact data was separately collected for health and education issues, it was rarely categorized any further, thus preventing any conclusions from being drawn about the motivations for the contact (i.e., particularized contacting to aid an individual or his/her family member vs. contacting for the purposes of influencing the policy process). This distinction is increasingly emphasised in political participation studies where efforts are made to assess whether participants are pursuing 'material selective benefits' or 'civic gratification' (Schlozman, Verba and Brady, 1995). A further problem encountered was the overlap between contact data collected in the local constituency and parliamentary offices.

In general, the paucity of high quality, comparable data for each community limited the ability to generate comprehensive community participation profiles, causing one to reflect, in hindsight, on the decision made to rely on secondary-level participation data. Although individual-level survey data would have provided a more comprehensive profile of participation it would not have produced the aggregate-level data required for the analysis.

The difficulties described above should not be used to abandon efforts to use secondary participation data. I would argue, on the contrary, that there is great potential in tapping existing sources of community participation data provided steps are taken to overcome the problems encountered in this study. Examples include:

1. The need to establish some common data collection guidelines for district health councils to allow for within and between-community comparisons of participation.

2. The need to identify the importance within health councils of maintaining up-to-date,
comprehensive files (e.g., applications received for council and committee membership; meeting attendance, etc.). The comprehensiveness of the issue-driven participation collected for the health services restructuring processes in each community suggests that health councils can collect this type of data. Further investigation is needed, however, to determine whether the decision to collect detailed data is driven by external requirements to do so (i.e., provincial government) or by the availability of resources.

Of course, the above recommendations require political will in order to be executed. As the analysis of contact data for provincial members of parliament revealed, M.P.P.s who were generally supportive and committed to public participation exhibited a greater propensity to collect detailed contact data suggesting a self-selection bias may have been built in to the contact data collected. Data comprehensiveness also depended on the resources available to the M.P.P., which were largely determined by their status as a member of the governing or opposition party. Conservative M.P.P.s (governing party) tended to have more comprehensive contact data than did Liberal M.P.P.s (opposition). Indeed, several Liberal M.P.P.s reported routinely referring constituency contacts regarding public policy issues to Conservative M.P.P. offices. Interestingly, the M.P.P. who collected the most comprehensive contact data was a member of the New Democratic Party, arguably the most ideologically committed to public participation. Finally, comprehensiveness in data collection may also be associated with the desire to demonstrate opposition to government decisions as was illustrated by the petition data recorded in Hamilton-Wentworth.

Contextual limitations

Case studies are limited by their contextual parameters. This is also what gives case studies their depth and richness. In the case of this study, the time period and political context deserve special attention. The emergence of health care

restructuring as a dominant issue in the health care sector was both fortuitous and unfortunate. While it provided much fodder for analysis of community participation and its influences, community informants were so preoccupied with this issue that it may have had a steering effect during the interview process. That is to say, comments about participation in health care generally may have been influenced by participation occurring in response to the issue of health care restructuring.

As the interviewing period began, two of the four study communities (Ottawa-Carleton and Hamilton-Wentworth) were embarking on community consultations in the area of health services restructuring. A third community (Renfrew County) had already entered into a process of hospital restructuring before the study period began and before the Progressive Conservative government was elected in June 1995. The context in which participation was observed in Renfrew County, therefore, was very different from that of the other communities. The DHC in this community was recommending the closure of a hospital well before the newly elected government had made its plans for restructuring (and hospital closures) clear to the public which may have explained some of the intense resistance to the notion of a hospital closure. The fourth community, Nipissing, had merged its two hospitals prior to the beginning of the study period. The absence of the health care restructuring issue from this community, therefore, set Nipissing apart from the others. The results and conclusions reached for this community, however, may have been influenced by the absence of this issue. Would the community have behaved as the others did in response to threatened hospital closures or would the characteristics of the community (i.e., absence of pre-disposing and enabling factors) have diffused participation around this highly contentious issue?

Methodological contributions

The problems described in the previous sections must be countered by several methodological contributions to the participation literature.

a) The introduction of new and innovative participation dimensions and measures

Opportunities to capture both qualitative and quantitative dimensions of participation were built into the research design to provide a more thorough understanding of the contextual aspects of participation. The separation of instrumental participation data into *routine* and *issue-driven* categories represents previously uncharted territory although issue-driven participation is closely related to concepts such as *purposive* participation. Other dimensions such as *tone*, *texture* and *intensity* have not knowingly been used in prior research thus identifying a new contribution to the literature. Despite definitions provided for each of these dimensions in Chapter 3, there is a degree of subjectivity involved in assessing their presence and role. Further work is recommended in this area to refine these dimensions and apply them to other studies.

In the interest of examining participation's multiple dimensions, and given the absence of readily available quantitative participation data, innovative approaches were devised to track participation in each community. As Table 4-6 illustrated, these included contacts made with government officials regarding health care and education matters, petitions, applications received for membership on local health care decision-making bodies, meeting attendance and community mobilization in response to specific health care and education issues. Innovative approaches to collecting data on the "sources" of influence on participation were also employed; most notably, the use of blood donation data as a proxy measure for community social capital.

b) The study of small area variations

The case study design allowed for in-depth analysis both across and within study communities. In Chapter 4, concerns were raised that aggregation would cover up within-region variations (particularly in the two larger study communities) that may exist leading to an incomplete portrayal of participation and its influences. This concern was realized as the research findings revealed within-community (i.e., intra-case) variations to be more distinguishable than between-community (inter-case) variations.

c) Reproducibility of measures used elsewhere

The methodology chosen provided the opportunity to assess the reproducibility of measures used in other studies. Of particular interest was the use of Putnam's (1993) proxy civicness measures. Of the four measures of civicness used in Putnam's analysis (vibrancy of associational life; incidence of newspaper readership; referenda voting; and preference voting) attempts were made to collect data for the first three.[1] As discussed in Chapter 6, referenda voting data were easily obtainable but newspaper readership and associationalism proved to be much more challenging stirring feelings of envy tinged with scepticism toward the Italian data. The difficulties encountered in collecting comparable data for this study should not deter future attempts to measure civicness in the context of Canadian communities. Further work is needed, however, to develop measures that are appropriate and relevant to Canadian jurisdictions.[2] The current state of this data suggests that significant impediments exist to aggregating this data from individual communities to larger regions.

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[1] The fourth measure, preference voting, is not a feature of Canadian elections.
[2] Some of this work is being undertaken by other Canadian researchers. See Veenstra, G. and Lomas, J. (1996).

Having discussed the strengths and weaknesses of the methodology, let us consider what conclusions can be drawn from the case studies of participation in health care decision-making.

The Contingencies of Participation

One is immediately struck, in drawing conclusions about the participation observed in this study, by the contingency of participation on the area studied. In reality, this study involved many more than four case studies. Descriptions of participation in each of the four original communities were often "footnoted" by depictions of vastly different participation patterns within the case study communities. Participation profiles presented for Renfrew County, Nipissing District and Hamilton-Wentworth were highlighted by the anomalous participation depicted in the communities of Deep River, Sturgeon Falls and Dundas. While supportive of local and neighbourhood participation studies, these findings contribute new material to the health care participation literature where few comparative studies of local participation have been conducted and demonstrate the application of research from other fields (i.e. neighbourhood participation) to specific policy areas. They also cast doubt over the findings of others (i.e., Putnam, 1993) where aggregate-level data was collected for regions of at least the same size or larger than those included in this study.

As illustrated in Chapter 8 and in a subsequent section of this chapter, participation is also contingent upon the policy area under investigation making it difficult to extract a clear set of conclusions from the analysis undertaken.

The Confirmed Role of Socio-economic Characteristics

On the whole, study findings confirmed the role of socio-economic characteristics (previously established in the general participation literature) in the

health care and education sectors where income and education were found to pre-dispose communities to consistently high levels of participation (Chapters 6 and 7). This study's findings go further, however, in identifying the influence of socio-economic characteristics over a particular *form* of participation, that is, *routine* versus *issue-driven* participation. Socio-economic characteristics were found to pre-dispose communities to higher levels of routine participation (e.g., committee representation, joining voluntary organizations, etc.). The same socio-economic characteristics, however, were much less influential over issue-driven participation (e.g., mobilization). Overall, education levels played a more influential role although they were more frequently cited in the education than the health care sector.

In assessing the applicability of various participation theories to the health care and education sectors, the standard socio-economic model played an important role in explaining the routine participation observed in all communities. It explained the propensity for committee membership and meeting attendance among Hamilton-Wentworth's health care elite (with pockets of involvement in Dundas), and the highly sophisticated and participatory citizenry in Ottawa-Carleton and Deep River. It also helped to explain the Hamilton-Wentworth health care elite's ability to dominate a less educated and highly deferential community in health care matters. It does not, however, tell the whole participation story.

The Role of Religion and Culture

The emergence of language and religion as powerful forces over the participation process was an unanticipated outcome of this inquiry and offers a new contribution to the participation literature, especially within the health care and education sectors. Despite the minimal attention given to either in prior studies, culture and religion repeatedly emerged through the interviewing process as a

dominant influence over participation, particularly in response to threats to linguistic and religious-based services. Upon further reflection, the role of culture and religion are perhaps more appropriately cast as "social cleavages" given the role played by religious and linguistic divisions in shaping the observed participation. The lack of attention given to the "social cleavage" phenomenon in the general participation literature may be explained by its link to the presence of culturally and linguistically based services that is characteristic of the health care and education sectors in Canada. This relationship has not been explored due to the paucity of participation studies in the Canadian health care context.

The presence of social cleavages within communities had the effect of producing social solidarity along cultural and religious lines. These social cleavages crossed all elements of the model outlined in Chapter 3 illustrating the overlap between pre-disposing, enabling and precipitating influences and the limitation of the model in accounting for these overlaps. Most effectively illustrated in Ottawa-Carleton and Renfrew County, the process of creating social solidarity from social cleavages saw long-standing linguistic and religious divisions and the threats posed to linguistic and religious-based services combine, with the help of the Catholic Church, to mobilize participation of unprecedented intensity and emotion around the issues of hospital closures and school board amalgamation.

The participation resulting from this combination of pre-disposing, enabling and precipitating factors was of an entirely different magnitude and style than that observed in other communities where linguistic and religious characteristics were absent. Even the participation mobilized by the Catholic Church in opposition to the threatened closure of St. Joseph's Hospital in Hamilton-Wentworth, although impressive, did not compare to that mounted in the other two communities.

The Role of Social Capital

As a vehicle for exploring the relationships between measures of social capital (e.g., blood donation, voluntarism, newspaper readership and referendum voting) and instrumental participation, the case studies did little to further our understanding of these concepts except perhaps to confuse us even more. Those communities that appeared to be "civic minded" exhibited varied patterns of participation. High levels of voluntarism and blood donation exhibited in Hamilton-Wentworth (and the Town of Dundas in particular), for example, were associated with high levels of participation. This same association, however, was not found in North Bay despite its high levels of voluntarism and blood donation. On the contrary, its strong commitment to community voluntarism was given as a reason for not engaging in instrumental participation leaving one to consider the possibility of a negative relationship between social capital and instrumental participation. Validity and reliability problems encountered in collecting the social capital data may explain these conflicting findings. Another explanation that must be considered, however, is the embeddedness of instrumental participation in the concept of social capital[3] making it difficult to isolate the independent influences of each on the other. Voluntarism, for example, although a measure of social capital in this study may also be interpreted as a form of instrumental participation.[4] This subject is clearly in need of further research. An avenue for further exploration would be the link between the presence of social capital and a community's predilection for a more collaborative approach to participation in local decision-making. A theme that emerged from the Hamilton-Wentworth and Ottawa-Carleton case studies was the striking contrast between the

[3] The reader will recall previous references to this point in Chapters 2 and 6.
[4] Veenstra's dissertation on social capital, for example, includes voluntarism as a measure of civic participation.

collaborative approach to decision-making taken in the former community and the divisive, competitive approach taken in the latter. Although some preliminary hypotheses were generated to explain these vastly different approaches, a more detailed analysis of the history of these communities is needed to uncover the underlying reasons. Similarly, Nipissing District deserves more careful scrutiny to fully explicate the reasons for its resistance to instrumental participation.

Enablers and Manipulators

> *... one of the difficulties faced by citizens today is making sense of what is presented as material for public debate, but is actually no more than the formalized propaganda of interest groups.*
>
> (Saul, 1995, p.61)

Prior studies of community decision-making, particularly in the area of health care decision-making, have identified the potential for communities to be manipulated by powerful elites (Short, 1989; Robertson and Minkler, 1994; Gittell, 1980; O'Neill, 1992). Evidence to corroborate these findings was found in both health care and education sectors while particular emphasis was given to the source and style of manipulation.

The health care restructuring cases presented in Chapters 5 through 7 demonstrated the fine line that exists between enabling and manipulating participation. In analyzing the tension between community participation and manipulation in the case studies presented here, several conclusions follow. The first is that as decisions become more contentious, communities are increasingly likely to be subjected to techniques of manipulation and co-optation by structural interests such as district health councils and health care providers. Secondly, it follows that communities that exhibit greater deference to elite decision-makers tend to be more easily manipulated while perceiving themselves to be consulted in the decision-

making process. This study goes further than those reached in other community studies which have emphasized the importance of elites achieving legitimacy from the wider community and the notion of non-elite members of the community seeking to bring elites under control in areas of concern to them (i.e., health care and education).

The role of enablers as manipulators was paralleled in the education sector where school boards, despite providing various mechanisms for parent involvement were found to dominate the policy and political agenda. Interviews with school board administrators repeatedly demonstrated (with some exceptions) reluctance in bringing about changes or improvements with respect to community participation while acknowledging its participation (see Chapter 7, Tables 7-3 through 7-6).[5]

Although this analysis has focused on the manipulation of participation by local elites at the local level, it is worth noting that local participation may also be subject to manipulation from sources external to the community. In the context of Canadian health care policy, these outside influences are often driven by long-standing jurisdictional tensions between the federal and provincial governments. Recurring debates over the presence of a health care funding crisis in Canada have pitted the federal and provincial governments against each other in a battle for popular support. In an era of fiscal retrenchment, provincial governments (in their role as allocators and managers of health care resources) have made very unpopular decisions such as hospital closures. Shrinking revenues, in the form of reduced federal transfer payments for health care, have been blamed for these unpopular decisions and provinces have accused the federal government of eliminating its deficit on the backs of the provinces. The federal government has defended its decisions based on the

[5] A more recent demonstration of this phenomenon has been the lack of resources allocated for operating the newly-established school councils in Ontario. School boards have, on the one hand, dutifully supported schools in the process of electing school councils, and on the other, severely

argument that the health care system is not underfunded and that provincial governments such as Ontario have inappropriately chosen tax cuts over stable health care funding. A "call to arms" was made recently by the Federal Health Minister who challenged communities concerned about hospital closures and decreased health care funding to fight their provincial governments on the issue of health care funding. Jurisdictional disputes over health care are now trickling down to the local level with the federal government attempting to manipulate the public into action while shifting the blame away from itself and onto the provinces.

The Role of Interests in Health Care and Education: Fragmented and Contingent vs. Predictable and Permanent

Perhaps the most significant finding with respect to the identification and role of interests in local participation was the absence, despite much rhetoric about its importance, of the "community interest". Actions taken by district health councils, school boards and others to obtain the views of the "community" and to make decisions reflecting the interests of the "community" inevitably resulted in their obtaining and incorporating the views of those with vested interests in the outcome of the decision-making process often under the auspices of a manipulated public (the subject of the previous section).

The diffuse and fragmented nature of community interests in the health care sector has been described and analyzed by others (Tuohy and Evans, 1985; Alford, 1975; Rasmussen, 1996). The case study findings presented here provide strong empirical evidence to support these prior analyses but they expand on earlier work by illustrating that this phenomenon may be unique or at least much more prevalent in the health care sector. The discussion in Chapter 8 illustrated a less fragmented

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curtailed their ability to function by leaving the decision to allocate funds to the school council to the individual school.

community interest in the education sector than in health care. While some fragmentation exists among the interests of parents of students with special needs (i.e., French immersion, special education and gifted programs), it is much less visible than that observed in the health care sector. A comparison of the committee structure for DHCs and school boards illustrates this point. The Special Education Advisory Committee is the only standing committee of each school board that separately addresses and/or represents the interests of special education students and their parents. In contrast, DHCs typically have separate committees of council dealing with mental health, long-term care, emergency health services, health promotion and, in some communities, French language services. Smaller working groups in areas such as speech pathology, trauma and primary care often augment these standing committees. To reiterate the findings in Chapter 8, education represents a predictable and permanent interest while children are in school in contrast to the contingency and heterogeneity of health care interests.

The differences outlined above might also be considered in the context of "constituencies" where that for education, as discussed in Chapter 8, was more clearly defined than that for health care. Despite the low level of voter turn out in municipal elections (during which school board trustees are also elected), their status as elected, special purpose bodies gives them at least some profile in their communities. Until recently, Ontario school boards have had revenue-raising powers through the municipal tax base giving municipal taxpayers (with or without school-aged children) at least some vague notion of what a school board does. DHCs, in contrast, are appointed, advisory bodies with no equivalent profile in their community. Those with knowledge of the DHC are typically those who play a specific role in the health care system either as a consumer or provider of service or as a volunteer council or

committee member. The average citizen is often unaware that a DHC exists in his or her community.

The health care and education constituencies are equally divergent at the micro-level. In the education sector, each school serves a group of children and their parents as well as a broader school community typically consisting of a few neighbourhoods. Boundaries between school communities are precisely defined while hospitals, in contrast, serve a heterogeneous population of "potential patients". The concept of a "neighbourhood health care facility" as compared to the "neighbourhood school" is virtually non-existent in the health care sector.[6]

The characteristics of community size and social solidarity also provide important clues to understanding the different approaches taken to participation in health care and education. A community school of a few hundred students and their parents living in the same neighbourhood would be expected to have a much easier time organizing themselves for routine and issue-driven participation than would a diffuse and heterogeneous group of people residing in a hospital catchment area.

Is there more to the story than meets the eye?

Yet an odd puzzle remains. If the above is true, then how are we to explain the magnitude of emotion and protest (whether manipulated or not) observed in each community facing the extinction of its hospitals? The scale of these protests certainly dwarfed anything equivalent that arose in the education sector. The opposition mounted against school board amalgamation in Renfrew County (see Chapter 8, Precipitating Influences) came closest in scale but it fell well short in matching the intensity of that displayed in response to hospital closures. If education interests are

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[6] Community health centres are health care's closest equivalent to neighbourhood schools but they serve only a small percentage of the population in Ontario (5-10%) and are not present in every community.

so much more permanent and predictable than those in health care how do we account for these differences? There are several possible explanations.

When faced with extinction, schools and hospitals draw upon very different groups of supporters. In the education sector, schools have only the parents of school-aged children (despite their cohesiveness) to draw upon to oppose a closure. Anyone without children in that school (even if they have children who previously attended that school) has no obvious interest in whether or not the school remains open. Furthermore, as taxpayers, the residents of the school area may support the school's closure as a method of improving efficiencies within the education system. The case of health care is markedly different. Despite the fragmented health care interests identified earlier, on the issue of hospital closures, everyone in the community has an interest (whether contingent or continual) in ensuring even the most basic access to hospital services. The differences between education and health care are highlighted even further by the fundamental relationship between health care and major life events such as birth, life-saving treatments and the restoration of health. Rightly or wrongly, hospitals continue to be equated with health. Although no one would deny the importance of education in preparing young people for their future role in society, we seem to be comfortable leaving the responsibility for watching over the education system to parents of school-aged children. Yet, when it comes to preserving our health care system everyone seems to feel the need to get involved.

In drawing conclusions on this subject, the education sector brings out a smaller group of dedicated individuals who share a collective interest in their children's education and get involved in routine matters concerning the day-to-day activities of the system. Health care participation, in contrast, appeals to the interests of a much broader sector of society who are want to ensure that they will have access to care

when they need it but are largely uninterested in the specifics of service delivery. It seems that even a highly diffuse constituency such as health care can be mobilized.

Reflections on the model's utility

Given its prominence throughout the analysis, it seems logical to offer some reflections on the utility of the model and what modifications might be warranted for future use. Its strength as a descriptive and explanatory tool will be given primary consideration although its potential as a prescriptive tool will also be assessed.

As a *descriptive* tool, the model provided a useful organizational framework for taking stock of participation and its contextual influences in each of the four study communities. Although not explicitly described to community informants the material obtained through the interview process was easily categorized into each of the model elements demonstrating some resonance between the views obtained from the field and the conceptual framework.

As discussed in earlier chapters the model was developed as a heuristic tool for examining the contextual influences exerted on the participation process. By amassing of evidence pertaining to each model element and through the development of profiles of participation for each community the model provided the framework for piecing together the participation puzzle in each study community. The model played a limited role in *explaining* the relationships between the model elements and their combined influence on participation. Beyond stating that these combined influences likely existed, the model was of little use in disentangling the relationships. In hindsight and with the knowledge accumulated from the case studies, certain modifications and additions would be recommended for the its future use. One of the more significant modifications required is the ability to account for the overlap between model elements. While originally conceived as mutually exclusive

categories of influence, a more accurate portrayal of the relationships between model elements would have allowed for more overlap between them. Some influences acted as both enablers and precipitants, others as pre-disposers and enablers. For example, institutional actions designed to reduce the costs of participation were found, in some instances, to precipitate rather enable participation.
Actions taken by DHCs and the local media to encourage participation through the provision of information had the effect of mobilizing intense, emotional community responses.[7] The line between interests and interest groups as precipitants and enablers also overlap. In conceiving the model, interests were seen to be the foundation for precipitating participation in response to issues. Interest groups, however, also played a crucial role as enablers of participation, offsetting the costs of and providing an infrastructure for participation.

The model, as depicted in this analysis, plays little or no *prescriptive* role in offering insights into what should or should not be done with respect to involving the community in health care decision-making. It does, however, provide a tool for participation advocates and analysts alike to better understand the contextual influences on participation that may serve them well in seeking to influence the decision-making process.

[7] Ottawa-Carleton is a good example where the combined actions of the DHC and local newspaper precipitated an emotional response to initial proposals for hospital closures.

Implications of the Research for Policy

> *Yet for all its consistent attractiveness, the ideal role for community in social policy has remained elusive for three hundred years; the well-functioning community continually slips through our collective fingers.*
> (Schlesinger, 1997, p.938)

If one assumes that community participation will remain on the government's agenda, as either a necessary evil or a desirable goal then what, if anything, does this analysis offer the decision-maker? The first implication of the research for policy-makers relates to the heterogeneity of communities, participation and the health care sector. The case studies clearly demonstrated the vast differences, even within the smaller communities like Nipissing District and Renfrew County, in structural and social characteristics and their corresponding approaches to community participation. This implies that although the same decision-making process may be initiated in a number of geographic communities, the approaches taken to influencing this process will differ both among and within communities. In the case of hospital restructuring, however, one can assume an intense, emotional response driven by those threatened most by the outcome of the decision. Although little may be done to alter these approaches a thorough understanding of the community's values and history will at least prepare policy-makers for the community's response or lack of response.

Understanding the community may also help those in the business of enabling participation. At a micro-level, knowledge of the values and characteristics of communities can guide decisions about how to involve the community. Understanding that committee representation and formal organizing works well in Ottawa-Carleton but not in Hamilton-Wentworth, and that the people of Nipissing and Renfrew County are unlikely to embrace involvement in formal decision-making

structures, may produce more meaningful community involvement in local decision. More attention needs to be given to achieving a balance between "voice" and "choice" (Hughes and Larson, 1991) in designing community participation exercises or structures that will reflect the characteristics of communities. Giving "voice" is akin to the consultation exercises described in the health care restructuring cases where community members were invited to provide input into the decision-making process but had no control over the final decision. "Choice", on the other hand, gives members of the community responsibility for the decisions themselves through some decision-making forum such as citizen panels for example. Whether one agrees on its normative value or not, there are some groups in the community who are more content to be consulted in these processes than to take responsibility for the decisions themselves (Abelson et al, 1995). Careful consideration needs to be given, therefore, to the balance that is struck between these approaches so that communities are comfortable with their level of involvement. Given the tremendous opposition to hospital closures observed in this study, it may be inappropriate for any community to be asked to make a decision for themselves on such a contentious issue. Or perhaps, as the Hamilton-Wentworth case illustrated, the community could reach some consensus on the need for hospital closures but it would not be asked to choose which one(s) would close. Although the notion of communities making decisions for themselves is appealing in theory, there are some decisions that may be too painful and too divisive for communities to make (Calabresi and Bobbit, 1978).

The implications of not obtaining the community's "buy-in" on contentious issues can be disastrous as the case of hospital restructuring in Ontario has demonstrated. In one community (not included in the case studies represented here), the local hospital and community have refused to co-operate with the provincial

government's restructuring commission which have not been supported by the community since they were first proposed. By relying on the community to offset 30% of the capital costs associated with implementing the restructuring recommendations through charitable contributions, the community has the power to derail the province's plans. Citing weaknesses in the restructuring commission's methods, health policy experts have argued that "hospital restructuring cannot proceed smoothly without a buy-in from the local community, especially as the local community must raise 30 per cent of the cost ..."(Rusk, 1998).

As Chapters 6 and 7 described, participation is shaped by the institutional structures and the actions taken by those structures that are operating within a community. The presence of an infrastructure for participation in Hamilton-Wentworth and Ottawa-Carleton, for example, influenced the propensity for routine participation in those communities and contributed to an active, engaged citizenry. If this is an objective for governments then consideration needs to be given to making such enabling resources available. This has clearly been shown to be a political decision, however, as the previous left-wing provincial government was a big supporter of community participation and devoted resources to enabling participation at the community level. In contrast, the Conservative government, elected in 1995, has been accused of being hostile to participatory democracy by drastically reducing or eliminating timeframes for public consultation and passing legislation to curtail the powers of school boards.[8]

The analysis of precipitating influences provides a clear message to policy-makers in the health arena that the characteristics of some issues such as hospital

[8] This issue was first discussed in Chapter 1 in the context of the government's introduction of the omnibus bill (Bill 26) in November 1995 without any planned public hearings. Bill 160, passed in January 1998, represents sweeping changes to the education system in Ontario by consolidating most of the power over decision-making in education at the provincial rather than the local level.

closures evoke emotional and intense participation. Failure to communicate the message that a hospital closure does not equal loss of service has been used to explain community reactions to proposed hospital closures. Given the findings of this study, however, it appears that the strong attachment felt toward a hospital's physical site, the fear of losing the beds in it, and a hospital's icon status in the community may be unparalleled on any other issue in any other policy sector. There is perhaps only one obstacle to reform greater than a community's attachment to its local hospital -- that is the opposition mounted by the vested interests in that community.

The heterogeneity findings are also relevant given the recent reduction and amalgamation of school boards that has taken place in Ontario and plans for reductions in the number of DHCs.[9] Expanding school board and health council jurisdictions will increase the challenges of involving communities (if this is a desired objective) in local decision-making. Given the heterogeneity described in the case studies, there is a genuine risk that smaller communities will get lost under a larger board or health council structure.[10]

Many of the study findings presented here lend support to those who favour the preservation of local autonomy in health care and education. They also resonate with the "smaller is better" findings of Dahl and Tufte (1973) in their analysis of size and democracy. The current policy directions of the provincial government in Ontario, however, are clearly at odds with these findings. By reducing the number of school boards and health councils and consolidating power at the provincial level, the government is pursuing an agenda focused on controlling costs and achieving efficiencies at the expense of understanding and incorporating the characteristics and

[9] By April 1, 1998, the number of district health councils in Ontario will be reduced from 33 to 16.
[10] The reader is reminded that this was the very issue around which the Renfrew County Catholic school board mobilized and successfully fought school board amalgamation (i.e., their concern about being swallowed up by a larger board and losing their local identity).

circumstances of heterogeneous communities. Judgements as to whether this course of action is the right one or not will be left to the sphere of political analysis. There are, however, several potential outcomes of pursuing such an agenda that are worth noting. First, those communities with deep divisions and social cleavages will not easily succumb to dilution within larger jurisdictions. Their voices, whether welcomed or not, will continue to be heard, only at a higher level and the provincial government will no longer have the luxury of blaming local decision-makers (i.e., DHCs and school boards) for making unpalatable community decisions. Second, groups will find ways to overcome feelings of dilution. This is already occurring in the education sector as individual schools see their unique qualities being dampened by unwieldy school boards and are pursuing alternative approaches such as charter schools. The merits and pitfalls of these decisions are beyond the scope of this analysis but the fact that they are occurring is noteworthy. Finally, given the course of history that has been followed to date, it is likely that the participation pendulum will swing in the opposite direction in a few years and there will be a renewal of support for participatory democracy.

Avenues for Future Research

The analysis presented throughout these chapters has sought to describe and explain the observed participation in four case study communities while attempting to refrain from placing any value judgements on it. One wonders, though, about the implications of some of these findings. For example, if participatory democracy is judged to be a 'good thing', then is Nipissing being adversely affected by its complacency toward participation? If more active steps were taken to "enable" participation, what would be the result? Does Renfrew County's aggressive and

mean-spirited approach to community participation around hospital closures suggest that it is a community where participation that is more 'civic minded' cannot occur and where collaborative problem solving can never be achieved? If so, what does this imply for future decision-making processes that are to take place in these communities?

The questions posed above illustrate the exploratory nature of the research presented here and the recognition that although much has been learned about the factors that shape the participation of communities in local decision making there are still many unanswered questions that remain on the subject. It is always easy to tempt a researcher to think about future studies. Given the exploratory nature of this inquiry there are many potential avenues that could be considered in developing a programme of research in this area. Keeping in mind that such a programme is being considered in the context of the Canadian health care system, the first avenue might involve survey work in each of the case study areas to bolster and augment the qualitative material gathered through the case studies. The survey would mirror some of the questions asked during the interviewing process to provide a clearer understanding of some of the relationships described in this analysis. For example, more work needs to be done in the area of community cohesion to confirm the findings of this study regarding the presence of strong community values and to determine whether there is a relationship between these factors and the observed participation.[11] A second area would focus on refining the dimensions of participation developed in Chapter 3 with the objective of developing a more robust tool that could account more systematically for both the qualitative and quantitative dimensions of participation. The consideration of both qualitative and quantitative dimensions of participation in this

analysis represents a significant methodological contribution to the participation literature and addresses a major weakness of prior studies that have ignored the context of participation (Leighley, 1995). The difficulties encountered in using the typology to summarize and compare participation in the case studies, however, signal a need for more conceptual and empirical work in this area.

The utility of such a tool, were it refined, would depend on the availability of more reliable participation data, an area of weakness that has already been identified and for which recommendations for improvement were made earlier in this chapter (see "Reflections on the Methodology – the problem with secondary data"). Better methods for collecting routine participation data are badly needed. Future research might involve interviewing decision-makers to better understand the barriers they face to collecting participation data and to evaluate different approaches to improving data collection in this area.

A third element would explore in greater detail some of the specific themes highlighted by the research. For example, the relationship between social capital and instrumental participation deserves more careful investigation. We are still not entirely sure why Nipissing, for example, demonstrates many features of a civic-minded community (e.g., blood donation, newspaper readership, voluntarism) but does not appear to engage in the political affairs of the community. Another avenue of research might be the development of more valid and reliable indicators of social capital. Blood donation data provided some insights into the voluntary characteristics of communities but more work could be done to refine these measures. Similarly, while comparability problems compromised the ability to obtain information about the density of community organizations, this data could be obtained through

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[11] There is strong potential for this work to be conducted in conjunction with survey work on a similar subject being carried out elsewhere in Canada. A modified survey instrument could be administered in

community surveys such as the one conducted in Hamilton-Wentworth (Abelson and Veenstra, 1996). An even broader approach to this theme, and one that would have significant policy relevance, would be to examine the conditions necessary for communities to engage in collaborative and co-operative decision-making processes as opposed to divisive and competitive ones. Although many of the tough decisions regarding health care restructuring have been made in Ontario, many of the same issues will arise during the process of implementing these decisions and, as this analysis has suggested, some communities will be better equipped than others to take on these tasks. These are just a few suggestions for future studies in this area. As with its past, the future of participation will be accompanied by continued widespread interest and lively debate from social scientists, decision-makers and practitioners, one and all.

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the case study areas included in this research.

References to Chapter 9

Abelson, J., Lomas, J., Eyles, J., Birch, S. and Veenstra, G. (1995). Does the Community Want Devolved Authority? Results of Deliberative Polling in Ontario. *Canadian Medical Association Journal*, 153(4), 403-12.

Abelson, J. and Veenstra, G. (1996). *Describing the Associational Life of a Community: A Survey of Community Organizations in Hamilton-Wentworth.* Hamilton, Ontario.

Alford, R. (1975). *Health Care Politics: Ideological and Interest Group Barriers to Reform.* Chicago: University of Chicago Press.

Berry, J., Portney, K. and Thomson, K. (1993). *The Rebirth of Urban Democracy.* Washington: Brookings Institution.

Calabresi, G. and Bobbit, P. (1978). *Tragic Choices.* New York: Norton and Co.

Dahl, R. and Tufte, E. (1973). *Size and Democracy.* Stanford, California: Stanford University Press.

Gittell, M. (1980). Limits to Citizen Participation: The Decline of Community Organization. Beverly Hills, California: Sage.

Hughes, T. and Larson, L. (1991). Patient Involvement in Health Care: A Procedural Justice Viewpoint. *Medical Care*, 29(3), 293-303.

O'Neill, M. (1992). Community Participation in Quebec's Health System: A Strategy to Curtail Community Empowerment? *International Journal of Health Services*, 22 (2), 287-301.

Parry, G., Moyser, G. and Day, N. (1992). *Political Participation and Democracy in Britain.* Cambridge: Cambridge University Press.

Postman, N. (1988). Social Science as Moral Theology. In: *Conscientious Objections*, pp.3-19. New York: Knopf, Inc.

Putnam, R. (1993). *Making Democracy Work: Civic Traditions in Modern Italy.* Princeton: Princeton University Press.

Rasmussen, K. Institutional Change and Policy Outcomes: District Health Boards in Saskatchewan. Paper presented to the Canadian Political Science Association Annual Meeting, June 2-4, 1996. St. Catharines, Ontario.

Robertson, A. and Minkler, M. (1994). New Health Promotion Movement: A Critical Examination. *Health Education Quarterly*, 21 (3), 295-312.

Rusk, J. (1998). Hospital board refuses to go along with shakeup. *Toronto Globe and Mail*, March 21, A3.

Saul, J.R. (1995). *The Unconscious Civilization*. Concord, Ontario: Anansi Press Limited.

Schlesinger, M. (1997). Paradigms Lost: The Persisting Search for Community in U.S. Health Policy. *Journal of Health Politics, Policy and Law*, 22 (4), 937-992.

Schlozman, K., Verba, S. and Brady, H. (1995). Participation's not a Paradox: The View from American Activists. *British Journal of Political Science*, 25, 1-36.

Short, S. (1989). Community Participation or Community Manipulation? A Case Study of the Illawarra Cancer Appeal-A-Thon. *Community Health Studies*, Vol XIII (1), 34-38.

Tuohy, C. and Evans, R.G. (1984). Pushing on a String: The Decentralization of Health Planning in Ontario. In: *The Costs of Federalism*. Golembiewski, R. and Widawsky, A. eds. New Brunswick, N.J.:Transaction Books, 89-116.

Veenstra, G. and Lomas, J. (1996). Home is Where the Governing Is: Social Capital and Regional Health Governance. Centre for Health Economics and Policy Analysis Health Policy Commentary C96-1, CHEPA, McMaster University.

Schlozman, K., Verba, S. and Brady, H. (1995). Participation's not a Paradox: The View from American Activists. *British Journal of Political Science*, 25, 1-36.

Bibliography

Articles

Abbott, J. (1995). Community Participation and its relationship to Community Development. *Community Development Journal*, 30, 158-68.

Abelson, J. and Lomas, J. (1996). In Search of Informed Input: A Systematic Approach to Involving the Public in Community Decision Making. *Health Care Management Forum*, 9 (4), 48-52.

Abelson, J., Lomas, J., Eyles, J., Birch, S. and Veenstra, G. (1995). Does the Community Want Devolved Authority? Results of Deliberative Polling in Ontario. *Canadian Medical Association Journal*, 153(4), 403-12.

Arnstein, S. (1969). A Ladder of Citizen Participation. *Journal of the American Institute of Planners*. 35, 216-24.

Aronson, J. (1993). Giving Consumers a Say in Policy Development: Influencing Policy or Just Being Heard? *Canadian Public Policy*, XIX:4:367-78.

Bachrach, K. and Zautra, A. (1985). Coping with a Community Stressor: The Threat of a Hazardous Waste Facility. *Journal of Health and Social Behaviour*, 26, 127-41.

Berry, J., Portney, K., Bablitch, M. and Mahoney, R. (1984). Public Involvement in Administration: The Structural Determinants of Effective Citizen Participation. *Journal of Voluntary Action Research*, 13, 7-23.

Bjorkman, J.W. (1985). Who Governs the Health Sector? Comparative European and American Experiences with Representation, Participation and Decentralization. *Comparative Politics*, 17, 399-420.

Bolland, J. and Redfield, K. (1988). The Limits to Citizen Participation in Local Education: A Cognitive Interpretation. *Journal of Politics*, 50, 1033-46.

Boix, C. and Posner, D. (1996). Making Social Capital Work: A Review of Robert Putnam's *Making Democracy Work: Civic Traditions in Modern Italy.* Working Paper No. 96-4, Center for International Affairs, Harvard University.

Brannstrom, I., Emmelin, M., Dahlgren, L., Johanssoon, M. and Wall, S. (1994). Co-operation, participation and conflicts faced in public health -- lessons learned from a long-term prevention programme in Sweden. *Health Education Research*, 9, 317-29.

Bridgeland, W. and Sofranko, A. (1975). Community Structure and Issue-Specific Influences: Community Mobilization over Environmental Quality. *Urban Affairs Quarterly*, 11, 186-214.

Brodie, M. (1996). Americans' Political Participation in the 1993-94 National Health Care Reform Debate. *Journal of Health Politics, Policy and Law*, 21, 99-128.

Bryden, K. (1982). Public input into policy-making and administration: the present situation and some requirements for the future. *Canadian Public Administration*, 25, 81-107.

Charles, C. and DeMaio, S. (1993). Lay Participation in Health Care Decision Making: A Conceptual Framework. *Journal of Health Politics, Policy and Law*, 18 (4), 881-904.

Checkoway, B. and Doyle, M. (1980). Community Organizing Lessons for Health Care Consumers, *Journal of Health Politics, Policy and Law*, 5 (2), 13-26.

Checkoway, B. (1982). The Empire Strikes Back: More Lessons for Health Care Consumers. *Journal of Health Politics, Policy and Law*, 7 (1), 111-24.

Checkoway, B. (1982). Public Participation in Health Planning Agencies: Promise and Practice, *Journal of Health Politics, Policy and Law*, 7 (3), 723-33.

Checkoway, B., O'Rourke, T. and Bull, D. (1984). Correlates of Consumer Participation in Health Planning Agencies: Findings and Implications from a National Survey. *Policy Studies Review*, 3, 296-310.

Cook, J. (1983). Citizen Response in a Neighborhood Under Threat. *American Journal of Community Psychology*, 11, 459-71.

Cooper, T. (1979). The Hidden Price Tag: Participation Costs and Health Planning. *American Journal of Public Health*, 69, 368-74.

Crosby, N., Kelly, J. and Schaefer, P. (1986). Citizen panels: A new approach to citizen participation. *Public Administration Review*, 46, 170-78.

Dahl, R. (1994). A Democratic Dilemma: System Effectiveness versus Citizen Participation, *Political Science Quarterly*, 109 (1), 23-34.

Davidson, W. and Cotter, P. (1989). Sense of Community and Political Participation. *Journal of Community Psychology*, 17, 119-25.

Eagles, M. and Erfle, S. (1989). Community Cohesion and Voter Turnout in English Parliamentary Constitutencies, *British Journal of Political Science*, 19, 115-25.

Eyles, J. (1993). The Role of the Citizen in Health Care Decision-Making, McMaster University Centre for Health Economics and Policy Analysis Policy Commentary Series C93-1, June 1993.

Fischer, F. (1993). Citizen Participation and the Democratization of Policy Expertise: From theoretical inquiry to practical cases. *Policy Sciences*, 26, 165-87.

Green, L. (1986). The Theory of Participation: A Qualitative Analysis of its Expression in National and International Health Policies. *Advances in Health Education and Promotion*, 1, 211-36.

Guest, A. (1984). Robert Park and the Natural Area: A Sentimental Review. *Sociology and Social Research*, 69, 1-21.

Gulati, P. (1982). Consumer Participation in Administrative Decision Making. *Social Service Review*, 56:72-84.

Haeberle, S. (1987). Neighborhood Identity and Citizen Participation. *Administration and Society*, Vol. 19, No. 2, 178-96.

Heller, K. (1992). Ingredients for Effective Community Change: Some Field Observations. *American Journal of Community Psychology*, 20, 143-63.

Hughes, T. and Larson, L. (1991). Patient Involvement in Health Care: A Procedural Justice Viewpoint. *Medical Care*, 29(3), 293-303.

Hurley, J., Birch, S. and Eyles, J. Geographically-decentralized Planning and Management in Health Care: some informational issues and their implications for efficiency. *Social Science and Medicine*,

Hutcheson, J. and Prather, J. (1988). Community Mobilization and Participation in the Zoning Process. *Urban Affairs Quarterly*, 23 (3), 346-68.

Jewkes, R. and Murcott, A. (1996). Meanings of Community. *Social Science and Medicine*. 43 (4), 555-63.

Johnson, W. (1984). Citizen Participation in Local Planning in the U.K. and U.S.A.: A Comparative Study, *Progress in Planning*, 21, 151-221.

Kathlene, L. and Martin, J. (1991). Enhancing Citizen Participation: Panel Designs, Perspectives and Policy Formation, *Journal of Policy Analysis and Management*, 10 (1), 46-63.

Keefer, J. (1993). The News Media's Failure to Facilitate Citizen Participation in the Congressional Policy-Making Process, *Journalism Quarterly*, 70 (2), 412-24.

Kraft, M. and Clary, B. (1990). Citizen Participation and the NIMBY Syndrome: Public Response to Radioactive Waste Disposal. *The Western Political Quarterly*, 299-328.

Krannich, R. and Humphrey, C. (1986). Using Key Informant Data in Comparative Community Research. *Sociological Methods and* Research, 14 (4), 473-93.

Kweit, R. and Kweit, M. (1987). Citizen Participation: Enduring Issues for the Next Century, *National Civic Review*, 76, 191-8.

Lee, B., Oropesa, R., Metch, B., Guest, A. (1984). Testing the Decline-of-Community Thesis: Neighborhood Organizations in Seattle, 1929 and 1979. *American Journal of Sociology*, 90 (5), 1161-88.

Leighley, J. (1995). Attitudes, Opportunities and Incentives: A Field Essay on Political Participation. *Political Research Quarterly*, 48, 181-209.

Leighley, J. (1996). Group Membership and the Mobilization of Political Participation. *The Journal of Politics*, 58, 447-63.

Light, D. (1997). The Rhetorics and Realities of Community Health Care: The Limits of Countervailing Powers to Meet the Health Care Needs of the Twenty-First Century. *Journal of Health Politics, Policy and Law*, 22 (1), 105-45.

Lomas, J. and Veenstra, G. (1995). If You Build It Who Will Come? *Policy Options*, November 1995, 37-40.

Lomas, J., Woods, J. and Veenstra, G. (1997). Devolving authority for health care in Canada's provinces: 1. An introduction to the issues. *Canadian Medical Association Journal*, 156 (3), 371-77.

Lomas, J. (1997). Devolving authority for health care in Canada's provinces: 4. Emerging issues and prospects. *Canadian Medical Association Journal*, 156 (6), 817-23.

Marmor, T. and Morone, J. (1980). Representing Consumer Interests: Imbalanced Markets, Health Planning and the HSAs, *Milbank Memorial Fund Quarterly/Health and Society*, 58(1), 125-165.

Marmor, T. and Wittman, D. (1976). Politics of Medical Inflation. *Journal of Health Politics, Policy and Law*, 1 (Spring), 69-83.

Massey, I. (1994). Impediments to Collective Action in a Small Community. *Politics and Society*, 22(3), 421-34.

McKnight, J. and Kretzmann, J. (1990). *Mapping Community Capacity*. Evanston, Ill.: Centre for Urban Affairs and Policy Research Report, Northwestern University.

McMillan, D. and Chavis, D. (1986). Sense of Community: A Definition and Theory. *Journal of Community Psychology*, 14, 6-23.

McNamee, S. and Swisher, K. (1985). Neighborhood Decentralization and Organized Citizen Participation, *Sociological Focus* 18, 4, 301-12.

Newton, K. (1982). Is Small Really so Beautiful? Is Big Really so Ugly? Size, Effectiveness, and Democracy in Local Government. *Political Studies*, 30 (2), 190-206.

Notkin, H. and Notkin, M.S. (1970). Community Participation in Health Services: A Review Article. *Medical Care Review*, 27, 1178-1201.

Oliver, P. (1984). If you don't do it, nobody else will: Active and Token Contributors to Local Collective Action. *American Sociological Review*, 49, 601-10.

O'Neill, M. (1992). Community Participation in Quebec's Health System: A Strategy to Curtail Community Empowerment? *International Journal of Health Services*, 22 (2), 287-301.

Oropesa, R. (1992). Social Structure, Social Solidarity and Involvement in Neighborhood Improvement Associations. *Sociological Inquiry*, 62, 107-18.

Petracca, M. (1991). The Rational Choice Approach to Politics: A Challenge to Democratic Theory. *The Review of Politics*, 53, 289-319.

Petracca, M. (1993). Tilling the Field of Interest Group Research: An Overview of New Insights. *Perspectives on Political Science* 22 (2), 61-9.

Phillips, S. (1993). Of Public Interest Groups and Sceptics: A Realists' Reply to Professor Stanbury. *Canadian Public Administration*, 36, 606-616.

Plante-Perkins, A. (1995). "Parent Council, School Council, Parent Advisory Council-What's in a Name? Plenty! *Parents Magazine.*

Putnam, R. (1995). Bowling Alone. *Journal of Democracy*, 6, 65-78.

Rasmussen, K. Institutional Change and Policy Outcomes: District Health Boards in Saskatchewan. Paper presented at the Canadian Political Science Association Annual Meeting, June 1996.

Renn, O., Webler, T., Rakel, H., Dienel, P. and Johnson, B. (1993). Public Participation in Decision-Making: A Three-Step Procedure. *Policy Sciences*, 26, 189-214.

Riska, E. and Taylor, J. (1978). Consumer Attitudes Toward Health Policy and Knowledge About Health Legislation, *Journal of Health Politics, Policy and Law.* 3, 112-23.

Robertson, A. and Minkler, M. (1994). New Health Promotion Movement: A Critical Examination. *Health Education Quarterly*, Vol. 21 (3), 295-312.

Rossow, M. and Dunwoody, S. (1991). Inclusion of "Useful" Detail in Newspaper Coverage of a High-Level Nuclear Waste Siting Controversy. *Journalism Quarterly*, 68, 87-100.
Salisbury, R. (1975). Research on Political Participation. *American Journal of Political Science*. 19:323-41.

Sampson, R. (1991). Linking the Micro- and Macrolevel Dimensions of Community Social Organization. *Social Forces*, 70, 43-64.

Sarason, S.B. (1974). *The Psychological Sense of Community: Perspectives for Community Psychology*. San Francisco: Jossey-Bass.

Scavo, C. (1993). The Use of Participative Mechanisms by Large U.S. Cities. *Journal of Urban Affairs*, 15 (1), 93-109.

Schlesinger, M. (1997). Paradigms Lost: The Persisting Search for Community in U.S. Health Policy. *Journal of Health Politics, Policy and Law*, 22 (4), 937-992.

Schlozman, K., Verba, S. and Brady, H. (1995). Participation's Not a Paradox: The View from American Activists. *British Journal of Political Science* 25, 1-36.

Sharp, E. (1982). Citizen-Initiated Contacting of Government Officials and Socioeconomic Status: Determining the Relationship and Accounting for it. *The American Political Science Review*, 76, 109-115.

Short, S. (1989). Community Participation or Community Manipulation? A Case Study of the Illawarra Cancer Appeal-A-Thon. *Community Health Studies*, Vol XIII (1), 34-38.

Shiell, A. and Hawe, P. (1996). Health Promotion, Community Development and the Tyranny of Individualism. *Health Economics*, 5, 241-7.

Smith, L. (1982). Mechanisms for Public Participation at a Normative Planning Level in Canada. *Canadian Public Policy*, 8 (4), 561-72.

Stanbury, W.T. (1993). A Sceptic's Guide to the Claims of So-Called Public Interest Groups. *Canadian Public Administration*, 36, 580-605.

Thomas, J. (1982). Citizen-Initiated Contacts with Government Agencies: A Test of Three Theories. *American Journal of Political Science*, 26 (3), 504-22.

Thomas, J. (1993). Public Involvement and Governmental Effectiveness. *Administration and Society*, 24, 444-69.

Thompson, B., Wallack, L., Lichtenstein, E. and Pechacek, T. (1991). Principles of Community Organization and Partnership for Smoking Cessation in the Community Intervention Trial for Smoking Cessation. *International Quarterly of Community Health Education*, 11, 187-203.

Vedlitz, A., Dyer, J. and Durand, R. (1980). Citizen Contacts with Local Governments: A Comparative View. *American Journal of Political Science*, 24, 50-67.

Vedlitz, A. and Veblen, E. (1980). Voting and Contacting: Two Forms of Political Participation in a Suburban Community. *Urban Affairs Quarterly*, 16, 31-48.

Veenstra, G. and Lomas, J. (1996). Home is Where the Governing Is: Social Capital and Regional Health Governance. Centre for Health Economics and Policy Analysis Health Policy Commentary C96-1, CHEPA, McMaster University.

Verba, S. Scholzman, K., Brady, H. and Nie, N. (1993). Citizen Activity: Who Participates? What do they Say? *American Political Science Review*, 87, 2, 303-18.

Wandersman, A. and Giamartino, G. (1980). Community and Individual Difference Characteristics as Influences on Initial Participation. *American Journal of Community Psychology*, 8, 217-28.

Wandersman, A., Florin, P., Friedmann, R. and Meier, R. (1987). Who Participates, Who Does Not, and Why? An Analysis of Voluntary Neighborhood Organizations in the United States and Israel. *Sociological Forum*, 2, 534-555.

Wandersman, A. and Hallman, W. (1993). Are People Acting Irrationally? Understanding Public Concerns about Environmental Threats. *American Psychologist*, 48(6), 681-6.

Whiteley, P. (1995). Rational Choice and Political Participation -- Evaluating the Debate. *Political Research Quarterly*, 48(1), 211-33.

Books

Alford, R. (1975). *Health Care Politics: Ideological and Interest Group Barriers to Reform.* Chicago: University of Chicago Press.

Almond, G.A. and Verba, S. (1965). *The Civic Culture: Political attitudes and democarcy in 5 nations.* Boston: Little Brown & Co. 379 pp.

Almond, G. (1989). *The Civic Culture Revisited.* Newbury Park California: Sage Publications.

Aristotle. (1988). *The Politics.* Edited by S. Everson. Cambridge: Cambridge University Press.

Barber, B. (1984). *Strong Democracy.* Berkeley: University of California Press.

Bell, D. (1993). *Communitarianism and its Critics.* Oxford: Oxford University Press.

Bellah, R., Masden, R., Sullivan, W., Swidler, A. and Tipton, S. (1985). *Habits of the Heart.* Berkeley: University of California Press.

Berry, J., Portney, K. and Thomson, K. (1993). *The Rebirth of Urban Democracy.* Washington: Brookings Institution.

Bookchin, M. (1995). *From Urbanization to Cities.* London: Cassell.

Bracht, N. (ed.) (1990). *Health Promotion at the Community Level.* Sage: Newbury Park.

Carr-Saunders, A.M. and Wilson, P.A. (1933). *The Professions.* Oxford: Clarendon Press.

Calabresi, G. and Bobbit, P. (1978). *Tragic Choices.* New York: Norton and Co.

Checkoway, B. ed. (1981). *Citizens and Health Care.* New York: Pergamon Press, Inc.

Cole, R. (1974). *Citizen Participation and the Urban Policy Process.* Lexington, Mass: D.C. Health and Company.

Creswell, J. (1994). *Research Design: Qualitative and Quantitative Approaches.* Thousand Oaks, California: Sage Publications.

Dahl, R. (1956). *A Preface to Democratic Theory.* Chicago, Ill.: University of Chicago Press.

Dahl, R. (1961). *Who Governs? Democracy and Power in an American City.* New Haven and London: Yale University Press.

Dahl, R. and Tufte, E. (1973). *Size and Democracy.* Stanford, California: Stanford University Press.

DeSario, J. and Langton, S. eds. (1987). *Citizen Participation in Public Decision-Making.* New York: Greenwood Press.

De Tocqueville, A. (1839). *Democracy in America.*

Etzioni, A. (1993). *The Spirit of Community: Rights, Responsibilities, and the Communitarian Agenda.* Crown Publishers, Inc.

Fishkin, J. (1991). *Democracy and Deliberation.* New Haven: Yale University Press.

Freidson, E. (1970). *Profession of Medicine: A Study of the Sociology of Applied Knowledge.* New York: Dodd & Mead.

Gittell, M. (1980). Limits to Citizen Participation: The Decline of Community Organization. Beverly Hills, California: Sage.

Herman, E. and Chomsky, N. (1988). *Manufacturing Consent.* New York: Pantheon Books.

Henig, J.R. (1982). *Neighborhood Mobilization.* New Brunswick, New Jersey: Rutgers University Press.

Hunter, A. and Suttles, G. (1972). The Expanding Community of Limited Liability, pp.44-81. In: *The Social Construction of Communities.* Chicago: University of Chicago Press.

Janowitz, M. (1967). *The Community Press in an Urban Setting: The Social Elements of Urbanism.* Chicago: University of Chicago Press.

Jordan, A.G. and Richardson, J.J. (1987). *Government and Pressure Groups in Britain.* Oxford: Clarendon Press.

Kemmis, D. (1990). *Community and the Politics of Place*. Norman, Oklahoma: University of Oklahoma Press.

King, G., Keohane, R. and Verba, S. (1994). *Designing Social Inquiry: Scientific Inference in Qualitative Research.* Princeton: Princeton University Press.

Klein, R. and Lewis, J. (1976). *The Politics of Consumer Representation: A Study of Community Health Councils*. London: Centre for Studies in Social Policy.

Kweit, M. and Kweit, R. (1981). *Implementing Citizen Participation in a Bureaucratic Society*. New York: Praeger Publishers.

Langton, S. ed. (1978). *Citizen Participation in America.* Lexington: Lexington Books.

Lofland, J. and Lofland, L. (1995). *Analyzing Social Settings : A Guide to Qualitative Observation and Analysis.* Belmont, California: Wadsworth Publishing Company.

Lukes, S. (1974). The one-dimensional view. The two-dimensional view. The three-dimensional view. (Chapters 2-4). In: *Power: A Radical View.* Oxford: Macmillan, pp.11-25.

Lukes, S. (1986). Introduction. Chapter 1. In: *Power*. New York: New York University Press.

Mansbridge, J. (1990). *Beyond Self-Interest.* Chicago: University of Chicago Press.

Milbrath, L. and Goel, M. (1977). *Political Participation.* Chicago: Rand McNally Publishing Company.

Morone, J. (1990). *The Democratic Wish.* United States: Basic Books.

Olson, M. (1971). *The Logic of Collective Action.* London: Oxford University Press.

Park, R. (1952). *Human Communities: The City and Human Ecology*. Glencoe, Ill.: Free Press.

Parry, G. (1972). *Participation in Politics*. Manchester: Manchester University Press.

Parry, G., Moyser, G. and Day, N. (1992). *Political Participation and Democracy in Britain*. Cambridge: Cambridge University Press.

Pateman, C. (1970). *Participation and Democratic Theory.* Cambridge: Cambridge University Press.

Patton, M. (1990). *Qualitative Evaluation and Research Methods.* Newbury Park, California: Sage Publications.

Pitkin, H. (1967). *The Concept of Representation.* Berkeley: University of California Press.

Polsby, N. (1963). *Community Power and Political Theory.* New Haven and London: Yale University Press.

Postman, N. (1988). Social Science as Moral Theology. In: *Conscientious Objections*, pp.3-19. New York: Knopf, Inc.

Pross, A. P. (1986). *Group Politics and Public Policy.* Toronto: Oxford University Press.

Putnam, R. (1993). *Making Democracy Work: Civic Traditions in Modern Italy.* Princeton: Princeton University Press.

Richardson, A. (1983). *Participation.* London: Routledge & Kegan Paul.

Salisbury, R. (1980). *Citizen Participation in the Public Schools.* Lexington, Mass.:D.C. Heath and Company.

Sandel, M. (1996). *Democracy's Discontent: America in Search of a Public Philosophy.* Cambridge, Mass.: Harvard University Press.

Saul, J.R. (1995). *The Unconscious Civilization.* Concord, Ontario: Anansi Press Limited.

Schattschneider, E.E. (1960). *The Semisovereign People.* Hinsdale, Ill.: Dryden Press

Sen, A. (1987). *On Ethics and Economics.* Oxford; New York, NY, USA: B. Blackwell.

Stake, R. (1995). *The Art of Case Study Research.* London: SAGE Publications.

Thomas, J. (1986). *Between Citizen and City.* Lawrence, Kansas: University Press of Kansas.

Titmuss, R. (1971). The Gift. In: *The Gift Relationship: From Human Blood to Social Policy*, 70-89. New York: Pantheon Books.

Truman, D. (1951). *The Governmental Process.* New York: Knopf.

Verba, S. and Nie, N. (1972). *Participation in America: Political Democracy and Social Equality.* New York: Harper and Row Publishers.

Verba, S., Nie, N. and Kim, J. (1978). *Participation and Political Equality*. Cambridge: Cambridge University Press.

Walzer, M. (1980). *Radical Principles*. New York: Basic Books, Inc.

Wilson, J.Q. (1973). *Political Organizations*. New York: Basic Books.

Yin, Robert. (1994). *Case Study Research: Design and Methods*. London: SAGE Publications.

Yin, Robert. (1993). *Applications of Case Study Research*. London: SAGE Publications.

Zorbaugh, H. (1929). *The Gold Coast and the Slum*. Chicago: University of Chicago Press.

Book chapters

Checkoway, B. (1981). Innovative Citizen Participation in Health Planning Agencies. In Checkoway, B. (ed). *Citizens and Health Care*. New York: Pergamon Press, Inc., 118-38.

Checkoway, B. and Van Til, J. (1978). What do we know about Citizen Participation? In: *Citizen Participation in America* (S. Langton, ed.), 25-42. Lexington: Lexington Books.

Immergut, E. (1992). The Swiss Case: Referendum Politics. In: Immergut, E. *Health Politics: Interests and Institutions in Western Europe*, 129-78. Cambridge: Cambridge University Press,.

Immergut, E. (1992). The Rules of the Game: The logic of health policy-making in France, Switzerland and Sweden. In: *Structuring Politics: Historical Institutionalism in Comparative Analysis* (Steinmo, S., Thelen, K. and Longstreth, F., eds.), 57-89. Cambridge: Cambridge University Press.

Kohn, R. and White, K. eds. (1976). Pre-Disposing and Enabling Factors. In: *Health Care: An International Study*, 41-57, London: Oxford University Press.

Minkler, M. (1990). Improving Health through Community Organization. In: *Health Behaviour and Health Education: Theory, Research and Practice* (K. Glanz, F.M. Lewis and B.K. Rimer , eds.), 257-87. San Francisco: Jossey-Bass Publishers.

Salisbury, R. (1980). Modes of Participation and Policy Impact in American Education. In Foster, C. (ed.) *Comparative Public Policy and Citizen Participation*, 99-116. Oxford: Pergammon Press.

Sears, D. and Funk, C. (1991). The Role of Self-Interest in Social and Political Attitudes. In: Zanna, M. ed. *Advances in Experimental Social Psychology*, 2-80. San Diego, California: Academic Press, Inc.

Tuohy, C. and Evans, R.G. (1984). Pushing on a String: The Decentralization of Health Planning in Ontario. In: *The Costs of Federalism.* (Golembiewski, R. and Widawsky, A. eds.), 89-116. New Brunswick, N.J.:Transaction Books.

Documents

Association of District Health Councils of Ontario. (1994). *Citizen Participation in the Local Planning Process: Broadening the Spectrum.* Toronto: ADHCO.

Canadian Medical Association. (1993). *The Language of Health System Reform: Report of the Working Group on Regionalization and Decentralization.* Ottawa: Canadian Medical Association.

Government of Ontario. (1995). *Interim Report of the Ontario School Board Reduction Task Force.* Toronto.

Hamilton-Wentworth Roman Catholic Separate School Board. By-laws and Regulations. Hamilton: HWRCSSB, November 1994.

Office of Technology Assessment. (1992). Evaluation of the Oregon Medicaid Proposal. Washington: United State Congress.

Renfrew County Roman Catholic Separate School Board. (1995). *Renfrew County Catholic Schools: Response to the Interim Report of the Ontario School Board Reduction Task Force.*

Royal Commission on Learning. (1995). *For the Love of Learning.* Report of the Royal Commission on Learning. Toronto.

Statistics Canada. 1991. *Profiles of Census Divisions and Subdivisions in Ontario – Part B.* No.95-338. Ottawa: Ministry of Industry, Science and Technology.