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Health Politics And Structural Interests: The Development Of Community Health Centres In Ontario

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HEALTH POLITICS AND STRUCTURAL INTERESTS: THE DEVELOPMENT OF COMMUNITY HEALTH CENTRES IN ONTARIO

by

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Abstract

Health care politics can be understood as a competition among interests for control and power. Traditionally, the medical profession has dominated the health sector because of its monopoly position as the provider of medical services. In Canada, the entrance of government into the medical market as a monopoly purchaser of medical services has challenged the dominant position of the medical profession.

Since the introduction of publicly financed health insurance, politicians and administrators have been concerned with gaining control over the cost of the health care system. A rethinking of the basic policy assumptions has led to efforts to rationalize the delivery of services. This has challenged the professional autonomy of physicians, especially in terms of the fee-for-service method of remuneration and the solo-practice method of organization. As an alternative means of funding and organizing the delivery of primary care, community health centres challenge both of these central aspects of the medical profession.

In Ontario, politicians and administrators have enlisted the support of other interests who might benefit from an alteration of the existing power structure in health care. These interests include corporate rationalist physicians, community-based service providers, local activists and previously repressed consumer interests, such as the poor and

shared-cost arrangement.[6]

2. Structural Interests and Canadian Health Politics

The fragmentation of the state and the diffusion of its power in Canada has resulted in interactions between the state and society in which:

> The citizens and socio-economic interests interacting with the state are not only fashioned into eleven territorial and jurisdictional communities by federalism, but they are also further subdivided into multiple categories by the departmental system of cabinet government, the sub-bureaucratic units within each department, and the host of specific policies that the latter administer."[7]

In this environment, state actors have enlisted the support of their clienteles or potential clienteles as policy communities, which are defined as clusters of "interest groups, associated agencies and interested/or informed individuals" around the lead government agencies in the policy field (see Appendix I).[8]

According to Pross, such communities can be divided into two distinct segments. The sub-government, or inner circle of the policy community, includes those state and private actors

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[6] Taylor, Health Insurance and Canadian Public Policy, 422-28; Carolyn Tuohy, Policy and Politics in Canada: Institutionalized Ambivalence, (Philadelphia: Temple University Press, 1992), 113.

[7] Alan C. Cairns, " The Embedded State: State-Society Relations in Canada," in Keith Banting, ed., State and Society: Canada in Comparative Perspective, (Toronto: University of Toronto Press, 1986), 70.

[8] A. Paul Pross, Group Politics and Public Policy, (Toronto: Oxford University Press, 1986), 68, 290, note 75.

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SETTING THE STAGE

Chapter I

Introduction

Traditionally, the delivery of health services in Canada has been organized to accommodate the needs of the medical profession. The medical model of health care, with its emphasis on curative medicine and hospital-centred care, has been reflected in both the payment mechanisms and the institutional arrangements that have characterized health policies in Canada and other Western nations. An important result of this bias has been the limited impact of alternative models of health care. The medical profession has resisted attempts to reform the health system in ways that challenge its central role.

In spite of this formidable impediment, alternative methods of financing and organizing health services have emerged. One such alternative is the community health centre (CHC), which is a nonprofit health corporation or association, controlled by an elected community board of directors. The community health centre provides "clinical diagnostic, therapeutic, and preventive services to regular, special care and transient patients as well as participatory health promotion to a defined geographic or demographic community."[1]

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[1] Stephen Birch, Jonathan Lomas, Michael Rachlis and Julia Abelson, HSO Performance: A Critical Appraisal of Current Research, Paper 90-1, (Hamilton: McMaster University, Centre for Health Economics and Policy Analysis, 1990), 1.

Usually, these services are provided through a multidisciplinary team of health and social service professionals, and allied workers on a non-fee-for-service or capitation basis, including nurses, doctors, chiropodists, nutritionists and social workers.[2] Medical professional associations have opposed the development of CHCs because they challenge the financial and organizational underpinnings of the traditional modes of delivering care (fee-for-service and solo practice). Nevertheless, CHCs have continued to increase in numbers in the Canadian health care system. One province in particular, Ontario, has recently emphasized the importance of CHCs as a means of reforming the health system. After an initial reluctance to embrace CHCs as a policy alternative, the provincial government in the mid-1980s adopted the organizations as an integral part of a newly articulated health policy strategy.

The purpose of this thesis is to explain the development of CHCs in the province of Ontario. Despite the power and influence of the medical profession in Canadian health policy decision making, CHCs have managed to become an accepted part of the system of health care delivery. This surprising fact can be attributed to the presence of structural interests

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[2] Ibid; Canada, The Community Health Centre in Canada: Report of the Committee on Community Health Centres, 3 volumes, (Ottawa: Information Canada, 1972-73); Ontario Ministry of Health, Community Health Centres: A Picture of Health, June 1993, 9.

within the health policy arena that compete for power and control of the system of service delivery.

A comprehensive overview of federal and Ontario provincial health policy is provided to establish the setting for detailed case studies of CHC development during two distinct time frames within the twenty years, in three Ontario cities and one town. The remainder of this chapter is devoted to developing a framework for analysis.

1. Health Policy in Canada: An Overview

The health care delivery system that has emerged out of fifty years of negotiations among federal and provincial governments, the medical profession, the insurance industry, and farm, labour and women's interests, includes comprehensive coverage for basic services provided in hospitals and by individual physicians operating in solo and group practice. The central means of paying physicians is fee-for-service. The system is funded through cost-sharing arrangements between the federal and provincial levels of government that have varied over time.

The national health policy was introduced in four stages. The first stage began in 1948, with the introduction of a federal program of National Health Grants (grants-in-aid) to provide financial support for a variety of activities including, "health planning, public health, hospital

construction, professional training and other basic services."[3] These were considered as the major infrastructural prerequisites to the establishment of a national health insurance program.

The second stage was initiated with the introduction in 1958 of national hospital insurance, in which the federal and provincial governments agreed to cost sharing arrangements to finance in-patient and out-patient services. Initially, the federal government provided approximately fifty percent of the funding necessary for the construction and operating costs of adequate hospital facilities. Also, the federal government funded ten provincially administered public hospital insurance programs, defined by a broader national health policy. The provinces were required to sign an agreement guaranteeing that they would establish agencies for the "licensing, inspection, and supervision of hospitals and the planning and development of hospital resources, as well as outlining the arrangements for the insuring of the total population."[4]

The third stage commenced in 1966 with the introduction of national medical insurance, in which the federal government agreed to pay fifty percent of the national per capita costs of provincially administered medical insurance programs

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[3] J. E. F. Hastings, "Federal-Provincial Insurance for Hospital and Physician's Care in Canada," International Journal of Health Services, 1, 4, 1971, 402.

[4] Malcolm C. Taylor, "The Canadian Health Insurance Program," Public Administration Review, 33, 1, 1973, 35.

provided that the provincial programs met four criteria: comprehensive coverage of all physicians' services; universal coverage and accessibility for all residents of Canada; public administration of the plans; and portability of benefits within Canada.[5]

A fourth stage of system development began in the mid-1970s as a result of the renegotiation of federal-provincial financial arrangements, after the introduction of universal health care. This renegotiation occurred largely because of a fear by the federal government of the financial implications of an open-ended funding mechanism for health care. The provinces were also dissatisfied with the administrative constraints placed on them by the public health insurance plan.

The net result of negotiations surrounding these concerns was to limit the federal contributions to provincial health insurance plans to the rate of increase in the nominal GNP plus population growth. This was subsequently further restrained by reducing the GNP contribution.

The new arrangements, known as Established Program Financing, left the provinces with all of the risk associated with cost increases beyond the general rate of inflation, GNP and population. The trade-off was the loss of federal control over provincial program developments afforded by the previous

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[5] Malcolm Taylor, Health Insurance and Canadian Public Policy, Second Edition, (Kingston: McGill-Queen's University Press, 1987), 364-65.

shared-cost arrangement.[6]

2. Structural Interests and Canadian Health Politics

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[6] Taylor, Health Insurance and Canadian Public Policy, 422-28; Carolyn Tuohy, Policy and Politics in Canada: Institutionalized Ambivalence, (Philadelphia: Temple University Press, 1992), 113.

[7] Alan C. Cairns, " The Embedded State: State-Society Relations in Canada," in Keith Banting, ed., State and Society: Canada in Comparative Perspective, (Toronto: University of Toronto Press, 1986), 70.

[8] A. Paul Pross, Group Politics and Public Policy, (Toronto: Oxford University Press, 1986), 68, 290, note 75.

who are involved in the routine policy formulation and implementation functions.[9] The attentive public are the remaining state and private actors who may occasionally participate in policy making, but are usually spectators to this activity.[10]The relationship between the state and the rest of the community is characterized as symbiotic.[11]It is manifest in a variety of "cross-cutting alliances".[12]

In the field of health care, policy has been developed from a process of continual negotiation between the major government, medical and non-medical interests in the health policy community. For purposes of the thesis these will be collectively referred to as "structural interests."[13] These interests manifest themselves in the policy community as coalitions of individuals and groups[14] who either do not have to organize to press their demands on the state because they

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[9] Ibid, 98.

[10] Ibid, 99.

[11] Hugh Faulkner, "Pressuring the Executive," Canadian Public Administration, 25, 2, 1982, 240; A. Paul Pross, Group Politics and Public Policy, 70.

[12] Alan Cairns, "The Embedded State," 58.

[13] Robert Alford, Health Care Politics: Ideological and Interest Group Barriers to Reform, (Chicago: University of Chicago Press, 1975), 13-14, uses the term in a similar fashion.

[14] Evert Lindquist, "Public managers and policy communities: learning to meet new challenges," Canadian Public Administration, 35, 2, 1992, 145-54; Paul Sabatier, " An advocacy coalition framework of policy change and the role of policy-oriented learning therein," Policy Sciences, 21, 2, 1988, 131-34.

are served by existing political and institutional structures, or have great difficulty in organizing because they are not well represented by the existing order. In this view the policy community comprises competing coalitions of groups and individuals which "span the sub-government and the attentive public within a policy community, their members trading ideas and information and working in concert in policy debates."[15] What holds each of these coalitions together is a common system of beliefs (basic values, assumptions and perceptions) that is consistently articulated over time.[16]

Both Pross and Sabatier recognize that one set of actors will usually dominate a policy community because it possesses superior resources and power. An important, source of power for this coalition of dominant interests is its ability to create and reinforce the social and political values and institutional practices that are least likely to damage its interests.[17]For Pross, the sub-government, or the decision-making core of governmental and private actors, is the locus of this set of actors.[18] For Sabatier, the dominant coalition

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[15] Evert Lindquist, " Public managers and policy communities: learning to meet new challenges, 146.

[16] Sabatier, " An advocacy coalition framework for policy change and the roles of policy-oriented learning therein," 139.

[17] Alford, Health Care Politics, 17; Peter Bachrach and Morton S. Baratz, Power and Poverty: Theory and Practice, (Toronto: Oxford University Press, 1970), 7.

[18] Pross, Group Politics and Public Policy, 98, 145-49.

may include government agencies, interest groups within the sub-government **and** interest groups and individuals located in the attentive public (see Appendix II).[19]

Despite competition over policy preferences, the dominant interests are unlikely to be dislodged under normal circumstances because the policy community in which they operate has developed " a mobilization of bias, [which is] a set of predominant values, beliefs, rituals and institutional procedures ('rules of the game') that operate systematically and consistently"[20] to the benefit of one coalition of interests at the expense of others. Accordingly, the core of government policies will remain largely unchanged and the balance of power and resources will remain relatively stable unless some external shock, such as change in socio-economic conditions or technology, arises to alter "the causal assumptions of present policies ... [or] the political support of various advocacy coalitions."[21] Internal conflict is easier to manage because it usually involves the assimilation of new actors. This is achieved through a process of mutual

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[19] Sabatier, "An advocacy coalition framework and the role of policy-oriented learning therein," 131.

[20] Peter Bachrach and Morton S. Baratz, Power and Poverty: Theory and Practice, (Toronto: Oxford University Press, 1970), 44.

[21] Sabatier, "An advocacy coalition framework and the role of policy-oriented," 136.

accommodation.[22]

In Canada, this tendency is reinforced by the weight of prevailing institutional patterns and policies. The vested interests of both the bureaucracy resulting from cumulative policy development, and the major private groups who have been affected by and have in turn helped to shape government policies, bias the system against radical reforms.[23]The fragmentation of the state and society under the federal system has made the mobilization of "diffuse support" for policy change a difficult task. Change, therefore, tends to operate around the margins of established policies.[24]Policy development tends to be characterized by incremental and periodic responses to challenges or threats.[25]

In such a complex environment, politicians or public administrators may act as both "policy brokers"[26] concerned

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[22] Pross, Group Politics and Public Policy, 242.

[23] Alan C. Cairns, "The Embedded State," 80-1; Banting, The Welfare State and Canadian Federalism, 213; John E. F. Hastings and Eugene Vayda, "Health Services Organization and Delivery: Promise and Reality," in Robert G. Evans and Greg L. Stoddart, eds., Medicare at Maturity: Achievements, Lessons and Challenges, Calgary: Banff Centre School of Management, 1986, 375; Tuohy, Policy and Politics in Canada, 122-29; Alice Sardell, The Institutionalization of Reform: An Analysis of Federal Support of Neighborhood Health Centres, 1965-1980, New York University, Ph.D. 1980, 15.

[24] Cairns, "The Embedded State," 69.

[25] Lindquist, "Public managers and policy communities," 150.

[26] Paul Sabatier, "An advocacy coalition framework of policy change and the role of policy-oriented learning therein," Policy Sciences, 21, 1988, 141; Pross, Group

with maintaining a policy consensus through mutual adjustment and accommodation or they may act as "an agent of policy change."[27] However, ministers in responding to external pressures for policy change may face significant opposition from the existing entrenched interests. Increasingly, the state must move unilaterally to implement change when achieving a consensus is no longer possible.[28]

While the weight of existing policy hinders radical reform efforts, Canadian policy communities (post-1960) have been affected by "fundamental changes in the country's social, economic and political systems [including] the spread of new technologies; urbanization; ... the decline of traditional communities; [and] general changes in life style."[29] Such changes have altered relationships between public and private interests, in such a way that the state has taken a much more direct role in the planning and management of the economy.

Politics and Public Policy, 239.

[27] Andrew F. Johnson, "A Minister as an Agent of Policy Change: the Case of Unemployment Insurance in the Seventies," Canadian Public Administration, 24, 4, 1981.

[28] Hugh G. Thorburn, Group Representation in the Federal State: The Relationships Between Canadian Governments and Interest Groups, Volume 69 of the research studies prepared for the Royal Commission on the Economic Union and Development Prospects for Canada, (Toronto: University of Toronto Press, 1985), 60-62.

[29] Pross, Group Politics and Public Policy, 242.

2.1 Dominant Interests

The medical profession has traditionally maintained a dominant structural position in the health care policy community by virtue of its occupational monopoly.[30] This control has extended over the major aspects of production and distribution. In turn, organized medicine has been served and legitimated by the existing social, economic and political institutions. In essence the power generated by the control of specialized knowledge has aided in legitimating the claim of the profession to a central and indispensable role in the delivery of health care services. This legitimacy is reflected in political, legal and economic institutions which serve the dominant interests.[31]

By conferring legal self-regulatory status on the medical profession, the state has played an important role in legitimating the legalized monopoly of expertise upon which the dominant position of the medical profession in Canada has been based. This state-supported position has not been easily

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[30] C. David Naylor, Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911-1966, (Kingston: McGill-Queen's University Press, 1986), 12; Carolyn Tuohy and Patricia O'Reilly, "Professionalism in the Welfare State," Journal of Canadian Studies, 27, 1, 1992, 73-92; G. Bruce Doern and Richard W. Phidd, Canadian Public Policy: Ideas, Structures, Process, (Toronto: Methuen,1983), 80.

[31] Alford, Health Care Politics, 17; Tuohy and O'Reilly, "Professionalism in the Welfare State," 74-5.

challenged.[32]

Public funding of health care infrastructures, such as medical schools, hospitals and public health programs, has further reinforced the legitimacy of medical power. The medical profession continues to dominate in these areas of health care decision making because it determines the scope of medical training, and the definition and clinical treatment of disease.[33]

Central to the power of dominant structural interests in health care has been the degree of professional autonomy exercised by physicians. This freedom has manifested itself in the ability of the medical community to define what constitutes disease and how best to treat it. At the level of the individual physician this has translated into the ability to diagnose and treat illness unfettered by hierarchical controls. Both the occupational monopoly and professional autonomy of the medical profession have been exercised by organizing the delivery of services as independent fee-for-service practice. By operating as independent entrepreneurs, physicians have been able to avoid the hierarchical supervision associated with large bureaucratic organizations.

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[32] Naylor, Private Practice, Public Payment, 12; Giorgio Freddi, "Problems of Organizational Rationality in Health Systems: Political Controls and Policy Options," in Giorgio Freddi and James Warner Bjorkman, eds., Controlling Medical Professionals: The Comparative Politics of Health Governance, (London: Sage Publications, 1989, 4.

[33] Ibid, 13.

By charging a fee-per-service, the medical profession has been able to exercise discretionary control over the terms of payment.[34]

In the eyes of the medical profession, fee-for-service payment has symbolically represented the last bastion of clinical autonomy. For the majority of physicians, the end of fee-for-service would spell the end of freedom from outside control. Inevitably, this would result in a decline in the quality of medical services. Arguably, extra-billing represents an extension of the traditional autonomy to determine the method and amount of payment under a public system in which fees are determined by negotiations between professional associations and governments.

Traditionally, physicians have opposed any attempts to compromise the fee-for service method of payment for several reasons. First, any third party intervention increases the possibility of income control and eventual income reduction. Secondly, any intervention (third party, fee schedule, salary or capitation) involves a diminution in social status. Thirdly, the growth of institutionalized medicine leads to a restriction in clinical autonomy and a resulting decline in

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[34] Naylor, Private Practice, Public Payment, 12; Carolyn Tuohy, "Medical Politics After Medicare," Canadian Public Policy, 2, 2, 1976, 192-210; Carolyn Tuohy, "Medicine and the State in Canada: The Extra-Billing Issue in Perspective," Canadian Journal of Political Science, 11, 2, 1988, 271.

the quality of care.[35]

This common perception is well evidenced by a 1984 survey of the attitudes of physicians in Canada. A strong consensus exists among physicians that extra-billing should be allowed as a means of maintaining professional autonomy and incomes. While physicians are not dissatisfied with their incomes under public insurance, they are dissatisfied with a perceived loss of control over decisions affecting income. In practice the medical profession supports the public health system, but in principle they oppose it. This opposition is due largely to the principled objection to government intervention into areas of medical decision making. This objection is registered strongly by physicians who derive the majority of their income from fee-for-service and most strongly by current and former executive officers of national and provincial medical associations.[36] A 1993 survey of Ontario physicians tends to corroborate the finding of the national survey concerning principled opposition to government intervention into areas affecting professional autonomy.[37]

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[35] Freddi, "Organizational Rationality in Health Systems," 5-6.

[36] Malcolm Taylor, H. Michael Stevenson and A. Paul Williams, Medical Perspectives on Canadian Medicare: Attitudes of Canadian Physicians to Policies and Problems of the Medical Insurance Program, (Toronto: Institute for Behavioural Research, York University, 1984), 46, 72, 92, 128, 131, 136-42.

[37] Jeff Henry, "Government Control Over Medical Profession, Health-Care Funding, Key Issues for Physicians," Ontario Medical Review, February, 1993, 16-18.

However, even before the introduction of publicly financed health insurance, individual physicians were regulated by the organized profession. This regulation took the form of establishing the broad parameters of professionalism with the aim of ensuring the quality of services. Within this regulatory framework individual physicians determined how best to organize their practices, and the type and amount of services to be rendered. State intervention in the medical market was tolerated because of assurances that the profession's collective and individual power would not be curtailed.[38] Again the existing survey data, indicate that even this form of third party regulation is not favoured by over 40 per cent of the profession.[39]

Traditionally, physicians through representative organizations were able to protect their professional autonomy by maintaining decision-making control over the organization and funding of health care delivery. As Taylor has noted about this predominant position in Canada:

> Organized medicine influences legislative policy with respect to the timing and design of public programmes, guides the choice and structure of administration agencies, prescribes certain of the administrative procedures, participates in continuing decisions of administrators, and in four provinces, actually serves as the governmental

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[38] Tuohy and O'Reilly, "Professionalism in the Welfare State," 78.

[39] Taylor et al, Medical Perspectives on Canadian Medicare: Attitudes of Canadian Physicians to Policies and Problems of the Medical Care Insurance Program, 131.

agency in the administration of major programmes.[40] In essence, the medical profession is the major private actor in the sub-government.

Although the introduction of national health insurance altered the financing of health services, organized medicine was able to maintain its dominant position, because the existing institutional and organizational arrangements, which favoured medical interests, were "frozen" in place under the government-sponsored system. Increasingly, however, this central role has been challenged by politicians, public administrators, allied health professionals and consumers as the policy objectives of the state and the profession have taken divergent paths.[41]

As governments have become more involved in financing a wide-range of social services, the narrower concerns of the medical profession have been joined by government concerns with ensuring access and controlling overall costs.[42] Increasingly professional medical associations have found themselves in conflict with politicians and public administrators over who is best suited to make decisions concerning the allocation of financial resources. The

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[40] Malcolm C. Taylor, "The Role of the Medical Profession in the Formulation and Execution of Public Policy," Canadian Journal of Economics and Political Science, 26, 1, 1960, 125.

[41] Tuohy and O'Reilly, "Professionalism in the Welfare State," 79.

[42] Ibid.

traditional power of the medical profession, based on medical knowledge, has been challenged by political power, based on control of tax resources, and bureaucratic power, based on knowledge of the administrative apparatus of government.[43]

The dominance of the medical profession has been weakened in several respects. The continuing fragmentation of medical knowledge caused by technological advancement and the state-sponsored expanding definition of what constitutes "health" have combined to weaken the ability of the medical profession to make an exclusive claim on the body of knowledge central to providing health care. Physicians are now challenged by other health professionals and para-professionals who are staking a claim to some specialized aspect of health care knowledge. More importantly, the emergence in public policy circles of a public health model of health care delivery, emphasizing a preventive approach to health care delivery directly challenges the curative model central to the philosophy of organized medicine.[44]Community health centres are often associated with the preventive approach to health care because of their increased emphasis on the provision of preventive and promotional health services.

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[43] Carolyn Tuohy, "The Political Attitudes of Ontario Physicians: A Skill Group Perspective," (Ph.D. Dissertation, Yale University, 1974); Tuohy, "Medical Politics After Medicare," 192-210.

[44] Geoffrey Weller, "The Determinants of Canadian Health Policy," Journal of Health Politics Policy and Law, 5, 3, 1980,405-18.

The medical profession has been further fragmented by the impact of federalism on interest group formation in Canada. Physicians are represented at the national level by the Canadian Medical Association and at the provincial level by provincial medical associations and regulatory colleges. While provincial associations are represented on the executive of the federal association, they are influenced by conditions specific to their own province.[45]The tendency is for provincial associations to dominate the relationship. As Helen Jones Dawson notes about the problem posed by the federal system, "the achievement of a consensus on desirable national, as opposed to regional or provincial, policies often verges on the impossible."[46]

At the provincial level, divisions within the medical profession have been institutionalized[47] through the state required establishment of separate organizations to carry-out the self-regulatory and collective bargaining roles. Implicit in this division is that the former represents the broader public interest and the latter represents the narrower

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[45] J.W. Grove, Organized Medicine in Ontario, A Study for the Committee on the Healing Arts, (Toronto: Queen's Printer, 1969), 36-9.

[46] Helen Jones Dawson, "National Pressure Groups and the Federal Government," in A. Paul Pross, ed., Pressure Group Behaviour in Canadian Politics, (Toronto: McGraw-Hill Ryerson, 1975), 30.

[47] Tuohy and O'Reilly, "Professionalism in the Welfare State," 75.

professional interest.[48] While the self-regulatory status has added legitimacy to the position of organized medicine in relation to other health actors, the separation of the regulation and collective bargaining roles has:

> led to more or less profound divisions within the medical profession as to the appropriate stance of the profession toward the state and toward redistribution issues. This lack of cohesiveness could ultimately diminish professional power more than would any direct government action.[49]

The divisions revolve around the two central aspects of the monopoly: entrepreneurial freedom and clinical discretion.

While the majority opinion of organized medicine in Canada continues to support the entrepreneurial aspects of professionalism as advocated by provincial associations, a strategically placed minority has been willing to limit the fee-for-service method of payment in an effort to protect the core value of the profession: clinical discretionary authority within the boundaries of professionally determined standards. The minority position tends to be situated in the central institutions of organized medicine: the regulatory colleges, health care institutions and the medical schools. This "academic and institutional perspective" is not strictly confined to these two categories of physicians. Nor do all

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[48] William D. Coleman, "Analysing the associative action of business: policy advocacy and policy participation," Canadian Public Administration, 28, 3, 1985, 414, Coleman suggests that the two types of activity produce an inherent tension within interest associations.

[49] Tuohy and O'Reilly, "Professionalism in the Welfare State," 85.

physicians in these categories necessarily hold this view.[50] These physicians are more likely to derive the majority of their income from salary or a combination of salary and fee-for-service.[51] Their strategic advantage lies in the nature of the work they perform. They tend to be involved in the regulatory and academic aspects of medicine. Thus they determine and regulate the scope and practice of the profession.

The emergence of this variation on the core values and beliefs of medical professionalism is a result of the continuing development of the technological infrastructure underpinning health care. The increasing scale of organization required to capture the potential benefits of emerging technologies and techniques in a cost efficient manner has challenged the small scale, independent fee-for-service methods of service delivery. The strategic minority of physicians has recognized that "both the technological and the political context of modern medicine require that the physician accommodate himself to his peers and to other groups in society in new organizational contexts and power

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[50] Tuohy, " Medical politics after medicare: the Ontario case," 203.

[51] Tuohy, Policy and Politics in Canada: Institutionalized Ambivalence, 119; Tuohy, "Medicine and the State in Canada: The Extra-Billing Issue in Perspective," 278 at note 32, According to Tuohy "the linkages between the medical schools and self-regulatory colleges are both functional (deriving from a common interest in entry standards to the profession) and structural (deriving from the representation of medical schools on the governing councils of the colleges).

relationships."[52]In practice this has meant that they are willing to negotiate fee schedules with government, and experiment with different methods of remuneration and organization. These concession have allowed non-medical influence into the remunerative and organizational aspects of the medical profession.

What this minority expects in exchange for these concessions is recognition by government of professional control over "the content and standards of medical practice" so that individual physicians continue to enjoy clinical discretion subject to the standards of the profession.[53]

Such division of opinion is not unusual for structural interests as long as it remains largely hidden from public view. The greatest weakness of the medical monopoly is the political dilemma of maintaining "a united front vis-a-vis outside threats and at the same time finding some viable method of dividing up the spoils."[54]

In Ontario, where the concentration of medical schools is highest, the division between the majority and minority opinions of the profession is more visible. The professional association (Ontario Medical Association) is increasingly presenting itself as the defender of the entrepreneurial majority while identifying the regulatory body (the Ontario

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[52] Tuohy, "Medical politics after medicare," 203-04.

[53] Ibid, 204.

[54] Alford, Health Care Politics, 198.

College of Physicians and Surgeons) with the opposing state interest. Organized medicine in Ontario has been further fragmented by the appearance of a small, but vocal minority of physicians practising in community health centres, who oppose both the fee-for-service method of payment and the relative distribution of power between physicians, other health workers and the public.[55]

While these divisions remained internalized, organized medicine was able to present a reasonably united front against any challengers, but the institutionalization of these differences within the realm of public decision making, has increasingly weakened the legitimacy of the majority medical opinion as represented by the professional associations.

In Ontario, the failure to maintain a consensus within the policy community in the face of external cost pressures, has led to an increasing willingness by government to act unilaterally on policy issues affecting the profession.[56]

2.2 The Nature of the Challenge

The developments that have occurred since the advent of a publicly financed system of health care have led to the emergence of new challenging structural interests. Among the

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[55] Tuohy and O'Reilly, "Professionalism in the Welfare State," 85.

[56] S. Heiber and R. Deber, "Banning Extra-Billing in Canada: Just What the Doctor Didn't Order," Canadian Public Policy, 13, 1, 1987, 71.

most important are the "corporate rationalists", comprising a coalition of individuals and groups within government and the health policy community, who support state intervention in the delivery of health care to promote integration of the system. The various interests of minority opinion physicians, government health planners, medical schools, public health agencies and hospital administrators, share "a common relationship to the underlying changes in the technology and organization of health care ... [that] generates their developing structural interest in breaking the professional monopoly over the delivery of services."[57] The common goal shared by this coalition of interests is the maintenance and extension of organizational control over the work of physicians.[58]

Each of these interests accedes to this goal for different but overlapping reasons. For some politicians, the extension of control over the professional realm of the physician is pursued to the extent that controlling public expenditure is politically salient. This stems from the parliamentary conventions of individual ministerial and collective governmental responsibility.

For some bureaucrats, the extension of administrative control over the work of physicians allows them to enhance their ability to "manage" the system. This relates to the

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[57] Robert Alford, Health Care Politics, 14.

[58] Ibid, 192.

administrative objectives of coordination and integration. Both of these objectives relate closely to the administrative values of efficiency and responsiveness. This involves an increased scope of decision-making authority concerning the allocation of public resources. According to Warren and Williams, the pursuit of a mutually recognized economic rationale "almost automatically implies some increase in government influence over the health care delivery system and with it, increased bureaucratization."[59]

Some interests within government and locally-based agencies such as universities and public health departments envision an expanded definition of health in which the provision of physicians' services and acute care play a diminished role. In particular they see an enhanced role for the consumer and ancillary health personnel as a means of achieving cost effectiveness in service delivery. They also see these changes as a means of enhancing accessibility and appropriateness of service delivery. They are, then, influenced by the administrative values discussed above.

In essence, the recognition by governments of the cost implications of a system driven by demand pressures and technological expansion, without subsequent significant gains in the relative level of health, has led to a reconsideration of the principles underlying the policies upon which the

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[59] Sharon Warren and J.I. Williams, "Physicians and Health Regionalization: Response to Implied Government Involvement," Social Science and Medicine, 10, 39.

system is structured. In response to democratic pressures, politicians have acted to provide publicly funded health services for all citizens. After realizing the cost implications of this plan, they have acted to gain control over the process. As the health system has become increasingly subject to the principles of public administration, public administrators have gained in power at the expense of doctors. Professional management skills have become increasingly important in relation to medical diagnostic skills in the public health economy. The result has been a "further elaboration of the overriding bureaucratic structure."[60]

From the early 1970s, political executives and senior bureaucrats have attempted to control costs.[61] To this end, a variety of measures have been adopted to rationalize the delivery of health care by linking the objectives of co-ordination, integration and planning with the programmatic conceptions of regionalization, consumer participation and the adoption of health centres:

> Regionalization, it is claimed, not only will make the administration of health systems easier, but more constructively, will aid in the distribution of services to all regions on a more equitable basis. Its promoters maintain that, depending on the details of its application, regionalization also can help avoid duplication of services, promote coordination among specialist and generalist services, and provide numerous points of

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[60] Alford, Health Care Politics, 219.

[61] Anne Crichton, David Hsu and Stella Tsang, Canada's Health Care System: Its Funding and Organization, (Ottawa: Canadian Hospital Association Press, 1990), 181-82.

> access for consumer participation. The concept of regionalization is thus linked closely to that of consumer participation. It is also common for the terms to be related to the concept of the community health centre, which customarily is seen as the institutional focus of the recommended regionalized health system.[62]

While the province of Quebec has been the only province to undertake a comprehensive restructuring of the health care system along these lines (see Appendix III), the majority of provinces are also involved to varying degrees with implementing similar reforms.[63]

A visible outcome of the changes occurring since the advent of public health insurance has been an increased consumer and bureaucratic presence in the health decision-making process. Where the decision-making autonomy of the physician is in greatest jeopardy is in those areas outside of clinical decision making, such as control over the resources needed to implement these decisions.[64]

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[62] Geoffrey Weller, "From 'Pressure Group Politics' to 'Medical-industrial Complex': Approaches to the Study of Health Politics," Journal of Health Politics, Policy and Law, 1, 1977, 459-60.

[63] Alberta, Ministry of Health, Regionalization of Health Services Planning and Management: A Canadian Overview, April, 1993.

[64] G. Ross Baker, " Changing Patterns of Governance for Hospitals: Issues and Models" in Raisa B. Deber and Gail G. Thompson, eds., Restructuring Canada's Health Services System, (Toronto: University of Toronto Press, 1992), 203; Joan M. Eakin, "Hospital Power Structure and the Democratization of Hospital Administration in Quebec," Social Science and Medicine, 18, 3, 1984, 221-28; Ann Crichton, "Equality: A Concept in Canadian Health Care: From Intention to Reality of Provision," Social Science and Medicine, 14, 1980, 243-57; Bernard Blishen, Doctors in Canada, (Toronto: University of

Community health centres have been an important policy option for governments because in theory they address the objectives of coordination, integration and cost control. They also address the programmatic or, perhaps more correctly, the political requirement of increased consumer participation. More importantly, they have provided corporate rationalists with a visible symbol of the potential challenge to medical power; especially to the organizational and financial aspects of the profession.[65]

The employment of physicians on salary or capitation payment as part of multidisciplinary health and social services teams represents a challenge to the dominant interests. By vesting decision-making authority in community-based, non-medical boards of directors and a professional manager, they challenge the decision-making authority of individual physicians. This professional power is further challenged because physicians do not exercise the same degree of control over other allied health personnel as in the traditional setting. Not surprisingly, physicians in Canada have given little support to "alternative modes of health

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Toronto Press, 1992), 142.

[65] Weller, "From 'Pressure Group Politics', to 'Medical-Industrial Complex': Approaches to the Study of Health Politics," 459-60; C. David Naylor, Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911-1960, Chapter 2 and pg. 245.

structuring" such as community health centres.[66]

Politically, a major restructuring of the health care system remains difficult because it implies a substantial shift of resources from existing health services and their associated interests in order to create and sustain change. Despite the ability of the system to absorb potential major change, the increasing government presence in the health sector has resulted in a steady increase in the power of health administrators and an increase in the numbers and diversity of consumer-based self-help and advocacy groups focusing on specific fragments of the population.[67]

2.3 Repressed Interests

A third category of structural interests, those that are repressed, comprises individuals and groups, such as the poor, women, the disabled and ethnic minorities, that are not well served by existing social or political institutions. In terms of health care these interests constitute segments of the population not well served by the existing health system. The key distinction between dominant and repressed interests is that significant political and organizational mobilization is required by the latter to alter their societal position of

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[66] Taylor et al, Medical Perspectives on Canadian Medicare: Attitudes of Canadian Physicians to Policies and Problems of the Medical Care Insurance Program, 161.

[67] Hastings and Vayda, "Health Services Organization and Delivery: Promise and Reality," 347.

disadvantage; whereas, the former is not required to mobilize.[68]

The mobilization difficulty faced by repressed interests is manifest in several ways. First, as Pross notes, the dominance of technical competence in the policy process that has evolved during the twentieth century has "changed the language of policy-making in a fashion that excluded lay people, including politicians."[69]Changes in state-societal relations have provided both new opportunities and new challenges for policy advocacy and participation by those previously excluded segments of the population. As the policy process has become increasingly complex, the need for enhanced levels of organizational capacity has placed new demands on policy actors. This capacity has traditionally not been possessed by repressed interests.[70]

In recent decades, there has been a widespread growth of consumer groups representing the lower socio-economic population strata, women, the disabled and ethnic minorities. Such groups tend to cut across socio-economic and political

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[68] Alford, 17.

[69] Paul Pross, Group Politics in Canada, 51; Cairns, "The Embedded State", 83.

[70] Ibid, 261; Peter Aucoin, "Pressure Groups and Recent Changes in the Policy-making Process," in A Paul Pross, ed., Pressure Group Behaviour in Canadian Politics, 183; Kenneth Bryden, "Public Input into policy-making and administration: the present situation and some requirements for the future," Canadian Public Administration, 25, 1982, 90.

interests.[71] That the efforts of activists are often focused on the locality reflects the distinctive nature of the urban political arena. As Manuel Castells notes, in contrast to national and sub-national politics, urban politics focuses on new social differentiation and contradictions that express themselves through collective consumption activities. In the urban context Castells is referring to "new social cleavages related to the accessibility and use of certain collective services, from housing conditions ... [to] the type and level of health, education and cultural facilities."[72]The problems from which these public services spring are so complex and large that their organization and management necessitates a collective approach. Large urban areas are particularly susceptible to collective action because they tend to have large concentrations of repressed interests that are not well served by the existing network of services.

The perception of health care as a local commodity is exemplified by the traditional organization of medical practice. Traditionally, health services delivery was decentralized. "Except for highly specialized tertiary care providers, individual physicians served local markets, developed local referral patterns and worked in local 'plants'

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[71] Hastings and Vayda, "Health Services Organization and Delivery: Promise and Reality," 373; Blishen, Doctors in Canada, 150; Pross, Group Politics and Public Policy, 69.

[72] Manuel Castells, City, Class and Power, (London: The Macmillan Press Ltd, 1978, 16.

(hospitals)."[73]While the intervention of government in the market place has disrupted the ability of local medical associations to control the price mechanism, the other local characteristics of medical practice have remained largely intact. Given that the market tends to be localized, a collective response by repressed interests seeking to alter patterns of service delivery should be expected.

Despite the local nature of health care as a commodity, most studies of Canadian health policy have tended to focus on either the federal or provincial policy arenas. While examining the federal and provincial contexts, this research differs from most studies of Canadian health politics in that it examines the impact of the urban context on health care.

The urban setting is most suited to accommodate this process of collective consumption because of the importance of the locality in the experience of everyday life. While Castells sees collective consumption activities as being organized in the urban arena, production activities by their very nature tend towards centralization of organization. We can hypothesize, that the local level, then, is the setting in which repressed interests are likely to have greater relative influence on health care than at other levels. While urban systems are, in part characterized by their production activities, they tend to be a small cog in a larger regional,

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[73] Tuohy, "Medicine and the State: The Extra-Billing Issue in Perspective,"274.

national or international process of production and distribution. Thus the production function of capitalism alone is insufficient in explaining urban politics.[74]

According to Castells, community mobilization has tended to revolve around three major themes: demands focused on collective consumption; defense of cultural identity as associated with a particular territory (neighbourhood); and political mobilization in relation to the state.[75] Community mobilization has been triggered by three trends:

1. The disruption of life caused by urban renewal, demographic immigration, changing employment patterns and tight housing markets.
2. The development of social networks among the poor and ethnic communities around voluntary associations, churches, and government-sponsored agencies.
3. The influence of strong leadership, usually comprising the educated segment of the repressed interests.[76]

Given that community health centres represent a type of locally generated collective service, community mobilization might be expected to spring from one or more of these trends.

Acting as spokespersons for repressed interests, local activists, including clergy, community development workers, volunteers, allied health workers and public servants (as

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[74] Manuel Castells, The Urban Question, 444; Patrick Dunleavy, Urban Political Analysis: The Politics of Collective Consumption, (London: Macmillan Education Limited, 1986), 45.

[75] Castells, The City and the Grassroots, xviii.

[76] Ibid, 55-6.

members of the community),[77] have advocated improved health services for these groups. These individuals form voluntary shifting alliances "to locate resources found in the broader society and attract them to the locality."[78] They are successful at attracting funding to the locality because of their ability to build networks[79] of personal contacts which provide the link between the locality and senior levels of government. When supported by the existing local health and social services network,[80] they may pressure government for either specific or general reforms. The outcome of focusing on a specific program or need is usually the development of a new

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[77] Manuel Castells, The City and the Grassroots, Berkeley: University of California Press, 1983, Castells refers to these social Categories as "major agents of urban mobilization."

[78] Carl Milofsky, "Scarcity and Community: A Resource Allocation Theory of Community and Mass Society Organizations," in Carl Milofsky, ed., Community Organization: Studies in Mobilization and Exchange, (New York, Oxford University Press, 1988), 19; J.A. Barnes, "Networks and Political Process," in Marc J. Swartz, ed., Local Level Politics, (Chicago: Aldine Publishing Company, 1968), 107, refers to voluntary associations as "those processes whereby individuals and groups attempt to mobilize support for their various purposes and to influence the attitudes and actions of their fellows."

[79] Carl Milofsky, "Networks, Markets, Cultures and Contracts - Understanding Community Organizations," In Carl Milofsky, ed., Community Organizations: Studies in Resource Mobilization and Exchange, 5; William D. Coleman and Grace Skogstad, Policy Communities and Public Policy in Canada: a structural approach, (Toronto: Copp Clark Pitman Ltd., 1990), 26.

[80] Wim Wievel and Albert Hunter, "The Interorganizational Network as a Resource: A Comparative Case Study of Organizational Genesis," Administrative Science Quarterly, 30, 1985.

program or service agency.

Albert Hunter and Suzanne Staggenborg note that such networks are essential to attracting resources to the locality to support "locally organized collective action."[81] Local activists also generate the sense of identification with a place and mobilize the necessary local support to have the appearance of consensus when approaching outside funding agencies.[82]

In their efforts to pressure government for new services, the representatives of repressed interests have formed alliances with corporate rationalists to overcome the inherent bias of the system towards the medical model. These alliances are key to the successful establishment of new services. Corporate rationalists within local and provincial institutional networks have been sympathetic to these local pressures to the extent that they fit into the rationalist model of health service delivery. Those corporate rationalists who are state actors, have also been motivated by the desire to ensure that "the weak and under-represented could participate in policy-making" as a means of developing larger

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[81] Albert Hunter and Suzanne Staggenborg, "Local Communities and Organized Action," in Carl Milofsky, ed., Community Organizations: Studies in Mobilization and Exchange, 249

[82] Milofsky, " Scarcity and Resources ...", 26; Milofsky, "Neighborhood-Based Organizations: A Market Analogy," in Walter W. Powell, ed., The Nonprofit Sector: A Research Handbook, (New Haven: Yale University Press, 1987), 280.

policy communities.[83] Local pressure has added legitimacy to governmental efforts to reform the system of health care delivery.

In Canada much of the focus of new social and health programs has been on an array of population segments defined in terms of ethnicity, gender, age and economic status. These populations have been identified by some bureaucrats, politicians and local activists as being "under serviced" by the existing government-sponsored network of services:

> Under these social and political circumstances, many policies and social programs, including the multiculturalism policy, were developed by the state to respond to the existing and potential problems of an increasingly fragmented society . These programs couched in the rhetoric of 'citizen participation' represent different ways to administer government funding to community groups for managing their own affairs and working out their own solutions to specific problems of their respective communities and constituencies.[84]

The result of these pressures in the health field, in Ontario, has been the development of programs designed to address the needs of repressed structural interests. Community health centres constitute one of these programs.

As Warner notes, community groups have pressured the government to respond to perceived inadequacies in the existing network of services in terms of the amount of services available and access to those services. For

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[83] Pross, Group Politics and Public Policy, 68.

[84] Roxanne Ng, The Politics of Immigrant Women, Class and State, (Toronto: Garmond Press, 1988), 26.

government, community participation addresses the demands of citizens and also allows for continuing control through the delegation of authority. By adding community participants to the mix, politicians hope to check the discretion of health professionals and public administrators alike. Clearly, this is aimed at influencing decisions concerning the allocation of resources.[85]

Local activists have strengthened their bargaining position with government by developing a broadly-based consensus comprising community and institutional leaders. Much of the success of this consensus-building process is dependent on the receptiveness of the local institutional network and the community to alternative methods of service delivery. Neither provincial politicians nor bureaucrats have been willing openly to support the development of alternative services without a clear indication of some sort of broad local support. Government has relied on the development of local coalitions to lend legitimacy and support to proposed changes to health policy.[86] In turn, the alliances that local

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[85] Morton Warner, "The Rise of Community Participation: Its Impact on Health Professionals and the Health Bureaucracy," in David Coburn, ed., Health and Canadian Society, (Toronto: Fitzhenry and Whiteside, 1981), 361; Blishen, Doctors in Canada, 151; W.J.B. Church, District Health Councils: The Local Advisory Body and Health Policy in Ontario, M.A., Department of Political Science, University of Waterloo, Waterloo, Ontario, 1986.

[86] Gail Siler-Wells, "An Implementation Model for Health System Reform," Social Science and Medicine, 24, 10, 1987, 823.

activists form with corporate rationalists within provincial and local institutional networks are crucial to the ability to mobilize because of the potential availability of political and organizational resources.

3. Dependent, Independent and Intervening Variables[87]

Given that the thesis seeks to explain the development of CHCs in Ontario, the dependent variable is the development of Community Health Centres. There are three possible outcomes to CHC development: 1) establishment of a CHC based on the original ideological and organizational intentions of local activists; 2) establishment of a CHC in which the original ideological and organizational intentions of local activists are not maintained intact;3) failure to establish a CHC.

Five independent variables can be identified. Each independent variable will be assigned a high, medium or low value according to their effect on the dependent variable. The first independent variable is the local political environment (as distinct from the provincial or federal). This recognizes the distinctiveness of the urban political arena. Among other things, local politics involve issues of collective consumption, neighbourhood preservation and local self-

[87] The choice of this terminology does not imply that the data will be subjected to quantitative analysis. For purposes of explanatory analysis, the terminology is utilized in the context of this thesis as a means of differentiating among qualitative influences on the development of individual community health centres.

government. Given this, we would expect that the response of local politicians and institutions to these three broad themes would either facilitate or hamper the development of Community Health Centres. Thus, an important attribute of this variable is receptiveness to innovation in the organization and delivery of health services.

The second independent variable is labelled local activists. This relates to their ability to mobilize and maintain a supportive local constituency. Another attribute is the ability of local activists to forge links with corporate rationalists. Following from Castells, we expect that strong local leadership will mobilize repressed interests around issues of collective consumption, such as access to appropriate health care. In major urban centres, ethnic minorities are often, but not exclusively, unable to gain adequate access to such collective goods. As well, we expect that local activists will successfully establish links with corporate rationalists.

The third independent variable is labelled local corporate rationalists. An important attribute of this variable is the receptiveness of local corporate rationalists to innovation in the organization and delivery of health services. We expect that corporate rationalists in medical faculties, government agencies or other local institutions will provide valuable political and administrative resources to local activists. They may also act as a visible lead agency

in efforts to establish community health centres.

The fourth independent variable is labelled medical professionals. An important attribute of this variable is opposition to innovation in the organization and delivery of health services. We expect the amount of time to develop a health centre to be greater where medical opposition is present.

The fifth independent variable is labelled provincial bureaucrats. An important attribute of this variable is the receptiveness of provincial bureaucrats to innovation in the organization and delivery of health services. While we recognize that provincial bureaucrats play a de facto role by virtue of the provincial responsibility for health services, they may become involved also in a non-routine fashion in response to the circumstances surrounding individual cases. This bureaucratic intervention may have an impact on the other variables.

The time at which individual community health centres are developed acts as an intervening variable. An important attribute of this variable is an increased receptiveness within the policy community generally to innovation in the organization and delivery of health services.

The case studies are divided between two distinct time frames over a twenty year period. The two time frames, 1970-1978 and 1982-1989, are chosen because they represent two distinct waves of activity, both at the provincial and local

levels, surrounding the development of health centres. During the first period, when the policy concerning CHCs is in its infancy, we would expect that the policy response would be limited. Related to this would be the limited availability of resources. Local activists might have difficulty determining the requirements for success.

During the second period, when government policy has matured we would expect the policy response to be clearer and more extensive. If government is committed to a program, then the policy infrastructure necessary to support activities at the local level should be in place. This means the operational aspects of the program become routine. In this environment, the development of CHCs should be better facilitated, if local activists meet the necessary requirements.

4. Outline

Chapter Two examines the historical development of CHC policy and suggests that there has been a growing challenge by corporate rationalists to the dominance of the medical monopoly and the curative approach to health care delivery. However the challenge has not yet resulted in a radical reform of the system. Due to the continuing resistance of dominant interests within the federal policy arena, community health centres have not been introduced on a national basis, but have developed piecemeal at the provincial level.

Chapter Three discusses the development of health care

policy and community health centres in Ontario. The evidence indicates that the introduction of measures to control costs, and promote egalitarianism in government have influenced the development of health policy and health centres. In turn, the existing political and institutional biases have determined the pace of reforms to the system. While a concern with the efficiency has forced the promoters of health centres within government to justify their worth in economic terms, increasing political pressures have made CHCs attractive vehicles for a broader range of egalitarian issues currently on the government policy agenda.

Chapter Four examines the development of three health centres in the City of Ottawa, (two during the early period and one during the later period). A positive political climate and the emergence of institutional leadership by local corporate rationalists are identified as important variables affecting the development of a network of health and social service centres throughout the Ottawa-Carleton Region.

Chapter Five assesses the development of two health centres in the City of Toronto, (one during the early period and one during the later period), in light of the progressive strain in local politics. During the earlier period local activists faced significant barriers because of the ambiguous political response at the local level. The rise of the reform movement in municipal politics during the early period led to the development of new policies and institutional roles, which

have been supportive of health centre development during the later period. Both the impact of a climate of reform and the evolution of a municipal role in health centre development have assisted local health activists in achieving their goals.

Chapter Six focuses on the development of two health centres in the City of London and the neighbouring town of Tillsonburg. In the City of London, the health centre has been initiated by community development officers employed by an existing community-based agency. Municipal politics and institutions played had a minimal impact on the CHC development. The impact of local corporate rationalists as members of the local network of established organizations played an important role in the successful establishment of the health centre as did the ability of local activists to achieve a broadly based consensus.

In the case of Tillsonburg, local activists were unable to gain sufficient support at the local level to overcome the existing local bias. Medical opposition played an important role in the failure to establish a community health centre.

5. Methodology

Primary data collection began in the fall of 1989 when the executive directors of health centres were contacted by mail and asked to provide general information about the process of development in the health centre. They were also asked to suggest the names of possible informants for personal

interviews.

Based on the response to the mailing, a potential sample group of health centres was chosen for the case studies and a questionnaire comprising specific and open-ended questions was developed. As the interview process unfolded, questions were added to the research instrument to verify information given in previous interviews and to take into account a rapidly changing policy environment.

Potential subjects were contacted by telephone and personal interviews were arranged. A first series of interviews was conducted with local informants in the cities of Ottawa and Toronto, the location of the majority of health centres. Some interviews were by necessity conducted by telephone.

During this and subsequent interview trips, primary documentation was accumulated from the organizational records of the health centres with the permission of the executive directors and/or key informants. The relative availability of this crucial information led to some alteration of the original group of health centres chosen for the study. However, the underlying balance between the early and the later period was maintained as was the balance between cities.

Informants in London and Tillsonburg were also interviewed because of proximity, the noted similarities between the cities of Ottawa and London, and the importance of

Tillsonburg as a deviant case. The author was also involved in an advisory capacity with the London development and was therefore, privy to an inside look at the process, including establishing key contacts with officials from the Ontario Ministry of Health.

A second set of interviews was conducted in 1990 with key political and administrative informants - former ministers, deputy ministers, assistant deputy ministers and program officers - and further primary documentation was obtained. During all of the interviews, informants were given a choice in the form of a written contract of remaining anonymous or being on the record. Since the researcher preferred to audio tape interviews to speed the process and avoid inaccuracies, informants were also given the option of not having the interview recorded. The tapes were later transcribed and used for analysis.

Chapter II

National Health Policy and Community Health Centres

Prior to the introduction of national medical insurance, the medical profession exercised extensive decision-making authority in the health care sector. Physicians maintained control over their individual and collective working conditions, as well as the working conditions of subordinate occupations associated with the medical services market. This preeminent market position was further enhanced by the profession's unilateral control over market pricing.

The entrance of government into the medical market place as the monopoly purchaser of services was strongly resisted by dominant medical interests in the province of Saskatchewan because it constituted a centralized form of third party intervention in the doctor patient relationship. The outcome of the Saskatchewan experiment served as the model for national health insurance and related provincial plans.

Both in Saskatchewan and elsewhere in Canada third party intervention by government has also triggered the development of community health centres. In Saskatchewan, community clinics developed during the heightened period of conflict between the government and the medical profession. At the federal level, the idea of community health centres was put forward immediately after the introduction of national

medicare as a means of controlling costs. The strong opposition from organized medicine was a result of the threat posed to the entrepreneurial aspects of professionalism by the development of alternative organizational and funding mechanisms such as the CHC model.

The chapter begins with a brief sketch of the impact that government intervention has had on the medical market place. This is followed by a discussion of the development of health insurance in Saskatchewan that illustrates the nature of the conflict between structural interests and the role of community health centres. The discussion then focuses on attempts to establish a national network of CHCs under national health insurance. In both cases, the dominant interests moved decisively to block the challenge.

1. Background

Despite the lack of jurisdictional authority from the Constitution Act[1], the federal government has been involved in health care since the early twentieth century. Government involvement has been a gradual progression from the early grant-in-aid programs(circa 1912), later named shared-cost agreements, to the eventual introduction of national medical

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[1] The movement towards state involvement at the federal at the federal level was initially limited by section 92 (7) of the Constitution Act, 1867, which gave the provinces exclusive powers for medical facilities other than marine hospitals. On this see Keith Banting, The Welfare State and Canadian Federalism, Second Edition, (McGill-Queen's University Press, 1987), 47-48.

care program in 1968. While initially the medical profession appeared to support the idea of government intervention, the delays caused by federal-provincial negotiations allowed physicians to develop their own solutions, making government intervention less acceptable. Only through generous financial incentives and reassurances of minimal interference was the federal government able to secure general support from the medical profession.

The net effect of government intervention in the health sector was an increased demand for and utilization of services and a concentration on a hospital-centred delivery system. While the medical profession lost the battle to create a privately administered national health insurance plan, it initially managed to maintain the preferred fee-for-service method of remuneration and remained a central actor in the decision-making process.

As for the system itself, the introduction of grants-in-aid for health planning and hospital construction, allowed for the development of the infrastructure necessary to provide national hospital and medical insurance. Of equal importance, the introduction of government-sponsored health insurance plans relieved the individual citizens of the substantial financial burden associated with direct payment for health care services. Although there is provincial variation, physicians are paid through provincially administered health plans for each service they perform.

Of the 33,388 active physicians responding to a 1990 Canadian Medical Association questionnaire, 21,210 (63%) received 95-100% of their incomes from fee-for-service payments. An additional 5742 (17%) received 50-94% of their incomes from fee-for-service payments. Of these combined fee-for-service totals, 10,718 (39%) were located in Ontario and 6,045 (22%) were located in Quebec (see Appendix IV).[2]

The number of surveyed physicians receiving 95-100 % of their incomes from salary was 2,724 (8%). An additional 1,879 (6%) received 50-94% of their income from salary. Of these totals, 1,651 (36%) were located in Ontario and 1,123 (31%) were located in Quebec. Other payment mechanisms of lesser numerical significance included capitation and sessional payment.[3]

The fee schedule is determined through negotiations between the provincial government and the provincial medical association, which acts as a collective bargaining unit for physicians. Patients are free to choose which doctor they wish to consult and may consult more than one. They are not billed directly by the physician, but may either pay a premium to the government or not directly pay anything at all. Most provinces have now eliminated premiums. Where premiums have been

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[2] Canadian Medical Association, Physician Resource Questionnaire, (Ottawa, 1990).

[3] Ibid.

eliminated, services are funded entirely through a province's general revenues.[4]

Aside from these admirable achievements, the focus of the system on the most expensive health care personnel (doctors), methods of delivery (hospitals) and payment mechanism (fee-for-service) has meant increased costs. Between 1965 and 1975 the total cost of all health services in Canada rose from $ 3.3 billion to more than $11 billion. However, because the government contribution through health insurance increased from 43 % to 75 % of public sector costs, government spending between 1960 and 1975 increased from $ 1 billion to $ 9 billion dollars, and by 1978/79 had reached $ 13 billion. As a percentage of the gross national product (GNP) health expenditures rose from 5.5 % in 1960 to 7.3 % in 1971 for an increase of 250 per cent.[5]The amount of money and the rate of increase of the expenditure was alarming to politicians charged with managing the public purse. This growth of expenditures has been fuelled by changing demographics, the supply of physicians, utilization patterns, and the cost of

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[4] Eugene Vayda and Raisa B. Deber, "The Canadian Health Care System: An Overview," Social Science and Medicine, 18, 3, 1984, 191-93; Crichton, Hsu and Tsang, Canada's Health Care System, 35-9.

[5] Health and Welfare Canada, National Expenditures in Canada, 1960-1975, Ottawa, 1979; Vayda and Deber, "The Canadian Health Care System: An Overview, 194

health technology.[6]

The entrance of government into the medical market, has led to increasing clashes between corporate rationalists in government and the dominant interests. Government has sought to gain control over those aspects of medicine that have allowed physicians to maintain a dominant position in the medical services market. Organized medicine has attempted to defend its position by pursuing an entrepreneurial approach to the funding and delivery of services. Corporate rationalists have attempted to co-opt the dominant interests into a public economy by constantly reassuring them that a public health market will not interfere with professional autonomy or clinical freedom. They have been backed in their efforts by representatives of repressed interests who have pressed government for reforms of the health care sector that would fundamentally undermine the position of the physician.

Since the introduction of national medical insurance, conflict has become more narrowly focused on the issues of cost containment and accessibility. Information generated by the discussion of these inherent health sector problems, has suggested continuing the existing patterns of expenditure may only yield marginal returns. The emergence of this statistical fact and its continuing verification over the past two decades

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[6] OECD, Measuring Health Care, 1960-1983, 89; Canadian Medical Association, Health: A Need For Redirection, A Task Force on the Allocation of Health Resources, (Ottawa: Print Action Limited, 1984); Taylor, "The Canadian Health Insurance Program," 38.

has provided governments with the justification if not the incentive to alter spending patterns.[7]

Corporate rationalists have focused on doctors and hospitals as the culprits in cost escalation. This approach has been aided by expanding the definition of "health" to include "a state of complete physical, mental and social wellbeing and not merely the prevention of disease or infirmity."[8] The legitimation of this view by governments has contributed to a diminution in the power of the medical monopoly. In essence this has meant increased political pressures to reallocate resources from the traditional aspects of the system to emerging alternative organizational and payment mechanisms. Community health centres have been beneficiaries of this shifting emphasis.

More importantly for the medical profession, the encroachment of corporate rationalists into the medical market has resulted in an increasing bureaucratic presence. The

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[7] Pranlal Manga, "The Underfunding of Canada's Health Care System: Myth or Reality," in Medicare : The Decisive Year, Proceedings of the Canadian Centre for Policy Alternatives,(Calgary: University of Calgary Press, 1986), 108-120; Gordon H. Hatcher, Peter R. Hatcher and Eleanor C. Hatcher, Canada, in Marshall W. Raffel, Comparative Health Systems, (Pennsylvania: Pennsylvania State University Press, 1984), 90; Organization for Economic Co-operation and Development, Financing and Delivering Health Care, Social Policy Studies No. 4, (Paris: OECD, 1987); Organization for Economic Co-operation and Development, Measuring Health Care, 1960-1983, Social Policy Studies No. 2, (Paris: OECD, 1985).

[8] World Health Organization, "Constitution of the World Health Organization," World Health Organization Chronicles, 1, 1947, 29.

resulting hierarchical and formalized relationships have posed a threat to the less-formalized collegial patterns of organization characteristic of the medical profession.[9]

Community health centres have been an important example of the invasion of professional autonomy through the organization of practice.

2. Health Centres: The Saskatchewan Experiment

The development of the CHC model in Canada has been an uncertain and politically dynamic process. The CHC model originally surfaced as a political issue in Saskatchewan[10], in the wake of a province-wide doctors' strike precipitated by the introduction of government-financed universal medical care. Community health centres were established by members of local communities and some doctors with the support and approval of the provincial government. They were designed to employ a team approach to medicine that allowed doctors and other health care personnel of various specialties to pool their knowledge, resources and incomes. Because they were consumer-sponsored, recipients of the service were heavily involved. Salary was based on experience and expertise as

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[9] Blishen Doctors in Canada, 129-30.

[10] A lengthy discussion of the initial development of CHCs in Saskatchewan is provided here because as in other areas of health policy Saskatchewan was a trend setter prior to the 1970s. The issues of medical autonomy, consumer control, and method of payment are central to the development of health centres of this nature elsewhere, as are the political and ideological connotations.

decided by the group as a whole.[11] As outlined below, the historical background leading up to the establishment of this organizational form is indicative of how CHCs have been an outcome of the competition between the dominant and challenging interests for control of the health care system.

The first definite move towards providing some sort of comprehensive health insurance was taken by the Provincial Legislature of Saskatchewan in 1916 with the enactment of the Rural Municipalities Act. Under the Act rural municipalities were given the authority to levy taxes, based on property assessment to maintain a doctor on retainer to provide services to municipal residents. By mid-century the population served by community-hired physicians rose to 210,000 persons or over twenty percent of the province's total population. The program was so successful that it was adopted in one form or another by the other prairie provinces.[12] This "demonstration effect",[13] in which the province of Saskatchewan would develop and test a new policy idea which would then be adopted by other governments, was the engine that drove the development of other aspects of the national health insurance program.

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[11] Samuel Wolfe and Robin F. Badgley, "The Family Doctor,"in Coburn, ed., Health and Canadian Society, 221.

[12] Sylva M. Gelber, "The Path of Health Insurance," in Carl A. Meilicke,ed., Perspectives on Canadian Health and Social Services Policy: History and Emerging Trends, (Michigan: Health Administration Press, 1980), 156

[13] Tuohy, Policy and Politics in Canada, 111.

The impact of the Depression of the 1930s on the incomes of physicians led the Saskatchewan Medical Association to endorse a state health insurance program to offset the deficiencies of the municipal doctors program. The government felt that its resources were strained and therefore failed to act on this suggestion. This left the door open for other actors, namely individual municipalities and the medical profession to fill the void. Through the efforts of an individual Reeve and an Order-in-Council from the government, an experimental municipal medicare program was established in 1939. The program allowed the rural municipality of McKillop to raise a $ 5 per person tax with a maximum of $ 50 dollars per family to fund the provision of basic health services. In response to the success of the experiment, the government passed the Municipal Medical and Hospital Services Act in 1939,[14] to allow other municipalities to participate. This experiment served as the precursor to regional medicare and finally provincial medicare.[15]

The government also moved to allow for the establishment of voluntary health insurance plans through the Mutual Medical and Hospital Benefit Association Act (1938).[16] Consumer groups established a co-operative insurance plan in which physicians

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[14] Statutes of Saskatchewan, 1939, C. 55.

[15] Robin F. Badgley and Samuel Wolfe, Doctors' Strike: Medical Care and Conflict in Saskatchewan, (Toronto: Macmillan Canada, 1967), 10-16.

[16] Statutes of Saskatchewan, 1938, C. 24.

worked in a clinic and were paid on salary. Physicians in Regina, quickly organized to counter this by establishing their own insurance plan. Pressure applied by the local medical society to the doctors enlisted to work in the clinic resulted in their eventual withdrawal from the consumer-sponsored scheme.[17]

The opposition to the consumer-sponsored co-op indicated that urban physicians would not accept any attempt to compromise their right to control the method of organization and payment of medical services.[18]This incident served as an impetus for government involvement in the development of medical insurance policy. It also served as a dire warning of the consequences of attempts to intrude into the territory of the dominant interests.

The federal government was also moving in response to the problem of providing health services caused by the Depression. The federal Royal Commission on Dominion-Provincial Relations (Rowell-Sirois Commission)[19] was appointed in 1937 to explore the development of a number of universal social welfare programs in Canada. The Commission found that the provincial

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[17] Badgley and Wolfe, Doctors' Strike, 104-106; The major source of sanction possessed by local medical associations was the denial of hospital privileges. While over time this has become an unacceptable practice, in the pre-medicare period medical advisory committees to hospital essentially controlled hospital boards.

[18] Ibid, 16-17.

[19] Canada, Report of the Royal Commission on Dominion-Provincial Relations, (Ottawa: Kings Printer, 1949).

jurisdiction over health insurance was the best approach to dealing with regional differences. Some form of federal control to achieve national uniformity was also seen as essential. By 1945 the C.M.A. had endorsed the recommendations of the Royal Commission in two specific areas: the adoption of publicly-funded health insurance, and equal protection (financial compensation) for those rendering and receiving the services.[20]

The Federal-Provincial Conference in 1945 brought health care further into public focus, emphasizing the economic disparity between the provinces, and between rural and urban areas. The health professions, especially doctors, began to realize that the magnitude of the financial burden would make future third party involvement inevitable. However, the federal government and the provinces could not agree on the sharing of costs. Thus, for the time being, the provinces were left to go it alone.

In 1943, as a response to activities in the federal political arena, the Liberal government of Saskatchewan established a select special committee of the legislature to study the health services problem. Acting on the

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[20] Ibid, 27; Richard Splane, "Social Policy-Making in the Government of Canada," in Shankar A. Yelaga, ed., Canadian Social Policy, revised edition, (Waterloo: Wilfred Laurier University Press, 1987), 224-26; Splane, "Further Reflections: 1975-86," in Yelaga, ed., Canadian Social Policy, 254; Splane suggests that the proposals for the creation of a national system of social welfare found a receptive audience from certain key administrators within the federal bureaucracy.

recommendations of the committee, the provincial government passed the Saskatchewan Health Insurance Act on March 31, 1944, only a week after introducing the legislation.[21] The medical profession objected to the legislation because in its opinion, insufficient consultation had taken place and the head of a proposed Health Services Commission was not specified as being a physician by the legislation. However, the liberal government was soon swept out of office and replaced by a Cooperative Commonwealth Federation (CCF) government with an overwhelming majority and an election pledge to introduce socialized medicine. The College realized that this new political reality held ominous possibilities for the pattern of medical services.[22]

In 1944 , the CCF party was elected in the province of Saskatchewan on a platform of social reform. The government immediately moved to establish the Health Services Study Commission to assess existing health services and make recommendations for the development of a government funded network of health services. The general conclusion of the Commission was that the province should establish a system of province-wide socialized medicine to provide a basic level of services for all residents.[23] Included in the recommendations

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[21] E.A. Tollefson, Bitter Medicine: The Saskatchewan Medicare Feud, (Saskatoon: Modern Press, 1965), 29.

[22] Ibid, 32.

[23] Ibid, 34.

were plans for a regionalized system of health care delivery and the establishment of a province-wide public hospital insurance plan.

The government acted quickly on the recommendations by passing the Health Services Act in 1944.[24] Under the new legislation a Health Services Planning Commission was established to begin developing a provincial health insurance program. The department of Public Health was also authorized to provide funding for both individuals seeking services and municipalities, hospital boards or health regions seeking to provide health services. In 1945, the Commission developed a plan for the regionalized provision of health services in rural areas. Under the proposed model:

> the province would be divided into three or four health regions of approximately the same size (40,000-50,000 population). Each region would be divided into three or four health districts, each district being comprised of a number of local health units. At each level there would be a "health centre". The extent of facilities and the sophistication of services offered would depend on whether the centre was local, district or regional. It was recommended that medical practitioners working in these health centres would be paid on a salary basis.[25]

The provincial College of Physicians and Surgeons reacted negatively to the proposed plan for several reasons. The Health Services Planning Commission was inadequate because it was not an independent commission as the Premier had promised

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[24] Statutes of Saskatchewan, 1944 (Second Session), C. 51.

[25] Tollefson, Bitter Medicine, 35.

and it did not include adequate medical representation. On the matter of the regionalized model, the medical profession objected to having its power as a provincial collective bargaining unit diminished by having to bargain with geographically decentralized authorities.[26] The medical profession also objected to the payment of physicians services by salary alone.[27]

Notwithstanding the continuing dissatisfaction of the medical profession, the government pressed on with the implementation of the recommendations. In 1946, the Saskatchewan Hospitalization Act[28] was introduced as the first step to a system of socialized medicine in the province. In the same year, a pilot regional health services project was initiated in the Swift Current Region and for the most part proved satisfactory to both local residents and the local medical community. Through a prepaid health insurance plan the residents received medical, dental and hospital care. Physicians in the area were grateful to be given a guaranteed source of income since many had been unable to collect fees from individual patients during the Depression.[29]

The satisfaction of physicians in this region indicates

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[26] Crichton, Hsu and Tsang, Canada's Health Care System, 175.

[27] Tollefson Bitter Medicine, 35-8.

[28] Statutes of Saskatchewan, 1946, C. 82.

[29] Badgley and Wolfe, Doctors' Strike: Medical Care and Conflict in Saskatchewan, 18; Tollefson, Bitter Medicine, 40.

the difference of opinion[30] between rural and urban physicians. Those situated in rural areas had suffered greater financial hardship during the Depression than those in urban areas. Thus the ability to receive full or near full payment for services was appealing to the rural segment of the medical community.

Although this experiment was successful, when similar schemes were suggested in other regions in 1955, they were defeated by a substantial majority of the population. Physicians were adamant in their opposition to such schemes because they were compulsory and were administered by a board accountable to the provincial government.[31]

This apparent change of attitude by the medical profession from its endorsement of universal, government health insurance during the Depression and during the early 1940s can be attributed to a variety of factors. First, as the economy recovered patients were more able to pay their medical bills. Therefore, the financial crisis for physicians had subsided. Second, an influx of disgruntled physicians from the British national health program fuelled the sentiments supporting the development of physician-sponsored voluntary insurance programs.[32] Third, the failure of the federal and

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[30] Ibid, 17.

[31] Tollefson, Bitter Medicine, 42; Joan Feather, "Impact of the Swift Current Health Region: Experiment or Model," Prairie Forum, 16, 2, 1991, 227-29.

[32] Ibid, 44

provincial governments to arrive at an agreement in 1945 had left the ball in the court of the medical profession. Fourth, the past experience with the provincial government had revealed that physicians were likely to suffer a loss of professional control over health care services. Fifth, the composition of the medical profession had altered drastically since the Depression. By the 1960s only half of the doctors would have practised in the province for more than a decade. Many were also migrating to the cities, thus allowing for increased disciplinary control by the urban medical societies.[33]

In 1961, universal medical insurance was introduced in the wake of a bitter election campaign in which the government had pledged to introduce medicare despite a well organized public campaign by the medical profession with the support of the Liberal opposition to prevent this from happening.[34] At the heart of this debate were the issues of the organization and payment of physician's services. Continued federal-provincial wrangling between 1945 and 1955 over proposals for a national public health insurance scheme had allowed physicians to pursue private health insurance options.

As was the case elsewhere in Canada, by the tim the

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[33] Ibid, 28.

[34] Ibid, Chapters Three and Four; Badgley and Wolfson, Doctors' Strike, Chapter Two; Taylor, Health Insurance and Canadian Public Policy, Chapter Two; Saskatchewan, The Saskatchewan Medical Care Insurance Act, Statutes of Saskatchewan, 1961, (Second Session), C. 1.

provincial government was prepared to act on the issue of the financing of physicians' services, the medical association in Saskatchewan had already decided that privately-sponsored prepayment plans based on a fee-for-service schedule were preferable to any government administered approach:

> What the SCPS [Saskatchewan College of Physicians and Surgeons] feared was a concentration of purchasing power in government hands , that could countervail the profession's own considerable market strength and potentially lead to interference with the doctors' clinical autonomy as well.[35]

In an effort to assuage the fears of the dominant interests, the government offered to remove any offensive aspects of the legislation. Despite this concession, the provincial medical association was so opposed to the intended government plan that in July of 1962, doctors began withdrawing services.

The "strike" hinged on the provisions in the Saskatchewan Medical Insurance Act, 1962, which according to the medical profession threatened the professional autonomy of physicians. Of particular importance were the provisions of the Act pertaining to the Commission charged with administering the program, the lay and medical advisory committees and the payment for insured services. In all three cases the major criticism was that there was a lack of sufficient independence from the government. Membership on all three bodies was determined by the Lieutenant Governor-in-Council. The medical profession was also opposed to the composition of the

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[35] Naylor, Private Practice, Public Payment, 200.

Commission because it did not have adequate representation from the medical profession, nor were those medical representatives initially subject to approval by the College. On the third issue, the legislation did not specify what the preferred method of payment would be. Although it was implicit from prior negotiations that the government intended to adopt fee-for-service, this was not initially stated in the Act. The choice of method, the amount and the method of resolving disputes was at the discretion of the Commission.[36]

While the government and the dominant interests continued to haggle over the details of the new legislation, the public began to mobilize to develop interim arrangements to ensure the continuation of adequate services. Spearheaded by the Community Health Services Association (CHSA), which represented repressed interests, local communities attempted to respond to the withdrawal of services by establishing community clinics along the lines of the CHC model. By the end of the strike clinics had been established in five municipalities, with an additional ten in the process of being developed.[37]

The development of the community clinics during the strike was viewed by the medical profession as a major threat

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[36] Tollefson, Bitter Medicine, 114-23; Taylor, Health Insurance and Canadian Public Policy, Chapter Five.

[37] Taylor, Health Insurance and Canadian Public Policy, 326; Naylor, 208; the CHSA membership was comprised of members of farm and labour groups, CCF sympathizers and other anti-medical factions.

to its autonomy, as it coincided with the original plans of the government in 1944 to organize physicians' services as salaried group practices. The clinics were seen as handmaidens to the government. The fear of the dominant interests seems to have been somewhat justified. The government was actively recruiting physicians from outside of the province to staff the clinics. The lay organizers of the clinics were well known C.C.F. sympathizers and the two key physician organizers were pro-medicare, and had been appointed to the Medical Care Insurance Commission without the approval of the College.[38]

The weapon employed by the dominant interests to combat this perceived threat to professional autonomy was the denial of hospital privileges. As was the case when consumer co-operatives were attempted, doctors employed by community clinics found themselves unable to gain access to hospital beds because of the power of medical advisory committees over hospital boards. In the broader context, some communities were so divided by the medical strike that physicians practising in clinics were literally driven out of town by well orchestrated smear campaigns.[39]

After a twenty-three day withdrawal of services, a resolution to the impasse was provided through the Saskatoon

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[38] Badgely and Wolfe, Doctors' Strike, 68, 102; Tollefson, Bitter Medicine, 139-40.

[39] Badgley and Wolfe, Doctors' Strike, 81-5, 102-06; Tollefson, Bitter Medicine, Appendix G; Dennis Gruending, The First Ten Years, (Saskatoon: Saskatoon Community Clinic, 1974), 1-12.

Agreement and subsequent amendments to the Act. As a result of the Agreement, the composition and method of appointment to the Commission was changed to enlarge its size and increase the number of representatives from the medical profession. The appointment of these representatives was changed so that it was a matter of agreement between the government and the College. The lay and medical advisory committees were removed, thus ending any role that lay representation might have played in the administration of the plan.[40]

The regulatory powers of the Commission were reduced as a result of spelling out in detail the methods of payment. Under the revisions physicians could now be paid either by private contract (no government involvement); patient reimbursement (direct billing with patient reimbursement by the government); physician billing under the plan (opted-in); or approved health agencies (indirect payment through an approved medical insurance plan). Thus the dominant interests were allowed to maintain the freedom of choice on method of payment and organization. The approved health agency was authorized only to perform a post-office role for the commission, not to alter the method of payment from fee-for-service to salary. This allowed the variety of private insurance arrangements, including the physician-sponsored plan to remain.[41]

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[40] Tollefson, Bitter Medicine, 114-18, Appendices C-F.

[41] Badgley and Wolfe, Doctors' Strike, 97-99.

The importance of the payment issue in the dispute is evidenced by the fact that of the twenty-nine clauses of the Saskatoon Agreement, nine dealt specifically with payment for services. Half of the amended legislation was devoted to the payment issue.[42]

The issue of the lay-controlled clinics was dealt with in Article 14 which stated:

> There may be places where few or no doctors have enrolled for direct payment by the Medical Care Insurance Commission, so that patients are denied the choice of such doctors. It is not for the Commission to appoint doctors in such places. The remedy is in the hands of the citizens themselves. They can establish premises and invite doctors who wish to enrol for direct payment to rent such premises and set up a practice in them ... The interests of such enrolled doctors must be safeguarded from improper citizen pressure. The role of the citizen group in the provision of insured services must be limited to that of landlord.[43]

The inclusion of this clause in the final agreement between the provincial government and the medical profession indicates that the involvement of repressed interests in the delivery of health care clashes directly with the traditional professional autonomy and dominance of health care decision making, especially in clinical settings. In effect, lay involvement in this fashion inverts the traditional power relationship

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[42] Tollefson, Bitter Medicine, 123.

[43] Government of Saskatchewan, Memorandum of Agreement: Government of Saskatchewan and the College of Physicians and Surgeons, (Saskatoon Agreement), July 23, 1962; T. Kue Young, "Lay-Professional Conflict in a Canadian Community Health Centre," in Coburn, ed., Health and Canadian Society, 306; Tollefson, Bitter Medicine, Appendix F.

between doctor and patient. The conflict is particularly evident when an attempt is made to alter the fee-for-service method of payment.

No provision was made for the payment of services provided through community clinics other than through fee-for-service, either in the Agreement or the Act. Communities were required to raise their own funding if they chose to pay physicians through an alternative mechanism. Without the legitimacy that such an inclusion would have implied, clinics were in a weak position in terms of attracting physicians and developing an alternative to fee-for-service payment. Despite this handicap, by the mid-1960s, eight clinics had developed including three located in Regina, Saskatoon[44] and Prince Albert.[45] There are currently five urban clinics that fit the CHC definition.[46] A number of the CHCs developed during and after the strike failed because of the perceived inability of member doctors to maintain their decision-making autonomy.[47]

While the dominant interests complained that the

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[44] Correspondence dated April 10, 1989 with Sheila Ragush, Membership/Health Promotion Developer for the Saskatoon Community Clinic; Recent evidence suggests that the Saskatoon clinic is now split into two separate locations: the main Clinic in downtown Saskatoon, and the Westside Community Clinic.

[45] Badgley and Wolfe, Doctors' Strike, 103-04.

[46] Saskatchewan, Ministry of Health estimate.

[47] Taylor, Health Insurance and Canadian Public Policy, 329, During the strike the number of clinics based on the regional model grew to eight and after the strike declined to a low of two in 1974.

government support of the development of clinics was a potential threat to the autonomy of the physician, the larger implication of the introduction of medical insurance was that physicians must attempt to maintain control of all aspects of the system or be supplanted in this role by government.[48]

Notwithstanding the significance of instituting public medical insurance, physicians were allowed to opt out of the government plan; the existing system of voluntary prepayment plans was allowed to continue; and the fee-for-service method of payment was maintained as an option. The compromise solution ended any hope of establishing the regionalized system envisioned in 1945.[49]

Perhaps, the most significant outcome of the Saskatchewan experiment was that while corporate rationalists had gained a foothold in the medical market as the major purchaser of physicians services, and the dominant interests of physicians had been protected, repressed interests were essentially dealt out of the final hand in the game. The role that they might have played through the advisory committee to the Commission or through the control of physicians in community clinics was minimized through the process of negotiation.

Health clinics were a political bargaining chip in the struggle between the dominant and challenging interests. The

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[48] Naylor, Private Practice, Public Payment, 213.

[49] Taylor, Health Insurance and Canadian Public Policy, 327-29.

government encouraged their development because of the symbolic threat they posed to the autonomy of individual physicians over conditions of practice and method of payment. By being community-organized they appeared to add legitimacy to the government plan to rationalize the delivery of services.

The dominant and challenging interests drew on different resources in the dispute. Unlike other provinces, the collective bargaining and self-regulatory functions of the medical profession were not separated into two distinct organizations.[50] Thus the interests of the "red tory" strain of medicine in controlling the norms of practice and the remunerative interests of the entrepreneurial strain[51] were fused in one representative organization. In effect this meant that the decision-making authority of the profession, including those aspects pertaining to the protection of the public interest, was concentrated in the hands of "a tiny group of highly organized, angry and committed men who were convinced they were defending themselves and the general public against a foreign ideology [communism]."[52]

This fusion of the two distinct interests of medicine gave the dominant interest an enhanced capacity to both

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[50] Taylor, Health Insurance and Canadian Public Policy, 264-65.

[51] Tuohy, Policy and Politics in Canada, 118-19.

[52] Badgley and Wolfe, Doctors' Strike, 170.

advocate and participate in the policy process. The College possessed both the capacity to develop a consensus on important policy issues and maintain sufficient autonomy from its membership and the government.[53]It was organized in such a fashion so that geographic and sub-disciplinary interests received adequate representation.[54] Its relative autonomy came from the government-sanctioned self-regulatory status and compulsory membership.[55]This included even those dissident doctors who were pro-medicare or practised in community clinics.[56] There was no institutionalized contradiction between the public and private obligations of the profession. The challenge to the dominant interests would have been better served by the institutionalized division of these two roles, as would be the case elsewhere in Canada.

The government could claim a "mandate from the people."[57] However, despite these formidable political resources, the CCF had actually received less than a majority of the popular vote and the official opposition Liberals had

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[53] Coleman and Skogstad, Policy Communities and Public Policy, 20-3.

[54] J.W. Grove, Organized Medicine in Ontario, A Study for the Committee on the Health Arts, (Toronto: Queen's Printer 1969), 312-14.

[55] Taylor, Health Insurance and Canadian Public Policy, 264-65; Coleman and Skogstad, Policy Communities and Public Policy in Canada, 20-3.

[56] Badgley and Wolfe, Doctors' Strike, 103

[57] Grove, The Medical Profession in Ontario, 311.

commanded 33 per cent and aligned themselves with the physicians. The physicians were also supported by the business community as represented by the Chamber of Commerce. Thus the government could hardly go to the public for support on the issue.[58]

While the Saskatchewan case provides the clearest evidence of the policy dynamics surrounding the CHC model prior to the introduction of national health insurance, the first CHC in Canada was actually established in Sault Ste. Marie, Ontario, in 1958. Sponsored by the local branch of the United Steel Workers of America, the centre was developed in response to the high level of extra-billing[59] in Sault Ste. Marie. Initially comprising union members and their families, the target population has gradually expanded to encompass approximately fifty percent (42,309) of the municipal population.[60] The large population served by the centre makes

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[58] Ibid.

[59] Canada, House of Commons, Debates, Monday April 9, 1984, 2837, Extra billing occurred when a physician billed a patient above the schedule of fees established by the provincial professional association.

[60] Jonathan Lomas, First and Foremost in Community Health Centres, (Toronto: University of Toronto Press, 1985): Association of Ontario Health Centres' Health and Health Care in Ontario: A Brief for Consideration at the Minister's Policy Conference, (Ontario Ministry of Health, April 24-27, 1983, 17; Statistics Canada, Census: Sault Saint Marie, (Ottawa: 1986), 1-1.

Sault Ste. Marie is mentioned here because it predates federal and provincial involvement in the CHC debate and it demonstrates the same political dynamics that were present in the development of CHCs in Saskatchewan.

it unique in Ontario, if not in Canada, as most CHCs serve populations of between one and five thousand.

Not unlike the experience in Saskatchewan,[61] the Sault Ste. Marie experiment faced strong opposition from the local medical community. Doctors practising at the centre were denied hospital privileges and publicly ostracized for many years. Those who resisted the temptation to leave, as evidenced by the high turnover rate, found themselves faced with limited professional freedom. The strong union-dominated board attempted to control many aspects of the centre's operations.[62]

The internal struggle between the lay board and the medical group eventually led to a drastic reduction in the board's decision-making authority. The introduction of universal medicare finalized the division of decision-making authority. Under the original funding arrangements, the board had controlled the physicians' salaries. Under government fee-for-service arrangements, the money went directly to the medical group. The end result was that while the board maintained control of capital expenditures, it no longer controlled the physicians' salaries.[63] The entrance of the

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[61] The major difference being that, in Ontario, the government tended to side with the medical profession on the issue. This reflects the government preference for private market service delivery arrangements.

[62] Lomas, First and Foremost in Community Health Centres, 63-77.

[63] Ibid, 80-1.

provincial government into the medical market actually reinforced the position of the dominant interests in Sault Ste. Marie because the choice of payment mechanism under national and provincial medical insurance was the fee-for-service method preferred by the medical profession.

Both Saskatchewan and Sault Ste. Marie provide useful examples of the political dynamics surrounding the structural interests in health care. After the introduction of national public medical insurance, the battle between the dominant and challenging interests would reach a heightened pitch.

3. Community Health Centres in the Post-Medicare Era

Even as the federal Medical Care Act[64] came into force in 1968, the federal Committee on the Cost of Health Services in Canada headed by Dr. John Hastings[65] argued that the system encouraged rampant cost escalation and misuse of resources. The first major point made by the Report of the Committee was that the key element of the system, the acute care hospital, was "being administered and used in a way that drove up costs."[66]Doctors and hospitals were identified as

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[64] Statutes of Canada, 1964, c. 64.

[65] Health and Welfare Canada, Task Force on the Cost of Health Services in Canada, (Ottawa: Queen's Printer, 1969).

[66] Peter Aucoin, "Federal Health Care Policy," in Carl A. Meilicke and Janet L. Storch, Perspectives on Canadian Health and Social Services Policy: History and Emerging Trends, (Ann Arbor: Health Administration Press), 251; see also , Health and Welfare Canada, Task Force on the Costs of Health Services in Canada, Volume Two.

the two groups linked directly to the mismanagement of health care resources.

The Reports of the Committee on the Costs of Health Services (hereafter referred to as Reports) stated further that the system placed undue emphasis on the private physician, practising either individually or in a group, while placing little emphasis on the use of other methods of delivery; including greater utilization of nurses and other health personnel, and the development of alternative settings to the acute care hospital. This aspect of the Reports recommended programs of CHC construction, supported by the federal and provincial governments, to house public, mental and voluntary health personnel, including physicians. The purpose of such facilities would be to provide appropriate diagnostic services.[67]

The third major issue raised by the Reports was that the coordination of the entire system was essential to improved efficiency in the formulation of policy and implementation of programs. Regional organization was the recommended remedy for this problem.[68] Finally, the introduction of greater public participation was suggested as a means of involving the consumer in discussions about proposed changes to the

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[67] Health and Welfare Canada, Task Force on the Costs of Health Services in Canada, Volume II, 285-86, Volume III generally, 379-80 specifically.

[68] Ibid, Volume II, 118, 147, 149, 280-85.

system.[69]That the provinces were in agreement with the findings of the Reports indicates that there was a general recognition by governments in Canada of what the problems were with the current health system and what the solutions might be.[70]

The worst fears of the Task Force were echoed in the 1970 Annual Review of the Economic Council Of Canada, entitled Patterns of Growth. The Economic Council feared that if the current pattern of expenditures was not curbed, "these two areas of activity [health and education] alone would absorb the entire potential national product before the year 2000."[71]Presented with this grim prediction, politicians were compelled to seek a solution. Community health centres offered one possible option for curbing health costs.

To this end the government commissioned the Community Health Centre Project in 1971, headed again by Dr. Hastings to examine the potential of the CHC model for reorienting the system away from the expensive acute care hospital-centred model of delivery to a "people-centred" preventive

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[69] Ibid, Volume I, 8.

[70] Aucoin, "Federal Health Policy, 263; Weller, "From 'Pressure Group Politics' to 'Medical-Industrial Complex': The Development of Approaches to the Politics of Health Care,"329-30.

[71] Canada, Economic Council of Canada, Patterns of Growth, Seventh Annual Report, 1970, 38.

approach.[72]With some reference to experience in the United States with prepaid group practice,[73] but with specific reference to community health clinics in Canada[74], a variety of studies indicated that the CHC model was capable of reducing hospital admissions by between fifteen and fifty percent.[75]The use of the model was also seen as a means of providing health care along the lines of the WHO definition of health.

The three major recommendations of the Hastings Report were:

1. to develop in the provinces a significant number of CHCs as non-profit corporate bodies in a fully integrated health services system.

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[72] J.E.F. Hastings, The Community Health Centre in Canada, Volume I, Foreword.

[73] Morris L. Barer, Community Health Centres and Hospital Costs in Ontario, Occasional Paper 13, (Toronto: Ontario Economic Council, 1981), Chapter Two, The author provides a comprehensive review of the relevant studies in both the U.S. and Canada.

[74] J.E.F. Hastings, F.D. Mott, A.T. Barclay and D. Hewitt, "Prepaid Group Practice in Sault Ste Marie, Ontario, Part I: Analysis of Utilization Records, " Medical Care, 11, 2, 1973; Hastings et al, "An Interim Report on the Sault Ste. Marie Study: A Comparison of Personal Health Service Utilization," Canadian Journal of Public Health, 61, 4, 1970; A.P. Ruderman, Economic Characteristics of Community Health Centres, Report to the Community Health Centre Project, (Ottawa: Queen's Printer, 1973).

[75] Barer, Community Health Centres and Hospital Costs in Ontario, 67; Hastings, "Health Services Organization and Delivery: Promise and Reality," 340; Ruderman, Economic Characteristics of Community Health Centres, 28, Studies of Clinics in Saskatchewan and the Sault Study in Ontario indicated an average reduction in hospital utilization of 24 per cent.

2. to reorganize and integrate all health services to ensure basic health service standards for all Canadians and to assure a more economic and effective use of all health care resources.

3. to initiate a dialogue between vested interests to plan, implement, coordinate and evaluate the system, supported by federal funding.[76]

Once again the message of challenging interests, to integrate, coordinate and plan services with a focus on CHCs was being put forward as a means of reforming the system.

Following the logic of corporate rationalists, the report emphasized administrative decentralization of decision making within provincial health systems. Under the revised system, the province would maintain ultimate responsibility for overall planning, allocation of resources and evaluation within the provincial framework. Subject to final provincial approval, a district or area health authority [the choice of terminology here is my own] would "compile budget requirements for individual services and facilities in its area and [present] a total package."[77]

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[76] John E.F. Hastings and Eugene Vayda, "Health Service Organizations and Delivery: Promise and Reality," in Robert G. Evans and Greg L. Stoddart, eds., Medicare at Maturity: Achievements, Lessons and Challenges, (Calgary: University of Calgary Press, 1986), 340; John E.F. Hastings, The Community Health Centre in Canada, Report of the Community Health Centre Project to the Conference of the Health Ministers, July, 1972, iv; Birch et al, HSO Performance: A Critical Appraisal of Current Research.

[77] Hastings, The Community Health Centre in Canada, 30-2; The importance of this regionalized system of delivery should not be under-estimated because it has allowed other countries

In essence , the CHC model incorporated all of the major recommendations of the Task Force Reports on the Costs of Health Services. The first criterion of the Reports met by the community health centre approach was that it would encourage not only a multidisciplinary team approach to primary care, but also "a greater degree of substitution of personnel and a more rational division of labour."[78] Both productivity and cost efficiency would be achieved if centres were of a reasonable size. The second criterion that the health centre model addressed was the reduction of costs for in-patient hospital care. The third criterion met by CHCs was the implicit assumption that such organizations would function in a regionalized system. The final important overlap between the CHC report and the previous Task Force Reports was the opportunity such organizations would provide for community input.[79]

To facilitate the adoption of this alternative health system, the CHC Project Report recommended that changes be made to the legislation governing the financing of health care. Specifically, the scope of the original Hospital Insurance and Diagnostic Services Act needed to be broadened

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such as Great Britain to effectively cap health care expenditures.

[78] Aucoin, "Federal Health Policy," 253.

[79] Ibid, 254.

to include community health centres.[80] The scope of the federal and provincial legislation pertaining to medicare would also have to be broadened to allow for the substitution of personnel and payment mechanisms that would be employed by community health centres.[81]

The implication of these recommendations was that the federal government would have to allow sufficient flexibility in financial arrangements for the provinces to allocate funding according to provincial priorities. The federal government appeared willing to do this as long as the cost escalation was contained. For their part the provinces indicated a willingness to experiment with alternative forms of financing and delivery. Other studies conducted at the provincial level[82] placed similar emphasis on a corporate rationalist approach. Some of these reports, in particular, the Castonguay Report, provided background evidence for the

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[80] Ibid, 254; Health and Welfare Canada, The Community Health Centre in Canada, 59.

[81] Health and Welfare Canada, The Community Health Centre in Canada, 34-5.

[82] John Browne, "Summary of Recent Major Studies in Health Care in Canada," in Meilicke and Storch, eds., Perspectives on Canadian Health and Social Services Policy: History and Emerging Trends, 294-305.

The reports were as follows: Quebec, Commission of Inquiry on Health and Social Welfare 1972 (Castonguay Report); Manitoba, White Paper on Health Policy; Ontario, Report of the Health Planning Task Force 1974 (Mustard Report); B.C., Health and Security for British Columbians (Foulkes Report), 1973.

CHC Project. Subsequent studies[83] carried out during the 1980s by most provinces simply reiterated the major aspects of the first series of studies.

By the time the CHC Project Report was presented to the Conference of Health Ministers, a general consensus in support of its ideas had emerged from the three federal political parties and the three major health sector actors: the Canadian Nurses Association, the Canadian Hospital Association, and the Canadian Medical Association. At that time the federal government proposed a one-time, thirty-dollar per-capita "thrust fund" to provide capital funding and seed money for the development of alternative organizations and regional service provision. The Canadian Medical Association withdrew

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[83] Newfoundland, Royal Commission on Hospital and Nursing Home Costs, February, 1984, A Green Paper on Our Health Care System Expenditure and Funding, January, 1986, Advisory Committee Nursing Workforce, June, 1987; New Brunswick, Commission on Selected Health Care Programs, June 1989, Nursing Resources Advisory Committee, term unspecified; Nova Scotia, Royal Commission on Health Care, December, 1989; Quebec, Commission d'Enquete sur les Services de Sante et les Services Sociaux, December, 1987; Ontario, Minister's Advisory Group on Health Promotion, October 1987, Ontario Health Review Panel, June 1987, Panel on Health Goals for Ontario, August 1987, Premier's Council on Health Strategy, 1987-91, Conjoint Review Committee, July 1988, Task Force on the Use and Provision of Medical services, term unspecified, Deciding Our Health Future, April, 1989, (discussion paper), Health Professions Legislation Review, November 1982, Task Force on the Implementation of Midwifery in Ontario, January, 1986; Manitoba, Health Advisory Network Steering Committee, December 1988; Saskatchewan, Saskatchewan Commission on Directions in Health Care, March, 1990; Alberta, Advisory Committee on the Utilization of Medical Services, September 1989, Premier's Commission on Future Health Care for Albertans, December, 1989; Canada, Task Force on the Allocation of Health Care Resources, June 1984, Committee on the Health Care of the Elderly, 1987.

its support after being pressured by provincial associations. Provincial hospital associations were also opposed to the ideas presented at the federal level. In both cases, the proposed changes to the system would have meant increased constraints on the financial and decision-making autonomy of the dominant structural interests.[84]The failure to reach an agreement in 1972 meant the end of the thrust fund. With the exception of Quebec, which had already moved unilaterally to reform its system,[85] few health centres have been developed. Other problems, such as the association of CHCs with "socialized medicine", influenced the failure to act coherently on the Report. Beyond the sub-government of the policy community there continued to exist significant support

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[84] Hastings and Vayda," Health Service Organization and Delivery: Promise and Reality," 341-42.

[85] Marc Renaud, "Reform or Illusion ? An Analysis of the Quebec State Intervention in Health," in David Coburn, ed., Health and Canadian Society, (Toronto: Fitzhenry and Whiteside, 1981, 369-392; Federic Lesemann, Services and Circuses: Community and the Welfare State, (Montreal: Black Rose Books, 1984); Luciano Bozzini, "Local Community Services Centres (CLSCs) in Quebec: Description, Evaluation, Perspectives," Journal of Public Health, Autumn, 1988, 346-75; Taylor, Health Insurance and Canadian Public Policy, 484.

Attempts by the Quebec government to reform health and social services by imposing an ideal type corporate rationalist model were met by strong opposition from organized medicine. The establishment of seventy-two community service centres (CLSCs) by government was countered by the establishment of 400 private, physician-controlled polyclinics.

from the public and other non-medical, non-dental groups.[86]

The continuing research into system reform at the provincial level was closely associated with the continuing federal-provincial discussions surrounding the revision of cost-sharing arrangements. The underlying goal of the provinces was to obtain greater control over the planning and delivery of health care without losing the federal financial commitment. The federal government was concerned about cost containment, as were the provinces, but wanted to maintain sufficient leverage through financial commitments to maintain the national character of health care. These negotiations carried on for the better part of the decade.[87]

The position of federal government policy continued to shift away from a continuing heavy commitment to an open-ended system. The 1974 position paper, A New Perspective on the Health of Canadians (Lalonde Report), re-emphasized the recommendations of the previous two federal reports concerning regionalization; and called for consumer involvement in decision making; increased emphasis on promotional and preventive activities; integration of services ; and more efficient use of allied personnel. The major thrust of the position paper was the emphasis it placed on viewing the current health care delivery system as only one alternative.

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[86] Hastings and Vayda, "Health Service Organization and Delivery: Promise and Reality," 342.

[87] Ibid, 337-39.

The paper indicated that further improvements in the health status of Canadians were likely to occur through a broader preventive approach to health care.

The Lalonde Report emphasized collective responsibility and individual action. Continued state involvement in health care in the future would be supplemented by greater individual responsibility for the lifestyle factors (e.g. smoking, exercise), which have the greatest impact on better personal health. By calling for active rather than passive individual participation, the federal government effectively issued a challenge to the dominant medical approach to health care.[88]

The report's author, Hubert Laframboise, then Director of the Long Range Planning Group of the Department of National Health and Welfare, has since emphasized that:

> ...when he assumed the position of Long Range Planning he made a careful assessment of what he could do without treading on the toes of his established colleagues. His group was to attempt to legitimate a new approach for the Department of National Health and Welfare, to establish that health care is more than medical care, and to enable government to break away from the dominance of the medical profession with its emphasis on diagnosis and treatment according to the biomedical model.[89]

In essence, the position paper signalled that the federal

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[88] Canada, National Health and Welfare, A New Perspective on the Health of Canadians, (Ottawa: Queen's Printer, 1974),5; Warner, 360.

[89] Anne Crichton, "Healing Ourselves," Policy Options, 7, 9, 1986, 14; see also, Hubert L. Laframbroise, "Health policy: breaking the problem down into more manageable segments," Canadian Medical Association Journal, Feb. 3, vol. 108, 1973, 388-93.

government was interested in developing alternative methods of service delivery as a means of controlling costs.[90]

In 1977, renegotiation of the cost-sharing arrangements culminated in the addition to the 1972 Fiscal Arrangements Act[91] of a provision called Established Programs Financing (EPF), making the new title of the legislation governing cost-sharing arrangement, The Federal Provincial Fiscal Arrangements and Established Program Financing Act.[92] The net result of the new arrangements was, in effect, to give the provinces the requested flexibility and control in the health and education fields. This was largely a result of the vague wording of the program conditions for health and education. By 1982, the federal government was actually paying for sixty percent of the program costs, when under the old arrangements they had paid only fifty percent.[93]

In 1979, the federal government appointed Mr. Justice

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[90] Hubert Laframboise, "Non-Participative Policy Development: The Genesis of A New Perspective on the Health of Canadians, Journal of Public Health Policy, Autumn, 1990, 316, In light of the intention, the decision by the department to develop the paper without prior outside consultation with either other government departments or affected interests groups is interesting.

[91] Statutes of Canada, 1972, C. 13.

[92] Statutes of Canada, 1977, C. 13.

[93] Van Loon and Whittington, The Canadian Political System: Environment, Structure and Process, 293-95, The federal government spent much of the 1980s attempting to back pedal on this mistake by introducing countervailing fiscal measures. The net result of supplemental fiscal arrangements during the 1980s has been a reduction in the federal share of health-insurance-program costs.

Emmett Hall to review the system of universal health care in light of the continuing confrontation between health care providers and governments over the question of inadequate funding. The two significant findings of the report were, as noted above that the EPF arrangements had actually generated more money from the federal level than the original cost-shared arrangements and provincial health spending was increasing, and that the provinces should end extra-billing by doctors.

The outcome of the Hall Report[94] was a federal government position paper, Preserving Universal Medicare[95] emphasizing the extra-billing sentiments of the Report and foreshadowing the introduction and passage of the 1984 Canada Health Act.[96] The Act tied the transfer of funds through EPF to the discontinuance of extra-billing. Where EPF had resulted in a massive transfer of responsibility from the federal to the provincial government, the Canada Health Act appeared to both the provinces and the medical profession to be an attempt to reverse this shift.[97] Despite resistance from several provinces, especially Ontario, which endured a doctor's strike

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[94] E. M. Hall, Canada's National-Provincial Health Program for the 1980's, (Ottawa: Health and Welfare Canada, 1980).

[95] Canada, Preserving Universal Medicare, A Government of Canada Position Paper, (Ottawa: Department of Supply and Services, 1983).

[96] Statutes of Canada, 984, C. 6.

[97] Taylor, Health Insurance and Canadian Public Policy, 435.

in 1986 over the issue, all provinces have now complied with the legislation. The termination of extra-billing, a symbol of professional autonomy, represents "a clear policy rejection of the position of the medical profession."[98]

The most recent round of federal-provincial meetings concerning health care have suggested a far more aggressive approach to the management of health services than had previously been contemplated. The provincial and federal governments have agreed in principle that limitations must now be placed on the numbers of physicians and where they practice. In conjunction with this, some sort of regionalized global budgeting is being considered.[99] Again, a central aspect of the traditional autonomy of the medical profession is under attack on a national scale.

4. Outcomes

Despite the failure to reach a consensus on CHCS in 1972, the advancement of a corporate rationalist approach to health care has yielded a number of results. To varying degrees, most provinces have implemented those aspects of the Hastings

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[98] Heiber and Deber, "Banning Extra-Billing in Canada: Just What the Doctor Didn't Order," 71.

[99] Ontario Ministry of Health, "National Physicians' Strategy Announced," Joint Release by the Provincial/Territorial Ministers of Health, January 28, 1992; Morris L. Barer and Greg L. Stoddart, Toward Integrated Medical Resource Policies for Canada, Report Prepared for the Federal/Provincial/Territorial Conference of Deputy Ministers of Health, June 1991.

Report reflected in their own provincial studies. The development of CHCs (see Appendix V) and regionalization have occurred in a number of provinces. But, there has been no standardized approach to the development of either concept.

The province of Quebec undertook a comprehensive reform of health and social services in an effort to promote the aspirations of the provincial administrative and political elite (sometimes referred to as technocrats). Ontario on the other hand has taken a much less radical approach, choosing instead to maintain pluralism and choice in the system. Unlike Quebec, Ontario has introduced change to the system on a piecemeal and voluntary basis.[100]

5. Analysis

The development of community health centres in Canada is indicative of the competition between dominant and challenging interests for control of the health care system. The external pressure which led to this fundamental rethinking of the role of government in health policy was the result of the economic hardship generated by the Depression. The ensuing conflict between the dominant and challenging interests was the result of the extent to which government rethought its position. Two factors: economics and ideology continued to be the source of

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[100] Anne Crichton, David Hsu and Stella Tsang, Canada's Health Care System : Its Funding and Organization, (Ottawa: Canadian Hospital Association Press, 1990), 248.

conflict as health insurance was introduced across Canada.

Prior to the introduction of national health insurance, the province of Saskatchewan served as the experimental laboratory for the intervention of government into the medical services market. As Carolyn Tuohy notes, "the catharsis and demonstration effect of the Saskatchewan program eased the introduction of national health insurance."[101] Thus most provinces were able to avoid the immediate confrontation with organized medicine with the implementation of hospital and medical insurance.

By establishing provincially-funded hospital services prior to medical care insurance, the Saskatchewan experiment generated a pattern which guaranteed that the system would be costly because of its focus on the treatment of illness in an acute care setting (the curative model). By establishing a medical insurance program which allowed physicians freedom to choose their method of remuneration and the conditions of practice, the government in essence entrenched the dominant position of organized medicine in the publicly-funded system. As indicated by Martin Lipset prior to the introduction of provincial health insurance, those who seek to reform a sector of the economy which is dominated by powerfully entrenched societal interests must perform a precarious balancing act between achieving the required reforms without threatening the power, privileges or beliefs of the dominant interests. If

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[101] Tuohy, Policy and Politics in Canada, 111.

proposed change is too radical, dominant interests are likely to offer a strong opposition.[102]

In Saskatchewan, organized medicine was initially willing to acknowledge the necessity of government involvement in the medical market. The failure of the government to act at this opportune moment, meant that the dominant interests were left to seek their own solutions to the problem. While government intervention in the provision of hospital services did not pose an immediate threat to the dominant interests, intervention in the medical market did. By the time government became capable of responding, organized medicine had already developed a solution that was least disruptive to the established norms of practice and method of payment. When government attempted to impose a solution which was antithetical to these core aspects of the profession it met with a strong and coherent resistance. The result was a compromise which allowed the government to gain a further foothold in the medical market, but not as far as was intended.

Community clinics were developed by repressed interests in response to the impasse between dominant and challenging interests. This activist stance on the part of patients, alarmed the medical profession because it was associated with the approach to service delivery envisioned by the government,

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[102] S.M. Lipset, Agrarian Socialism: The Co-operative Commonwealth Federation in Saskatchewan, (Berkeley: University of California Press, 1950), 242-52.

and it introduced another and perhaps more menacing threat to professional autonomy. It was one thing for government to suggest that it was going to become the monopoly purchaser of services, but it was quite another for patients to dictate to individual physicians how they should practice medicine and how much they should be paid. For the dominant interests this was just another means for the challenging interests to attack the central aspects of professionalism.

During the post-medicare era the concerns of the dominant structural interests to protect their position in the medical market have been overshadowed by government concerns with cost control and accessibility. Where the original external pressure that generated a fundamental rethinking of health policy had been the inability of individuals to pay for health service, the external pressure generated once health insurance became government-funded was the perceived collective inability of the taxpayers to pay.

The entrance of government into the market did not change the expansion of medical knowledge or technology. Nor did it stem the demand for services. In fact the open-ended nature of financing and the removal of individual responsibility for health care, likely contributed to an acceleration of the process.

The issues in the post-medicare period have been cost containment and accessibility to services. In response to these concerns governments have attempted to create a

coordinated and rationally planned system of delivery on a national and sub-national basis. Part of this strategy has involved developing alternative organizational and funding mechanisms. This strategy would in essence allow the system to shift away from reliance on a curative hospital-centred approach to health care to a decentralized system of community health centres, employing multidisciplinary human service teams and a preventive approach for health care.

Underlying this further reconsideration of the fundamental aspects of health policy has been the implicit discussion of how medical practice should be organized in Canada.[103]The scope of this debate includes the payment of physicians, utilization of hospital services and the organization of medical practice. A regionalized system of delivery including community health centres has repeatedly been advanced by challenging interests as a cheaper alternative to the current system. In this respect, CHCs have demonstrated the potential to decrease hospital utilization costs, take the pressure off of hospital emergency rooms and substitute cheaper forms of labour than physicians. They offer an alternative and more controllable payment mechanism than

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[103] Samuel Wolfe and Robin F. Badgley, " How Much is Enough? The Payment of Doctors - Implications for Health Policy in Canada," International Journal of Health Services, 4, 2, 1974, 245-64; Morris L. Barer and Robert G. Evans, "Riding North of a South-Bound Horse ? Expenditures, Prices Utilization and Incomes in the Canadian Health Care System," in Robert G. Evans and Greg L. Stoddart, eds., Medicare at Maturity: Achievements, Lessons and Challenges, 53-164.

fee-for-service. They have also demonstrated an ability to coordinate the delivery of primary health and social services with an emphasis on the prevention of illness.

However, politicians have been reluctant to rapidly restructure the system. This reluctance has been married to the mobilization of bias in the existing system. By altering the overall financial arrangements of the system without altering the organization of the delivery of services, politicians removed any incentives for organizational change. They now appear to be attempting to somehow put these incentives into the system.

Until recently, the question of who should bear the brunt of the financial commitment to maintaining the system has also been met by, a lack of resolve on the part of governments in confronting the dominant interests. However, as the drive for cost containment has been reinforced by future demographic projections, a consensus has gradually emerged among challenging interests that now appears to be allowing them to confront effectively the dominant interests. In the post-EPF environment governments have moved more forcefully to contain costs and realign the system. The termination of extra-billing in the mid-1980s is the most visible symbol of this new resolve on the part of government to control costs and make the system more cost effective for the future. In the emerging environment, the goal of corporate rationalists to extend organizational control over the work of professionals has

become more important with increasing levels of government intervention in the organization and delivery of services.

The changes that are occurring to the system reflect the accommodation of the major structural interests. Fee-for-service and hospital-centred delivery systems have been maintained to accommodate the interests of the medical profession. Regionalized planning, and alternative methods of payment and organization of services have been developed to accommodate the interest of corporate rationalists. Greater community input into the decision-making process has been developed to accommodate the repressed interests, as represented by community advocates. The net result is that while the system is moving slowly towards a model that favours the challenging and repressed interests, the dominant interests still remain central to the success of health policy.

In the case of CHCs, the evidence suggests that they have played an important symbolic role in the competition between structural interests for control over the organization and delivery of health services. They have been viewed by the dominant interests as the thin edge of the wedge of state intervention. Although sometimes limited, government support of CHCs is a symbolic indication of what government could do in terms of reforming the system.

The failure to develop a comprehensive system of CHCs as originally envisioned by corporate rationalists reflects both

the bias of the system toward the fee-for-service method of payment and the withdrawal of support for the Hastings initiative by the dominant structural interests. At the provincial level, the initial experimentation with health centres in Saskatchewan, during the doctors strike and the earlier development of the Sault Ste. Marie health centre are visible manifestations of the relationship between health centres and structural interests.

As the Saskatchewan case illustrates, community activists and corporate rationalists in government have formed an alliance to develop health centres. The medical profession has responded by attempting to prevent governments from developing a policy framework to accommodate alternatives such as community health centres, which openly threaten medical power. They have also dealt individually with doctors who choose to defy the policies of the representative associations.

The Sault experience elicited a similar local response from organized medicine. The introduction of public health insurance after the establishment of the Sault, because of the bias towards fee-for-service and unrestricted access, actually worked against maintaining the financial viability of the experiment. Where large numbers of government or consumer-sponsored CHCs have emerged, such as in Quebec and Ontario, organized medicine has countered by developing group practices under the control of physicians.

The failure by the federal government to establish a

viable role in the development of a national network of community health centres has left provincial governments with the major responsibility for this task. Not surprisingly, the provinces have not responded in an entirely uniform fashion to the development of health centres. The next chapter discusses health policy and the development of CHCs in the province of Ontario.

Chapter III

Health Care Politics in Ontario[1]

Politics in Ontario is a study in contrasts, both in terms of leadership and policies. About Ontario two decades ago, Fred Schindeler commented that:

> It seems the province suffers from philosophical schizophrenia: compelled to preach old-fashioned liberalism but forced to practice something quite different.[2]

This contrast is nowhere more evident than in the area of health care policy. The development of a public health care system in the province has been the result of an ongoing debate between those interests espousing a business liberalism reminiscent of the nineteenth century and those promoting a reform based on positive rights. Health policy has reflected this conflict in the attempts of the professional medical monopoly to maintain a system of delivery that serves their needs while corporate rationalists and community activists have attempted to rationalize an economically inefficient delivery system and shift power away from physicians. The result has been an increasing government role in the planning

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[1] Information for this chapter was obtained through interviews conducted with the following individuals: Ray Berry, Dave Brindle, Elinor Caplan, Darwin Kealy, Larry Grossman, Joan Milling, Frank Miller, and Jim O'Neill. Brief biographical notes are included in the bibliography.

[2] Fred Schindeler, "Responsible Government in Ontario: Will Government Be Up to the Task," in Robert F. Nixon, ed., The Guelph Papers, (Toronto: Peter Martin Associates, 1970), 138.

and management of health care services and an increased diversity of clienteles.

Community health centres have been developed in Ontario as a means of addressing, on the one hand, the containment of the costs generated by physicians' services and hospital utilization, and on the other hand, the emerging demands for targeted service provision. From the government perspective they are an alternative funding mechanism and organizational form to those most preferred by dominant medical interests. The strength of the CHC as an alternative to the fee-for-service method of remuneration is that they eliminate the potential for excessive billing practices. The purpose of alternative funding arrangements is to remove the demand driven incentive to generate services associated with the fee-for-service method of remuneration. By placing the physician within a multidisciplinary setting controlled by a community board and professional administrator, they challenge the ability of the physician to make decisions about the allocation of work to other ancillary health workers. By placing greater emphasis on a preventive as opposed to a curative model of care, CHCs contribute to a reduction of hospital utilization. Finally, by promoting greater citizen input into decision making they are symbolically democratic and in practical terms incorporate new participants into the policy process. Thus, as a policy option they are attractive because they address both political and administrative

concerns.

These reform efforts have been initiated because of concerns for cost containment. They have evolved through the political process to encompass the concerns of health activists with accessibility to services. Despite these dual pressures, the process of developing alternative services has been hampered by the existing bias of the system that favours dominant interests.

The chapter begins by providing a sketch of politics in the province. Specific emphasis is placed on the impact of interest group pluralism on the development of new policies. It is against this background that developments in health policy in general and community health centres in particular are discussed.

1. Background

Historically in Ontario, politics has reflected a diversity of viewpoints concerning religious and language issues, and differences between a shrinking rural culture and an increasingly urbanized society. Above all else, however, politics in Ontario has reflected the coexistence of two competing ideologies: market liberalism and reform liberalism. The two are able to coexist because of their general agreement on government based on the minimal use of coercive force. Where they differ most markedly is on the matter of inequality of condition, especially economic conditions. Historically,

the two ideologies have manifested themselves in Ontario through a ruling conservative elite and a liberal democratic reform movement.[3]

The hallmark of political success in Ontario politics has been a leadership based on the image of "the businesslike management of provincial affairs" ... and a "capacity for maintaining an equitable balance among the principal interests of the province."[4] Therefore, government largesse has extended beyond strictly party lines. Notwithstanding the emphasis on the principles of business, success in governing has also depended on the ability of political leaders to recognize and respond to economic and social changes. Taken together, this political balancing act relates to the two competing ideologies in that:

> each [leadership and capacity to balance interests] reflects a different, and perhaps conflicting, set of values. On the one hand the demand for sound leadership, especially in the form which it has appeared at the time of government defeats suggests a rather conservative cast of mind, oriented only to the maintenance of order. The idea that a balance must be maintained between the interests, however, points in a different direction, to the rather more progressive notion, of fair play and

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[3] S.F. Wise, " The Ontario Political Culture: A Study in Complexities," in Graham White, ed., The Government and Politics of Ontario, Fourth Edition, (Toronto: Nelson Canada' 1990), 45.

[4] John Wilson, "The Red Tory Province: Reflections on the Character of the Ontario Political Culture," in Donald C. Macdonald, ed., The Government and Politics of Ontario, Second Edition, (Toronto: Von Nostrand Reinhold Ltd., 1980), 219.

equal treatment of all.[5]

The development of health centres has been affected by the balancing act that provincial political elites must perform between structural interests.

The penchant for sound fiscal management has been complicated by the increasing political significance of a number of distinctive sub-groups within the provincial population which have placed increased demands on the government for specialized services. Historically, both a rural-urban distinction and the development of a variety of ethnic and linguistic enclaves have characterized the political landscape, but the growing importance of these two elements, especially ethnicity, has led to the development of a variety of new programs. Other demographic segments of the population affecting recent government attitudes to service provision include: women, the elderly, and the disabled.

Ethnicity has become increasingly important for two reasons. First, since 1871 when Ontario's population was predominantly of British descent (82 %), the provincial demographic make-up has shifted to the point where the British descent component now only comprises about sixty percent of the total population. The remainder consists of a mixture of other European, Asian, Caribbean and South American groups. In the past two decades, the number of more visible ethnic

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[5] Ibid, 223; Wilson suggests that this apparent contradiction in terms makes Ontario's political culture "progressive conservative" or "red tory".

minorities arriving from Asian and Caribbean destinations has increased dramatically in comparison to arrivals from Britain, other European destinations and the United States.[6]

Second, the concentration of the relatively newer ethnic participants in Ontario's major urban centres, especially Toronto, has increased the relative electoral power of these ethnic fragments. This change has placed new demands on the political process:

> The debate over multiculturalism is ... centred in the Toronto region where entire communities and neighbourhoods are primarily Italian, Chinese, Greek, Portuguese, Jewish, Black, or South Asian ... Multiculturalism raises such questions as adequate representation of such groups in public employment, discrimination in the private sector, and heritage language programs in the public and separate school systems.[7]

Ontario has been transformed during the latter half of the twentieth century from a fragment of British culture to a multicultural society. Increasingly provincial and federal political parties are scrambling to capture the votes of the newly arrived.

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[6] Desmond Morton, "Sic Permanent: Ontario People and Their Politics," in Graham White, ed., The Government and Politics of Canada, 5; Rand Dyck, " The Socio-Economic Setting in Ontario Politics," in White, ed., The Government and Politics of Ontario, 37-41; Marvyn Novick, "Social Policy: The Search for a New Consensus," in Macdonald, ed., The Government and Politics of Ontario, Third Edition, 350.

Novick notes that Ontario has traditionally received 50 % of immigrants to Canada and of that number, half have settled in Toronto.

[7] Dyck, "The Socio-Economic Setting in Ontario Politics," 38.

In the case of the other repressed interests (women, youth, the elderly and the disabled), their growing significance in the design of government services has been largely determined by their increased ability to organize and participate in the political process and their role as consumers of government services.[8]

The policy process is characterized by a plurality of competing inputs from traditional associations, single-issue public groups, businesses, individuals and social service agencies which lobby government directly.[9] Those segments of the population that do not mobilize and effectively pressure government are likely to receive less from the resource allocation process. Provincial policy outputs have taken on an increasingly categorical appearance as indicated by the development of: health centres to serve the needs of women, the elderly, the poor, aboriginal and multicultural populations; heritage language programs serving 93,000 students in sixty-two different languages; pay equity and affirmative action programs affecting both the private and public sectors. The development of government agencies such as the Race Relations Directorate, the Human Rights Commission, the Ministry of Culture, the Office for Disabled Persons, the Office for Senior Citizens, the Office of Francophone Affairs,

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[8] Ibid, 38-39.

[9] Coleman and Skogstad, Policy Communities and Public Policy in Canada: A Structural Approach, 27.

the Ontario Native Affairs Directorate, and the Ontario Women's Directorate, has provided new institutionalized voices for the fragmented interests of the province.[10]

The growing emphasis on representative bureaucracy reflects a trend in government towards:

> a greater acceptance that all individuals may not, or cannot be represented by groups, thus leaving some citizens under-represented except by government itself.[11]

Policy outcomes are the result of the ongoing competition between factions within government and within policy communities. Government has both responded to and fostered the fragmentation of clienteles along functional lines, producing an increasing variety of policies and programs targeted at segments of the population.[12]Health policy provides a good example of how these various pressures have resulted in a more categorical approach to service delivery.

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[10] Dyck, "The Socio-Economic Setting in Ontario Politics," 38; James Mackenzie, "Interacting With Government," in Donald C. Macdonald, ed., The Government and Politics of Ontario, Third Edition, (Toronto: Nelson Canada, 1985), 292; George G. Bell and Andrew D. Pascoe, The Ontario Government; Structure and Functions, (Toronto: Wall and Thompson, Inc., 1988), Table of Contents.

These changes in the structure of government departments may coincide with similar changes or pre-existing agencies at the federal level.

[11] Mackenzie, "Interacting With Government," 292.

[12] Cairns, "The Embedded State," 56.

2. Health Care in Ontario

Unlike Quebec, whose population since 1960 has been much more amenable to the introduction of progressive change through government intervention, Ontario has responded in an incremental fashion. This guarded response reflects a clientele pluralist approach to health care policy in which a dependency relationship between state actors and interest groups leads to an exchange of information in return for the opportunity to participate in the policy process.[13]

This relationship can be attributed to the continual Conservative rule in Ontario from 1943 onward that allowed maximum interest group penetration in policy areas such as health. Thus the relationship between the government and the medical profession was long in duration and indispensable to the vision of health services in the province. The underlying small business ideology found in the medical profession assured that it was viewed favourably by the government.

This special status afforded the medical profession was demonstrated in the government willingness to allow the profession to remain self-regulating under a public insurance scheme and to be closely involved in the formulation of health

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[13] Coleman and Skogstad, Policy Communities and Public Policy in Canada: A Structural Approach, 27; Carolyn Tuohy, "Private Government, Property and Professionalism," Canadian Journal of Political Science, 9,4, 1976, 668-81; Tuohy,"Corporatism and Pluralism in Ontario Medical Politics," in K.J. Rea and J.T. Macleod, eds., Business and Government in Canada, (Toronto: Methuen, 1976), 410; Joan Boase, "Regulation and the Paramedical Professions: An Interest Group Study," Canadian Public Administration, 25,3, 1982, 339-341.

policy. To this end, prior to the 1970s many health ministers and ministry workers came from medical backgrounds.[14] When hospital insurance was introduced in 1959, the government deliberately opted not to introduce out-patient diagnostic services as an appeasement to the medical profession.[15]

Although the province entered the medical insurance field between 1963 and 1966, it chose a voluntary enrolment plan, with maximum annual premiums and guaranteed renewable participation, applicable to either a non-profit government plan or one of the existing private sector plans. The presumption on the part of the government in 1966 was that this would meet the four criteria established by the federal government. This allowed physicians and insurance companies to maintain their existing relationship.

Again the importance of the market economy philosophy was stressed in the option of choosing either government or private. The influence of the private sector was so large that in 1966, ninety-five percent of the population of Ontario had some form of protection without a universal government program. Of this, approximately twenty-five percent of the population were estimated to qualify for government

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[14] Geoffrey Weller, "Health Care and Medicare in Ontario," in G. Bruce Doern and Seymour V. Wilson, eds., Issues in Canadian Public Policy, (Toronto: MacMillan of Canada, 1974), 86-89.

[15] Ibid, 158.

subsidies.[16]

The 1965 decision of the federal government at the federal-provincial conference to establish a national medical care plan drew strong opposition from several provinces, including Ontario. The provincial government was angry over the choice of the federal government to finance its share of the financial commitment through a "social development tax" as opposed to withdrawal from certain tax fields.[17]The introduction of universal medical insurance placed the government of Ontario in opposition to private enterprise, especially doctors and insurance companies. The latter were phased out of health insurance by 1972.[18]

Once the provincial government had assumed the new role as universal insurer, it moved in an incremental fashion to gain greater political control over policy-making, including the establishment of policy objectives and priority setting. This change from a laissez-faire to a more interventionist government role was the result of mounting costs, poor availability of doctors and growing fragmentation of services.[19] However, efforts to gain greater control over the system were hampered by the existing organizational and

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[16] Ibid, 341, 368.

[17] Weller, "Health Care and Medicare in Ontario," 94.

[18] Taylor, Health Insurance and Canadian Public Policy, 376.

[19] Weller, "Health Care and Medicare in Ontario," 97-9.

political bias which viewed the role of government in health care as one of "paymaster" and not "manager."[20]

The lack of a strategic overview of the system and the dominance of the decision-making process by organized medicine minimized the ability of government to plan and control expenditures and led to a lack of overall priority setting (a common problem throughout the provincial government structure at the time). One means by which government initially attempted to rectify this problem was to "rationalize" policy making by creating groupings of departments in the decision-making process called "policy fields."

The move to reorganize government along these lines was the result of the Committee on Government Productivity, appointed by Premier Robarts in 1969, with a mandate to improve the efficiency and effectiveness of the provincial government. The Committee's Interim Report Number Three, issued in December of 1971, proposed the grouping together of Ministries with related programs providing direct services to the public. Each field reflected an attempt by decision makers to group together those departments bearing the most direct relationship to each other in terms of the programs and services provided. Thus in the case of health care, the Ministry of Health was grouped together with Community and Social Services, Housing and Education to create the Social

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[20] This observation is based on discussions with former Ministers of Health and senior public administrators.

Development Policy field. The Social Development Policy field was identified as those programs concerned with "the detection, prevention or treatment of social problems and the social betterment of the Citizens of Ontario." A policy secretariat was established to coordinate policy among the four ministries.[21]

One of the outcomes of the implementation of the COGP recommendations in the Ministry of Health was:

> the gradual replacement of doctors by professional administrators in Health partly because of the committee's stated goal of improving what the author's called the "corporate" allegiance of the bureaucrats. One of the problems with the bureaucracy, as COGP saw it, was that individual Ministries tended to become parochial and to lose sight of the overall objectives of the government as a whole... The decision to employ generalists who would take a corporate view within ministries led to a search for bureaucrats with management or administrative training.[22]

As medically trained physicians were replaced by professional managers, the traditional institutional base of service provision became the focus of increased scrutiny and control.

Whether or not the rationalization of the MOH has succeeded in eradicating the parochial nature of the component departmental branches is debatable. Much like similar developments at the federal level, the new system failed to fully take into account the resistance of line departments to

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[21] Committee on Government Productivity, Interim Report Number Three, Government of Ontario: 1971, 20.

[22] Harvey G. Simmons, Unbalanced: Mental Health Policy in Ontario, 1930-89, (Toronto: Wall and Thomas, 1990), 143-44.

interference with their own internal decision-making processes. The fault lies with the failure or lack of will on the part of the creators of the new innovation to vest sufficient power in the newly created structures to force the compliance of line ministries to the larger objective of overall policy coordination. In essence the role of policy secretariats was consultative and coordinative rather than executive in nature.[23] The lack of resolve to use the new system to its full potential reflected the successful resistance of the line ministries in health and education supported by strong professional constituencies[24] and the threat that strong policy secretariats would have posed to the autonomy of the Cabinet and the Premier's Office as "effective centres of negotiation and appeal."[25]

Despite the failure of the new system to encourage innovation in the development of policy and its eventual abandonment by the Liberal government in 1985, the

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[23] Peter Aucoin, "Organizational Change in the Machinery of Canadian Government: From Rational Management to Brokerage Politics," Canadian Journal of Political Science, XIX, 1, (March, 1986), 3-27; Ian D. Clark, " Recent Changes in the Cabinet Decision-making System in Ottawa," Canadian Public Administration, 28, 2, (Summer, 1985), 185-201; Hugh Segal, "The Evolving Ontario Cabinet: Shaping the Structure to Suit the Times," in Macdonald ed., The Government and Politics of Ontario, Third Edition, 70-81; Novick, "Social Policy: The Search for a New Consensus," 332-34, Robert J. Williams, "The Social Policy Field," in Graham White, ed., Government and Politics in Ontario, Fourth Edition, 334-36.

[24] Marvyn Novick, "Social Policy: The Search for a New Consensus," 332-33.

[25] Ibid, 332.

introduction into government of the management techniques suggested by the COGP formalized the Cabinet decision-making process at the provincial level and led to a greater degree of central control over expenditures through the Management Board of Cabinet and the Planning and Priorities Committee. It also created a means of filtering the multitude of inputs to Cabinet.[26]

Efforts to reform the decision-making process in health care have been supplemented by attempts to control expenditures in the two biggest segments of the health care budget: hospital and physicians' services. The introduction of corporate rationalism within the MOH has shifted policy from decision making based solely on the demands of the dominant interests to formulating public needs and developing services according to what government believes is in the best interest of the public. This responsibility formerly rested with the medical profession. In other words, government is no longer writing a blank cheque for health care based solely on the opinions of health care providers. Since the redefinition of the federal provincial cost-sharing arrangements in 1977, a belief has developed in public policy circles that government's role should be one of allocating scarce public

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[26] Segal, "The Evolving Ontario Cabinet: Shaping the Structure to Suit the Times," 72-3.

resources, not just acting as paymaster.[27]

Part of the government strategy to gain greater control over health care expenditures was to cap expenditures on hospital services and rationalize physical facilities. From 1974 on, the ministry began to fund hospitals at below the level of inflation, even though the demand for patient services remained at a constant or increasing level. As Minister of Health, Frank Miller even attempted to close a number of existing facilities and met with extreme professional and public opposition to such a move.[28]

The redevelopment of hospitals began to reflect the emphasis on rationalized service delivery and economic efficiency. In many communities, where two or more hospitals were providing the same services, the Ministry required redevelopment plans to involve amalgamation of existing facilities and specialization between institutions (acute vs. long term care). The result of this emphasis has been controversial battles between local medical communities and the ministry, lasting for decades. Since the early 1970s,

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[27] Geoffrey Weller, "From Pressure Group Politics to Medical-Industrial Complex," Journal of Health Politics, Policy and Law, 1, 4, 1977, 44; The new role of government as "manager" is found in the Ontario Ministry of Health, Deciding the Future of Our Health Care: An Overview of Areas for Public Discussion, April, 1989, 3.

[28] Ontario, The Report of the Special Program Review, November, 1975; Mr. Miller's thinking during his tenure as Minister of Health was heavily influenced by this study which essentially stated that government spending was out of control.

district health councils have found themselves in the middle of these battles and have borne the brunt of criticisms from local stake holders.

In the continuing atmosphere of cost constraint and rationalization hospitals have responded by internal reorganization to produce more "economically efficient" service delivery. However, continued pressure from government to maintain quality on a constrained budget has destroyed whatever consensus might have existed between the ministry and hospitals. The shift to negotiations "involving power, influence and information,"[29] has meant a continual movement away from serious internal cost saving or rationalization measures.

Doctors were targeted for reasons of economic efficiency because they "control the number of visits, tests and hospitalizations and [have] considerable discretionary power within the boundaries of acceptable practice."[30] Physicians not only affect the system through individual referrals and advice, but also collectively by either promoting the status

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[29] V.V. Murray et al, "Hospital Funding Constraints: Strategic and Tactical Decision Responses to Sustained Moderate Levels of Crisis in Six Canadian Hospitals," Social Science and Medicine, 18, 3, 1984, 217; Interestingly enough during the 1985-1989 period the relationship between the government, doctors and hospitals was characterized by confrontation, a provincial doctors strike and a rash of hospital deficits. Perhaps these patterns are endemic to health care politics in Ontario.

[30] Ontario Council of Health, Medical Manpower for Ontario, (Toronto, 1983), 31.

quo or supporting innovative change. In an attempt to control costs, the government in Ontario has pursued three options: 1) negotiations with doctors to control the per unit costs; 2) direct and self-regulatory control over the volume of services; 3) legislative and organizational change (including method of payment) leading to a reallocation of functions to health care personnel who are highly trained, but less expensive.The first of these challenges the physician's discretionary control over price; the second challenges discretion over service volumes and the third challenges professional discretion over the allocation of functions among other health personnel. While the first two challenge the economic aspects of medicine, the third challenges the licensing and educational aspects.[31]

The government has been most effective in the area of price controls. Since the introduction of public health insurance physicians' fees have been based on a standardized schedule of payments determined through negotiations between the provincial government and Ontario Medical Association.[32] While the professional association has generally determined the relative worth of various specialty services, the province determines the total extent of the increase in physicians' payments. This has been augmented by the development of

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[31] Carolyn Tuohy, "Medical Politics After Medicare: The Ontario Case," Canadian Public Policy, 11, 2, 1976, 191.

[32] Ibid.

funding formulas that factor in utilization or billing changes which might drive up overall costs.[33] The most recent development in this respect has seen the OMA sign an agreement with the provincial government to place an upper limit on physicians' earnings. In the second area, the establishment of the Medical Review Committee of the College of Physicians and Surgeons has allowed the government indirect regulatory control over the volume of billable services. The Committee which reviews aberrant billing patterns of physicians, as identified by the health insurance plan computer, is appointed by and accountable to the Ministry of Health. The introduction of this in 1972 marked a shift from the College's position of enforcing "the general principle of 'a just fee for a service rendered' to place restraints upon the physician's productivity."[34]

Activity in the third area has been facilitated by the increased scale of organization in the delivery of health services. Simply put, increasing numbers of physicians are practising in hospitals and other institutions such as universities, group practice, CHCs and health service organizations.

In an effort to appease the dominant interests corporate rationalists in government have not suggested that physicians be compelled to adopt these alternative payment mechanisms.

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[33] Sutherland and Fulton, Health Care in Canada, 212-13.

[34] Tuohy, "Medical Politics After Medicare," 201

For example, physicians can voluntarily enter into salaried arrangements either in group practice or as individuals. Health service organizations (HSOs) are physician sponsored and controlled equivalents to community health centres. Under such arrangements, the corporation receives a set payment for each patient on an official roster (capitation payment) and from this salaries are paid to physicians and other staff. Of the approximately 14,408[35]physicians in the province in 1992, 2,197 (6.6%) received their income from non-fee-for-service payment mechanisms (see Appendix VI).[36]An earlier study conducted for the OMA in 1973, estimated that between twenty-five and thirty percent of physicians were paid either partially or entirely by salary. The study predicted that the number was likely to increase.[37]

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[35] Matt Borsellino, "It's not easy turning ship the size of the OMA around," Medical Post, June 15, 1993, 40, This number is based on the estimated number of members per (OMA Board) Director in 1992.

[36] Ontario Ministry of Health, Health Human Resources Branch, 1993; This number does not include physicians who are full-time salaried members of university faculties. While data is available on the total numbers of tenured positions in medical faculties, there is no accurate breakdown by specialty.

[37] E.A. Pickering, Report of the special study regarding the Medical Profession in Ontario, (Toronto: Ontario Medical Association, 1973), 119; The discrepancy between this earlier estimate the recent data is explainable. Neither the Ministry of Health or the national and provincial faculty associations have data on the number of "academic" physicians employed on salary. Nor did the OMA admit to having this information. The government has contracted with McMaster University to develop a comprehensive data base on physician manpower.

Despite the voluntary nature of such programs, the implication for the majority who hold to an entrepreneurial ideology is that in such settings their discretionary control over price, productivity and allocation of functions is threatened.[38]

However, as the publicly funded system has evolved, the College of Physicians and Surgeons has been more willing to sacrifice the economic discretion of its members in an effort to maintain regulatory control over clinical standards. As Tuohy suggests, government efforts in these three areas have led to a form of corporate accommodation between government and the core regulatory and educational institutions of the medical profession in Ontario.[39]

Coupled with efforts to cap the expenditures of both hospitals and physicians has been a growing emphasis on shifting resources away from the hospital sector to foster the development of what are viewed as more cost-effective alternative methods of service delivery. Community health centres have been beneficiaries of this policy trend.

3. Community Health Centres

Beginning in 1970, the Report of the Committee on Health Manpower recognized the validity and future necessity of group

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[38] Ibid.

[39] Ibid, 199; Tuohy, Policy and Politics in Canada: Organized Ambivalence, 119.

practice by physicians in order to meet the health care needs of the province.[40] A survey conducted by the OMA in 1972 indicated the population of the province overwhelmingly supported a "one-stop" approach to the delivery of human services. Eighty-six percent of those surveyed favoured medical clinics based at the neighbourhood level, employing a team approach to health care.[41]

The provincial response to the federal Community Health Centre Project report was a pamphlet, issued by the Ontario Council of Health, a provincially appointed advisory body, entitled A Review of the Report of the Committee on the Community Health Centre Project. The review essentially supported the CHC Project findings by calling for the continued development of community health centres in the province on an experimental basis. Community health centres were to be part of a "planned, integrated and coordinated system [their emphasis] of health services" introduced on a gradual basis.[42]Emphasis was placed on the belief that CHCs should be developed from existing provincial and local resources and should not be seen as an add-on to existing

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[40] Government of Ontario, Report of the Committee on Health Manpower, (Toronto, 1970).

[41] Ibid, 12; Pickering, Special study regarding the Medical Profession in Ontario, (Toronto: Ontario Medical Association, 1973).

[42] Ontario Council of Health, A Review of the Report of the Committee on the Community Health Centre Project, (Toronto, 1973), 2-3.

expenditures.[43]

Although publicly unenthusiastic about community-sponsored health clinics, the Minister of Health, Dr. R.T. Potter,[44] requested in 1973 that the MOH investigate the possibility of organizing existing local resources into community health centres without requiring additional funds.[45] This did not even necessarily involve the use of common facilities. A number of health centres were already operating in the province under a variety of funding sources.[46]

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[43] David J. Falcone and William Mishler, "Canada," Jack Desario, ed., International Public Policy Sourcebook: Health and Social Welfare, Volume 1, (New york: Greenwood Press, 1989; The question of whether or not alternatives such as CHCs which employ lower cost personnel were add-ons was a crucial issue in the initial federal discussions surrounding E.P.F. and subsequently has always been viewed as an issue. The complicating factor is that doctors control their own practice and there is already an oversupply of doctors.

46 "Province Won't Aid in Building Ottawa Health Centre: Potter," Toronto Globe and Mail, October 12, 1972, 3; Apparently Dr. Potter's pet project as minister was the development of convalescent care.

[45] Ontario Legislative Assembly, Debates, June 5, 1975, 2608, 2632; Exactly what constituted a CHC or HSO is unclear. The Minister indicated that in either case the government did not see the need to establish such arrangements in areas that were already adequately serviced, unless it involved the amalgamation of existing individual practices. Thus the two purposes of the Ministry were to allow physicians to switch from fee-to-service to salary or to provide services to underserviced areas.

[46] Ontario Ministry of Health, Chronology of Major events Associated with Health Service Organizations' Development, 1; Those health service organizations developed prior to 1973 include Sault Saint Marie, St. Catherines and District Community Group Health Foundation, Alexandra Park Community Health Centre (Toronto), Centretown Health Centre Inc.

Dr. John Aldis was appointed by the Minister to establish the Project Development and Implementation Group to develop a limited number of CHCs and health service organizations[47] on an experimental basis. Although not clearly stated until 1980, the goals and objectives of the program included the following:

GOAL:

To encourage the continuous evolution of health care methods through the development of alternative systems of organizing and funding health services to support cost effective health programs.

OBJECTIVES:

1. Create an environment supportive to physicians and other health care personnel which allows flexibility in the response to the needs of individuals in the delivery of

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(Ottawa), St Anne's Clinic (Ottawa),St. George Health Centre (Toronto), Springhurst Community Health Centre, St. Mary's Medical Clinic, Regent Park Community Health Centre (Toronto), Charlton Family Centre (Hamilton), Flemingdon Health Centre, (Toronto), Caroline Medical Group (Burlington). These HSO which include a variety of group practice arrangements were funded through a vast array of sources and mechanisms including: unions, universities, hospitals, regional municipalities, donations, grants from the Alcoholism and Drug Addiction Foundation, the Ontario Health Research Development Program, Ontario Hospital Commission, Ontario Hospital Services Commission, Research and Analysis Branch (MOH), and after 1973 through the OHIP Data and Development Branch, Program Development and Implementation Branch and the Program Development Branch.

[47] A distinction is made here between CHCs and HSOs because in the case of the former, community boards are the decision-making body and in the case of the latter doctors are the executive decision makers. Funding arrangements are also different. The MOH at this time made no distinction between the two and lumped them together under the generic title of health service organizations.

health care.

2. Develop a coordinated system of health care which will meet the health needs of the population served by the HSO and establish a accessible, efficient health delivery system at the primary care level.

3. Provide special attention to health maintenance and illness prevention measures which will enhance the health status of the people served.

4. Meet the health needs by using the most appropriate and economical health care resources.

5. Increase ambulatory care, self-care and home care.

6. Decrease institutional health care.[48]

The Ministry envisioned two types of organization. One would comprise an amalgamation of several existing solo practices and would be paid through a capitation method. Decision-making control in this form would remain with the participating physicians. The other form involved a variety of health and possibly social services provided at one central location and paid through "a fixed budget based on the salary of a physician, a nurse practitioner and a fixed overhead cost."[49] Control in this form would rest with a community board and an executive director. At the outset PDIG was willing to consider a wide spectrum of arrangements in an effort to see which were

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[48] Ontario Legislative Assembly, Proceedings of the Standing Committee on Public Accounts, Fourth Session, Thirty-First Parliament, December 9, 1980, 28.

[49] Ibid, 27.

viable options. The drawback of this approach was that the individual health centres were so different that attempting to evaluate them later with common criteria would prove extremely difficult.

The initial interest in the new program was substantial, with approximately thirty CHCs and HSOs in operation or with Ministry approval in writing and another sixty in the proposal stage by the Spring of 1975. Clinics could and did originate from initiatives sponsored by doctors, community groups, community hospitals and unions. The common elements that linked all the initiatives from the ministry perspective included: the emphasis on continuity of care rather than episodic treatment; the use of health and social service resources; and the utilization of lower cost health care personnel to supplement physicians' services and reduce overall costs.[50]

In 1974, Dr. Fraser Mustard, then Dean, Faculty of Medicine, and Vice President Health Sciences, McMaster University, issued the provincial Report of the Health Planning Task Force. The recommendations essentially reiterated those of the CHC project. More importantly, it called for the centralization of planning and management at the local level. The role of the province was to be one of planning for the allocation of resources on a province-wide

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[50] Ontario Ministry of Health, Overview of the Health Service Organization Project, internal ministry document, 6-8.

basis. This would be achieved through a five-level structure for the administration of the health system. Included in this arrangement would be local primary and secondary care groups, including CHCs; an area management board, a district health council (DHC); a regional director, and at the top of the hierarchy, the Ministry of Health (see Appendix VII). In presenting the possible arrangements under the regionalized system, however, the report suggested that , "the development of CHCs is not an immediate solution to the problem of primary care and may not be feasible in some areas."[51]

Of the major recommendations for the rationalization of planning, only DHCs were implemented (DHC). At the local level, these agencies, funded by the MOH, staffed by paid professionals and "managed" by voluntary boards of directors, appointed with the approval of the Minister, review all new and expanded programs and priority rank them before they are reviewed at the Ministry level. The majority of the "volunteers" sitting on the Board's of Directors do not represent organized medicine.

The result in theory, and for the most part in practice is that individual institutions no longer appeal directly to the government for additional, funding, but must go through a

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[51] Dr. J.F. Mustard, Report of the Health Planning Task Force, (Toronto: Ontario Ministry of Health,1974), 15; This report was important because it represents the closest thing to an overall comprehensive plan that has ever been developed in relationship to the provincial health care delivery system. All other major reports that have been issued since are largely a repeat of Mustard's 1974 report.

priority setting process at the local level. The working principle of the process is that at best, a district health council will receive approval for funding the top two priorities on its list. The exception to this rule is when a recognized government priority is not within the top two at the local level. The role of the DHCs was recently expanded to include the rationalization of hospital services and long-term care.[52]The receptiveness of the Ontario Medical Association to sharing decision-making power at the local level has been notably cool.[53]

The response to the CHC aspects of the report was a policy statement supporting "the evolutionary development of organized community health services provided that there would be no additional cost to the government and that the development would not be initiated by the Ministry of

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[52] W.J.B. Church, District Health Councils: The Local Advisory Body and Health Care Policy in Ontario, unpublished M.A. Thesis, University of Waterloo, Department of Political Science, 1986; Ontario Council of Health, Report on the Regional Organization of Health Services: Annex A, (Toronto: Government of Ontario, 1969) and Supplement I Par II, A Proposed System; J.F. Mustard, Report of the Health Planning Task Force to the Provincial Secretary for Social Development and the Minister of Health, (Ontario: Ministry of Health, 1974); Ontario Ministry of Health, The District Health Council: Action Centre in Ontario's Health Care Delivery, (Toronto, 1974); Ontario Ministry of Health/Ministry of Community and Social Services, Partnerships in Long-Term Care, April 1993.

[53] Ontario Medical Association, "Report of the Special Committee to Study and Evaluate District Health Councils," Ontario Medical Review, April 11, 1977, 193.

Health."[54] The PDIG financial guidelines which followed reflected this limitation with the additional provision that no capital funding would be provided.[55] By this time PDIG had managed to recruit a small staff to respond to the flood of funding proposals. Prior to this, the government had reached agreements with a number of doctors in the Hamilton-Burlington and Mount Forest areas, and with York Community Services, a multi-service centre demonstration project.[56]

The PDIG was limited by a number of factors. First, it was not mandated to announce that such a program existed. The Program Development and Implementation Group was categorically denied its request to advertise the new program and solicit proposals for CHC\HSO development.[57] This was further complicated by the lack of resources within disadvantaged communities to come forward and request the development of a

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[54] Dr. J.F. Mustard, Final Report of the Task Force to Review Primary Health Care, (Toronto: Ontario Ministry of Health, 1982), 1.21.

[55] MOH, Overview of the Health Service Organization Project, 7; Lomas, First and Foremost; 110, The public statements of the Minister concerning the potential worth of CHCs essentially ended any notion of providing capital funding.

[56] MOH, Overview of Health Service Organization Project, 9.

[57] This stems from the fact that the MOH had discretionary control within the confines of their budget. Since, at the time they controlled the medical insurance payment mechanism they had considerable flexibility in funding a variety of programs on an experimental basis. Not having to ask Cabinet permission to develop the CHC experiment proved to be a double-edged sword.

new service. Second, opposition from within the MOH itself came from the Special Projects Branch, which was only interested in developing HSOs with a proven cost benefit (i.e. doctors converting to group practice salary) as opposed to a spectrum of community-based approaches to alternative delivery.[58]

Almost before PDIG could become established, Frank Miller, who replaced Dr. Potter as Minister of Health, announced a funding freeze on additional health centres. The freeze was the result of a combination of pressures including: the OMA representing the complaints of individual physicians; opposition from within the MOH toward CHCs and HSOs; the lack of the necessary method for evaluating the innovations; and, the atmosphere of fiscal restraint that had gripped the government. Since CHCs\HSOs remained essentially experimental, they were the first to be cut from the budget.[59] The general drive to curb spending was fuelled by a review of government spending in the area of social policy.

The Special Program Review released in 1975, suggested that social spending was unchecked and a major contributing factor to inflation. The report strongly suggested that the province develop "mechanisms to improve the planning and coordination of health services at the local level," including in the longer term "the extension of block funding to a

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[58] Ibid, 110.

[59] untitled internal MOH document.

locally elected body for all aspects of health expenditures, excluding medical services."[60]

Speaking in the legislative assembly Mr. Miller repeatedly stressed that the HSO program had been put on hold until such a time as some sort of "value for money spent" assessment could be conducted. In response to criticism, Miller admitted that he could not give a clear definition of what an HSO was because he was receiving contradictory opinions on this question and also on the question of how best to evaluate the participants in the HSO program. Much of this stemmed from the larger difficulty of agreeing on how best to measure the cost and quality of health care delivery. At the time the methodology being used to evaluate HSOs (St. Catherines and Sault Ste. Marie) was being seriously questioned.[61]

When Miller halted the further development of CHCs in 1975, PDIG was dissolved and the Special Projects Branch took over the development of alternatives.[62] In 1976, the name was changed to "Data Development and Evaluation" and eventually a second distinctive branch, Program Development was created to

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[60] Ontario, Ministry of Treasury and Economics, The Report of the Special Program Review, November, 1975, recommendation 8.15.

[61] Ontario Legislative Assembly, April 7, 1975, 509; June 5, 1975, 2606-13.

[62] Lomas, First and Foremost, 110, The Special Projects Branch had been involved in evaluating the Sault and St. Catherines CHCs since 1973 from a cost-benefit perspective.

implement the findings of the Data Development and Evaluation Branch. Much like the earlier Special Projects Branch, Data Development and Evaluation was clearly interested in "cost-containment and comparison with fees for service."[63]

The Minister asked the Ontario Council of Health under the direction of Dr. Spitzer, to "develop an evaluation tool for health service organizations to be based on comparisons with fee-for-service practice."[64] The evaluation mechanism developed by the task force reporting to the Council used the registered patient rosters of CHC\HSOs as the measure of comparison with fee-for-service patterns within geographically defined areas. The problems with this comparison were that: it failed to recognize the difference between the general population served by fee-for-service practice and the special populations (low income, transient, ethnic and elderly) served by CHC\HSOs; defining populations served by fee-for-service was unrealistic; and, the size of the CHC\HSO sample was to small to yield statistically significant results. Spitzer noted that a minimum of fifty CHC\HSOs were needed and at the time only thirty existed. Essentially the comparison was invalid and this became particularly evident in comparisons within urban areas and between CHC\HSOs in southern and northern Ontario. Local social and economic conditions were

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[63] Ibid, 112.

[64] Lomas, First and Foremost in Community Health Centres, 110; Dr. W.O. Spitzer, Evaluation of Primary Health Care Services, (Toronto:Ontario Council of Health, 1976).

not included as evaluation criteria.[65]

By 1977, the constant shifting of responsibilities within the Ministry meant that there were few field development officers left and senior Ministry officials appeared to have lost interest in funding alternatives. The internal bureaucratic struggle and the lack of political will left CHCs hanging in the financial balance until the early 1980s. While some centres eventually converted back to fee-for-service,[66] those that survived had to deal with the shifting array of Ministry negotiators and funding procedures.[67]

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[65] Lomas, First and Foremost in Community Health Centres, 111-12; MOH, Overview of HSO Project, 13-14; Untitled internal document; confidential document; Ontario Ministry of Health, Health Care Report Sault Ste. Marie District Group Health Association and the Glazier Medical Centre, Oshawa, (Toronto: Ministry of Health Data Development and Evaluation Branch, 1976); Ontario Ministry of Health, Health Care Report St., Catherines and District Community Group Health Foundation and the Brantford Clinic, (Toronto: Ministry of Health Data Development and Evaluation Branch, 1976); Eugene Vayda, "Prepaid Group Practice Under Universal Health Insurance in Canada," Medical Care, XV, 5, 382-389.

[66] Ontario Legislative Assembly, Debates, June 12,1979,2837-38; HSOs and CHCS which were terminated during this period include the following: Rideau Medical Clinic, Newboro, June 1976; Scarborough CHC, Scarborough, August 1976; Village Health Centre, Toronto, September, 1976; Springhurst (Drs. J. Cowell and W. Weiss, September 1976; Well Medical Centre, Hamilton, June 1977; Dr. H.S. Neilson, Burlington, July 1978; Southwest Middlesex CHC, Mount Brydges, March 1979; Ignace Family Health Centre, Ignace, April 1979; Dr. Stephen Hodgetts, May 1979.

[67] For example the one year funding contract for York Community Services expired in September 1976 at which time Joan Milling and M.P.P. Donald Macdonald approached Frank Miller for a funding extension. Miller granted a three month extension. This initial extension was followed by a six month extension granted by the new minister Dennis Timbrell, followed by another six month extension, etc. The result of

That the emphasis of the attempt to develop an evaluation tool for CHCs was linked to the philosophy of sound economic management is well illustrated by the running battle that the MOH fought with the provincial auditor over the payment mechanism developed during this period. The Ministry was unable to convince the Provincial Auditor that the capitation method of payment was economically sound. Without the backing of the Provincial Auditor, the Ministry proceeded to implement the new approach, and a battle between the proponents of the HSO program and government economists, which had always been present, reached a new level of intensity.[68]

The Provincial Auditor and the Standing Committee on Public Accounts were concerned that the MOH had failed to properly plan, "including a clear definition of the objectives of the program, including the cost effectiveness objective, and the establishment of a means of measuring the degree to

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this funding uncertainty was a high turnover rate among the staff. York Community Services operated as a demonstration project through the Ministry of Community and Social Services and the Ministry of Health for seven years. Only after Joan Milling in conjunction with a staff doctor previously from a Saskatoon clinic compiled statistics and fed them to Donald Macdonald, who peppered the Minister in the legislature for a week, was York granted a funding contract for an indefinite length of time.

[68] Ontario Legislative Assembly, Report of the Provincial Auditor For Year Ended March 31, 1979, Section 64, 88-94, The Auditor's Report to the Provincial Legislature in 1979 indicated that the capitation payment mechanism was "poorly conceived and improperly managed." The Auditor's concerns were followed up in 1980 and 1981 by the Standing Committee on Public Accounts. The organization in question was a group practice health service organization.

health care.

2. Develop a coordinated system of health care which will meet the health needs of the population served by the HSO and establish an accessible, efficient health delivery system at the primary care level.

3. Provide special attention to health maintenance and illness prevention measures which will enhance the health status of the people served.

4. Meet the health needs by using the most appropriate and economical health care resources.

5. Increase ambulatory care, self-care and home care.

6. Decrease institutional health care.[48]

The Ministry envisioned two types of organization. One would comprise an amalgamation of several existing solo practices and would be paid through a capitation method. Decision-making control in this form would remain with the participating physicians. The other form involved a variety of health and possibly social services provided at one central location and paid through "a fixed budget based on the salary of a physician, a nurse practitioner and a fixed overhead cost."[49] Control in this form would rest with a community board and an executive director. At the outset PDIG was willing to consider a wide spectrum of arrangements in an effort to see which were

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[48] Ontario Legislative Assembly, Proceedings of the Standing Committee on Public Accounts, Fourth Session, Thirty-First Parliament, December 9, 1980, 28.

[49] Ibid, 27.

services which were not more costly than fee-for-service, the outcome of the Committee process indicated that alternatives to fee-for-service would only be utilized to the extent that they were able to save money.

The concern by the Provincial Auditor with the payment mechanism and the comparative economic worth of the work performed by the physician in a group setting continue to be points of contention. Although designed as a cheaper alternative to fee-for-service, the capitation funding mechanism and related financial incentive plans used to fund HSOs have actually led to an average increase in the revenues of physicians in health service organizations of seventy percent in comparison to what they earned through fee-for-service.[72] Health service organizations have also benefitted under the funding arrangement because it allows them to profit by not employing ancillary staff. The intended objective of the funding arrangement conceived at the end of the 1970s was to achieve cost saving by capping the salaries of physicians and employing cheaper ancillary staff to enhance the performance of the organization. In the case of physician-sponsored HSOs this has not been the outcome.[73]

The one positive element to this development was that for

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[72] Ontario Ministry of Health, New Beginnings: Draft Discussion Paper by the Ministry of Health on the Review of the HSO Program, 1991, 9.

[73] Ibid, Not surprisingly, this review of the HSO program was undertaken by a committee comprised of representatives from the MOH, the AOHC and the OMA.

the first time the provincial government had formally committed itself to alternative forms of delivery.[74] The negative effect of the lengthy process of reaching a commitment meant the demise of a number of existing CHCs\HSOs. Based on recent information, the process does not appear to have been vastly improved. Evaluation and funding arrangements are still a matter of negotiation between the Ministry and individual CHCs.

The most important developments concerning the relationship between CHCs and the provincial government occurred during the 1980s. This period was characterized by a general change in the MOH approach to policy formulation, involving a broad consensus-building process. The process, initiated by Larry Grossman when he assumed the portfolio in 1982, was designed to broaden the basis of public input into policy and to develop a new consensus among the major policy actors. Of particular interest to Grossman was strengthening the role of community-based agencies:

> It was not the [community] activists' intimate knowledge of what was happening in the community that Grossman wanted to tap, but to show them that the Progressive Conservative Party could be responsive to their needs ... Grossman wanted to wean them away from the NDP and show them that they could get direct access to the government without having to go to the NDP and give them ammunition to launch hand grenades across the floor of the House against the government.[75]

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[74] Lomas, First and Foremost in Community Health Centres, 113.

[75] Simmons, Unbalanced, 197-99.

This approach to the portfolio was atypical for two reasons. First, unlike other politicians who had held the position, Grossman acted as an agent of policy change. Second, he attempted to encourage the development of a more cohesive and stronger lobbying effort from the community-based sector. Some of this was accomplished by shifting funds from other budgets within the ministry to expand the number of programs in the community-based sector.[76]

In the case of CHCs, Grossman provided funding to establish several new health centres and to create a representative provincial association. In essence, Grossman was attempting to enhance the organizational capacity of CHCs so that they might perform more effectively in the policy community. The Association of Ontario Health Centres was created as a communications and coordination mechanism between individual health centres and the Ministry. The decision to fund HSOs and CHCs as a regular program took place against the background of a two-day walk-out by the OMA and increasing costs for both physician and hospital services. Community health centres were viewed by Grossman as a means of shifting

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[76] Ibid, 198, Grossman shifted the funds and initiated new programs without prior approval or discussion with either the Social Development Committee or the Management Board of Cabinet.
Currently the AOHC has a membership of 36 health centres and 20 health service organizations.

the emphasis from hospital to community-based services.[77]

Publicly, Grossman pursued a consensus-building approach to dealing with the various actors in the policy sector. In 1983, the MOH sponsored a series of planning conferences involving health care providers, consumers and patient advocate groups. Privately, Grossman assured the OMA executive that he realized they felt excluded by the bureaucratic process and that he very much wanted to reintegrate them into the decision-making process. Sometime later in the midst of the growing debate over extra-billing, he declared that it was not the intention of the government to turn physicians into public servants or to make them subject to the decisions of politicians or administrators.[78]

Thus on the one hand Grossman was attempting to incorporate a broader set of actors into some sort of consensus, and on the other hand he was privately and publicly reassuring the medical profession that its interests would not be sacrificed. After Grossman's departure from the portfolio, however, the consensus-building process gradually stalled and was not re-activated until the Liberal government established

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[77] Irmajean Bajnok, Lillian Bayne, Joe Leonard, David McKeown, Anthony Shardt, Lorraine White, Luba Wolchuk and Raisa Deber, "Championing Alternatives in Primary Health Care Delivery: A Minister Makes His Mark," in Raisa Deber, ed., Case Studies in Canadian Health Policy Management, Volume 1, (Ottawa: Canadian Hospital Association Press, 1992), 244.

[78] , "OHIP increases preferred to user fees by Grossman," Globe and Mail, April 18, 1983, 4.

the Premier's Council on Health Strategy in 1986.[79] In the meantime the impending confrontation over extra-billing was looming large on the political horizon.

In 1982, Dr. J.F. Mustard was again called into service to examine the state of the existing network of primary care and make recommendations. The 1982 study entitled, the Final Report to Review Primary Health Care, recommended that HSOs and CHCs be accepted as legitimate funding alternatives for the provision of primary health-care services. Some specifications were suggested concerning the problems of the existing funding arrangements. The vision put forward by the 1982 Report was similar to that in 1974: a network of primary care services that was pluralist both in terms of organizational and funding characteristics.

Concerning the process of establishing new centres, the 1982 Report recommended that:

> where a community wishes to establish a new health centre requiring a global budget, it should be with the endorsement of a broadly based community group. In some areas, where district health councils have established with local groups effective planning arrangements for local care, they would be the most appropriate group. In other areas public health units, regional governments, hospitals or other community-based organizations may be the community endorser.[80]

The Report also suggested that the establishment of new

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[79] Ibid, 22; The Minister's strategy was to personally tie the process to his reputation and thus after his departure the impetus was removed.

[80] Mustard, Final Report of the Task Force on Primary Health Care, 1.30.

services should depend on a demonstration of need for a specifically defined population, and a clear procedure for evaluation. Funding of new and existing CHCs was to be provided on the basis of individually negotiated global budgets.[81]

While boosting the legitimacy of alternatives such as CHCs, Mustard did not advocate a radical reform of the system. Instead he suggested that a mix of organizational and funding mechanisms to meet the needs of providers and consumers was the most appropriate course of action. Thus CHCs could be legitimately incorporated into the primary care service network and the physician's freedom of choice in terms of payment mechanisms and methods of practice would remain largely intact. The intention of this and the report produced a decade earlier was to "diversify the organizational and professional planning basis [as a means of introducing) a broader set of perspectives to health services."[82]

The release of the 1982 Report was followed by an official announcement by the MOH that CHCs "which have previously been viewed as experimental alternatives to the traditional health care delivery ... are now recognized as legitimate and permanent elements within the health care

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[81] This was what the existing CHCs had been fighting to maintain in the face of capitation negation.

[82] Novick, "Social Policy: The Search for a New Consensus," 339.

system of Ontario."[83] Community health centres would act as both an alternative and a compliment to institutional services. As J.F. Mustard stated in the 1982 Report:

> Despite the problems and difficulties, the developments that began in the 1970s have demonstrated that within primary health care services, the development of a pluralistic approach is possible. Our experiences with these arrangements have shown that those groups which are effective: can decrease unnecessary utilization of institutional services such as active treatment beds; can work productively with a variety of professional services to achieve coordination and integration; and can allow for the evolution of expanded roles for health professionals.[84]

After a decade of uncertainty, CHCs were now an essential element of provincial health care policy. In the wake of these developments the Community Health Programs Branch of the MOH released a general set of guidelines for the establishment of community health centres.[85] Another piece of the corporate rationalist approach to health care was now in place.

As Bajnok et al note, medical opposition to CHCs revolves

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[83] Ontario Ministry of Health, "Ontario Health Centres - An Idea Whose Time Has Come," Community Health Matters, June 1983, 8; interview conducted with Joan Milling, Executive Director of York Community Services.

One individual, who sat of the 1982 Task Force, suggests that the Report was put together in about three months and served as justification for a decision that the Minister of Health, Larry Grossman had already made. The recommendations and the Minister's speech were actually written before the Report was released.

[84] Mustard, Final Report of the Task Force on Primary Health Care, 1.30.

[85] Ontario Ministry of Health, Guidelines and Procedures for the Community Health Centre Program, (Toronto: Community Health Programs Branch, 1983).

around the issues of income, professional freedom and evaluation. However, in 1982 physician opposition was not overt because the program was so small and was not being heavily promoted by the government. It was concentrated mainly in the OMA group practice section.[86]

The coming to power of the Liberal government, first as a minority with the backing of the NDP and then in a majority, marked a turning point for community health centres. Whereas, the previous government had appeared to lack any real commitment to establishing CHCs in significant numbers, the new political regime was committed to doubling the number of community health centres and HSOs in the province according to demonstrated local need. This was linked to two factors: the resolution of the extra-billing issue and a broader strategy of reforming government services.

The Liberals initially came to power in the wake of the Canada Health Act, which was forcing an end to the professionally coveted practice of extra-billing. The provincial Conservative government had delayed ending the practice in the hope that a change of government at the federal level might yield a reversal of the policy. This strategy was pursued because the end of extra-billing would have meant an increase in the fee schedule, costing the province more than the potential loss of revenue under the

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[86] Bajnok et al, "Championing Alternatives in Primary Health Care Delivery: A Minister Makes His Mark," 248.

legislation. Even when the Conservatives gained power in Ottawa, the new legislation was not altered.

In the election that occurred in 1985, the provincial Conservatives found themselves in a minority position and were quickly ousted through a joint agreement[87] between the Liberal and NDP parties. An important aspect of the agreement was a promise "not to defeat the Liberals for two years, in exchange for a Liberal agreement to move on a number of policy fronts, including the abolition of extra-billing."[88]

The OMA misinterpreted the signals of the incoming political regime and in the end failed to demonstrate solidarity among the membership. The impetus for the rotating closure of hospital emergency rooms did not originate with the medical association executive. It was the result of the actions of a local medical society in Metropolitan Toronto. Those affluent areas which joined were, not surprisingly, the stronghold of opted-out specialists. Despite the belated efforts of the provincial association to enlist the support of the medical staffs at the teaching hospitals and the threatened closure of entire hospitals in the suburbs; the intervention of the College meant the termination of the job action. After twenty-five days without an agreement with

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[87] Rand Dyck, Provincial Politics in Canada, (Scarborough: Prentice-Hall Canada, Inc., 1986), 304-06, 326-27, provides an account of the legislative outcome and a copy of the text of the agreement.

[88] S. Heiber and Raisa Deber, "Banning Extra-Billing in Canada: Just What the Doctor Didn't Order," 69.

organized medicine, the government moved unilaterally to end the practice.[89]

The dynamics of the 1986 provincial doctors' strike provides evidence of the institutionalized division within the medical profession. During the strike the provincial corporate regulatory body, the College of Physicians and Surgeons convinced the membership of the Ontario Medical Association, the pressure group representing the professional monopoly, to adopt a more conciliatory stance than that advocated by its leadership.[90]

The outcome of the extra-billing issue has dispelled any remaining myth that the medical profession was monolithic in its viewpoint. The failure of the OMA to deliver effectively its membership has symbolically weakened its position at the bargaining table with government.[91]

The Health Care Accessibility Act[92] did not dismantle

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[89] Tuohy, "Medicine and the State in Canada," 288-89.

[90] Ibid, 70; Henry J. Jacek, "Interest Groups and Public Policy in Ontario: A Political Economy Analysis," in White, ed., The Government and Politics of Ontario, Fourth Edition, 269; Health Care Accessibility Act, RSO, 1985.

Ironically despite the traditional avoidance of financial issues by the College in favour of the legal mandate and quality assurance roles, the method of monitoring physician quality relies heavily on an evaluation of individual billing patterns.

[91] Heiber and Deber,"Banning Extra-Billing in Canada: Just What the Doctor Didn't Order,"71.

[92] Ontario, Health Care accessibility Act, S.O., 1986, c. 20.

the OMA as the representative association for organized medicine, but it did contain a provision allowing the Minister to negotiate separately with specialists. This would have the effect of further fracturing organized medicine.[93]

In the wake of the major public blow dealt to the dominant interests and a legislative majority after the 1987 election, the provincial government has had significant autonomy in pursuing policy change. A series of task force reports have emphasized the philosophy of the Lalonde Report and the previous provincial reports. A somewhat broader definition than that advocated by Lalonde has been adopted; therefore, health policy is seen as affecting a number of different Ministries within the provincial government.[94]

The broadening definition of health dovetailed nicely with the developing government-wide strategy to promote the

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[93] Heiber and Deber, 71; Ontario, Health Care Accessibility Act, 226, Section 3(3) states that "The Lieutenant Governor in Council may make a regulation providing that a Minister may enter into an agreement under subsection 91) with a specified person or organization other than an association." The associations listed are the Ontario Medical Association, the Ontario Dental Association and the Ontario Association of Opthamologists.

[94] Dr. R.A. Spasoff, Health for All Ontario, Report of the Panel on Health Goals for Ontario, (Toronto: Ontario Ministry of Health, 1987); Steve Podborsky, Health Promotion Matters in Ontario, A Report of the Minister's Advisory Group on Health Promotion, (Toronto: Ontario Ministry of Health, 1987); Dr. J.R. Evans, Toward a Shared Direction for Health In Ontario, Report of the Ontario Health Review Panel, (Toronto: Ontario Ministry of Health, 1987); Roy Aitken, From Vision to Action, Report of the Health Care System Committee, (Toronto: Ontario Ministry of Health, 1988); Elinor Caplan, Deciding the Future of Our Health Care System, An Overview of Areas for Public Discussion, (Toronto: Ontario Ministry of Health, 1989).

value of equity in government. In this new policy environment CHCs became a vehicle for promoting greater access to services for various population fragments: ethnic minorities, the elderly, women, low-income groups, and linguistic and rural communities. While the previous role of CHCs had been to serve certain target populations, specifically low income and transient populations, the government had never utilized this as part of a government-wide strategy. In essence CHCs have provided government with a means to serve a range of specific populations.[95]

Community health centres also provided a convenient vehicle for promoting the government's new health strategy. In the 1987 Throne Speech, the government declared:

> We also recognize that for many individuals such as seniors, the disabled and others in need of special services, quality health care is not enough to ensure they lead independent and productive lives ... We will address these challenges through a new health strategy which emphasizes health promotion, prevention of disease, community-based services and alternatives to institutional care ... We will look to community health centres and health service organizations to play a greater role in health promotion. We will encourage the development of innovative health care proposals by community groups, health care providers, agencies, researchers and others.[96]

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[95] Ontario Ministry of Health, "Ontario Health Centres - An Idea Whose Time Has Come," However, Larry Grossman did mention the multicultural connection when CHCs achieved program legitimacy and other Conservative statements began to put more emphasis on the multicultural fact in Ontario.

[96] Ontario Legislative Assembly, Debates, 3 November , 1987, 7; subsequent announcements in the legislative assembly concerning CHCs have placed emphasis on the target populations being served. For example, see Ontario Legislative Assembly,

Clearly, in the long run, corporate rationalism in health care has both economic and political advantages. It has provided government with an economic rationale for shifting the emphasis away from the costly medical model of service delivery to a cheaper alternative. As well, it has provided a political rationale for the development of new programs to serve politically important segments of the population.

The development of a "new health strategy" consistent with the policy direction initiated through the federal Lalonde Report has given politicians a means of developing new links to their constituents through the provision of new services for specific categories of the population. For corporate rationalists, the new strategy provides an opportunity to further develop a cost effective health care system. For both politicians and public servants, a shift away from the dominant curative model of health care to a preventive approach means a potential weakening of the power of the dominant interests. This has been achieved by increasing the number of participants in the policy community and forging a new coalition. Community health centres have provided a convenient policy vehicle for achieving all of these ends.

The CHC program that has evolved under the Liberal government exhibits:

> a common rationale and a consistent set of

Debates, 5 January, 1988, 1683.

> objectives ... (i.e. a belief in the determinants of health and the aims of providing accessible health care, coordinated services, activities focused on wellness, prevention and empowerment and an holistic approach to health care.[97]

The current mission statement of the CHC program emphasizes several roles for CHCs including: allowing communities to address the determinants of health; providing integrated and coordinated primary care, health promotion and prevention; enabling community development and social action; and contributing to health reform.[98]Clearly, the Ministry policy concerning CHC has reached a mature stage. The Ministry has now recognized and legitimated the importance of CHCs as vehicles for health system reform and community empowerment.

Community-sponsored health centres have increased from 11 in 1985 to 47 in 1992. Of the 47 CHCs in existence in late 1992, 67 percent are located in the large urban centres. Toronto has 50 percent and Ottawa has 13 percent. The remainder are found in smaller urban centres (21 percent) and rural communities (16 percent).[99]This skewing of CHC

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[97] Ontario Ministry of Health, Community Health Centre Program, Final Report: Evaluability Assessment of Ontario's Community Health Centre Program, (Toronto: ARA Consulting Group Inc., October, 1992), iii.

[98] Ontario Ministry of Health, Community Health Centre Program: Strategic Directions 1993/94 - 1996-97, Strategic Planning and Evaluation Project, June, 1993, 21.

[99] Ontario Ministry of Health, Community Health Centre Program,Final Report: Evaluability Assessment of Ontario's Community Health Centre Program, (Toronto: The ARA Consulting Group Inc., October 1992), 32.

development can best be explained by the concentration of visible minorities and the poor in major urban centres. Although recent government policy has placed greater emphasis on rural communities as special needs populations, these localities have not shown a much interest in the CHC model.

One-third of CHCs receive 30 to 50 percent of their budgets from non-Ministry of Health sources, including the Ontario Ministry of Community and Social Services, Ministry of Skills Development, the Ontario Legal Aid Society, Municipalities, the United Way, Health and Welfare Canada, Secretary of State, and the federal and provincial Ministries of Culture. In addition, two-thirds receive small short-term grants from sources other then the Ministry of Health.[100]

Perhaps because of the benefits reaped by some of its membership, the recent reaction of the OMA to the adoption of CHCs as a mainstream program has been guarded.The official position of the OMA concerning community health centres states that:

> The profession must participate in carefully controlled experiments with new methods of delivery and is dedicated to maintaining physicians' freedom to choose their methods of compensation.[101]

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[100] Ontario Ministry of Health, Community Health Centres in Ontario: A Picture of Health, June 1993, 5.

[101] David Peachey, M.D., and Adam Linton, M.D., "What you Should Know About HSOs," Canadian Medical Association Journal, Vol. 138, 15 February, 1988, 355.

Underlying this conciliatory approach is a more typical response from the dominant structural interest:

> It is fair to conclude that the vast majority of the public cares little about how physicians are compensated as long as they receive the service and do not pay for it directly. Even though the public would like to be surrounded by happy physicians, this is frequently overlooked if it comes to the choice about the method of payment. Behind this overall stance is the reality that many members of the public are influenced by the belief that unnecessary services are being perpetrated upon them by doctors who have a vested interest in the fee-for-service model... The only rational conclusion is that the political movement behind HSOs has been successful in positioning many of the various players in a way that already isolates those members of the medical profession who wish to protect fee-for-service as the dominant compensation model.[102]

During the review of the HSO program in 1990-91, the OMA indicated its concern with ministry proposals to impose a level of supervision on HSO physicians to which not even fee-for-service physicians were subject. The issues of capitation negation, rostering and criteria for evaluation also remained unresolved from the perspective of the profession.[103] Thus, HSOs and CHCs are viewed by the core of the dominant structural interests as a direct threat to the entrepreneurial aspects of the profession.

Despite the hostile attitude of the core entrepreneurial element of organized medicine, some physicians have opted for

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[102] Ontario Medical Association, The Politics of Health Service Organizations, June, 1987, 7-8.

[103] Ontario Medical Association, Section Position paper on the HSO Program and Funding Review, February 25, 1991.

the alternative funding and organizational arrangements. Since 1988, the number of HSOs has tripled from twenty-six to eighty-one.[104]Each physician converting to this arrangement further weakens the position of the entrepreneurial core.

4. Analysis

The development of health care policy has been shaped by the need within government to control expenditures and the political necessity of addressing issues involving equity. Pressure for cost containment has emanated from the business community which has viewed social spending as a potential liability to the province's economy. This was made clear by proposals from the Special Program Review to cut social spending. Pressure to address the equity issue has originated from the political left. This is evidenced by the fact that from the time medicare was put into place, the NDP applied continuous pressure on the provincial government in the legislature to develop a comprehensive health care system that focused on the broader definition of health. By pressing for a focus on community-based services such as CHCs, the NDP were explicitly advocating to have physicians placed on salary. The Conservative government was caught in a difficult position. Forced to introduce medicare, the Conservatives found

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[104] Community Health Programs Branch, New Beginnings, (Toronto: Ontario Ministry Of Health, February 1991), 2; Association of Ontario Health Centres, Summary of the Development of Health Centres, Toronto, October, 1991, (fact sheet); HSOs now serve over 760,000 residents of Ontario. CHCs serve over 110,000.

themselves walking a tightrope between controlling expenditures to appease the business community, and introducing sufficient incremental change to satisfy the NDP, without interfering with the central role of the physician. As Novick notes:

> the concept of a 'direct response' to a specific problem was easier to get into a political system of negotiation and compromise than a general reshaping of programs, or the rationalization of intergovernmental and public/private roles.[105]

This fragmented approach to service delivery was also fostered by the nature of the policy process which involves competition between government actors for resources in the form of new and expanding programs.

To address the issue of cost containment, the province attempted to rationalize the decision-making machinery of government during the 1970s. To address both the cost and equity concerns during the 1980s, the government gradually shifted away from a policy of standardized human-service delivery to developing categorical programs based on narrower geographic and demographic criteria. The fragmentation of service delivery has weakened the decision-making authority of the dominant structural interest in an incremental fashion, while strengthening the power base of corporate rationalists and repressed interests.

Since the shift from a private to a public medical

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[105] Novick, "Social Policy: The Search for a New Consensus," 331

services market began in the 1970s, the Government of Ontario has pursued a strategy of increased bureaucratic intervention into the professional autonomy of the medical profession, and a gradual movement away from a model of service delivery serving strictly the professional needs of physicians. At the present time the government is placing increasing emphasis on a more decentralized community-based approach. The transitional nature of the current system has created a substantial amount of uncertainty for the three sets of structural interests.

Underlying the continuing uncertainty is the debate between corporate rationalists and medical entrepreneurs over the best means of providing services. In attempting to both control costs and address existing and emerging unmet needs, government has gradually moved toward a realignment of the system to focus on preventive as opposed to curative aspects of health care. In doing this it has threatened the role of dominant medical interests as the central actor in the policy community. Increasingly the professional medical association is being isolated in the policy community as politicians and public administrators have formed new alliances with the community-based sector and their constituencies. The alliance of challenging and repressed interests has been motivated by the goals of cost containment and equity in service provision.

The mobilization of bias has been a formidable barrier to change. At the root of this has been the Conservative

government's ideological preference for private solutions to social policy issues. This has manifest itself in the ideological resistance by successive Conservative governments to an interventionist approach to public health insurance. The health system was originally structured to allow maximum freedom to the dominant interests. The Ministry of Health was designed to function as a third party payment mechanism and physicians were allowed to control decisions over method of organization, method of payment and location of practice.

As the corporate rationalists in government attempted to reorganize the structures of government to address efficiency goals, the discretionary decision-making authority of physicians was increasingly challenged. However, with the Conservatives in a minority government position for the latter half of the 1970s, major policy initiatives which might seriously upset the dominant interests were unlikely. It was the defeat of the conservative regime and the subsequent political agreement between the Liberal and NDP parties that triggered a more forceful policy response.

In the longer term, the pressure to contain costs has meant that government has been forced to develop policies which challenge the professional autonomy of the medical profession. This has occurred through the development of alternative payment mechanisms, an increased emphasis on community-based service (as opposed to hospital-based), and increased emphasis on preventive as opposed to curative

medicine. On all three counts, CHCs have provided government with an important policy option because they involve alternative payment and organizational arrangements, and place an increased focus on preventive non-medical services.

The alliance of corporate rationalists and repressed interests forged by Larry Grossman was mobilized by the Liberal government in support of ending the practice of extra-billing and pursuing a strategy of change in health policy. At the root of both the actions of Larry Grossman and, later, the Liberal government, was the desire to win over the constituency of the NDP party, which included the major Labour interests, the Equal Pay Coalition, the Women's Lobby Coalition, a large Black coalition, and a variety of provincial ethnic coalitions.[106] The Liberals were compelled to pursue this strategy because of the political deal struck with the NDP party.

Whether this translated into voter support for the Liberals is highly debatable. However, the promotion of the value of equity fit well with the Liberal philosophy of governing and allowed them to clearly distinguish themselves from their predecessors, the Progressive Conservatives, while borrowing heavily from the political platform of their major political adversary, the New Democratic Party.

Despite the continuing efforts by politicians to act as

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[106] James Mackenzie, "Interacting with Government," 302-03.

policy brokers and maintain a broad consensus, there remains a fundamental cleavage between the dominant and challenging interests over the future direction of the system. The dominant interests wish to continue the fee-for-service method of payment and to maintain the curative approach to service delivery. Corporate rationalists have adopted a broader definition of health, which places increased emphasis on community-based preventive approaches to delivering health care.[107] Implicit in this latter approach is the shift of resources from curative services such as fee-for-service physicians and hospitals to community-based alternatives such as community health centres.

Having failed to resolve this impasse, politicians in Ontario have acted unilaterally to introduce policy change. While the government has capped the total resources available for health care services, the variety and mix of services available to the public has continued to grow.

Community health centres (see Appendix VIII) are a good example of how the outcome of the competition among structural interests affects the development of services. From the beginning of government involvement in their development, CHCs have been hampered by their inability

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[107] Dr. J.F. Mustard, Final Report of the Task Force to Review Primary Health Care, 1.21; Interestingly enough the source of Mustard's descriptions of the current situation in Ontario was a report on the contemporary health system in Great Britain.

to overcome the predisposition of the MOH and the Conservative party for a curative model of health care. Not surprisingly, the outcome of the competition between corporate rationalists and medical interests over the CHCS/HSO initially resulted in the creation of a program which attempts to accommodate the needs of both sets of interests. While not radically objecting to the development of health centres, the sensitivity of the medical profession to government intrusion into their autonomy has led government policy makers to opt for a broad spectrum of sponsors, including physicians in group practice.

The medical monopoly has been further protected by the preference of the MOH for limiting the development of health centres to already underserviced areas. The targeting of underserviced areas has been legitimized both in economic and egalitarian terms. The areas and populations served by CHCs are generally viewed as undesirable for private practice by physicians because of the complexity of the clientele. Therefore, new services can be justified because they are not a duplication of the existing physicians' services. At the same time, underserviced population fragments can be provided with an equitable level of access to primary care.

Despite these concessions to dominant interests, the recently stated program mission statement places

increased emphasis on the empowerment of repressed interests and the promotion of the broader definition of health. This emphasis does not bode well for dominant interests because it suggests that the social health strand of corporate rationalism has gained a foothold in government circles.

Although designed as a cheaper alternative to fee-for-service, the capitation funding mechanism used to fund HSOs actually led to a large increase in participating physicians' revenues. Health service organizations have also benefitted under the funding arrangement because it allows them to profit by not employing ancillary staff. The intended objective of the funding arrangement established at the end of the 1970s was to achieve cost savings. In fact the opposite has resulted. So while the physician-controlled organizations have generally reaped an excellent return without meeting the reform objectives of corporate rationalists, CHCs have been penalized for attempting to produce those outcomes. Since discovering this situation through a review of the program, the Ministry has ended the HSO advantage. Health service organizations may now apply for program-based funding (as do CHCs) to fund additional health promotion and prevention activities. In this fashion, they are required to meet Ministry program

personnel guidelines.[108]

The major benefit from the promotion of alternative services has likely been the increased support for corporate rationalist strategies in the provincial health policy arena. In an effort to shift the focus in health care away from the medical model of service delivery, corporate rationalists in government have successfully appealed to repressed interests to support proposed policy changes, which will be mutually beneficial.

The response of the dominant medical interests to government encroachment on professional territory has been similar to the pattern historically at the national level and in other provinces. The introduction of DHCs was met by strong objections because of the threat posed by the imposition of a bureaucratic process on the autonomy of local decision making by dominant interests. The adoption of CHCs as an important element of government efforts to reform the system of delivery was met by a guarded response, only because the program was designed to avoid challenging the physician's freedom of choice. Notwithstanding this, the OMA is well aware of the potential threat that government policy continues to pose to physicians' professional autonomy. The recent capping of physicians' fees and proposals to limit the number of physicians and their location within the

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[108] Community Health Programs Branch, New Beginnings.

province are indications of the continuing trend towards corporate rationalism.

If the current round of proposals for reform developed over the past five years are implemented, we can expect to see the power of dominant structural interests weakened in several respects. The introduction of local health and social service authorities with executive decision-making powers will weaken the ability of the provincial medical association to act as a collective bargaining unit. A continuing combination of cost-control measures on hospitals and physicians, and a shifting of resources to community-based services will challenge the clinical and remunerative autonomy of physicians.

Having examined the overall provincial framework within which the CHC program has evolved, the research will now turn to an examination of the development of individual health centres.

PART TWO

THE CASE STUDIES

In Part One, a framework for analysis was established and CHC policy development was discussed in both the federal and provincial contexts. The framework identified five independent variables: the local political environment; the ability of local activists to mobilize and maintain a supportive local constituency; the presence of local corporate rationalists; the presence of local medical opposition; and provincial bureaucratic intervention. The time at which individual health centres are developed was identified as an intervening variable. The dependent variable was divided into three possible outcomes: establishment of a CHC based on the original ideological and organizational intensions of local activists; establishment of a CHC in which the original ideological and organizational intensions of local activists are not maintained; and, failure to establish a CHC.

In Part Two, the variables are employed to examine the process of developing CHCs in seven case studies from the province of Ontario. The case studies were chosen because they represent examples of CHC developments during two distinct periods, in terms of activities at both the local and the provincial levels.

Chapter IV

The Development of CHCs in Ottawa[1]

Unlike most Canadian cities, municipal governments in Ottawa have focused an unusual amount of energy and commitment on such issues as social housing, social services, neighbourhood development and citizen participation.[2] During the 1970s, local activists mobilized around issues of social housing and neighbourhood preservation. The catalyst for this mobilization was the displacement of residents by urban renewal. Federal and provincial housing policies affected both the character of urban renewal and the role of the citizen in the land-use planning process. Within the urban policy arena, municipal politicians developed policies to facilitate citizen participation in land-use planning. They also developed a broader set of policies that facilitated community

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[1] Information for this chapter was provided, in part, through interviews conducted with the following individuals: Denise Albrecht, Marjorie de la Bastide, Patricia Deline, Stuart Godfrey, David Hole, Barbara Linds, Mary Lynch, Sandra Mark, Kyoshi Shimizu, and George Wilkes. More complete biographical information on these individuals is provided in the main bibliography. Other documentation sources are cited where applicable.

[2] Carolyn Andrew, "Ottawa-Hull," in Warren Magnusson and Andrew Sancton, eds., City Politics in Canada, (Toronto: University of Toronto Press, 1985), 141,142, 149-58; Henry B. Mayo, Report of the Ottawa-Carleton Review Commission, (Ottawa, 1976), 165; As Andrew notes the consumption orientation of the local politics is due largely to the predominance of the federal government and its major impact on land-use and socio-demographic patterns in the core area. Ottawa has a large, middle-class, public service population.

mobilization around issues of collective consumption.

As the case studies will demonstrate, the five independent variables have impacted on the development of community health centres. The first independent variable (local political environment) had a high value and positive relationship with the dependent variable. The second independent variable (local activists) had a high value and positive relationship with two of the three cases. The third independent variable (local corporate rationalists) had a high value and positive relationship in two of the three cases. In the third case independent variables two and three had a medium value, but positive relationship with the outcome. Situated within the established local institutional network, corporate rationalists promoted and fostered the development of new services for repressed interests in health care. This was accomplished by providing resources and developing policies to foster community mobilization around issues of collective consumption.

The legitimacy that existing agencies conveyed to corporate rationalists at the provincial level played a strong role in the establishment of a network of multiservice social and health service centres. As the case studies will demonstrate, the support of the Ottawa Social Planning Council, the Regional Municipality of Ottawa-Carleton Social Services Department, the University of Ottawa and the other community-based agencies viewed as legitimate by the Ministry

of Health has played a key role in the development of health centres.

Only in one of the three cases did the fourth independent variable have a negative relationship with the dependent variable. Even then, it did not take the form of visible protest. The fifth independent variable (provincial bureaucrats) had a high value and positive relationship in one case; a high value and negative relationship in one case and a medium value and negative impact in one case. In one case, provincial bureaucrats acted as an initial catalyst for the development of a CHC. In another case provincial bureaucrats changed the outcome of the CHC development. In the third case, provincial bureaucrats extended the time required to develop the health centre.

What distinguishes the Ottawa case studies from those presented for Toronto, London and Tillsonburg is the extent to which the local political environment and institutional network has sustained collective consumption activities during the earlier and the latter time periods.

1. Background

Federal Policy

During the late 1950s and early 1960s approximately 200 urban renewal studies were undertaken to determine the nature

and location of new public housing developments. Such studies led to the extension of National Housing Act funding to upgrade water and sewage systems and revitalize neighbourhoods in local communities. Further amendments to the Act in 1964 facilitated a new and expanded role for provincial governments in housing policy. Provincial governments could now establish their own housing corporations to develop non-profit and cooperative housing through high-ratio loans and subsidies. The 1964 amendments also included a section on non-profit housing organizations, allowing capital funding, but no subsidies.[3]

In the late 1960s the federal government became interested in assuming a greater role in the development of policies affecting urban areas. In 1971, this resulted in the creation of the Ministry of State for Urban Affairs to coordinate urban-oriented federal initiatives. Specifically the new federal ministry priorities for urban reform included: the preservation and enhancement of inner city neighbourhoods; the minimization of the social costs and conflicts associated with urban change; and the relief of the resultant pressures on inner city residents.[4]One result of this new thrust was the

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[3] Canada, CMHC and the National Housing Act, (Queen's Printer: Ottawa, 1980); George Fallis, Housing Programs and Income Distribution in Ontario, (Toronto: Ontario economic Council, 1980).

[4] Deborah Lyon and Lynda H. Newman, The Neighbourhood Improvement Program, 1973-1983: A National Review of an Intergovernmental Initiative, Research and Working Paper # 15, (Winnipeg: Institute of Urban Studies, 1986), 3-4.

Neighbourhood Improvement Program. Introduced as a result of changes to the National Housing Act in 1973, the new program authorized the Canadian Mortgage and Housing Corporation (CMHC) to loan money to municipalities "for the purposes of improving the amenities of neighbourhoods and the housing and living conditions of the residents of such neighbourhoods."[5]

The program was designed to be implemented through a trilevel process. At the federal level, CMHC acted as a financial, technical and information resource. It also was responsible for the coordination and evaluation of the program. The provinces were responsible for negotiating NIP agreements with municipalities and the CMHC; determining the extent of provincial contributions; setting provincial goals and guidelines; and coordination of NIP at the provincial level.[6]

At the local level, planning and implementation was undertaken by local municipal officials and NIP area residents. This included the designation of a neighbourhood as a NIP area, assessment of problems, priority setting, project planning, and program delivery. Planning in the City of Ottawa coincided with the events at the federal level.

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[5] Canada, An Act to Amend the National Housing Act, 21-22, 1973, ch. 18, s. 10.

[6] Ibid, 10-12.

City of Ottawa

The influx of middle-income families and individuals into the inner-city neighbourhoods and a resulting gentrification led the City of Ottawa in the early 1970s to undertake a massive planning exercise to review existing zoning by-laws. A major element of the planning review was the involvement of citizens in the development of neighbourhood plans. Committees of interested people worked with city planning officials to develop plans that often dealt with a broad range of social issues as well as the more traditional issues of land-use planning. In some cases, these committees and their plans served as blueprints for the development of neighbourhood services involving other levels of government.

In general terms, the development of increased citizen participation in municipal politics was most evident between 1968 and 1972. During this time citizens' groups were established to "seek an active role in shaping change within the communities."[7] This was highlighted in 1971 by the formation of the Federation of Citizens Associations of Ottawa-Carleton. The Federation provided a voice for over 100 community groups "that decided to unite around common causes to make their collective wishes known to municipal

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[7] Walter Baker et al., "Public Participation Policy: A Report with Proposals," Study Team Draft Report for Ottawa City Council (Centre for Policy and Management Studies, Ottawa, 1981), Annex II.

authorities."[8] Initially, this activity was focused around the development of the Official Plan for the Region (1972-74). The Federation remained active in planning matters until 1977.

One impact of this growing movement for citizen involvement was the election of a number of reformist politicians who placed an increased emphasis on the value of citizen participation:

> The neighbourhood planning efforts were instrumental in organizing and channelling consumption interests in municipal politics. The 1960s and particularly the 1970s witnessed an important increase in the organization and articulation of consumption interests, largely as a result of the creation of neighbourhood-based citizens' groups ... The neighbourhood planning process served also as an initiation ground for municipal politicians. Through citizen groups, particularly those involved in neighbourhood plans, a whole generation of municipal politicians has attained office.[9]

These progressive municipal politicians have tended to emphasize collective consumption issues such as public housing, public transportation, improved social services and recreational facilities, and neighbourhood preservation. They also fostered the development of a Public Participation Policy

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[8] Geoffrey Baker, "Ottawa's Public Participation Policy," in Donald C. Rowat, ed., Recent Urban Politics in Ottawa-Carleton, (Ottawa: Department of Political Science, Carleton University, 1985), 118.

[9] Andrew, "Ottawa-Hull," 151; Caroline Andrew, "Ottawa: Progressives in Power," in James Lorimer and Carolyn MacGregor, ed., After the Developers, (Toronto: James Lorimer and Company, 1981), 96-107, provides a profile of the progressives in Ottawa.

in the City of Ottawa.[10]

The strong commitment of the City to strengthening the role of the citizen in municipal planning began in 1971 when the Department of Community Development established the Neighbourhood Studies Programme to gather information from citizens about their neighbourhoods. This was later extended and broadened by the City's Planning Committee to encompass nineteen studies. The City also established a Citizens Information Committee in 1972 to develop a freedom of information policy to give citizens access to the information necessary for effective participation in the municipal decision-making process.[11]

At the regional level, the Social Services Department of the Regional Municipality of Ottawa-Carleton has been supportive of innovation in the delivery of social services and devoted more municipal money to this end than many other municipalities in Ontario.[12] This trend is illustrated by the development of a network of community service centres through the joint efforts of the Social Services Department and the Social Planning Council of Ottawa and District.2.

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[10] Ibid, 151-52, Andrew notes that the uniqueness of municipal politics in Ottawa during the 1970s was "the organization of consumption interests"; Baker, "Ottawa's Public Participation Policy".

[11] Baker, "Ottawa's Public Participation Policy," 110.

[12] Ibid, 158; Mayo, Report of the Ottawa-Carleton Review Commission, 176.

2.Community Service Centres (CSCs):[13]

During the 1970s the Regional Municipality of Ottawa-Carleton in conjunction with the Social Planning Council of Ottawa and District developed a number of multiservice centres in an effort to better coordinate the delivery of health and social services which served primarily repressed interests. This network of agencies served as an institutional basis for the development of many of the CHCs in Ottawa-Carleton. It also added legitimacy to the activities of local activists seeking to establish community health centres.

In 1968, the Social Planning Council of Ottawa and District[14], under the directorship of John Horricks, took a lead role in coordinating the delivery of social services in the Lower Town East area of Ottawa. The impetus for this move was due in part to the massive dislocation of residents caused by a large urban renewal project taking place in the area at the time.[15] Initially, the Social Planning Council met with

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[13] Much of the background information for this section was provided through correspondence with Stuart Godfrey, former Commissioner of Social Services, Regional Municipality of Ottawa Carleton, dated May 8, 1990. Other documented and interview sources are cited throughout, where appropriate.

[14] H. Philip Hepw rth, Personal Social Services in Canada: A Review, Volume 8, (Ottawa: Canadian Council on Social Development, 1975), 33, The Social Planning Council is a voluntary organization with a membership of 80 community organizations, including such government agencies as the Social Services Department and the Health unit of the Regional Municipality, and a number of hospitals.

[15] The Public Welfare Department (Social Services Department) was already aware of the problem and had assigned a bilingual social worker who eventually became a source of

seven direct social service agencies[16] to develop an implementation strategy. The group agreed that they would continue to meet as the Joint Administrative Committee to plan and manage the first centre, "under the umbrella of the Social Planning Council and partial funding by the United Way of Ottawa-Carleton."[17]The Lowertown Community Services Centre opened in 1970.

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information and advocacy for the residents of the area in terms of obtaining the necessary resources to address the problems of dislocation. Some of the needs that arose as a result of the urban renewal included: emergency shelter, feeding, transportation, school, health and welfare problems, including in-home care for adults and young children. One of the results of this first brush with urban renewal was a recognition by those in municipal government that some restructuring of the municipal department responsible for physical planning and development was needed to take account of the social costs of large scale urban renewal. The experience also demonstrated the need for a new approach to providing primary health and welfare services that would foster the development of indigenous leadership and management. In this respect local church leaders as distinct from municipal politicians played an important role. At the municipal political level this eventually resulted in the introduction of a Social Service Advisory Committee which initially took on the task of "cutting back on welfare". Despite this the community service centre idea survived and flourished.

[16] The seven agencies were: the Children's Aid Society of Ottawa; Family Service Centre; Catholic Family Services; the Youth Services Bureau; the District Health Service (Ottawa Department of Health); Ottawa Department of Public Welfare (Social Services); and the Ontario Ministry of Community and Social Services. The organizations comprising the original group already were operating as an interactive network.

[17] Kathy Secord, Community Service Centres, Regional Municipality of Ottawa-Carleton, Social Services Department, January 1988, 1-2; Social Planning Council of Ottawa-Carleton, Terms of Reference for Community Services Centres in the Regional Municipality of Ottawa-Carleton, undated,(circa 1979), 1.

In 1969, the Neighbourhood Improvement Committee in the Dalhousie Ward area approached the Social Planning Council for assistance in conducting a similar review of services. In December of 1971, the Dalhousie Community Service Centre began operations, staffed by employees of the Joint Administrative Committee.[18] On June 14, 1972,[19] the Council of the Regional Municipality of Ottawa-Carleton gave formal approval to the establishment of two community service centres. From this point, the Regional Municipality assumed responsibility for the administration of community service centres through its Social Services Department, and the Joint Administrative Committee became the Joint Advisory Committee to the Commissioner of Social Services.

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[18] OCSPC, Annual Report,1974-75, 36; OCSPC, Annual Report, 1976-77, 7; Dalhousie operated a community resource centre until March of 1975 when primary health services were added and it became technically a multi-service health and social service centre. The negotiations to add the health component took place between Kyoshi Shimizu, the Coordinator of the existing CRCs, an employee of the Joint Advisory Committee (formerly the Joint Administrative Committee), the Regional Municipality of Ottawa Carleton and the Ontario Ministry of Health. The original contract was between the Ministry of Health and the Joint Advisory Committee and remained this way until 1979 when Dalhousie incorporated and added a community board of directors. At this time the contract was changed to reflect the independent legal status of the multiservice centre. Between 1975 and 1979, community participation was gradually introduced at Dalhousie; first through a hiring committee, used to assist in hiring the medical staff for the health centre component and later through a management committee which eventually became the board of directors for the centre. A similar process can be observed at both Southeast Ottawa and Pinecrest Queensway.

[19] Minutes of Regional Council, June 14, 1972, Report 38/48, 913-23; Report of the Joint Advisory Committee for 1972, Annex A, Report 4/43.

The Joint Advisory Committee is composed of the administrators of the participating agencies[20], senior staff, and representatives of the Association of Community Service Centres.[21]The responsibilities of the JAC include reviewing the objectives of CSCs, advising the Social Services Department and reviewing proposals for other centres. District Directors are responsible for all CSCs within their district. The major link between the Social Services Department and the centres is that the administrative staff are employed by the municipality. This has facilitated the development of an administrative hierarchy linking individual CSCs with the regional department.[22]

With the successful implementation of the first two community resources centres and the assumption of

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[20] Secord, Community Service Centres, The participating agencies as of 1986 were the Ottawa-Carleton Children's Aid Society, Family Service Centre, Catholic Family Services, Youth Services Bureau, and Service d'Entraide Communtaire.

[21] Ibid, The Association acts as a forum for the sharing of information and discussion of common issues.

[22] The relationship between the Social Planning Council and the Social Services Department had predated the establishment of the Joint Administrative Committee. John Horricks began the initial discussion and planning for community service centres (circa 1967) on an informal basis with the heads of each participating agency to avoid a high public or political profile at that stage. Stuart Godfrey was favourable towards the idea and thought that the proposal would likely receive approval in principle from the Regional Council. The intention was to allow sufficient flexibility for the major administrative players to withdraw should the next Regional Municipal Council be opposed to the reform. Unlike politicians, the various agency heads were all in the business of resource planning for the long term and couldn't afford to permanently damage working relationships.

responsibilities by the regional municipality, there was general political and public support for the program. This is attributable to two benefits: the potential to improve the nature and availability of social services; and the potential to reduce the duplication of service, and therefore, overall expenditures.[23] In 1973, the OutReach Program South-East Ottawa started as a joint initiative by Catholic Family Services and the Family Service Centre and was administered after 1976 as a community service centre. In 1977, Centretown Community Clinic, adopted a community service component and became Centretown Community Resource Centre. In 1979, Centres were established in Gloucester Township and Pinecrest-Queensway in Ottawa. In 1982, Sandy Hill Community Health Centre, expanded its range of services to include some community service centre programs.[24]

The CSC program was developed to serve the following end:

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[23] Not all municipal politicians and administrators were excited about the implications of increased community participation associated with the centres. A long educational process was necessary to bring dissenters on side. However, after 1970 there appeared to be a greater appreciation of social and poverty problems by those seeking elected municipal office, and by those seeking administrative positions in the Social Services Department. The provincial government, both in terms of Community and Social Services and Health were not initially interested and tended to view community resource centres as a frill. This attitude, too, eventually changed.

[24] Kathy Secord, Community Service Centres, Annex I, These other developments are mentioned here because they indicate the close relationship between health centres and resource centres. Southeast-Ottawa and Pinecrest Queensway were both approved for CHC funding by the Ministry of Health in September of 1987.

> Community service centres serve as a catalyst to assist geographical communities to achieve optimum physical, mental, economic and social well-being within their community in order to enable its members to achieve greater self-sufficiency as determined by each community.[25]

In practical terms this translated as "a way of bringing scarce resources of staff and funds into an effective community-based delivery system,"[26] through the cooperation of professionals and citizens at the neighbourhood level. In essence, the social services department created an environment which legitimated the activities of the voluntary associations of local activists in their efforts to organize for collective consumption. This was facilitated by adopting a definition of health similar to that advocated by the World Health Organization and Health and Welfare Canada.[27] Institutional leaders played an important role in this process.

Community service centres acted as coordinating agencies

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[25] Kathy Secord, Community Service Centres, 2; OCSPC, Annual Report, 1968-69, 8, also expresses this sentiment.

[26] Ibid, 1; Warren Magnusson, "Community Organization and Local Self-Government," in Lionel D. Feldman, ed., Politics and Government of Urban Canada, 4th edition, (Toronto:Methuen, 1981), 86, Magnusson provides a theoretical discussion of this idea as it applies to governance in urban areas; Sources of funding for community resource centres include the following: Benefits and Assistance (provincial), Canada Assistance Plan (federal), General Welfare Assistance Act (provincial, but administered through municipalities), Family Benefits Act (provincial), Day Care for Infants and Young Children (provincial).

[27] Ottawa-Carleton Social Planning Council, Terms of Reference for Community Service Centres in the Regional Municipality of Ottawa Carleton, 1979, 2.

for the provision of a variety of social and health services including: emergency assistance; crisis counselling; therapy involving individuals, families and groups; public health services; specialized youth and children's services; information, advice and referral; community development; self-help; and primary health care. The definition of primary health care was broad enough to encompass the "gate-keeper" function of the physician plus health promotion and continuity of care through referral.[28]

Citizen participation has been incorporated through the election of community boards responsible for financial and program planning and coordination. These boards are assisted by a management committee comprising the coordinator, the president of the community board and other support staff.[29]

The Regional Social Services Department provides funding for a coordinator and 1.5 clerks to all but three centres. Two of these receive core funding from the Ministry of Health. Individual centres pursue funding arrangements for programs from the Ministry of Community and Social Services, Ministry of Health, Canada Employment and Immigration, Municipalities, other community-based agencies and through private donations. In 1986, total funding from all sources was $5, 500,000, of

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[28] Ibid, 1; Secord, Community Services Centres, 4.

[29] Social Planning Council of Ottawa-Carleton, Terms of Reference for Community Service Centres in the Regional Municipality of Ottawa-Carleton, 1979, 2; Secord, Community Service Centres, 5.

which nearly $2,000,000 came from the Ministry of Health. During this period over 40,000 clients in ten communities received services from 259 staff and "55,000 community volunteer hours."[30]

As the case studies presented below will indicate, the presence of a supportive political and institutional network had a marked impact on the development of community health centres.

3. Sandy Hill Community Health Centre:

The neighbourhood of Sandy Hill was defined geographically in 1974 as that area running along "Rideau Street to the north, the Rideau River to the east , the Queensway to the south and to the west ... the Rideau Canal."[31] The population of the community at the time was estimated to be over 20,000 and to be relatively heterogeneous, in terms of income, age and ethnicity. The neighbourhood was not self-contained, since the majority of residents worked and sought services outside of the geographic boundaries.[32]

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[30] Secord, Community Services Centres, 4.

[31] Sandy Hill Development Corporation, Co-ordination, Communication and Consumption: A Study of Health and Social Services in Sandy Hill, Ottawa, (Ottawa, July 1974).

[32] Nils Larson, "Political Participation at the Municipal Level," in Donald C. Rowat, ed., Urban Politics in Ottawa-Carleton: Research Essays, (Ottawa: Carleton University, Department of Political Science, 1983), 88; Sandy Hill Development Corporation, Co-ordination, Communication and

A major issue in the neighbourhood at the time was the lack of suitable housing caused by a combination of pressures including the cost of maintaining property, the expansion of the university, the destruction of existing family housing stock and the replacement of housing stock by highrise apartments and rooming houses. In reaction to this, local residents formed a number of community groups to address the problems of changing demographics and housing accommodation.

The first community organization to form around these issues was Action Sandy Hill (1968). This represented the largest of the estimated 40 neighbourhood associations established after 1960.[33]The new community group carried out several studies of heritage and recreational buildings in the area, and convinced the City of Ottawa to develop a neighbourhood plan for Sandy Hill.

Beginning officially in 1971, the development of a neighbourhood plan, the first planning exercise in the City on a community involvement basis, sparked a social animation process that would carry over into later issues. The association created the Citizens' Committee for Planning in Sandy Hill to represent the neighbourhood's interests during

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Consumption: A Study of Health and Social Services in Sandy Hill, Ottawa, (Ottawa, July 1974), The population mix included 45% Francophone, 11% European, Asian or African, an increasing transient population in the 20-30 age bracket, and a large number of middle-aged and elderly permanent residents.

[33] Larson, "Political Participation at the Municipal Level," 88, The association had an estimated active membership of 400 members.

the formulation of the neighbourhood plan. The efforts of the Committee resulted in a one-year freeze on high-rise construction until the study of the neighbourhood was completed. The planning proposal developed by the Committee was supported by a petition with 2,000 signatures.[34]

During the process of developing a neighbourhood plan, the Association developed a fairly close relationship with the City Planning Department. This relationship was encouraged by the apparent sympathy of the planners to neighbourhood demands. The relatively strong leadership at the neighbourhood level and the shortage of professional staff in the municipality allowed local activists to develop a more equitable partnership.[35]

One of the by-products of Action Sandy Hill's attempts to deal with the housing issue was the creation of the Sandy Hill Community Development Corporation.[36] The Corporation was created as an incorporated non-profit organization in May

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[34] Larson, "Political Participation in Ottawa-Carleton," 88, 93, suggests that the committee was actually established at the insistence of the city planning department which felt that Action Sandy Hill was not sufficiently representative. The history of the association includes a successful bid to stop the Region from building a freeway through the middle of Sandy Hill which was recommended by the Ottawa/Hull Transportation Area study. On these issues the association found themselves in more frequent contact with municipal administrators and politicians.

[35] Ibid, 97.

[36] The corporation would include on its board of directors at various times the ward alderman, religious leaders, university representatives and citizens living in the neighbourhood.

1973, in response to changes in the National Housing Act and the mandate of the CMHC, allowing non-profit community based corporations to develop housing. After the neighbourhood plan was completed, the task of the corporation was to develop non-profit housing in the area in response to a shrinking housing stock, which was caused by the expansion of the University of Ottawa. Many of the residents affected by the shrinking housing stock were elderly, on fixed incomes and interested in remaining in the neighbourhood. However, the idea of building non-profit housing eventually failed.[37]

Despite the failure of the housing initiative, the objectives that were set out in the letters patent allowed the for a whole range of potential activities:

> The Corporation was created to provide and/or administer health centres, day camps and nurseries and social centres for the use and benefit of the people in the said Regional Municipality of Ottawa-Carleton.[38]

The Sandy Hill Health Centre was in turn developed from the mandate of the development corporation.[39]

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[37] The Corporation received some funding for this undertaking from the Local Initiatives Program and the Opportunities for Youth Program.

[38] SHCDC, A Health and Community Services Centre, an undated preliminary report, 5.

[39] The activities of the community were divided into two distinct entities. One, Action Sandy Hill was to play the role of identifying problems in the neighbourhood. The other the Sandy Hills Development Corporation was to perform more of a management role in the development of individual projects to address those needs identified by the Association. The Corporation also purchased a number of properties at strategic locations in the neighbourhood. Over time the link between the

While initially the executive of the Corporation had not given serious thought to a health centre, (the housing issue being paramount at the time), it was approached by the Ontario Ministry of Health. The provincial government suggested that there was money available to develop health centres and the Corporation was ideally suited for this purpose.[40] Subsequently, Dr. John Aldis, Executive Director of the Project Development and Implementation Group of the MOH met in Ottawa on November 7, 1973, with George Wilkes[41] of Sandy Hill and Jean Pigott, Chairman of the recently established Ottawa District Health Council. The outcome of the meeting was endorsement of the establishment of a health centre in Sandy Hill by both the PDIG of the Ministry and the Ottawa District

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two organizations and thus the grassroots support has faded. This has proved detrimental in mobilizing community support for more recent initiatives to expand and relocate the Centre. The increased sophistication of board activities has left them with less time to do the community outreach activities that characterized the earlier period. Board members are now besieged by a flood of paperwork associated with ministry guidelines and subsequently spend much of their time attending meetings. The increased level of sophistication has also narrowed the extent of community input on the board to those with the prerequisite experience or educational background.

[40] Sandy Hill Development Corporation, Review of SHCDC Position on Community Health and Social Services, undated; The original contact from the Ministry came from Dr. Wigle of the Research and Analysis Branch of the MOH via the Development Corporation's lawyer indicating an interest in the organization's powers to "provide and/or administer a community health centre."

[41] George Wilkes was a resident and long time community activist in the Sandy Hill neighbourhood. He was a career public servant with the federal government and President of the Sandy Hill Development Corporation.

Health Council. George Wilkes was also informed that, while the proposed needs assessment would produce a useful data base, it was not essential to the Ministry's decision to fund a health centre in the neighbourhood.[42] The endorsement from the Ministry and the DHC provided the necessary institutional legitimacy for establishing the health centre.

When the Corporation expressed interest, the Ministry provided a $10,000 grant to do a needs assessment of the neighbourhood between January and June of 1974. Prior to initiating the neighbourhood survey, interviews were conducted with the major institutional actors including the Regional Health and Welfare Department,[43] social service agencies, the neighbourhood medical community, the University of Ottawa, the Caisse Populaire,[44] religious leaders, public health nurses,

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[42] Sandy Hill Community Development Corporation, Review of SHDC Position on Community Health and Social Services, undated; Members were aware of the health centres established in Centretown and Lowertown, and in the larger context of the Sault Ste. Marie health centre and the federal Hastings Report. George Wilkes suggests that the Ministry became aware of Sandy Hills through the usual process of circulating new letters patent to applicable government departments. According to Albrecht, at the time the Ministry was most interested in already established community groups as possible sponsors of community health centres.

[43] Sandy Hill development Corporation, A Health and Community Services Centre, undated preliminary report; The Regional Health and Welfare Department had a recently established policy to: "support the establishment of community social service centres and depending on availability of sufficient space (to) encourage their use for appropriate purposes by the area residents."

[44] SHCDC, Review of SHCDC Position on Community Health and Social Services, At the time the Caisse Populaire was interested in being located near the new community facility.

community health clinics and community groups. The process of consultation continued throughout the developmental process. With the assistance of a community volunteer and a professor from the University of Ottawa, a survey was conducted in both French and English. By including the medical community and the existing network of human services in the area, the corporation was able to determine the level of support it would receive if the health centre idea was fully developed. The survey revealed a high level of support from the medical community, existing social service agencies and the population in the area.[45]

From the initial needs assessment the members of the corporation decided that a health centre would be developed to provide bilingual services with the knowledge that many patients from Quebec received their health care in the area.[46] Organizers realized that they would have almost immediate access to equipment and patients because the Rideau Clinic, operated under a grant from Health and Welfare Canada,

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[45] SHCDC, Co-ordination, Communication and Consumption, 67-8; SHCDC, Sandy Hill Community Health Centre,: A Prospectus, (Ottawa, August, 1974), 1; SHCDC, Minutes, 19, July, 1973; The majority of the doctors interviewed for the survey were in favour of a CHC in the area and one even offered to help. Most were also associated with the University of Ottawa medical school. Social services agencies were generally in favour of the project with Catholic services requesting space for a representative at the new health centre.

[46] This somewhat unusual phenomenon resulted from the difference in the quality of services provided in the two provinces.

was closing due to the expiration of the grant.

By October, 1974 the Corporation had completed a site plan study and had narrowed the choice down to three possible sites. The criteria used for choosing the final site and the design specifications for the facility were based largely on the development of the Regent Park Clinic in Toronto "because of its similarity to the program for the Sandy Hill Community Health Centre."

Negotiations were undertaken with the executive and doctors of the Rideau Clinic, after a letter was received from the Rideau Clinic indicating that they would be interested in participating in a central development committee to work out the details of a merger between the two legal entities. Rideau agreed to hand over their assets to Sandy Hill on January 1, 1975, provided that a suitable location had been acquired for the new facility. Negotiations with Rideau continued beyond the January 1 deadline. At a meeting held in March of 1975, Dr. John Pearson, representing Rideau, indicated that his organization was ready to transfer its assets to the Sandy Hill Community Development Corporation. At this time the board of Sandy Hill approved a motion to that effect. Sandy Hill also agreed to appoint a member of the Rideau Clinic board to the SDCHC Board.[47]

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[47] SHCDC, Minutes, 19 September, 1974; Minutes, 25 February, 1975; Minutes, 17 March, 1975, Dr. Aldis expressed his support for such a merger. Negotiations as to the exact details of the merger were to continue beyond the January 1 deadline. The government, however, considered the SDCHC to be

With a ready-made community base and a good start on diminishing capital expenditure as a result of the acquisition of the Rideau Clinic assets, a health centre was established at a Freil Street location that had previously been utilized by two private physicians. In December of 1975, the Sandy Hill Community Health Centre officially opened its doors with funding on a global budget provided by the Ministry of Health.[48]

The residents of the neighbourhood had participated in the process through the interlocking relationship between Action Sandy Hill and the Sandy Hill Development Corporation. A volunteer monthly community newspaper delivered to the doors of the residents kept them abreast of developments by the community organizations before and after the health centre opened.

While the regional municipal government was not directly involved in the negotiations with the MOH, discussions were carried out with Kyoshi Shimizu, who had been hired by the region's social services department to develop a coordinated network of community resource centres. The regional department had already been involved directly in the development of the

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the body with which they would negotiate for the new CHC.

[48] Sandy Hill Community Development Corporation, A Community Health Centre for Sandy Hill, Planning the Facility: A Study of the Site Selection and Development Process, (Ottawa, 1974), 20; individuals involved in preparing this study included representatives from the Ottawa Board of Education, Carleton University School of Architecture and Regent Park Health Clinic in Toronto.

Ste. Anne's, Lowertown and Dalhousie community resource centres as they were set up as multi-service centres, with partial funding for social services coming from the social services department. All would eventually apply for and receive funding to offer a primary health component as part of their service spectrum.

During this period, Sandy Hill had very little relationship to the region[49] because it essentially operated as a family practice according to provincial guidelines. Little movement was made towards a multi-service approach until Denise Albrecht took over as the Executive Director in 1980, bringing with her the multi-service experience she had acquired as a volunteer staff member at Centretown. A move towards a multi-service approach to delivery during the 1975-79 period might have jeopardized the funding relationship with the Ministry of Health, since the Ministry had already put a freeze on the development of further centres and was delaying the process of renegotiating budgets with the existing organizations.

A review of the programs (see Appendix IX, Exhibit A), personnel and funding provided by the Sandy Hill CHC indicates that it has not moved much beyond the traditional medical model of health care. The majority of funding (85%) comes from the Ministry of Health for the funding of the three

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[49] Despite the lack of direct involvement by the region, the Alderman for Sandy Hill was the chairman of the health committee of the regional government.

physicians, two nurse practitioners and two nurses. The spectrum of programs included under primary health care is somewhat broader than that of a solo fee-for-service practitioner. Other, "non-medical" services are limited in terms of scope and funding. The presence of an administrator and support staff indicates a certain degree of bureaucracy.

While Sandy Hill had faced little opposition because it had the support of the local institutional network and pursued a strategy which fit well with the Ministry of Health requirements, Centretown would find that failing to fulfil these prerequisites had serious liabilities.

4. Centretown Community Health Centre:[50]

Centretown Community Health Centre was initiated as a street clinic in 1969 by a network of local activists comprising concerned citizens, local politicians and human service administrators. The original sponsor for the clinic[51] was the Mayor's Committee on Youth, with the primary focus being on the "drug problem" in the Centretown area of the City

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[50] An unpublished essay by Linds entitled, From "Ottawa Street Clinic" to Centretown Community Resource Centre" - A History, December 14, 1979, was consulted for this section. Other sources are listed throughout.

[51] The Centre was originally called the Centretown Community Clinic, but was changed to the Centretown Community Resource Centre in 1978 when a multiservice approach was adopted through funding from the regional social services department.

of Ottawa. A sub-committee composed of representatives from the Addiction Research Foundation, the local medical community, the Canadian Mental Health Association, the Ottawa University Chaplaincy and other members of the community, acted as liaison with the Mayor's Committee. Administration of the initia project funding was managed by the Ottawa YM-YWCA. The purpose of this initial phase of the Centretown project, which lasted for four months, was to demonstrate to established service agencies a "street-level" approach to providing services to youth. Prior to this the YM-YWCA had operated a drop-in centre for youth with drug problems, but organizers soon realized that the people they were seeing were multi-problem cases. Drug abuse was only the most visible issue. Other problems included nutrition, basic hygiene and health care. From this, organizers realized that a multi-service approach to service delivery would be more appropriate.[52]

The philosophy of the volunteers and paid staff focused on the breaking down of traditional authority barriers in the

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[52] Patricia Deline headed up the original four month project and remained afterwards for many years as a volunteer; Other individuals who took a personal and lasting interest in the development of the CHC included Marion Dewar, then an alderman for the City of Ottawa and later the Mayor of Ottawa, Rolphe Hussenack, an alderman, Jesuit priest and long time chairman of the Regional Social Services Committee and Jean Pigott, who was Chairperson of the National Capital Commission and later became the first Chairman of the District Health Council. Some of the original staff volunteers included a nurse from Thunder Bay, two trained medics from Vietnam and two university students who later went on to establish a health centre in Surrey, B.C..

provision of services and was implemented by operating the clinic as a "co-operative" rather than an hierarchically structured organization. Thus the staff rotated from one responsibility to another, with some non-medical personnel performing essentially medical tasks such as the administering of allergy shots. Volunteer staff did receive training in these matters from medical or nursing personnel associated with the clinic.[53] When the founding group decided to apply for regular funding from the MOH, recognition was given to the fact that such an unstructured approach would not meet Ministry criteria for funding.

Originally the non-medical services were administered by four full-time staff provided and paid for by the Addiction Research Foundation. Four full-time volunteers supplemented the professional staff. The medical services component of the project was developed through the Chief of Paediatrics at the Ottawa General Hospital who developed a system of rotation for 22 fourth-year medical students and supplementary community physicians.

During this period, volunteers spent a great deal of time meeting with agency representatives, especially established human service providers, to convince them of the validity of the idea. Since the outward appearance of the volunteers did

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[53] This "non-medical" approach to the delivery of services would have been viewed very questionably by both the local medical community and the Ministry of Health, if it had been common knowledge at the time.

not always initially impress established organizations, one of the barriers faced by initiators of the project was developing a constituency among existing agencies. Unlike Sandy Hill, Centretown did not have a ready made constituency on which to establish legitimacy with funding agencies. An additional problem was the largely transient population targeted for servicing.

The more that the networking progressed, the more the hospitals and other agencies began to see the validity of the approach suggested by the fledgling health clinic. Resistance from the local medical association was to be expected and continued for some years afterwards. It was the on-going process of networking that had first attracted the interest of agencies such as the Addiction Research Foundation and the Chief of Paediatrics, who was teaching at the University of Ottawa at the time.

Despite opposition, the volunteers managed to locate key individuals in the major local human service agencies, and local and provincial governments who were supportive of their cause. Over time then, a constituency was developed to lend legitimacy from the MOH perspective to the development of the health centre.

The networking process also involved scrounging for medical equipment and supplies. In this respect the clinic was fortunate enough to enlist the aid of a nurse whose husband was a doctor, and who was therefore connected to the

established medical community. Through this avenue, the clinic acquired drug samples, furniture and equipment from the practice of a deceased physician's wife. During this time the project continued to be supervised from an office provided by the YW-YMCA.

The staff and clinic committee applied for and received a Research and Development Grant from the MOH in December 1970[54] ending in March, 1973. By mid-1972, the staff and committee of the clinic grappled with the question of the mission of the organization. At this point the issue of "community control" vs. "institutionalization" split the volunteers and paid staff. This discussion of philosophy would continue through most of the 1970s and eventually result in some of the more "radical" founding members leaving the organization. The discussion arose as a result of the changing nature of the clientele being served. Originally established with the intention of dealing with the drug problems of a transient youth population, the clinic began to attract a broader spectrum of the community as it became more established in the neighbourhood.[55]

The provincial grant ended in March of 1973, after the

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[54] Roger Smith, "Government immune to clinic's pleas," Centretown News, 9 December, 1973, 2.

[55] According to Linds the issue of community control raised the problem for the core group of maintaining control of the direction of the clinic if too much power were divested to the broader community.

province refused to renew funding because it claimed that the Centre's activities no longer fit into the Ministry criteria for the R&D Grant category. During the following year the Clinic survived essentially on funding provided through a Local Initiatives Project Grant for a women's health project and an Opportunities for Youth project (YW-YMCA) to provide dental prevention and nutritional education, while the operations of the medical component were limited to evening medical clinics conducted by medical students and community doctors.[56]

At this point an application was made for a $ 350,000[57] demonstration grant from Health and Welfare Canada, which was rejected in November of 1973 due to the service orientation as opposed to the research orientation of the Centre.[58] In the wake of this failure a number of interim strategies were pursued. One was to appeal directly to other local agencies and the community for donations and another was to attract a

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[56] Both the LIP and Opportunities for Youth Grants originated from federal funding sources.

[57] Roger Smith, "Government immune to clinic's pleas," Centretown News, 9 December, 1973, 2.

[58] Street Clinic Emergency Meeting, Minutes, 26 November, 1973; According to the minutes, Barb Linds speculated at the time that while she suspected the real reason for the Health and Welfare refusal of final approval for the grant (it had previously been approved at lower levels of the Department) was that the federal government wished to shift responsibility for funding these types of initiatives to the provinces. This suspicion was later confirmed in a meeting with Health and Welfare officials as reported in Ottawa Street Clinic Committee, Minutes, February 13, 1974, 2.

physician who could then bill directly through OHIP. Funding during this period consisted essentially of a private donation of $ 1700 for 17 weeks to fund a coordinator (Linds). Since the Centre had no budget to advertise for a physician, free advertising was solicited from a number of non-establishment publications.[59]

More importantly, the committee decided to approach Dr. John Aldis, who was heading up the recently established Program Development and Implementation Group within the provincial Ministry of Health. Dr. Aldis thought that the first grant did not expire until April of 1974 and was willing to begin funding the Centre at that point. During the period of January to March of 1974 the committee interviewed prospective physicians, maintained the Clinic during the evening, networked with other health centres in the Ottawa area and continued lobbying the regional government for interim funding.[60] The region continued to be sympathetic to the plight of the Centre, but was not forthcoming with

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[59] Minutes, 26 November, 1973; At the time the Centre had $ 800 left from the grant and the monthly operating budget was approximately $ 300. Again, during this stage the on-going networking process proved crucial in terms of securing letters of support from local service and neighbourhood organizations, such as the Centretown Neighbourhood Association, headed up by Michael Cassidy.

[60] Some interim funding was provided by the Carleton University Students Association who paid the rent, the above mentioned money for Barb Linds's salary, and a donation for telephone expenses from the Kiwanis Club. The rest of the staff went on unemployment insurance and worked anyway. The YW-YMCA donated office supplies.

funding.[61] After on-going negotiations with PDIG the Centre secured a global budget of $ 40,000 a year paid in monthly instalments based on the employment of a physician. Over half of the money was for the physician's salary. At the time the committee realized that the government rationale for funding the centre was to employ a physician to provide primary health care for cheaper than the normal OHIP rate, not to empower the community.

The result of this realization was a revision of the image of the organization from one catering to essentially the "second-class" citizens associated with the drug counter culture of the 1960s to a family-oriented medical practice serving the mainstream population in the area. The location of the centre itself was shifted and the name of the Clinic was changed through incorporation to reflect the new emphasis. This action would facilitate the longer term maintenance of a funding link with the Ministry of Health.[62] Shortly after the

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[61] Minutes, 26 November, 1973, 1; Barb Linds speculated at this point that a commitment in principle from the MOH might convince the Region to provide interim financing.

[62] The new organization continued to emphasize the principle of non-hierarchy and continued to supplement the full-time paid physician with four part-time medical students. Staff members all had some medical training, but were rotated through a variety of positions at the centre on a regular basis. However, the Centres documentation reflected a service orientation approach to health care as opposed to a broadly based preventive approach. This might be attributed to the political recognition of the MOH attitude. Letters of support for Centretown in its bid for interim funding from the regional government were provided by Dr. Aldis and Jean Pigott.

move the centre received a grant from the federal Secretary of State to fund three Summer students to do community development and outreach.[63] In August of 1974, a draft constitution was developed and a campaign to encourage community involvement in the new facility was initiated.

In early 1975, the MOH released new guidelines concerning the funding of health centres, advocating both the development of a patient roster system[64] and the employment of capitation funding. In response to the change in funding arrangements, the board of the clinic drafted a letter to the new Minister of Health, Frank Miller, outlining the confusion that the sudden shift in policy had caused. In short, the Centre, in continuing negotiations with their contact (project officer) at the ministry, had been encouraged to apply for additional funding to provide a second physician and had been given some assurance of reimbursement for additional expenses incurred during the previous year. The Centre had also done everything it could to comply with the new guidelines concerning rostering and had developed a roster of 2500 patients after only one year of official operation. Ninety new patients per

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[63] Jane Mingay, "Centretown Clinic Now On Lewis Street," Centretown News, 6 July, 1974, 3; Vivian Macdonald, "Old street clinic has a new image," Ottawa Citizen, 2 May, 1974; With respect to dealing with the Ministry, the District Health Council and the Region, Dewar and Pigott were very much involved. Dewar was a municipal representative on the DHC.

[64] The roster issue was a particularly difficult one for Centretown because their original clientele had sometimes not used their legal names when registering with the clinic for treatment. Some did not even have OHIP numbers.

month were being added to the roster at the time the letter was sent. Despite this compliance, the Centre was informed by the project officer that the renewal of its present level of funding was in doubt and that the discussed extras were entirely out of the questio...[65]

A brief prepared in conjunction with the other CHCs in Ottawa-Carleton was presented to the Eastern Ontario Region District Health Council (now Ottawa-Carleton DHC) in mid-April of 1975, asking the DHC to intervene on behalf of CHCs in Ottawa and area to clarify the funding situation. The brief also suggested that, since the MOH was now interested in evaluating health centres, the DHC might serve as a useful vehicle for evaluating the network of CHCs in the Ottawa-Carleton region. The proposal to use the DHC as the evaluating agency fell on deaf ears as the funding of health centres was now being seriously questioned at the provincial level and the administrative unit with which Centretown had established a funding link was in the process of being dissolved.[66]

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[65] Centretown Health Care Community Clinic, Correspondence with Frank Miller, Minister of Health, dated 10 April, 1975; At this time the Centre Received a global budget of $ 44,000 of which $ 15,000 was used to fund a physician with a patient roster of 3,600 and the remainder was used to fund three full-time staff and operating costs. OHIP paid $ 30.00 per patient per year to provide basic health care services.

[66] Clinique Rideau Clinic, Centretown Community Health Centre, Eccles Street Community Service Centre, Sandy Hill Neighbourhood Health Centre and Ste. Anne's Clinic Inc., Brief to the Eastern Ontario Region District Health Council, 16 April, 1975; Jane Mingay, "Funding change worries clinic staff," Centretown News, 16 February, 1975, 9; Barb Linds left the Clinic around this time because she felt that the Ministry

A survey of the staffing, funding and programs at Centretown (see Appendix IX, Exhibit B) reveals that despite the capitulation of its ideological underpinnings, the Centre provides a broad spectrum of human services Out of a total staff of 30, only seven are medical personnel. The total administrative staff of eight actually outnumbers the medical staff. Unlike Sandy Hill, Centretown receives 58 per cent of its budget from the Ministry of Health. This includes funding for one administrative position. From this we can conclude that Centretown has managed to provide services according to a broader definition of health. The trade-off, however, appears to be an increased propensity for bureaucratic organization. Also, of note is the lack of a formal relationship with an area hospital (see Appendix VI, Exhibit B).

Like other existing and developing CHCs, Centretown was a victim of the lack of coherent policy at the provincial level. The development of South-east Ottawa indicates that this problem with the province continued to persist until well into the 1980s.

5. South-East Ottawa Community Resources Centre:

The South-East Ottawa neighbourhood is geographically located within the boundaries of the Queensway on the north,

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policy was forcing a shift of emphasis in the philosophy of the organization from one of preventive medicine to a traditional curative approach.

the City limits on the south and east, and Bank Street on the west. The mainly residential population of 55,000, with an average income of $ 25,000, has several distinctive disadvantaged groups including about 7,000 senior citizens (of which 1,200 or more live in subsidized housing, and over 4,000 households (approximately 13,500 individuals) living below the poverty line, of which some 3,000 are subsidized. The South-East Ottawa Community Resources Centre developed as a result of the efforts of the citizens and human service professionals to respond to the needs of these target populations.[67]

In 1972, two social services agencies, Catholic Family Services and Family Services developed an outreach project, with United Way funding, for the Southeast Ottawa area. This was the result of space made available through a community centre in a housing project. The housing project was part of a larger program initiated by the Ottawa Housing Authority.[68]In 1973, a grant was obtained from the regional social services department to maintain the project.

In 1975, the two agencies approached the regional social services department to have the outreach project designated as a community resource centre. By establishing a clientele link with the social services department, the project was able to access the administrative and funding resources of the

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[67] Health Committee, South East Ottawa Community Services Centre, Design and Analysis of a Community Health Survey in South East Ottawa, (Revised) December 1988, 1.

[68] Hepworth, Personal Social Services in Canada, 53-4.

regional department's community resource centre funding envelope. This essentially entailed the regional municipality seconding core administrative staff to the newly designated community resource centre. At this point the centre functioned without a community-based board of directors and continued to do so until 1980 when there was a recognition of mutual needs between the CRC and these local activists (mainly operating from church organizations) attempting to develop a community health centre.

In response to this recognition and the needs expressed by the public health department and residents of local government housing projects, a steering committee was established in 1980 to investigate the possibility of creating an agency to address the special health and social service needs of the neighbourhood. After three years of discussions with the groups and agencies in the neighbourhood, a community service board was elected at a public meeting.[69]

The immediate task of the board was to design a strategy to address the needs of the community. Four main areas of

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[69] Margaret Harrison, Southeast Ottawa Community Service Board Needs Assessment, (Ottawa: Southeast Ottawa Community Service Board, 1984), 1 During this time the City of Ottawa had also conducted a planning study, the Action Walkley Study with community input to determine the unmet needs of the Ottawa-Carleton region. The a neighbourhood planning study conducted by the City acted as a guide for the fledgling organization in developing their own study. It also spawned the development of other federally funded initiatives. One such initiative was the creation of the Keyword Walkley Word Processing Training Program. The Program trains single parent mothers in word processing and places them in jobs.

concern had been identified during the three years preceding the board and from this four "action committees" were established: the legal committee, the education committee, the youth committee, and the health committee. Beginning in September of 1982, a community outreach process was initiated in which informal (livingroom) discussions were held with 153 residents during a five month period.[70] The election of the community board and the outreach process that followed allowed the local activists to broaden the basis of their constituency to include the targeted populations.

The outcome of this initial survey was the recognition of three distinct populations with special unmet health and social service needs: single parent families, adolescents and seniors. Based on these findings, the health committee recommended that the board investigate the possibility of establishing a CHC to address the specific health needs of the three population groups.[71] From this recommendation the board decided to apply for CHC funding and conduct a formal needs assessment.

An application for funding of the needs assessment was submitted to the City of Ottawa and a grant was received. The needs assessment was conducted between June and November of

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[70] Ibid.

[71] The recommendation was based on the definition of a CHC found in the Hastings Report as providing a comprehensive range of health and social services through a multidisciplinary team; funded by an alternative to fee-for-service; and managed by a community board.

1984.[72] Again local activists established a link with the local level of government to acquire the necessary financial resources because the Ministry of Health would not fund such activities.

During this time, the board members realized that they knew very little about how a health centre operated so they undertook a process of self-education. Tours were arranged and discussions held at three existing CHCs: Centretown, Dalhousie and Sandy Hill.[73] Until then, they had not been in contact with the other existing centres but, with the proposal in the development stages, they realized the value of input from the existing network. From this point, ongoing consultation was maintained with the existing health centres. This strategy proved important in achieving final funding approval from the provincial MOH. The existing health centres acted as blueprints for estimating inventory and capital expenditures.

At a later stage of negotiations, the MOH revealed that it was interested in developing new health centres in Ottawa as satellites of the existing centres. When funding was approved for South-East Ottawa, it was channelled through Sandy Hill Community Health Centre. Funding for Pinecrest-

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[72] Ibid. Consultation with the University of Ottawa Health Administration Program faculty was held on the design and implementation of this and the assessment that followed several years later.

[73] Centretown and Dalhousie are actually formally considered community resource centres with a health centre component.

Queensway, another centre in the developmental stage at this point was eventually channelled through Centretown Community Health Centre. Again we see an indication that the Ministry policy has favoured providing funding to established community organizations.

As part of the preparation of the first funding proposal, endorsements were solicited from 40 agencies and groups in the area. Municipal, provincial and federal politicians were approached for support and advice, and all proved helpful. In one case, the federal MP, who was responsible for the Summer Employment and Educational Development Program, allotted thirteen students for the community resources centre. Other centres received an average of three students.

Based on the findings of the needs assessment, a funding proposal for a CHC was submitted to the District Health Council in October of 1984. The proposal indicated that a CHC in South-East Ottawa would strive:

> to provide bilingual, accessible, affordable primary health care, education and treatment services ... offer a comprehensive approach to social causes and medical consequences ... offer an alternative mode of health care delivery to those residents now utilizing other health services and to those currently not accessing the health care system.[74]

The process of review at the District Health Council and ministry levels was very drawn out and involved on-going

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[74] Southeast Ottawa Community Resources Centre, Community Health Centre Funding Proposal, (Ottawa, 1985), 25.

discussions and several revisions of the proposal before and after submission to the District Health Council.

A response was not received from the DHC until May of 1985. In November of 1985, the MOH officials contacted the Board, indicating that they wished to meet to discuss the status of the funding proposal.[75] At the meeting the Ministry staff expressed their recognition of the need for a health centre in the neighbourhood.[76]They made it quite plain at the time that funding was not available because the Ministry required further data on the situation and they were now looking at establishing new health centres in Ottawa as satellites of existing centres, thereby channelling funding through the existing centres.

In order to complete the Ministry requirements to receive funding, the board was requested to provide additional information on the specific health problems of the target populations; the problem of access by these populations to existing services; and the expressed desire of these populations for a community health centre. The MOH was also interested in acquiring an inventory of services provided

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[75]. An on-site visit from Ministry staff was standard procedure for all applications for health centre funding. Potential applicants usually went to the Ministry as well. The District Health Council acts as liaison in these matters

[76] They also informed Southeast Ottawa that the MOH was looking at funding a health centre component in the existing Pinecrest-Queensway Community Resources Centre The two proposals were not considered to be in competition.

through the existing Community Resource Centre.[77] In light of the newly expressed Ministry requirements, the board decided to conduct a larger study of the main areas of low rental housing and seniors' apartments. The process of collecting and analysing the sample (212 residents) took place between September 1987 and January 1988.[78] The results of the survey confirmed many of the previous findings of the community needs assessment in 1984 and some of the widely recognized links between age, income and health status.[79]

During this period the board continued to develop programs geared towards the target populations. In conjunction with a neighbourhood seniors group, Victorian Order of Nursing and the Elizabeth Grey Health Centre, a program was developed and implemented to provide special care for seniors.[80] Start-

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[77] This information was to be provided in a shorter version of the original proposal. From the beginning of the process, the Ministry had made it clear that they would only fund certain basic primary care services. Health promotion and education were not considered part of these basic services. These services were eventually arranged through the local public health department who provided a public health nurse on site for 35 hours per week. The Ministry requirement for additional data coincided with their turnover in staff and institutional reorganization with the election of a new government.

[78] The questionnaire had been previously pilot tested. Since no funding was available to conduct the new assessment, the board relied on volunteers and existing CRC staff.

[79] Southeast Ottawa Community Resource Centre, Funding Proposal for a Community Health Centre, Of importance here were a number of studies conducted by the District Health Council.

[80] The Legion was approached at a later date and provided some additional funding.

up funding for the program was provided by the VON and through donations raised from the community.[81]

In 1987[82], the MOH announced that the South-East Ottawa Community Resources Centre would be receiving funding. The funding, however, would be channelled through Sandy Hill Community Health Centre. The original funding only covered basic primary health-care services, reflecting the traditional bias of the Ministry against an expanded definition of health care. Since the centre has opened, the Ministry view has changed and such things as health promotion and mental health counselling are now being funded.[83]

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[81] The program to provide footcare for seniors has been a great success, with a waiting list of up to three months. in the Spring of 1988, the MOH suggested that the Centre apply for funding and the program is now funded by the province.

[82] The discrepancy of the funding being announced before the proposal had even been reviewed can be attributed to the relationship with Sandy Hill and to the impending provincial election. Southeast Ottawa had been attending meetings for months with lawyers and accountants attempting to sort out the details of the MOH funding process. At a meeting in September of 1987 with the Executive Director of Sandy Hill, a phone call was made to the ministry by the Executive Director and when she hung up the receiver start-up funding had been arranged.

[83] Prior to this, the Centre had developed a program for women on social assistance funded by Centretown CHC. The Ministry seeing how these innovations have survived has changed its tune. What many respondents across the province have noted and should be emphasized here is that when Murray Elston left the health portfolio, there was a changeover in the staff of the Community Health Branch of the ministry and the new "group" proved to be much easier to work with from the perspective of health centres. Based on discussions the author believes that this change was the result of personalities, administrative burnout and the overall shift in government policy.

A review of the staffing, funding and programs of South-East Ottawa (see Appendix IX, Exhibit C) reveals a broad spectrum of health and social services. This appears to be in accordance with the stated mission of the organization. Of the 30 staff, six are related to the provision of primary care, three are related to preventive and promotional health care, 11 are related to other human service activities and 11 are engaged in administration. Thus, like Centretown, South-East Ottawa exhibits a greater propensity to bureaucratic organization than Sandy Hill.

6. Analysis

The first independent variable (local political environment) had a high value and positive relationship with the second independent variable and the dependent variable. Sandy Hill was a by-product of the planning and citizen participation policies of the City of Ottawa. It was these policies that facilitated the development of Action Sandy Hill and the Sandy Hill Development Corporation. This in turn led to the development of the Sandy Hill Health Centre. The third independent variable (local corporate rationalists) had a had a high value and positive relationship with independent variable two and the dependent variable in the Sandy Hill and Southeast Ottawa cases. Located in a coordinated and supportive institutional network, these individuals played an important role in enhancing the ability of local activists to

develop CHCs according to their original ideological and organizational intentions. With a strong corporate rationalist presence, local activists were able to form voluntary alliances, including representatives from the existing political and institutional networks. By forging relationships with existing institutional actors, local activists were able to acquire the various resources (manpower, funding, expertise) necessary to develop and sustain a local consensus supportive of the introduction of a new service (the second independent variable). The legitimacy generated by this process was a necessary prerequisite to gaining a commitment from the Ministry of Health. This process, however, was not predetermined or standardized across the three cases presented here.

As Castells predicts, community mobilization in Ottawa-Carleton was a response to the disruption of life due to changes in traditional spatial and demographic patterns in urban neighbourhoods. The federal government focus on urban policy indicated the political significance of issues associated with the urban political arena. The City responded to this trend in two ways: fostering a collaborative approach between municipal planners and residents in developing neighbourhood plans; and fostering the development of a network of agencies for the organization of collective consumption. At the neighbourhood level, local activists responded to the emerging challenges by creating neighbourhood

organizations for collective consumption. In the case of Sandy Hill, the emergence of a community development agency from the neighbourhood planning movement during the early 1970s served as an institutional springboard for developing a community health centre in the neighbourhood. The objectives of the Sandy Hill Community Development Corporation created the potential for a broad scope of health and social services activities. Having already legitimated itself through the planning process and through a funding relationship with the federal government, the Sandy Hill Development Corporation was viewed as a legitimate local actor by the Ministry of Health.

Local activists were able to broaden the base of their support by consulting with existing health and social services agencies and gaining their support. This is attributable to the "conservative" character of the neighbourhood response. The strong presence of academic based physicians also had an impact on developing a broadly-based consensus. While not clearly elaborated by the MOH at the time, the presence of a strong local support was a prerequisite to a provincial commitment to fund a new health centre.

The goal of establishing a CHC was further supported through a needs assessment which enlightened the ministry about the unmet needs of certain segments of the neighbourhood population. Again these segments matched the views of the government as to which target populations should receive these services.

The outcome of the community mobilization was characteristically a non-radical approach to the delivery of the service. The amalgamation of an existing community clinic with the proposed new service minimized the disruption to the existing local medical market and utilized existing physical and manpower resources. The Centre was also structured to operate as a traditional family medical practice, with the exception of the community board, administrator and method of payment. This was precisely the type of arrangement the ministry was hoping to encourage as a means of converting physicians to an alternative payment mechanism, and to meet unmet needs without requiring the allocation of additional resources. Such an apprcach, from the provincial perspective, would lead to the coordination and integration of existing services at no additional cost. At the time this was the stated preference of the Minister of Health.[84]

In terms of the dependent variable, Sandy Hill Community Health Centre reflected the original ideological and organizational intentions of local activists. These motives were congruent with the prevailing logic of the Ministry of Health. Local activists had an established neighbourhood constituency through the neighbourhood membership and achievement record of its progenitor organization, Action Sandy Hill. They developed a coalition with corporate rationalists associated from the university and other

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[84] see note 42 in Chapter III.

established human services organizations. A member of the University Department of Health Administration assisted with the needs assessment.

Overall, the positive environment for collective consumption activities fostered by municipal government, in response to emerging urban problems, allowed local activists in Sandy Hill to mobilize the neighbourhood around issues of collective consumption. This was institutionalized through the creation of the Sandy Hill Community Development Corporation and the Sandy Hill Community Health Centre. In this environment, local activists were able successfully to provide a necessary service for repressed interests in the neighbourhood without encountering opposition from the dominant interests. Over time, the CHC was able to adapt to the network of community service centres in an effort to expand the scope of services.

Centretown was a much different story from Sandy Hill. Although Centretown was fostered by the local political environment and nurtured through the local institutional network, local activists failed to capitalize successfully on the first and third independent variables in the same fashion as local activists in the other two cases. This is attributable to two factors: the nature of the target population and the overt ideological preferences of local activists. The nature of the population initially served by the clinic was difficult, if not impossible to mobilize for

collective action. Clients were, for the most part, university students with drug problems and no fixed addresses. Most would not even use their real names when seeking medical services through the clinic. Under these circumstances, local activists were unable to present the sense of traditional community found in Sandy Hill.

The issue of drug abuse was confined to a fairly small, although highly visible, segment of the neighbourhood population. Thus mobilizing the neighbourhood for col'ective action was not feasible because the issue was not broad enough in scope to develop a strong local constituency. Even accurately assessing the need would have been difficult at best.

Of equal importance as a barrier to developing a CHC as originally envisioned was the ideological stance adopted by local activists and their attempts to translate this into organizational form. The type of service organization envisioned by the local activists did not fit the medical approach to the delivery of primary care services favoured by the ministry. By choosing to develop the service from a Marxist perspective, local activists guaranteed that they would encounter an unreceptive audience from the existing health service network and the provincial government. Even corporate rationalists muted their support of the venture.

As the clientele shifted and began to resemble a more orthodox neighbourhood, local activists were able to establish

a more stable base of local support. This and the impending funding difficulties led local activists to rethink their ideological stance and adopt the family-practice model favoured at the provincial level. This was done to increase the chances of maintaining a long term funding relationship with the province. Thus, local activists were able to develop a CHC, but unable to maintain either their original ideological objective or their non-hierarchical organizational structure. The lack of a strong local constituency (related to the second independent variable); a weaker corporate rationalist relationship (related to the third independent variable); resistance from the medical community (related to the fourth independent variable); and the overt radical ideological stance of local activists (related to the second and fifth independent variables) ensured that the CHC would take five years before achieving any sort of stability. The expanded range of services provided at the Centre has emerged through the later establishment of a relationship with local corporate rationalists.

The first (local political environment) and the third (local corporate rationalists) independent variables had a high value and positive relationship with the South-East Ottawa Community Resources Centre. It had its genesis in a joint project between established institutional actors. This in turn led to becoming part of the developing CSC network supported by the regional municipality and the Joint Advisory

Committee. By establishing themselves in the existing local institutional network, local activists were able to access the necessary resources to mobilize the neighbourhood around social service and health issues. This allowed them to conduct a needs assessment, develop new services and develop a community-based constituency.

Not unlike Sandy Hill, local activists were recognized as legitimate local actors. They were also able to clearly identify a population which fit the ministry's conception of a potential clientele. Once the target population was clearly identified, local activists designed and implemented a strategy to mobilize the neighbourhood. This was legitimated through the election of a community board for the CRC. The board then decided to formally apply for funding to add a CHC to the existing inventory of services provided through the community resources centre. This may account for the lack of resistance from the local medical community (related to the fourth independent variable).

Local activists were successful in maintaining their ideological and organizational objectives because their organizational structure was well entrenched before a community health centre component was contemplated. South-East Ottawa was also fortunate in that they arrived on the CHC scene during the second distinct time period in the life of the government program (intervening variable). While interim arrangements were required to allow the broader preventive

mandate of the CHC to become operational, the shifting Ministry attitude concerning health promotion and mental health counselling eventually solidified the broader spectrum of services. Contrast this with Sandy Hill which did not move to develop a broader range of services until eight years after being established.

Unfortunately, South-East Ottawa also chose a period of acute political turmoil at the provincial level to apply for CHC funding. During such periods when administrative and political leadership is shifting rapidly, applications for funding are often subject to bureaucratic paralysis. For South-east Ottawa this meant confirming and reconfirming needs assessment data.

The three case studies indicate that during the earlier period the ministry had no formalized procedure for developing health centres, since they were presumably experimental in nature. Despite the relative success of local activists in establishing contact with the MOH, the lack of legitimacy for the CHC concept at the provincial level meant that the requirements for securing a stable supply of funding were unclear. What became clear to those health centres attempting to utilize a non-medical approach to service delivery was that the MOH was locked into a medical model of health care. The limited view of the ministry would not begin to change until the late 1980s. Not surprisingly, Sandy Hill in developing as a family practice was established in two years. Centretown and

South-East Ottawa took considerably longer to develop than Sandy Hill because of the emphasis placed on a non-medical model of service delivery. Both, also exhibit an increased presence of administrative staff.

Chapter V

The Development of CHCs in Toronto[1]

Politics in the City of Toronto in the past two decades has been characterized as a battle between those who wish to see the municipal government continue its traditional and limited role as promoting business and those who would have municipal government function as a more general-purpose authority.[2] Despite this apparent battle between opposing forces, the efforts of reformers to redirect the emphasis of local government have met with limited success.[3] However, in the area of public health, reformist policies have been instituted with marked success, especially since the late

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[1] Information for the case studies in this chapter was obtained through interviews with the following people: Margaret Bryce, Sheila Cram, Anna Fraser, Father Jim Webb, Michael Faye, Ilda Furtado, Dr. Sandy Macpherson, Dr. Duyet Ngyen, and Dr. Michael Rachlis. Other documentation sources are cited where applicable.

[2] Bureau of Municipal Research, "Citizen Participation in Metropolitan Toronto: Climate for Cooperation ? Civic Affairs, January 1975, Chapter Two, traces the development of the 'citizens' movement in Toronto municipal politics from the mid-1960s to the mid-1970s.

[3] Warren Magnusson, "Toronto," in Warren Magnusson and Andrew Sancton, eds., City Politics in Canada, (Toronto: University of Toronto Press, 1983), 94; The context referred to here is both Toronto's place as the inner city of a large metropolitan area and the unique relationship that Metropolitan Toronto has with the provincial government both in terms of its potential political power and its close proximity to the physical location of the provincial legislature and other government offices.

1970s.

In the two case studies presented in this chapter, the first independent variable (local political environment) had a high value, although varying relationship with the second independent variable and the dependent variable. The second independent variable (local activists) had a medium value and positive relationship with the dependent variable in both case studies. Again this varied between the earlier and the later cases. Of particular note about the third independent variable (local corporate rationalists) is that over time its value and relationship have increased. The fourth independent variable (medical opposition) had a medium value and negative relationship with the second independent variable and the dependent variable in the earlier case. In the later case, the fourth independent variable had a low value and neutral relationship with the second independent variable and the dependent variable. The fifth independent variable (provincial bureaucrats) impacted on the outcome of both case studies. In the earlier case, provincial bureaucrats (fifth independent variable) provided local activists with added legitimacy when negotiating in the urban political arena. However, the narrow definition of health, meant that the earlier outcome involved a limited scope of service provision. In the later case, provincial bureaucrats required local activists to modify their organizational vision to suit provincial administrative norms.

The intervening variable also had an effect on the dependent variable. Provincial policies promoting equity in service provision during the second period lent legitimacy to the activities of local activists that was not present during the first period. The first, third, fourth and fifth independent variables were also influenced by the intervening variable. Over time, the positive relationship of the local political environment (first independent variable) and local corporate rationalists (third independent variable) have become increasingly apparent. In turn the resources available to local activists in their efforts to mobilize and sustain supportive constituencies have been enhanced. The impact of medical opposition at the local level (related to the fourth independent variable) has waned over time as the relationship of the other independent variables has increased. This reflects changes in provincial health policy that have favoured challenging and repressed interests.

What distinguishes Toronto from Ottawa is that, despite parallel local political reform movements during the 1970s, Toronto reformers were less successful in transforming their vision into meaningful policy outputs than were their counterparts in Ottawa. Change in Toronto proceeded at a slower and less consistent pace. Unlike Ottawa, change in Toronto mirrored more closely the changes occurring within the provincial policy arena.

1. Background

Since the end of the Second World War Toronto has undergone a gradual demographic change that has had a marked impact on the direction of municipal politics. From a population of 80 per cent British descent at the outset of the War, by the mid-1970s those residents of Toronto with English as their mother tongue were clearly declining in numbers, with almost 40 per cent speaking a language other than English.[4]

This transformation has manifested itself geographically with recent immigrants dominating in the west and east ends of the city and with ethnic enclaves developing around old industrial areas where work is most readily available. Culturally, the addition of a variety of nationalities to Toronto's social fabric has added to its self-proclaimed image as a world class city.[5] Politically, increasing attention has been focused on addressing the culturally specific needs of these populations when providing services. Sensitivity to particular immigrant populations has manifested itself in the provision of policing, education, health and social services.[6]

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[4] Ibid, 111-12.

[5] Ibid, 112.

[6] Admittedly many of the policies pertaining to immigrant populations have been developed by the relevant provincial and federal ministries, and implemented through the various provincial, federal, municipal and non-governmental organizations operating within the boundaries of the municipality and the wider metropolitan area. In Metropolitan Toronto, where policing is governed by a semi-autonomous police commission, claims of racial discrimination against visible minorities have plagued the police force for well over

Toronto was affected also by the consolidation of the surrounding municipalities and the creation of an upper-tier municipal government. Despite the limitations placed on the physical growth of the city by the creation of metropolitan government, Toronto's central business district continued to thrive and place demands on the municipality for increased office and residential space in the core area. Private developers often requested and received zoning variances to accommodate the demand for increasing residential and commercial development in an essentially fixed geography.[7]

To complement private development, the municipality, beginning in 1947, engaged in the destruction and redevelopment of housing stock in the more depressed areas of the city. Not unlike Ottawa, which carried out a similar redevelopment, albeit on a smaller scale, Toronto encountered strong opposition from those residents displaced by the redevelopment. After being pressured by senior levels of government and local activists during the 1960s, the planning process was opened up to increased citizen participation.[8]

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a decade. To combat this, the police force has created a number of liaison positions, staffed whenever possible by visible minorities and the provincial government has created a public review process to investigate complaints against individual officers. Thus far neither has proved effective in appeasing the demands of residents.

[7] Magnusson, "Toronto", 112-13.

[8] Ibid, 113-14; Donald Gutstein, Jack Long and Dorothy McIntosh, "Neighbourhood improvement: What it means in Calgary, Vancouver and Toronto," in James Lorimer and Evelyn Ross, eds., The City Book; The Politics and Planning of

In 1971, the City created the first Neighbourhood Improvement Program in Canada. This followed the freeze on intergovernmental funds for urban renewal in 1969. The City's program had six main objectives:

1. ultimate municipal responsibility for urban renewal
2. elimination of gaps and lags between planning and implementation
3. continuity
4. flexibility in providing both social and physical facilities
5. meaningful participation of affected residents
6. independent municipal funding

The federally initiated new trilevel NIP program (1973) complemented Toronto's existing effort. The province released guidelines concerning the new arrangement and its relationship to the provincial Planning Act[9]. The City complained that the process was overly bureaucratic and contradicted the goals of the City's program.[10]

Canada's Cities, (Toronto: James Lorimer and Company Publishers, 1976), 204, The federal government was in the unusual position of promoting slum clearance through various funding arrangements and also funding the development of organized opposition to these redevelopments. Eventually, the federal policy of funding slum clearance was abandoned.

[9] Statutes of Ontario, R.S.O. 1970, Chapter 349, s. 12(1)(b).

[10] Donald Gutstein, Jack Long and Dorothy McIntosh, "Neighbourhood Improvement: What it means in Calgary, Vancouver and Toronto," in James Lorimer and Evelyn Ross, eds., The City Book: The Politics and Planning of Canada's cities, (Toronto: James Lorimer and Evelyn Ross, 1976), 212-13.

The end result of this direction in land-use planning was two-fold: the emergence of a host of community organizations, developed by community organizers that placed increasing demands on municipal governments; and the emergence of a new reform movement in municipal politics that eventually gained control of the Toronto City Council.[11] The common thread binding these two emerging trends was a concern on the part of all residents with the preservation of the character of their neighbourhoods.[12]Thus while the new group of politicians were considered reformist in nature, they also represented a set of "conservative" values relating to land development. These values placed them in opposition to the large land development companies involved in changing the physical landscape of the City and to those councillors who supported this type of development.[13]

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[11] Ibid,114-15; Warren Magnusson, "Community organization and Local Self-Government," in Lionel D. Feldman, ed., Politics and Government of Urban Canada, (Toronto: Methuen, 1981), 81; Community organizations also sprang up in middle and upper-income neighbourhoods in response to a host of proposed development changes to existing land-use patterns in neighbourhoods. For example see Christopher Leo, The Politics of Urban Development: Canadian Urban Expressway Disputes, (Toronto, 1977).

[12] Bureau of Municipal Research, "Citizen Participation in Metropolitan Toronto: Climate for Cooperation ?" 12.

[13] Bureau of Municipal Research, "Citizen Participation in Metro Toronto: Climate for Cooperation? 14, 20; Jon Caulfield, "David Crombie's housing policy: Making Toronto safe - once more - for the developers," in James Lorimer and Evelyn Ross, The City Book: The politics and planning of Canada's cities, (Toronto: James Lorimer and Company, 1976, 146; Magnusson, "Community Organization and Local Self-Government, 127, Magnusson suggests that the earlier wave of

In this climate, citizen participation was not well received by the "old guard" at City Hall. Citizens groups tended to find themselves treated in a paternalistic fashion, if they were given a voice at all. Inevitably the more insistent of the citizen's organizations found themselves in open conflict with some municipal politicians over land-use issues.[14]

While the new reformers (first elected in 1969) did not always act as a group, they were all in agreement that wider citizen participation in Council proceedings was essential. The basis of this sentiment is expressed by John Sewell:

> That double-barrelled position - politicians being controlled by their constituents and people having the power to make decisions about community matters - is what I am striving for now. That would make me into a true agent for the community. I would be their delegate in the political forum.[15]

Sewell had cut his political teeth as a community organizer for a community development project sponsored by the United Church. He was not a professional organizer, but a middle-

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reformers defined reform in terms of municipal efficiency while some new reformers of the 1960s and 1970s defined reform in terms of urban conservatism. Neither stance seriously challenged the traditional view of the municipality as an agency to support business.

[14] James Lorimer, The Real World of City Politics, (Toronto: James Lewis and Samuel, 1970), Chapters Two and Three; Bureau of Municipal Research, "Neighbourhood Participants in Local Government," in Lloyd Axworthy and James M. Gillies, eds, The City: Canada's Prospects, Canada's Problems, (Toronto: Butterworth and Company, 1973), 287.

[15] John Sewell, Up Against City Hall, (Toronto: James Lewis & Samuel, 1972), 170.

class lawyer with the opinion that the working-class people in ward 7 were not being fairly treated by the politicians. He saw his role as assisting working-class neighbourhoods to challenge the bias of City Hall toward developers.[16] His activities, especially around the Trefann Court issue, served as a springboard into municipal politics in 1969 as Ward 7 Alderman.

Interestingly enough, Magnusson claims that Sewell turned out to be one of the less "radical" members of this new group of municipal politicians, mainly because he was less inclined to embrace the ideas of the political left. Clearly, a philosophy of this nature posed a substantial threat to those municipal politicians who ascribed to a more elitist approach to government.[17]

In 1972, the reformers won a majority of the seats on City Council, although they soon split as a group between radicals and moderates. After the election of 1974, the reformers again coalesced as a group, but disbanded several years later. They had, however, left an indelible imprint on the minds of the voters. One of the best examples of the populist and decentralist aspirations of the movement was the 1976 Report of the City of Toronto's Neighbourhood Services

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[16] Maureen Quigley, Citizen Participation in Development in the City of Toronto, (Toronto: Ontario Department of Municipal Affairs, 1971), 54.

[17] Magnusson, "Toronto," 123; see also Bureau of Municipal Research, "Citizen Participation in Metro Toronto," 26.

Work Group which called for citizen participation at the neighbourhood level in "planning, budgeting and administration of localized services within the city." Part of the plan was to encourage the development of a variety of community organizations with varied levels of authority. That some of these organizations would essentially resemble municipal governments in terms of accountability structures and functions, led to the eventual shelving of the idea by the City Council.[18]

The most notable success of this group was the election of John Sewell as Mayor of Toronto in 1978. Surprisingly, Sewell's less radical stance and his maintenance of an image as an independent force on council won him significant support from the community-based constituencies in the middle-class neighbourhoods, as well as his own base of support in the working-class areas. As a populist, but not a socialist reformer, Sewell's appeal was in his philosophy of ensuring that neighbourhoods would have some control over land-use planning, regardless of the demographics of the neighbourhood. Thus, politics in the City of Toronto was partially focused on an issue, that according to Castells, was conducive to

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[18] Warren Magnusson, "Community Organization and local Self-Government," in Lionel D. Feldman, ed., Politics and Government of Urban Canada, Fourth Edition, (Toronto: Methuen), 81-2; City of Toronto, Report of Neighbourhood Services Work Group, (April, 1976); The majority on council was not held by the reformers at this point. as Magnusson notes, "not even the 'radicals' on Toronto City Council thought that neighbourhoods should be organized as separate municipalities."

community mobilization.

During this period of municipal reformism, many residents in Toronto were organizing to prevent developers from redeveloping their neighbourhoods in undesirable ways. Other neighbourhoods were organizing to demand a better response from City officials to a variety of problems - environmental, health, parking, land-use. One of the larger experiments in neighbourhood government took place in the Greater Riverdale Area. The development of a community health centre in South Riverdale was an offshoot of the larger effort to organize the community around issues relating to municipal government.

2. South Riverdale Community Health Centre

The South Riverdale neighbourhood is bounded geographically within the City of Toronto by the Don River, Riverdale Avenue, Greenwood Avenue and Lake Ontario. At the time the neighbourhood was ethnically mixed, with a population of approximately 75,000. Twenty-five percent lived below the poverty line, with only five percent earning in excess of $ 9,000 per year.[19] Paediatric and maternal care needs were higher than the average for the City as were health problems associated with drug abuse and mental illness. School-age children did not have access to adequate services for learning disabilities, emotional problems or dental care. The general

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[19] Dollar figures used here and elsewhere are not corrected for inflation.

population was medically underserviced.[20]

The idea of a community health centre developed in three stages, from the community animation process which took place in the larger Riverdale neighbourhood during the late 1960s and early 1970s to the more narrowly focused attempts of different combinations of voluntary associations to develop a health centre. Local activists faced difficulties in establishing a lasting local consensus because of the lack of a lead agency to provide the necessary resources and lend legitimacy to the project. The development of the CHC also came in the shadow of the collapse of a larger and fairly radical attempt to build a "mass-based community power block."[21]

Stage 1:

The mass-community based movement that developed in the Greater Riverdale Area[22]of Toronto had its origins in the East Don Urban Coalition. The community organization was

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[20] Health Committee of the Riverdale Community Organization, Proposal from the Health Committee of the Riverdale Community Organization for a Community Controlled Health Centre, (Toronto: RCO, 1972), The RCO was an umbrella organization composed of the following sub-organizations: Woodgreen United Church; Family Services Association; Broadview Y.M.C.A.; and concerned citizens.

[21] Bureau of Municipal Research, "Citizen Participation in Metro Toronto: Climate for Cooperation ? 19.

[22] The Greater Riverdale Area was represented in municipal government by two reformers (Karl Jaffary and John Sewell) and two traditionalists (Fred Beavis and Tom Clifford). Clifford rose to the rank of City Controller.

formed by five clergy, the president of a local ratepayers association and the director of a community centre to act as a watchdog against the expropriation of neighbourhood properties by the City for redevelopment. The catalyst for the formation of the Coalition was the expropriation and destruction of houses in the Don Mount area against the wishes of the residents.[23]With the approval of the City of Toronto Board of Control, the Development Department provided funding in 1969 so that the Coaliticn could hire a community organizer. The participating religious organizations also contributed money for this purpose.[24] From these humble beginnings, the Greater Riverdale Area was organized to pressure municipal government to respond to citizen demands for increased input into decisions affecting their neighbourhoods.

In March of 1970, a growing number of neighbourhood groups and human services professionals were invited by the Coalition to form the Riverdale Community Organization (RCO). The purpose of the new organization was to collectively address identified community problems. This new creation enhanced the numeric strength of community organizing from

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[23] Don Keating, The Power to Make it Happen, Mass-based community organizing: What it is and how it works, (Toronto: Green Tree Publishing Company, 1975), 13-17.

[24] Don Keating, Greater Riverdale Organization: Reflections on the Project as a Model for Community Development, (Toronto: Ontario Ministry of Community and Social Services, 1974), 1, The amount totalled $ 16,000.

seven representatives of seven groups to 80 representatives from forty groups. Between 1970 and 1972, the RCO tackled eighty separate issues. Funding, which was always difficult to obtain, came from a variety of federal, municipal, community-based and private sources.[25]

From this original organization, the first attempt to establish a community health centre took place. Interest in health issues was not a new concern in the neighbourhood. In fact, much of the organizing that had occurred prior to this initiative surrounded the unusually high levels of lead found in the blood streams of residents and their children.[26]To address this long standing issue and the more general concern about the inadequacy of primary health and social services in the neighbourhood,[27]the RCO executive proposed that a health

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[25] Keating, Greater Riverdale Organization: Reflections on the Project as a Model for Community Development, 2, provides a summary of these activities and funding sources.

[26] Michael Rachlis, M.D., Second Opinion: What's Wrong with Canada's Health Care System and How to Fix It, (Toronto: Collins Publishers, 1989), 278, Education and housing were the other prime concerns of the community organizing. The South Riverdale CHC continued to reflect this basic community concern even after its establishment through its environmental health committee which has lobbied government for tougher standards on lead emissions. In conjunction with the City of Toronto Public Health Department, the committee has educated the neighbourhood on such topics as controlling dust and growing vegetables safely in contaminated soil. As Rachlis notes in his book, the traditional health organizations (with the exception of public health) and the medical profession were noteworthy for their absence in the fight to regulate lead polluters in the neighbourhood.

[27] RCO Community Health Committee, Proposal, 1, The more general concern seems to have originated from a variety of social agencies in the neighbourhood. Included in this

committee be struck to investigate the possibility of establishing a community health centre. Approval for the committee was gained at a general meeting of area residents and at a meeting shortly after this, a public forum was held to gauge the extent of need in the neighbourhood.

The result of these initial meetings was a recognition that, while a community-controlled clinic was needed for South Riverdale, different groups and individuals had different concerns that would have to be addressed. Thus, the work of the health committee was divided into three sub-committees: the social committee, to identify and prioritize needs; the human resources committee, to identify staff resources; and the financial-site committee, to inquire into possible locations and available funding for the project.

Once these various committees had met and reported back to the Health Committee, a draft proposal was put together and possible funding sources were approached. Letters were sent to both federal and provincial ministers of health, city health officials, Sick Children's Hospital, Toronto Western Hospital, East General Hospital, St. Michael's Hospital, the Ontario Division of Rehabilitation Services and the Queen Street Mental Health Clinic. The response was that they would meet to discuss a proposal when it was ready. The financial committee

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definition of primary health and social services would be primary health care plus child care, health education, drug and alcohol treatment and information, dental care, family planning, eye care and adequate services for seniors.

met with a representative from the provincial Ministry of Health and some seed money was provided to put a proposal together.

In the beginning there was good support from both the professional community and their clients. The success of the committee hinged on the "solidarity between professionals and local people."[28] Dr. Aaron Auerbach of the Ontario Crippled Children's Centre spearheaded the effort to forge a consensus between professionals and their patients; however, after he left the area, the initial solidarity disappeared. Eventually the committee "lost the broad base that was so necessary to give it credibility with funding sources."[29]

A proposal was put together and Ministry officials were invited to a discussion with the committee. At the meeting it became apparent that the MOH was not committed to supporting the project any further. The RCO organizers had never been fully committed to using their resources to develop a health centre because the proposal did not come from those who needed the services, and developing a CHC would not contribute to building a broadly-based community organization.

While the idea of establishing a CHC had run aground, the overall effort at community organizing continued to enjoy marked success. Buoyed by several years of successful action

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[28] Don Keating, The Power to Make It Happen: Mass-based community organizing: What it is and how it works, (Toronto: Green Tree Publishing Company, Ltd.), 133.

[29] Ibid.

and a $ 28,000 grant received from CMHC in 1972, members of the RCO decided to attempt to formalize the process of neighbourhood activism. The RCO was dissolved and became the steering committee for the creation of a mass-based community organization. In September, over 500 people from 83 groups voted to hold a founding convention. In November a community convention of 1,000 people from 75 groups met to establish the Greater Riverdale Organization. The convention included representatives from the Chinese, East Indian, Greek and Italian communities. The intention of the creation of GRO,[30] "was to organize the people so they could win control over their neighbourhoods, with the ultimate goal of challenging the existing power structure."[31]

Despite the success in formalizing a mass-based community organization, the outcome of the convention spelled the beginning of the end for the Greater Riverdale Organization. The executive of the RCO was not elected to the executive of the new Greater Riverdale Organization. Thus, from the outset there was a rift between the founders of the movement and the elected representatives of the new organization. This was reflected in the adoption of a less radical approach to community organization and power struggles between various factions within the organization. The combination of this rift

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[30] The total Riverdale area was defined geographically by the Don River, the Danforth, Coxwell Ave and Lake Ontario.

[31] Bureau of Municipal Research, "Citizen Participation in Metro Toronto: Climate for Cooperation ? 19.

and a funding crisis led to the demise of the Greater Riverdale Organization.[32]

Stage 2:

With the withdrawal of MOH support and the unravelling of the GRO, the health centre initiative was essentially dead and would not be revived until mid-1973. An attempt was originally made to revive the previous health-centre efforts, but was abandoned after about a year because of a lack of progress.[33]

In early 1974, a newly formed Riverdale Interagency Council met with Dr. Aldis and his assistants from the PDIG of the MOH to discuss the possibility of developing a health

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[32] Keating, The Power to Make it Happen, Chapter Ten, Keating suggests that the structure of representative democracy adopted at the convention was incompatible with the underlying purpose of community organizing.

[33] Because of some remaining animosity over the dissolution of the early community movement, many of the individuals involved in the second attempt were either new to the neighbourhood or had not been directly involved in the first movement. Some of the original neighbourhood activists did remain involved. The new group might best be characterized as individuals with a greater knowledge of and experience with politics and government bureaucracy then the first group.In fact, a number were attached to established community or government agencies in the area. After attempting to re-establish the health centre movement through the GRO Father Jim Webb, a Jesuit community development worker and Charlotte Stuart, an Executive Vice President of GRO, former Chairman of the RCO Parks and Recreation Committee and Deaconess at the Queen Street East Presbyterian Church, decided that the health centre could best be developed through an issue specific group as opposed to a general purpose community organization. This became the basis of organizing around other issues such a housing, the environment and parking as well as health in the post-GRO period.

centre in the South Riverdale neighbourhood.[34] At the meeting the Council reviewed the spectrum of services in the area and discussed the need for additional resources. Dr. Aldis explained the funding requirements and resources for health centres that were available through the ministry.[35] The ministry would fund a centre that had submitted a proposal and received final approval, but no "seed money" would be provided to prepare the submission. In the future, there was the possibility that some support staff would be available from the MOH to provide advice on certain aspects of policy.[36] Again, after some further efforts, the project faltered and was temporarily abandoned.

Stage Three:

In January of 1975, at a meeting chaired by the South Riverdale Site Planning Office a motion put forward by

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[34] At this time the South Riverdale area was defined as that area located between the Don River and Victoria Park, lying south of the Danforth.

[35] The Ministry guidelines included that the project be initiated from within the community (including a group of doctors) as opposed to from the Ministry; that it operate on an alternative funding mechanism to fee-for-service; that existing services be integrated where appropriate; and that a population of 25,000 would probably be the maximum that a CHC could service.

[36] Ministry of Health, Notes on a Meeting with Representatives of the Riverdale Interagency Council, 28 February, 1974; Particular emphasis was placed on the need for a grassroots approach to developing the centre. The emergence of PDIG and what appeared to be a more positive attitude towards health centre development, and the availability of a site at an abandoned postal station had triggered the renewed interest in the health centre project.

Alderman John Sewell[37] called for the creation of, "a working group of residents and supporters, agency representatives and politicians ... to bring about the implementation of a health-care centre as soon as possible."[38] From this meeting Sewell and Anna Fraser[39] met with the MOH to discuss the possibility of reviving the health-centre project in South Riverdale. At the meeting of the Working Group the following week, Sewell (not a member of the Working Group) and Fraser reported back on the Ministry meeting and suggested how to proceed from there. The Working Group disbanded shortly after this time and was not re-activated until early May, with a slightly different combination of people.[40]

The reformed Health Centre Working Committee met with the

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[37] Keating, The Power to Make It Happen, 166, John Sewell was a supporter of working committees, but did not believe that they should include elected officials as either executive or voting members.

[38] City of Toronto Planning Board, South Riverdale Planning Office, Minutes of a Meeting, 7 January, 1975; During this phase individuals from the City of Toronto Planning Department, Public Health, Aldermen and the provincial M.P.P. Jim Renwick would be added to the list of crucial players in the developmental process.

[39] Anna Fraser was a resident of South Riverdale at the time and worked for the City of Toronto, Planning Department. She has since become a lawyer and an adjudicator for the Ontario Municipal Board.

[40] Jim Webb noted that when he brought the new group together he was careful to invite those people from the first rendition and others who could work effectively together. The combination of individuals the first time around simply did not work.

Neighbourhood Improvement Program (NIP) Steering Committee[41] to discuss the status of the health-centre project. The freeze on funding at the provincial level by health Minister Frank Miller had left all prospective and existing health centres in a state of confusion and South Riverdale was no exception. One of the topics for discussion was a vaguely worded letter received from Frank Miller stating that funding had not been suspended, and that the Health Centre Working Group should continue negotiations.[42] The second issue of discussion was

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[41] Ed Kothiringer, South Riverdale Neighbourhood Improvement Program Co-ordinator's Report,(City of Toronto Planning and Development Department), 28 January, 1981; The NIP Steering Committee operated out of the site planning office and was formed to apply for, and later administer funds available through the federal governments Neighbourhood Improvement Program. From the outset, one of the projects slated for funding under the NIP grant was renovation of the Police Precinct building in which the health centre was to be located. Negotiations between the Health Centre Working Committee (later the interim board of directors) and the NIP Steering Committee continued until December of 1977. Funding, totalling $ 210,000, was approved and renovations were completed in 1979. There was an overlap in membership between the two organizations.

[42] Legislative Assembly of Ontario, Debates, 7 April, 1975, 568-69; 2 June, 1975, 2465-73; 5 June, 1975, 2606-15, 2630-35; Important to note here is that the NDP health critic had been waging a running battle with the Minister of Health in the provincial legislature since the beginning of the April over the freeze on funding of new health centres. During the course of this debate, South Riverdale and several other proposals in the negotiation stage were specifically brought to the Minister's attention. The whole issue of funding alternatives to fee-for-service and the two-faced approach of the government to the issue was questioned in the legislature. Miller's response was that the funding was not cut off and that the Ministry was simply reviewing the policy. Also noteworthy is the fact that South Riverdale had been given some form of written commitment by the ministry to a health centre during the time that the first funding proposal was submitted by the RCO health committee in 1972. What is clear

the discovery that St. Michael's Hospital was also in the process of establishing a health centre in a location within a block from the proposed site of the South Riverdale Health Centre. After hearing a presentation from a representative of St. Michael's, those present agreed that a meeting should be arranged with the administrator of St. Michael's to obtain further clarification of the hospital's plans.

At a meeting with St. Michael's on Monday May 12, both sides again presented their respective projects. Jim Renwick (NDP-MPP), representing the South Riverdale community, attacked the St. Michael's proposal because it had been formulated without input from the community-at-large and without knowledge of the already established initiative of the Health Centre Working Group. Renwick deplored the hospital for taking such an elitist approach to developing a new community service. Several other residents of the area commented that the expressed desire of the community was for a health centre responsive to the needs of the community through a community-controlled board of directors. The meeting concluded in an atmosphere of restrained animosity.[43]

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from the legislative exchange was that the Ministry had no clearly developed policy. One informant suggested that the fact that a commitment was already on record worked in South Riverdale's favour during the provincial freeze in 1975.

[43] Health Centre Working Group, Minutes of a Meeting of Health Centre Working Group and Representatives of St. Michael's Hospital, 12 May, 1975, According to one observer Jim Renwick had a skill for developing an argument from which an opponent could not escape. Renwick was crucial in situations of this type at the constituency level, and in

A second meeting was held the following week with a smaller number of community members attending (the core of the Working Group). The mood was more conciliatory, with St. Michael's pledging to inform the Ministry of its support for the health centre and agreeing to coordinate the services of its own clinic and the hospital with those of the health centre, especially where referrals were required for non-physician services.[44]

During this time Anna Fraser had been working in conjunction with several public health nurses to compile statistics and write a new funding proposal to be submitted to the Ministry. Both Fraser and the public health nurses worked on their own initiative rather than in response to directives from their employers. The proposal was submitted to the Ministry and by mid-June had received tentative approval to fund two doctors.[45]

The City of Toronto Board of Health was aware of the development of health centres in Toronto. In a meeting held on April 18, the board initiated a process of reviewing the health-centre concept and the role of the Public Health

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lobbying and feeding valuable information to the NDP health critic at the provincial level.

[44] Health Centre working Group, Minutes of a Meeting of Health Centre Working Group and Representatives of St. Michael's Hospital, 21 May, 1975; St. Michael's had already been involved in providing diagnostic services to the Regent Park CHC.

[45] The minimum Ministry requirement for personnel to make a health centre viable was two doctors and one nurse.

Department to establish a definition of the term "health centre" and to consider extending the program activities of the Public Health Department to accommodate health centres.[46] On May 15, the Board was made aware of correspondence from the Minister of Health and Dr. Aldis concerning health centres currently funded and in the process of being funded by the Ministry. A request from Alderman Dan Heap (later an NDP MP) was also brought forward asking that the board:

> reiterate its request of April to meet with the Minister to consider the restriction of funding to health centres ... That the board invite community-sponsored health centres ... currently funded and potential, ... to meet with the Board to discuss the problems of funding ... and that the Board request the Minister of Health to provide the Board with a statement of the budget of the Provincial Ministry of Health, indicating the amounts respectively allotted to public health, community-directed health services, and health services based on a fee for service; with comparative figures for the past five years, and a five-year projection for the future.[47]

The Board pursued these requests, but eventually received only a partial response from the Ministry of Health.[48] The Medical

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[46] Department of Public Health, Memo re: Community Health Centres, 10 November, 1975, origin of request: Local Board of Health, Minutes, 18 April, 113.

[47] City of Toronto, Local Board of Health, Minutes, 16 May, 1975.

[48] City of Toronto, Local Board of Health, Minutes, 17 November, 1975, 327, A response received by Dr. Aldis on November 6, and tabled with the Local Board of Health on November 17, only provided information on health centre activity in Toronto, claiming breach of confidentiality as the reason for the limited response. A further motion was put forward to have the Chairman contact the leaders of the provincial opposition parties to obtain a complete province-wide list. A list would not be tabled in the legislature until

Officer of Health submitted reports on November 10 and December 15 outlining the health-centre concept and the extent of involvement of the Public Health Department in seconding public health nurses to the centres operating in the City of Toronto.[49]

While the Department of Public Health attempted to clarify its role, local activists continued the search for a suitable location. One site was an old post office on Queen and Saulter Streets. A second site was a former bar, the Grad Club, located at 1130 Queen Street East. A third site, discovered sometime later was a police station at 126 Pape Avenue, converted for emergency services planning, which at the time only housed an ambulance service in part of the building.

The Health Centre Working Group met again on July 16 with representatives from the Ministry, Public Health Nursing, the Addiction Research Foundation, Woodgreen Community Centre, St Michael's Hospital, Alderman Janet Howard and M.P.P. Jim Renwick to further clarify the status of the project from everyone's point of view. Despite the view of members of the Working Group that provincial funding was in jeopardy, MOH officials reassured the meeting, "that there was a commitment

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June 22, 1979. See Legislative Assembly of Ontario, Debates, 22 June, 1979, 2837.

[49] What is most noteworthy about the Department's inventory is that almost all of the health centres listed are either attached to hospitals or are group practices.

to [the] programme, although not yet a commitment of funds."[50] This was followed by advice that the Working Group and the City continue negotiations for the establishment of the centre. Funding would be provided when there was a clear indication that Ministry requirements had been met. At the conclusion of the meeting, Margaret Bryce, representing the Site Planning Office, advised the Working Group that they could not recommend for or against acquisition of the Grad Club site and that they request the Executive Committee of Council to mandate the Public Health Department to provide staff to assist in locating a suitable site.[51]

A meeting was held the following night to provide detailed information to the Department of Public Health and the Local Board of Health, as well as the local agencies involved, as to the specific land needs of the health centre. The NIP Steering Committee was already in negotiations with the federal government and the City to acquire the Post Office site. This location was eventually abandoned as an option for

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[50] Health Centre Working Group, Meeting of the Health Centre Working Group, 16 July, 1975.

[51] Ibid, 17 July, 1975; South Riverdale Health Centre Working Group, Memo to City of Toronto Executive Committee, re: proposed acquisition of 1130 Queen street east, the Grad's Club, Ward 8 , for a Community Health Centre, 31 July, 1975; The NIP Steering Committee was interested in acquiring the post office site as a possible location for a number of community based services, including the health centre. John Sewell had advised the Health Centre Working Group to look for a smaller and more manageable site for the health centre. This is where the Grad's Club site, a former bar, came into play.

the CHC because of its proximity to the St. Michael's Clinic and difficulties in achieving a commitment from the City.

At a meeting of the Executive Committee of Council on July 23, Fred Beavis, Ward 7 alderman, spoke in favour of the acquisition of the Post Office site by the City for the health centre. The Committee deferred further consideration of the matter until its next meeting on July 31, when representations were heard from the BREMM Residents Association and the "Ward 8 Ratepayers' and Tenants Association"[52] (the Health Centre Working Group). Mutually supportive presentations were made by these two organizations and Alderman Beavis at the July 31 meeting, but the City again deferred a decision because there was no money available to purchase the site. The brief presented by the Working Group informed the City of the MOH support for the project and requested that the Executive Committee of Council direct the Public Health Department to assist the Group in finding and evaluating available sites.[53]

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[52] Madelaine Grimm, Assistant Secretary, City of Toronto Executive Committee, Correspondence with Mrs. Maureen T. Kasaba, Bremm Residents Association, 25 July, 1975, Apparently the Executive Committee staff mistakenly called the Health Centre Group by this other name.

[53] South Riverdale Health Centre Working Group, Presentation to the City of Toronto Executive Committee re: Proposed Acquisition of 1130 Queen Street East Grad's Club, Ward 8, for a Community Health Centre, 31 July, 1975; Margaret Bryce, Community Development Officer, Memo to Graham Emslie, Commissioner of Development re: Proposed Acquisition of 1130 Queen Street East, the Grad's Club, Ward 8, for a Community Health Clinic, 30 July, 1975, Margaret Bryce had been assigned to the Site Planning Office to assist the Health Centre Working Group. While assigned to the same Office, Anna Fraser was working on Phase 2 of the Riverdale Area Plan. Both were

A letter of response from the Executive Committee to the Working Group indicated that the Medical Officer of Health in his report to the Committee prior to the meeting had indicated that Public Health was not presently interested in the Grad Club site for a health clinic and that the Commissioner of Housing did not see it as a viable site for public housing. Only the Commissioner of Planning had indicated any level of support for the idea. The project was again at an impasse.[54]

In the aftermath of this disappointing reply from the City, attendance at Health Centre Working Group meetings dropped significantly. Jim Webb and others drafted a memo asking whether or not there was enough remaining support to keep the project alive.[55] At a meeting held in late October of 1975, the Group reassessed its position and decided to continue.[56] The meetings of the Working Group that transpired

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residents of South Riverdale at the time.

[54] Barbara Caplan, Secretary, Executive Committee of the City of Toronto, Correspondence with Mrs. Kasaba, South Riverdale Health Centre Working Group, 7 August, 1975; The housing angle presumably was tied to the activities of the N.I.P. Steering Committee. At this point the Working Group was somewhat demoralized and disbanded. When it reformed, only a core of individuals who had the requisite skills and ability to work together as a group were included.

[55] Health Centre Working Group, undated memo.

[56] South Riverdale Health Centre Working Group, Minutes, 27 October, 1975, The composition of the meeting was a mix of agency representatives and community activists. The group decided that the task ahead of them would require a substantial time commitment. The Ministry was still in support of the project, but required a structure at the local level from which to deliver the service. The Grad Club was effectively dead, but since rental accommodations were readily

during the next five months would involve mainly a detailed discussion of the operational aspects of the clinic with the MOH representative and other concerned agencies. Discussions also took place concerning the continuing issue of lead levels in the community and the testing that was now being done by the Public Health Department. The link between the MOH and the Working Group had been established, with the Ministry now pledging its support for the project. But the lack of a local consensus caused by the multiplicity of actors and the procedural problems surrounding acquiring a suitable site threatened to end the relationship.[57]

During April and early May of 1976, the South Riverdale Interim Board decided to enter into negotiations with the City

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available, a site would not be a major problem. In the future, those community members present at this meeting were to be considered the ad-hoc Board of Directors for the health centre. Non-residents were to continue participating on a consultative and manpower basis. Sheila Cram, a resident, local activist and nurse was hired to coordinate the effort of the Group.

[57] Health Centre Working Group, Minutes, 12 November, 1975; 27 November, 1975; 18 December, 1975; 28 January, 1976; 11 February, 1976; 16 February, 1976; 25 February, 1976; 8 April, 1976 These discussions involved mainly sorting out the by-laws of the proposed organization and complying with remaining MOH specifications. The Don District Health Centre organizational structure and by-laws were used as a guideline . A representative from the Don District Health Centre acted in an advisory capacity in this matter. Jim Webb and the site planning staff continued to search for suitable locations. In April he reported that the Pape Street E.M.O. building (the former police station at 126 Pape Ave.) had some available space. The Queen Street East Presbyterian Church also had some space available.

to acquire the Pape Avenue site[58] which they had recently toured. The BREMM representative on the Board was given authority to negotiate with the City. The board requested and received from the MOH a letter of intent to fund the project in preparation for approaching the Executive Committee of Council again. The board was informed that at an upcoming public meeting of the NIP Steering Committee a $ 200,000 working budget for health facilities and equipment would be announced.[59]

On May 26 the NIP Steering Committee Public Meeting was held. The budget allocations were put forward and a discussion of the individual items took place. Margaret Bryce of the Site Planning Office briefed those present of the progress of the health centre. Dr. Pasternak, a physician with a practice in the area, spoke out against the health centre on the grounds that the existing medical community was providing adequate service for the neighbourhood. The health centre was defended by the residents.

The same doctor appeared at several of the following Health Centre board meetings to reiterate his objections and those of several other doctors to introducing a community-

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[58] The Pape Avenue site which was a former Police station building was owned by the Municipality of Metropolitan Toronto.

[59] South Riverdale Community Health Centre Interim Board, Minutes, 8 April, 1976; 21 April, 1976; BREMM had been heavily involved in maintaining pressure for regular lead testing. The Riverdale Health Unit had approved the location. Incorporation as a non-profit organization took place during this time.

controlled health centre with doctors on salary. He suggested that the existing doctors could provide the services in the Centre and bill on a fee-for-service basis. He was ultimately unsuccessful in swaying either the board or the MOH to alter their position.[60]

Jim Webb appeared before the Executive Committee of City Council on June 30, to make a presentation concerning the acquisition of the Pape Avenue site and the leasing of space to the health centre. Support was given to the presentation by aldermen Sewell, Beavis, Clifford and Howard, and MPP Renwick. Dr. Pasternak again raised opposition on behalf of the existing physicians.[61]

Despite the continued objections of Dr. Pasternak, the health centre was given approval for the leasing arrangement on October 19 and the centre commenced operations in November of 1976. By the time the City had given final approval to the leasing arrangement, the MOH had already approved the operating budget for the centre's first fiscal year and staff

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[60] South Riverdale N.I.P. Steering Committee, Minutes of a Public Meeting, 26 May, 1976, Mike Fletcher, who chaired the meeting was also a member of the interim board of the health centre and was elected as President of the board at the first annual general meeting; South Riverdale Community Health Centre Interim Board, Minutes, 3 June, 1976; 9 June,1976; 23 June, 1976, Dr. Pasternak represented four other doctors and affiliated group practices in the area.

[61] According to an observer, John Sewell played a crucial role at this meeting. He approached the Chairman of Metro council, Paul Godfrey, privately and gained assurances that the deal would go through.

had been hired by the board.[62]

An examination of the staffing, funding and programs of South Riverdale indicate that, like Sandy Hill, it has not developed much beyond the traditional medical model. Most, if not all of its funding comes from the Ministry of Health for the funding of three physicians, two nurse practitioners, a part-time nutritionist, a chiropodist and three administrative staff. The range of programs funded by the Ministry is broader than that usually associated with fee-for-service practice. A small administrative hierarchy is present (see Appendix IX, Exhibit D).

Several years after the successful development of the South Riverdale Community Health Centre, John Sewell was elected as Mayor of the City. Having gained a prominent political platform, Sewell set about the task of promoting

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[62] South Riverdale Community Health Centre Board of Directors, Minutes, 20 October 1976, 27 October, 1976; Kothiringer, South Riverdale N.I.P. Co-ordinators Report, 28 January, 1981; Municipality of Metropolitan Toronto, Report No. 4 of the Metropolitan Executive Committee, for Consideration by the Council of the Municipality of Metropolitan Toronto on February 21, 1978; The original deal, a year to year lease with an option by the City to terminate was pending on approval from the Minister of Housing. The lease was changed to an eight year lease and sublet with no right to prior termination when the renovations were nearing completion in December of 1977. N.I.P. paid for renovations, relocation costs and gave two grants for medical equipment. Furniture and equipment falling outside of the capital budget was acquired from existing agency surpluses and from some health centres in the Toronto area that were forced to close because of the new MOH funding policy.

policies geared towards traditionally repressed interests[63] and subsequently developing new policy directions at the departmental level. One example with direct relevance to the case studies was the shift in direction in public health.

3. Public Health Reform

Coinciding with the election of John Sewell as Mayor, the City of Toronto Board of Health also exhibited a marked tendency for reform.[64] Beginning in 1978 with the release of a Board report entitled, Public Health in the 1980s, the City of Toronto embarked on a new direction in the provision of public health services. Following the lead of the federal Lalonde Report, Public Health in the 1980s emphasized social, environmental and lifestyle determinants of health. To accommodate the new focus, a departmental reorganization was

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[63] Magnusson, "Toronto," 123-24, in particular, the new set of issues promoted by John Sewell as Mayor centred around those populations traditionally excluded from the decision-making process, including the growing minority populations in Toronto.

[64] Trevor Hancock, Bernard Pouliot, Pierre Duplessis, "Public Health," in Richard Loreto and Trevor Price, eds., Urban Policy Issues: Canadian Perspectives, (Toronto: McClelland and Stewart Inc, 1990), 192-93, This represents the second wave of reform for public health in Toronto. The late 19th and early 20th century was also a period of innovation in public health that affected the development of urban planning, housing, social services and public works in Toronto. Like John Sewell, the membership of the Board of Health in 1978, was connected to the community organizing efforts of the late 1960s and early 1970s, especially surrounding the issue of lead contamination.

recommended. The thrust of the reorganization was to place greater emphasis on health research, education and promotion, community development and advocacy activities, and the use of community development officers and health educators.[65] Part of the change was to encourage increased citizen participation in decision making.[66]

In 1979, a health advocacy unit was established. In 1982, four health areas were defined by the Department to provide:

> personal health, environmental health and inspection, preventive clinical and supportive services managed by multidisciplinary teams. At the same time Community Advisory Boards were set up in each Health Area.[67]

The implementation of the new public health policy has placed an increased emphasis on the community development approach to

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[65] City of Toronto, Department of Public Health, Healthy Toronto 2000, September, 1988, 34, Hancock, Pouliot and Duplessis, "Public Health," 193, 195.

[66] Hancock et al, "Public Health," The report received unanimous support from the City Council. The City of Toronto has a long and unique history of encouraging citizen participation on its Board of Health. Council-appointed community members form the majority on the Board which also includes councillors and representatives from the public and separate school boards. This long tradition was recently challenged by an unsuccessful attempt to remove the community component from the Board structure. The Board is responsible to the Minister of Health (Health Promotion and Protection Act). The chief executive officer, the Medical Officer of Health, is both responsible to the Minister and is a City Commissioner. The Department of Public Health is a municipal department, receiving 60 percent of its funding and 100 percent of its employees from the municipality.

[67] City of Toronto, Healthy Toronto 2000, 34; The core of each team comprises a doctor, a nurse, a public health inspector and a business administrator.

solving health problems, especially with regard to the growing ethnic minority communities. One result of this has been the establishment of a multicultural health coalition that has gained provincial and national prominence.[68]

The provincial Ministry of Health has facilitated these changes through changes in its own direction to reflect a more community-based approach to the planning and delivery of services. A government-wide multicultural initiative was launched by the provincial government during the late 1980s.

Beyond these administrative innovations, the Board of Health has also been active in developing new policy directions for public health that have influenced the public health community on an international scale. In 1984, the Board of Health sponsored two international public health conferences to address the broadening scope of public health concerns. The second of these conferences became the inspiration for "Healthy Cities" a WHO health promotion project initiated in Europe, and subsequently implemented in Toronto.

In 1986, the Toronto Board of Health established a strategic planning subcommittee which produced a report in 1988 designed to initiate a city-wide effort to make Toronto as healthy a city as is possible. In Healthy Toronto 2000 the

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[68] Hancock et al, "Public Health", 196-97, Thirty-three heritage languages are taught in the schools and the majority of the population do not have either English or French as their mother tongue.

board recommended that the Department strive to reduce inequities resulting from social and economic factors, create supportive environments and advocate for a community-based services system.[69]Specifically, the Report recommended that the department:

> facilitate the process of community development and empowerment through such processes as the development of indigenous leadership, mobilization of community support and the formation of networks and coalitions.[70]

In early 1989, City Council endorsed the recommendations unanimously. A multi-sectoral Healthy City Workgroup, chaired by the Planning and Development Department has been established to manage the Healthy City project through a Healthy City Office, created in 1989.[71]

In the context of these later developments, local activists seeking to develop community health centres have been able to enlist the support of the Public Health Department and utilize the resources obtained from this relationship to mobilize neighbourhoods around health issues.

4. Access Alliance Multicultural Health Centre:

The Access Alliance Multicultural Health Centre was

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[69] Ibid, 199-200; see also, City of Toronto, Board of Health, Healthy Toronto 2000, September, 1988, 21, 25, 42, 71, and 73, The impetus for the conferences was the department's attempts to place some limits on its own mission statement: "to make Toronto the healthiest city in North America."

[70] City of Toronto, Health Toronto 2000, 42, 83-4.

[71] Hancock et al, "Public Health", 200.

developed through the efforts of a team of community development workers representing four ethnic communities in the City of Toronto. The City of Toronto Public Health Department played an important role as a lead agency because of both the resources and legitimacy it conveyed to the activities of the Access Alliance during the long process of development.

In 1984, Michael Fay was employed by the City of Toronto Health Department as a multicultural community worker and was involved in community development related to health issues with the Salvadoran community in Toronto.[72] After the public showing of a film on the problems faced by the Salvadoran community in Toronto, Fay and Dr. Mauricio Perez, a local activist, decided to form a Salvadoran community association.

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[72] Fay was also working on community development activities with the Portuguese. At the time, the mandate for his job was somewhat confused and he was able to obtain the resources and support he needed to aid the communities in developing their health centre proposal mainly through the support of Dr. Sandy Macpherson, the Chief Medical Officer. The Department itself had no official policy concerning multicultural health needs and because of this Fay's manager was reluctant to commit resources to these projects. Macpherson was key to by-passing this organizational roadblock. When Fay needed resources and couldn't get them through normal hierarchical channels, he approached Macpherson, a known advocate of CHCs, and was given whatever he needed. Dr. Macpherson was never directly involved in developing the health centre. He simply acted as a benign patron of the Steering Committee's activities. Much of this activity took place because of the actions of certain individuals who gravitated to the Department during this time rather than because of official policy. The Department now has an official policy concerning multicultural health activities. Although no longer the Chief Medical Officer, Dr. Macpherson is a registered patient with the new health centre.

The main objective defined by the newly formed association was to develop a community health centre. As a first step toward this end, a meeting was held in early 1985 with Mark McGuire, the Executive Director of the Association of Ontario Health Centres. Armed with some practical suggestions from McGuire, Fay and Perez went through the process of incorporating SALUD, including holding some public information and fund raising activities.

During the same period, Marie Lee, another community development officer with the Public Health Department was working with the Southeast Asian community[73] in Toronto, as part of the Task Force on Southeast Asian Needs. Another member of the Task Force was Dr Nguyen,[74] who began working on a voluntary basis for the Toronto Public Health Department as a community representative on the Task Force. One of the proposals that emerged from the Task Force on Southeast Asian Needs[75] was to set up a network of special health services to address the needs of the Southeast Asian community.

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[73] The Southeast Asian community in Toronto is actually comprised of three separate nationalities: Vietnamese, Cambodian and Laotion.

[74] Although trained as a physician in Vietnam, Dr. Nguyen has been unable to get certified by the College of Physicians and Surgeons in Ontario to practice medicine. This is consistent with a long standing agreement between the College and the provincial government to limit the number of foreign trained doctors practising medicine in the province.

[75] The Task Force was comprised of representatives from community groups in the target community and the department of Public Health.

Armed with this information, Dr. Nguyen approached community leaders of the Southeast Asian community with the idea of establishing a community health centre. Some of the sub-groups of the Southeast Asian community were not interested in the project and the provincial government had indicated that it would not fund an ethno-specific service.

Having encountered a barrier, he decided to broaden the scope of the population to be served by the health centre. Dr. Nguyen approached the Salvadoran community and received a positive response to his idea. Michael Fay became acquainted with Dr. Nguyen because the activities of doctors Nguyen and Perez were coordinated through the Public Health Department.

In late 1985, Dr. Perez was introduced to Dr. Nguyen by Fay so that they could discuss their common interests.[76] A strong sense of mutual belief in a community participation approach to developing services emerged from the meeting. Fay realized that despite the common interest expressed by the two community representatives, they would likely encounter difficulties in convincing the MOH because of the statistically small populations. The emphasis on the licensing of foreign physicians was also a drawback to achieving

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[76] Both had been involved in attempting to organize doctors who had immigrated from their respective countries to receive certification from the College of Physicians and Surgeons. Both had provided primary medical care in their country of origin.

Ministry support.[77] The three decided that in order to become significant enough to attract Ministry attention they would have to involve other ethnic communities, thereby boosting both their numbers and their multicultural mandate.

Access Alliance was formed in response to the desire of the Vietnamese and Salvadoran communities to develop a health centre. Under the auspices of the new organization, invitations were sent to 25 different communities to attend a meeting on March 20, 1986 to discuss common interests.[78] The organizers realized that certain conditions would have to apply for participants. The criteria that were developed to apply to participating organizations were that:

(i) participants were to be organizations and not individuals.[79]

(ii) a needs assessment would be conducted.

(iii) a community meeting would be held to present the concept and solicit the support of the affected communities.

(iv) a community board would be elected to

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[77] During this time the government was in the midst of reviewing and revising the legislation concerning the regulation of health professionals and one of the eventual outcomes of this review was an even more restrictive approach to the licensing of foreign physicians.

[78] Those attending the first meeting included representatives from the Vietnamese, Salvadoran, Chinese, Korean, Czech, Italian, Portuguese, Aboriginal and Russian communities in Toronto.

[79] This criterion was included because of the presence of a number of self-declared representatives from some communities. The intention was to ensure that organizations recognized as legitimate in their communities were involved with the project.

represent the community. Each ethno-specific group as represented by an organization would have one vote.

(v) a steering committee would be developed from the community board to develop the health centre proposal.

From this meeting a steering committee emerged as an organization comprising representatives from seven minority communities: the Vietnamese, the Salvadoran, the Korean, the Czechoslovakian, the Aboriginal, the Russian and the Portuguese.[80] The purpose of the committee was to develop a proposal for the funding of a CHC for submission to the district health council.[81]

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[80] Access Alliance, Multicultural Health Centre Application for Community Health Centre Funding, February 23, 1987,2; The union of the different ethnic communities was essentially a marriage of convenience. Government policy specifically favoured a multicultural as opposed to an ethno-specific approach to developing services and the separate communities recognized their common interest in collaborating to develop the health centre. However, the Czechoslovakian and Aboriginal communities eventually withdrew from the process. The Aboriginal had made it clear from the outset that they were interested in developing their own proposal and were there to observe the process. The Portuguese were the largest community with over 10,000 and they also had the largest population of younger people who were natives of Canada and had a good command of the English language. The Steering Committee was a committee of the Access Alliance Organization, which was an umbrella organization comprised of community organizations from the separate ethnic communities. The health centre was only one project, albeit the largest, that the organization was developing.

[81] The representative from the Portuguese community on the Steering Committee was a doctor already serving the Portuguese. Michael Fay acted as the secretariat for the Committee. Fay also provided the committee with a graduate student from the University of Toronto who acted as the drafter of the proposal.

Between 1985 and 1987 meetings between the various representative organizations and Public Health were held on a weekly basis to develop a funding proposal.[82] During this time a list of supporters was compiled and the neighbourhoods to be affected by the proposed new service were canvassed. From this networking and needs assessment process the group developed the funding proposal.[83] The three main objectives of the original proposal were:

> (i) to provide better access to health and social services for persons in the five ethnocultural communities who cannot access these services due to language and cultural barriers, as well as barriers of distance and inconvenience.
>
> (ii) to maximize the health status of the residents of the five ethnocultural communities through activities and programs to respond to the health, social, educational, cultural and legal needs of these communities.[84]
>
> (iii) to promote the certification of Vietnamese physicians in the province of Ontario.

In terms of the structure of the health centre, the steering

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[82] Meetings were also held with Doctor's Hospital, which were building a new facility and were interested in having the proposed health centre locate in the new building. The idea was eventually abandoned by the Steering Committee because the price that the hospital wanted to rent the space was beyond what the MOH would fund for a CHC.

[83] This was done according to the application form provided by the Ministry. The Steering Committee also attempted to lobby the Minster of Health and met with one of the Minister's assistants on December 17, 1986 to discuss the proposal. The Minister's office indicated at that time that they recognized the significance of the proposal both in terms of health care and politics. Eventually, the "multicultural access" aspect of the project became the driving force.

[84] Access Alliance, Multicultural Health Centre Application for Community Health Centre Funding, 2.

committee envisioned five multidisciplinary health care teams, to serve each of the five communities along ethnospecific lines. The multiculturalism aspect of the health centre would be achieved through team decision making and the co-ordination of service delivery through one central location. Eventually the group hoped that five satellite clinics might be established to decentralize the delivery of services further to the five communities. In essence the proposal was both ethno-centric and multicultural.[85]

This first draft of the funding proposal was then distributed to a number of local organizations for comment and submitted to the Ministry of Health for review and approval. The MOH responded that the proposal was too ethno-specific and procedurally must be reviewed by the Metro Toronto District Health Council. Reflective of the Ministry's concern was a response received from one of the other organizations, the Department of Health Administration, University of Toronto, concerning the third objective outlined in the proposal:

> I note that(and am somewhat concerned about) the specific objectives of some of the participating community groups are not consistent with the overall objectives that represent a consensus of all the groups. In fact some of these community-specific objectives seem to lead the endeavour away from what can be achieved by a Community Health Centre. For example, the first priority of the Vietnamese physicians that is to increase the number of physicians is actually contrary to the principle of the provision of necessary services by appropriate personnel (not necessarily physicians)

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[85] Ibid.

that underlies the Health Centre concept.[86]

After receiving feedback from this and other organizations (mainly those involved with ethnic communities) the proposal was rewritten to exclude the Vietnamese doctors' objective.[87]

The funding proposal was submitted to the Metropolitan Toronto District Health Council for review on March 3, 1987. Access Alliance was invited to make a presentation on the proposal to the Subcommittee to Review New and/or Expanded Community Health Programs on April 21, 1987. Several questions were raised by the Subcommittee about the proposal concerning how the health centre would be multicultural as opposed to ethnospecific and what geographic area would be served. A supplemental proposal was resubmitted to the Subcommittee on May 15, 1987. The funding of Phase I, the one central location aspect of the funding proposal was supported by the Subcommittee in a letter to the Minister of Health on October 26, 1987. Final funding approval from the Ministry of

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[86] John McLaughlin, Research Officer, Department of Health Administration , University of Toronto, Correspondence with Access Alliance, August 6, 1986; The University of Toronto has a long history of aiding in the establishment of community health centres in Metro Toronto. They were involved in the establishment of the Alexander Park, Niagara Neighbourhood Health Centres (later amalgamated as the West Central Community Health Centres, and Regent Park Community Health Centre.

[87] One of the group noted that the decision to omit this objective was difficult because it was one of the original intentions of the project. However, since this seemed to be a major impediment to further progress the group voted to drop it.

Health did not come until October of 1988.[88]

The long delay in receiving funding approval from the Ministry can be attributed to several factors. First, the MOH itself cautions those who wish to apply for funding that " in order to give adequate consideration to all submissions, [the] total review process may take in excess of five months.[89]Second, during the time period that the Access Alliance proposal was developed, multiculturalism became an important political issue with the governing provincial Liberal party. This resulted in the creation of a number of advisory bodies including the Minister's Advisory Committee on Multicultural Health Care. Thus the Access Alliance proposal actually had to go through the regular Ministry process of review plus an additional review by the Multicultural Advisory Committee. A separate presentation was required for this Committee. After several meetings with Ministry officials during this period, the committee recognized that the Ministry was in the midst of organizational chaos, with the department itself being restructured and many personnel changes taking place, and the political party in power was also changing.

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[88] Metropolitan Toronto District Health Council, Report of the Subcommittee to Review New and/or Expanded Community Health Programs on the Proposal to Establish the Multicultural Community Health Centre, September 1987; J.R. Nethercott, M.D., Chairman of the Subcommittee, Correspondence with the Honourable Elinor Caplan, Minister of Health, October 26, 1987.

[89] Ontario Ministry of Health, Community Health Programs Branch, How to Apply for Funding of New Community Health Centres: Submission Guidelines, 8.

Within the Community Health Branch, the personnel involved with CHCs was changing rapidly, destroying any sense of rapport that had been established during the earlier process of negotiations. The Steering Committee had difficulty determining which messages emanating from Ministry officials to believe.

In the interim the Committee pursued the development of an AIDS education program through the Department of Public Health. Through the health promotion section of the Department, Fay was able to get resources that could be used for these related projects. A grant of $ 40,000 was received from the Department along with a further grant of $ 2000 to cover the cost of incorporation.[90] This set a precedent with the Public Health Department for funding cultural groups which eventually led to the development and funding of a very successful cultural interpreter service.[91]

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[90] The funding, which took the form of a contract to provide basic planning services and to translate some documentation, was provided in anticipation of funding approval from the Ministry. Final funding approval was announced in a speech by the Minister of Health (provincial Liberal) made on the same day that the Prime Minister of Canada (federal Conservative) was delivering an address to ethnic communities in Toronto. As one of the Alliance members noted, the political timing of the announcement coincided both with an impending provincial election and the presence of the Prime Minister. The member noted that the planning cycle for the development of provincially funded projects such as health centres should probably be based on a four year cycle to coincide with provincial elections.

[91] There had previously been a cultural interpreter service developed for the Southeast Asian community which was developed with full funding, but was not adequately utilized once it began operations.

The CHC was officially opened in 1990 and has been fully operational for two years. As the information on personnel and funding indicate (see Appendix IX, Exhibit E) Access Alliance has moved beyond the traditional medical model in terms of programs and personnel. The two physicians and two registered nurses are outnumbered by the four health promoters, four community workers and four administrative staff. Clearly, the recent Ministry conception of the role of CHCs is reflected in the variety of ancillary personnel found at Access Alliance. Given that the original intention of local activists was to establish an organization based on non-hierarchical, consensus-based decision making, the health centre does not reflect this objective. The goal of promoting the certification of foreign physicians has not been met. It does, however, provide greater access to health services than was previously available.

5. Analysis

The first independent variable (local political environment) has had a varied relationship with the second independent variable (local activists) and the dependent variable. The urban political arena in Toronto did not sustain community mobilization efforts as well as Ottawa.

While Toronto elected a significant number of reform candidates between 1969 and 1978, there was always a significant resistance from the "old guard" on city council.

Even after the 1972 election, which was hailed as a victory for citizen participation, citizen activism declined in intensity and visibility. The outcome of the election produced several side-effects on local citizens' groups:

1. A general confidence in the new Council for promoting the interests of citizens
2. The pattern of council decisions helped to diffuse citizen discontent
3. Many of the leaders of the citizens' groups had been elected to council, thus depriving citizens' groups of their organizing abilities
4. A wider scope of community activists were coopted through over thirty local planning committees established by the City
5. Many activists were emotionally exhausted from a decade of fighting in the trenches.[92]

Rather than empowering neighbourhoods, municipal reform in Toronto had simply co-opted neighbourhood activists.

The South Riverdale CHC was developed within the context of this environment. The prevalence of the disruptive influences of poverty and neighbourhood redevelopment provided the necessary catalyst for community mobilization efforts in the Greater Riverdale Area. It was this broader effort, encompassing both issues of neighbourhood preservation and collective consumption that spawned the effort to develop a community health centre.

Despite this fertile ground for community organizing, in the case of the South Riverdale CHC, local activists

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[92] Bureau of Municipal Research, "Citizen Participation in Metro Toronto: Climate for Cooperation ?, 21.

experienced difficulty in effectively mobilizing the community around a collective consumption issue. Thus, the value of the second independent variable (local activists) was negatively influenced by the first independent variable (local political environment). The outcome of the larger effort at mass organizing was that community leaders were divided and senior levels of government suspicious of the legitimacy of local organizations claiming to represent the neighbourhood.[93]Given that the CHC was developed in the wake of this sense of malaise within the neighbourhood, forging a broad coalition to support a CHC at that time would have constituted a minor miracle.[94]Within the larger context of Metropolitan Toronto, the larger "citizens' movement" was suffering from fatigue by the mid-1970s. Riverdale was likely suffering from a similar fate, enhanced by a chronic shortage of funding.

Both the RCO and the GRO had been unpopular with some elected municipal representatives in the area because of the threat they posed to the municipal power base. They tended to view experiments in community government as a threat to their power.[95]As was the case with Centretown in Ottawa, efforts to develop a CHC in South Riverdale were somewhat tainted by a

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[93] Castells, The City and The Grassroots, Chapter 13, notes a similar process of disintegration in San Francisco's Mission District.

[94] One individual approached for an interview declined because of the residual neighbourhood animosity generated by the demise of the GRO.

[95] Keating, The Power to Make it Happen.

left wing label.

The second independent variable (local activists) was also influenced by the third independent variable, characterized by the relative lack of local corporate rationalists. The lack of a lead agency left local activists with fewer political or administrative resources. Not surprisingly, a series of voluntary associations were formed, but proved unable to move beyond initial discussions of developing a health centre. Local activists became effective only after they became involved with neighbourhood planners from the City of Toronto and enlisted the support of John Sewell (Alderman) and Jim Renwick (MPP). The political and administrative resources provided by these individuals and through the evolving neighbourhood planning process facilitated the development of a broadly-based consensus.

However, pursuing an issue of collective consumption through the land-use planning process was a double-edged sword. The NIP process allowed local activists to access resources and generate a broader and supportive coalition. It also ensnared local activists in the complexities of land-use politics in Toronto. Unlike Sandy Hill which became established through the land-use planning process and then branched out into community development, South Riverdale was narrowly focused on the health issue before it became associated with the municipal planning process. Thus local activists in South Riverdale chose an inappropriate channel

through which to develop a community health centre. At the time, however, it was the only available means of moving the proposal forward. In the end the inappropriateness of this choice became evident when local activists relied on ministry approval of funding to legitimate their position in the municipal arena. The various departments of the municipal government failed to take any definitive lead role to expedite the property issue.

The fourth independent variable (medical opposition) also had a negative with the second independent variable and the dependent variable. Not only were existing physicians vociferous about what they viewed as a potential threat to their share of the medical market, but one of the hospitals in the neighbourhood was developing its own health clinic to serve approximately the same geographic area as the community-based proposal. This in part reflects the lack of a coordinating agency at the local level for health and social services.

Unlike Ottawa, where processes and institutional mechanisms had evolved to encourage mobilization around issues of collective consumption, such efforts in Toronto during the 1970s did not develop these mechanisms at the same pace. Without a positive relation among the first (local political environment), third (local corporate rationalists), or second (local activists) independent variables, only the skill of the local activists and the network of key individuals they had

forced (related to the second independent variable), and the positive relationship of independent variable five with independent variable two, allowed this obstacle to be overcome.

Not unlike Sandy Hill, provincial bureaucrats (fifth independent variable) added legitimacy to the activities of local activists. In South Riverdale, provincial corporate rationalists came into play because of the relative weakness of the first (local political environment) and third (local corporate rationalists) independent variables. Dominant interests were essentially overridden by the alliance of the local activists (and the repressed interests they represented) with corporate rationalists at the provincial level. Sewell and Renwick were crucial actors in negotiations with challenging and dominant interests.

However, the relationship of the fifth independent variable was a double-edged sword. Local activists gained legitimacy in the urban political arena through provincial backing. The trade-off, as reflected in the outcome, was the establishment of a CHC that does not match the original intentions of local activists. Instead, the outcome indicates the bias of the provincial government at the time towards a narrow definition of health services.

During the 1980s, local political reformers have been successful in broadening the scope of developing policies to positively affect repressed interests. Issues other than land-

use, such as multiculturalism, have become firmly entrenched in the urban political arena. The growing demographic presence of ethnic minorities in Toronto has prompted urban politicians and policy makers to reform municipal structures and processes to accommodate demands for increased participation and equity in local service provision. The growing impact of ethnic minorities on provincial politics has reinforced the changes occurring in the urban political arena. During the 1980s, ethnic communities have increasingly sought a voice in the decision- making process, both in the urban and the provincial political arenas. At the provincial level, the government response was the development of a multicultural strategy that placed emphasis on, among other things, equity in access to services. Over time, the character of the first independent variable has changed to encompass a broader range of issues.

Of particular importance to the Access Alliance case has been the emergence of a high value for third independent variable and its positive relationship with the second independent variable and the dependent variable. This trend is evidenced through the emergence of Public Health as a lead agency for facilitating the development of indigenous leadership, community mobilization, and the formation of networks and coalitions. In essence, Public Health has become an institutional sponsor of the second and third trends identified by Castells as leading to community mobilization. Given the nature of the service associated with public health,

the City of Toronto has moved to provide institutional support for communities wishing to mobilize around an issue of collective consumption. During the 1980s local activists have had access to local political and administrative resources that were not available in the previous decade. Thus the intervening variable (the time period) has had a marked influence on the developments in Toronto.

In the case of Access Alliance Multicultural Health Centre populations, local activists developing a CHC for a multicultural population had access to resources of funding and personnel through the Public Health Department. The expertise provided by the community development worker allowed local activists to mobilize several ethnic communities around an issue of collective consumption; specifically, adequate access to health services. They were successful in establishing and maintaining a local consensus consistent with the province's multicultural health strategy. Backed by the active support of legitimate local agencies (including the DHC), Access Alliance was able to avoid the pitfalls encountered by the earlier South Riverdale experiment.

In the case of Access Alliance, the fourth independent variable (medical opposition) had a low value and neutral relationship to the second independent variable and the dependent variable. Also evident was the negative relationship of the fifth independent variable to the dependent variable. It had an effect on the organizational structure that could be

adopted. The broader definition of health adopted by the ministry during the 1980s has allowed Access alliance to offer a broader range of services. However, the consistent ministry position on organizational form has meant that local activists were unable to realize their original organizational vision in developing the Access Alliance CHC. In all likelihood, the difference of visions accounts for the delay in approval from the Ministry.

As was the case with Centretown, during the earlier period, provincial corporate rationalists have required CHCs to be structured in accordance with accepted bureaucratic norms. This extension of the bureaucratic structure and process to the local level through the DHC program approval process has effectively muted the political conflict found during the earlier period. This has occurred because the process is now part of a provincial bureaucratic infrastructure which even encompasses multicultural issues. However, as already noted, the addition of the multicultural dimension has in effect added an additional administrative hoop through which local activists associated with ethnic politics must jump.

Chapter VI

The Development of CHCs in the London, Ontario Area[1]

The City of London is the centre of economic and government activity for Southwestern Ontario. As such it has attracted a host of federal and provincial agencies, and a variety of major commercial and industrial firms. That London is often described as an astute business city is well supported by the Triple-A credit rating on the municipal bond market first received during the 1970s. The emphasis of municipal politicians and administrators on economic development and physical growth indicates a keen, almost textbook awareness of the limitations of municipal government.

Thus the City has remained largely uninvolved in the direct provision of social, health and public housing services beyond provincially legislated requirements.[2] These "redistributive" activities have largely been taken up by

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[1] Information for the case studies in this chapter was obtained through interviews conducted with the following individuals: John Armstrong, Charles Lyons, Marina Lundrigan and Shanthi Radcliffe. Biographical information on these individuals is provided in the comprehensive bibliography. Other documentation sources are cited where applicable.

[2] While economic development has clearly been a central focus of municipal politics, several other issues, not directly related to the economy of the city have managed to work their way onto the municipal agenda: environmental pollution, recycling and race relations.

provincially-funded, public non-profit corporations.

Municipal politics in the Town of Tillsonburg has also been characterized by the emphasis it places on promoting economic development. This is most evident in the enduring ties between the municipal council and local tobacco interests.

As the case studies will demonstrate, the first independent variable (local political environment) in both London and Tillsonburg, had a low value and neutral relationship with the second independent variable and the dependent variable. However the high value and positive relationship of the second (local activists) and the third independent variables (local corporate rationalists) allowed CHC advocates in London to overcome the potential barrier posed by the lack of a positive relationship with the first independent (local political environment).

In the case of Tillsonburg, there the first (local political environment) and third independent (local corporate rationalists) variables had low values and a neutral relationship to the second independent variable and the dependent variable. This in turn mitigated against a high value or positive relationship of the second independent variable (local activists) in relationship to the dependent variable. The high value and negative relationship of the fourth independent variable (medical opposition) to the second independent variable and the dependent variable essentially

sealed the fate of a CHC development in Tillsonburg.

1. Background

The major focus of municipal politics in the City of London has been on economic development. This concern with economic growth has focused on issues of downtown development, annexation and cultural development. While the extent of development in the City in general during the 1980s raised the issue of the preservation of historical, architectural and naturally significant areas, municipal politicians did not adopt these issues as the battle cry for reform in municipal politics as was the case in both Ottawa and Toronto a decade earlier. Opposition to development has come largely from community-based groups.[3]

The focus and support of economic development, despite vociferous opposition is not surprising given the relative importance of London to the economy of the region. As the position of the municipality on the issue of annexation

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[3] Frederick H. Armstrong, The Forest City: An Illustrated History of London, Canada, (Windsor: Windsor Publications Ltd., 1986); Tony Hodgkinson, "Westmount Mall expansion latest move in ongoing rivalry," London Free Press, April 1, 1989, C-1; "What's Going Up and Where in Downtown London," London Free Press, January 24, 1989, B-1; Brent Jang, "London mall lease space to grow 45%," London Free Press, February 28, 1989, B-1; Joe Matyas, "Downtown development task force proposed," London Free Press, March 2, 1989, B-8; Marianne Fedunkiw, "Coalition may quit Talbot fight," London Free Press, October 11, 1988, B-1; Howard Burns and Dahlia Reich, "Planners call for heritage protection," London Free Press, October 25, 1988, B-3; Paul Berton, "Vanishing london," London Free Press, February 18, 1989, A-1; "Talbot streetscape gets another chance," London Free Press, January 21, 1989, C-3.

states:

> The growth of London is essential to the continued economic prosperity of southwestern Ontario. As the urban leader of the region, the City provides the economic stimulus that sustains the area. If London stagnates, the entire region will suffer ... But London must be allowed to grow if this regional prosperity is to continue.[4]

Mayor Gosnell's own campaign appeal during recent municipal elections has placed emphasis almost exclusively on the record level of economic development during his tenure in office. He has been personally involved in annexation negotiations.[5]

On other issues, such as recycling, the city council has been reluctant to act because of the cost involved, even though the majority of start-up costs were covered by the province and the private sector.[6] This reflects not only the view of the majority on council, but also the prevailing

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[4] Office of the City Administrator, Corporation of the City of London, Let's Grow Together, undated pamphlet, 3.

[5] London is moving forward, October/November, 1988, campaign add for the re-elect Tom Gosnell as Mayor campaign; Rob Mackenzie, "Mayor says London bound for the big league,' London Free Press, November 15, 1988, B-1; David Pelwig, "Growing Pains," London Magazine, November, 1988.

[6] Joe Matyas, "Interim London plan starts today," london free Press, February 27, 1989, B-1; Joe Matyas, " City program won't be in place now until 1990," London Free Press, July 5, 1989, B-1; Tony Hodgkinson, " London council backing off from blue box garbage plan," London Free Press, A-1; Joe Matyas, "Province, manufacturers cover cost of start-up," London Free Press, undated; Morris Dalla Costa, "Council doing a slow dance on recycling,' London Free Press, August 5, 1989, C-1; Greg Van Moorsel, "Wernham fails to speed decision on recycling,' London Free Press, August 9, 1989, B-1; Greg Van Moorsel, "Blue-box plan approved for London, london Free Press, September 6, 1989, A-1; Even the "green" candidate on council has taken a somewhat cautious approach to municipal involvement in recycling.

attitude among the City administration:

> If D'Arcy Dutton [former Chief Engineer] had his way, the asphalt would be heaving and London's inner city would be crawling with construction workers ... And proposals to recycle garbage would be out on the curb.[7]

The municipal government has demonstrated a reluctance to become involved in issues that do not yield a direct benefit to the local economy.[8] This policy vacuum created by the relatively narrow focus of municipal government has been filled by other governmental and non-governmental agencies operating in the locality.[9]

For example, the London Urban Alliance, an umbrella organization was formed in 1980 as one of seven such organizations across the province and now represents more than 20 organizations and cultural groups in London. Representatives from the London Police force, the London and Middlesex Housing Authority, the London Board of Education, the University of Western Ontario, the London Multicultural Youth Group, N'Amerind, the London Citizen's Committee for Human Rights, the African Canadian Association, the Caribbean Cultural Society and the Vietnamese Assistance Association are

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[7] "Shaking the Foundations," London Free Press, september 3, 1988, 3, insert magazine.

[8] Paul Berton, "Racism fighters awaiting city appointees," London Free Press, January 27, 1988, B-1.

[9] On the concept of the local state and local special purpose bodies see, Warren Magnusson, "The Local State in Canada: Theoretical Perspectives," Canadian Journal of Political Science, 28, 4, 1985, 575-99.

also involved with the organization.[10]

2. Social Services

Despite London's pre-eminence as both a centre of commerce and administration in central southwestern Ontario, and the wide spectrum of social services provided from within the City boundaries, the municipality itself remains largely uninvolved in direct delivery:

> The City of London, more than most Ontario municipalities, seems rigidly committed to restricting municipal involvement in the social services. Such involvement as there is stems directly from the provincial requirements and from the traditional municipal responsibility to provide "relief" to the very poorest of its residents. London's involvement in ... the municipal home for the aged, subsidies to local agencies, payments made under general welfare assistance, and day nurseries - reflects either reluctant local administration of provincial programs or parsimonious charity.[11]

The general welfare assistance and nursing home responsibilities are mandatory through provincial legislation. The provision of day care services is provincially legislated, but flexible enough to allow the City of London to contract out, rather than provide direct services, and to subsidize well below the provincial average. In the case of London and other municipalities with minimalist day care policies, the

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[10] Berton, "Racism fighters awaiting city appointees,".

[11] Andrew Sancton, Municipal Government and Social Services: A Case Study of London, Ontario, Local Government Case Studies, No. 2, (University of Western Ontario: Department of Political Science, 1986), 8.

province has by-passed the municipality to provide direct subsidies.[12]

Outside of these responsibilities the City also donates a small amount to a limited number of social services organizations on an annual basis. Therefore the majority of social service activity in the City of London revolves around the regional offices of various provincial and federal ministries involved in the social policy field and the public nonprofit agencies that form the client groups of these government agencies.

The high degree of specialization in the provision of services characteristic of human services in the London area is based in part on the inherent territoriality of the organizations and the resulting lack of consensus on developing a single agency for coordinating service delivery:

> Despite the commitment and support shown by the Ministry of Community and Social Services, and the work of numerous 'coordinating' councils and committees, the concept of improved coordination remains, to some extent, an elusive goal. While information sharing, informal cooperation, and a spirit of collegiality are found throughout London's social service system, the actual sharing of resources and/or joint project development remain the exception rather than the rule.
> The history of service development in our community has in fact, fostered a strong sense of independence among various service providers, many of whom have invested considerable time and effort developing autonomous Boards of Directors, and

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[12] Ibid, 8,9,11,17.

securing the resources required to function.[13]

While a relative lack of coordination in service delivery is not unique to London, what differentiates it from Ottawa in particular and to a lesser extent, Toronto, is the failure of a municipal institutional actor to assume a leadership role in this task. This in part stems from the "conservative" nature of municipal politics in London and the lack of a clearly defined municipal reform movement in local politics. Efforts to coordinate service delivery have been left to provincial and federal government agencies and voluntary nonprofit organizations.[14]

3. London Intercommunity Health Centre

The London Intercommunity Health Centre began as the Immigrant Seniors Project, a study of the service needs and lifestyles of five elderly populations in London[15], Ontario,

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[13] United Way of Greater London, Listening to London, (London: Ontario, 1991), 50.

[14] One example of the involvement of the non-profit sector in the coordination of human services is the London Community Resource Centre. By locating a variety of programs and agencies at one central geographical location and providing administrative and planning support services LCRC has facilitated a fertile cross-pollination of ideas, personnel and resources towards the development of a more coherent network of neighbourhood services. Local activists dealing with a variety of policy issues and funding agencies have been able to pool their resources.

[15] The five target populations included the South East Asian, Lebanese, Chinese, Polish and Portuguese elderly communities.

sponsored by the London Cross Cultural Learner Centre (LCCLC).[16] The five populations are located in an area southeast of the downtown, and in a north-south corridor in the east of the City.[17] The east part of the City is the mainstay of low-income earners.

While the initial focus of what was to become two surveys was on the needs and concerns of the target populations, one of the stated objectives was to create a model for service delivery sensitive to the needs of these populations that might be applied elsewhere in Canada. Thus, as the survey progressed and the researchers gained increased insights into the needs and problems associated with the study groups, they were able to match these to an appropriate model of human service delivery.[18] The major problem identified by the research was one of accessing mainstream health and social services because of linguistic and cultural barriers. The CHC

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[16] The London Cross Cultural Learner Centre is a non-profit community-based organization operating with funding provided by the Canadian International Development Agency, , the London Board of Education, the London and Middlesex Separate School Board, the Department of the Secretary of State, and the Ontario Ministry of Citizenship and Culture. Between September of 1979 and March of 1981, LCCLC acted as the coordinating agency for the City of London's Refugee Sponsorship and Resettlement Programme and continues to provide a variety of services for newly arrived immigrants.

[17] Immigrant Seniors Project, London Inter-Community Health Centre, A Proposal to the Ontario Ministry of Health, August 31, 1987, section 2, pg. 20a.

[18] Shanthi Radcliffe and Marina Lundrigan, "The Immigrant Seniors Project," Canadian Journal of Public Health," 79, 1, (March/April) 1988, 11-15, provides a discussion of the survey instrument and its implementation.

model, as envisioned by the federal Hastings report, was deemed to be the most appropriate approach.

Building a Local Consensus:

In 1983, Joe Barth and Shanthi Radcliffe began discussions on conducting a survey of the needs and concerns of elderly ethnic populations in the City of London. The source of the initial idea was the work conducted by the LCCLC[19] to develop community networks, provide resources for this purpose and act in a liaison capacity with multicultural and immigrant communities, and local human service agencies. From the initial discussions, the two local activists decided to conduct a telephone survey of the services available for elderly immigrants through local agencies and ethnic associations. The results of the survey indicated that there was a shortage of services for elderly immigrants and that because many were newcomers to the country, language and cultural norms posed an additional barrier to accessing services.[20]

After reviewing the results of the initial survey, the

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[19] London Cross Cultural Learner Centre, The Elderly Immigrant, Application to Health Promotion Contribution Programme, January, 1984, 2.

[20] Funding to cover the administrative costs of the telephone survey was obtained through a $ 5000 grant from the Ontario Ministry of Citizenship and Culture. The initial survey was considered the "community preparation phase" by the researchers.

two activists, in conjunction with the LCCLC, decided to apply for funding to carry out a more detailed study of the needs and concerns of immigrant seniors in London. A grant application was made to the Health Promotion and Services Branch of Health and Welfare Canada (HAWC). The intentions of the project were: to evaluate the needs and concerns of the community; to make local service agencies more aware of and responsive to these needs; and to develop and deliver a series of programs including "information and orientation workshops, independence training and co-operative skills marketing."[21]

While waiting for a response from HAWC, the final report on the Community Preparation Stage was completed and submitted to the Ministry of Culture and Citizenship (MOCAC) and planning of the questionnaire for the next survey was initiated. During this period, the networking process with human service agencies and ethnic communities was intensified, including initiating community building activities in the ethnic communities. Such basic activities were necessary in the ethnic communities because as the researchers discovered, unlike large urban centres where ethnic communities tend to be larger in number and to have well developed community networks, the ethnic communities in London were smaller in number and individual families tended not to use their own

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[21] London Cross Cultural Learner Centre, The Elderly Immigrant, Application to Health Promotion Contribution Program, 1984, abstract, 5-7.

cultural community as a resource for solving internal problems. This sense of isolation was even more pronounced in terms of accessing the resources of the city-at-large.

The networking process that took place at this stage included phone calls and personal interviews with key individuals who had been identified during the first survey. Through the LCCLC new contacts were made with other agencies working in the immigrant field. The response to the report by those contacted was "enthusiastic". Presentations were made to the network of agencies dealing with immigrant issues within the City and copies of the report were mailed to members of the Ontario Coalition of Agencies Serving Immigrants (OCASI) and a response solicited. The response to the province-wide mailing led local activists to plan to visit some of the other locations at a later date.

Within the ethnic communities themselves a similar networking strategy was employed. Personal visits were made to identified community leaders in each ethnic enclave and their support was solicited. From discussions with these contacts, a strategy was developed for each community including compiling a mailing list, a list of potential interviewers for the questionnaire and establishing a schedule of meetings with the seniors to inform them of the project. After this, a schedule of activities for seniors was arranged to begin the process of developing skills. An information letter addressed to the seniors was sent to each community leader for

translation and eventual mailing. Public announcements were also arranged with the variety of primary service organizations in each community (churches, mosques, seniors' centres, etc.). In at least one of tne communities, health services were immediately identified by the seniors as the most urgent priority.[22]

During 1985, the strategy of constant networking with the ethnic communities and the existing services agencies continued while the design of the questionnaire entered its final stages. Having established linkages with the representatives of repressed interests and the major social-service agencies, the local activists turned their efforts to those organizations within the medical service community linked to the target populations. Between January and March a meeting was held with Dr. J.D. Pudden, the Medical Officer of Health to provide information on the findings of the project thus far and to solicit support. The response from Dr. Pudden was that he was aware of the general problems associated with the communities, but not the extent. Meetings were also held with the Thames Valley District Health Council

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[22] LCCLC, Quarterly Report: September-December 1984, Elderly Immigrant Project, File No. 6552-2-102, 1-3, The Portuguese seniors responded to the health issue. The other community involved in meetings at this point was the Vietnamese. Fruitful contact with them was facilitated through the cultural interpretive services of the Ontario Welcome House in Toronto and the Vietnamese Liaison Officer with LCCLC's Settlement Program. Funding during this period came from HAWC, MOCAC, the Secretary of State (SOC), and MOCASS (Help the Aged Grant).

(TVDHC), the Middlesex-London Health Unit staff (MLHU), St. Joseph's Hospital and St. Mary's Hospital Pastoral Care personnel to discuss areas of mutual concern. Because of the overwhelming need for adequate access to health services, some of these meetings involved a discussion of the possible development of a CHC to serve the Latin American and Portuguese communities.[23]

Community-building activities continued with the Portuguese, Chinese and Vietnamese populations.[24] A meeting was held with senior citizens at the Portuguese Seniors' Centre, where a slide presentation on services for seniors in the city was shown followed by an open discussion. The outcome of this was a meeting between Dr. Pudden and the Director of the Portuguese Centre to develop a strategy to address the issues raised at the meeting. An open forum was also held so that citizens might speak directly to the MLHU about their concerns. The meeting was widely advertised through religious organizations, community radio, printed flyers and newspaper coverage, attracting approximately 130 members of the

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[23] The consensus at these meetings was that the development of a health centre would have to be preceded by an extensive community building and awareness process so that the centre would be used.

[24] This process was facilitated by a student hired through the Challenge '85 program of the Employment Development Branch of the C.E.I.C..

Portuguese community.[25]

Between April and June several all-day workshops were organized for the Chinese elderly at a variety of accessible locations. The programs included a lunch, some Chinese television programming, the distribution of a brief questionnaire, and a discussion of the larger survey and the possibility . volunteering through the Seniors' Volunteer Service program. An information session was held on the services in the city available for seniors. The response to the call for volunteers was positive. The second and third workshop days were held at which time seniors formed interest groups to organize recreational activities, a Committee for Seniors was formed, and the Mayor and MPPs were on hand to distribute plaques provided by the city to those seniors over the age of eighty.

An important secondary networking activity was carried out by interviewers from the community who had been trained to administer the questionnaire. Prior to the survey, interviewers pre-tested questionnaires and carried out information sessions and discussions within their respective communities on a continuous basis. This was important because

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[25] LCCLC, Quarterly Report: January - March 1985, Elderly Immigrant Report, file # 6552-2-102,1-3, The coordinators also attended a variety of meetings with smaller community groups and were present at cultural events. The project coordinator was elected to the executive of the Board for the Portuguese Centre. The newspaper article on the project led to interest being expressed by the Catholic Women's League in providing support for the project.

it gave the survey an elevated profile in the ethnic communities. Several staff hired through additional grants provided support and outreach services to groups as requested. As noted by the coordinators, "the overall objective of our efforts at this stage remains the strengthening of the identity of each community and the development of the profile of the project with seniors."[26] In essence, the local activists were employing a classic community development strategy to build a broad consensus and to identify repressed interests as the recipient of the proposed new service. This later facilitated the establishment of the funding relationship with provincial corporate rationalists in the Ministry of Health.

With the support of the project staff, some of the communities undertook efforts to develop their own group of volunteers to work with seniors as counsellors and translators. The Seniors Volunteer Program was also in full swing with approved funding from the Ministry of Community and Social Services. The project staff acted as administrative brokers between the ethnic centres and the various service agencies in negotiating contracts.

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[26]. LCCLC, Quarterly Report, Immigrant Seniors Project, File # 6552-2-102, 4-5, A full-time student was hired under the S.E.E.D. program of the Employment Development Branch to provide support services. A social worker was hired under the Section 38 program of the EDB to provide community outreach through the Portuguese Centre. Five senior volunteers were enlisted to work through funding provided by the Ministry of Community and Social Services, Help the Aged Grant.

A number of educational initiatives were also launched, including the development of a series of information sheets regarding services for seniors and a popular education program on topical issues. An article which appeared in the Health Educator, led to inquiries from a variety of organizations across the country.[27]

Interviewers to administer the questionnaire who had been picked and trained earlier were gathered together to discuss the finer aspects of the survey. The survey was administered by trained interviewers from each community and was forwarded to the Computer Centre at the University of Western Ontario for processing.

In the latter half of 1985, the mechanisms put in place were reinforced. Community-building activities continued mainly with the Portuguese, Chinese and Vietnamese communities. Community leaders from these three enclaves were enthusiastic about the opportunity to develop services:

> These three communities, although they have different needs and are at different levels of organization, have a strong and committed leadership which is eager to develop their body of services to their constituents and participate actively in initiating or supporting new ideas

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[27] Ibid, 5, Organizations expressing an interest in the project included the Ministry of Health; the Secretariat for Social Development; the Metropolitan Immigrant Settlement Association, Halifax; the School of Nursing, Memorial University of Newfoundland; Centennial College of Applied Arts and Technology, Scarborough; the Jamaican Canadian Association, Toronto; and a Seniors Health Survey conducted in Saskatoon.

which may contribute to this objective.[28]

The leaders of the various ethnic organizations were pleased when presented with the opportunity to forge new linkages leading to an expansion of the services available to their communities.[29]

The idea of developing a CHC still remained at the exploratory stage, but two communities, the Portuguese and Latin American, expressed a high degree of interest in such a venture. The Chinese took a wait-and-see attitude.[30] Based on the results of the survey, the local activists decided to develop a community health centre.[31]

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[28] LCCLC, Quarterly Report: July-September, 1985, Immigrant Seniors Project, File # 6552-2-102, 1, The Lebanese community remained essentially uninvolved in the project at this point. They were interested in a series of information sheets when they became available, but no regular contact was maintained and no workshops arranged.

[29] During this period, one of the coordinators, Joe Barth left the project to become Programme Coordinator for LCCLC. He was replaced by Marina Lundrigan.

[30] LCCLC, Quarterly Report: July-September, Immigrant Seniors Project, File # 6552-2-102, 2-3, An application was in the preparation stage to the CEIC to fund the training of two outreach workers/translators from each of the Chinese, Portuguese and Vietnamese communities. The coordinators envisioned such para-professionals as part of the staff of a health centre should one be developed. In the same light, the volunteers trained through the Senior Volunteer Program could serve a similar purpose. Of course, the immediate task of all these individuals was to assist in the community building process.

[31] Shanthi Radcliffe and Marina Lundrigan, Immigrant Seniors Project Submission to the Honourable Tony Ruprecht, Minister without Portfolio, 12 February, 1986, One of the major findings of the survey was that their was a lack of co-ordination in the information available concerning services in London. The greatest lack of co-ordination came from the

With the decision to develop a CHC, a new wave of networking was undertaken to publicize the direction that the project was now taking. Meetings were held with project officers from the MOCAC and the SOS; the Executive Director of the TVDHC and its community health officer; the MOCASS; and the ethnic communities. All of these individuals and groups were considered "key persons and organizations who will be associated with us in future planning."[32] The TVDHC advised the coordinators that one of the keys to successfully developing the centre would be the availability of a doctor who was willing to work as part of a team and on salary. The Ministry of Community and Social Services indicated that core funding for the para-professional aspects of the centre would probably be available through their Neighbourhood Support Services Program. Contact was established with individuals at the UWO Faculty of Nursing who agreed to act in an advisory capacity on interpreting the data and developing the health survey for the health centre proposal.[33]

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caregivers.

[32] Shanthi Radcliffe and Marina Lundrigan, Correspondence with Ms. Ruth Plante, Programme Officer, Health Promotion Directorate, Ontario Regional Office, Health and Welfare Canada, 8 March, 1986, At this point the coordinators had arranged further meetings with the Director of Public Health; Ron Van Horne, Minister for Seniors Affairs; Premier David Peterson; and policy analysts from the provincial Senior's Secretariat.

[33] Immigrant Seniors Project, Proposal, April, 1986, 9, Community development activities continued along the course established earlier. A series of workshops was held in early 1986 dealing with financial matters such as RRSPs. One

In April, 1986 an application for increased funding was submitted to the Health Promotion Directorate.[34] The application reviewed the goals and objectives of the project to date, indicated the various actions taken to fulfil the mandate of the project and linked all of this to the development of a multicultural health centre "which [would] involve ethnic seniors, primary health service providers and the community-at-large in a coordinated strategy for health

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workshop was taped professionally as a trial run for taping other workshops to be developed during the summer months by students hired through the Challenge '86 program of the EDB.

[34] Immigrant Seniors Project, Quarterly Report: April - June 1986, File # 6552-2-102, 1, While the application for additional funding to the Health Promotion Directorate was the major funding thrust, funding for related activities was also sought through the following sources:

MOCAC for the production of the audio-visual materials for the information bank - translation and voice-over.

SOS for the written component of the bank - translation and printing

The Employment and Development Branch (EADB):

(i) Summer students to be employed under the SEED program to work on the material for the information bank and carry out related networking activities with the seniors.

(ii) Training of six para-professionals from the ethnic communities including job placement with the appropriate ethnic and service agencies.

A placement from the Chinese community through the London Urban Resource Centre to do secretarial work for the project.

A copy of the application was also forwarded to Murray Elston, then the provincial Minister of Health for information purposes.

enhancement."[35] The model as explained in the proposal included: a holistic team approach to care; the co-ordination of related human services; the promotion of personal and community responsibility; and increased accessibility to services.[36]

Much of the ground work for the health centre application had already been done during the previous surveys:

> The main requirement for a credible proposal is the Programme Planning Information stipulated by the Ministry, which will need to be developed with a very specific, focused and professional study of health needs. The possibility that there might be the need for another specialised study was anticipated in the original proposal but its exact nature could not be defined until the results of the first survey were analyzed. The demographic information required by the Ministry has already been obtained through the first questionnaire, but we would like to make the survey of health professionals as broadly based as possible, and invite the co-operation of experts in the field. Discussions to this end have already taken place with the Faculty of Nursing, U.W.O., the Department of Family Medicine, U.W.O., the Thames Valley District Health Council, and also the Minister for Seniors Affairs, The Hon. Ron Van Horne, and a policy analyst for the Seniors Secretariat.[37]

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[35] Ibid.

[36] The proposal also cited supportive statements from the WHO and the provincial Implementation Group on Health Promotion and Disease Prevention. Not surprisingly, as written, the proposal looks as though it draws heavily on the underlying themes of the federal and provincial government reports outlining the corporate rationalist approach to health care delivery.

[37] Immigrant Seniors Project, Proposal, April 1986, The President of the London and District Real Estate Board, who is a leader of the Portuguese community, had agreed to co-ordinate any "land assemblage or development needs" related to establishing the health centre.

All of these actors would play a crucial role in developing the health centre, both in terms of providing the necessary technical resources and legitimacy from the local professional community.

While the community networking, the development of the information bank, and the Seniors Volunteer Program continued to evolve during the Summer of 1986, the CHC had moved to the forefront of the coordinators' activity. With the approval of additional funding from the Health Promotion Directorate to finance the needs assessment study for the MOH application for the health centre, a first draft of the questionnaire was designed with the aid of two professors from the Faculty of Nursing. A meeting was then held with the director of the Health Care Research Unit at UWO[38] to discuss the research direction that the project should take, possible sources of information and analysis of the original data. The Health Research unit suggested that they might process some of the necessary background statistics and do the analysis.

To enlighten themselves as to how the various aspects of the CHC model might work, the coordinators met with the Manager of the Family Medical Centres[39] of Victoria Hospital to observe the multidisciplinary approach to patient care; and

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[38] The Health Care Research Unit was funded by the Ontario Ministry of Health.

[39] This includes the Byron Medical Centre and the Hamilton Road Family Medical Centre.

the administrators of the Southwest-Middlesex Family Centre and the St. Joseph's Health Centre to discuss administrative and operational issues. The Southwest-Middlesex Family Centre served primarily native clientele from reserves and presented a similar access problem to that encountered by ethnic seniors in London.[40]

A new networking strategy, focusing on promoting the health-centre concept, was initiated and meetings were held with the following individuals: the Premier of Ontario, the Minister for Seniors Citizens Affairs, the Chairman of the Ontario Advisory Council on Senior Citizens, the Chairman of the Ontario Gerontology Association, the Deputy Mayor of the City of London, the Director of Social Administration for the City of London, the Executive Director of the TVDHC, the Chairman of the Department of Family Medicine, Faculty of Medicine at UWO, and the Director of Nursing for the Middlesex-London District Health Unit. The purpose of this first series of meetings was to make these various actors aware of the progress of the project and solicit their advice and support. Networking also included a continuation of contact with the leaders of the various ethnic communities targeted for the health centre.[41]

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[40] Immigrant Seniors Project, Quarterly Report: April to June 1986, File # 6552-2-102, 5, Meetings were also arranged with a representative of the Toronto Department of Public Health, which was fostering the health centre concept in that city and with one of the CHCs operating in Toronto.

[41] Ibid, 5-6.

Aside from the continuous community development process taking place in the ethnic communities, a tour of several health centres in Toronto took place, including meetings with the Multicultural Health Coalition[42] and Toronto Public Health. A first draft of the questionnaire was developed through the Health Research Unit at the university and was distributed to key individuals for comment prior to revisions. Preparations were made for choosing and training interviewers based on the estimates of the size of the sample provided by the Health Research Unit. The coordinators had been in contact with the MOH through the DHC to obtain guidelines on conducting the needs assessment. The development of the questionnaire and the training of interviewers would continue as a central activity for the remainder of the year.[43]

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[42] The Multicultural Health Coalition was an advisory agency established with the assistance of the Liberal government to provide advice to the Premier on multicultural issues.

[43] Immigrant Seniors Project, Quarterly Report: July-September 1986, File # 6552-2-102, 6-7; Immigrant Seniors Project, Quarterly Report: October-December 1986, File # 6552-2-102; Other related activities taking place during the last quarter of the year included meetings with the Health Science Committee at U.W.O. concerning their development of a multidisciplinary geriatrics program; the Public Utilities Commission of London to discuss a number of new multicultural initiatives on their part; and with new volunteers. Seniors workshops continued to be held. Shanthi Radcliffe was elected to the Senate of the University in November as the Representative of the Community-at-Large and sits ex officio on the Council of the Faculty of Part-time and Continuing Education. Both coordinators attended national and international health conferences to make presentations on elderly care, multiculturalism and community health centres. They were invited to make a presentation to the Canadian Mental Health Task Force on May 6-7 of 1987.

By February of 1987 the survey was completed and being processed by the health research unit. The study indicated that among the targeted groups there were problems with accessing the existing service network associated with language, cultural sensitivity and transportation barriers. Along with these previously unknown problems were the usual health issues surrounding nutrition, physical and psychological maintenance.[44] The TVDHC invited the coordinators to make a presentation on May 6th concerning the health centre proposal. An official from the MOH was on hand for the presentation. At the end of March the first meeting was held at the UWO Medical School to establish a local chapter of the Multicultural Health Coalition. The Steering Committee for this event comprised the coordinators of the Immigrant Seniors Project, a representative from the Provincial Government Race Relations Directorate, and the individuals from the Faculty of Nursing involved in the survey. The meeting was well attended and was chaired by Dr. Douglas Bocking, the Vice Provost of Health Sciences. London was a strategic locality for the development of multicultural initiatives because it was the home riding of Premier David Peterson. Peterson had pledged on a number of occasions to

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[44] Immigrant Seniors Project, London Inter-Community Health Centre:Supporting Document, A Proposal to the Ontario Ministry of Health, August 31, 1987.

move Ontario from biculturalism to multiculturalism.[45]

The funding proposal was submitted to the TVDHC in August to begin the process of review before being sent to the MOH for final review and approval. Coinciding with the submission was the release for public comment of a report by the TVDHC Mental Health Task Force. The needs of the elderly and ethnic populations were listed as the first priority. In November, the CHC coordinators met with the Adjudication Committee of the TVDHC to discuss the proposal and suggested changes. The coordinators were invited to sit as members of the Task Force on Mental Health Services in Thames Valley. As in the past, the coordinators realized the value of participating in such a Task Force:

> We see the development of political networking, for which the base was laid last summer, as taking on increasing importance as the Multi-cultural Health Centre concept comes nearer to implementation. In

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[45] Immigrant Seniors Project, Quarterly Report January-March 1987, File # 6552-2-102; Bill Eluchok, "London 'strategic' to multiculturalism," London Free Press, September 30, 1988, B-9; The development of the multicultural health coalition in London is important to the health centre for several reasons. Shanthi Radcliffe was elected as Secretary for the provincial Multicultural Health Coalition organization at its June meeting and was elected as the provincial President in 1989. She was also elected as the first President of the local chapter. No doubt, Radcliffe's high profile through this organization contributed to her appointment to a number of provincial government advisory bodies, including the provincial multicultural advisory health committee and the Premier's Council on Health Strategy. Dr. Bocking, who was a very supportive member of the medical community became the first Chairman of the Board of Directors for the community health centre. All of this boosted the profile of the health centre and added to its legitimacy with the local professional and ethnic communities.

> this networking would be included information sharing on our progress with local, provincial and federal officials, the media and other prospective funding sources.[46]

This perhaps best sums up the dominant strategy that was developed and employed constantly by local activists from the time the first funding application from the federal government was approved.

In their efforts to establish a client link with the provincial Ministry, they realized the importance of establishing a broadly-based constituency that linked different levels of government and funding agencies. Along with the support of the target communities established through several years of community development, the coordinators proved their ability to acquire and manage resources to both local community leaders and potential funding sources at senior levels of government.

During 1989, an interim Board of Directors for the London Intercommunity Health Centre was established to carry out the pre-operational phase of the process. During this time, a suitable site was acquired, renovations carried out, equipment purchased and staff hired. By October of 1989, the centre was incorporated and operating. In January of 1990, the

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[46] Immigrant Seniors Project, Final Quarterly Report: October-November, 1987, File # 6552-2-102; This document also reported that funding approval had been received in early 1987 to fund the para-professional education program to train cultural interpreters through a program developed in conjunction with Fanshawe College. The information bank was now fully functional.

Minister of Health officially opened the London Intercommunity Health Centre.[47]

An examination of the staffing, funding and programs suggests that like South-East Ottawa, the London Intercommunity Health Centre has moved beyond the traditional medical approach to service delivery. The London CHC includes primary health care, prevention and promotion, a dental clinic, foot clinic and a variety of other non-conventional human services programs. In 1991-92 the CHC received 89 percent of its total budget from the provincial Ministry of Health. In the following fiscal year the percentage funded by the Ministry of Health had dropped to 82 percent. The remainder of the budget has been funded by other provincial and federal ministries and private donations.[48]Despite the strong financial presence of the provincial Ministry of Health, the mix of personnel reflect a multidisciplinary approach to the delivery of services. This includes three

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[47] London Intercommunity Health Centre, Meeting of the Board of Directors, January 26, 1989; LIHC Finance Committee, Meeting, January 13, 1989; correspondence from Dorothy Loranger, Director of the Community Health Branch, Ontario Ministry of Health, January 26, 1989; The pre-operational phase includes hiring of medical and administrative personnel, acquiring and renovating a suitable site and purchasing necessary equipment. The Ministry agreed to recover costs from the date of receipt of the letter of confirmation and to reimburse on an accrual basis. The total preoperational grant of $. 387, 743 was confirmed by the Ministry by the end of January. The health centre had actually been operating since September 25, 1989.

[48] London Intercommunity Health Centre, Annual Report, 1991-92, 1992-93.

physicians, one nurse practitioner, three RNAs, one health educator, two community workers, one social worker, five program coordinators, an executive director and three administrative support staff. If program coordinators are included as part of the administrative hierarchy, London exhibits a strong administrative presence, especially when compared with South Riverdale and Sandy Hill. This clearly indicates the acceptance by the Ministry of Health of a broader definition of health.(see Appendix IX, Exhibit F).

The failure of the first independent variable (local political environment) to have a high value or positive relationship to the second independent variable and the dependent variable is reflected by the uncoordinated and territorial nature of the human services network and the lack of a well developed sense of community within the existing ethnic enclaves. Under these circumstances, a positive relationship among the second independent variable (local activists), the third independent variable (local corporate rationalists) independent variables and the dependent variable was key to an outcome number one. Local activists were able to build a consensus among existing organizational and ethnic leaders through the development of a series of elementary programs to serve the identified needs of ethnic communities. An important aspect of this strategy was the involvement of key members from the medical school at UWO and the utilization of university research facilities. This assisted local

activists in avoiding a direct conflict with the local medical establishment. The support of the existing organizational network for the project was also crucial.

Prior to the development of the CHC in London, organizers in Tillsonburg faced similar institutional barriers, but failed to overcome them.

4. Tillsonburg

Tillsonburg, is a community of approximately 11,000 situated on the southern border of Oxford County. Tillsonburg and the surrounding area is populated by several strong and self-reliant ethnic communities (Belgian, Dutch, Hungarian and German)[49], and has relied on the tobacco industry as the major source of economic activity since the 1920s. This is indicated by the formation of the Southern Ontario Flue-Cured Tobacco Growers' Association in 1933 and the subsequent close relationship between tobacco interests and the municipal council. In 1957, the Ontario Flue-Cured Tobacco Growers' Marketing Board was formed by registered growers under provincial legislation to regulate the industry. Again Tillsonburg was the preferred location for this new regulatory body.[50]

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[49] J.I. Cooper and John Armstrong, Tillsonburg: A History 1825-1982, Chapter XXII.

[50] Ibid, 105.

5. Social Services

In terms of health and social services patterns, Tillsonburg services clients from Oxford, Norfolk and Elgin Counties. Many residents from the "tri-county" area cross over county borders to receive services in Tillsonburg.

While this would seem like a good scenario in which to develop a CHC, efforts to do this in Tillsonburg have failed in the past and continue to be met by opposition from health professionals, and disinterest from the surrounding communities. The root of the problem encountered by local activists can be seen by comparing the attempt to establish a health centre with an earlier move to establish a multiservice centre.[51]

In the mid-1970s, the Tillsonburg District Memorial Hospital underwent a process of refurbishment and expansion. During this process recognition was given to the fact that psychosocial services were uncoordinated and inadequate. Although a number of agencies provided social services, they had very little contact with each other. In an attempt to remedy this situation, the hospital created the Community Services Council. The mandate of the new organization was to create a family services agency to provide some sort of coordinating mechanism for the existing , fragmented array of services that were provided on a piecemeal basis through

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[51] Ibid, 161.

existing organizations in Woodstock, St. Thomas and London.[52]At this point, John Armstrong,[53] a key member of Council contacted Charles Lyons, the Director of Catholic Social Services in London.[54]Mr Lyons met with the group and agreed that some sort of coordinated locus for social services would be beneficial for the Tillsonburg area. With the assistance of the Tillsonburg group a needs assessment was conducted. Roughly 50 percent of those surveyed saw the need for family services while the other 50 percent were concerned with coordinating the existing services and increasing the visibility and accessibility of these services. Part of the process was to survey and gain a commitment from the social service agencies currently serving the area to provide staff and resources for a new multiservice centre.[55]

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[52] Cooper and Armstrong, Tillsonburg: A History, 160-61; For example, agency x in Woodstock might agree to send one of their case workers down to Tillsonburg two days per week. For the other three days, referrals would be made to the parent agency in Woodstock.

[53] John Armstrong was a high school teacher and town councillor in Tillsonburg. Shortly after the multiservice centre was established he was elected Mayor of Tillsonburg for the first of three consecutive terms.

[54] Catholic Social Services was contacted because the major focus of the organization was planning, developing and initiating new social services in communities where they were needed. The catchment area for the organization was the London Conference District which included Tillsonburg. Mr. Lyons's reputation for developing Family Service agencies was known to John Armstrong and other members of the Tillsonburg group.

[55] The survey was conducted with approximately 75 people of which 12-15 were those drawing on services, a somewhat larger group made up of service providers, 12-15 from other professions interacting with and coming in contact with those

In 1975, Harry Parrott, MPP for Oxford County and cabinet minister in the provincial Conservative government convinced his Cabinet colleagues on the Social Development Committee that a multiservice centre in Tillsonburg was a good idea and funding was approved. While the idea received favourable support at the Cabinet level, just before the final presentation by the group to the MOCASS, an austerity program was announced and a number of the agencies which had committed resources to the proposed centre had to withdraw. Notwithstanding this problem, the multiservice centre began operations with the remaining programs.

The Tillsonburg and District Multi-Service Centre has been in operation since 1975, but it has continued to be affected by provincial funding policies since that time. Therefore, the programs developed by the Centre are largely indigenous to the Tillsonburg area, and services provided by larger agencies external to the community continue to function on a piecemeal basis.[56] The funding crisis has been at times so acute that the centre could not afford to employ a full-time coordinator.

In 1983, staff members at the multi-service centre were

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needing social services, and a significant number of members of the business community. The purpose of this mix was to determine if there was a consensus among the major interests in the community.

[56] Information Tillsonburg, Tillsonburg and Tri-County Area: Community Information Directory, 1989-90, 8, The guide provides a listing of the services coordinated through the multi-service centre.

interested in expanding the base of the services to include a primary health-care component. At the time, the same logic that had been applied to developing the multi-service centre seemed to hold for developing a health-care component, and the basis for a new needs assessment was already in place with the data from the first assessment. However, when meetings were held with the other existing health organizations in the tri-county area, organizers of the multi-service centre realized that, with few exceptions, they were the only ones interested in establishing a health centre. Informal meetings were held with the TVDHC, the MLHU, the Tillsonburg and Woodstock hospitals and Adult Mental Health. While Adult Mental Health saw a possible benefit in a health centre, most of the organizations located in Woodstock were not interested because they felt that the needs on which the health centre was to be based were already being adequately served by the existing organizations.

At this time multiculturalism had not yet taken hold at the provincial level, therefore, much of the need in the ethnic communities remained unseen (or unacknowledged), except by the staff of the multi-service centre who were providing in-home services and gaining first hand knowledge of conditions. As for the ethnic communities themselves, they tended to be self-sufficient in terms of providing services through their own ethnic organizations. While some representatives from several Church organizations were

approached about the health centre idea, they too would not acknowledge that there were problems that needed to be addressed. The major opposition to the idea, however, came from the Woodstock medical community. Without any real basis for developing a consensus, either within the professional or ethnic communities, the idea was dropped.[57]

In 1987-88, the TVDHC developed A Plan for Community Health Centres, in which it identified a number of potential future sites for health centres, including Tillsonburg. The comments in the study on the presentation made by the Tillsonburg multi-service centre underline the continuing problem for health centre advocates in the area:

> It appears that the needs of the various target populations identified are non-specific and generally exclude primary health care needs. With the Tillsonburg Multi-Service Centre currently offering a wide range of social service programs, the problem is not one of service gaps, but one of co-ordination and accessibility to existing services. A coordinated effort by the Oxford County health and social services agencies to identify the need for CHC's (sic) was not evident. The TVDHC Mental Health Services Review found that in Oxford County, the ethnic population was least adequately served by mental health programs. Children, adolescents and the elderly are also under-serviced. The priority recommendations of the Mental Health Services Review were for the development of problem-recognition services for the elderly, symptom-reduction service for the developmentally handicapped, and crisis intervention services for the farming community in Oxford County. The Public Health Units identified a

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[57] Part of the problem also stemmed from the existence of the Tillsonburg Medical Clinic. The Clinic had been organized by three physicians in 1967 and operated on a fee-for-service basis.

need for epidemiological health personnel.[58]

Clearly, while there have been unmet needs identified by the Thames Valley DHC that might be met through a CHC, the continuing lack of local consensus will likely prevent such a development in the near future. Most notable in this case were the objections of the medical community and the hospitals.

6. Analysis

The first independent variable (local political environment) had a low value and neutral relationship on the second independent variable and the dependent variable in the London and Tillsonburg cases. What differentiates London from Ottawa and Toronto is the relative lack of municipal involvement in issues of collective consumption. The strong focus of the municipal political arena on economic issues has limited the benefit of organizing neighbourhoods for collective consumption in the municipal political arena.

Instead of focusing on the municipal political arena, local activists in London concentrated on the provincial political arena. In this respect, the intervening variable, the time at which the CHC was developed, had an important influence on the outcome of the London case. The replacement of the long-entrenched Conservative government by a Liberal one with a left-of-centre political agenda led to extensive

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[58] Thames Valley DHC, A Plan for Community Health Centres Thames Valley District Health Council 1987-1988, (London, 1988), 7.

policy reforms. Policies favouring both multicultural services and CHCs acted like a political lightning rod for local activists. This was of particular importance, given that the Premier had his constituency in London. The lack of a galvanizing agency or policy at the municipal level further enforced the focus on provincial politics.

Despite the absence of a high value and positive relationship among the local political environment (the first independent variable) and local activists (second independent variable), the high value of the second (local activists) and third (local corporate rationalists) independent variables and their positive relationship with each other facilitated the development of a CHC in London. Local activists were able to mobilize support from local human-service, municipal and ethnic leaders about the development of a new service. The third independent variable (local corporate rationalists) enhanced the value and relationship of the second independent variable (local activists) with the dependent variable. Of particular importance to this success was the involvement of key members of the university health-education community. The LCCLC and the University provided a fertile institutional environment in which to develop the idea of the multicultural health centre because of the existing organizational resources available to the activists. These agencies, in turn received their funding from the provincial and federal governments. The impact of local corporate rationalists allowed local activists

to avoid any major confrontation with the local medical community (the fourth independent variable).

The fifth independent variable (provincial bureaucrats) had a moderate value and positive relationship with the second independent variable and the dependent variable. Although provincial bureaucrats did not directly intervene as was the case in Toronto and Ottawa, local activists noted that the support of the various provincial agencies was crucial to the overall success of the CHC development. Through community development a series of programs were also established to serve the target communities and demonstrate the abilities of the activists to manage government funds. In Tillsonburg, the CHC development never made it to potential provincial sponsors.

While the disruptive influence of urban renewal was not present, as was the case in both Toronto and Ottawa, ethnic minority groups still faced similar barriers to accessing local health services. This reflects the relationship between these groups and the state characterized by the bias of policy towards a health system that has favoured white middle-class consumers. Lacking the strong presence of Castells' conditions for mobilization, local activists undertook the development of social networks within and among the various ethnic communities to mobilize around an issue of collective consumption. Even though leadership was present in the ethnic communities, language was a barrier. Local activists from

outside the ethnic communities served to alleviate this barrier.

To broaden the supportive coalition, local activists networked with key political, administrative and community leaders. In this context, they were able to enlist the support of local corporate rationalists and provincial bureaucrats in developing the CHC. They also successfully developed a variety of programs supportive of the longer term goal of a "holistic" approach to health services delivery.

From the outset, local activists were interested in identifying the needs and problems of the target populations; making local service agencies more aware of these needs; developing a service delivery model sensitive to these needs; and establishing services to meet these needs. By adopting this pragmatic approach to development, local activists found good levels of support from corporate rationalists at the local and provincial levels. The conflict associated with ethnic and neighbourhood empowerment was largely absent in London because of the lack of cohesive ethnic communities. Thus local activists in London succeeded in establishing a CHC according to their original intentions.

The fourth independent variable (medical opposition) had a low value and neutral impact on the outcome of the London case because of the high value and positive relationship of the third independent variable (local corporate rationalists) enhanced the relationship of the second independent variable

with the dependent variable. Local activists were able to enhance their own capacities by tapping into the political and institutional resources available to local corporate rationalists through the University. The centre was also developed in an underserviced area and, therefore, did not disrupt existing patterns of medical practice.

Not unlike the London case, local activists in Tillsonburg were operating in a local political environment that was not supportive of community mobilization around issues of collective consumption. However, their efforts were confounded by the two additional conditions: the lack of a high value or positive relationship of the third independent variable (local corporate rationalists) and the high value and negative relationship of the fourth (medical opposition) to the second independent variable (local activists) and the dependent variable. There was no lead agency or a cadre of institutionally-based corporate rationalists to provide resources or moral support. Instead, local activists met with a wall of resistance from the medical community and the institutional network.

A further detriment to local activists in Tillsonburg was the lack of the disruptive tendencies of urban redevelopment or the need to defend the cultural identity of a defined geographic neighbourhood found in both Ottawa and Toronto. Lacking these galvanizing forces, Tillsonburg might still have succeeded if strong local leaders from the various ethnic

enclaves or local corporate rationalists in the institutional network had taken a lead role in the promoting the development. Again, this level of support was not present in the Tillsonburg case. Local activists were unable to forge a consensus either from the existing network of human-service providers or from community leaders.

This task was complicated because the human-service network was not confined to within the municipal boundaries of Tillsonburg, but involved two levels of municipal government and a variety of human services providers in several municipalities. Building a consensus in such a geographically decentralized and uncoordinated service network was impossible. The lack of a positive relationship among the appropriate independent variables ensured that attempts to develop a CHC in Tillsonburg would fail. Not even the influence of the intervening variable on the definition of health and the focus on target populations was enough to overcome the prevalence of the traditional bias in health services delivery in Tillsonburg.

PART THREE

CONCLUSIONS

Chapter VII

Community Health Centres and Structural Interests

1. Overview

Community health centres in Canada have developed as an outcome of the competition among structural interests in the health policy field for control of the system of delivery. As such, they have been designed and modified to reflect the concerns of the dominant, challenging and repressed interests.

The medical profession has been structurally dominant because of the traditional monopoly it held in the medical services market. As a means of entering the medical market without strong opposition from dominant interests, government structured the public economy to reinforce the position of the professional monopoly. As Alford would predict, in this environment physicians have not been required to mobilize to meet every localized challenge because the overriding institutional and policy arrangements are protective of their collective interests.

Despite this bias, the structuring of the system has also created an inherent weakness for the dominant interests. In Ontario, the creation of separate regulatory and lobbying bodies has institutionalized the split within the medical profession between corporate and entrepreneurial forces. While the Ontario College of Physicians and Surgeons works closely with the MOH in monitoring and disciplining the activities of

the profession, the Ontario Medical Association plays an adversarial policy-advocacy role in the protection of the profession's autonomy and pre-eminent market position. By focusing the majority of its organizational energy on collective action at the provincial and federal levels, the medical profession has left itself somewhat more vulnerable to attack at the local level.

While not immediately damaging to dominant interests, the entrance of government into the medical market place has challenged the traditional monopoly position of the medical profession. The original compromise necessary to move from an essentially private to a public market has been eroded by the related problems of cost efficiency and shifting demographics. These external pressures have forced the government to reconsider the underpinnings of the health policy framework upon which the system is based. This is reflected in efforts to rationalize the delivery of services by shifting the emphasis away from a hospital-centred curative approach to medicine to a more community-based preventive approach.

In an effort to address these requirements, government has adopted a corporate rationalist approach to providing health services. This systems approach is by its very nature antithetical to the central concerns of the dominant interests. Organized medicine has preferred the curative approach to medicine because of its reliance on the diagnostic skills of physicians and their ability to prescribe

therapeutic treatments. The provision of primary care under this approach has been based on the solo fee-for-service medical practitioner, who has traditionally maintained control over the determination of the price, volume and mix of services. Secondary care has been provided through hospitals, which traditionally have served as the clinical workshops for physicians.

Conversely, the community-based preventive approach to health care delivery relies less on the diagnostic skills of physicians and more on the skills of other health professionals such as nurses, nurse practitioners, midwives, community development workers and health educators. The provision of primary care is based on a multidisciplinary team of allied health professionals, of which the physician is only one component. The goal of this approach is to promote "wellness". In essence, this means, as much as is possible, keeping people healthy so they don't require secondary care.

By becoming the major source of revenue for the health care sector, government has counterbalanced the position of the medical profession as the monopoly provider of services and has effectively intervened in the doctor-patient relationship which is the foundation of the organization of medical practice. In effectively imposing bureaucratic norms and structures on the market place, government has disrupted the collegial aspects of medical professionalism. Informal decision-making has been gradually replaced by formalized

structures, controlled by corporate rationalists, which stretch from the federal to the local level. This tendency is unlikely to diminish in the future because the increased fragmentation of medical knowledge and the increased technical nature of decision making in a public economy will ensure a strong and continuing role for professional public sector managers, who control the requisite technical knowledge.

In its efforts to legitimate the public economy, government has enlisted the support of other corporate rationalists within the health sector, namely, the strategic minority leadership of physicians found in the provincial Colleges of Physicians and Surgeons and the medical schools. This important minority has been joined by another medical interest: those doctors who prefer to practice in a non fee-for-service setting.

The separation of the regulatory and collective bargaining functions of organized medicine has been institutionalized under the publicly financed health system and thus the strategic minority has found itself increasingly drawn into accommodative relationships with the state and increasingly at odds with the professional medical associations which represent the entrepreneurial majority of the profession.

Since the early 1970s, governments have exerted increasing influence over the determination of the price, volume and mix of services generated by physicians. The

strategic minority of physicians associated with the provincial Colleges and university medical schools have been willing to accept a diminution of entrepreneurial discretion as a means of safe-guarding collegial control over clinical discretion. As Tuohy notes:

> For these physicians, it is crucial to preserve medical control over the volume and mix as matters of clinical judgment but not as instruments of income generation. Indeed they appear to recognize that as long as the volume and mix are capable of being used as instruments of income generation under a fee-for-service regime, they are likely to attract the attention of governments seeking levers of cost control [1]

This implicit recognition has opened the door for the introduction of remunerative and organizational changes that threaten entrepreneurial autonomy.

The alliance between government and this strategic minority and the other more radical fragment of the medical community has left the professional association representing the entrepreneurial interests increasingly isolated. This isolation has been enhanced by the apparent ambiguity of the business community to the plight of the medical entrepreneurs.[2]

The other important challenging interest is the cadre of

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[1] Tuohy, "Medicine and the State in Canada: The Extra-Billing Issue in Perspective," 278.

[2] Tuohy, Policy and Politics in Canada: Institutionalized Ambivalence, 130, 157. Tuohy suggests that the insurance industry, which once held a major interest in the medical market and was an ally of organized medicine, has been organized out of the health market by government intervention.

public administrators, both within government and within the health care sector, that has played an increasingly important role as the health care technostructure has expanded under public health insurance. From the program managers within the government structure to th executive officers in hospitals, community-based agencies and regional planning agencies, administrative norms are now pervasive throughout the system.

As Sutherland and Fulton suggest:

> Professionalism is, by definition, a decentralized and individualized concept with emphasis on personal responsibility and control ... A bureaucracy is, by definition, centralized, systematized, regulated and supervised. Individuals within a hierarchical authority structure write rules and collect data to be certain the rules are obeyed. Individual decision-making takes place within the constraints laid down by the system.[3]

While the bureaucratization of the medical profession is not new, the source of control in the administrative hierarchy has been shifting. Prior to the entrance of government into the medical market, control was based on the "formal and informal sanctions of medical colleagues,"[4] exercised through professional associations and self-regulatory licensing bodies with authority delegated from the state. This control extended not only throughout the major institutions of the health sector, but also penetrated the government administrative structure.

Since entering the medical market place, government has

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[3] Sutherland and Fulton, Health Care in Canada, 217.

[4] Blishen, Doctors in Canada, 116.

revised the policy assumptions underlying the system, due to external financial and demographic pressures. Through the "logic of policy development in the health policy arena"[5] this re-evaluation of policy has led to the replacement of medical professionals in the government bureaucracy by administrative professionals concerned with cost control.

The rational basis of the challenge posed by this emergent coalition of interests to the entrepreneurial core of organized medicine is illustrated by the plethora of reports and studies generated by the academic community. The inability of physicians to continue to lay an exclusive claim to the expanding body of medical knowledge, has necessitated an increasingly rational organization of the division of labour.[6] This management of the health care system requires bureaucracy as a means of coordinating information gathering and resource allocation.

The combination of the expansion of medical knowledge and the increased capacity of challenging interests to generate information supportive of restructuring has left dominant interests in a weakened position. When the external pressures of economic and social change are added to the underlying logic of the challengers, the philosophy underlying the position of the dominant interests is further threatened.

Corporate rationalists have been joined by local

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[5] Tuohy, Policy and Politics in Canada, 116.

[6] Alford, Health Care Politics, 212.

activists representing those repressed interests which have not traditionally been served by the way in which the system is organized. For politicians, the basis of the alliance between repressed and challenging interests is the political legitimacy that repressed populations can lend to government efforts to restructure the system to better address the goal of cost control. In exchange for this legitimacy, repressed interests receive services that provide them with greater access to the health care system. Under the Conservative government, Larry Grossman attempted to forge a new alliance with the community-based sector. This strategy was later pursued by the liberal government as a means of promoting health reform and distributing patronage to ethnic minority communities.

For bureaucrats, the basis of the alliance is the desire to mobilize repressed interests around the issue of equitable access to services. This has contributed to the expansion of the CHC program, and its enhanced status in the thinking of government policy makers.

Community health centres represent one of the organizational changes introduced by governments that serves both challenging and repressed interests. They are an important part of the health system idealized by corporate rationalists. By organizing physicians as part of a non-hierarchical team of human-service workers, CHCs dislodge the physician from the traditional position of dominance over

other allied health workers. In employing physicians on salary, CHCs remove the physician's discretionary control over income. This also has the effect of eliminating the financial relationship between the volume and mix of services and income. By eliminating the economic incentive to vary the volume or mix of services, CHCs represent a direct challenge to the majority entrepreneurial strain of medical professionalism. By employing professional managers to coordinate their operations, CHCs challenge the physician's clinical discretion with bureaucratic authority. Finally, by making physicians subject to the decision making of lay boards of directors, CHCs invert the traditional doctor-patient power relationship.

For repressed interests, they have provided visible minorities with greater access to and control over health services. CHCs have provided local activists with a useful target for community mobilization efforts.

While all of these changes are subject to the personalities of the individuals involved with particular health centres, the symbolic importance of the governments' choice of CHCs as a policy option has not been lost on the representatives of the dominant interests. The doctors' strike in Saskatchewan; the creation of polyclinics in Quebec and HSOs in Ontario, and the intensive resistance from the local medical community in Sault Ste. Marie and Tillsonburg are indicative of the extent to which CHCs are viewed as a threat

by the medical profession to their professional autonomy and market position.

2. Case Studies

The case studies indicate the manner in which the competition among structural interests has affected the development of CHCs in Ontario. The main implications of the intervening, independent and dependent variables[7] are discussed below, beginning with the intervening variable. Chart 1 (page 321) provides a synopsis of the variables as they apply to the case studies.

Although South East Ottawa occurred during the later period, the intervening variable exhibited a low value. This appears to be attributable to the high value of Independent Variable 1 (Local Political Environment) and the medium to high value of Independent Variable 3 (Local Corporate Rationalists) across the Ottawa cases. In turn, this seems to have a positive relationship with Independent Variable 2 (Ability of Local Activists). The most marked contrast between the two time periods is seen in the Toronto case studies. In the earlier South Riverdale case, Independent Variable 3 (local corporate rationalists) had a low value and a negative relationship with both Independent Variable 2 (local

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[7] Where one independent variable affects another, the variable being acted upon becomes dependent in that particular relationship.

TABLE 1

The Development of CHCs in Ontario: Summary of Variables

		Ottawa			Toronto		Southwestern Ontario	
		Sandy Hill	Centretown	South East Ottawa	South Riverdale	Access Alliance	London	Tillsonburg
Independent Variables	1 Local Political Environment	High (P)	High (P)	High (P)	High (N)	High ( )	Low (Neut)	Low (Neut)
	2 Local Activists	High (P)	Medium (P)	High (P)	Medium (P)	Medium (P)	High (P)	Medium (Neut)
	3 Local Corporate Rationalists	High (P)	Medium (P)	High (P)	Low (Neut)	High (P)	High (P)	Low (Neut)
	4 Medical Professionals	Low (Neut)	Medium (N)	Low (Neut)	Medium (N)	Low (Neut)	Low (Neut)	High (N)
	5 Provincial Bureaucrats	High (P)	High (N)	Medium (N)	High (P)	High (N)	Medium (P)	Low (Neut)
Intervening Variable	Time Period	Earlier	Earlier	Later	Earlier	Later	Later	Later
Dependent Variable	Outcome	1	2	1	2	2	1	3

Legend

Low - Low value

Medium - Medium Value

High - High Value

(P) - Positive Relationship

(N) - Negative Relationship

(Neut) - Neutral Relationship

Outcome 1: Establishment of a CHC based on original ideological and organizational intentions.

Outcome 2: Establishment of a CHC in which original ideological intentions are not maintained intact.

Outcome 3: Failure to establish a CHC

activists) and the Dependent Variable. Local activists in South Riverdale were unable to gain the support of local corporate rationalists. In the later case, Independent Variable 3 (Local Corporate Rationalists) had a high value and positive effect in relation to Independent Variable 2 (local activists) and the Dependent Variable. Local activists relied heavily on the resources of the Toronto Department of Public Health. This stemmed from the effect of the Intervening Variable (Time Period) on the evolution of municipal Public Health policy over the preceding decade. Where previously the municipal government had shown a reluctance to openly support community mobilization around issues of collective consumption, by the mid to late 1980s, this was the official policy of the Department of Public Health.

Changes at the federal and provincial levels have also occurred between the two time periods. One observable trend has been the gradual decentralization of health policy. During the 1970s the federal government moved to divest itself of responsibilities for financing the delivery of health services. The provinces assumed the additional financial burden in exchange for increased flexibility in how the money is spent. While the federal government continues to have an impact on the national health policy framework, the provinces are now largely in control of how health services are organized and delivered. As well, decentralization has occurred within provinces. The development of health planning

advisory bodies in Ontario and Quebec during the 1970s decentralized some aspects of health planning to the local level.

During the late 1980s and early 1990s, most provinces had moved to decentralize health planning in a similar fashion. A number of provinces are now in the process of expanding the roles of these regional planning bodies to include decisions about the allocation of resources within regional\district boundaries. Some of these bodies will be locally elected.

As was the case with the federal government during the 1970s, the provincial governments appear to be decentralizing the political responsibility for resource allocation decisions to the regional level. At the same time they remain committed to maintaining control of the overarching policy framework and total expenditures in the public health sector. Over the course of the two time periods, then, health policy has pushed its way further into the urban political arena.

Changes to provincial health policy between the two periods have also affected the outcome of CHC development. During the 1970s, the provincial government continued to embrace a limited definition of health. Both levels of government were preoccupied with the increasing costs of health services. Community health centres were promoted at the federal level as one means of providing primary care in a cost efficient manner. In the province of Ontario, CHCs were developed on an experimental basis, but faced considerable

difficulty because they could not be readily justified in terms of economic efficiency. The MOH spent the latter half of the decade addressing criticisms from the provincial auditor and the legislature. What the MOH had discovered was that CHCs could not be accurately measured in terms of cost efficiency because of the special circumstances under which they were established. This situation was enhanced by the lack of a Minister to act as a policy advocate for health centres. Once the critics were satisfied that some sort of regular effort was being made to monitor the expenditures on CHCs and HSOs, then they could be adopted as a regular program.

Under these circumstances, local activists wishing to develop CHCs according to a broader definition could not rely on the province to fund the provision of an expanded range of services. Instead they relied on accessing the additional resources through the local political and institutional network. During the later period the adoption of an expanded definition of health at the provincial level has allowed local activists to provide a broader range of services with Ministry funding. Other provincial government policies concerning multiculturalism, which have developed during the later period, have also had an effect on the financial and political resources available to local activists. Once-marginalized populations are now gaining a political and institutional voice in the health policy community. The South East Ottawa, Access Alliance and London cases provide evidence of this

trend.

For politicians this has meant a new means of distributing patronage and gaining support for policy change. For bureaucrats this has meant the development of new programs to serve these newly legitimated participants in the policy community. For local activists, this has meant increased access to resources for community mobilization and the creation of jobs for themselves and the repressed interests they represent.

During the 1980s, government health policy embraced a broader definition of health. Under this definition CHCs were recognized as a legitimate approach to service delivery. One of the political strategies behind the adoption of CHCs as a regular program was an attempt to convince local activists that the NDP was not the only party to promote repressed interests.

Both in terms of the pace at which they have been developed and the design of the program, CHCs are products of the competition between structural interests within the political process. Their long struggle to become an established program indicates the bias of the system in favour of dominant interests. The uncertain administrative environment in which they operate, indicates the effects of the political process. However, CHCs have been beneficiaries of the political dynamics of the policy community. With the assistance of some Ministers of Health and government

administrators, they have strengthened their policy network and have found a constituency within government.[8]

Community health centres became part of a larger political strategy to promote equity in government programs. They also fit well with the continuing corporate rationalist agenda for reform of the health-care delivery system. That the government was still concerned with the reform agenda was well indicated by its public confrontation with the medical profession over the issue of extra-billing and the resulting majority election victory. Not unlike Mackenzie King's introduction of social welfare programs, the Ontario Liberals were able to steal the agenda from the political left.

The urban political arena was also affected by the intervening variable. In the Ottawa cases, we noted what seems to be the positive effect that the Local Political Environment (Independent Variable 1) had on Independent Variable 2 (Local Activists). During the decade, municipal policies were developed to support community mobilization around the preservation of neighbourhoods and the provision of services. During the course of the decade, this moved from a political commitment to tangible policies and institutional structures. The Social Services Department of the Regional Municipality emerged as a lead agency in the promotion of community mobilization for collective consumption. The tangible outcome

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[8] Coleman and Skogstad, Policy Communities and Public Policy, 26.

was the development of a coordinated network of community service centres providing an array of health and social services to repressed interests.

Despite the presence of similar conditions (urban renewal and neighbourhood preservation) in Toronto, the municipal response was ambiguous and uncertain. The focus on land-use issues overshadowed efforts to organize for collective consumption. Policies focusing on the mobilization of repressed interests for collective consumption did not begin to emerge until the end of the decade. These policies were not translated into tangible outputs until the mid-1980s. Unlike Ottawa, where the local political environment was very conducive to mobilization around collective consumption issues, Toronto did not reach this stage until the late 1980s. Thus, in contrasting the South Riverdale and Access Alliance cases, we see the effect of the Intervening Variable on Independent Variable 1 (Local Political Environment), Independent Variable 3 (Local Corporate Rationalists) and Independent Variable 2 (Local Activists).

The difference between the Ottawa and Toronto can be partially explained by the moderate to high value of local corporate rationalists (Independent Variable 3) in the municipal government across the Ottawa cases and the low value in the earlier Toronto case. As the Toronto cases indicate, over time, local corporate rationalists have gained a foothold in municipal structures. A tangible manifestation of this

development has been the establishment of the Public Health Department as the lead agency in the promotion of community mobilization for collective consumption.

The cases also indicate the conditions that seem to influence the degree of hierarchy and the sharing of functions across categories of personnel. When the original ideological intentions of local activists called for the provision of a broad range of services, this has been most likely to occur when local corporate rationalists (Independent Variable 3) had a high positive value in relation to the outcome. This was the case with South East Ottawa, Access Alliance and London. This has been characterized by the development at the local and provincial levels of policies and institutional mechanisms that favour the coordination and integration of a broad range of services. The trade-off for local activists seems to be an increased propensity for bureaucratic organization characteristic of those health centres providing a broader range of services. As the influence of challenging interests on health policy has increased, so to has the extent to which existing and emerging organizational forms reflect this change. The time required to develop a CHC also reflects the effect that the dominant or challenging interests have on the cases. Delay in the developmental process of individual CHCs appears to occur where either Independent Variable 3 (Local Corporate Rationalists) or 4 (Medical Professionals) have a medium or high value and a negative relationship to

Independent Variable 2 and the Dependent Variable.

Independent Variable 1 (Local Political Environment) appears to have a mixed effect on the development of health centres. In the Ottawa cases, a political environment favouring the mobilization of neighbourhoods around land-use and collective consumption issues provided a fruitful urban policy arena for local activists seeking to develop community health centres. Thus in the Ottawa cases, Independent Variable 1 (Local Political Environment) seems to have a high value and a positive relationship with Independent Variable 2 (Ability of Local Activists).

However, in the Toronto cases, the value of Independent Variable 1 appears constant in the two cases, but its relationship to Independent Variable 2 and the Dependent Variable is not. In the case of South Riverdale, the Local Political Environment (Independent Variable 1) was characterized by a competition between municipal reformers and traditionalists.

Unlike, Ottawa, during the late 1960s and early 1970s, citizens' organizations were not well received by local politicians. They were viewed more as a threat to the power base of some aldermen then as partners in the governance of the municipality.[9] As a result, the emergence of municipal policies supportive of collective consumption activities

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[9] Larson, "Political Participation at the Municipal Level," 96.

occurred at a slower pace than in Ottawa. Thus during the first period, the Local Political Environment (Independent Variable 1) appeared to have a high value, but a negative relationship with Independent Variable 2 (Ability of Local Activists) and the Dependent Variable in the case of South Riverdale. This is a product of both the failure of the mass-based community organizing effort at the neighbourhood level and the wavering support of municipal government for community mobilization efforts. Although, not clearly evident from the cases, we suspect that Independent Variable 1 (Local Political Environment) also had a negative effect on Independent Variable 3 (Local Corporate Rationalists) in the South Riverdale case.

Contrast this with the Access Alliance case during the later period, when the City had developed a public health policy favouring the mobilization of neighbourhoods around collective consumption issues. In the Access Alliance case, then, Independent Variable 1 (Local Political Environment) seemed to have a high value and a positive relationship with Independent Variable 2 (Local Activists).

In summary, the positive effect of the local political environment is not constant in its effect on the Dependent Variable across the cases. In the Centretown and Access Alliance cases the high value of Independent Variable 1 (Local Political Environment) and positive relationship with Independent Variable 2 did not guarantee that the Dependent

Variable is characterized by Outcome 1 (Establishment of a CHC based on original ideological and organizational intentions).

In the London case, the Local Political Environment (Independent Variable 1) had a low value and seemed to have a neutral effect on both Independent Variable 1 and the Dependent Variable. The narrower focus of municipal politics in London on economic development has meant that local politicians have not developed policies to foster the mobilization for collective consumption, as is the case in Ottawa and Toronto. Local activists seeking to develop a CHC have operated in the larger policy arena of the local state, in which the municipal government is only one of a variety of governmental and non-governmental actors. Local corporate rationalists are part of this larger local policy arena. It is here that the link between Local Activists (Independent Variable 1), Local Corporate Rationalists (Independent Variable 3) and Provincial Bureaucrats (Independent Variable 5) is most likely to occur.

What seems to be of greater importance to the Dependent Variable with Outcome 1 as its major attribute is the combination of a high values and for both Independent Variable 2 (Ability of Local Activists), and Independent Variable 3 (Local Corporate Rationalists), and positive relationships among the three variables. In the cases of Sandy Hill, South East Ottawa and London, where the Dependent Variable was defined by Outcome 1 (Establishment of a CHC based on original

organizational and ideological intentions), Local Activists (Independent Variable 2) developed alliances with Local Corporate Rationalists (Independent Variable 3). In their efforts to establish and maintain a broad supportive consensus, local activists relied on the political and institutional resources of local corporate rationalists. Therefore, in these cases Independent Variable 3 (Local Corporate Rationalists) would seem to have a positive correlation with Independent Variable 2 (Local Activists).

In two of the three cases (Centretown and Access Alliance) where the Dependent Variable is defined by Outcome 2 (Establishment of a CHC in which the original ideological and organizational intentions are not maintained intact), a similar correlation appears to have occurred between Independent Variables 3 (local corporate rationalists) and Independent Variable 2 (local activists) within the urban arena. However, the values of the two variables in these cases are less than those the cases of Sandy Hill, Southeast Ottawa and London. As well, in both the Centretown and Access Alliance cases Independent Variable 5 (Provincial Bureaucrats) seem to have a high negative value. The high negative value of Independent Variable 5 appears to have a negative effect on Independent Variable 2 (Local Activists). In the third case (South Riverdale), the low value of Independent Variable 3 appears to have a negative effect on Independent Variable 2 (Local Activists). The void left by the lack of high value

for Independent Variable 3 (local corporate rationalists) appears to be filled by the high value of Independent Variable 5 (provincial bureaucrats). In the London case Independent Variable 5 (Provincial Bureaucrats) has a moderate value and appears to have a positive effect on Independent Variable 2 and the Dependent Variable. Provincial bureaucrats from a variety of Ministries were receptive and supportive of the CHC model proposed by local activists.

In the South Riverdale case, Independent Variable 5 (Provincial Bureaucrats) seems to have a positive effect on Independent Variable 2 (Local Activists). This took the form of the guarantee of funding support to overcome the procedural resistance associated with Independent Variable 1 (Local Political Environment). In turn, Independent Variable 5 (Bureaucratic Intervention) appeared to have a negative effect on the medical opposition as a major attribute of Independent Variable 4 (medical professionals). Related to this observation, is the high value of Independent Variable 4 and its apparently negative effect on Independent Variable 2 (Local Activists) and the Dependent Variable, in the Tillsonburg case study. All of the other independent variables had a low to medium value, and a neutral relationship with the Dependent Variable. As we would expect, the absence of a strong value and a positive relationship with the Dependent Variable for any of the other independent variables, especially 1, 2 and 3, resulted in an Outcome 3 (Failure to

establish a CHC) in the Tillsonburg case. Contrast this with the relationship of these same independent variables in the three cases where Outcome 1 (Establishment of a CHC based on the original ideological and organizational intentions) occurred. In these cases, Independent Variables 2 (Local Activists) and 3 (Local Corporate Rationalists) had high values and Independent Variable 4 (Medical Professionals) had a low value.

This confirms the hypothesis stated at the outset that the alliance between repressed and challenging interests may be the key to the successful establishment of a community health centre. The alliance is most likely to occur where the existing institutional network is receptive to the activities of local activists. From this we can conclude that whether the alliance is between local activists and local corporate rationalists, or local activists and provincial corporate rationalists, the relationship is consistently important across the case studies.

3. The Importance of the Urban Context

The continuing trend toward decentralization in health care decision making suggests that in the future the urban context will have an increased impact on health care politics. As the case studies indicate, over time municipal governments have developed policies supporting neighbourhood mobilization around collective consumption issues, such as access to health

services. At the same time, the provinces are gradually decentralizing allocative decision-making to newly created structures at the local level. To the extent that these structures are accountable to the local level, or at least relatively independent of provincial control, they are becoming part of the urban political arena. In any event the regionalization of allocative decision making has placed an increased focus on decisions at the local level.

As Castells has predicted, the environment in major urban centres has been conducive to community mobilization due to the following trends: the impact of urban renewal and demographic immigration; the concentration of a variety of repressed interests and the agencies that service them; and the emergence of strong leadership. These trends are present in one form or another throughout the case studies. Urban renewal was predominant during the earlier period. The development of social networks among repressed interests and their service agencies, and the leadership this has spawned has been predominant during the second period. The concentration of repressed interests in major urban centres has enhanced their political significance.

The related themes of neighbourhood preservation, political mobilization in relation to the state and collective consumption have also been present in varying forms across the case studies. These trends have been reinforced by the presence in major urban centres of well developed

institutional networks, which tend to be repositories for corporate rationalists. As Wievel and Hunter have noted:

> the existence of a dense interorganizational network ... [has] meant that numerous organizational resources, including money, potential members, skilled leaders, and other facilities, existed that could be brought together in a new way to form a new organization.[10]

By forging local coalitions encompassing academic corporate rationalists, human-service providers and repressed interests, local activists have gained sufficient legitimacy with corporate rationalists in government to develop new services. Where this coalition of interests is sufficiently present, both in terms of numbers and strategic organizational placement, the dominant interests are literally overwhelmed.

Over time, federal and provincial health policy has evolved from focusing on the medical and economic aspects of health services provision alone to emphasizing the broader determinants of health. This shift in emphasis has clearly identified quality of life issues such as adequate housing, education, physical and social environments and empowerment of the individual that are part of the urban political arena. At the local level, these issues are subject to community mobilization for collective consumption.

In rural areas, where the institutional network is likely to be significantly less developed and less inclined to reform

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[10] Wim Wievel and Albert Hunter, "The Interorganizational Network as a Resource: A Comparative Case Study of Organizational Genesis," Administrative Science Quarterly, 30, 1985, 488.

strategies, dominant interests have been more effective in preventing local innovation in service delivery affecting their market position. As Alford recognized about small towns in the United States, physicians still control the health system through the county medical societies. This situation is also a characteristic of health care in Canada. Small-town hospital administrators are more isolated than their counterparts in large urban centres and are, therefore, more susceptible to medical control. Since small towns are unlikely to have more than one hospital, dissident physicians are kept in check since they have no alternative, other than relocating to another area.[11] Such was the case in Tillsonburg where the medically dominated institutional network opposed the development of a CHC and the community leaders representing the ethnic communities to be served by the proposed new service opposed the idea as well. Unlike the larger municipalities where medical power is more fragmented, in Tillsonburg power tends to be fairly ideologically homogeneous and concentrated. Under such conditions innovation is less likely to occur.

Government efforts in Ontario now appear to be focused on restructuring the overall process of health- care resource management. If it is successful in establishing a regionalized management structure, the relative strength of the dominant interests will be diminished in relationship to challenging

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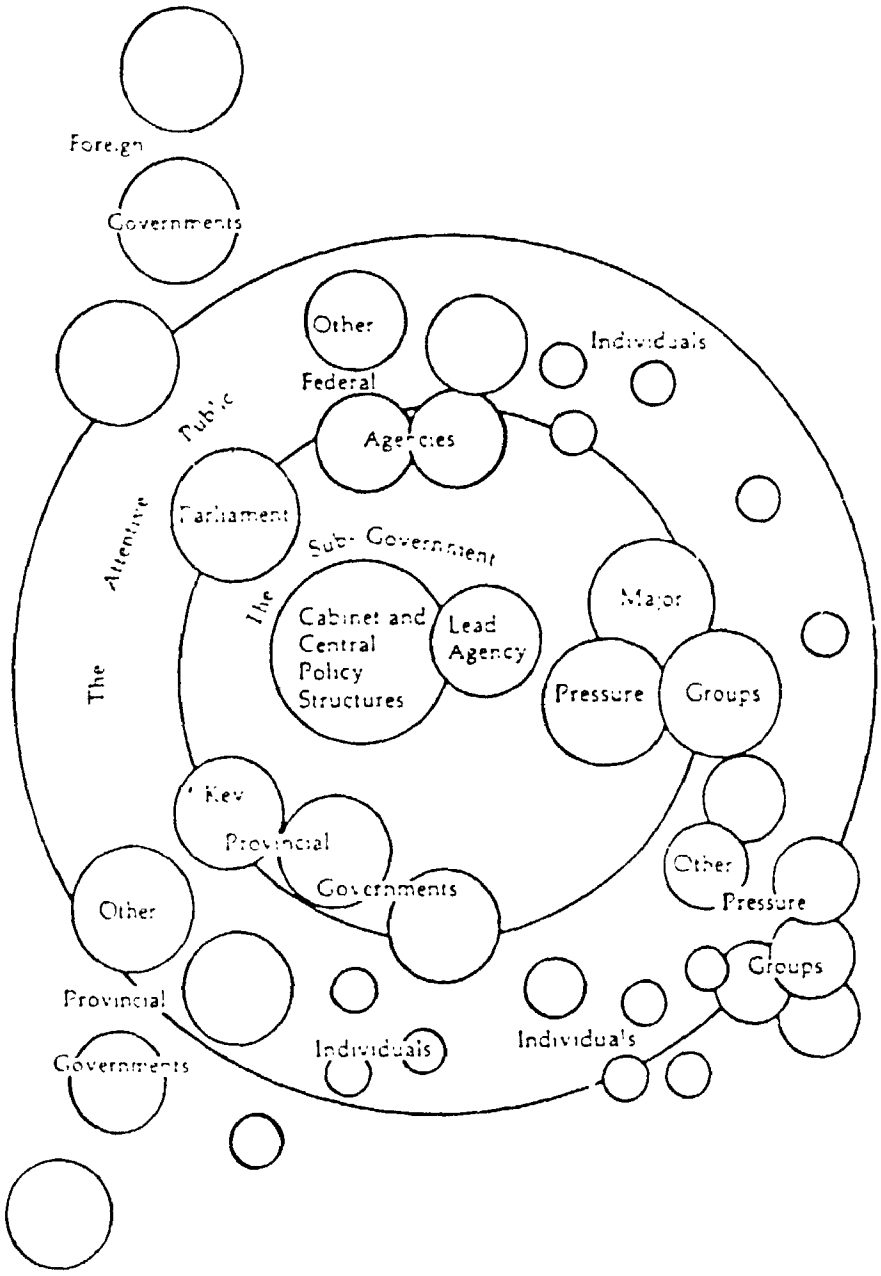
[11] Alford, Health Care Politics, 213.

interests. The regionalization of the health system will further bureaucratize the environment in which both dominant and repressed interests must operate and push the competition between structural interests to the local level. This will require a restructuring of the representative mechanisms of dominant interests to place less emphasis on the provincial policy arena and more emphasis on localities.

Appendix I

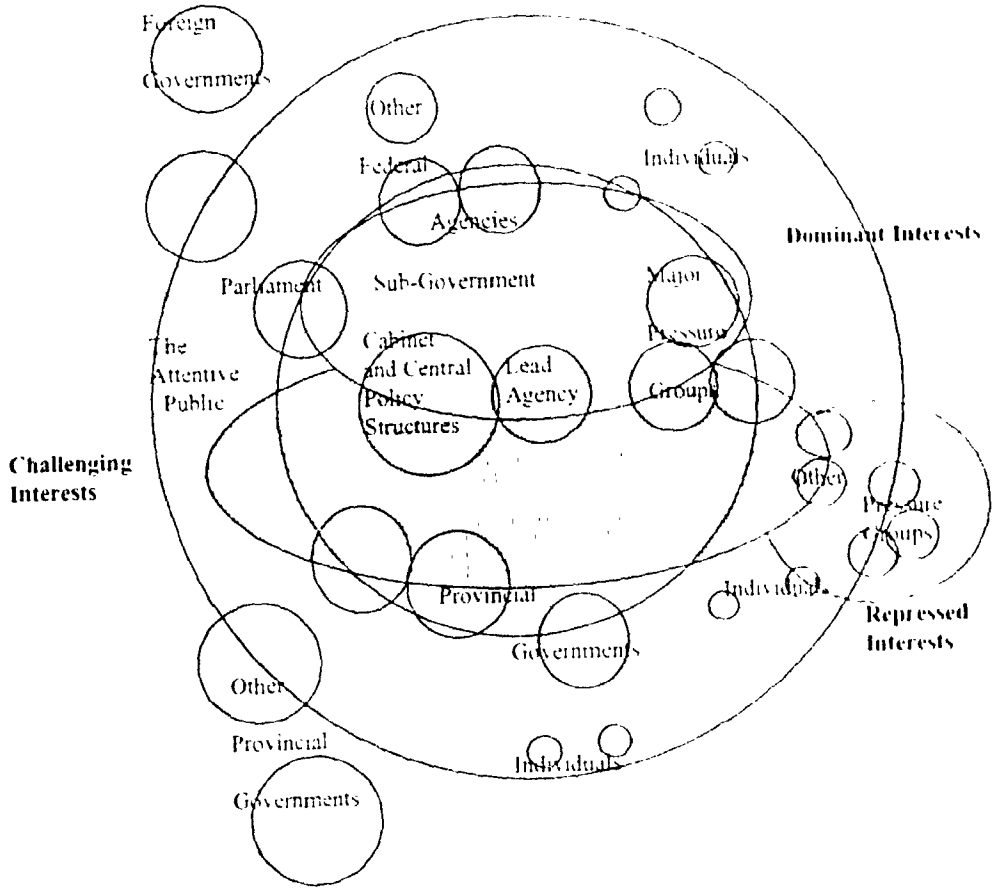
The Policy Community



Source: A. Paul Pross, Group Politics and Public Policy, Toronto: Oxford University Press, 1986.

Appendix II

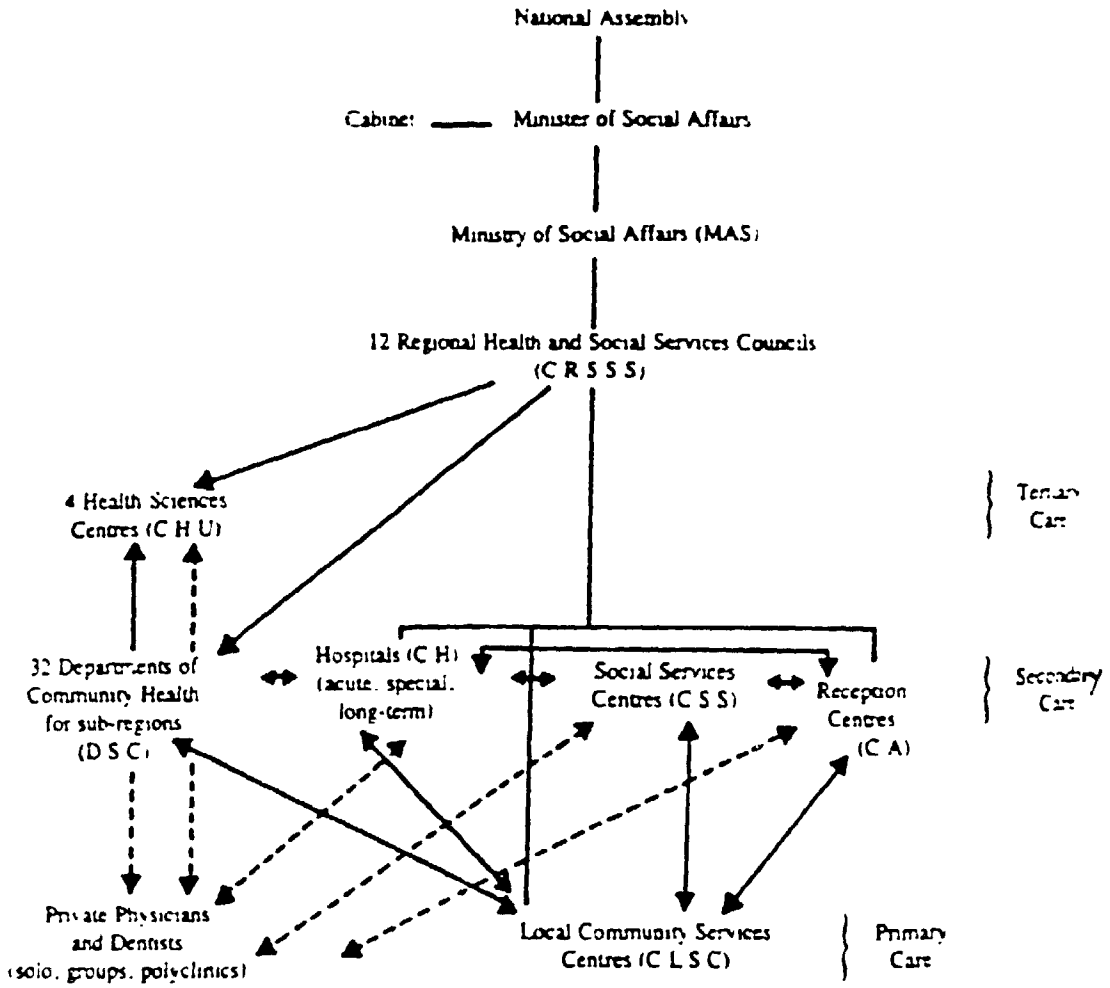
The Policy Community: An Alternative View



Source: Paul Sabatier, "An advocacy coalition framework of policy change and the role of policy-oriented learning therein", Policy Sciences, 21, 2, 1988

Appendix III

The Quebec Model



NOTES Solid lines represent the interrelations among the public components of the system. The broken lines represent the interrelations between the majority of doctors and dentists, who are in forms of private practice, and the components of the public system. It should be noted that they receive payment through the public plan although they function as independent practitioners.

Source: John E.F. Hastings and Eugene Vayda, "Health Services Organization and Delivery: Promise and Reality," in Robert G. Evans and Greg L. Stoddart, eds., Medicare at Maturity: Achievements, Lessons and Challenges, (Calgary: University of Calgary Press, 1986), 344.

Appendix IV

Distribution of Active Physicians Responding to the 1990 PRQ by Method of Remuneration, 1990

Region	Method of Remuneration								
	Other Models	95-100% FFS	95-100% Salary	95-100% Sess	95-100% Cap	50-94% FFS	50-94% Salary	50-94% Sess	50-94% Cap
	Count	Count	Count	Count	Count	Count	Count	Count	Count
East	85	1676	330	37	na	471	210	19	na
Quebec	378	4597	616	110	18	1448	507	124	36
Ontario	419	8477	976	51	107	2241	675	36	150
Prairies	151	3290	518	59	5	863	332	42	na
BC/Terr	148	3170	284	97	na	719	155	69	na
Total	1181	21210	2724	365	134	5742	1879	290	194

Source: 1990 Physician Resource Questionnaire
Department of Health Policy and Economics
Canadian Medical Association

Appendix V

Number of Community Health Centres by Province

Province	Number of Centres
Newfoundland	0
Nova Scotia	0
New Brunswick	1
Prince Edward Island	0
Quebec	158
Ontario	49
Saskatchewan	5
Manitoba	11
Alberta	3
British Columbia	9

Source: These numbers are based on best guesses by Ministry of Health officials in each province. The one exception is Ontario where information was obtained from both the Ministry and the Ontario Association of Community Health Centres. Some provinces have health clinics, but they did not meet the criteria of the definition used in this study.

Appendix VI

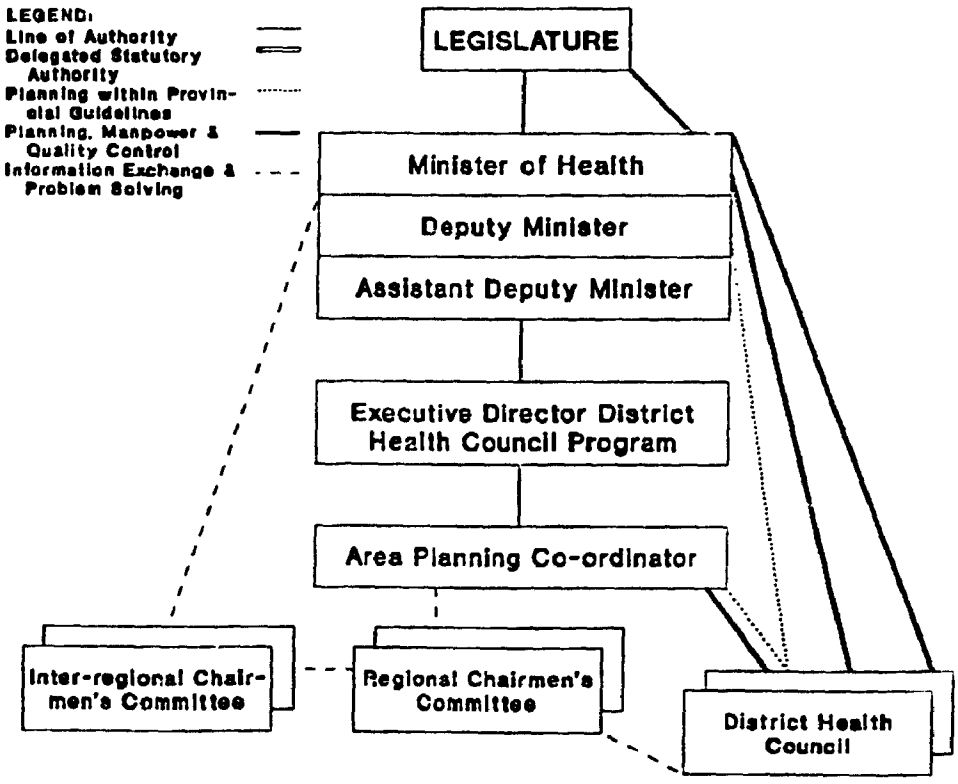
Number of Non-Fee-For Service Physicians Funded Through the Ministry of Health	
Program/Group	**Number**
Alternate Payment Program	800
Community Health Centre Program	100
Health Service Organization Program	422
Independent Health Facilities	5
Alternative Funding Unit	138
Public Health	74
Psychiatric Hospitals	207 F.T. + 11 P.T.
Laboratory (Private/Hospital)	289
Provider Services Branch	8
Cancer Treatment Centre (GPs, Gyn., Oncologists)	63
Health & Welfare Canada	8 F.T. + 3 P.T.
Workers' Compensation Board	75 F.T. + 2 P.T.
Total	2197

Source: Ontario Ministry of Health, Health and Human Resources Unit, 1993

Note: Numbers are approximate, and some physicians may also bill OHIP. Methods of payment include salary, capitation, sessional and GFTs).

Appendix VII

District Health Council Structure in Ontario



Appendix VIII

Community Health Centres in Ontario

Access Alliance Multicultural
Community Health Centre
509 College Street
Toronto, Ontario. M6G 1A8
Administrator: John Paterson (324-9697)

Anishnawbe Health Toronto
761 Queen Street West
Toronto, Ontario. M6J 1G1
Executive Director: Bill Lee (360-0486)

Barrie Community Health Centre
80 Bradford Street, Unit 25B
Barrie, Ontario L4N 6S7
Executive Coordinator: Clinton Tyler (734-9690)

Bernard Betel Centre for Creative Living
1003 Steeles Avenue West
North York, Ontario. M2R 3T6
Executive Director: Ed Segalowitz (225-2112)

Black Creek Community Health Centre
1181 Finch Avenue West, Unit 24
North York, Ontario. M3J 2V8
Executive Director: Cary Milner (739-8529)

Centre de sante communautaire de l'Estric (Ontario)
348 chemin Montreal, local 17
Cornwall, Ontario. K6H 1B4

Centre Medico-Sociale Communautaire
22 College Street, Main Floor
Toronto, Ontario. M5G 1K3
Executive Director: Wesley Romulus (922-2672)

Centre for Women's Health
c/o Jane Hill NCR
117 Eglinton Avenue East
Toronto, Ontario. M4P 1J1

Centretown Community Health Centre
340 MacLaren Street
Ottawa, Ontario. K2P 0M6
Executive Director: Karen Stotsky (563-4771)

Dalhousie Health and Community Services
755 Somerset Street West
Ottawa, Ontario. K1R 6R1
Executive Director: Jack McCarthy (238-8210)

Davenport-Perth Neighborhood Centre
1900 Davenport Road
Toronto, Ontario. M6N 1B7
Executive Director: Michael Barkley (656-8025)

Dr. Frank O'Leary Community Health Centre
c/o 437 Parkside Drive
Toronto, Ontario. M6R 2Z8

Lakeshore Area Multi-Service Project Inc. (LAMP)
185 - 5th Street
Toronto, Ontario. M8V 2Z5
Executive Director: Mr. Joseph Leonard (252-6471)

Lawrence Heights Community Health Centre
3 Replin Road
Toronto, Ontario. M6A 2M8

London Intercommunity Health Centre
659 Dundas Street East
London, Ontario. N5W 2Z1
Executive Director: Shanthi Radcliffe (660-0874)

Mary Berglund Family Clinic
202 Beaver Street
P.O. Box 141
Merrickville, Ontario. K0G 1N0
Office Manager: Ms. Beverly Ogilvie (269-3400)

North Hamilton Community Health Centre
554 John Street North
Hamilton, Ontario. L8L 4S1
Administrator: Ms. Joanne Doyle (523-6611)

North Kingston Community Health Centre
400 Elliot Street
Kingston, Ontario. K7K 2R1
Executive Director: Charlotte Rosenbaum (542-2813)

Parkdale Community Health Centre
1257 Queen Street West
Toronto, Ontario. M6K 1L5
Coodinator: Ms. Almerinda Rebelo (537-2455)

Pinecrest-Queensway Community Service Centre Inc.
203-1365 Richmond Road
Ottawa, Ontario. K2B 6R7
Coordinator: Ms. Sandra Mark (820-4922)

Regent Park Community Health Centre
19 Belshaw Place
Toronto, Ontario. M5A 3H6
Administrator: Ms. Sheila Cram (364-2261)

Sandy Hill Community Health Centre
250 Somerset Street East
Ottawa, Ontario. K1N 6V6
Executive Coordinator: Ms. Dennise Albrecht (232-2613)

Sandwich Health Centre
749 Felix Avenue
Windsor, Ontario. N9C 3K9
Executive Director: Isabella Cimolino (258-6002)

South-East Ottawa Community Resources Centre
1480 Heron Road
Ottawa, Ontario. K1V 6A5
Coordinator: David Hole (737-5115)

South Oshawa Community Development Project
777 Simcoe Street South
Oshawa, Ontario. L1G 4K5
Director: Mr Wayne Oake (723-0036)

South Riverdale Community Health Centre
126 Pape Avenue
Toronto, Ontario. M4M 2V8
Administrator: Ms. Elizabeth Peltes (461-2494)

Teen Health Centre-Windsor/Essex
30 Tuscarora Street
Windsor, Ontario. N9Y 6Y6
Executive Director: Dr. Ken Jaggs (253-8481)

West Central Community Health Centres
64 Augusta Avenue
Toronto, Ontario. M5T 2L1
Executive Director: Walter Weary (364-4107)

Woolwich Community Health Centre
35 King Street, Box 419
St. Jacobs, Ontario. N0B 2N0
Coordinator: Clint Rohr (664-3794)

York Community Services
1651 Keele Street
Toronto, Ontario. M6M 3W2
Executive Director: Ms. Joan Milling (653-5400)

Source: Ontario Ministry of Health, CHC Program, February 14, 1990.

Appendix IX

Exhibit A

CITY: OTTAWA

COMMUNITY HEALTH CENTRES

CENTRE	SPONSOR/ORGAN. STRUCTURE	TOTAL POPULATION SERVED FEBRUARY 1986	PROGRAMS	FUNDING	STAFF	AGENCY RELATIONSHIPS
SANDY HILL COMMUNITY HEALTH CENTRE 250 Somerset Street West Ottawa, Ont. Est. 1975	Sandy Hill Comm. Development Corp an incorporated non-profit organ. Operated by a Board of Trustees, 14 elected by the membership, and one staff representative	Roster: 5,870 Geographic Area: St. George Ward (includes Sandy Hill and Ottawa East) 50% of clients from outside area	Primary Health Care - Medical - Health Education - Community Education - Prevention and Health Maintenance - Outreach	MOH - Program-Based Budget (83%) Federal Grants (15%)	3 MDs, 2 NPs, 2 RN's	Agency: Informal Soc. Services, community, justice, ARF, contractual - Soc. Serv. Dept., Catholic Family Serv.
		Special Needs: - highly transient - 20% require social services	Non-medical Social Services, Seniors. Information Centre and home support, work with transients and single parents		2 P-Time S.W.	Hospital: 1 MD has hospital privileges University: Informal contracts and provide placements for students DHC: Make regular presentations and keep informed (Ottawa-Carleton DHC)
			Administration		1 Co-ordinator 3 Support Staff	

Appendix IX

Exhibit B

CITY: OTTAWA

CENTRE	SPONSOR/ORGAN. STRUCTURE	TOTAL POPULATION SERVED FEBRUARY 1986	PROGRAMS	FUNDING	STAFF	AGENCY RELATIONSHIPS
CENTRETOWN COMMUNITY HEALTH CENTRE 100 Argyle St. Ottawa, Ont. Established: 1969 as Ottawa Street Clinic - a "hassle-free" drug drop-in crises intervention Centre Multi-service Centre	Community Sponsord Operated by Board of Directors consisting of 15 members of which 2 are staff; 2 from community agencies in Centretown, and 11 community members of the Centre elected annually	Roster: 775 Population served: Not identifed geographically; programs serve different areas ranging from central Ottawa-Carleton to Centretown itself	Primary Health Care medical services with emphasis on prevention and promotion	MOH - Program-based (58%)	3 MD/s, 1NP, 3 RNs, 1 Admin	Referral 21 health social service, legal recreation, etc.
			Community Service Unit	Regional Municipality	1 PHN, 1SW 1 Teacher Homemaker	Planning and Policy relationships- 24 agencies, councils, committees etc.
			Adult Protective Services Infant Stim. Program	COMSOC (28%)	1 SW 4 Child Dev. Workers	Hospital: No formal relationship with an area hospital
			Legal Advice Ser.		1 lawyer	University: Provide field placements
			Lifestyle Enrichment for Senior Citizens	Municipality and City	2 Counsellors	DEC: Presented briefs to public, requests (Ottawa-Carleton DEC
			Healthstyles	Grant (excluded from above %)	4 Ed., 2 Adm. 2 Eval.	
			Admin/Support		7 Admin/ Support	

Appendix IX

Exhibit C

City: Ottawa

CENTRE	SPONSOR/BOARD STRUCTURE	TOTAL POPULATION SERVED	PROGRAMS	FUNDING	STAFF	AGENCY RELATIONSHIPS
SOUTH-EAST OTTAWA 1460 Heron Road Ottawa, Ont K1V 6A5 Est 1971 Health services since 1988 Multiservice Centre	Community-Sponsored Incorporated Community non-profit charitable organization. Operated by a Board of Directors, 22 elected by the membership. Membership open to all residents and workers aged 18+ in S E Ottawa.	Roster: 2,415 Geographic Area: Municipal wards of Billings, Alta Vista and Canterbury. Catchment Area pop. 60,000 Identified pop. poverty, socially-assisted housing seniors, refugees/ immigrants -high requirement for social services	Primary Health - Medical - Health Ed \Prom - Community Ed. - Outreach - Prevention - Maintenance Social Services - Crisis Interv. - Information - Referral - Counselling - Emergency Support (food, clothing) - Home Support - Home Management - Employment Support Counselling Seniors' Services - Seniors' Home Support - Friendly Visiting - Volunteer Transportation - Paid Worker Program - Foot Care - Respite Care Better Beginnings Better Futures - Primary prevention for infants/preschoolers - Playground - Parent education - Well Baby/child clinics - Family Visitors	MOH (50%) MCASS (25%) Regional Municipality of Ottawa Carleton (13%) Federal Gov't Grants (12%) City of Ottawa (2%) Other (2%)	2.5 MDs 1 NP 2 RNs 4 Social Workers .2 Nutritionist .6 Chiropodist 2 Health Educators 1 Community Developer 3 Seniors Home Support Workers 2 Home Management Counsellors 1 Employment Services Counsellor 11 Admin \Support staff	Liaison and partnership with a wide range of local human service agencies. Coalition of CHCs of Ottawa-Carleton ADHC, OPHA, etc. Informal university research contacts with Univ. of Ottawa, Carleton and Queen's. Also Algonquin College and Cite Collegial Regular present. to DHC, municipal and provincial policy-making bodies.

Appendix IX

Exhibit D

CITY: TORONTO

CENTRE	GOVERNANCE/ORGAN. STRUCTURE	TOTAL POPULATION SERVED FEBRUARY 1986	PROGRAMS	FUNDING	STAFF	AGENCY RELATIONSHIPS
SOUTH RIVERDALE COMMUNITY HEALTH CENTRE 126 Pape Ave. Toronto, Ont. Est: 1976	Community-Sponsored Board of Directors responsible for policy and executive decisions. Administrator responsible for day to day operation; Clinical co-ordinator responsible supervision and quality in clinical area	Roster: 5,750 Geographic Area: Lower East Side of Toronto Identified population. Characteristics: mixed socio-economic group of low to middle class; anglo-saxon with 2 main ethnic groups - Chinese and Greek Higher than average number of seniors, single-parent families, teenage pregnancies, and functional illiteracy Mental health and substance abuse are also problems	Primary Health Care - Medical - Health Education - Community Education - Prevention and - Health Maintenance - Outreach Services - Chiropody	MOH -Program-Based Budget	3 MDs, 3 NP's P-time Nutritionist 1 Administrator 2 Support Staff 1 Chiropodist	Agency: Referral advice and support to PH, VON, Soc. Serve agencies and programs. Informal relationship with variety of community Hospital: Referral to selected specialists University Consulting for studies. Student placements DHC: None (Metro Toronto DHC)

Appendix IX

Exhibit E

City: Toronto

CENTRE	SPONSOR/ORGAN. STRUCTURE	TOTAL POPULATION SERVED	PROGRAMS	FUNDING	STAFF	AGENCY RELATIONSHIPS
ACCESS ALLIANCE 509 College St. Toronto, Ont M6G 1A8 Established 1990 CHC	Community-Sponsored	Roster: 2,000 populations served: Vietnamese Korean Portuguese Spanish-speaking	Primary Health Care medical services with an emphasis on prevention and promotion Translation services AIDS Education program Substance Abuse Research Unit	MOH City of Toronto	2 MDs 2 RNs	Addiction Research Foundation Department of Public Health Doctors Hospital Gerstein Centre Hospital for Sick Children Parkdale CHC Canadian Hispanic Congress Elderly Vietnamese Centre Korean Canadian Cultural Association Korean Canadian Womens Association SALUD Vietnamese Association Vietnamese Physicians Association

Appendix IX

Exhibit F

City: London

CENTRE	SPONSOR/ORGAN STRUCTURE	TOTAL POPULATION SERVED FEBRUARY 1992	PROGRAMS	FUNDING	STAFF	AGENCY RELATIONSHIPS
[illegible] COMMUNITY HEALTH CENTRE [illegible] LONDON, ONTARIO N5W 2X1 Established 1989 Multiservice Centre	Community Sponsored Operated by Board of Directors consisting of 15 members	Roster: 2,000 Population served: South-east London primarily. City wide for some target populations. Area Wide for some.	Primary Health Care medical services with emphasis on prevention and promotion. Women's Programme Youth Programme Seniors Programme Art-therapy Collective Kitchens Tai-Chi English As A Second Language Anonymous H.I.V. Testing Dental Clinic Foot Clinic Chiropody	MOH-Program-based NCSS Citizenship Secretary of State/Health & Welfare Canada	3 MDs 1 N.P. 3 R.N.A. 1 Health Educator 2 Community Workers 1 Social Worker 5 Program Coordinators 4 Admin.	Relationships with community agencies hospitals university Placements for students

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Interview with David Thornley, Parkdale CHC organizer, October 18, 1989.

Interview with Beare Weatherop, Parkdale CHC organizer, October 18, 1989.

Interview with Saul Cowan, community leader in Lawrence Heights, October 19, 1989.

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Interview with Denise Albrecht, former Centretown volunteer and current Coordinator of Sandy Hill Community Health Centre, November 27, 1989.

Interview with Marjorie de la Bastide, community leader in Southeast Ottawa, November 27, 1989.

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