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Understanding the role of contextual influences on local health-care decision making: case study results from Ontario, Canada

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Abstract

Approaches to involving the public in local health care decision making processes (and analyses of these approaches) have tended to treat participation and publics uniformly in search of the ideal method of involving the public or providing the same opportunities for public participation regardless of differing socio-economic, cultural, insitutional or political contexts within which decisions are made. Less attention has been given to the potential for various contextual factors to influence both the methods employed and the outcomes of such community decision-making processes. The paper explores the role that context (three sets of contextual influences more specifically) plays in shaping community decision-making processes. Results from case studies of public participation in local health-care decision making in four geographic communities in Ontario are presented. During the study period, two of these communities were actively involved in health services restructuring processes while one had recently completed its process and the fourth had not yet engaged in one. Several themes emerge from the case studies regarding the identification and role of contextual influences in differentially shaping participation in local health care decision-making. These include the propensity for communities with different social and structural attributes to engage in different "styles" of participation; the importance attached to "community values" in shaping both the qualitative and quantitative aspects of participation; the role of health councils, local government and inter-organizational collaboration as participation "enablers"; and the politicization of participation that occurs around contentious issues such as hospital closures. © 2001 Elsevier Science Ltd. All rights reserved.

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Introduction

For centuries, participation analysts and advocates have debated the merits and deficiencies of different methods for involving citizens in the decisions affecting them. Inextricably linked to the democratic principles of 'government for the people, by the people' is the involvement of the citizenry, either directly or indirectly, in government decisions. Democratic participation involves sharing power for government decision-making, and hence, discussions about how that power should be shared (i.e., among citizens, experts and elected officials). These issues are being actively debated among policy-makers and researchers in the health care domain where questions of who should be involved, in what decisions, how, and in what capacity, are at the forefront of discussions pertaining to the allocation of resources within and across global budgets. That the public should be involved in these decisions is no longer under serious debate as decision-makers, faced with increasingly difficult resource allocation decisions, welcome the opportunity to share this task (and the associated blame) with the public. Choosing an appropriate combination of public, elected officials, experts and stakeholders to make these decisions, however, can

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be complicated and determining how and what public views will be obtained and incorporated in the decision-making process even more challenging. Much of the health services research that has been conducted in this area has focused on eliciting public preferences or priorities, often from a list of pre-determined programs or services. This input is frequently obtained using either a single consultation method for a particular group (e.g., citizen surveys, citizen panels, etc.) (Lenaghan, New, & Mitchell, 1996; Bowie, Richardson, & Sykes, 1995) or a single method across comparison groups (e.g., surveys of providers, administrators, patients) (Bowling, 1996; Myllykangas, Ryynanen, Kinnunen, & Takala, 1996). Other research has focussed on evaluating the merits and deficiencies of public and community consultation exercises within a specific service sector (e.g., long-term care reform, health services restructuring) (Aronson, 1993; Abelson & Lomas, 1996).

The research that falls into each of these broad categories has improved our understanding of the results obtained and challenges faced when trying to involve the public in health services decision making. However, approaches to involving the public in local health care decision-making processes (and subsequent analyses of these approaches) have tended to treat participation and publics uniformly in search of the ideal method of involving the public or providing the same opportunities for public participation regardless of the differing socio-economic, institutional or political contexts within which decisions are being made. Little attention has been given to the potential for various contextual factors to influence both the methods employed to involve the public and the outcomes of such community decision-making processes. The purpose of this paper is, therefore, to explore the role that context (three sets of contextual influences more specifically) plays in shaping community decision-making processes in the health services sector and to inform future research and practice in the area of public participation in health-care decision-making.

Description of the research

The research upon which this article is based involved case studies of public participation in local health-care decision making in four geographic communities in Ontario, Canada conducted between October 1995 and December 1996. When the fieldwork began, two of the four communities were actively involved in health services restructuring processes. One had recently completed its process and the other had not yet engaged in such a process. The health services restructuring that occurred throughout Ontario during this period typically involved reallocating and reconfiguring the health services delivered in a community with the dual objectives of reducing the overall expenditures for health services and shifting resources away from the institutional acute care sector (i.e., hospitals) to the community sector (i.e., home care and long-term care institutions). While the research was originally designed to focus on health care participation more generally, the presence of health services restructuring in three of the four study communities provided a unique opportunity for in-depth examination of participation in this area (i.e., a "case within a case").

Objectives of the research study were to: (1) identify the contextual influences that shape various qualitative and quantitative dimensions of community-level participation (discussed in the section below) (2) describe *how* the presence or absence of these influential factors shaped participation; (3) explore their independent and combined influence on participation. The empirical component of the analysis was guided by the development of a framework informed by an in-depth, interdisciplinary review of the literature examining the population, institutional and political influences on individual and aggregate-level participation. A detailed discussion of the framework and literature review is presented elsewhere and is discussed only briefly here.[1]

Framework for analyzing participation and its influences

Fig. 1 presents a framework that depicts participation in the centre of the diagram (i.e., dependent variable) with three sets of influences (i.e., independent variables) acting either independently or in combination with one another to shape participation. As discussed in Abelson (1999), an instrumental definition of participation was used (i.e., actions taken with the objective of influencing a decision-making process) that could account for both quantitative and qualitative dimensions (e.g., tone, texture, intensity, method, quantity, form, etc.) A detailed description of these dimensions is provided in Appendix A.[2] The first set of influences in Fig. 1 (i.e., *predisposing*) deals with the structural and social context of the population (e.g., income, education, residential stability, social ties and networks, etc.) where varying levels of evidence support an associational relationship to participation (Milbrath & Goel, 1977; Verba & Nie, 1972; Parry, Moyser, & Day, 1992; Haeberle, 1987). A second category of influence (i.e., *enabling)* deals with the institutional context for decision-making and examines the actions taken by the media, local govern-

[1] See Abelson, J. Bridging Academic Disciplines and Policy Sectors: Understanding the Influences on Community Participation. McMaster University Centre for Health Economics and Policy Analysis Research Working Paper #99-3.

[2] See Abelson, J. (1999) for a detailed discussion of the conceptualization of these dimensions.

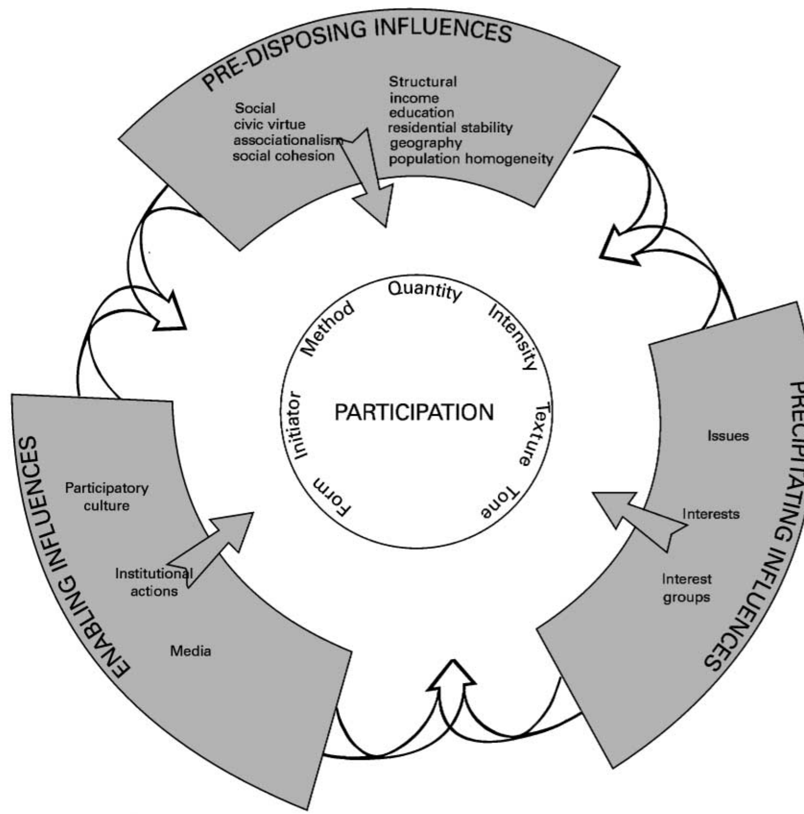

Fig. 1. A framework for analyzing participation and its influences.

ment, cultural and health institutions to foster (or impede) participation. Institutions may be specific to a policy area such as a local health planning body in the health sector or they may play an enabling role across a wide range of policy issues (e.g., regional or municipal government or the media). The participation literature is replete with accounts of institutional efforts to enable citizen, consumer or community participation in decision-making processes (McNamee & Swisher, 1985; Marmor & Morone, 1980; Checkoway & Doyle, 1980; O'Neill, 1992). These efforts have often been viewed as failures with respect to the achievement of broad-based community involvement or viewed cynically as exercises in manipulation to achieve a pre-determined outcome or to put off making a decision. Finally, a third contextual category (i.e. *precipitating*) addresses the role of interests and interest groups in shaping the participatory process and examines the array of local stakeholders and coalitions that form around a specific issue, in this case, health services restructuring. The link between issues and interests is embedded in our understanding of the influence that precipitants wield over participation. Empirical studies from a number of policy sectors (e.g., environment, housing and public health) identify the importance of "threatened interests" such as property values or public safety as catalysts for community mobilization (Lee, Oropesa, Metch, & Guest, 1984; Zorbaugh, 1929; Wersman & Hallman, 1993; Henig, 1982; Kraft & Clary, 1990). Within the health care domain, the specific role of interests and interest groups in the health care decision-making process have been observed in several empirical studies (Alford, 1975; Marmor & Morone, 1980; Checkoway & Doyle, 1980; Short, 1989; Eakin, 1984; Godbout, 1981). The emphasis of this research has been on the dominant role played by health care providers (with "concentrated" interests) relative to the public (with "diffuse" interests) in influencing health care decision-making processes in the United States, Canada and Australia.[3] Alford's (1975) structural interests typology which was applied to an analysis of health system reform in the United States is also relevant to the study of health services restructuring where Alford's 'dominant'

[3] For a detailed discussion of concentrated and diffuse interests, see Marmor and Morone (1980).

and 'repressed' interests are closely matched to the interests of (1) health care providers and administrators and (2) the community, respectively.

Methods

A case study design was used to investigate the phenomenon of interest (i.e., participation in health care decision making) in the context of geographic communities (Yin, 1994; King, Keohane & Verba, 1994; Stake, 1995). Each case was defined as "*the participation of the public in the decisions affecting health care*". Communities were defined according to existing geographic boundaries for health districts". The use of administrative and political units was essential to defining community in this study since participation was often geared toward local institutions such as health facilities and involved local decision-making bodies that have jurisdiction over health care matters such as district health councils.

Interviews and archival records (e.g., organizational documents, newspaper articles) were used as principal sources of evidence while direct and participant observation were used in a complementary manner (Yin, 1994).

Community informants were selected based on the principle of obtaining different functional perspectives on the subject of participation in health care (i.e., from participants themselves, and those who manage, observe and enable the participation process). The perspectives of elected officials, senior management, community appointees and citizen participants were obtained using the following selection criteria:

(i) representatives from similar organizations in each study community; and
(ii) referral from previously identified informants.

Representatives were selected from the following positions within organizations:

(a) senior administrative officials or chief executives for the local district health councils, school boards and regional or municipal government;
(b) senior elected or appointed official (i.e., chairperson) for the local district health council, municipal or regional government;
(c) consumer or parent representatives to the local district health council; and
(d) representatives of the local media (e.g., health, education or local affairs reporter for the local newspaper).

In some communities, additional administrative, elected or appointed officials were interviewed to obtain more in-depth information about a particular topic or to corroborate other sources. Another method employed to select informants was to ask informants (either at the beginning or end of the interview) to identify anyone else in their organization or in the community more broadly whom they felt should be interviewed. Primary and secondary participation data were collected for a range of qualitative and quantitative participation dimensions. Data were also collected for each of the influential factors described above (i.e., predisposing, enabling, precipitating).

Study communities

Four geographic communities were selected using a maximum variation sampling strategy to allow comparisons to be made for the following variables of interest: education and income; population size; and population density and cohesion. The sampling strategy, therefore, involved selecting communities with the objective of maximizing variation with respect to high and low education and income levels; large and small populations; and sparse and dense populations.

Analysis

The analysis focused on developing participation profiles for each community as well as profiles for each of the contextual influences thought to explain the observed participation. The analysis used an iterative process of reviewing data, categorizing and clustering information, and preparing preliminary briefs to summarize the information collected along the way. Two principal triangulation methods were used to ensure data validity: data source triangulation and methodological triangulation (Stake, 1995).

Research findings

The research findings reported here draw on material collected during 85 interviews conducted across the four study communities. A profile of each of the geographic communities studied is provided in Table 1. At the outset of each interview, community informants were asked to speak broadly about participation in their communities and then with specific reference to participation in the health sector. An instrumental definition of participation was provided (i.e., actions taken to influence a decision-making process) during the interview preamble to focus informant comments. Several themes emerged from the responses received to this general question.

Table 1
Community profiles

	Hamilton–Wentworth	Ottawa–Carleton	Nipissing District	Renfrew County
Population	Large urban region with academic health sciences centre presence (pop. 450,000)	Large urban region with academic health sciences centre presence (pop. 680,000)	Small, mainly urban area with highly concentrated population (pop. 84,000)	Small urban/rural area (pop. 90,000)
Socio-economic characteristics	Lower than provincial average socio-economic status and education level	Higher than provincial average household income and education level	Lower than provincial average household income and education level	Lower than provincial average household income and education level
Employment characteristics	Manufacturing is the dominant industry with expanding service sector	"White collar community" with a large concentration of government employees	Service, managerial and administration are largest employer groups	Diverse economies (government and service sectors in larger centres; resource-based industries in smaller communities; a large scientific community; military base)
Geographic and Administrative Characteristics	Dominant geographic centre (i.e., major city) within several bordering municipalities with strong local identities.	Numerous large, uniform city municipalities organized as administrative units rather than natural communities	Dominant centre (single, large city) with few bordering towns	No dominant centre; sparsely populated communities
Cultural characteristics	Culturally diverse with large Italian population	Large French-speaking population (16%)	Large French-speaking population (20%)	Religious denominations evenly divided between Catholics and Protestants

Depictions of participation

Communities were portrayed differently regarding approaches, magnitude and styles of participation. Table 2 provides a summary of quotes generated by community informants. The participation dimensions listed in Appendix A provide a framework for comparing community profiles of participation as depicted by community informants. These are accompanied by a more detailed discussion of each community in the sections below.

Hamilton-Wentworth

Hamilton-Wentworth's participation in local affairs was depicted as "typical of other communities" although informants felt that the community was perhaps more active than others in providing input into local decision-making on a routine basis. Several informants described the community's approach to participation as "combative and unpretentious" and an "agressiveness" in its demand for ownership of local government and early involvement in community decision-making processes. A culture of collaboration and co-operation was also believed to characterize Hamilton-Wentworth, particularly within the health care stakeholder community, fostering a perception that the community is easily able to influence its decision-makers. One former hospital executive described the culture in this way:

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

Informants held mixed views about the general public's participation in health care decision-making. While some acknowledged that everyone in the community had a stake or an interest to pursue, most expressed the view that the community at large held an elitist view of who should be involved in health care decisions, a view thought to be largely driven by the health care elite itself. One senior regional politician identified a "lack of sophistication and feeling of intimidation" among the public with respect to its capacity to participate in health care decisions as compared to other sectors such as the environment or transportation. A review of applications received for membership on the local health council provides some empirical support for these observations. Of the 51 applications received in 1995 for membership on the health council, two-thirds (34) were submitted by providers as compared to one-third from consumers.

The *tone* of participation in health care was felt to be more polite due to the respect, intimidation and deference felt towards the community's health care elite (i.e., physicians and hospital administrators). One

Table 2
Depictions of participation in health care decision-making (through the eyes community informants)

Participation Dimension	Hamilton–Wentworth	Ottawa–Carleton	Nipissing District	Renfrew County
Form	"*... typical of many other communities – until an issue affects them directly you don't see people getting involved.*" "*... the health care lobby is very organized*"		"*Mobilization occurs around problems but not around solutions or about how to build capacity in the community.*"	"*... difficult to get people involved early on in the decision-making process.*"
Method	"*coordinated partnership from the stakeholder community.*"	"*Participation in health care usually occurs through groups and associations.*" "*... people are used to functioning this way.*" "*If you have letterhead people will listen to you.*"	"*People get more involved through voluntarism than by influencing policy decisions.*"	"*People are more likely to volunteer to obtain benefits that affect them directly. They are not as interested in government-related voluntarism* [*e.g., health care decision-making*].*"*
Quantity	"*... a pretty active community with regard to input into decision-making.*"	"*About 3,000 people make up the voluntary sector who are 'generalists' who do a stint in health and social services and then move on to another area.*"		
Intensity				"*You would have thought that all of ... was concerned about this issue the way people were talking but when we held a meeting on it, only 40 people showed up.*"
Texture	"*... a medium-sized community with stable power structures and a large group running things, not an internal clique.*" "*There is a high degree of variation across communities within* [*Community A*]"	"*Once you scratch the surface it's the same people who are involved.*"	"*Decisions are made by an elite group of small business leaders.*" "*... professional community activism* [*occurs*] *with only a core group of people who cross over between sectors.*"	"*People who are vocal are a real minority. You never know if people are with you or not because the vast majority is silent. People like to let their politicians do the work for them.*"
Tone	"*Everyone knows everyone and all the players ... There is easy access to all the players ... and people expect to have this easy access.*"	"*polite*", "*formal*", "*bureaucratic*"	"*reticent*", "*apathetic*", *complacent*"	"*aggressive*", "*acrimonious*"

former regional government official described the public perception this way:

> 'We're just little Hamiltonians, what do we know about health care?

A former hospital executive who has worked in several Ontario communities, including *Hamilton-Wentworth* concurred:

> The broader community leaders like the chamber of commerce and regional Government had tremendous blinding respect for hospitals.

Ottawa-Carleton

By contrast, participation in *Ottawa-Carleton* was depicted as "sophisticated", "bureaucratic" and "polite". The community was described overall as

exhibiting high levels of political participation exercised predominantly through membership in groups and associations. As one volunteer stated, "people are used to functioning this way". A former health council member emphasized the community's propensity for and receptivity to bureaucratic forms of expression (i.e., *tone*) by suggesting that:

> If you have a letterhead people will listen to you.

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

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

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

Despite the perception of a broad base of community involvement in health planning, some informants expressed the view that there still remains only a small, core group of active participants and that "once you scratch the surface, it's the same people who are involved".

At the elite decision-maker level, the environment was described as "highly competitive and divisive". This is contrasted with the more collaborative history that has characterized health care decision-making in *Hamilton-Wentworth*. According to one community informant who has worked in both communities:

> "Hamilton-Wentworth has had a long history of collaboration while Ottawa-Carleton has worked painstakingly towards collaboration."

Despite a sophisticated, well-organized populace in *Ottawa-Carleton* the health care elite was still believed to wield tremendous power over health care decision-making processes and the broader community's involvement in them. One informant described the difficulty in achieving a balance between academic centres and the community when "hospitals and physicians have tremendous power over the community [and] fuel perceptions that more services are better".

Nipissing District

Nipissing District offers another striking contrast to the communities described thus far. Views regarding the general public's approach to involvement in local issues ranged from "complacent" and "reticent" to "apathetic", "selfish" and "afraid of change". *Nipissing District*'s dominant city was described as being run by an "elite group of small business leaders". A number of informants described it as a community that "seems to wait until a crisis erupts or until a decision is made before getting involved". According to one community informant, "mobilization occurs around problems but not around solutions or about how to build capacity in the community".

Outside of the dominant city though, smaller municipalities were depicted differently. A community of 6000 residents, for example, was described as exhibiting very active involvement in all aspects of local decision-making and able to "mobilize when necessary". Participation in community consultations on the issue of long-term care illustrate this point. Of the 141 community residents who attended one of the three meetings to discuss long-term care, 57% of participants were from this community which comprises only 7% of the area's total population.

Consistent with the depictions of general involvement described above, *Nipissing District* was described as exhibiting a low level of involvement in health care matters. The community's lack of interest in policy matters was described by one informant who observed that "people get more involved through voluntarism than by influencing policy decisions". A related observation was the absence of any "professional community activism with only a core group of people who cross over between sectors" (former district health board member).

Renfrew County

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

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

Those who do get involved, however, make up for their small numbers in ferocity. As one community volunteer observed:

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

Participation was described by a health council official as only occurring when proposals were provided to the public and that it is "difficult to get people involved early on in the decision-making process". Local variations in participation patterns were identified with better participation cited in larger towns where there is a concentration of interest groups and media.

With respect to participation in health care decision-making, a long-serving member of provincial parliament for the area reinforced depictions of a low level of routine community involvement observing that:

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

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

One smaller community within *Renfrew County* was depicted as an anomaly with respect to its active participation in health care decision-making. This small town was described as close-knit and able to organize itself quickly and easily to respond to issues that arise while exhibiting a high degree of involvement in routine activities. Attendance figures for a community consultation on long-term care planning in 1994 support informants' observations. Of the 10 meetings held throughout *Renfrew County*, 30% of participants were residents of this town which constitutes only 8% of the area's total population. Described as "... very vocal and well-organized with about 60 local groups functioning in [the] community", an illustration of the community's high level of organization was its ability to arrange for its own transportation to community meetings.

The depictions presented above highlight the heterogeneity of participation reported among and within the four study communities. Attempts to explain this heterogeneity will be the subject of the remaining sections of the paper which will be guided by an examination of the contextual influences identified in Fig. 1 (i.e., structural, social, institutional and political contexts).

The social and structural contexts of participation ("predisposing influences")

Table 3 presents a list of characteristics generated by informants when asked the question: "What do you think influences or shapes participation in your community?" In most cases, the characteristics that appear in the table represent direct quotes as reported by informants (e.g., "education", "income", "geography", "population size", "distance between communities"). Others reflect the distillation of longer quotes into a single phrase (e.g., "elite dominance of local decision-making", "desire to preserve local identities"). The contents of the table should not be interpreted as an indication of agreement among informants as no attempt was made to reach consensus on the list. However, most if not all characteristics were mentioned by at least one informant, and in many cases, by several.

A detailed discussion of Table 3 is presented in the sections below organized around several themes that emerged from the interviewing process: (1) the role of education and income; (2) the role of culture and religion, and (3) the role of community values. Each of these three major themes is believed to capture at least some aspect of all the influences identified in the table although some are more explicitly addressed than others (e.g., education and income, culture and religion).

The role of education and income

A number of the characteristics identified in Table 3 (under structural characteristics) refer to the role that education and income play in shaping participation. In addition to the explicit references made to these influences, the role played by education and income were implicitly referred to as one informant describes here:

> It is the "middle classness" of the community that is the big variable in Ottawa-Carleton. This is played out through higher education levels, the confidence that comes with education, the feeling that you have the right to be involved ... and having sufficient income to be able to devote time to this. These characteristics are what pre-dispose people to join organizations, volunteer their time on health boards

Table 3
Population/community characteristics that influence participation a summary of community informant responses

Hamilton–Wentworth	Ottawa–Carleton	Nipissing District	Renfrew County
Structural characteristics			
Sense of community vs. Physical isolation University presence Workplace/Residence proximity Population size Education Income Geography Ethnicity	Sophisticated, well-informed community Linguistic divisions Ethnicity	Population size	Education Income Single company town Religious divisions Cultural homogeneity Residential stability Sparse population/distance between communities Population size
Social characteristics			
Strong commitment to collaboration and coordination Desire to preserve local identities Resistance to change Elite dominance over health care	Large volunteer base with strong commitment to public service Government town with high level of interest in politics and policy Emphasis on community development	Preservation of cultural identity Conservative, traditional community values Lack of interest in collective problem-solving/decision-making Elite dominance of local decision-making	Rural community values, e.g., resistance to change Resentment felt toward provincial government Desire to preserve local identities Strong community values

in the same way that they would get involved in community garage sales.

(former District Health Council member)

As illustrated in the previous section, *Hamilton-Wentworth*'s education and income level not only appears to influence the ability to participate (i.e., whether participation occurs or not) but the manner in which it is carried out (e.g., through groups and associations; letterhead, etc.)

In contrast, the more modest education level of *Hamilton-Wentworth*'s population may help to explain the sense of intimidation felt among the public with respect to participating in health care decision-making (see references to deference in the depiction of participation in *Hamilton-Wentworth*). According to a former chairperson of the local health council, the implications of this deference is a high level of participation from *Hamilton-Wentworth*'s stakeholder community (i.e., those with direct interests in the health care sector) along with ''elitist voluntarism''.

Education and income did not emerge as perceived influences over participation in *Nipissing District*; however, both were perceived to contribute to the highly participatory municipality described in *Renfrew County*'s depiction of participation.

The role of culture and religion

Cultural and/or linguistic characteristics were also found to influence the context for health-care decision making. A long history of linguistic (and religious) divisions between French Catholic and English Protestant residents in *Ottawa-Carleton* has led to the development of ''parallel health care systems''. The two major teaching hospitals in the region have French-Catholic and English-Protestant roots and failed attempts to establish a common governance structure has perpetuated a long-standing rivalry between the two hospitals. In an era of abundant resources, each was able to build its own empire with relative ease. In the more recent environment of budget cutbacks (i.e., health services restructuring), however, a more pronounced rift appeared between the English and French-speaking communities driven by the cultural divisions within the community. As one local investigative reporter described the situation:

The evolution of Ottawa-Carleton's hospitals snags on the intense sectarian rivalry that splits the city. (Gray, 1995, E1)

Cultural and linguistic characteristics were also found to fuel participation in some communities in the interests of preserving cultural identity. For example, the highly

participatory town depicted in *Nipissing District* is predominantly francophone and several informants shared the view that a major impetus for this community's ability to mobilize was rooted in its desire for self-preservation.

While cultural and linguistic characteristics played only a modest role in influencing health care participation in *Hamilton-Wentworth* and *Renfrew County*, religious characteristics played a much more visible role. Several informants in *Renfrew County*, for example, cited religious divisions between supporters of the local Protestant and Catholic hospitals as fuelling much of the opposition to the proposed closure of one of the community's hospitals. Some spoke of the "quiet scrutiny" of council members' religious affiliation in assessing the outcome of a council vote. The following quotes capture the essence of these divisions.

> There have been two hospitals in…since 1902 and people have their preferences for one or the other.
> (Chair, citizens group opposing hospital closure)

> The underlying problem with hospital restructuring is over governance and the fact that one hospital is Protestant while the other is Catholic. If the [Protestant hospital[4]] is closed there will only be a Catholic hospital ... people could handle the [Catholic hospital] being closed but not the [Protestant].
> (local newspaper reporter)

> Religious divisions were used to stir up trouble. You go to the hospital that your doctor sends you to. There was no opposition to either hospital until people made it an issue.
> (health council member)

Similarly, the proposed closure of the only Catholic hospital in *Hamilton-Wentworth* led to an emotional outcry as well as a sophisticated, highly-organized response from the Catholic community (Morrison, 1996)

> In a pastoral letter read to congregations throughout the region, Bishop … expressed concern that the proposal 'will erode the ability of [the Catholic hospital] to continue its healing mission in the tradition of the Catholic Church and the [Catholic hospital].' He urged church members to voice their opinions to the task force through a card inserted in yesterday's church bulletins.
> (excerpt from local newspaper, 1996, A1)

[4] Hospital names have been omitted and replaced with generic titles.

Role of community values

A number of the characteristics identified in Table 3 fall into a broad category of "community values" where informants in three of the four communities emphasized their influence over participation of a general nature, and in the health care sector more specifically. *Nipissing District*, for example, was identified as having "conservative", "traditional" values that emphasize elite decision-making over grass-roots involvement. A general distaste for collective problem solving (e.g., involvement in public affairs and policy-making) was also identified despite a strong spirit of voluntarism (e.g., local fundraising efforts, and blood donation) (see Table 2, *Nipissing District* depictions of participation).

For one informant in *Renfrew County*, a "long tradition of doing battle with and feeling resentment toward the provincial government" was believed to translate into widespread skepticism and distrust of many provincial government initiatives (including the local health council which was seen as an arm of the provincial government).

A number of informants identified "resistance to change" and a "strong desire to preserve local identity" as a commonly held value in rural and smaller communities. This value (in addition to the religious divisions described in the previous section) was believed to drive community opposition to hospital closure proposals in *Renfrew County*. Informants in this community also identified the threats imposed by large, powerful neighbouring communities on small, rural communities as the "urban assault on rural values" and the intense, vociferous participation it evokes.

Several informants in *Hamilton-Wentworth* also identified their sense of inferiority to a large, neighbouring city as a commonly held value and unifying force and that promotes the strong tradition of collaborative problem-solving among agencies and institutions that was depicted earlier and will be discussed in more detail in the next section.

The institutional context of participation ("enabling influences")

A variety of institutional actions were identified and explored in the case studies that address the second set of influences presented in Fig. 1 (see Enabling Influences). These include the mandates of local government and the local health council to involve the public in their decision-making processes; the reduction of impediments to participation through information provision, accessibility to decision-makers, etc. and the presence of a media culture that promotes participation. These

institutions and their role as "enablers" are discussed in the sections below.

The District Health Council as an enabler of participation

District Health Councils (DHCs) in Ontario play a pivotal role in obtaining community input on all aspects of health care decision-making that fall under their mandate. DHCs are intended to reflect and incorporate the views of their community through membership on council, committees of council and through community involvement in health council activities. Historically, this has been restricted to the area of health planning but over the past few years DHCs have been given increased responsibilities in the areas of priority setting and resource allocation (although they do not have responsibility for decision-making in these areas, only advisory powers).

DHCs are all "enablers" of participation in that they are required to "develop strategies to assure and enhance public participation in all parts of the planning process" (Association of District Health Councils of Ontario, 1994, p.59). Despite their universal commitment to enabling participation, they may be perceived differently by their respective communities. DHCs in *Hamilton-Wentworth* and *Ottawa-Carleton* were established in the early 1970 s and are among the oldest in the province. DHCs in *Nipissing District* and *Renfrew County* were two of a newer crop established in the early 1990 s and overcame much community resistance to their establishment. Opposition to the establishment of *Renfrew County*'s DHC was explained in the following manner:

> Renfrew County has historically been very isolated from the provincial government and has resisted interference in local affairs. There was a perception that the DHC was a tool of the government.
>
> (DHC chairperson)

Underlying this resistance to provincial government interference is a history of local politicians successfully fighting for community resources from a distance.[5] The prospect of letting the government into the community was perceived as a threat to the status quo arrangement. While DHCs in *Hamilton-Wentworth* and *Ottawa-Carleton* established their presence and cultivated strong ties to their community over 20 years, *Nipissing District* and *Renfrew County* were only beginning this process when the health services restructuring processes began in their communities. As a result, the DHC in *Nipissing District* was absent from the local decision-making process that resulted in the merger of two local hospitals. In *Renfrew County*, where the DHC attempted to lead the restructuring process, its work was bitterly opposed every step of the way by a group of hospital supporters (including the filing of a lawsuit against the health council). The DHC was heavily criticized for failing to adequately involve the community. According to one community informant "the process was closed despite the DHC's repeated commitment to a 'Made in *Renfrew County* solution'". Concerns were also raised about a hidden agenda being carried out by a new executive director who was not from the *Renfrew County* area.[6] Resistance to the DHC's establishment also played a role in deterring it from carrying out its enabling function. One informant expressed the view that "the people who resisted hospital restructuring were also resistant to the establishment of the DHC".

Actions taken to enable participation in health care decision-making varied considerably among DHCs highlighting differing degrees of "openness" and "inclusiveness" to public involvement.[7] Examples drawn from *Hamilton-Wentworth*, *Ottawa-Carleton* and *Renfrew County* (*Nipissing District* did not engage in a similar process during the study period) illustrate the tendency for institutional actions (i.e., approaches to involving the community) to reflect the different styles of participation described in an earlier section of the paper. *Hamilton-Wentworth*'s approach, for example, was open, consultative and collaborative with multiple opportunities provided for public input and discussion before any proposals were developed. In contrast, *Ottawa-Carleton*, while perceiving itself to be open and consultative was criticized for not widely disseminating its report to the public and offering only a very short period of time for public input into a limited set of proposals.

Renfrew County adopted a more traditional approach to enabling participation. Only after all the information was collected, analyzed and options were formulated did the DHC present its comprehensive plan to the public for discussion and response. Confrontational public meetings, pitting the community on one side against decision-makers on the other, were held to discuss the options and the community responded angrily and vociferously. In the case of *Renfrew County*, the community's perception was that they were not involved in the process and according to a local reporter "the

[5] Community D boasts the highest per capita spending in the province on long-term health care services despite population demographics that are not out of line with the provincial average.

[6] The executive director of Community D's DHC was newly appointed and had moved to the area from another DHC position in another region of the province. She was an outsider and considered to be a government representative carrying out the government's agenda

[7] A detailed analysis of these approaches has been published elsewhere. See Abelson and Lomas (1996).

DHC handled it poorly by announcing their decision and then providing reasons later".

Inter-organizational relationships

Relationships between health care organizations (and their leadership) were also found to shape the participation observed in local decision-making processes in the four study communities. As discussed in an earlier section and depicted in Table 3 *Hamilton-Wentworth* was described as exhibiting a "strong commitment to collaboration and cooperation" among its health care organizations. This historical relationship enabled health care leaders to present a united front to the community in their fight against hospital closure threats and to exert their influence over the decision-making process from behind closed doors by proposing an alternative to the health council's that would keep all hospitals open. Preying on the trust and esteem with which they were held by the public, hospital administrators were praised for working collaboratively toward a solution for the entire region that met a perceived public interest of keeping all hospitals open. The following editorial illustrates this point:

> The leaders of Hamilton-Wentworth's medical community have unveiled a hospital blueprint which represents a major improvement ... The report builds on the demonstrated ability of Hamilton-Wentworth's hospitals to work together in achieving necessary efficiencies.
>
> (Editorial, April 16, 1996, A8)

In striking contrast, *Ottawa-Carleton's* restructuring process was fraught with tension and conflict driven by a publicly acrimonious relationship between hospital CEOs (and a long history of deeply rooted competition between the two hospitals) that contributed to a sense of fear and outrage in the community. This atmosphere was fuelled by media that regularly monitored the trading of insults between senior hospital officials (Kirkey, December 15, 1995, p.C1)

Local government as an enabler of participation

As with DHCs, the institutional presence of local government differs markedly between communities, particularly between those with large and small populations. Local governments in *Hamilton-Wentworth* and *Ottawa-Carleton* were described as "strong enablers of participation". According to one community informant, the strong commitment to community development, nurtured by local government, has been responsible for the creation of a "culture of participation" which is believed to support the broad base of community involvement that exists in the long-term care area of local health care decision-making. Reports of approximately 25 community agencies, 5000 volunteers and extensive informal networks and coalitions in the long-term care area support these claims (DHC staff, *Ottawa-Carleton*).

The role of local government as an enabler in *Hamilton-Wentworth* was summarized succintly by one informant:

> Hamilton-Wentworth institutions are better than most communities in terms of involving the public in visioning and forming policies...
> (DHC consumer representative, *Hamilton-Wentworth*)

Like *Ottawa-Carleton*, regional government in *Hamilton-Wentworth* has historically been supportive of broad-based community participation and has enabled participation in various ways. Regional government has been instrumental in supporting coordination and collaboration between various community agencies through organizations such as the Social Planning and Research Council (SPRC).

> The Region took over [the] coordination function from SPRC over time and had higher profile and more resources to bring people together.
>
> (Former director, Department of Social Services, *Hamilton-Wentworth*)
>
> Leadership at the region is grass-roots minded. (Former director, Department of Social Services, *Hamilton-Wentworth*)

Other views of local government commitment to enabling participation in *Hamilton-Wentworth* included its "strong support of transparent, public decision-making" and an increasingly active role taken by the Department of Public Health in community development over the past 5 years. A frequently mentioned example of local government enabling participation was a recent community-wide "visioning" exercise described by informants as:

> an excellent process created by the region which had political leadership but lots of opportunities for public involvement
>
> (Consumer representative, *Hamilton-Wentworth* DHC) ha[ing] kept community groups interested and coordinated all along
> (Senior official, *Hamilton-Wentworth* regional government)

A different view of local government was presented in *Nipissing District* although the distinction must be made between its dominant city and the smaller surrounding municipalities. In general, the municipal government was viewed as an elite decision-making body with little

interest in or commitment to enabling participation. Although a former mayor in *Nipissing District* described decision-making as "open and inclusive" a more general view of local decision-making was that it was run by a small group of businessmen who were long-term residents of the community. The current mayor stated that "council tries to get public input when they see that an issue affects a large group of people" but suggested that "people are more interested in voluntarism than in influencing policy decisions".

The political context of participation ("precipitating influences")

In the preceding sections, health services restructuring, and the threat of hospital closures more specifically, has been addressed at various points but not explicitly dealt with. In this section, the issue of hospital closure threats as "precipitants" is examined to illustrate the role that political context (i.e., the array of local stakeholders and coalitions) plays in shaping the participation in a local health care decision-making process. In doing so, it addresses the third set of influences identified in Fig. 1 (i.e., precipitating influences).

Hospital closure threats as precipitants

Participation began as a fairly routine exercise in each community's health care restructuring process. DHCs took the lead in establishing committees to gather the information necessary to propose options for decision-making and demonstrated their usual commitment to involving the public in the process. Once preliminary restructuring recommendations were made public, however, and hospital closures emerged as a potential threat to the community, participation took the form of mobilization in response to a *precipitant* (i.e., threat of hospital closures).

Hospitals threatened with closure mounted elaborate campaigns to encourage the public to oppose the hospital closure threats by responding to the district health councils' proposals. Much of the community's response was engineered through the circulation of petitions, flyers, form letters, response cards and placards which only required the individual to produce a signature or drop a postage paid letter in the mail. The DHC in *Ottawa-Carleton* filled an entire office with boxes of submissions received from each of the threatened hospitals most of them form letters reproduced thousands of times. One of the smaller hospitals threatened with extinction produced election-style placards and automobile bumper stickers. All of this contributed to a highly competitive, confrontational style of participation that had everything to do with illustrating the *quantity* of community support that a particular hospital had garnered which would omit it from the chopping block. The public was easily and effectively mobilized in support of hospital interests at the expense of, as the following quotes illustrate, the community's interest:

> So many people are fighting for their own empires and their own visions of health care. But few among them are willing to say: This game of marbles *must end*. (Kirkey and Medline, 1996, p. B1-2)

> The problem with health care is that communities of interest don't have a shared agenda ... No one is looking at the system, everyone is looking at a piece of the system. ... No one worked for the community. Where were the people who supported the [task force] proposal?
> (Local politician and health council member, *Hamilton-Wentworth*)

The orchestration tactic used by the threatened hospital in *Renfrew County* was to establish a "community" front for hospital supporters. Hailed as a group of concerned citizens, the group was described as "coming together to oppose the closing of either of the city's hospitals in favour of rationalizing and eliminating duplication of services while ensuring the continued provision of accessible, high quality care". Several physicians opposed to the closure of the threatened hospital organized this group. A community representative on the DHC described the tactics of this hospital as "manipulated emotion" and observed that senior members of the hospital board behaved in a "divisive and sarcastic" manner throughout the restructuring process.

The role of the media — the combined influence of predisposing, enabling and precipitating influences

Health care restructuring was front and centre in the media in all communities. Local newspapers were the principal purveyors of information about the decisions being taken, the decision-makers, and key decision points in the process. Community informants had different views regarding the extent to which the media influenced public reactions to and participation in the restructuring process. While local newspapers routinely disseminated information about the date, time and location of public meetings and thus provided opportunities for public involvement, the angle taken on stories often focussed on the most sensational aspects of the decision-making process failing to give a full picture of the complexity of the health care restructuring process. By focussing on the contentious issue of hospital closures, the media, it was argued, contributed its share to *precipitating* the highly emotional community re-

sponses. Examples are provided in the following newspaper headlines:

> 'Close [hospital name]'. That's what health task force recommends.
> (The *Hamilton Spectator*, March 4, 1996, p. A1)

> Proposal to close [hospital name] met with anger
> (The *Hamilton Spectator*, March 9, 1996, p.B4)

> Hospital overhaul plan pits big against small.
> (The *Ottawa Citizen*, December 12, 1996, p.A1)

> Sleek [Hospital name] pulls ahead in hospital race.
> (The *Ottawa Citizen*, December 13, 1996, p.A1)

Although the media's role in shaping public opinion on restructuring was widely acknowledged, a comparative analysis of newspaper coverage in *Hamilton-Wentworth* and *Ottawa-Carleton* revealed contrasting approaches. As described in an earlier section, *Hamilton-Wentworth* was self-described as deferential to its health care leaders putting great trust in the hands of the medical establishment to do what was best for the community. This deference was strongly reinforced by local politicians and the media who routinely stepped aside to let the "experts" have their say. The following excerpt from the local newspaper illustrates this point:

> The council had the sense to borrow heavily from the constructive, restructuring proposals of the health care network, representing the area hospital chief administrators and the medical community. ... The health care network achieved a remarkable feat in reaching a consensus on complex health care issues. It is time to heal the wounds and implement the network plan.
> (Hamilton Spectator editorial, May 28, 1996, A8)

A greater degree of sophistication appears to have been exhibited in *Ottawa-Carleton* driven in some measure by the media's coverage of health care restructuring matters. *Ottawa-Carleton's* local newspaper was highly critical of the restructuring process (and the DHC's role in particular) and ran sensational headlines about hospital closures. It covered the issues in a more analytic fashion, however, than did *Hamilton-Wentworth*'s local newspaper, expressing many different viewpoints on a single issue including lengthy descriptions of the historical rivalry between the city's two largest hospitals and the bitter feud waged between its current leaders. The following excerpts illustrate this point.

> The community volunteers in charge of reorganizing the way our hospitals work have lost credibility with the public. And hospital bureaucrats, fighting for their jobs and their turf, are threatening to hijack the future of Ottawa-Carleton health care system.
> (*The Ottawa Citizen*, March 30, 1996, B1)

> The region's district health council gave [Ottawa-Carleton] residents what they wanted - no hospitals will close. But by saving hospitals, the health council has jeopardized health care.

> (The *Ottawa Citizen*, May 31, 1996, A1)
> A little trimming around the edges won't do it. What's needed is an approach to thinking about the system that sets aside the turf of individual hospital administrators and makes it as easy as possible for patients to find the help they need in the most cost-efficient way. Closing hospitals can save money. Building the most responsive system possible can save lives. The two don't have to be incompatible.
> (*Ottawa Citizen* editorial, September 17, 1996, A10)

Discussion

Several themes emerge from this study regarding the identification and role of contextual influences in differentially shaping participation in local health care decision making. With respect to the social and structural contexts of communities, the case studies illustrate the propensity for communities of different socio-economic levels to engage in different styles of participation (e.g., friendly, informal participation in *Hamilton-Wentworth* vs. highly organized, sophisticated approach in *Ottawa-Carleton*). Socio-economic characteristics also appear to shape a community's attitudes towards its health care elites as demonstrated by *Hamilton-Wentworth*'s unwavering and unquestioning support for the medical establishment.

Culture and religion also emerged as influences over participation shaping it in two distinct ways. In communities where there were linguistic and/or religious divisions these "social cleavages" served to mobilize intense, issue-driven participation typically in response to threats to linguistic or religion-specific services. Where cleavages were not present, these characteristics could also be found to instill a strong participatory ethos for the purposes of preserving cultural identity.

Community values represent a related set of influences that were only superficially explored in this study and deserve more thorough exploration in future studies. Numerous informants emphasized the role played by "community values" in shaping the style and magnitude of participatory engagement. *Nipissing District*'s conservative values, for example, were thought to stifle participation while the strongly held rural value of "preserving local identity" was felt to engender emotional, broad-based community involvement. While the notion of community values shaping participatory actions and health system change has intuitive appeal,

we are at an early stage in our understanding of these relationships. In a recent study of the factors influencing health system change in twelve communities in the United States, results indicated that "the ability of communities to influence health system change depends on the degree to which common values exist, across the community or across influential segments, and the effectiveness through which these values are expressed". (Rossi Steinberg & Baxter, 1998, p.150). As local communities continue to be the focal point for reform in the health care domain, the need to understand, measure and elicit community values will become increasingly apparent.

Despite the dark shadow cast by the literature over the ability for institutional mechanisms to positively influence participation efforts, findings from this study offer some new insights into this relationship. First, the recognition given to long established DHCs in *Hamilton-Wentworth* and *Ottawa-Carleton* (as compared to *Nipissing District* or *Renfrew County*) suggests that over time these organizations may exert a stronger enabling influence over participation in their respective communities. Second, the enabling role played by local government in addition to the DHC appears to influence two specific dimensions of participation: what *form* it takes and who *initiates* it (see Appendix A). More specifically, the actions taken by these organizations are primarily concerned with enabling *routine*, *solicited* participation as compared to *unsolicited*, *issue-driven* participation. Third, the culture of participation described in *Ottawa-Carleton* (i.e. history of encouraging community-based service delivery and decision-making) matches the "expectation of participation" described earlier in the depictions of participation. Similarly, the local government's commitment to community involvement through visioning exercises in *Hamilton-Wentworth* matches the participation profile depicted earlier. The lack of infrastructure or culture of participation in *Nipissing District* also provides a plausible explanation for the "apathetic" participation profile depicted in this community. While the potential for institutional actions to act as "enablers" has been illustrated here, they also suffer from an inability to explain the differential participation that might be observed within communities. This is explained by the fact that most institutional actions are designed to enable participation ubiquitously across an entire region and, as such, do not take into account the unique characteristics of smaller communities within that region. In other words, enabling influences alone do not explain the highly participatory pockets reported within some study communities. A further observation, although not specifically mentioned by community informants is that community size and the concentration of resources that accompanies large regions governed by two tiers of government, full-time politicians and a sizeable bureaucracy must surely account for the presence of well-established infrastructures in *Hamilton-Wentworth* and *Ottawa-Carleton* as compared to *Nipissing District* and *Renfrew County*.

With respect to the political context of local health care decision-making, the case study findings support much of the previous literature that has emphasized the relative ease with which the dominant and concentrated interests of elite health care providers can influence a decision-making process through their own and the public's participation. What the results of this study have added to this literature is that the methods used to achieve these goals and their measure of success may also be shaped by other factors such as the structural and social characteristics of the community (e.g., education, ethnicity and the presence of common values); and the institutional context within which decisions are taken (e.g., role of health council, local government and the media).

Conclusions

The case study results presented here offer a first cut at improving our understanding of the role that various contextual influences (i.e., structural, social, institutional and political) play in shaping community participation in local health-care decision making. Study results shed new light on a subject where prior research has tended to focus on reporting experiences with efforts to involve the public in a single community or through a single method and for which the various contexts within which participation occurs have not been systematically taken into account. The heterogeneity of participation depicted in these study results underscores the importance of grounding efforts aimed at incorporating public and community views regarding local health services in the contextual fabric of local communities.

The exploratory nature of the research presented here must be acknowledged. To build on this work, future studies in this area would benefit from undertaking comparative analyses of different approaches to obtaining public input both within and among communities to understand the role that local context plays in influencing participation generally and community decision-making processes in the health sector more specifically. Finally, achieving a better understanding of the contexts within which community participation occurs and is shaped takes us several steps forward. However, we are still a long way from being able to predict or potentially influence the outcomes of community decision-making processes in the health care arena by simply understanding the context within which they are made. If participatory democracy is judged to be a desirable goal, then what is to be done, for example, about *Nipissing District*'s apparent complacency towards participation?

Could more active steps be taken to "enable" participation in this community and if so, what would they be? Similarly, is a collaborative approach to decision-making a desirable goal if it leads self-serving hospital administrators to protect their interests over the public's? These are all questions for which I have no answers. To be able to ask the questions, however, provides a starting point for future debates and analysis.

Appendix A. Dimensions of participation

Form

Form refers to the overall approach taken to participation. For example, it may take the form of routine and on-going involvement through committee membership in contrast to issue-driven participation through meeting attendance, petitions, letter-writing campaigns and other mobilizing activities.

Initiator

The initiator refers to who initiates the participation and whether it is *solicited* or *unsolicited*. For example, a local decision-making body such as the district health council may solicit a community's involvement in a particular health planning exercise. A community may also organize in response to a particular issue, even if its involvement is not solicited by an external agent.

Method

Method is related to form but refers to the specific means used to involve participants (e.g., attendance at meetings, committee membership, letter writing, contacts with public officials, etc.).

Quantity

Quantity refers to the magnitude of community participation (e.g., number of people who attended a meeting, wrote letters, applied for committee membership, etc.)

Intensity

Intensity refers to the amount of participation directed to a particular issue over a defined period of time (e.g., how many people attended meetings held over two-day period on the subject of hospital closures).

Texture

Texture can be both a qualitative and quantitative measure referring to the breadth or depth of community involvement (e.g., a few key individuals or organizations vs. grass-roots participation).

Tone

Tone refers to the degree of emotion underlying the community's involvement (e.g., sophisticated, business-like approach to participation or one that is aggressive and emotional).

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