THE ORGANIZATION

OF

DISTRICT HEALTH COUNCILS

IN ONTARIO

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ABSTRACT

This action research project with district health councils (DHCs) in Ontario, Canada, took place between 1976 and 1980. The purpose of the research was to identify the most effective forms of organization for DHCs, bodies set up to provide a local focus for planning and coordination of health services in the Province.

The research method was based on social analysis, a method developed over the last thirty years through applications in industrial, commercial, health, education and social service settings.

The first DHC was created in 1974 to serve the Ottawa-Carleton Region and there are now 25 DHCs covering 88% of the provincial population. Councils are generally regarded as community bodies, consisting of interested local citizens who serve on a voluntary, unpaid basis. The members comprise a mixture of 'providers', 'consumers' and local government representatives. The intensive research work was carried out in collaboration with three DHCs (Hamilton-Wentworth, Kenora-Rainy River and Ottawa-Carleton) and the emerging research findings were tested in a wide variety of settings including a number of the other DHCs.

The first two chapters attempt to set the DHCs in an organizational and political context. Chapter 1 looks at the development of DHCs vis a vis other social developments, particularly regionalisation and decentralisation. Chapter 2 examines the political context in which DHCs emerged and identifies the policy tensions that are inherent in their work.

In Chapter 3 a detailed account is given of the three intensive research settings and the organizational developments that took place during the course of the research. This chapter is in effect a summary of the whole research project. Chapter 4 is concerned with the nature and composition of councils, the roles of DHC member and chairman, and relationships among the DHCs. The research findings on alternative models of DHC structure are in Chapter 5 and 6, respectively concentrating on the Council and its committees and on the executive staff of council. The focus lengthens again in the concluding chapter to examine the potential for making overall judgements about the effectiveness of DHCs and the implications of this organizational study for other experiments in community-based health planning.

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It is not often that academic researchers have the
opportunity to be involved in the creation of
something new. The research project of which this
report is an account was just such an opportunity.

The District Health Councils in Ontario willingly
collaborated in the research and the members and
staff of three DHCs in particular - Hamilton-
Wentworth, Kenora-Rainy River and Ottawa-Carleton -
devoted a great deal of time, interest and
perspicacity to making sure that the researchers
got it right.

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Maureen Dixon
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THE ORGANIZATION OF DISTRICT HEALTH COUNCILS IN ONTARIO

CONTENTS

Page

INTRODUCTION

The research project on which this report is based was aimed
at identifying the most effective forms of organization for
the District Health Councils in Ontario. The research started
as a result of exploratory discussions in 1976 with the then
DHC Executive Directors and Area Planning Coordinators from the
Ontario Ministry of Health. Three DHCs indicated an interest
in forming a collaborative research relationship - Hamilton-
Wentworth DHC, Kenora-Rainy River DHC and Ottawa-Carleton
Regional DHC. In September 1977 research funds were granted
by the Ontario Ministry of Health (Demonstration Model Grant
332) and this funding continued for the further three years
of the research project.

The objectives of the research were:
- to pursue development in DHC organization by a
  method which is aimed at the resolution of practical
  problems of organizational development;
- by a process of continuing analysis, to develop
  generalizations about DHC organization in the form
  of rigorously defined concepts and models which can
  be used to solve specific organizational problems;
- to communicate and test these concepts in an
  increasing range of applications, locally and
  provincially;
- by means of this continual process of analysis, testing
  and feedback, to assess the validity of the concepts
  and models at each stage of their development;
- to demonstrate how the concepts and models can be
  applied in particular situations and to provide
  opportunities for training in their use.

A full description of the research method is given in Appendix I.

The research concentrated on those features of organization which
can be made the subject of deliberate enactment or change, namely:

- the organizational aims or goals and
  the functions to be carried out by DHCs
- the structure and composition of DHCs
- the authority and accountability attaching
  to the various roles within the DHC structure
- the rules and procedures to be followed.[1]

The research method is social analysis, a method developed
over the last thirty years through applications in industrial,
commercial, health, education and social service settings.[2]
As indicated above, the method is concerned with those
features of organization which can be the subject of enacted
change, and the conceptual scheme is in the form of propositions
about requisite organization in particular circumstances. The
method is based on the hypothesis that individual behaviour
in organizations is affected by the nature of the role which
the individual occupies, its relation with other roles and
with the entire social system within which the role is
positioned.

The method is intended to achieve a collaborative relationship
between researchers and the organizations, which gives access
to the real problems, which is long-term and which leaves
responsibility for change within the organizations. Thus, the
DHCs participated voluntarily and not at the request of the
researchers.   The researchers' function was not to advise
the DHCs but to help them identify problems and look at
alternative solutions.

A paragraph from the 1979-80 Annual Report of the Kenora-
Rainy River DHC summarizes the essence of the research approach.

...For the past three years, the District Health Council has
been part of a research project in conjunction with (the author)
and the Health Councils in Hamilton and Ottawa. The purpose
of the project is to work with District Health Councils on
the organizational development of each Council and to examine
accountability and authority patterns. During the three year
period, the Council in concert with (the author) has reviewed
many aspects of its organization including the role and

structure of the District Health Council, the relationship to
other agencies, the role of staff and relationships to Council,
the role of Council members and the role of the Chairman.
Through a problem solving approach, the Council has been able
to work out many of the difficult issues which face a new
organization during its first years of existence.

So it was the Council members and staff who defined the
problems and directed research towards those problems. In
many instances, the same organizational issue came up in
each of the DHCs, albeit in different forms, suggesting that
many of the problems were not related to idiosyncratic
circumstances but to unresolved difficulties affecting Councils
in general.

The research relationship was subject to explicit rules of
confidentiality so that findings identifiable with any one
DHC remained confidential to that organization until such
time as they were approved for wider discussion and publication.
This requirement did not however prevent the early generalization
of research findings as propositions about optimum organization.
These propositions were tested for validity and amended as
necessary in a variety of situations and with many of the DHCs -
seminars, research papers, research conferences and technical
discussions with others working in this field. Details of
the work undertaken to test the research findings in these
broader settings are given in Appendix II.

The task of distilling the findings of a research project that
lasted for more than four years is a daunting one. New and
interesting ideas emerged from each of the collaborative
relationships with the District Health Councils but it is
difficult to show this richness and complexity in a single
report. The depth of the analysis that DHC members and staff
were prepared to sustain is perhaps best conveyed by the
Analyses of Organizational Change in Chapter 3.

The report has also been written with a number of audiences
in mind. For those with a general interest in the organization
and politics of health services management, the first two
chapters attempt to set the DHCs in a broad context. Chapter 1
looks at the development of DHCs vis à vis other social
developments, particularly regionalization and decentralization.
Chapter 2 examines the political context in which DHCs emerged
and identifies the policy tensions which are inherent in their
work.

Those who work in or with DHCs are likely to be more interested
in the subsequent chapters. In Chapter 3 a detailed account
is given of the three intensive research settings and the
organizational developments that took place during the course
of the research; this chapter is in effect a summary of the whole
research project. Chapter 4 is concerned with the nature and
composition of the Councils, the roles of DHC member and chairman
and relationship among the Councils. The research findings on
alternative models of DHC structure are in Chapters 5 and 6,
respectively concentrating on the Council and its committees
and on the DHC staff.

The focus lengthens again in the concluding chapter to
examine the potential for making overall judgements about
the effectiveness of DHCs and the implications of this
organizational study for other experiments in community based
health planning.

CHAPTER 1   DISTRICT HEALTH COUNCILS AND REGIONALIZATION

The organizations with which this report is concerned,
District Health Councils in Ontario, are just one example
of a contemporary trend in many countries with organized
health systems. The trend is towards increasing decentrali-
zation of the planning and operation of health services,
with a simultaneous effort to involve communities and
consumers in the decision-making. Strong control of health
services from the centre has been found wanting, both in
terms of responsiveness to local needs and constraining
the rapidly increasing costs of health care.

DECENTRALIZATION AND REGIONALIZATION

The development of local health planning bodies in Canada
can be traced back to the Hall Commission in 1965 which
laid the foundation for comprehensive health insurance in
Canada and advocated the development of regional planning
and coordination of health services.[1] The Castonguay-Nepveu
Report, 1967, recommended a system for Quebec based on regional
offices for health and social services with executive authority
over institutions.[2] In other provinces, there were similar
proposals. For example, the Foulkes Report in 1974 suggested
capital planning districts for the health care system in
British Columbia.[3] On the other side of the country, the
Newfoundland government has been encouraging the decentrali-
zation of hospital management from provincial government to
local hospital boards since the late 1960s, although a regional
structure has not been developed there because of the
relatively small population.[4]

The changes in Quebec are particularly interesting, since they
have been the most fundamental in two respects - the creation
of a single system that applies across the Province and the

bringing together of health and social services under one
jurisdiction. The philosophical underpinning for the changes
emerged from the 'quiet revolution' of the late 1960s in
Quebec which started a series of social and political
changes in the Province. The philosophy is based on the
recognition of the capacity of the individual to define
his own needs and to produce services at the local level;
hence the right to different services, in nature and type,
from community to community. Such variation is more likely
if each local or regional community is involved with the
management of its services.[5]

Some of the tangible outcomes of this philosophy were the
creation of the Ministry of Social Affairs in 1970 with
responsibility for both health and social services, the
merging of many social service agencies into 14 Social
Service Centres (CSS) and the establishment of some 80
Local Community Service Centres (CLSC). Departments of
Community Health (DSC) were set up in general hospitals
to provide preventative and other public health services
and a network of reception centres (nursing homes and homes
for the aged) has also been created.

Since 1972, planning of health and social services in Quebec
has been the responsibility of Regional Councils for Health
and Social Services (CRSSS) which are comparable to District
Health Councils in Ontario. However, since 1972 the
CRSSS have gradually been given more authority to plan and
rationalize services on a regional basis. Bill 10, passed in
1977, gave an added impetus to decentralization by allowing
the CRSSS to create an Administrative Commission to administer
its responsibilities and Bill 103 in 1978 conferred new and
more powerful duties on the CRSSS. A subsequent review of
the CRSSS by the Ministry of Social Affairs has resulted in
a clarification of the Regional Council's functions - to
undertake regional planning, allocation of development monies
and proposed resource reallocation and control and evaluation
to ensure budgetary control.[6]

In the United States, there are also local health planning
bodies somewhat akin to DHCs in Ontario. These Health Systems
Agencies (HSAs), like DHCs, are decentralized voluntary bodies
comprising a mixture of health care providers and consumers.
Both HSAs and DHCs are advisory bodies to a higher level
of government - through a Statewide Health Coordinating
Council to a State Health Planning and Development Agency in
the case of HSAs and directly to the Ontario Ministry of
Health in the case of DHCs. Both HSAs and DHCs are expected
to consider the allocation of health resources in terms of
constraining costs and improving the quality and accessibility
of service. Both bodies review and recommend approval of
funds for specific health programs in their area. Neither
HSAs nor DHCs has 'executive authority' to implement approved
plans.

There are, however, some important differences between the
two bodies. In Ontario, DHCs have developed over a period
of time and only where there has been local support for the
concept. In the United States, HSAs are mandated by
legislation for every locality. The National Health Planning
and Resources Development Act of 1974 (Public Law 93-641)
provides for the creation of a network of 213 area-wide HSAs.[7]
The areas covered by HSAs tend to be considerably larger, both
in land area and population, than the districts covered by DHCs.
Hence, many HSAs establish sub-area councils to represent
geographical interests in the planning process. Although
there are some exceptions, most HSAs cover areas ranging in
population size from half a million to 3 million.[8] The staff
also tends to be larger, with many HSAs having about 20 full-
time staff and several having more than 60. Unlike DHCs, HSAs
are funded on a per capita basis, the budget being determined
by the population of the area. The boards themselves vary a
little more in size than do DHCs, ranging from about 10 to
30 members. The HSAs enlist a broad general membership from
their areas and then conduct elections according to rather
detailed membership categories. Consumers must be in the
majority.

Perhaps the major feature that distinguishes DHCs from HSAs
is the precision and specificity of the enabling legislation and
governmental rules. In the United States, there exists highly
regulatory legislation and subsequent National Guidelines
for Health Planning issued by the Department of Health
Education and Welfare. HSAs are expected to develop
comprehensive Health Systems Plans according to the ground
rules laid out for them.[9] By contrast, there has been a
notable absence of legislative guidance for DHCs in
Ontario and policy guidelines have been enunciated by
government in a largely pragmatic and incremental way.
Ontario has opted for flexible evolution whereas both
the United States and Quebec have chosen strong central
direction and standardized methods.[10]

It may or may not be significant for DHCs that in the United
States federal support for the health planning program is
to be phased out over a two year period as part of the
major spending cuts being introduced by the present
administration. The cuts to the HSA program reflect both
the administration's commitment to 'privatization' as a
means of achieving health financing reforms and three
perceived deficiencies in the HSA program - too much
regulation, lack of effectiveness and inappropriate federal/
state/local responsibilities.

REGIONALIZATION IN ONTARIO

In common with other provinces, states and countries,
there has been a continuing commitment to decentralization
through regionalization in Ontario for the last twenty years
or so. The three most obvious manifestations of this
commitment are the provincial planning regions, regional
government and district health councils.

In the late 1950s, the Ontario Government adopted ten
planning and economic regions, to be used primarily for the
analysis of economic and social development. By the early
1970s, the existing regions were judged to be too small and
were consolidated into six regions by the Ministry of Treasury,
Economics and Government Affairs (TIEGA) in 1972. Each region
is to have a major developmental analysis conducted; the report
on Northwestern Ontario was published in 1978. [11]

The development of regional government was strongly encouraged
in the late 1960s in the Province, being seen as a method
of pooling resources and achieving a more equitable distribution
of services. There are now twelve regional governments in Ontario,
all in major urban areas. Some regional governments, including
Metropolitan Toronto, Waterloo, Hamilton-Wentworth, Ottawa-
Carleton and Niagara, have been formally assessed and evaluated.
However, there has been continuing opposition to the notion of
regional government, with a determination in some areas to retain
the county system, and the unofficial policy now appears to be
to play down regionalization in this form.

1969 saw the production of the first report of the Committee
on Government Productivity (COGP), [12] which had been established
to 'inquire into all matters pertaining to the management of the
government of Ontario'. A major emphasis for the COGP was the
elimination of overlap and confusion between government
ministries. Arising out of the COGP recommendations, a number
of changes were made in the structure of government, including
the creation of the Ministry of Treasury, Economics and
Governmental Affairs in 1972 and the creation of the three
policy fields each with a Provincial Secretary, in Social
Development, Resources Development and Justice. The Ministry
of Health was also restructured in 1972 in such a way as to
accommodate the impending establishment of District Health
Councils.

The move towards a decentralized model for health planning began in 1965 when the Royal Commission on Health Services (Hall Commission) recommended regional and local health planning councils. District Health Councils were proposed by the Ontario Council of Health in its 1969 and 1970 reports on Regional Organization of Health Services.[13] These reports recommended a number of forms of decentralization including:
- health regions in the province, each to include a health science centre, which would provide the basis for setting goals, developing plans and coordinating health services;
- within each region, a number of districts which would participate in planning and coordination at a more local level.
It was recommended that councils be established at the regional and district levels to exercise the authority and responsibility delegated by the Province. The regional council was seen as having the role of planning for the provision of health services and of ensuring that efficient, effective and economic use was made of available manpower, facilities and funds. The district council was envisaged as organizing the provision of health care for the residents of the district and coordinating operational functions. Both the region and the districts would have financial authority "commensurate with responsibilities".

In 1976, a report of the Ontario Economic Council commented on the unproven and experimental stage of decentralization through regionalization.[14] The report pointed out the problem of delegation of planning, management and administrative functions to a local level without accompanying fiscal delegation, creating "perverse incentives for cost control".

DEVELOPMENT OF DISTRICT HEALTH COUNCILS

Perhaps the most significant manifestation of the policy of decentralization in Ontario is the development of District Health Councils. In 1974, the so-called Mustard Report,[15] following the lead of the Hall Commission Report and the Ontario Council of Health, recommended the creation of

District Health Councils for the primary purpose of planning
and coordination. The other major recommendation was the
creation of Area Health Services Management Boards within
districts which would be responsible for the operation of
services and the implementation of plans. Regional
Directors of the Ministry of Health were also envisaged.

The Ontario Ministry of Health responded by endorsing the
idea of DHCs but rejecting the other proposals.[16] In 1975
the government published the basic terms of reference for
DHCs in what has become known as the 'black book'[17] and it
is on the basis of this report that the 25 existing DHCs
have developed. There is no specific legislation setting
up DHCs. A report from the Ontario Council of Health in
1975 made proposals on the composition of Councils, district
boundaries, the DHCs' responsibility and authority and
models for organization and management.[18]

The first DHC, formed to serve the Ottawa-Carleton region,
began operation in January 1974. It was soon followed by
the creation of Councils in Thunder Bay and in the
Niagara region. Since that time 22 other Councils have
been formed. The 23rd DHC, that in Metropolitan Toronto,
was created in September 1980, based on the recommendations
of a Steering Committee published in February 1980.[19]
(See Chapter 2 for an analysis of the events surrounding the
creation of a Metro Toronto DHC).

The DHCs are in districts ranging in population size from
approximately 81,000 (Kenora-Rainy River) to over 2 million
in Metropolitan Toronto. In population terms, the present
25 DHCs serve 88% of the total provincial population.
(See pages 12 and 13).

Some District Health Councils were preceded by the
development locally of voluntary hospital councils.
Notably in the health sciences centres of London, Hamilton,
Toronto, Kingston and Ottawa, these hospital councils
performed major planning functions connected with the

DISTRICT HEALTH COUNCIL BOUNDARIES

MANITOBA

1

2

3

USA

Lake Superior

4

5

QUEBEC

5

Lake Huron

Georgian Bay

6

21

17

18

7

11

20

24

8

9

10

16

19

22

23

25

12

15

13

14

Lake Erie

Lake Ontario
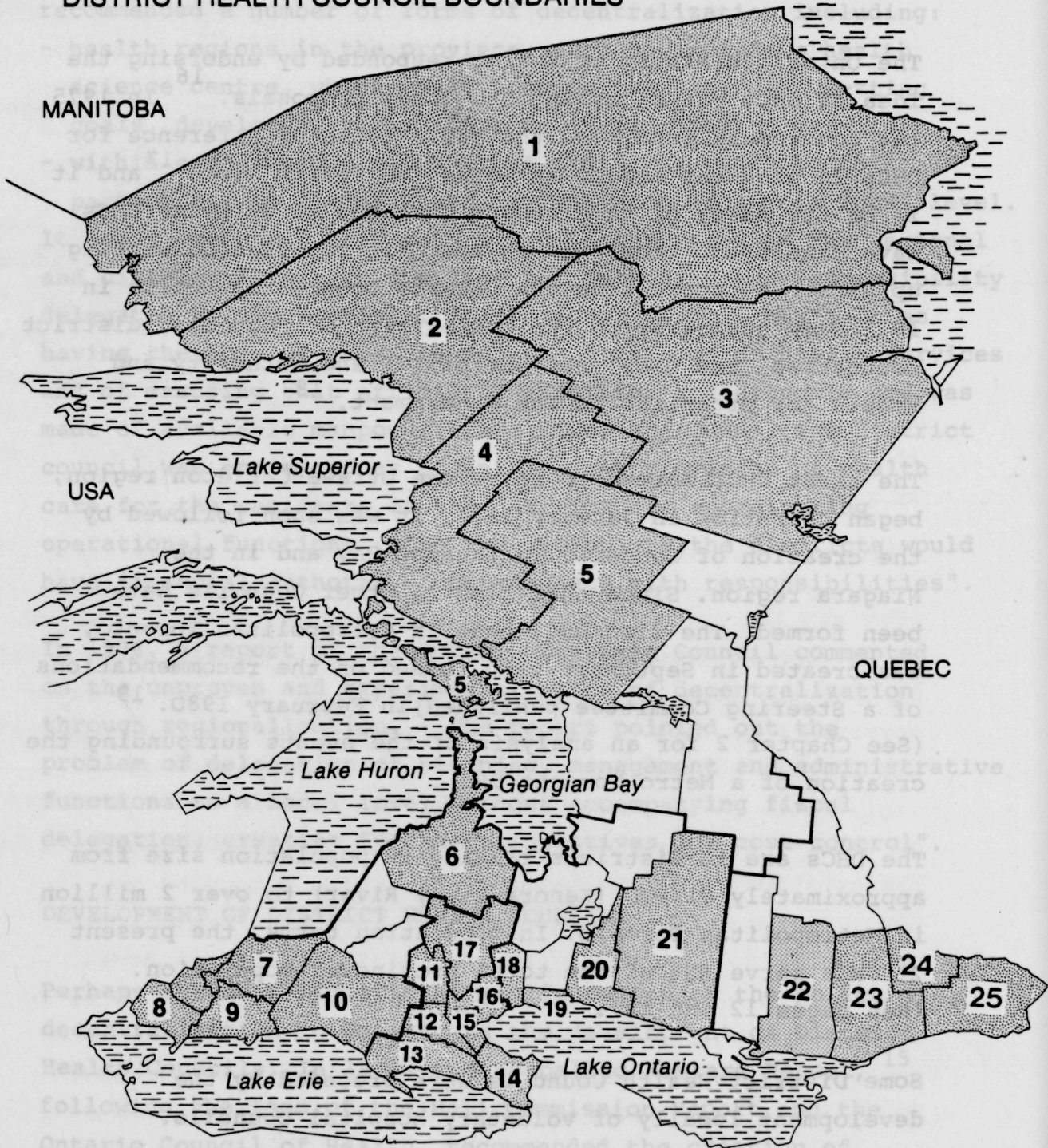
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DISTRICT HEALTH COUNCILS IN ONTARIO

Map Reference	DHC	Created	1980 Population	Size in sq. miles
North West Region				
1	Kenora-Rainy River	1975	80,938	159,713
2	Thunder Bay	1974	158,294	42,281
North East Region				
3	Cochrane	1975	97,856	56,153
4	Algoma	1977	127,941	19,771
5	Manitoulin-Sudbury	1976	213,474	18,129
South West Region				
6	Grey-Bruce	1976	138,019	3,261
7	Lambton	1977	127,835	1,077
8	Essex County	1976	323,065	1,000
9	Kent County	1976	109,663	958
10	Thames Valley	1976	475,114	2,778
Central West Region				
11	Waterloo Region	1977	318,533	525
12	Brant County	1976	104,435	354
13	Haldimand-Norfolk	1981	91,369	1,124
14	Niagara	1975	377,659	715
15	Hamilton-Wentworth	1976	421,049	524
16	Halton	1976	254,408	370
17	Wellington-Dufferin	1976	173,843	1,602
Central East Region				
18	Peel	1977	442,500	473
19	Metropolitan Toronto	1980	2,092,931	242
20	Durham Region	1977	275,409	960
21	Haliburton, Kawartha and Pine Ridge	1975	227,618	5,124
Eastern Region				
22	Kingston, Frontenac and Lennox and Addington	1981	148,032	2,572
23	Lanark, Leeds and Grenville	1977	125,043	2,492
24	Ottawa-Carleton Regional	1974	546,922	1,064
25	Seaway Valley	1980	152,647	2,045

allocation of federal funds in development of the medical centres.
Other smaller communities also used the hospital council model.
Some of these, for example in the Wellington/Guelph area, the
Waterloo region and the Niagara region, operated for a number
of years prior to the official development of the DHC model. These
bodies demonstrated the importance and effectiveness of cooperative
planning for the health care services in Ontario.[20]

The DHC concept has been consistently supported by provincial
government as the preferred model for decentralization of health
planning. In the Minister of Health's presentation to the Health
Services Review in 1979, he said:

> ... it is our belief and our experience that no-one
> is better able to assess and coordinate the health
> care resources of a community than the people who live
> and work there. Thus, we have developed the system
> of district councils to examine available resources
> and needs and make recommendations on the health
> priorities for their communities.[21]

The mandate for DHCs outlined in the black book in 1975
remains the only official statement on the overall role and
terms of reference for DHCs. The mandate was as follows:

> The District Health Council should:
> - identify district health needs and consider
>   alternative methods of meeting those needs that
>   are consistent with Provincial guidelines
> - plan a comprehensive health program and
>   establish short-term priorities that are
>   consistent with long-term goals
> - coordinate all health activities and ensure a
>   balanced, effective and economical service,
>   satisfactory to the people of the district
> - work towards cooperation in the social
>   development activities for the district.[22]

This mandate was set in the context of an <u>advisory</u> relationship to the Minister of Health. It was foreseen by many that there would be increased delegation of authority to the DHCs as they gained experience, particularly in the reallocation of funds realized from cost-saving planning. In practice, the DHCs have developed the ability to influence both the government and organizations and agencies in their communities to a greater or lesser degree. One of the major themes of this research project was the legitimate authority carried by DHCs within this advisory relationship; this aspect is analyzed in detail in Chapter 4.

A small number of DHCs have held responsibility for the provision of some direct services, notably placement and coordination services. In recent years, the tendency has been for the DHCs to divest themselves of these service functions.

Analysis of the operation of DHCs during the last few years suggests a wider range of aims in their creation than just the four offficial terms of reference. These aims, similar to those implicit in other models of decentralization in other jurisdictions, include:
- more local involvement in decision making
- representation of the consumers and the public in general
- greater equity in resource distribution
- more flexibility to accommodate local conditions and characteristics
- greater efficiency and effectiveness
- coordination and integration
- greater government control, particularly financial control.

It is arguable that some of these expectations are incompatible. For example, greater public involvement can often be inconsistent with increased government control, and a more equitable distribution of resources may require that local considerations be discounted . So it may be that DHCs, like other decentralized bodies, have somewhat unrealistic expectations laid on them.

COUNCIL FORMATION

Councils are generally regarded as community bodies, formed
of interested local citizens who serve on a voluntary, unpaid
basis. The members comprise a mixture of so-called 'provider',
'consumer' and local government members. The definitions of
these membership categories are imprecise. But, by and large,
members who earn their living or have a major volunteer
involvement in health services are regarded as providers.
Consumer members are those who have no formal affiliation with
health services. These broad categorizations mean that most
of the local government members of Councils are simultaneously
consumer, rather than provider, members.

The proportion of provider, consumer and local government
members differs from Council to Council. The original Ministry
guidance indicated a 40/40/20 split but in fact some Councils
have one-third of their membership drawn from local government
whereas others have few local government members. Councils
range in size from 14 to 24 members.

The creation of a Council has traditionally started with the
setting up of a local steering committee, sometimes as a
result of canvassing existing interest groups, sometimes as a
result of public meetings and newspaper advertisement. The
Area Planning Coordinators from the Ministry of Health, who
are the primary liaison officers between the Ministry and
DHCs, have played a central role in the establishment of
steering committees and in helping the local people to organize
the process. The steering committees have followed different
patterns in different places. Indeed, at least one steering
committee ultimately recommended that a DHC not be formed
in its area. But for the most part, the steering committees
have conducted the initial negotiations in their areas, have
received nominations for membership of the prospective Council,
and have passed their recommendations forward to the Ministry
of Health. On the basis of recommendations of the Minister of

Health to Cabinet, Council members are appointed by Order-
in-Council, a legal document of Cabinet ratified by the
Lieutenant-Governor-in-Council.

Until recently, Ministry policy was that chairmen of boards and
chief executive officers of health care institutions and/or agencies
were ineligible for Council membership. This policy was rescinded
in 1980 and there is now no occupational or interest group
affiliation which renders an individual ineligible.[23]

The Chairman of a newly-formed Council is appointed by the
Minister of Health from among the membership. Councils appointing
subsequent chairmen elect an existing member into the role, the
appointment being ratified by the Ministry.

With regard to the representative base of Council membership,
the black book suggests that members should behave in an
objective, impartial manner.

> ... each member must set aside parochial interests
> and function as a representative of the public at
> large, rather than as spokesman for a vested interest.[24]

Once a Council has been formed, the first task has usually been
to appoint the executive staff or secretariat. Each Council has
an executive director and the other staff typically include an
assistant executive director and secretarial and clerical staff.
Some of the older Councils do have additional staff and the
Metro Toronto DHC has a staff of ten at present.

This limited staffing has been an explicit policy of the
Ministry, the intention being to keep costs as low as possible
and to avoid the criticism that DHCs are another layer
of bureaucracy in the system.[25] The small staff of DHCs
is in marked contrast to Health Systems Agencies in

the United States, which employ large staffs of health planners
and researchers.

A 1980 study of the continuing education needs of DHC members
and staff shows that two-thirds of all Councillors were men,
the majority of Councillors were over 40 years of age, 15%
were retired, the average Councillor had served on a Council
for two years, spent about 17 hours per month on Council work
and had a history of volunteer work in the community. The
female Council members were younger than the men, had
higher levels of education and, if employed outside the home,
were more likely than the men to work as professionals,
particularly in the health service field. The majority of
the DHC staff were women and were 39 years of age or younger.
One of the Executive Directors was female (now two); most of the
women were in support roles such as secretary or research
officer. The average staff member had been in the position
for about two years. For about half the staff, their current
position was their first in the health field. [26]

DISTRICT HEALTH COUNCIL ACTIVITIES

The activities undertaken by DHCs differ considerably, partly
as a result of the different age of the Councils, partly as
a response to the different needs and characteristics of the
districts. Some DHCs have necessarily concentrated on hospital
matters; others have been more concerned with community health
services in their districts. Some have had to devote considerable
time and effort to identifying health care needs in their
localities; others started with a relatively good basis of data
about the needs and the existing health services. Some Councils
have had to start by building a network of relationships with
other agencies and community organizations whereas in other
districts the networks were already in place.

However, a circumstance which has affected all the DHCs is the
provincial programme of rationalization and reduction of hospital
beds which began to have an impact around the time many of the
Councils were being established. One of the outcomes of this
policy was that since 1977 the Ministry of Health has required
all DHCs to carry out the process of institutional review -
that is, reviewing all proposals for new or expanded programmes
in hospital settings, assigning a priority order to the proposals,
and submitting them to the Ministry. [27] Since 1979, the DHCs
have similarly all been required to review proposals from
local boards of health for new or expanded programs in community
health. [28] DHCs are also required to review district laboratory
and computer services. (The procedures for carrying out these
reviews have been changed recently and the Councils now spend
less time on these activities).

Apart from the internal, 'housekeeping' activities such as the
preparation of annual budgets, these review functions were
the only ones which had been specifically delegated to DHCs
by the Minister of Health. Otherwise, the activities which
a DHC chose to undertake were discretionary.

Through an informal polling of 21 Councils in the summer of
1980 and a review of annual reports, the following details on
DHC activities were obtained. (Seaway Valley, Metropolitan
Toronto, Haldimand-Norfolk and Kingston, Frontenac and Lennox
and Addington DHCs had not been established). The analysis
does not attempt to assess the quality or impact of the
various activities but some comments are made on their scope.

DHC ACTIVITY AREA	NUMBER OF DHCs INVOLVED
Long-term care and services for the aged (Many different activities were reported in this area ranging from comprehensive planning to investigations of specific problems like nursing home beds).	20
Mental health services and programs	19
Bed rationalization	18
Emergency services, ambulance services, disaster planning	17
Alcohol and drug abuse, other dependencies	15
Laboratory services	15
Placement coordination	15
Needs assessment/surveys (The range of activities in this area is wide. Some DHCs have conducted comprehensive surveys of health needs; many DHCs have surveyed needs with respect to specific areas of service.)	13
Community and primary care services	12
Health promotion	12
Distribution of health professionals, manpower (Many DHCs have looked at this issue as an aspect of another study. The ten which have focussed on the issue are mainly in underserviced areas.)	10
Rehabilitation (Ten DHCs have given comprehensive consideration to some aspect of rehabilitation; most have reviewed proposals with implications for rehabilitation.)	10

Community relations (There are many components of this activity - increasing the public visibility of the DHC, encouraging cooperation with social services, establishing relationships with municipal government, for example. Few DHCs concentrate on community relations per se but rather as an aspect of their other activities.)	10
Public health (apart from program review activity)	8
Dental health (Primarily an issue in underserviced areas).	8
Health services for Francophones (An issue in those parts of the Province with a substantial French-speaking population).	6
High technology (In the course of reviewing proposals for sophisticated equipment, several DHCs have analyzed the philosophy and effectiveness of high technology in health care).	6
Cardiac care (not only as an aspect of emergency services)	5
Maternal and child health	3
Services to Native Indian people	1

Twenty activity areas were identified by the DHCs as taking up a significant amount of time and effort. Of the 21 DHCs surveyed, 5 had been engaged in 15 or more activities and 3 had been involved in 5 or fewer. The activity areas that appeared to be of most general concern were long-term care, mental health, bed rationalization and emergency services. Several others, for example Indian health services, cardiac care and high technology, were significant activities for fewer than a quarter of the DHCs.

It is clear that although DHCs are constitutionally alike, they differ considerably in almost every other aspect - the size and characteristics of their districts, the size and membership of the Councils and the type and range of activities they have chosen to undertake. These differences can be largely explained by reference to the particular constellations of political factors surrounding the development of each DHC. These political factors, some general and some quite specific and local, are considered in the next chapter.

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CHAPTER 2   THE POLITICAL CONTEXT

The introduction of DHCs in Ontario met with less than
overwhelming support. Many existing organizations felt
that their territory was being invaded and, although there
are some significant exceptions, many health organizations
and associations have been quite resistant to the DHC
concept. Understandably, these organizations wished to
ensure that their authority and influence were maintained
and often saw the DHCs as a threat in this regard. The
development of DHCs thus illustrates the general difficulty
of establishing new organizations in already well developed
systems.

REACTIONS TO DISTRICT HEALTH COUNCILS

The Ontario Council of Health (OCH) was instrumental in
promoting the DHC concept through its 1969, 1970 and 1975
reports[1] and it has continued to endorse this model for
local health planning. In May 1977, the OCH produced a
report of a Task Force on the planning function of DHCs
which examined the operational, comprehensive and strategic
planning functions of Councils.[2] In 1980, at the request of
the Minister of Health, the OCH looked at the question of
how DHCs might be evaluated. In September 1981 a "developmental
assessment steering committee" was formed to review the
performance of the DHCs. The steering committee will oversee
the work of independent consultants who will conduct the
review, and the report to the Minister of Health is expected
in 1983.

In May 1973, before any DHCs were formally established, the
Ontario Hospital Association (OHA) and the Ontario Medical
Association (OMA) issued a joint position paper on the concept
of DHCs.[3] In that statement, both organizations endorsed the

phased implementation of DHCs as advisory bodies to the Minister
of Health. They also favoured the development of Councils in
response to initiatives from the districts concerned, rather
than by imposition by the Ministry.

In September 1977, the OHA developed a revised position paper
which was sent in draft form to the membership for its opinions
and comments. The draft was quite critical of DHCs, but the position
paper which was finally issued in February 1978 had been
considerably amended and had a generally supportive tone.[4]

> The OHA still supports the principle that local
> citizens and health care providers should be
> involved together to coordinate the planning of
> health services on a decentralized basis, and to
> advise both the Ministry of Health and the local community.[5]

The paper applauded the sense of local advocacy which DHC members
had demonstrated and recommended that hospitals cooperate fully
with their DHCs. However, the OHA was still concerned about
the "continuing proliferation" of DHCs before there was evidence
to allay concerns of providers and to demonstrate the extent
to which DHCs will improve the health care system in Ontario.
The two central issues for the hospital sector were, and
continue to be, that DHCs should not "usurp the independent
authority of local hospital boards" and that they should not
be used by government "as instruments to reduce health care
spending (rather) than as a means to improve local health
care services". The recommendations included:

- that DHCs should be limited to a planning
  advisory function;
- that no DHC be required to carry out the
  institutional review process (recommending
  hospital program priorities to the Ministry)
  until it signifies its readiness for that
  responsibility and until it has established
  a mechanism for obtaining guidance from qualified
  hospital people;

> - that hospital chief executive officers should
>   be eligible for Council membership.

Overall the OHA felt that "the jury is still out on DHCs"
and that Councils still had to win wholehearted support
and acceptance from the hospitals.

The OMA expanded its position in response to the 1974
Health Planning Task Force (Mustard Report). The OMA
stated that Councils should be responsible for identifying
health needs and health resources, evaluating the
effectiveness of the delivery system and recommending
changes. In a 1977 report of the special committee appointed
by the OMA President to study and evaluate DHCs, opinions
of physicians already involved in DHCs were presented.[6]
The doctors expressed scepticism about Councils' eventual
effectiveness but they did consider it "better to negotiate
than boycott" in order to retain influence over the direction
of health care services. The report reaffirmed the OMA position
outlined in the OMA-OHA statement of 1973, but added the
following concerns and reservations.

> - The balance of representation between
>   providers and consumers on some of the
>   Councils was open to question;
> - The designation of people considered to be
>   providers of health care had not always
>   conformed to the medical profession's
>   understanding of the term;
> - Government appeared determined to continue
>   the development of DHCs without allowing
>   for a period of observation of the already
>   established Councils. The effectiveness
>   and value of DHCs should be evaluated by
>   an outside, neutral source;
> - The ability of DHCs to work with local
>   physicians, local medical societies and
>   with other provider groups was questioned;

- The role that government was prepared to
  allow the DHCs to play was limited, as was
  the government's ability to respond to the
  priorities and advice of Councils;
- There was seen to be the possibility of undue
  influence and interference from some individuals
  or groups;

- There was concern that DHCs represented
  another costly level of bureaucratic
  interference and delay;
- It was feared that the executive director
  might manipulate the direction and activities
  of the Council.

The OMA report, nevertheless, encouraged physician involvement
in DHCs in order to forestall threatened changes in the
doctor's role which would reduce the scope and quality of
health services. The OMA argued that "the physician on
the District Health Council is the expert and will probably
be the most knowledgeable person on the topic of the delivery
of health care." The preferred method of obtaining physician
representation on Councils and their committees was by
nomination of the local medical society branch.

The Ontario Council of Administrators of Teaching Hospitals
(OCATH) expressed many of these same concerns in its 1977
brief to the OHA as a contribution to the OHA's position
paper.[7] In addition, OCATH suggested that DHCs had not had
any significant effect on the planning and development
of a health care system which was already coordinated and
effective, and that they had not shown any tangible success
in containing the costs of the system.

OCATH resisted any suggestion that DHCs should have
executive authority, arguing that Health Councils have no
place in a management role. With regard to the teaching hospitals,
OCATH considered that their problems were not easy to present

in an understandable manner to a Health Council and were better
dealt with in organizations such as the University Teaching
Hospitals Association in Toronto and OCATH itself.

This concern that DHCs might not accommodate the special needs of
the teaching hospitals and the health sciences centres was expressed
also by the Council of Ontario Faculties of Medicine,[8] arguing
from the similar position adopted by the Association of Canadian
Teaching Hospitals in 1975.

The nursing organizations have not been as critical of DHCs
as their administrative and medical counterparts. For example, the
Ontario Nurses Association (ONA) strongly endorsed the concept
of local planning and consumer participation in its 1977 position
paper on the health care system.[9] The ONA argued that local
health planning bodies may need fiscal authority in order to
achieve cost savings. But the lack of representation on Councils
of various employee groups from hospitals was criticised.

REACTIONS TO A METROPOLITAN TORONTO DHC

The creation of a DHC for Metropolitan Toronto in 1980 resulted
in a focussing and polarization of the arguments about DHCs. The
Hospital Council of Metropolitan Toronto (HCMT) and the University
Teaching Hospitals Association (UTHA) had both expressed
reservations about DHCs in general and a Metro DHC in particular,
but on the whole they were supportive of the development. In a
1975 report of a joint HCMT/UTHA task force, the likelihood of
a DHC for Metro Toronto was recognized and recommendations put
forward on how to organize it.[10] But the expressed hope was
that any such Council would affect the operating policies of
the existing health care system very little indeed.

> ... as much as possible, the operating entities
> (eg hospitals, clinics, primary care practitioners,
> and public health agencies) must be granted authority
> and operating autonomy to tailor their delivering of
> services to the specific functional and geographic
> areas assigned to them in the full health service spectrum.[11]

Metroplan was a project of the Metropolitan Council and the
Metropolitan Toronto Planning Board designed to involve the
public in the preparation of new long-term plans, physical,
social and economic. In 1976, Metroplan recommended that the
Province take no further action regarding the establishment
of a DHC in Metropolitan Toronto. Rather, the Metro Corporation
should prepare a human services plan which addressed the
problem of fragmented jurisdictions of health, education
and social services.[12] This suggestion that DHCs are a limited
response to coordinated planning, since they only deal with
'health' matters, has been a recurring theme in the debate.
In the same year, a report on Metropolitan Toronto was published
as part of an international study of health care in the big cities.[13]
The report was based on a study of the existing health care services
in Metro and opinions, obtained by a survey, about those services.
Many of the opinions quoted in that report refer to the lack of
coordination among the deliverers of health services, the
absence of clear objectives, the uncoordinated planning and hence
the lack of an overall plan, and the need for an organization
responsible for coordinating and controlling services. Among the
recommendations derived from the survey was the creation of a
District Health Council for Metro whose decisions would be binding.

In 1977, the City of Toronto Executive Committee questioned
whether a DHC should be established in Toronto. It was argued
that DHCs must reflect the balance of power in the local health
sector, and in Toronto this would mean domination by the
hospitals and medical school. If a DHC was inevitable, the
report endorsed the notion of the DHC as an extension of the
Metropolitan Toronto Council as suggested in the Robarts
Report,[14] not as a conventional non-elected Council.

The same general argument was put forward in 1977 by a
Special Committee of the City of Toronto studying the
Robarts and Comay Reports which, while questioning the

wisdom of a DHC for Metro at all, recommended that the
Metro Council be designated as the DHC on the grounds that
it "stands the best chance of dealing with the power
politics of the hospital community". [16]

At that time, the Borough of Etobicoke, the North York
and Etobicoke Boards of Health and the Etobicoke District
Health Council Committee all supported the concept of a
DHC but they argued that DHCs should be established at the
area municipality level, not the Metro level. The Borough
of Etobicoke pointed out that the Regional Municipalities
of Ottawa-Carleton and Hamilton-Wentworth each had a
DHC and that both had populations smaller than some of
Metro's area municipalities. [17]

In June 1977, HCMT was asked by the Ministry of Health to
act for an interim period in lieu of a district health
council on matters pertaining to hospital and hospital-
related services, including the setting of priorities for
new or expanded programmes and services. HCMT was also asked
to plan for eliminating unnecessary duplication of hospital
services and to initiate innovative ways of improving
health services. When the membership was polled, 80%
voted to accept the Ministry's invitation to expand
the role of HCMT in this way.

Also in 1977, UTHA and HCMT supported the concept of a
single DHC in Metropolitan Toronto but rejected the
Robarts Report recommendation that Metro Council be
designated as the DHC. [18]

In its March 1977 Toronto Bed Study, the Ontario Council
of Health recommended that a District Health Council for
Metro be established and that a steering committee to
prepare for setting up of a council be established by the
Ministry of Health. [19] The report concluded that the principles
of DHC organization should apply to all parts of the Province,

including metropolitan areas such as Toronto. It was argued
that Metro must be considered in its entirety for a planning
body to be effective; the complexities of Toronto, rather
than making an argument against a DHC, make Metro-wide
planning imperative. An impartial body acting in the
interests of the system as a whole was thought to be the
best way of rationalizing beds whilst maintaining the quality
of care. As the debate about a Metro DHC went on in 1979 and
1980, the Mayor of Toronto was reported as saying that much of
the work of the DHC was already being done by the City and
Borough boards of health. The DHC would add another level
of bureaucracy that would act as a buffer between the
Province and the municipal boards of health.[20] In North
York, the chairman of the local board of health and
several councillors were concerned that health boards
would get the short end of the stick if they had to compete
against hospitals in the planning priorities of a
health council.[21]

However, the pressure to go ahead with a DHC for Metro
increased and in July 1979, the Minister of Health announced
the formation of a six-member Steering Committee to advise
him. The decision to proceed with the establishment of a
Metro DHC was made clear in the announcement and was based
upon endorsement of the principle by Ministry of Health
officials, HCMT, UTHA and the Robarts Commission. The Steering
Committee was asked to make recommendations on the best
adaptation of the DHC concept to meet the special problems
of scale and complexity of Toronto's health care delivery
system, on a phased introduction of a DHC and its priorities
during the formative period, and on the required staff and
administrative support for the Council. The Steering Committee
was also to make recommendations regarding the Council's
size and representation, the expertise and experience of members,
tenure and conditions of re-appointment, and nominees for
chairman and initial membership of the Council.

The Steering Committee was given advice by a twenty-member
Advisory Group composed of representatives of the major
interest groups.[*][+] In addition, the Steering Committee
received submissions and briefs from many organizations
and individuals. The briefs were numerous and diverse, the
arguments being largely variations on the concerns already
identified in this chapter. It was also suggested that a
DHC should, as far as possible, use existing organizations
and agencies to deal with local issues. Most of the
interest groups were concerned that they should be well
represented on the Council itself.

The Steering Committee's report was issued in February
1980 and recommended a DHC for Toronto which conforms
broadly to the general pattern of existing DHCs.[22] A
Council of 24 members was proposed as large enough to
permit balanced representation and to ensure the effective
participation of Council members across a wide range of
activities. A central issue in the Steering Committee
and Advisory Group discussions was how to accommodate
the strong political and geographical identifications
within Metro, and this is reflected in the proposed
membership of the District Health Council:

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* Members of the Advisory Group were representatives of:
the Municipality of Metropolitan Toronto; the six area
municipalities; Academy of Dentistry; Consumer Association
of Canada; Faculty of Medicine, University of Toronto; the
Hospital Council of Metropolitan Toronto; Labour Council of
Metropolitan Toronto; Liaison Committee of Metropolitan
Toronto Boards of Health; Social Planning Council of
Metropolitan Toronto; Ontario Association of Homes for the
Aged; Ontario Medical Association District 11; Ontario
Nursing Home Association; Registered Nurses Association of Ontario;
United Senior Citizens of Ontario; University Teaching
Hospitals Association.

+ The author served as technical advisor to the Steering
Committee and the Advisory Group.

- At least 2 members should be resident
  in each of the 6 municipalities;
- The Councils of each of the 6 municipalities
  and the Municipal Council of Metropolitan
  Toronto should be asked to make a nomination
  to Council;
- At least one District Health Council member
  should be directly employed, or active in
  each of 10 fields (e.g. public health,
  university health science faculties, hospitals,
  health professions, social services, organized
  labour);
- At least 10 members of Council should be
  non-providers of health care;
- At least 8 Council members should be health
  care professionals who are actively practising
  or otherwise employed directly in the health
  care field.

Political considerations were also central to the discussions
on the Council's committee structure, with a significant
minority of the Advisory Group pressing for a sub-structure
based on the political subdivisions of Metro. But the final
recommendation on organization structure was that the
operational committees of Council should be based on
major health care areas: personal and community services,
treatment and rehabilitation services and specialized
services. The interests of particular municipalities,
geographical areas, special interest groups, community
groups and institutions would be served by membership on
these operational committees and on the proposed working
groups, task forces and advisory groups.

Following the deliberations of the Steering Committee, some
members of the Advisory Group submitted a minority report in
February 1980 which raised a number of objections to the
recommendations made by the Steering Committee.[23] The major

criticism was that the Steering Committee had been required
to limit its considerations to a single DHC for the whole of
Metropolitan Toronto. It was argued that Metro Toronto is too
large and too complex to be served adequately by a single
DHC. Other points were based on judgements of DHCs in general
and suggested that:

- the existing DHCs had not been evaluated
  and have not been shown to improve health
  care or achieve better value for money;

- the existing DHCs are dominated by health
  service providers, at the expense of the
  interests of consumers and municipal
  government; consequently, the DHC would
  be unlikely to achieve the shift from
  treatment-based services to preventative services;

- the mediating role of DHCs might result in
  a lessening of the pressure on the government
  to carry out reform in the system.

In spite of these objections, the Steering Committee's
recommendations were the basis for the new Metropolitan
Toronto DHC announced by the Ministry of Health on September 9,
1980. A single Council of 24 members was created for the
2¼ million population of Toronto, the first Chairman being
chairman of a local board of health and of the Liaison
Committee of the Metro Toronto Boards of Health. The
advertisement for the DHC's first Executive Director,
(The Globe and Mail, November 20, 1980) spoke of the
Council's monumental task "considering the size and
diversity of the population and the continuing demand
for more sophisticated services". An Executive Director
was appointed in February 1981 and the Council now has a
staff of ten.

INDIAN HEALTH CARE PLANNING

A further significant aspect of the political context of
DHCs is the needs of particular ethnic and/or religious
groups within their districts. In the course of the research,
there was the opportunity to work with one such group in the form
of the Indian organizations in the northwestern part of the
Province. Although the situation is not the same in all the
treaty organizations, there is a general concern that the health
status of the Indian population is poor, that services are
fragmented and that financial cut-backs are having a
disproportionately severe effect on the Indian people.[*]

The Indian organizations argue that the Indians' special status
with regard to health care relates to their aboriginal and treaty
rights recognized in the British North America Act (BNA) which
states that (s.91(24)) "Indians and lands reserved for Indians"
are a federal responsibility. The Indian Act, RSC 1951,
authorizes the Minister, with the consent of the council of the
band, "to promote the general welfare of the band or any member"
(s.66(1)) by expending funds "to assist the sick, disabled, aged,
destitute" (ss.2) "to prevent, mitigate and control the spread
of diseases on reserves" (s.18(2)). The Indian Act also allows
for local control of health services; a band can make by-laws
"to provide for the health of the residents on the reserve and to
prevent the spreading of contagious and infectious diseases" (s.81).[24]

In the early days of Indian affairs administration,
Indian health care consisted mainly of doctors accompanying
the Indian agents on their visits to reserves to pay treaty

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* This section is confined to a consideration of the health system
as it affects status and non-status Indians, although it is
appreciated that the Métis and other minority groups have their
own concerns and positions regarding the provision of health care.

annuities. In 1945, Indian Affairs transferred its
responsibility for Indian health services to the newly-formed
Department of National Health and Welfare and since 1962
services have been provided to registered Indian people by
the Medical Services Branch of the federal department. According
to the federal viewpoint, this is done "as a matter of policy
rather than as a statutory or treaty obligation."[25] Today,
Indian Health Services is one of eight sections of the Medical
Services Branch and divides its activities into treatment
services, public health services and involvement of Indian
people in health programs.

The pattern of health care for Indian people is complicated
and inconsistent. In general in Ontario, public health services
on reserves are provided by federal Medical Services, but
health services off reserves, which are used by Indian
people, are predominantly a provincial responsibility.
The accepted forum for negotiation of the federal-provincial
relationship in Ontario has been Indian Chiefs-Federal-Provincial
tripartite discussions.

Apart from the problem of confused and overlapping jurisdictions,
the other dominant political issue is the desire of the Indian
people, increasingly articulated in recent negotiations,
for what has been called 'Indianization' of health care. As
expressed by Grand Council Treaty No. 3, this policy implies:

- a return to, and encouragement of, traditional
  medicine and self-reliant ways;
- a gradual control of a new health care
  system by native people;
- training and apprenticeship of native people
  in health care (from medicine men and women
  to doctors, nurses, therapists, researchers
  and administrators);

- coordination of all community services to
  provide a better socio-economic environment;
- coordination of Indian federal and provincial
  health services.[26]

This move towards greater control of their health services
by the Indian people was supported in a 1968 paper from ·
the Medical Services Branch, Ontario Region, which argued
that it was timely to consider the desire of Indian groups
to manage their own affairs related to health and to pool
resources of the Indians themselves,the provincial government
and the federal government.[27]

DHCs come into this whole picture since many of them have
sizeable Indian populations in their districts, particularly
those in the northern part of the Province. There are 67,460
status Indians in the Province, of whom 43,864 live on the 182
reserves. (December 1978 population figures). Yet Kenora-Rainy
River DHC is the only one with formal representation of treaty
organizations on the Council.

The Kenora-Rainy River DHC, which was one of the DHCs where
the intensive field-work for this research project was carried
out (see Chapter 3), has a close working relationship with
Treaty No.3 and Treaty No.9; a representative from both
treaty organizations sits on the Council. But as an advisory
body to the provincial Ministry of Health, the DHC has no
mandate to deal with services administered by federal Medical
Services, nor are federal officials obliged to coordinate
their activities with those of the DHC. Consequently, in its
work the DHC has often to omit the needs of status Indians -
for example, in their survey on the aged published in April 1980.
(Future Developments of Health and Social Services for the
Elderly).

Discussions in May 1979 identified three possible responses
to the problem on the part of the DHC;

- in view of the jurisdictional divisions,
  to continue with the representation of
  the treaty organizations on Council but
  otherwise take no special initiatives;
- to increase the Indian representation on
  committees of Council, or to set up a
  special committee of Council to deal with
  Indian health affairs;
- to encourage the setting up of tribal
  health councils within the treaty organizations.

The last arrangement was already being pursued by the treaty
organizations and was seen to have the advantages of providing
a mechanism for concentrating on Indian health problems, which
could represent both status and non-status Indians, and which
could use the affiliation with the DHC as a way of gaining
expertise in health planning.[28] It was subsequently agreed
that the Council and the Treaties should work together to
find a solution which was acceptable politically within
the District.[29] The provincial Minister of Health met with
Treaty No. 3 and the DHC in August 1979 and agreed to fund the
DHC to continue its meetings with the two treaty organizations.

In September 1979, the Minister of National Health and Welfare
announced that consultation funds would be made available for
discussion of health care for all status Indians across Canada.
There was disagreement between the federal officials and the
Indian organizations about who should handle the funds and the
Honourable Mr.Justice Berger was appointed in December 1979
to undertake a Commission of Enquiry to recommend methods of
consultation that would ensure substantive participation by the
Indian and the Inuit peoples in decisions affecting the provision
of health care to them.

Among the documents used by the Berger commission were a concept paper on an Ojibway Tribal Health Council presented by Treaty No. 3 [30] and a resource paper prepared by the National Commission Inquiry on Indian Health, a technical sub-committee of the National Indian Brotherhood.[31] Both of these presentations drew on the findings of this research project in putting forward organizational proposals for Indian health councils.

The Treaty No. 3 presentation proposed a model of Band Health Committees, comprising local Band members, which, in contrast to DHCs, would not include health professionals or local professional support groups. These basic organizational units would each elect a member to make up the Ojibway Tribal Health Council serving the entire Treaty No. 3 area. Both levels would be provided with administrative and technical staff support through an Administrative Core Group. The DHC is identified as one of the external organizations with which the Tribal Health Council would need to work. More formal linkages, such as cross-membership between the two Councils, were not envisaged immediately but might emerge in the future.

The National Commission Inquiry on Indian Health paper puts forward alternative models of organization for Indian health councils, one based on a two-level structure, as in the Treaty No. 3 proposal, the other being a three-level system which might be required for larger organizations. The staff support would be provided by a small core group of staff. Like the Treaty No. 3 proposal, these models separate the community representation function of the health councils and the committees themselves from the technical and planning functions of the health professions and the staff, who would not be members of the planning bodies but advisory or accountable to them.

Both of the above papers raise the issue of the desirable
amount of authority to be carried by health councils within
the Indian organizations, the same issue that is central
to the operation of DHCs. The possibility of actual executive
control of some services, probably the educational,
preventative and developmental programs, is seen as an option, in
interesting contrast to the current emphasis with regard to
DHCs. (See Chapter 4).

The Berger Commission reported in February 1980 and, with regard
to the Indian people, recommended that the management of the
consultation process and the consultation funds (a total of
$950,000 per annum) be in the hands of the Indian organizations.
The Commission recommendations were based on the principles
of the new Indian Health Policy adopted by Federal government
on September 19, 1979, which supported further moves towards
decentralization of decision-making and greater self-determination
in the planning and provision of health services to Indian
people. Also in line with this policy, an appointment was
made in 1980 to a new post of Director, Native Health Policy
within the federal Medical Services Branch.

POLICY TENSIONS

It is clear from the foregoing that there are many interested
parties holding an almost equal number of positions regarding
DHCs. The context in which DHCs operate is highly political,
influenced both by organized political activity at provincial,
regional and municipal levels and by local political forces
of an idiosyncratic and unpredictable kind. The reactions to
DHCs in recent years reflect the key questions raised by the
various models for local health planning.

- Should health be planned in isolation
  from other human services, particularly
  social services?
- At what level should planning occur -
  municipality, region, district or province?
- Can the needs of special interest groups
  be given sufficient prominence in a body
  that is enjoined to consider the needs of
  a geographically defined population?
- Can DHCs carry sufficient accountability
  to the public with an appointed membership,
  or ought they to be integrated into local
  or regional government?
- Should the membership of Councils favour
  professional or lay members?
- Should the DHCs exercise advisory or executive
  authority?

These questions are usually discussed in terms of management,
legal processes, administrative mechanisms and other
organizational concepts. But if the analysis is made using
organizational and political theory, it is clear that there
are some intrinsic tensions built into the DHC model.[33]

Decentralization and regionalization
Unless our social institutions can tolerate a totally
individualistic approach to planning and operation of
services, what is decentralizing for one group is inevitably
centralizing for another. The Ministry of Health in Ontario
undoubtedly sees the DHCs as a force for decentralization;
but the individual hospital board or local board of health
has yet to be persuaded of the benefits of what it sees as
centralization. Furthermore, to be effective, decentralization
requires clear delegation of accountability and authority,
a feat not easily achieved by normal bureaucratic mechanisms.
Even in the models which are relatively defined or prescribed,
there is often an intentional blurring of the organizational

relationships, apparently in order to leave open as many
options as possible. So, in Ontario, DHCs are repeatedly
described as 'advisory' bodies, but they are also expected
to carry out functions which stretch the meaning of the word
'advisory' beyond any normal interpretation.

Another paradox of schemes for decentralization is the general
reluctance of the central body, usually government in some
form, to provide the broad, strategic policies within which
the decentralized bodies will be expected to make their more
local decisions. This reluctance may be explained partly by the
exigencies of the electoral system, which hardly encourage
governments to be explicit about their aims, and partly by the
fact that it is much easier for the centre to exert control
through administrative and financial procedures than through
the imposition of clear policy limits. Hence the familiar
situation of the decentralized body receiving little clear
guidance on broad objectives and aims but being tightly
controlled on detailed and relatively insignificant matters.

The 'natural' district
It is interesting that the largest district in land area is
the smallest in population terms, and vice versa. The
Kenora-Rainy River district has a population of 80,000 in
a land area of 150,000 square miles whereas the 242
square miles of Metropolitan Toronto contain a population
of over 2 million. The districts also differ widely in other
respects - urban versus rural, well-provided with service
versus under-serviced, different local government structures,
and so on. This wide variation in the size and nature of the
districts provides another source of debate about the
optimum size of the basic planning unit for health and social
services.

If we exclude Toronto, this range in district population size
is about the same as the range in the districts within the
British National Health Service, notwithstanding the quite
different patterns of population distribution in Ontario
and Britain. The reorganization of the British NHS in 1974
created districts - which unlike DHC districts are both
planning and operational units - ranging from approximately
78,000 to 500,000, even though the population figure of
250,000 was theoretically used as the basic operational unit.[34]

In the United States, the Health Systems Agencies generally
serve much larger populations. Of the 200 or so areas with
an HSA, only 4 have a population of under 200,000 and 5 have
a population of over 3,000,000.[35]

In the British situation, it has been argued that many of
the existing districts are too large. Following the 1979
Report of the Royal Commission on the NHS,[36] a consultative
paper was produced by the Department of Health and Social
Security which made clear the intention of government to
decentralize further the management of health services.

> We are determined to see that as many decisions
> as possible are taken at the local level - in
> the hospital and in the community. We are
> determined to have more local health authorities,
> whose members will be encouraged to manage the
> Service with the minimum of interference by any
> central authority, whether at region or in
> central government departments.[37]

Although no precise population or geographical definitions
were given, it was argued that the ideal district would be
a locality which is 'natural' in terms of social geography
and health care, large enough to justify the range of
specialties normally found in a district general hospital
but not so large as to make members of the authority remote
from the services for which they are responsible and from
the staff who provide them.[38]

An additional criterion which has been identified for the
'natural' district is that it must be small enough to allow
each independent medical practitioner the sense of possible
personal involvement in official, sanctioned, developments.[39]
Applying these various criteria in the British situation,
this leads to the suggestion of a population size of
150,000 to half a million as appropriate for the basic unit
in the health system.

In practice, the 'small is beautiful' principle has turned
out to be relatively fragile in the face of local and national
political considerations. When the next reorganization is
implemented in April 1982, the new districts in England will
range in population size from 86,000 (Rugby) to 836,000
(Leicester).

If we apply the criterion of size to the DHC districts in
Ontario, there are two obvious confounding factors.

> - As already emphasized, the DHCs are
>   accountable for planning but not
>   for the operation and management of
>   services at the local level. Does this
>   mean that smallness is not so important,
>   and that is why HSAs in the United States,
>   also not accountable for management, can
>   cover so much larger populations? Or does
>   the explicit community involvement
>   function of the DHCs mean that the

basic unit of organization should be even
smaller and more local?
- The population in the northern part of Ontario
is extremely sparse and scattered, and
the DHC districts with the smallest populations
are in the north. But is it reasonable
at all to apply the same criteria of
the 'natural' district to these huge, sparsely
populated regions and to small heavily
populated localities? In many parts of the
north, if the criterion of social geography
was to be dominant in determining the 'natural'
unit, many individual communities of no more
than 10,000 people or so would be the main
contenders.

This question of how local is local has been a constant
source of picayune argument in the DHC context and in other
systems. The fact of the matter seems to be that, much as
planners would prefer it otherwise, population size of itself
is not a reliable indicator of the 'natural' administrative
or organizational unit. Other social and environmental
factors are at least as important as size, and in the final
analysis all these factors succumb to gerrymandering.

Coterminosity of boundaries

Another aspect of the debate about the 'natural' district
is the desirability of the district boundaries being coterminous
with the jurisdictional boundaries of other central and
local government agencies. It has been generally assumed that,
to the extent that the various boundaries are the same, so the
organizations will be able to work together more easily and
achieve coordinated planning. All the agencies would be
considering the needs of the same community or social territory.

In many systems, Ontario being an example, there has been an attempt in recent years to achieve closer coordination between health and social services, since these services in particular need to be closely interrelated. Some systems, in Quebec and Northern Ireland for example, have gone as far as fully integrating administration of health and social services in one organization, with a single governmental department accountable for both areas. But the more familiar pattern has been to retain separate government departments and to attempt to achieve collaboration through coterminosity of boundaries at the regional or district levels.

The NHS in England provides an interesting case study in this connection. The 1974 reorganization established the principle of coterminosity of health authorities and local government boundaries at the so-called area level. But the 1979 Royal Commission Report judged that coterminosity had not, on its own, resulted in effective collaboration between health and local government services.[41] Joint administration of health and local government services was considered feasible only if regional government was introduced in England.[42] The subsequent consultative paper came to the conclusion that collaboration between agencies does not necessarily mean common administrative boundaries.[43] The recommendation was, therefore, that the area tier in the NHS in England should be removed and that new, and generally smaller, district authorities, or DHAs, created. The Circular implementing the change states that the new health districts "should as far as possible comprise natural communities, and the boundaries of one or more DHAs should normally be coterminous with the boundary of a social services or education authority".[44]

Compared with the English situation, the Ontario system
is much more complex, containing not only different types
of local government structures but also a multiplicity of
governmental and voluntary agencies whose boundaries overlap
and which are administratively autonomous. Some of the DHC
districts are coterminous on a one-to-one basis with local
government, some comprise a grouping of local government
counties or municipalities and some include areas which are
unorganized from a local government point of view. All the DHCs
have to relate to a wide range of service agencies, some
strictly local in nature, others which are outposts of
provincial or national organizations. If the added problem
of natural catchment areas for health services extending
beyond the official district boundaries is taken into account,
the principle of coterminosity becomes even more jejune.

Community involvement*

As illustrated in Chapter 1, the schemes for decentralization
of health care planning and provision have as a common
denominator the aim of greater public participation at the
local level. But in general, efforts to achieve increased
community involvement have not been notably successful. Some
explain this failure by the assertion that the community at
large will always be apathetic about health matters in general
and so efforts to involve the community are inevitably a form
of tokenism. Others suggest that the health systems themselves
have prevented real community involvement and so the challenge
is to devise more effective mechanisms for public participation.

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* There is a common tendency to discuss 'consumer involvement'
and 'community involvement' as if they were the same. As used
here, they are different concepts and have different organ-
izational and political implications:
- consumer involvement: providing access, for the
  individual consumer and families, to the system as
  it affects them - complaints procedures, 'open'
  systems, ombudsmen, consumer associations etc.
- community involvement: providing access for the
  local community, through representatives, to affect
  the system as it operates in their locality -
  membership on boards and committees, local planning
  bodies, selection of representatives etc.

Nevertheless, there have been striking developments in public participation in the last ten years or so through community groups, media coverage, local community action and pressure groups of various kinds. (Consider, for example, the rapidly organized and successful opposition to the closing of hospitals in Ontario in 1975 and 1976). Also, there has been a change in the sorts of demands which these groups represent. Traditionally, they were concerned with criticism and complaint about the standard of services being provided; now they are just as likely to be asking for involvement in setting priorities and in the planning process.

There seem to be two distinct schools of thought about how this kind of public involvement can be achieved. The first starts from the assumption that bureaucracy (organizational power) and democracy (social control) are inversely related, if not totally incompatible. The only way out of the dilemma is to demolish the organizational bureaucracies and replace them with some other form of institution which brings consumers and providers together in a political partnership.

The other view is that organizational power and social control are not only compatible but mutually reinforcing. To be effective, organizations must have authority to regulate their internal affairs and external relations; the delicate balancing task is to restructure relationships so that organizational elites cannot insulate themselves from external demands and use their power for their own ends, or be overwhelmed by the conflicting demands upon them. The complementary and contending interests of organizations and the communities in which they exist need to be placed in a political process which is capable of coordinating changes in decisions about allocation and integration. This approach does not reject politics as being an irrelevant nuisance, but attempts to create a political microcosm which has some autonomy vis à vis the larger system.*

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* The consequences of the two approaches to devising mechanisms for public participation were examined in greater detail in 'Trends in Organisational Design' (Dixon, 1976), an unpublished M.Phil. dissertation.

District Health Councils, like may other public service
bodies, are a compromise solution to the dilemma. Directly
appointed and indirectly elected members are intentionally
mixed together in Councils, as are providers of health services
with 'lay' members. The resulting tensions are palpable,
particularly since all members are enjoined to function as
representatives of the public at large, not of any special
interest group. It will be argued later that a body comprising
directly appointed members, local government members and
quasi-elected representatives of provider groups, does not of
itself ensure democratic community involvement. A version of
this argument has been put forward in the past by some sections
of government in Ontario, criticizing the creation of 'special
purpose bodies' on the grounds that the non-elected membership
cannot be accountable to the public.

Operation and Planning

DHCs are held accountable for planning and coordination but have
been given no accountability for operation of health services
in their districts; this accountability remains with the
individual organizations such as hospital boards or local boards
of health. The research findings bring into question the
feasibility of thus separating accountability for planning and
for executive action.

If the DHCs remain purely 'advisory', their advice can presumably
be rejected by either the Minister of Health or local agencies.
Councils might attempt to persuade the recipients of their advice
that their recommendations are sound but they would have no real
sanctions to employ. It is difficult to see how such organizations
would attract members or retain those they already have.[44] At
the other extreme, the notion of DHCs as 'executive' bodies ,
with accountability for operation and management of services as
well as planning, is quite clearly unacceptable in the present
political context. But in practice, the DHCs do carry more
authority than would normally be conveyed by the word 'advisory'.
As discussed in the analysis of DHC activities in Chapter 1, the
delegated function of reviewing program proposals in itself

confers considerable informal authority on the DHCs.

But the debate about how far DHCs can go without compromising their advisory status is, perhaps, the greatest source of tension for those working on or for the Councils. It can be argued that unless a Council is recognized as having legitimate authority to be involved in the implementation of plans it has negotiated, its whole raison d'être is removed. This point of view is based on the premise that accountability for planning and for executive action can be with separate bodies as long as there is explicit recognition of the requisite limits of their respective authority.

In summary, the DHCs are operating in a highly political and labile situation, but in this they are not alone. The intrinsic tensions in the DHC model are characteristic of other schemes for decentralization of health and social services. The catchphrase 'centralized authority and decentralized blame' cannot be confined to the example of DHCs. But if we discount criticisms of DHCs that are merely protection of the status quo, there does seem to be general agreement on the need for some form of local planning and coordinating body for health services. It seems likely that the success of DHCs will be determined by their ability to balance their responses to the pressures on them - to provide sound advice to the Minister, to maintain and increase their credibility in planning and, over time, to have an increasing impact on the organization of health care in Ontario. The older Councils have been able to achieve a marked degree of cooperation from local agencies and organizations, as shown by the amalgamation of hospital units and other schemes for rationalization which they have negotiated.

The remainder of this report is concerned with the efforts, through the research study, to unravel the organizational implications of this complex situation, to clarify the principles involved and to test those principles in the actual working of District Health Councils.

CHAPTER 3   ORGANIZATIONAL DEVELOPMENT IN DISTRICT
            HEALTH COUNCILS: THREE CASE STUDIES

RESEARCH SETTINGS

The research project was concentrated in the three
DHCs with which collaboration was originally established
in 1977 - Hamilton-Wentworth, Kenora-Rainy River and
Ottawa-Carleton. The intensive fieldwork with the members
and staff of these three DHCs provided the basic research
material. The social analytic method is not based on
statistical or survey techniques, so there was no attempt
to select the DHCs on the basis of their similarities or
differences. Indeed, the DHCs were effectively self-selected.
Nonetheless, the three organizations do provide interesting
contrasts, as shown by the profiles and analyses which follow
in this Chapter.

In addition to the intensive work with the three DHCs, less
intensive research relationships were established with a
number of other DHCs, usually in order to work through
organizational problems in a one or two-day conference with
Council members and staff. Such conferences were organized
at the request of Durham Region. DHC, Manitoulin-Sudbury DHC,
Grey-Bruce DHC and Waterloo Region DHC. In most of these cases,
the appropriate Area Planning Coordinator from the Ontario
Ministry of Health was also present at the conference. In
each case, a working paper was prepared after the conference,
identifying for the DHC the major issues and possible solutions.

During the final year of the research project, three
general research conferences were organized as an integral
part of the study. The research conferences were designed

to allow the participants to work with the researchers
on the critical organizational issues in DHCs and covered:
- the organization of DHCs (October 1979)
- the role of DHC Chairman (April 1980)
- the role of DHC Executive Director (June 1980).
The three Working Papers resulting from these conferences
are reproduced in full in Appendix III.

The other settings in which the emerging research findings
were tested included presentations at Action Centre Conferences
(the annual meeting of all the DHCs), seminars in the
University of Toronto and other universities, presentations
on courses and conferences and discussions with the District
Health Council Program of the Ministry of Health and with others
involved in research and consultancy in the DHC area.
(See Appendix II for details of those events.)

These various and varied research settings provided a good
base for testing the research findings. The material was
exposed to the criticism of those actually involved in the
practical work of DHCs, of academics, of Ministry staff and
of informed practitioners in health and social services.
The districts in which the research has been applied encompass
most of the important variables that might affect the
functioning of a DHC, such as:
- degree of urbanization
- size, nature and density of the district population
- size and remoteness of the district
- sophistication and availability of health
  and social services
- linkages with universities and health sciences centres
- distribution of health manpower
- form of local government organization
- political and cultural characteristics.

In addition, the DHCs involved in the research range from
those earliest established to ones created quite recently.

THREE CASE STUDIES

The following descriptions and analyses of the three DHCs
that collaborated in the intensive research work are in
effect a summary of the whole project. The characteristics
of each DHC and its district are described, followed by an
analysis of the organizational changes that took place during
the period of the research relationship. The analyses are
chronological and show the process of change from identification
of problems to analysis, diagnosis and consequent action.
In each case, the analysis has been approved by the DHC for
presentation in this form.

Hamilton-Wentworth District Health Council
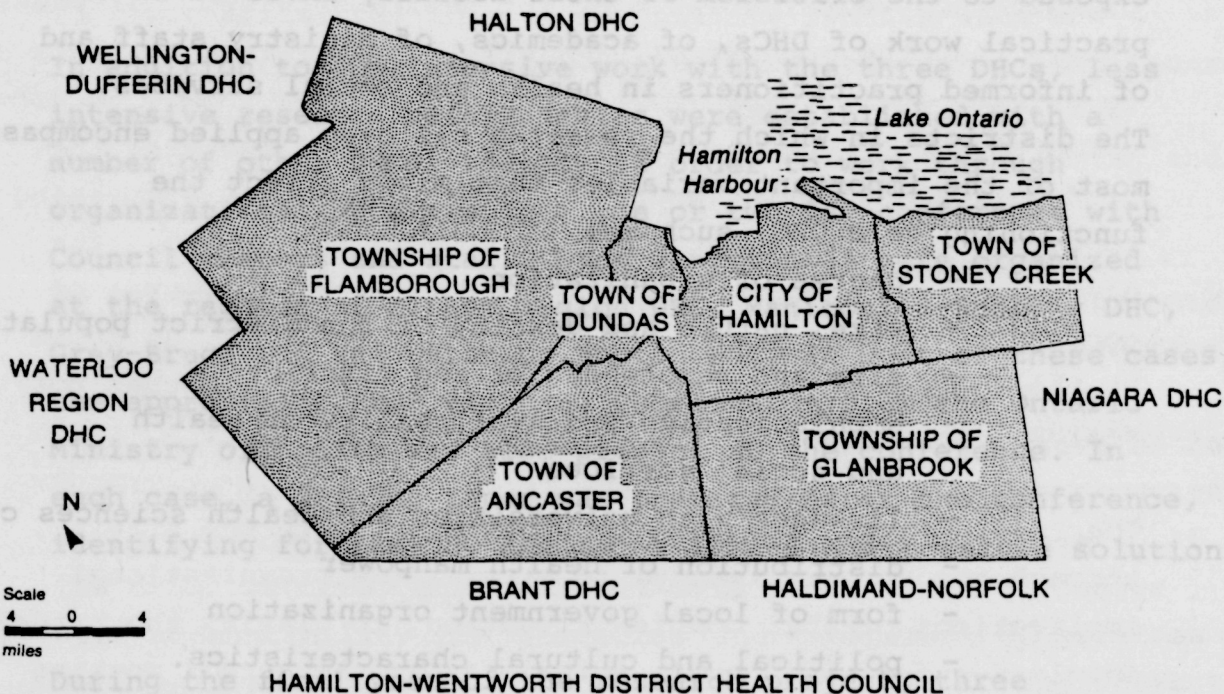
HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL

Source: Planning Development Hamilton-Wentworth Region

Formally established in January 1976, the Hamilton-Wentworth
DHC developed from the Hamilton District Hospital Council
(1965-70) and the subsequent Hamilton District Health
Council (1970-76). The two predecessor bodies were
innovative in coordinating health services and their develop-
ment on a regional basis in the Hamilton-Wentworth Region.
Located in southwestern Ontario, about 50 miles from Toronto,
the district is bounded by 6 other regional districts, all
of which have a DHC.

The DHC has worked to maintain the close cooperation among
the institutions that led to the development of health care
planning along programmatic lines.

The Council has 19 members, 3 of whom are regional councillors
appointed by the Regional Municipality of Hamilton-Wentworth.
The remaining members are evenly split between health care
providers and consumers. In a deliberate effort to avoid
domination of the Council by the City of Hamilton, which
represents nearly 70% of the population in the Region, members
are chosen to give a balanced representation between the City
and the rest of the Region. Approximately 480 people from
within the Hamilton-Wentworth Region serve on the committees
and other working groups of the DHC.

The Hamilton-Wentworth DHC has 6 permanent staff - an
Executive Director and Assistant Executive Director, an
Administrative Assistant and 3 secretarial positions. From
time to time, other researchers have been hired for limited
periods through Special Project funding.

The Region is comparatively small (524 square miles) and
densely settled (1,009 people per square mile). The
population (1980) is 421,049 and nearly 70% of the population
lives in the City of Hamilton. Hamilton is bounded by the
towns of Dundas, Ancaster and Stoney Creek. Two relatively
rural townships complete the Region. According to the

population projections of the Regional Municipality, the population will increase from 401,300 in 1971 to 550,000 by the year 2001. The population is slightly older than in Ontario as a whole and, as elsewhere, is growing older.

The area is heavily urbanized and contains a high proportion of heavy industry. The major employment sectors are steel production, manufacturing and service industries.

McMaster University, its affiliated health facilities and Mohawk College, all in Hamilton, comprise one of Ontario's five health sciences centres. As a consequence, the district is heavily supplied with health manpower, particularly medical and surgical specialists. The referral population for hospital beds in the Region is nearly 40% greater than the resident population. The surrounding districts rely heavily on the health services in Hamilton for tertiary care, as do some areas of Northern Ontario. Nevertheless, the Faculty of Medicine at McMaster University has a policy of promoting primary care physicians, particularly to work in under-serviced areas.

There are 5 active treatment hospitals, all in the City of Hamilton and all teaching institutions. Chronic care is available in 2 of these hospitals and rehabilitation in all 5. There is also a chronic care hospital specializing in geriatric care. Acute psychiatric care is available at 4 of the active treatment hospitals and there is an Ontario psychiatric hospital in the district. Within the Region there are 18 nursing homes and homes for the aged.

The ratio of active treatment beds to the referral population was 1:3.75 per 1,000 in 1980 and was expected to drop to 1:3.5 within a year. The decrease will be achieved without a reduction of beds through a growth and aging of the population.

Contrary to the pattern found in many large cities, virtually all medical services have been regionalized on a programmatic basis. In this way, major resources are deliberately concentrated in one institution and a referral network exists to ensure that patients are appropriately placed. This approach has led to the formation of inter-institutional programs such as nephrology, neuro-sciences, laboratory medicine, chronic and continuing care, primary care, in-patient paediatrics and obstetrics.

Public health services in the district are provided by the Hamilton-Wentworth Public Health Unit with headquarters in Hamilton. In the Region there are both acute and chronic home care programs and an assessment and placement service which was the first to be set up in the Province in 1970.[1]

Analysis of Organizational Change - Hamilton-Wentworth DHC

This analysis is chronological and covers the period of the research collaboration, September 1977 to June 1980.

Problem Identification	Analysis and Diagnosis	Action
Initial agreement between the DHC and researchers September 1977 that research should concentrate on clarifying the role of the DHC and its relationships, specifically: - the function and role of Council as a whole and of individual members - the extent to which Council should delegate activities to its groups and committees - the role of the Executive Director (ED) and relationships to Council and other staff.		Discussion and analysis with Council members, Chairman and ED. Researchers carried out individual role analyses of members and staff October 1977 - February 1978. Research Report No. 1 produced July 1978 identifying major organizational anomalies and problems.
PROBLEMS RAISED IN RESEARCH REPORT NO.1: Absence of a commonly understood definition of DHC's role and function July 1978.	DHC and Ministry of Health have different and sometimes conflicting views on role, functions and priorities. No mechanism within the DHC for developing policy in this area. Need for clarity on role and function before organizational issues can be addressed.	Ad Hoc Objectives and Priorities Committee (Ad Hoc Co.) re-activated to address issues in Research Report December 1978. Researchers requested to collaborate with the Ad Hoc Co. Decision by the Ad Hoc Co. to concentrate on those organizational issues which the Council has the authority to resolve. (See below).

Problem Identification	Analysis and Diagnosis	Action
Concern about the DHC-Ministry relationship. July 1978.	Lack of clarity about the relationship, internal and external. Absence of clear Ministry policies within which DHCs could be held accountable for local application. Inadequate communication links between Council and Ministry. Area Planning Coordinator's role unclear. Ministry organization structure not designed to fit with DHCs.	Not an issue which the Council has the authority to resolve; deferred for later consideration
Perceived domination of the DHC by the institutional sector July 1978.	Operational committees based on groups of health providers: Group A - health professions Group B - community agencies Group C - institutions Group D - health educators. Historical domination by institutional sector embodied in this structure.	Council decision to activate organization of Group B July 1979. Other attempts to shift emphasis from hospitals to community health programs and services.
Unclear to which Group or committee some issues should be addressed July 1978.	None of the Groups set up to consider across the board, programatic issues e.g. care for the elderly, mental health.	Decision to continue working with the existing structure since radical change not feasible January 1979.
Members feel unable to make well-informed decisions July 1978.	Over-delegation by Council to its sub-structure, resulting in loss of control and coordination. Almost complete separation of Council and committee membership. Council itself must retain planning and coordination functions. Members may lack pertinent information and analytical skills.	Continuing analysis of Council structure and relationship to sub-groups. Research reports on Council and committees prepared for Ad. Hoc. Co. January 1979.
Unclear role of Council members including distinction between consumer, provider and local government members July 1978.	Different perceptions about actual and desirable 'representative-ness' of members. Conflict between requirement that members be unbiased and non-parochial, and selection of members on the basis of external affiliations and interests.	No immediate action taken but related decisions made regarding development of Groups A and B.
How best to establish Group B (community agencies) July 1979.	Perceived need to relate to all community based agencies in health care-over 100 agencies. Yet involvement of large numbers of people and agencies should be a means to an end rather than an end in itself. Lack of clearly defined role for Group B.	A Council member, staff and researcher analyzed and refined role of Group B to reflect current needs of DHC July 1979. Group B not to include all district agencies but to consist of small, representative group which would draw on outside assistance as necessary. Development of accurate inventory of community agencies, task forces and committees involved in community care. Formation of Steering Group to explore organizational and membership arrangements March 1980.

Problem Identification	Analysis and Diagnosis	Action
Confusion about distinctive roles within Council's structure: Chairman, Executive Committee, Executive Director July 1979.	Need for analysis of functions, taking into account voluntary, part-time nature of Chairman's position and pervasive view that Executive Committee has too much power.	Discussion and analysis aimed at refining the definitions of roles of Chairman, Executive Committee, and Executive Director. Ad.Hoc. Co. report to Council that present role definitions for Executive Committee and Executive Director are satisfactory. Agreed that role of Chairman should be further analyzed and defined February 1980.
Continuing concern about lack of communication between, and coordination of, Council and its sub-structure Spring 1979.	Current Council policy that Council members should not be on subordinate committees. Council staff, rather than committee chairmen, report to Council. Groups largely determine their own work rather than having tasks delegated by Council. Unclear role and function of Operations Committee.	Ad. Hoc. Co. proposed and Council approved that: - Council members to participate in meetings of Groups and committees as non-voting members - Group and committee chairmen to participate in Council meetings as non-voting members. Elimination of Operations Committee July 1979.
Two of major sub-committees unwilling to allow participation of Council member(s) in its meetings Fall 1979.	Committees see themselves as autonomous, external groups, not as creations of Council or part of the DHC infrastructure.	After negotiations October 1979 issue temporarily deferred. Attempts to improve liaison and communication to continue. Organizational relationships of Council to external groups, particularly institutions, to be reviewed.
Continuing concern about lack of clarity in Council's overall role and function Spring 1980.	Use of Working Paper from Research Conference on DHC organization to diagnose the problem in the Hamilton-Wentworth DHC March 1980 concerning: - role and function - accountability - authority of the DHC.	Preparation of Research Report on Role and Organizational Policies of the DHC. Amended by Ad. Hoc. Co.and approved by Council as statement of principle on the DHC's role and working relationships. Statement to be made available to agencies and others who work with the DHC. (NOTE: THIS STATEMENT IS ATTACHED AT THE END OF THIS ANALYSIS).
Consideration of Chairman's role brought forward June 1980.	Need to analyze role of Chairman vis a vis the explicated statements on: - role and organizational policies of the DHC - role of the Executive Committee - role of the Executive Director.	Working Paper from Research Conference on role of DHC Chairman made available to Ad. Hoc. Co. and Council May 1980. Analysis of Chairman's role undertaken by Ad. Hoc. Co. with Chairman and Vice-Chairman June 1980.

THE STATEMENT ON ROLE AND ORGANIZATIONAL POLICIES OF THE HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL IS ON THE FOLLOWING PAGES.

ROLE AND ORGANIZATIONAL POLICIES OF
THE HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL

PREAMBLE

The policy statements below are based on the decision
of the Hamilton-Wentworth District Health Council to define
clearly its basic role and working relationships and to
make these definitions available to individuals and organizations
who work with the District Health Council.

ROLE AND FUNCTIONS

The official terms of reference for the District Health
Councils as given in The District Health Council, Ontario
Ministry of Health, 1975 are:

- "identify district health needs and consider alternative
  methods of meeting those needs that are consistent
  with Provincial guidelines
- plan a comprehensive health care programme and establish
  short-term priorities that are consistent with long-
  term goals
- coordinate all health activities and ensure a balanced,
  effective and economical service, satisfactory to the
  people of the district
- work towards cooperation in the social development
  activities for the district."

In order to fulfill these terms of reference, it is
considered that the Hamilton-Wentworth District Health Council
must, at different times and with respect to different issues,
act in the following roles:
- an advisor to the Minister of Health
- an advocate for the District with regard to health
  needs
- a mediator between the Ministry of Health and the
  community
- a mediator between agencies and organizations in the
  community

The mandate for all District Health Councils specified
by the Ministry of Health should be clearly defined but
sufficiently broad to allow interpretation and application
according to local needs.

Within the general terms of reference, the Hamilton-Wentworth District Health Council should be carrying out the following functions:

- advice giving (collect and forward information and interpretation to the Minister and Ministry)
- network building (create linkages between agencies and individuals in the community)
- needs assessment (identify health care needs in the community and take appropriate action)
- programme development (study, coordinate and rationalize within the present system)
- planning (plan health services for the future)
- monitoring implementation (monitor the implementation of agreed plans)

The Hamilton-Wentworth District Health Council will not be accountable for the allocation of resources or management of programmes; but it must be authorized to coordinate planning and monitor the implementation of plans.. If the Hamilton-Wentworth District Health Council is prevented from being actively involved in these functions, the motivation for the Health Council members to carry out any of the other functions will be substantially diluted.

Recognizing that there are issues which the Minister will expect Health Council to work out in its own District, the Hamilton-Wentworth District Health Council will judge its own priorities.

Accountability and Authority of the Hamilton-Wentworth District Health Council

The relationships of the Hamilton-Wentworth District Health Council to the Minister, the Ministry, provider agencies and individuals and the community in general differ with regard to the accountability and authority involved.

ACCOUNTABILITY	AUTHORITY
The Minister:	
In the absence of specific legislation, the accountability of the DHC to the Minister has been given substance by precedent and experience. The DHC is accountable to the Minister for carrying out specific tasks within the functions outlined above. But the accountability is limited to these specifically delegated tasks; otherwise the DHC has discretion to decide its own tasks.	The Minister carries limited authority over the DHC. It is assumed that the Minister could dismiss a DHC judged to be incapable of fulfilling its role and has the authority to veto the appointment of particular members to the Council.

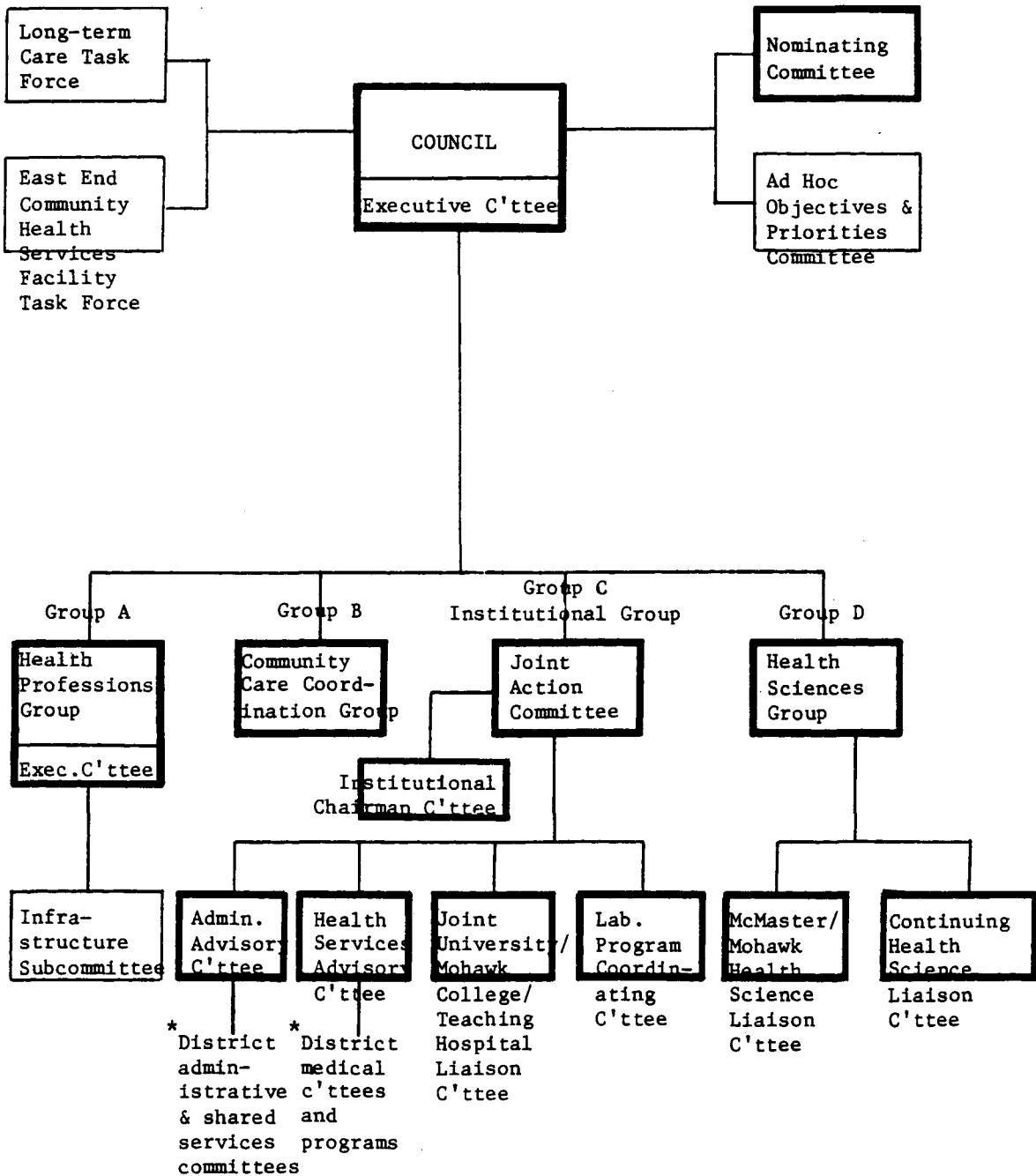| ACCOUNTABILITY	AUTHORITY
Ministry Staff:	
The DHC is not accountable to individual members of the Ministry staff nor to the Ministry as a whole. The Executive Director of the DHC is accountable to the Council.	Since the line of accountability and authority is between the Minister and the Council, the Ministry staff, including Area Planning Coordinators, do not carry authority over the DHC or its staff. Rather the relationship is one of mutual information giving and communication.
Providers of Health Care:	
The DHC is responsible for ensuring that the views of provider agencies and individuals are taken into account in its decisions. But the DHC is not directly accountable to such providers and cannot, therefore, guarantee that their views are upheld.	The DHC carries limited authority affecting provider agencies and individuals: to monitor the implementation of agreed plans and to coordinate programme development and health planning activities. The authority does not extend beyond these limits. The DHC cannot direct providers nor can it directly employ sanctions.
The Community:	
The DHC is responsible for taking community concerns into account in its decisions. Within this community responsibility, the DHC may decide that local needs are not best met by a particular local or Provincial policy and so attempt to have that policy changed. But the DHC cannot be held directly accountable by the community.	Neither the DHC nor the community carry authority with respect to each other.

June 18, 1980

ORGANIZATIONAL STRUCTURE OF THE HAMILTON-WENTWORTH
DISTRICT HEALTH COUNCIL (as at July 1980)

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┌──────────────┐                                              ┌──────────────┐
│ Long-term    │                                              │ Nominating   │
│ Care Task    │           ┌──────────────────┐               │ Committee    │
│ Force        │           │     COUNCIL      │               └──────────────┘
└──────────────┘           ├──────────────────┤
                           │ Executive C'ttee │               ┌──────────────┐
┌──────────────┐           └──────────────────┘               │ Ad Hoc       │
│ East End     │                                              │ Objectives & │
│ Community    │                                              │ Priorities   │
│ Health       │                                              │ Committee    │
│ Services     │                                              └──────────────┘
│ Facility     │
│ Task Force   │
└──────────────┘
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                                    Group C
  Group A            Group B    Institutional Group        Group D

┌─────────────┐  ┌─────────────┐  ┌─────────────┐      ┌─────────────┐
│ Health      │  │ Community   │  │ Joint       │      │ Health      │
│ Professions │  │ Care Coord- │  │ Action      │      │ Sciences    │
│ Group       │  │ ination Grp │  │ Committee   │      │ Group       │
├─────────────┤  └─────────────┘  └─────────────┘      └─────────────┘
│ Exec.C'ttee │         ┌─────────────┐
└─────────────┘         │ Institutional│
                        │ Chairman C'ttee│
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┌─────────────┐ ┌─────────┐ ┌─────────┐ ┌─────────┐ ┌─────────┐ ┌─────────┐ ┌─────────┐
│ Infra-      │ │ Admin.  │ │ Health  │ │ Joint   │ │ Lab.    │ │McMaster/│ │Continuing│
│ structure   │ │ Advisory│ │ Services│ │Universit│ │ Program │ │ Mohawk  │ │ Health  │
│ Subcommittee│ │ C'ttee  │ │ Advisory│ │/Mohawk  │ │Coordin- │ │ Health  │ │ Science │
└─────────────┘ └─────────┘ │ C'tee   │ │ College/│ │ ating   │ │ Science │ │ Liaison │
                            └─────────┘ │ Teaching│ │ C'ttee  │ │ Liaison │ │ C'ttee  │
                  *          *          │ Hospital│ └─────────┘ │ C'ttee  │ └─────────┘
                District   District     │ Liaison │             └─────────┘
                admin-     medical      │ C'ttee  │
                istrative  c'ttees      └─────────┘
                & shared   and
                services   programs
                committees
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Key

Kenora-Rainy River District Health Council

(northern portion not shown)
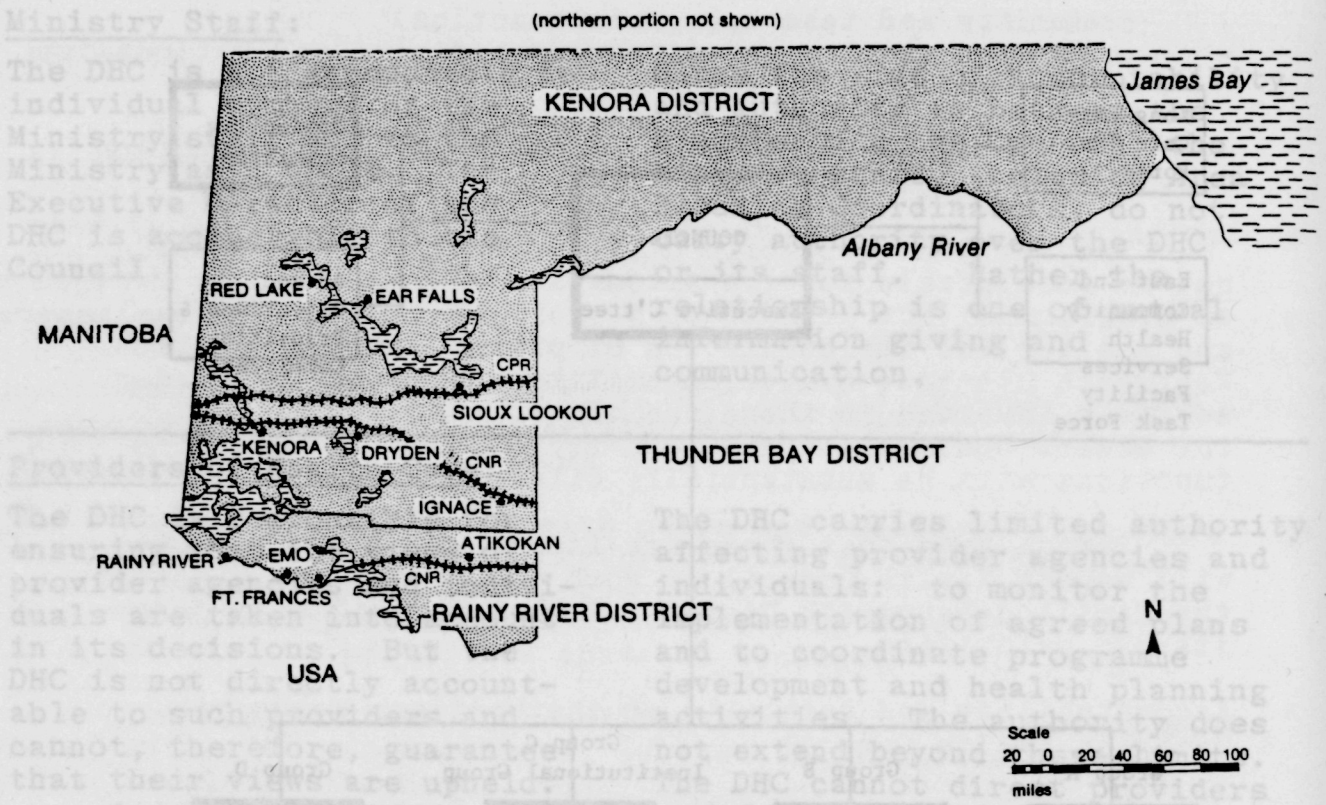
KENORA-RAINY RIVER DISTRICT HEALTH COUNCIL

Source: Ontario, Ministry of Treasury, Economics and Intergovernmental Affairs, Economic Development Branch

The Kenora-Rainy River DHC was established in December 1975 with offices located in the town of Kenora. The Council consists of 18 members selected from four groupings: health professionals, lay community members, municipal representatives and the two treaty organizations representing native Indians. Community members account for about half of the membership. Broad geographical representation is considered as important as a balance of interest groups. Over 150 individuals from across the area have served on committees and other working groups of Council.

The DHC is staffed by four full-time people: an Executive
Director, an Assistant Executive Director, a Senior
Secretary and a Secretary/Clerk.

The area served by the Kenora-Rainy River DHC is different
from the rest of the Province in a number of ways, explaining
both the nature of the health problems found there and the
often unconventional solutions required. The distinctive
characteristics arise from:
- the size of the area: one-third of the
  land area of Ontario or nearly 160,000
  square miles
- the nature and distribution of the
  population: more rural, younger and
  with a larger proportion of native Indians
  than in the rest of the Province
- the physical and psychological distance
  from the Ministry of Health in Toronto -
  over 1,200 miles.

The area served by the DHC comprises two geographical
'districts', the Kenora District and the Rainy-River District,
but for health planning purposes the two are combined. This
area contains only 2% of the provincial population or 81,000
people. It is sparsely and unevenly populated.

Settlement is dispersed in small communities most of which
are single industry towns. The primary employment bases
are pulp and paper, mining, transportation and tourism. The
income and employment situation is somewhat poorer than in
the Province as a whole and considerably poorer for native
groups. Kenora, Fort Frances and Dryden are the largest
centres in the area, with populations of 6-10,000. Most
other towns and settlements have fewer than 3,000 people
and are found along main transportation lines.

The overall population of the area is relatively stable.
The Rainy River District has experienced a rapid movement

of people from rural to urban areas, whereas in Kenora
District there has been a significant out-migration
counterbalanced by a high birth rate. A decline in
population is projected and the native population is
expected to be 50% of the total by the year 2000.

The Kenora District has a far higher percentage of
native Indians (21%) than the Rainy River District (7%)
but both are considerably higher than for the Province
as a whole (0.8%). Approximately three-quarters of
all the status or registered Indians live on reserves.
The reserves are affiliated with one of two federal
treaty organizations in the area. Treaty No.3 lies in
the southwestern portion of the area and contains
approximately 8,700 Ojibway living on reserves. The
area north of Sioux Lookout constitutes Treaty No.9 and
contains between 7-8,000 people belonging to the Ojibway
and the Cree tribes. In addition, there are registered and
non-registered Indians and Métis living off reserve.

The area is undersupplied with health manpower. There are
only about half the number of doctors and dentists and
about three-quarters the number of registered nurses per
1,000 population as in the rest of Ontario. On the other
hand, there is a generous supply of registered nursing
assistants because of the presence of two training schools
in the district.

The ratio of active treatment beds to population is
5.8:1000, considerably above the provincial ratio of
4.0:1000. (This figure includes the 70 beds at the Zone
Hospital in Sioux Lookout which are not included in the
provincial bed-to-population statistics). Nine general
hospitals are located in the area ranging in size from 14
to 95 active treatment beds. Five of the hospitals also
have a chronic care unit. There are two homes for the
aged, one nursing home and 8 federal nursing stations on
reserves. The Northwestern Health Unit home care program

is available in five communities.

Public health services are delivered through three different
programs, two under provincial and one under federal
jurisdiction. The Northwestern Health Unit with headquarters
in Kenora serves all the incorporated towns and the many
unorganized territories in the area. The Northern Ontario
Public Health Service provides public health nursing to
some unorganized areas, bush camps and parks in the northern
part of the Kenora District. On reserves, the Medical
Services Branch of Health and Welfare Canada is accountable
for public health services, including sewage and water
inspection.

Both ground and air ambulance services are provided for
emergency medical transport to the nearest hospital or if
more specialized treatment is required to Thunder Bay,
Winnipeg or Toronto. Routine health care is difficult for
those in remote areas to obtain. Most specialist services
are lacking for the entire population of the area and
have to be sought elsewhere. Dental and mental health
services are particularly scarce.

Registered Indians receive their health services from both
federal and provincial governments. Health related services
provided on reserves are organized through the federal
Medical Services Branch and remote Indian communities are
served by federal public health nurses at strategically
located nursing stations. On most reserves there are also
community health representatives who are usually reserve
residents with basic health care training. Under a shared
cost arrangement, both the federal Medical Services Branch
and the Ontario Ministry of Health finance the Zone
Hospital in Sioux Lookout whose clientele is mainly Indian.
Ambulance services and medical care are covered by the
Ontario Health Insurance Plan. The jurisdictional
responsibilities with respect to Indian health are not

at all clear and, as described in Chapter 2, Indian
organizations are taking steps to assume control over the
planning and management of their own health services.

The major health related problems, which exist across the
area, are:

- high infant mortality, particularly in
  the Indian population, due to prematurity,
  gastroenteritis and respiratory infections
- accidental and violent deaths, closely
  associated with alcohol consumption
- an inadequate array of community based
  services for the elderly
- poor dental health in children. [2]

Analysis of Organizational Change - Kenora-Rainy River DHC

This analysis is chronological and covers the period of the
research collaboration, January 1977 to June 1980.

Problem Identification	Analysis and Diagnosis	Action
January 1977 Initial agreement that research should concentrate on: -identifying purposes and goals of Council -establishing priorities among competing goals -developing principles of organization structure -setting action priorities for Council with special reference to: . adult mental health services . long-term care . institutional review.		Discussion and analysis with Council members, Chairman and Executive Director (ED).
Uncertainty about overall goals of Council Winter 1977.	Lack of sufficiently organized data and no way of setting priorities. Need for clarity on goals and functions before organizational issues can be addressed.	Weekend Seminar at Quetico for Council and staff April/May 1977. Resulted in initial clarification of: -goals of Council -priorities -consequent activities -tentative formulations on organization structure. Working Paper prepared following Seminar and used by Council members to address problems May 1977.
Impossibility of addressing all goals simultaneously April/May 1977.	No mechanism for putting goals in priority order.	Criteria were developed against which each Council member was asked to rank goals - a priority matrix. Resulted in identification of top priorities which were adopted by Council and published in First Year Report June 1977.

Problem Identification	Analysis and Diagnosis	Action
Confusion about extent to which Council should decide its own priorities April/May 1977.	Lack of general, clear statement on role and functions of DHCs within the health care system. Need for further definition of 'advisory' role of DHCs.	Through review of Ministry statements and discussion, further clarification of the the DHC's accountability and authority. Agreement that Council's advisory role should include the authority to monitor and coordinate activities at the local level April/May 1977.
Confusion over whether members should directly represent the interests of their constituent groups April/May 1977.	Inevitability of members identifying with their external interest groups when those interests under discussion. The objective, non-parochial member an unrealistic notion.	Issue worked through with Council as a whole. Agreement that Council decisions are binding on members and hence the limitation of decision-making by majority vote April/May 1977.
Difficulty in accommodating the needs of many communities with different needs in a huge District April/May 1977.	The consequences of geographical versus functional differentiation in Council structure - the structure must take into account both geographical factors and the need to foster comprehensive planning for the whole District. Limited staff to provide coordination and back-up.	Model of three local 'mini-DHCs' rejected. Acceptance of model of operational committees dealing with functions for the whole District possibly linked to sub-groups with a specific local mandate June 1977. Recognition of need for Executive Committee members to be drawn from three sub-areas.
Lack of clarity about ED's accountability and authority April/May 1977.	ED directly accountable to Council as a whole but Chairman has special responsibility to monitor the relationship. Executive Committee helps to dilute any exclusivity in the ED-Chairman relationship.	Organizational statements produced on clarified roles of Chairman, Executive Committee and ED May 1977.
Gaps, overlaps and confusion in organization structure. No obvious place in structure for some Council priorities to be pursued. Where to place accountability for functions that do not 'fit' under existing operational committees Summer 1977.	Basis for defining operational committees not internally consistent resulting in confused accountability. Need to distinguish between operational committees, working groups, internal committees and external advisory groups, in terms of function and organizational relationships.	November 1977 Discussion and analysis and working papers prepared. Resulting revisions made to structure March 1978: -defined internal committees (Executive/Finance, By-laws and Nominating Committees) -operational committees redefined in terms of agreed priorities (Mental Health, Care for the Elderly, Dental and Maternal and Child Health Committees) -working groups recognized e.g. Ignace Primary Care Committee -anomalous position of Institutional Review Committee recognized -recognition of external advisory groups e.g. Northwest Medical Association, Northwest Dental Association, RNAO branches, Hospital Advisory Committee.
Lack of clarity about appropriate role of health professionals in committee structure Summer 1977.	Need to distinguish between professionals who are involved to contribute technical expertise and those who represent their professional interest group.	The following external Advisory Groups acknowledged as sources of professional interest group advice: November 1977 -Hospital Advisory Committee -Northwestern Medical Association -Northwestern Dental Association -Registered Nurse Association of Ontario -Northwestern Health Unit.

Problem Identification	Analysis and Diagnosis	Action
Uncertainty about how the Committee for Services for the Elderly (CSE) might most effectively set about its task Fall 1977.	Broad scope of the topic involving many groups within the health sector and many jurisdictions outside DHC mandate. Early involvement of key interest groups necessary to ensure commitment to plans and their implementation. Need to develop precise and agreed terms of reference for CSE. Committee members carry more weight if nominated by external organizations rather than approached individually.	Formulation and statement of: -general philosophy regarding care for the elderly -consequent activities of CSE -terms of reference for CSE. Representative CSE established including health and social service members November 1977.
How to develop proposals for a comprehensive mental health service for the District Fall 1977.	DHC cannot be involved in direct service provision but mandate does allow it to coordinate and develop plans for the District. DHC and its Mental Health Sub-committee (MHS) the only potential source of development on a District-wide basis and can legitimize plans of local groups. Recognition nevertheless that DHC only authorized to deal with with services for adults.	Two-day Seminar December 1977 in Dryden on Organization of Adult Mental Health Services organized by MHS. Attended by over forty providers and led by researchers. Agreed that local mental health groups should develop plans, that MHS should make known its objectives and priorities and be responsible for pulling together plans from different community groups. Position Paper presented to Ontario Council of Health, Mental Health Services Committee June 1978. Proposals developed by Red Lake, Dryden and Kenora and funded Summer 1979.
Concern that too much detailed work delegated to committees - danger of Council becoming a rubber stamp.	Voluntary board with small staff cannot do all the work itself. It should nevertheless retain control of delegated decision-making.	Decision by Council to delegate in a clearly defined way. Agreement that Council itself must retain planning and coordination functions June 1978.
Need to consider amalgamation of hospital organizations in Fort Frances, Emo and Rainy River as part of rational-ization of services in the Rainy River area.	Primary coordinating role of DHC in the process. Necessity to consider organization of health services in western portion of Rainy River area as well as specific hospital study. Need for community involvement in process. Need to develop a model that balances efficiencies of amalgamation with responsiveness to local communities.	December 1978 Researcher worked with Technical Working Group of Tri-community Committee. Alternative models identified and preferred model selected. Proposal approved by Committee and Council and used as basis for amalgamation discussions.
Continuing concern with regard to: -function and role of the Council as a whole and of individual members -the relationship of members to their communities and to committees of Council -the extent to which Council should delegate tasks to committees and other groups -the role of ED and relationships to Council and other staff.		Council decision to focus research on these questions October 1978. Researchers carried out individual role analyses of members and staff January-May 1979. Report to Council identifying continuing problems May 1979. One-day Seminar organized in Kenora May 1979 and Working Paper prepared subsequently June 1979.
Differing perceptions of the DHC's overall role and relationship to the Ministry of Health and to agencies May 1979.	Formal terms of reference sufficiently general to allow many interpretations. DHC does not have an agreed working definition of its role. Need for discussion in Council to establish parameters more clearly.	No specific action. Issue continues to emerge more strongly as Council advocates on behalf of community March 1980.

Problem Identification	Analysis and Diagnosis	Action
Concern that little or no long-term planning going on May 1979.	No overall picture of needs and services on which to base long-term planning.	Agreed at Seminar that: -strategic planning essentially a function of the Ministry of Health May 1979 -comprehensive planning by DHC is unrealistic under present conditions -operational planning should be, and is, crucial DHC function. Agreed June 1979 to set up Reasonable Expectations Committee to review existing types and levels of health services in the District, to determine whether each community has minimally acceptable standards and thus whether priorities need changing. Discussion document, Health Resources Inventory, presented to Council by Reasonable Expectations Committee.
Impact of geographical and demographic factors May 1979.	On Council itself, geographical balance of membership is more important than any pre-determined balance between providers/consumers/ municipal representatives.	New members continue to be appointed with geographical representation strongly in mind. Meetings rotated routinely between Kenora, Dryden and Fort Frances.
Representativeness of members and composition of Council as a whole May 1979.	Importance of all major interest groups in the District having a voice on Council. Possibility of increasing representation of native Indian population, labour interests and health professions. Need to increase consumer representation.	These issues directed to Committee Structure and Composition Working Group - (See below) May 1979.
Competence and training of members May 1979.	Need for orientation of new members, workshops and seminars, more pre-analysis and summary of material distributed, more oral review of written material at meetings and greater involvement of Council members on committees.	Policies endorsed. Agreement to hold annual seminar to serve as both an educational event and as a forum for DHC analysis of overall direction.
Some perception that ED and staff still taking too heavy a coordinative load May 1979.	Need for Council members to take on more coordinative functions themselves.	New relationships established for Council members with committee structure - see below May 1979.
Anomalies in committee structure identified: - location of Alcohol and Treatment Services Committee (ATSC)	- overlap of function with Mental Health Committee	Agreed at Seminar: May 1979 - ATSC should become account-able to Mental Health Committee, not direct to Council
- group studying accidental and violent deaths	- in fact not a committee but a staff function in cooperation with others	- AVD not to be regarded as part of Council's committee structure but as research group
- tendency for operational committees to become secondary to non-operational committees.	- professional domination in some committees; natural preference for easily defined, specific tasks as opposed to less specific roles of operational committees	- review of committee structure — adequate community representation and real linkages between operational and non-operational committees

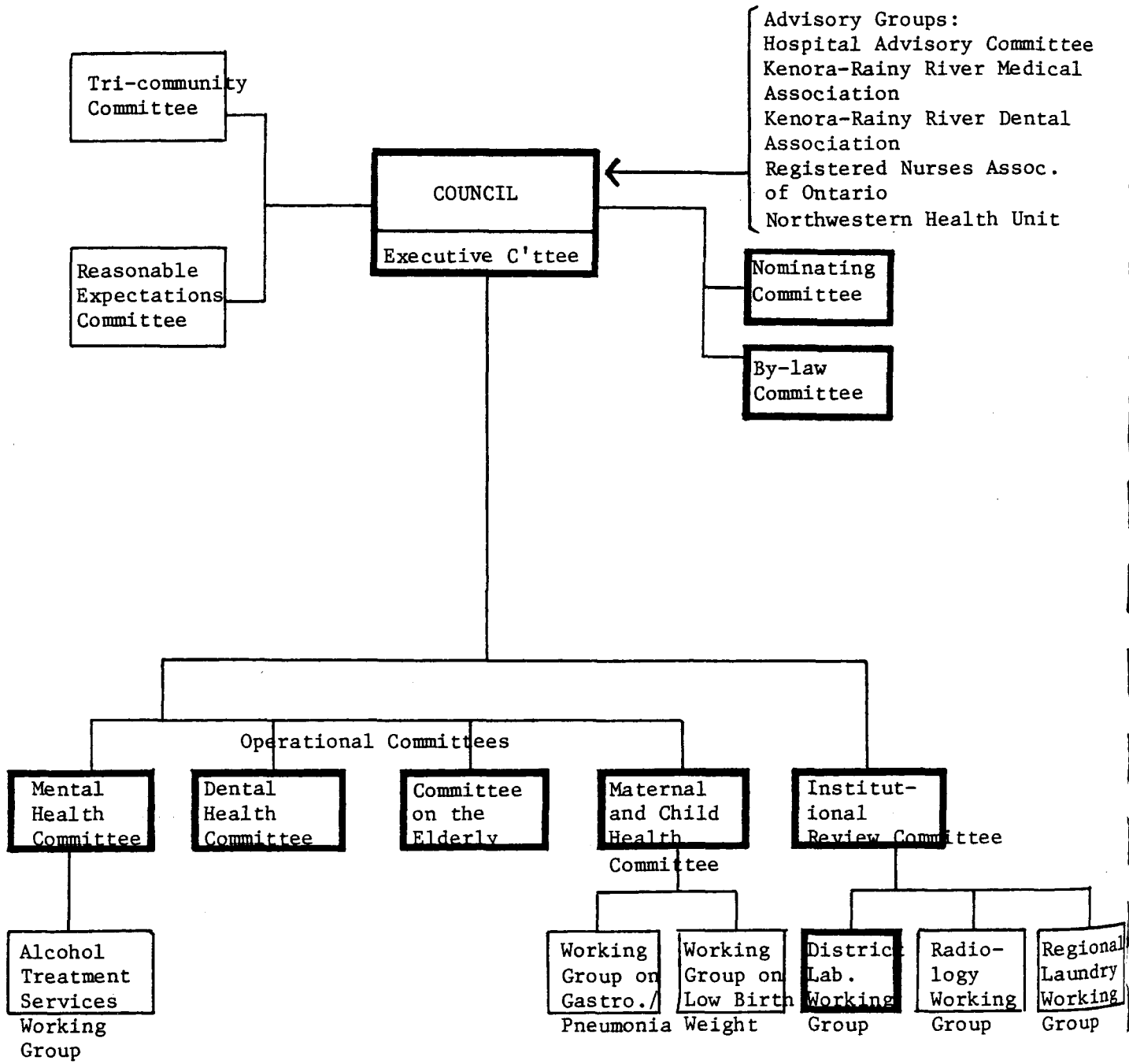| Problem Identification	Analysis and Diagnosis	Action
- function and location of Institutional Review Committee (IRC) May 1979.	- institutional sector is powerful external group. Only one Council member on IRC, the Chairman.	- additional Council members on IRC to be considered. Chairmen of operational committees to be allowed to attend IRC meetings as non-voting participants. More sharing of information between operational committees and IRC. Committee Structure and Composition Working Group set up comprising Council members and staff. Various organizational recommendations made August 1979 to increase clarity and consistency of interrelationships. Recommendations implemented.
Appropriate role for DHC in health planning for native Indian population May 1979.	Two Treaty organizations moving towards creation of their own health councils. The existence of three bodies with broadly the same mandate could be divisive and limit their power. Yet Federal-Provincial split in jurisdictions causes great difficulty for DHC in planning for Indian population.	Agreed at the Seminar May 1979 to bring together the DHC and the two Treaty organizations to consider alternative solutions. Funds granted by Ministry of Health and Treaties made presentations to DHC November 1979. Treaty 3 developed proposals for Tribal Health Council January 1980 in discussion with DHC and incorporating findings from research. Paper (Ojibway Tribal Health Council) presented at Berger hearing and to National Indian Brotherhood. March 1980 Conference organized by Treaty 3 in Kenora for Bands to consider proposals.
Relationship and communication with the Ministry of Health May 1979.	Need for more local understanding of how and why Ministry decisions are made, for more advance warning of new Ministry policies or initiatives.	Area Planning Coordinator to attend more meetings.
Concern that there is insufficient awareness of the Council and its work.	Need to decide whether public involvement is a means or an end in Council's work.	June 1979 Agreed formulation that public awareness is best created by Council working on specific problems with people and agencies in the community. Public relations exercises not appropriate if unrelated to a community concern. Continue issue of Newsletters.
Difficulty in achieving coordination with other health-related organizations.	Complexity of DHC relationships increased by geographical and demographic character of the District and by large number of agencies and Ministries involved. Need to consider DHC's future role in coordination.	Workshop held with McMaster University for health and social service agencies February 1980.
Lack of knowledge of other DHC's structures and operating methods.	No effective mechanism for sharing of information and experience between DHCs.	Chairman, Vice-Chairman, a Council member, the ED and the Assistant ED attended Research Conference October 1979 organized by researchers at University of Toronto. Assistant ED attended similarly organized Research Conference on Role of DHC Executive Director June 1980. Resulting Working Papers distributed to Council members, Chairman and staff highlighting relevant issues.

Organizational Structure of the Kenora-Rainy River DHC

In its 1979/80 Annual Report, the Kenora-Rainy River described the development of its organization as follows.

> Over the past three years, the Council has
> been assisted by (the author) in developing
> the organization of the Council, and its
> relationships with other agencies. This
> work has resulted in an organizational
> model based on operational sub-committees
> primarily related to population groups
> or health issues. The advantage of this
> model is that it permits a variety of
> agencies to come together to plan common
> approaches to common issues. Besides the
> operational committees, there are internal
> committees designed to maintain the ongoing
> operations of the Council and ad hoc
> committees to address short term issues.
> Interest groups such as the District Health
> Unit and the District Hospital Advisory
> Committee are considered advisory to the
> District Health Council.

The resulting structure, as at July 1980, is shown on the next page.

ORGANIZATIONAL STRUCTURE OF THE KENORA-RAINY RIVER
DISTRICT HEALTH COUNCIL (as at July 1980)

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Tri-community
Committee

                              COUNCIL          ◄────  Advisory Groups:
                                                      Hospital Advisory Committee
                         Executive C'ttee             Kenora-Rainy River Medical
                                                      Association
Reasonable                                            Kenora-Rainy River Dental
Expectations                                          Association
Committee                                             Registered Nurses Assoc.
                                                      of Ontario
                                     Nominating       Northwestern Health Unit
                                     Committee

                                     By-law
                                     Committee
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Operational Committees

Mental Health Committee	Dental Health Committee	Committee on the Elderly	Maternal and Child Health Committee	Institutional Review Committee

| Alcohol Treatment Services Working Group | | | Working Group on Gastro./ Pneumonia | Working Group on Low Birth Weight | District Lab. Working Group | Radio-logy Working Group | Regional Laundry Working Group |

Key

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┏━━━━━┓
┃     ┃        Permanent groups
┗━━━━━┛

┌─────┐
│     │        Ad hoc groups
└─────┘
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Ottawa-Carleton Regional District Health Council
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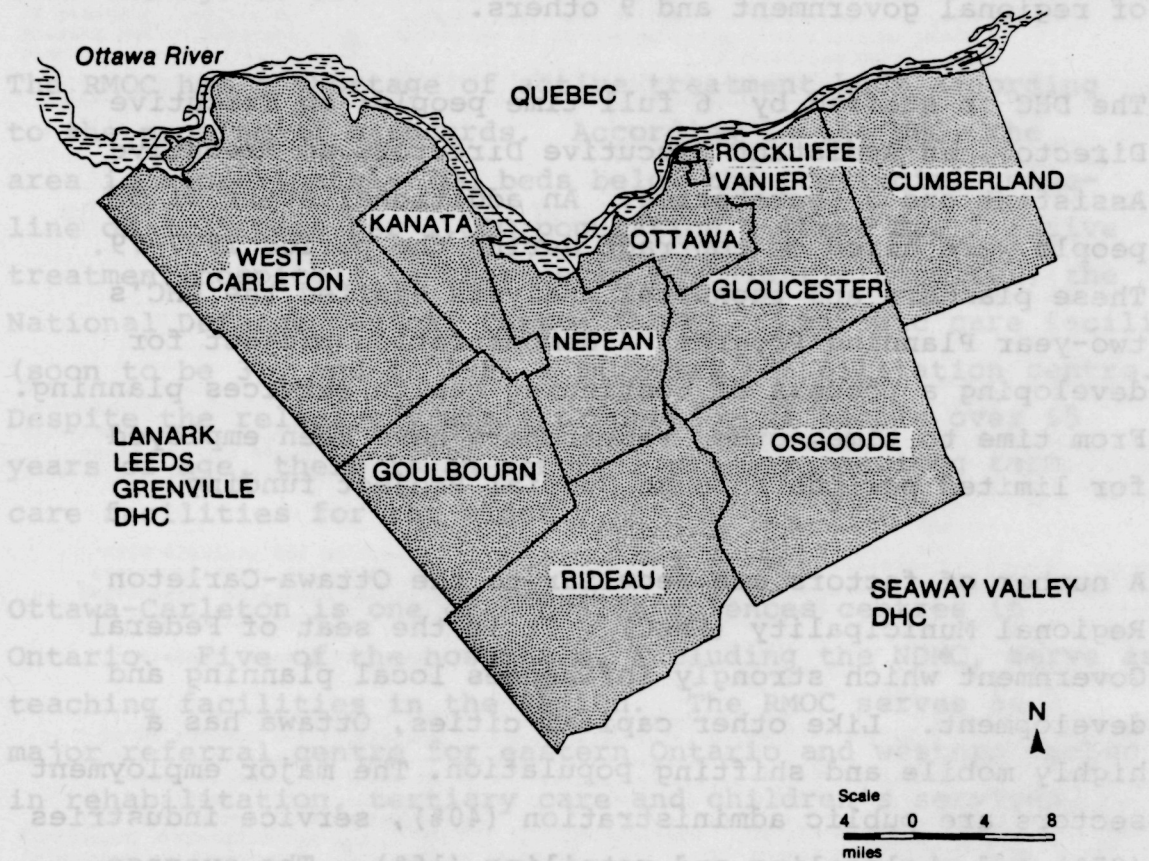
OTTAWA CARLETON REGIONAL DISTRICT HEALTH COUNCIL
Source: Regional Municipality of Ottawa-Carleton

As the first DHC in Ontario, established in January 1974, Ottawa-Carleton Regional DHC has been regarded as something of a pioneer. In a number of areas, notably the development of health planning methods, the DHC is further advanced than many of the others.

Prior to the establishment of the DHC, there existed in the Region both the Ottawa Regional Hospital Planning Council (1968-75) and the Health Sciences Complex Coordinating Council (since 1971) and the work of these organizations had set a precedent of health facility planning for the area.

The Council has a membership of 17 comprising 5 who are
practising health professionals, 3 elected representatives
of regional government and 9 others.

The DHC is staffed by 6 full-time people: an Executive
Director, an Assistant Executive Director, an Executive
Assistant and 3 Secretaries. An additional staff of 5
people were hired on contract during the period 1977-79.
These planners and technical analysts staffed the DHC's
two-year Planning Program, a demonstration project for
developing a process of continuing health services planning.
From time to time, other researchers have been employed
for limited periods through Special Project funding.

A number of factors are peculiar to the Ottawa-Carleton
Regional Municipality (RMOC). It is the seat of Federal
Government which strongly influences local planning and
development. Like other capital cities, Ottawa has a
highly mobile and shifting population. The major employment
sectors are public administration (40%), service industries
(27%) and wholesaling and retailing (15%). The average
income is higher than both the provincial and the national
averages.

The RMOC comprises 11 area municipalities and covers 1,064
square miles. The 1980 population, estimated at 547,000,
is primarily in urban centres. The population has been
growing at a higher rate than the provincial average. A
1977 policy to decentralize the federal civil service is
being implemented and might limit the projected growth rate.

Ottawa is the only major city in Ontario located on the
border with Québec. Over 19% of the resident population
of the RMOC has French as its mother tongue, over three
times the provincial rate. There is movement across the
border in both directions for employment, commercial and
social purposes.

The age distribution of the population differs markedly from
other regions, with a greater proportion between the ages of
15 and 44 and a smaller but rapidly increasing proportion
over the age of 65.

The RMOC has a shortage of active treatment beds according
to the provincial standards. According to the DHC, the
area is approximately 200 beds below the provincial guide-
line of 3.75 beds per 1,000 population. There are 7 active
treatment hospitals, a short-stay psychiatric hospital, the
National Defence Medical Centre (NDMC), 2 chronic care facilities
(soon to be 3), and in 1981 a regional rehabilitation centre.
Despite the relatively small proportion of people over 65
years of age, there is an abnormal pressure on long term
care facilities for the elderly.

Ottawa-Carleton is one of 5 health sciences centres in
Ontario. Five of the hospitals, including the NDMC, serve as
teaching facilities in the Region. The RMOC serves as a
major referral centre for eastern Ontario and western Québec
in rehabilitation, tertiary care and children's services.

In terms of health manpower, the RMOC has an abundance of
physicians relative to the resident population, far above the
provincial average. But the area falls below the provincial
average for full-time equivalent general practitioners. This
is accounted for by the large numbers of physicians practising
in specialties and working in administrative capacities.
Compared to the rest of the Province, there are more registered
nurses, fewer registered nursing assistants and an equivalent
availability of dentists, physiotherapists and optometrists.

The residents of western Québec regularly come to the RMOC
for general and specialty services. On any given day, over
400 hospital beds are occupied by Quebec residents.

Public health services are provided by the Ottawa-Carleton
Regional Health Unit with headquarters in Ottawa.

The major health related problems, as identified by the DHC, are services to the elderly, adult mental health services, rehabilitation services and alternatives to in-patient services.[3]

Analysis of Organizational Change - Ottawa-Carleton Regional DHC

This analysis is chronological and covers the period of the research collaboration, August 1977 to July 1980.

Problem Identification	Analysis and Diagnosis	Action
Initial agreement August 1977 concentrate on: - internal organization and board and committee structure - linkages to the community, professions and agencies.	that research should	Discussion and analysis with each major board and committee, Executive Director (ED) and staff.
Concern about representation of hospital sector in Council's subordinate structure September 1977.	Hospital Advisory Board (HAB) comprising 10 hospital trustees and 4 community members may not be sufficiently representative of hospital interests.	Discussion and analysis with HAB and staff. Working papers produced examining alternative models October 1977-August 1978. HAB given clearer mandate.
Council's subordinate structure based on levels of care. HAB does not encompass total function of secondary care. Are two boards required and what is requisite relationship between them?	Two boards would create awkward inter-relationship and/or overlap of function But secondary care is broader concept than hospital care.	Two medical and two administrative members added to HAB. Changes did not result in shift of emphasis from hospital sector. Separate organizational mechanisms were developed eg. Palliative Care Committee, Advanced Life Support Services Committee, Gerontology Task Force--all directly accountable to Council, to deal with problem areas that span the interests of two or more Boards.
Extent to which boards should be creatures of Council - should they primarily be under Council direction or be more autonomous groups initiating their own activities?	Need to develop organizational means for increasing Council's ability to guide and integrate. Boards are created to help Council do its work, therefore accountable to Council.	1977 Decision that Board chairman should attend Council meetings as non-voting participants and Council members assigned to attend board meetings as observers. 1978 Annual joint meeting of Council and boards instituted.
Communication between Council and boards considered inadequate.	Policy of having no Council members on subordinate boards and committees likely to lead to feelings of isolation and loss of influence on part of Council.	
Mental Health Committee (MHC) created as response to community pressure but role and function unclear. Conflict between 'medical' model of psychiatric services and broader model encompassing health and social aspects of mental illness. Hence, debate about appropriate membership of MHC.	Need for clarity on interpretation of role and functions before organizational issues can be addressed. Basic difference of view within the MHC regarding the definition of mental health. Medical model implies MHC should comprise mainly treatment-oriented health professionals. Second model implies members drawn from wide range of health and social service agencies, of professions and disciplines and of community being served.	Acceptance of broader definition of mental health. Did not wholly resolve problem. Terms of reference of MHC redrafted and membership allowed to evolve to include more members from social services and non-medical health professions.

Problem Identification	Analysis and Diagnosis	Action
How to ensure continuation of planning function on phasing out of contract planning staff.	Need to examine optimum size of staff and skills and roles of ED and others. Council to define its own role in planning.	Management consultant employed to recommend ongoing staff organization; reported. Staffing questions still unresolved June 1980. Decision January 1978 for Council to meet twice a month, alternately as Council and as Planning Committee of the whole. Seminars and working sessions arranged to familiarize members with the planning process. April 1980 Attendance at both meetings high and planning decisions getting made; members actively involved.
Demand for community involvement in Council affairs December 1977.	Lack of agreement on purpose of, and need for, community involvement. Can community involvement be identified as a function of Council separate from their other work? Lack of resources to liaise with and develop awareness in broad community.	Community Liaison Committee established September 1978. Ceased to meet September 1979. Recommended that there should not be an ongoing Committee for this function but that a group of individuals with experience in the PR/community liaison field should be available to assist the Council, the boards and committees when called upon. Council now advertises for volunteers to serve on boards and committees. Newsletter now circulated to community; public meetings and improved media coverage arranged.
Continuing concern about relationships of boards and committees to Council.	Need for further analysis and revision of organizational arrangements.	Detailed analysis undertaken, coordinated by one Council member. Working papers produced by researchers. Resulted in new arrangements agreed by Council December 1978: - all board chairmen to be appointed by Council. - boards to recommend their composition and Council to appoint members except where an external organization or group has right to nominate. - Council members not eligible to serve as board chairmen. - previous arrangement of board chairmen attending Council meetings and Council members attending boards ratified. Situation now felt to be satisfactory April 1980.
Difficulty of achieving consensus and action on specific ad hoc issues which do not easily 'fit' under any one of the existing boards.	Importance of maintaining consistency in definition of functions for operational boards. Distinction between task forces and committees to consider specific, finite issues and standing boards and committees. Task forces more readily involve those primarily affected by decisions.	1979 and 1980 Creation of a number of special-purpose committees and task forces, either directly accountable to Council (as mentioned above) or relating to the two relevant boards e.g. Emergency Medical Services.

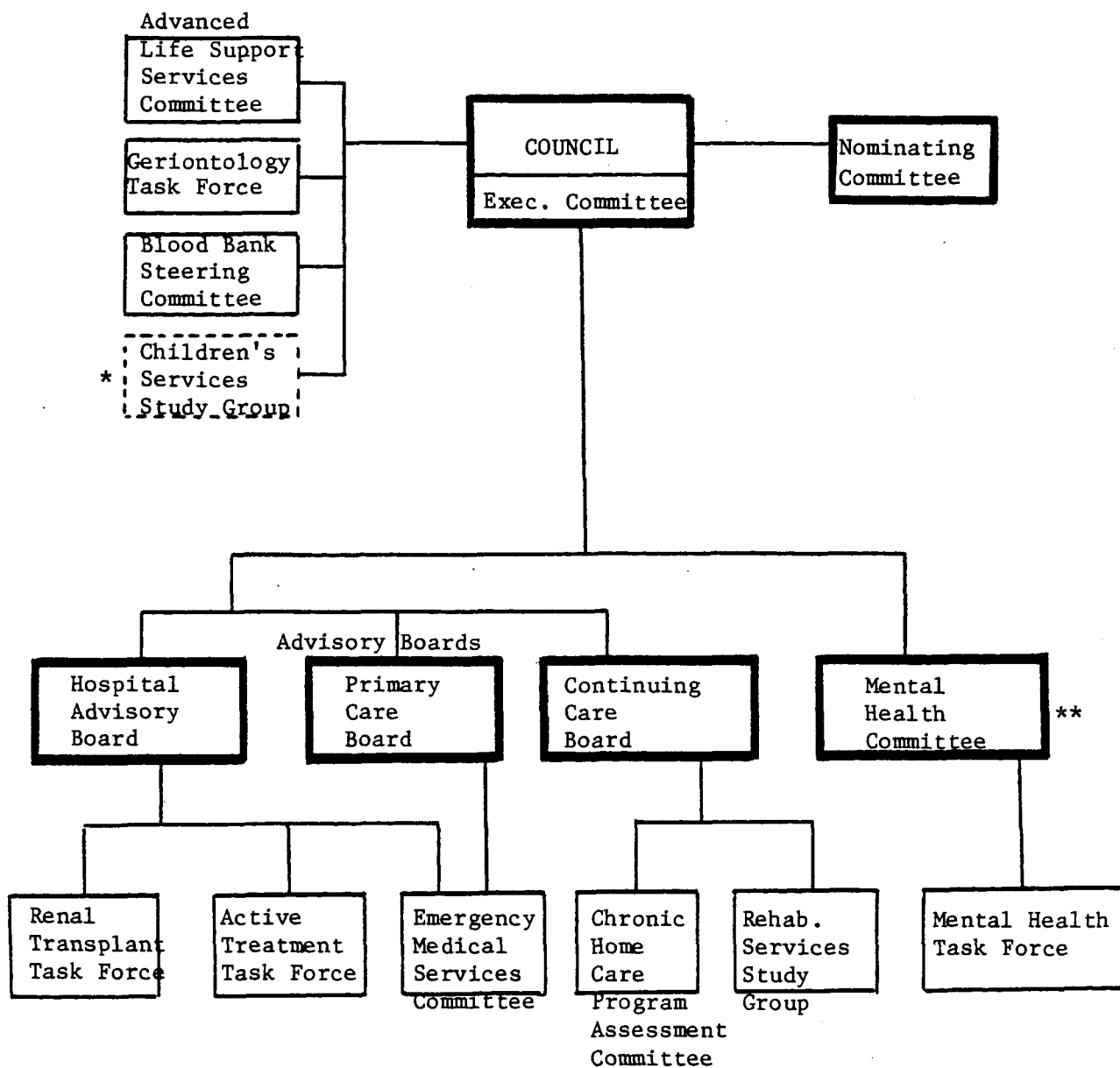| Problem Identification	Analysis and Diagnosis	Action
Concerns about the role of the Executive Committee January 1979.	Different views among members about need for more precise statement of Executive Committee's authority.	No major organizational change made. Powers of Executive Committee redefined and procedures altered so that Executive Committee minutes tabled with Council for information May 1979.
Community pressure to establish Children's Services Committee within DHC structure.	Lack of coordination in children's health and social services and continued delay in establishment of Regional CSC under COMSOC.	Internal discussions with existing Boards/Committees and external meetings with concerned agencies, leading to establishment of DHC Children's Services Study Group, July 1980, which can begin work of planning and coordination in child health and health-related sector, and which can later become advisory also to the eventual Regional CSC.

The organizational structure that resulted from these changes is shown on the following page.

ORGANIZATIONAL STRUCTURE OF THE OTTAWA-CARLETON REGIONAL
DISTRICT HEALTH COUNCIL (as at July 1980)

Advanced
Life Support
Services
Committee

Geriontology
Task Force

Blood Bank
Steering
Committee

* Children's
Services
Study Group

COUNCIL

Exec. Committee

Nominating
Committee

Advisory Boards

Hospital
Advisory
Board

Primary
Care
Board

Continuing
Care
Board

Mental
Health   **
Committee

Renal
Transplant
Task Force

Active
Treatment
Task Force

Emergency
Medical
Services
Committee

Chronic
Home
Care
Program
Assessment
Committee

Rehab.
Services
Study
Group

Mental Health
Task Force

Key

* In formation

** The Mental Health Committee has members from each of the Advisory Boards

Permanent groups

Ad hoc groups

ORGANIZATIONAL PROBLEMS

The foregoing analyses of organizational change in the
three DHCs underline two familiar principles in achieving
planned change in organizations. First, establishing new
organizational structure almost always involves changing
some aspect of the existing structure. It is not practical
simply to add new elements to the existing organization
because the whole organization is more than the sum of its
individual parts. The creation of a new committee or the
delegation of new tasks to an existing committee will
produce new relationships within the structure, a new
organizational dynamic. Individual changes need to be
thought through and implemented in such a way that the whole
structure is internally consistent and complementary.

Yet the work with DHCs illustrates the difficulty of changing
an organization once it has been established in a particular
way. There is a certain loyalty to the status quo, which
may have been achieved at much cost in effort and time;
and the people involved may be understandably reluctant
to change. So the second principle becomes crucial -
that those capable of making the changes are convinced of
the need to change, have thought through the alternatives
and have produced the solution themselves. Recommendations
from an external 'expert' are unlikely to be implemented
if the decision makers have not had the opportunity to
define (and perhaps redefine) the original problems, to
examine options and to feed in their knowledge of local
circumstances.

The implication of this fact for the researchers is that
they must follow the lead of the organization. The external
person can help by contributing concepts and models and

new ways of looking at the problems but does not take a
direct part in deciding which of the options to choose.
The decisions about change must remain where they belong -
in this case with members and staff of the DHCs.

This change process can be portrayed as a simple cycle:

PROBLEM
IDENTIFICATION

IMPLEMENTATION   ANALYSIS
OF CHANGE   AND DIAGNOSIS
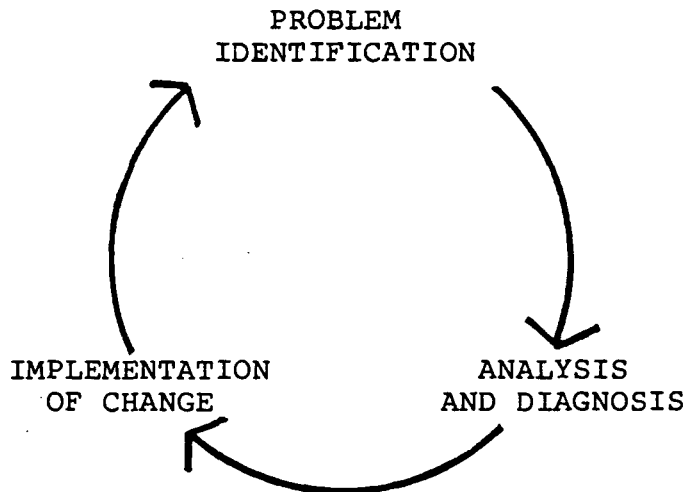
The long-term research relationship with the DHCs in Kenora,
Hamilton and Ottawa enabled this cycle to be completed a
number of times. That is, some of the changes introduced
in the early stage of a project were tested, in some
instances found wanting and therefore changed again. By
this process, the organizational principles were given
repeated testing, both in terms of their validity and their
robustness over a period of time.

Turning to an analysis of the nature of the problems
identified in the three case studies, it is striking that
although the DHCs differed widely in terms of location,
size of district and most other factors, and although the
problems emerged at different times and in different ways,
the problems were similar in kind. There were many
distinctive local operational problems, but the underlying
organizational difficulties were remarkably alike.

Expressed in a logical order, not necessarily the order
in which they appeared during the research, the problems
concerned:
- lack of clarity about the <u>overall role of the DHC</u>
- uncertainty about the <u>legitimacy of particular DHC</u>
  <u>activities</u>
- ambiguous <u>relationships with other organizations</u> in terms
  of both accountability and authority
- inadequate clarification of '<u>internal' components of</u>
  <u>organization</u>: the role of members and chairman, committee
  structure and the DHC-executive staff relationship.
The organizational propositions which emerged from the
analysis of these problem areas are presented in the
following chapters.

CHAPTER 4   THE NATURE AND COMPOSITION OF COUNCIL

The basic purpose of this research project was to assist those
working in DHCs to clarify how the organization is operating
and how it might be adjusted to produce better results. In
so doing, the researchers were inevitably concerned to develop
and test out concepts and to use these concepts to illuminate
the organizational problems encountered. Two particular factors
made this process more challenging than it might otherwise have
been. The first and probably less significant factor was the
novelty of DHCs. When the research started the oldest DHC
had only been in existence for a little over two years.
Consequently, the store of institutional memory and wisdom was
limited.

The second challenge for the researchers lay in the paucity of
relevant theoretical work. There have been few large-scale
organizational studies of public, volunteer bodies and those
that are in the literature tend to be grounded either in
political theory or management theory. Yet the problems being
identified by the DHCs were usually not amenable to constructs
from either of these theoretical fields alone. To take a
simple illustration, one of the problems which came up in the
research was the appropriate stance of DHC members in relation
to people in their local communities. Should a member feel
free to discuss local issues, canvas local opinion and give
interpretations of Council decisions as they affect local
groups? Or should the member act purely as a delegate from
the Council, taking no local initiatives unless specifically
asked to do so? Using the terms in their traditional sense,
there were both political and managerial issues embedded in
this question. It had to be construed in terms of theories
of representation and political power as well as in terms of
organizational role, accountability and authority.

In combination, these factors - the short experience of DHCs
and the need to apply integrating theory - meant that there
was no readily available framework to apply in the research.
It was therefore necessary to go back to basics and unravel
the different and occasionally conflicting assumptions about
the fundamental purpose for which DHCs were created.

THE ROLE OF THE DHC

To reiterate, the only offical statement on the overall role
of the DHC was issued in 1975 and required the Councils to:
- identify district health needs and consider
  alternative ways of meeting those needs that are
  consistent with provincial guidelines
- plan a comprehensive health care program and
  establish short-term priorities that are
  consistent with long-term goals
- coordinate all health activities and ensure a
  balanced, effective and economical service satisfactory
  to the people of the district
- work towards cooperation in social development.[1]
This statement of role has been expanded and given more precision
in subsequent policy statements but there still remains a wide
range of interpretation both among and within the Councils. In
one of the research settings, members felt inadequately informed
about the role of the DHC and many found the first year they
served on Council very confusing. The need for some form of
induction for new members and periodic review of the foundations
of the DHC was frequently mentioned. Members reported that
they gradually arrived at a personal conception of the role,
purpose and functions of the DHC, reached through experience,
discussions with staff and by studying the large amount of
written material directed to members.[2]

It also became clear during the research that there were different
views on the desirability of specifying the DHC role more
precisely. Some felt that the lack of a common understanding

engendered a sense of ineffectiveness in members. If a more
precise definition could be achieved and agreed, it would both
simplify the DHCs' work and reassure independent agencies and
institutions. The more precise mandate would not rigidify the
Councils but rather enable them to work freely within
legitimized boundaries. The opposing view was that more
specification would restrict the DHCs in carrying out different
activities and allow them less individuality. There was
concern that Councils should not be all the same but be able
to have different roles and functions according to the needs
of their districts. The mandate should therefore be left
vague and unspecific.

Whether the role definition for <u>all</u> the DHCs should be the
same is a difficult and in a sense an artificial question.
Even in systems where the central authority has prescribed a
very precise role for local bodies, the latter somehow
manage to remain quite individualistic, not to say idiosyncratic,
in their approach. Although the formal specification of their
role is the same, different objectives, priorities and styles
of operation emerge. The danger of standardization seems even
less in Ontario where the Ministry of Health has firmly
resisted pressure to specify the DHC role in detail. On the
other hand, if DHCs were to develop totally different roles
for themselves, it is hard to see how they could remain viable
as part of a provincial system of health planning.

However, it does seem that if there is a wide divergence of
view about the role <u>within</u> an individual DHC, there is little
basis for building an effective organization. It was for this
reason that some of the DHCs involved in the research chose to
pursue clarification. Within any one DHC, members can have
quite different views on its basic role. It can be seen as:

<u>advisor to the Minister of Health</u>: This interpretation
implies a somewhat autonomous research role for the DHC. It
is seen as an objective, fact-finding team, reporting its

findings and recommendations to the Ministry of Health. The
Ministry receives such briefs from all Councils and assumes
the political role of weighing the evidence and making policy
decisions. There is no implied accountability to the Minister
other than to give advice. The Council accepts that all
recommendations cannot be adopted due to limited resources and
accepts the Ministry's role as arbiter. The DHC is responsible
to the population of the district only for defining problems
and proposing solutions.

advocate of community health needs: This view sees a much
more political role for the DHC, including active lobbying on
behalf of community interests, and the need to assume an
adversarial stance occasionally with respect to the Ministry
or local agencies in order to promote implementation of the
Council's proposals. This view assumes DHC accountability to
the people of the district, not only for identifying problems
and proposing solutions but also for actual improvements in
health care delivery. As in the first model, the DHC is
accountable to the Ministry for giving advice but not to the
extent of implementing Ministry policies with which it is in
disagreement.

agent of the Ministry of Health: This (minority) view sees
the DHC as a creation and agent of the Ministry to ensure
Ministry policies are locally understood and implemented in
a way which is responsive to local conditions. The DHC is
clearly accountable to the Ministry of Health and works
primarily under Ministerial direction.

mediator between the Ministry and the community: This inter-
pretation embodies a sense of dual accountability. The
Council is accountable to the population of the district for
trying to bring about changes in existing agencies and services
that will improve overall effectiveness and for making the
Ministry aware of district health problems and proposals for
their resolution. This may require active lobbying efforts

by the DHC. At the same time, the DHC is accountable to the
Ministry to accept its policy decisions and actively participate
in their local implementation.

mediator among agencies: Proponents of this role see the DHC
as accountable to the Ministry for bringing together competing
organized interests in the district in a setting which will
foster conciliation, compromise and consensus. In this
process, the DHC assumes the role of mediator, not that of
researcher or advocate. The participative process of reaching
decisions is as important as the outcome itself.

Even though these views are presented here in pastiche form, it
is clear that they have very different implications in terms
of accountability and authority. Some of these views appear
to be mutually exclusive - for example the roles of agent of
the Ministry and advocate for local health needs - yet it was
often suggested that a DHC could carry all these roles at
different times and with respect to different issues. So in
those DHCs that wished to develop a clearer understanding of
their role, it was necessary to pursue questions of accountability
and authority in greater depth.

Accountability and authority

The first issue to test was whether a Council can, as implied
by some of the views of its role, be simultaneously and equally
accountable, in the sense of being held to account for its
actions, to the Minister/Ministry, to providers and to the
community. After lengthy discussion and analysis in individual
research settings and in research conferences, the formulation
was that there are forms of accountability to each of these
three groups but that they differ radically in kind.

In the absence of legislative accountability, the relationship
to the Minister/Ministry has been given substance by precedent
and experience. There is undoubtedly accountability to the
Minister to carry out directly delegated activities such as

the institutional review process (new or expanded programs in
hospitals) and the review of new or expanded programs in
public health. Outside these activities, the Councils have
discretion to decide their own priorities. But the overall
accountability to the Minister remains so that the Minister
could presumably choose to change the discretionary boundaries
within which Councils operate.

It was generally agreed that there is no direct accountability
to provider agencies and individuals in the district.
The Council is responsible for ensuring that providers' views
are accommodated in their decisions but not for ensuring that
the views are upheld.

Similarly, the Council is responsible for taking community
concerns into account in its decision making. Within this
responsibility to the community, a Council may decide that
local needs are not best met by a particular policy and so
attempt to have that policy changed. But being an appointed
rather than an elected body, a Council cannot be said to be
accountable directly to the community.

In summary, the formulation was that DHCs are accountable to
the Minister but that this accountability is limited and is
not an 'executive' relationship - the DHC is not simply a
regional office of the Ministry. The DHCs' responsibility to
the providers and the community gives them discretion to
interpret policies, to make their own judgements and to
challenge central decisions.

Some Councils have received funding from ministries other than
the Ministry of Health and from local government. It was
generally agreed that this does not imply accountability in
the same sense to these funding bodies. A Council is rather
in the position of a contractor, fulfilling the terms agreed
to with a particular funding body. In the event of dissatis-
faction with the Council's use of the funds, the only recourse

would be for the body concerned to withdraw funding. There is
no overriding accountability established between the Council
and these other agencies. Indeed, the Ministry of Health must
give approval for a Council to receive such funding.

In developing formulations about the accountability of the DHC,
it was also necessary to look at the authority in these same
relationships. The picture that emerged was that the Minister
does have limited authority over the Councils. In
principle, the Minister carries authority to veto the appointment
of particular Council members and executive directors and
to dismiss members judged to be incapable of fulfilling their
role. The Minister also carries authority to delegate
activities to Councils but this authority does not extend to
giving overriding directions to Councils to do things that
they judge to be unacceptable.

It seemed important for the DHCs to make a distinction between
this relationship to the Minister and the relationship to the
Ministry staff. It was felt to be requisite that the Ministry
staff, particularly the Area Planning Coordinators, should not
carry the same direct authority with regard to the Councils or
their staff since the line of accountability and authority is
between the Minister and the Council. Some Councils felt
that Ministry staff should act simply as an information
and communication link between the Ministry and Councils and
there was concern therefore at the introduction of such
practices as the APC being involved in the appointment of the
executive director. (This particular facet of the relationship
is examined in detail in Chapter 6). But it became clear that
it was simply not possible, even if desirable, for the Minister
to conduct all the business with all the DHCs on a personal
basis and he is obliged to work through his staff in the
Ministry. To expect them merely to inform and communicate
with the DHCs was clearly an unrealistic expectation, demanding
the kind of detachment that few people, even senior civil
servants, have.

In the spring of 1980, the Ministry of Health issued a role
description for the Area Planning Coordinator which described
the APC as a diplomat, coordinator, advisor, counsellor,
facilitator and intelligence officer. The role was conceived
in a much more active way, both within the Ministry and in
relation to DHCs, than simply as an information and communic-
ation link.

This whole issue continued to be a subject of discussion in
meetings of the Minister and DHC Chairmen and it was agreed in
the summer of 1980 that further clarification was necessary.
The research findings suggest that an acceptable formulation
of the relationship might be as follows.

It does seem that Ministry staff, particularly the APCs,
need to have clearly defined but limited authority:
- to monitor DHC activities to ensure that they
    conform to agreed policies and practices. This
    monitoring involves obtaining first-hand
    knowledge of DHC work problems and persuading
    (not instructing) DHCs to modify their activities
    where they do not conform. The authority does
    not extend to making official appraisals of DHCs
    (or individuals within DHCs) or to imposing new
    policies or standards;
- to coordinate a particular plan or program involving
    a number of DHCs. Coordination involves making firm
    proposals for action, scheduling meetings and
    obtaining first-hand knowledge of progress. It
    does not extend to issuing overriding instructions
    in cases of sustained disagreement among the DHCs.[3]
In both instances, the DHCs always have the right to direct
access to the Minister. This access arises on an individual
basis, usually between DHC Chairman and Minister, and on

an organized basis in the regular meetings of the Minister
and Chairmen.

DHCs often made the point that their relationship to the
Ministry of Health was complicated by the basis for the
organizational structure of the Ministry, with a different-
iation at the Assistant Deputy Minister level into
institutional health services, community health services
and administration and health insurance. The District
Health Council Program, with the Area Planning Coordinators,
is located in the Community Health Services division, yet
DHCs often need to relate to other sections of the Ministry.
However, it is understood that a change in the Ministry's
structure is being considered which would clarify the
relationship.

The relationship of the Council to the provider agencies and
institutions is again a subtle one. Terms like 'power' and
'influence' may describe the relationship more accurately than
authority. Nonetheless, the Councils can be seen to exert
influence in some fairly definitive ways - veto power on
certain decisions affecting local institutions, requiring that
providers provide information, and so on. As the research
progressed, this question of the requisite authority of DHCs
with respect to provider agencies was tested out in a number
of settings. In discussions with the Executive Directors, the
following hierarchical model of functions was developed.[*]
The least complex functions, and those requiring least authority,
are at the top of the hierarchy.

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[*] This model was first analyzed at a meeting of Executive
Directors at the instigation of B. Sullivan, then Executive
Director of the Wellington-Dufferin DHC.
The model has strong resonances with the work strata model
used in Chapter 6 to analyse the level of work of the DHC and
the Executive Director - see page 136.

Advice giving	Collecting and forwarding information to the Ministry
Network building	Creating linkages, getting people to talk together
Needs assessment	Identifying high risk groups and directing attention to them
Program development	Rationalization and coordination within the present system
Implementation	Monitoring the implementation of plans
Allocation of resources and management	Financial and managerial accountability

The general question was to what level in the hierarchy a DHC should be penetrating. There was seen to be a relationship between the age of a DHC and the level of work, in that the younger DHCs had to establish their advice giving and network building activities before they could move into the more demanding areas. But it was generally maintained that once a DHC was established in its community, it should be involved in program development and in the implementation of plans. Its requisite authority with regard to provider bodies is thus the authority to coordinate the health planning activities of agencies and individuals and to monitor the implementation of agreed plans. It was strongly argued by the older DHCs that if involvement at this level is not possible, the motivation to do any of the less complex or less authoritative tasks will be substantially diluted. This point was underlined in one of the research seminars:

> ... Council members discussed the need for Council to be involved in the implementation of a program or plan once it has been approved. It was agreed that the success of implementation depends on the thoroughness of the monitoring activities during the planning process. Reporting information to, and continually negotiating with, the groups in the community would enable Council to test the validity of the plan, to ensure that the participating groups are pursuing the agreed line of action and to make adaptations as required by unanticipated events.[4]

But this relationship is a far more open one than the Ministry-
DHC relationship. If, for example, a hospital board or a board
of health chooses to reject the DHC's attempts to monitor or
coordinate, there is no single point in the system to which
the problem can be referred for resolution. It therefore
seems necessary to ensure that the major provider groups and
organizations are involved in the ongoing work of the DHC and
are therefore committed to the decisions made at the earliest
possible stage. This case is argued more fully below in the
context of the representativeness of the DHC membership.

There was no significant support for the DHC moving into an
executive role with respect to health services and taking on
financial and managerial accountability for running services.
This option was not seen to be either desirable or feasible
in the context of the Province's health system. The DHCs
should be limited to coordination and monitoring of the
planning of health services in their districts.

From a research point of view, this construct still leaves
open a wider question - consideration of which must be deferred
until Chapter 7, of the feasibility of separating the planning
of health services (or anything else) from the provision and
operation of those services. It has been argued that a more
workable model is a local planning body which also carries
accountability for the operation and management of services
and there were those who favoured this model for Ontario;
as mentioned in Chapter 1, the Mustard Report in 1974
recommended an arrangement of this kind. It was recognized
however that this would require a legislated base and
quite different membership, staffing and relationships to
local agencies from the ones that DHCs currently enjoy.

THE DHC MEMBER

The Council members are drawn from three groups - providers, local government and consumers. Providers are generally defined as those employed in or closely associated with health services; consumers are defined by exclusion - that is, as non-providers and non-local government. As pointed out in previous chapters, the proportion of members drawn from each of these groups differs from Council to Council. Other factors that are often taken into account locally are the importance of a geographically balanced membership and representation of labour interests and distinct ethnic or religious groups.

The most striking aspect of the member's role is that, regardless of the source of their nomination, they do bring their local affiliations and concerns with them into the Council's work. In spite of the requirement that "each member must set aside parochial interests and function as a representative of the public at large, rather than as a spokesman for a vested interest",[5] members are not, nor can they reasonably be expected to be, completely objective or impartial. It is true that none of the Council members is in the strict sense a representative of an external group since none is directly elected to serve on Council by a defined constituency. All members are nevertheless apt to identify with the interests of different external groups when issues affecting those groups arise. This behaviour is predictable and is tacitly recognized in deriving members from the three major sources and from the different communities. Local government members are likely to identify with an external group because of their original elected status; providers will also tend to represent their institution or profession; consumer members have no way of relating to the community as a whole so tend to identify with those parts of the system they know best.[6]

This phenomenon has been noted in other public sector bodies
where the members are enjoined to be impartial, having
carefully been selected on a partial, interest group basis.*
It is puzzling why this fiction should be maintained. Perhaps
it is something to do with the desire - often expressed and
quite unrealistic - to 'keep politics out of health'. But
whatever the reason behind the fiction, it does produce an
equivocal situation for the members. During the research a
number of situations were encountered where there was strong
local opposition to a plan or proposal being developed by
Council. Members from that community or locality did not
feel able fully to voice their partial interests and views in
the Council discussion and the significance of the conflict
was therefore not revealed. The plan went through with the
approval of the majority, only to be completely undermined
by active resistance from the community in question. Had
the local members felt free to represent the strength and
nature of the opposition when the issue was being considered,
the outcome might have been different.

So in order to reach decisions which are subsequently implem-
entable, it seems necessary to recognize the inevitable
partiality of members, to ensure that disagreement is brought
into the open and to deal with conflict before rather than
after a major decision is made and publicly announced.

Seen from this point of view, the DHC is essentially a mediating
body where major local interests can be represented, compete
and some accommodation be found. It follows that:

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*
   Compare, for example, health authorities in the British NHS.
Members are sought from a wide range of interest groups,
including local government, but are told that "No member is
appointed to represent sectional (or personal) interest." 7

- in appointing members the concern should
  be less whether they are formally described
  as providers or consumers and more whether they
  can be said to represent a significant aspect
  of the socio-political character of the district;
- if any powerful local interests are excluded from
  Council membership, the basis for consensus
  may be lost;
- in this context, consensus implies unanimity among
  the members - that is, achieving decisions that
  are minimally acceptable to all the members. The
  making of decisions by a majority vote seems
  usually to be inappropriate, particularly where
  contentious issues are concerned.

Some of the DHCs that collaborated in the research took the
argument a step further in their formulations on the member's
role. In these cases, an explicit policy was adopted to the
effect that once a decision had been made by Council each
member should be bound by the decision and support it publicly.

A quite different aspect of the member's role is the extent
to which all members should be expected to make an equal and
similar contribution to the work of the DHC. Some felt that
members should be encouraged to accept responsibilities
according to their individual interests and talents; other
Councils specifically steered members away from areas in which
they had a particular personal interest. There were arguments
for both of these approaches and the chosen approach did not
seem to be a critical factor in the effectiveness of the
members' work.

THE DHC CHAIRMAN*

As in other public bodies, the Chairman is essentially seen as
the alter ego of the DHC. The Chairman's activities extend
far beyond the conventional one of chairing meetings and
although there is considerable variation Chairmen can spend
up to twenty hours a week on DHC work. The following activities
were identified which are normally part of the Chairman's role.
- chairing Council meetings and ensuring that follow-up action
is taken
- preparing and/or approving agenda for Council meetings,
usually in conjunction with the executive committee and executive
director
- reviewing the performance of Council and committee members
and providing opportunities for members to develop their skill
and knowledge
- assisting in the recruitment and nomination of new members
for Council and committes
- recruiting, directing and supervising the executive director
- acting as a member of the executive committee of Council
- acting as a member of other committees as required by the
constitution or as judged necessary
- representing the Council in relationship to the Minister
and Ministry of Health
- representing the Council in relationship to local health
agencies and institutions, to local and provincial government
and to social services and other related agencies
- representing the Council in relationship to the public and
the media
- carrying out preparatory reading and study in connection with
any of the other activities.

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* The material in this section is drawn largely from the Working
Paper from the Research Conference on the Role of DHC CHairman
which appears in full in Appendix III.

Although most Chairmen were carrying out most of these activities,
there was considerable variation in the amount of time spent
on the work and in the preferred emphasis. In general, this
variation was felt to be desirable. The consensus was that
the role of Chairman is not amenable to precise prescription
and that Chairmen should be permitted to engage in activities
and to develop styles of operating that suit the needs of both
themselves and their districts.

Nonetheless, it was possible to produce some general formulations
in clarifying the Chairman's role. For example, it was seen as
requisite that Chairman should stand in the same relationship
to the Minister, to Ministry staff, to providers and to the
community as does the Council as a whole. All that was said
earlier in this chapter on the Council's accountability and
authority in these relationships applies equally to the Chairman.
The Chairmen regard themselves as accountable to the Minister
of Health for ensuring that the Council works effectively within
the specified terms of reference and within other policies
specific to DHCs which have been promulgated by the Minister.
The reflection of this accountability is the recognized authority
of the Minister to affect who is appointed as Chairman, to
assess the performance of those in the role and to initiate the
removal of someone from the role. However, the accountability
is limited and is not an 'executive' relationship in the sense
of the Chairman being a managerial subordinate of the Minister.

There are two areas however in which the Chairman has a
distinctive role. The first of these is in relation to
other members of the Council. If the Chairman is to be held
accountable by the Minister, it follows that he or she should
have matching authority with respect to Council members. This
coordinating authority is limited in that the Chairman's
actions must be within the limits of agreed policy; hence the
requirement that any action taken by the Chairman between
Council or executive committee meetings should be reported
at the next meeting for ratification.   As coordinator, the

Chairman carries authority to make firm proposals for action,
to arrange and preside over meetings, to obtain first-hand
knowledge of progress and to decide what shall be done in
uncertain situations. But in the case of sustained disagree-
ment, the Chairman does not have the authority to issue
instructions to Council members.

There were different views on the appropriateness of the
Chairman assessing the performance of members. Some felt that
there is little that Chairmen can or should do to affect
individual members since they are externally appointed and
unpaid volunteers. Others felt that there is an implicit
expectation that the Chairman will assess the members and that
these assessments will be taken into account in the nominating
of individuals to the executive committee or the vice-chairman-
ship. In general, the sense was that Chairmen should not
carry formal authority to sanction the performance of other
members. The potential dangers in such sanctioning authority
were seen to be the potential for the Chairman taking on a
de facto chief executive role and the possibility of sanctions
being applied because of ideological disagreement with a member.

The second area in which the Chairman has a special role to play
is in relation to the Executive Director and staff. Although
the Executive Director is accountable to Council as a whole,
the Chairman has a special responsibility to direct the ED,
to assess the ED's performance and to report back to the Council
on a regular basis. In manifesting this relationship, the
Chairman should not become the sole 'manager' of the ED but
should rather act on the Council's behalf and with its mandate.

The Chairmen and the Executive Directors often felt that they
had not been sufficiently precise in establishing the criteria
against which the ED's performance would be assessed. There
was concern that these aspects of the relationship be clarified
within individual Councils in order that the accountability
of the ED to the Council should not be eroded. A significant
part of the research was therefore directed to this issue and
the findings are reported in Chapter 6.

The terms of office of Chairmen differ among Councils - one
to three years - and many Councils permit the re-election of
the Chairman for a second term. But since there is a six-year
limit on Council membership, and because the Chairmen are
almost invariably recruited from the existing Council member-
ship, most Chairmen are effectively limited to a short term
of office. It was felt that the DHC bylaws should permit the
Chairman to serve for a reasonable period, including preparation
as vice-chairman and a period as past-chairman, in the interests
of continuity and development of on-the-job skills and
knowledge.

COORDINATION AND COOPERATION AMONG DHCs

A continuing theme in the research project was the desirable
level of coordination and cooperation among the DHCs. The
topic was discussed in each of the three research conferences
(which were in themselves a coordinative mechanism) and in
papers and presentations to the Executive Directors' group.
There appeared to be two motives for developing links
between DHCs:

- to provide an administrative mechanism
  whereby DHCs could share and exchange
  resources and knowledge
- to provide a political mechanism through
  which the DHCs could manifest their
  common interests and concerns.

Although inter-related, these two purposes of coordination
require separate consideration. To illustrate, the common
criticism that DHCs are unable to cope with cross-boundary,
supra-district matters usually comes from sources that would
be happy to see more sharing of resources but would be
opposed to the DHCs developing a political association of
some kind.

This is not to imply that in talking of a political purpose
in coordination we should consider only the Chairmen and

Council members, any more than administrative coordination
is of concern only to the Executive Directors. This would
be to fall into the trap of assuming that members make
policy and staff execute that policy. As is true of other
similar organizations, this simplistic way of distinguishing
the role of the board from that of the staff is misleading.
The staff have a considerable influence on policy and the
members are frequently involved in executive action. This
point was made in a research paper in 1978 when the current
practice was for the Chairmen and the Executive Directors to
meet separately.

> ...The present practice of separating the meetings...does
> seem to cause some problems since it is important that the
> Councils and their staff act in concert. However, the
> Chairmen are the political representatives of the Councils
> and there may well be occasions when they wish to meet alone
> to discuss or express the political will of Councils.
> Similarly, there will be on-going issues which the Executive
> Directors will wish to discuss as a group. It seems however
> that there should be closer coordination of these two groups
> and that, as far as possible, there should be a joint agenda
> for joint meetings...[8]

The need for DHCs to share experience and information was
identified in 1977 in a report of the Ontario Council of
Health. The possibilities envisaged included shared services,
joint research, technical studies and library and information
services. There was also reference to the need for cooperation
in the planning and operation of specialized services which
serve the population of more than one district.[9] Many
cooperative arrangements have in fact developed. For example,
since 1978 a consortium of seven DHCs and McMaster University
has existed to develop approaches to research and planning
which could be useful for all Councils. In a research paper
to the Executive Directors' group in December 1979, other
forms of cooperation were identified including:

> - DHC staff working on a temporary basis in
>   another DHC to gain additional experience or
>   to make specialized knowledge available

- the dissemination of study or
  project results
- the identification of external resources
  that have provided assistance to one or
  more DHCs and which might be made more
  generally available
- the setting up of a central inventory of
  skills and technical studies within
  individual DHCs, possibly in conjunction
  with a library and information service.[10]

But among the DHCs there are pressures to maintain relative
autonomy as well as pressures to forge closer relationships.
On the one hand, the sharing of information, methods and
data can expand the capabilities of individual Councils.
But the Councils are also in competition for scarce resources,
creating disincentives to collaboration. This paradox is
particularly clear in the context of DHCs developing a
political coordinating mechanism.

Early efforts of DHCs to provide collective advice to the
Minister of Health on policy issues were discouraged. It was
emphasized that the Ministry staff and the Ontario Council of
Health were the appropriate sources of collective policy
advice at the provincial level. Indeed, the 1977 Ontario
Council of Health report to which reference has already been
made envisaged the possibility of the Council of Health
becoming a coordinating agency with respect to DHCs.[11] At
that time, there was no agreement among the DHCs themselves
that stronger coordinative mechanisms were needed. There
were those who saw the benefits in having a single point in
the system through which the advisory function of DHCs could
be manifested. This point of view stressed the need to develop
a common response to the Ministry and professional bodies on
specific issues and the value of a pressure group concerned
with health as a whole rather than with just hospitals or

public health. There was also felt to be a need for a wider
forum in which to test the political viability of developing
policies.

However, the other point of view argued that DHCs should be
concentrating on the needs and characteristics of their
individual districts. Furthermore, there were no provincial
issues which required, or should receive, a collective response
from all the DHCs. It was felt that formalized mechanisms
for coordination would introduce another, and by implication
unnecessary, level of decision making and that individual
Councils would be prevented from relating directly to the
Minister on matters of local concern. Any notion of a
Province-wide association of DHCs was considered premature
since the resources to support such an association were not
available nor were there sufficient common concerns among the
DHCs.

In practice, some accommodation between these two points of
view has been found through strengthening the regional/area
groupings of DHCs and Chairmen. In addition to the bi-annual
meeting of all DHC Chairmen with the Minister, the Chairmen
from each of the planning areas elect one of their number to
represent them for one year on a Chairmens' group which meets
with the Minister on a more frequent basis to discuss
policy and issues affecting DHCs. The group is staffed by
the Chairman of the Executive Directors group and is authorized
only to discuss issues with the Minister and share this
experience with their colleague Chairmen in the area. This
group has no executive or decision making role for DHCs as a
whole and it is not intended to replace individual DHC contact
with the Minister or Ministry staff.

This mechanism was introduced in 1980 and is to be evaluated.
It will be interesting to see whether this compromise

arrangement meets the needs of the situation. Certainly it can be argued that any formal kind of political association would be based on the false premise that the DHCs are quite independent agencies. As demonstrated earlier, notwithstanding the wide discretion that Councils exercise, they are accountable to the Minister and the mechanisms for coordination among them cannot ignore this reality.

This chapter has presented an analysis of the basic role of the DHC and the implications for Council members, Chairmen and inter-Council relationships. This analysis provides the necessary background for the exploration of alternative organization structures which is the subject of the next chapter.

CHAPTER 5   THE ORGANIZATION STRUCTURE OF DISTRICT HEALTH COUNCILS

From the start of the research project an area of general concern
to the DHCs was how best to organize the committees and other
sub-groups of Council. Once again, there was wide variation
in the DHCs. At one extreme, there were Councils with extensive
sub-structures of committees or boards, task forces and working
groups, involving literally hundreds of people as members and
advisors. At the other extreme, some Councils had chosen to
create very few sub-groups and these were concerned with
internal, administrative processes rather than with aspects of
health services in the district. In general, the more extensive
and formalized structures appeared in those districts with a
predominantly urban population, with a health sciences centre
and where a hospital planning council of some kind had existed
prior to the DHC.

The assumption in setting up the committee structures was that
the Council would simply not be able to do all the work itself
and that there would need to be groups of various kinds to
which aspects of the work could be delegated. Benefits of an
extensive committee structure were seen to be the involvement
of a much wider group of people in the work of the DHC, thus
broadening the community base, the ability to obtain specialized
advice and the reduction of the Council's dependence on the
executive staff. The disadvantages, emphasized by those DHCs
with few committees, concerned the tendency for the Council
itself to lose control and the large amount of administrative
and secretarial work generated by the committees.

But the DHCs generally faced organizational questions concerning
their subordinate structures - distinguishing the various types
of work to be performed by sub-groups, developing an organiz-
ational rationale for defining the groups' function and
membership and identifying the requisite relationships between
Council and the groups.

In those DHCs with more or less complex structures, particular
problems kept appearing and were identified by the Councils
as ones requiring analysis and clarification:
- The danger of responding to demands on the DHC by the
indiscriminate creation of committees and other working groups,
so producing an unwieldy and ever-expanding structure and
consequent obscuring of accountability;
- The creation of groups with no clearly defined task to
carry out, purely to extend the 'representative' base of the
DHC in the community;
- Overlap of mandate and function among the committees and
working groups;
- Difficulty in reconciling a geographical/political basis
for committee structure with a structure based on 'functional'
areas of work;
- The tendency for the interests of hospitals to dominate
the sub-structure, resulting in benign neglect of other areas
of health care;
- Difficulty in creating a committee structure which can
both cope with the technical planning function and provide
a realistic basis for community involvement;
- A confusion of role and function between groups set up by
the Council to carry out work on its behalf and groups that
are representative of external interests and not part of
the Council's structure;
- Loss of control by Council as its committee structure
becomes more complex and attenuated, variously ascribed to
an overpowerful executive committee, exclusion of powerful
interests from the Council itself and inadequately defined
relationships between the Council and its committees.

In attempting to resolve these problems, all three of the
DHCs involved in the intensive research made a number of
changes in their organization structure - see the analyses
of organizational change in Chapter 3. It was therefore
possible to develop and test out some rules of thumb about
requisite organization and to propose tentative principles

upon which future adaptation of the organizations could be based. By the time of the research involvement with the Steering Committee and the Advisory Group for the Metro Toronto DHC, these principles had been sufficiently refined to be applied to the Toronto situation and the organizational choices to be made.

COMMITTEES AND WORKING GROUPS

In creating their organization structures, most of the DHCs differentiated only on the basis of function (what tasks or areas of activity a group would be expected to address) and whether the group would be permanent or temporary. This simple classification was found to hide some significant differences in the kinds of group created which appeared to be of five discrete types:

- operational groups
- task groups
- working groups
- support groups
- advisory groups

(The titles used here are arbitrary except inasmuch as they conform to the normal usage in DHCs. The important distinction is not in the meaning of, say, a committee versus a group but in the classifying difference in function, composition and location.)

The characteristics of these types of group are described below.

Operational Committees:
The primary groups set up by Council to help it carry out the work it has been created to do. These committees are usually defined in terms of function, relating to the district as a whole. Members are selected on the basis of their knowledge, expertise and local involvement.
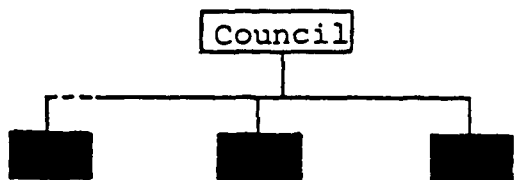
Task groups:

The major committees may need
to create Task Groups,
accountable to them, to consider
issues in a particular part of
the district or a particular
aspect of their overall
mandate. Members are
selected on the basis of their
special local or professional
knowledge.
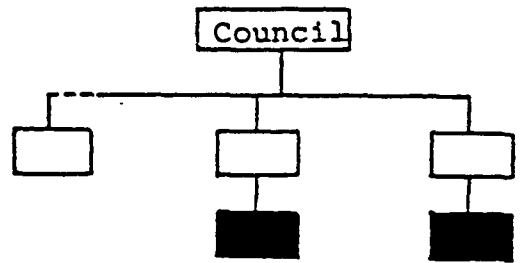
Working Groups:

There may be the need for
Council to delegate the
detailed consideration of a
topic that does not fit
naturally under any of the
existing operational committees.
Such issues can be given to
Working Groups, directly
accountable to Council,
which may disband once their
task is complete.
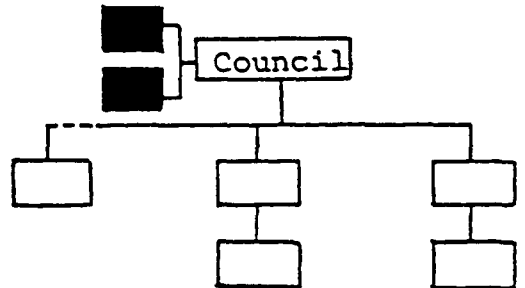
All the three types of group above are concerned with the
operational work of Council - that is, the work that the DHC
has been established to do. These operational activities can,
and should be, distinguished from the supporting or enabling
activities which, although important, are secondary to the
fundamental purposes of the organization.*

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*"The distinction between operational and support tasks is an
important one for organizational purposes. It lays the basis
for precision in assigning accountability and in fixing the
authority relationship between different positions (in the
hierarchy)."[1]

Support Groups:

The Council may need to set up groups to deal with aspects of the internal operation of the DHC organization - for example, a nominating committee.
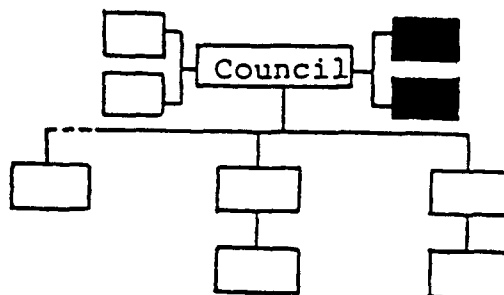
DHCs can exhibit a symptom of organizational pathology often found in other systems - the tendency to concentrate time and money on the support and maintenance activities at the expense of the operational work. For example, analysis in a DHC showed that no clear distinction was being made between ends and means; that is, the Council was spending relatively little time on pursuing the basic goals of the DHC (identifying needs, planning, coordinating) and was devoting a lot of time and attention to the supportive, internal kinds of functions (education of Council members, administration and clerical work). This concentration on means rather than ends may be an inevitable fact of life for a relatively new Council but it was emphasized that changes may have to be made, particularly to the organization structure which was largely based on support functions, if the balance was to be redressed.[2]

Advisory Groups:

Councils need to seek advice on a regular basis from various external groups such as professional bodies, associations of professions and agencies, consumer bodies and so on. This consultation process is two-way; on occasion the Council asks for reaction to a proposal but external bodies also take the initiative in presenting their views to Council on matters of concern to them. Precisely what advisory groups should be identified is a question for each DHC. Some of these advisory relationships may be quite informal and ad hoc; others need to be more formalized. In some cases, potential advisory groups with established constituencies already exist in a district; other areas of activity of interest to the DHC do not have a natural coordinating or representative

body. But the test question is: does the Council need the
sanction of a particular interest group or groups, not
already represented in the DHC organization, in order that
its decisions can be implemented?

Such advisory groups are not part of the Council structure
nor are they accountable to the DHC. The Council cannot,
therefore, delegate tasks to them. Rather the relationship
is one of cooperation and consultation on matters of mutual
concern. In a number of instances in the research project,
it became clear that there had been an attempt to regard such
an independent advisory group as a creature of Council. This
occurred, for example, in the case of an external group
representing hospital interests, which had existed before the
DHC was created and which had ostensibly been 'welded' onto
the DHC committee structure. In practice, the group had
its own external constituency and continued to behave as
an autonomous group. The Council could not delegate tasks to
it and it could not hold the group accountable. In one
case, such a group refused to allow Council members to attend
its meetings.

The resolution of this problem lay in recognition of the
group as an independent entity which could be a
source of advice, nominations or members but could not itself
come under the control of Council.

The analysis of advisory groups also revealed another common
confusion of role with regard to the so-called providers of
health care. These professionals are involved in the work
of the DHCs in at least two ways:
- professionals on the Council, its committees or groups,
are there as individual technical advisors to contribute their
particular knowledge and expertise;
- professionals who represent their professional colleagues
in response to the Council's activities - for example, the
physician nominated by the local medical society. This kind
of involvement of key provider groups in the community is

often found to be essential to the Council's work and is best achieved through strong links with such externally organized advisory groups.

There was a tendency for this distinction to become blurred. For example, a physician acting as a specialist advisor on a task group might attempt to put forward broader medico-political arguments of the 'speaking for my colleagues' variety. It does seem to be important that these two forms of professional involvement in the DHC are kept distinct from each other. The individual professional on a committee or task group does not have the constituency backing, as it were, to give a general professional response to the DHC's activities. The response must be sought from representatives of organized professional groups.

OPERATIONAL COMMITTEES

The primary committees below Council were often defined in such a way as to cause confusion and overlap and there was a confounding tendency to add a new committee each time a new area of work was identified. The following extract from a research document contains the principles which were found to be helpful in resolving these difficulties.

...The first level of operational committees should be based on as few areas of work as possible - that is, be as few in number as possible - to reduce the possibility of confusion and overlap. If more detailed work is necessary within any one area, there is always the option of setting up a subordinate group at the second level for this purpose... To reduce further potential overlap between operational committees at the first level of Council sub-structure, their areas of interest should be as mutually exclusive as possible. That is, each committee should have an area of concern that does not unduly overlap with the other committees' concerns. This is best achieved by using the same kind of basis for defining all the (operational) committees. If, for example, some of the committees are concerned with institutions and agencies, some with general programs and some with particular professional services, the potential for overlap and confusion is considerable. 3

Even these common-sense principles were not always easy to
apply to the existing organizations. In one of the research
settings, considerable discussion took place on this issue
and several alternative models were considered. But it was
decided that to alter the committee structure radically would
be politically unacceptable. The committees had been
operating for some time and there was concern that interest
and support, particularly from the hospitals, might be lost
by major change.

However in another research setting the operational committees
had originally been set up on a fairly consistent basis (in
this case the basis was areas of service such as mental health
and dental health) and the only exception was the institutional
review committee which had the task of priorizing proposals
for new and expanded programs in hospitals for submission to
the Ministry of Health. There was consequent overlap of
function between the institutional review committee and the
others. Applying the principle of a single basis for the
definition of operational committees, the Council deicded
eventually that the more appropriate place in the structure
for the institutional review process was a working group,
existing just to carry out its specialized task. The chairmen
of the operational committees were allowed to attend the
meetings of the working group as non-voting participants.
This change produced a clearer differentiation of work and
was also found to improve communication and sharing of
information. Secondary effects were to simplify subsequent
decisions on where in the structure to locate other
working groups and task forces and to reduce the heavy
coordinative and interpretative load on the executive
director and staff.

A second aspect of this question concerns which of the many possible bases to use in differentiating the work of the operational committees. Primary dimensions often used in classifications of the health system include:

- medical specialties (general medicine, surgery, obstetrics, etc.)
- settings (hospitals, nursing homes, health centres, etc.)
- resources (hospital beds, equipment, nurses, physicians, etc.)
- intervention modes (prevention, diagnosis, treatment, rehabilitation, etc.)
- disease categories (cancer, heart disease, end-stage renal disease, etc.)
- level of specialization of treatment modalities (primary, secondary, tertiary etc.)
- age (the elderly, children, etc.)
- geographical subdivisions. [4]

Most of these dimensions were used by the DHCs for defining committee structure. The most common bases were settings (hospitals, community), age (services for the aged, maternal and child health), disease categories (mental illness, communicable disease) and geography. In trying to resolve which of these bases was the 'best', it was clearly necessary at least to speculate about the likely consequences of using one basis rather than another. After testing with a number of DHCs, the tentative propositions that emerged were:
- to the extent that the committee structure is based on dimensions that are basically institutional or professional in character, so there is the tendency to reinforce the existing patterns of service and to prevent developments which challenge institutional and professional boundaries;*

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*With the change in eligibility for Council membership in 1980, allowing hospital administrators and chairmen of hospital boards to become Council members, one of the arguments for a specifically 'hospital committee' was eliminated.

- to the extent that the committee structure is based on
dimensions such as areas of health care, health care groups
or programs, so there is an increased likelihood of identifying
needs that are not being met, of producing innovative
solutions and of providing services that cut across juri-
sdictional boundaries.

The same point was made in a 1977 Ontario Council of Health
report on the planning function of district health councils.

> There seems to be a general trend away from
> the institutional/agency model which is based
> on existing interest groups because this model
> tends to reinforce the status quo and limit
> the possibilities of innovation. The program
> model...and the model based on health care
> user groups...both have the advantage of
> directing attention to the consumers or the
> potential consumers. Both force a new look
> at the needs in the community, unhampered by
> the limitations tending to emphasize service
> effectiveness, the user group by focussing on
> the specific needs of a given sector of the
> community. [5]

One of the DHCs involved in the research adapted its committee
structure to the 'health care group' model over a period of
about eighteen months. In its 1980/81 annual report, the DHC
reported on the research collaboration.

> This work has resulted in an organizational
> model based on operational sub-committees
> primarily related to population groups or
> health issues. The advantage of this model
> is that it permits a variety of agencies to
> come together to plan common approaches to
> common issues. [6]

The health care group basis for committee structure was also
found to be more consonant with the activities and priorities
of the DHCs. As shown in Chapter 1, (page 15), long-term
care and services for the aged and mental health services
were the highest priority areas in DHC work. Where a single
committee was able to look at the full range of services in
these areas, including those in hospitals, in the community
and in the home, it was generally found to facilitate planning
and development. Where, on the other hand, the committee
structure enforced a fragmented approach to the issues, they
tended not to be given high priority.

However, as shown by the following extract from another research paper, the desired change in emphasis will not be achieved by simply renaming the committee. Supporting changes in membership and terms of reference are needed too.

...Discussion covered both the preferred role of the mental health committee and its composition. It became clear that there is a basic difference of view within the committee regarding the range of services which it should be considering. The difference of opinion centres on whether:
- the committee should be concerned with the 'medical model' of psychiatric services i.e. treatment services provided predominantly but not exclusively by doctors;
- the committee should be concerned with a broader model of mental health services ranging from prevention and health promotion, through treatment, to rehabilitation and maintenance of mental health.

The implications of these two models are considerable. The first implies drawing the boundaries closely round treatment services, leaving other agencies to accept primary responsibility for the non-treatment aspects of mental health services. The proponents of this view accept that the committee might have representatives of non-treatment agencies or professions attending meetings, but to provide for information exchange rather than to affect the decision making and accountability of the committee. A major reason for supporting this view is the differentiation of jurisdictions, both at government and local levels, and the perceived limitation on the DHC to affect directly any matters which fall outside the jurisdiction of health.

The second model sees the committee's area of legitimate concern much more broadly, encompassing health and social aspects of mental illness. The proponents of this view see the committee as necessarily concerned with the full range of services and therefore requiring authoritative contributions from social agencies and the community. The separation of jurisdictions is recognized, but is not seen as a bar to coordinative planning by the DHC. [7]

The pros and cons of a <u>geographical</u> model for committee
structure were also considered in detail as part of the
research work. In particular, the problem was presented as
how successfully to combine geography and function[*] in the
organizational framework of the DHC. In at least two of the
settings where research findings were tested, there were
strong arguments for using geographical subdivisions of the
district as the basis for committee structure. In Kenora-
Rainy River, the concern was to reflect the different needs
in the widely scattered communities. In Toronto, there was
strong pressure to use the six area municipalities in Metro,
or some grouping of them, as the basis for setting up
operational committees. In both cases, the idea was to set
up a committee, in effect a mini-Council, for each of a
number of geographical - and in the case of Toronto, political -
areas within the district. Each committee would address all
matters of health service planning and coordination within its
area.

A number of models for committee structure were identified
and evaluated, incorporating geographical and functional
dimensions in different patterns. The essential features of
these models are represented in the four illustrations below.

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[*] The term 'function' is used here to include all the possible
dimensions for differentiation of DHC work, shown on page 113,
other than geography.

Models of DHC committee structure

(C = Council   G = geographical base   F = functional base)

A.

```
        C
   ┌────┼────┐
   F    F    F
        ├────┤
        G    G
```

B.

```
        C
   ┌────┼────┐
   G    G    G
        ├────┤
        F    F
```

C.

```
        C
   ┌────↑────┐
   G    G    G
        ├────┤
        F    F
```

D.

```
           C
   ┌──┬──┬──┬──┬──┐
   F  F  F  G  G  G
```
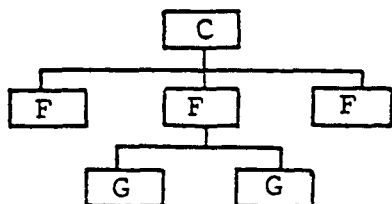
The criteria against which these models were evaluated included:
- the intrinsic potential for coordination and integration
- potential for community involvement
- simplicity and clarity
- political acceptability
- 'fit' in relation to local government
- potential for dealing with health services comprehensively in the district
- ability of the Council to retain control of its system
- minimum duplication of effort, maximum economy of scale
- viability in relation to the Ministry of Health.[8]
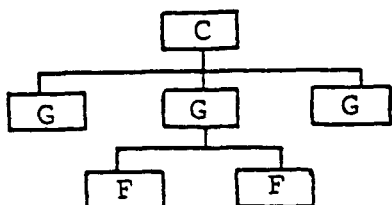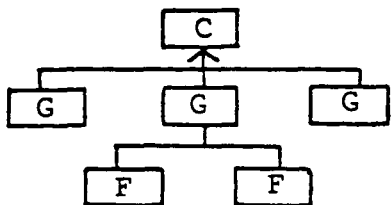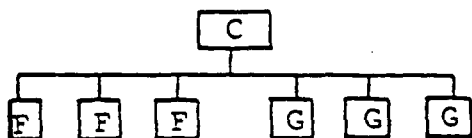
Model D, with one set of functional committees and another based on geographical areas, was judged to be the least satisfactory. The possibility of confusion and duplication of effort is great, the Council would have an impossible task of coordination and external organizations would be obliged to relate to the DHC in a diffuse and inconsistent fashion.

In both Models B and C, the operational committees of Council are based on a geographical subdivision of the district. Model B involves the Council creating the committees and deciding membership in the normal way; in Model C, the operational

committees would be constituted first and each would then
nominate Council members from among its committee membership.
Although both models allow for specific local involvement and
representation, they were generally rejected on the grounds
of the likely inability of the Council to coordinate,
integrate and control the activities of the committees. It
seemed likely in fact that there would be little role left
for the Council and that the district would cease to have
much meaning. These models were also expected to create
confusing relationships with other agencies in the district
and difficulty in achieving development and innovation.

Model A, where the operational committees are each concerned
with a function of Council for the whole district, was
generally felt to provide the most effective framework; it
allows for comprehensive consideration of health issues
across the district, it places Council in a strong coordinative
relationship with its committees and it facilitates relationships
with other district based organizations. If there are issues
of concern to a particular geographical area, a task group
can be established accountable to the appropriate operational
committee.

However, the problem of some topics not fitting naturally
under any one of the operational committees did occur. The
choice was to create a new operational committee if the topic
was of sufficient scope and defined on the same dimension as
the other committees; or to create a specially constituted
working group directly accountable to the Council; or to
set up a task group under an operational committee with cross-
representation from the other operational committees with
an interest in the topic.

On this question of how best to achieve coordination of
specialized activities within a committee structure, the
research evidence suggests that vertical differentiation and
specialization by the creation of task groups produces a
more easily coordinated structure than horizontal differentiation

through the creation of numerous working groups. Although
working groups are often intended to be temporary, they do
tend to become permanent features of the organization and
thus to compete with the operational committees. A judicious
mixture of task groups and working groups does seem to be
necessary but the number should be kept to a minimum.

COORDINATION AND CONTROL

Many of the earlier established DHCs encountered difficulty
in maintaining control as their committee structure became
more extended and complex, a phenomenon which has been observed
in other consumer-based boards.[9] Members described the problem
as becoming redundant, isolated, a rubber stamp, and there
is no doubt that the effectiveness of some of the Councils
was being reduced by incomplete information from, and
communication with, the various committees.[10] The reasons
for this situation were initially couched in terms of:
- the volume and complexity of the work coming to Council,
necessitating considerable delegation to committees
- inadequate information on which to make decisions
- the part-time availability of members
- the difficulty for members in grasping the technical
intricacies of health services planning and operation
- too much delegation, implicit or explicit, to the
executive director and other staff. (This aspect of the
problem is examined in greater detail in Chapter 6).

Important as these factors were, there were also organizational
reasons for Council forfeiting its ability to coordinate
and control. In one of the research papers, the following
analysis was put forward.
...Confounding the problem of role definition is the issue
of effectiveness in decision making. Many of those interviewed
either stated or implied that clearer policies would not of
themselves ensure the Council's effectiveness. There is a
strong sense that Council has become subservient to its
infrastructure with operational committees assuming too much
responsibility for identifying the health care needs of the
community and developing program proposals, with Council
sitting in an intermediate position in the approval process.

This situation may be the result of one or all of the
following:

> - over-delegation by Council to its sub-structure
> - the almost complete separation of Council
>   membership and committee membership
> - the basis of the committee structure itself may
>   be antithetical to planning and control at
>   the Council level. [11]

In another research setting, the question was expressed as
follows:

...The basic question concerns the extent to which the Council
wishes to control the activities of the committees. Should
the committees be creatures of Council, taking guidance and
direction from Council, or should they be more autonomous
groups initiating their own activities, deciding their own
priorities and keeping the Council minimally informed? Or
is the ideal position somewhere between these two extremes?...

Maximum control by Council: If the Council wishes to achieve
maximum control of its activities it could create committees
which are made up largely (or totally) of Council members.
The Council would appoint committee members, the committee
chairmen would be Council members and the chairmen would
report to Council. This model would achieve high control and
accountability but would have the following disadvantages:
- a tendency for Council itself to lose its unity
- a heavy workload for Council members
- a limited range of expertise and external input in the
committees
- the consequent need to create many ad hoc groups to deal
with specific issues
- elimination of the committees as a training ground for
potential Council members.

Minimum control by Council: The other extreme would be
committees with no Council members. The committees themselves
would define their detailed functions and terms of reference,
would select their own members, would appoint their chairmen
and would decide on their own methods of reporting to Council.
The disadvantages of this model could be:
- a difficult coordinating task for the Council itself
- the potential isolation of Council and loss of control
- potential overlap and confusion between various committees'
activities
- differentials in levels of activity and competence of the
committees
- an excessive need for coordination, information-seeking and
interpretation by the Executive Director and staff. [12]

In this particular DHC, it was decided that the most workable
model lay somewhere between the two extremes. The principles
which were helpful in resolving the issue were:

- Committees should have some Council members appointed by
Council itself. Other committee members should be drawn
from appropriate fields of knowledge and expertise and be as
representative as possible of crucial external interest
groups. It does not seem to be necessary that Council
members should form the majority on a committee;
- The committee chairmen should be Council members appointed
by Council. Otherwise, the Council members could be placed
in a difficult situation in decision making and in the
Council. The chairmen would be the ones to report to Council
as a whole;
- As committees appoint new members or replace old ones, as
long as the Council retains its involvement of one member as
chairman plus a specified number of others, there seems to
be no reason why the committees should not themselves appoint
new members;
- It does seem important that each of the committees operates
on the same principles of membership and composition in
order to be equally authoritative in their relationship to
Council.

It was argued that within these general principles there is
still plenty of room for variation and recognition of
individual contributions. It was also emphasized that these
principles concerned only the committees set up to carry out
the major activities of the Council on a permanent basis.
Quite other considerations might apply to the creation of
temporary or ad hoc groups set up to undertake specific
tasks or to the creation of advisory groups of various kinds.

Other arrangements which were found to be helpful in reducing
the remoteness of Council included:
- limitation of the power and monopoly on information of
the executive committee, possibly by ensuring a regular change
of membership;
- keeping the numbers of people involved in DHC committees
and groups to the minimum consistent with the demands of the
work to be done. Involving large numbers of people should

be a means to an end rather than an end in itself.

These principles were tried and tested in various DHCs and were generally found to be helpful in ensuring that the Council's work was more than merely a coordinated and rationalized sum of the work of the committees. The committees need to have considerable freedom to select issues and produce alternative solutions but the Council needs to be clear about the overall policies and plans within which the work of the committees is contained.

ORGANIZATION FOR PLANNING

As already noted, many Councils reported achievements in program development but were having difficulty moving into the planning phase. The reasons for this difficulty were many - small staff, lack of time, expectations in the local community, the fire-fighting which Councils must undertake, lack of expertise and so on. Experience from some of the older DHCs suggested that a Council may have to refuse to do many of the less complex tasks if it is to undertake planning on any sort of long-term basis. The younger DHCs found that they had to establish a foundation by undertaking the less complex tasks before they could even contemplate moving into program development and planning. The problem was identified by one of the DHCs as follows:

...A further concern regarding the Council's role is that no long-term planning is going on...the Council does not have an overall picture of needs and services in its district and therefore has no basis for planning. Instead, individual issues and crises are dealt with on a single basis, without the guidance of some overall objectives and priorities. This situation is of concern to some, particularly as the pressure to constrain costs is likely to encourage the Council to be more conservative in its decision making.[13]

In another DHC the problem was construed in a slightly different way:

... - too much crisis management, not enough planning
    - no clearly defined and agreed role and objectives
    - need to gain local credibility
    - institutional domination of priorities
    - requirement to carry out Ministry-directed activities.[14]

At a more general level, the issues were related to the philosophical underpinning of Council - whether it seeks to promote major innovations or seeks incremental change in a fundamentally satisfactory system; the extent to which it expects to be proactive in planning versus responding to externally imposed problems; and how far it is prepared to intrude into 'non-health' jurisdictions such as social services and environmental control.

The following schema was developed to help identify the source of the problem;
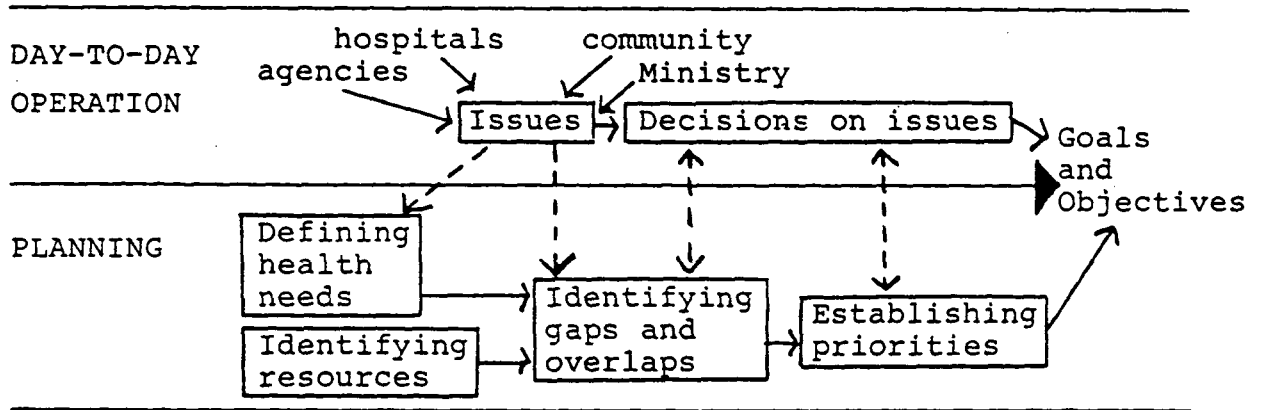
In some DHCs, the whole effort was concerned with day-to-day operation. Others were planning but found difficulty in inter-relating the planning process with the day-to-day operation. In both cases, part of the solution seemed to lie in finding mechanisms to link the two processes - shown as the dotted arrows in the diagram.

It emerged that two kinds of change were needed. The first involved the development of mechanisms to ensure the conscious, systematic setting of priorities in the Council's goals or objectives. This approach was taken up by three or four DHCs involved in the research project. Since the technology of planning and priority setting were not the central focus of the project, the mechanisms developed were no doubt simplistic

and will not be reported on at great length here.* The
essential features of the process were:

- identification by Council members and staff of the health
needs of the district. An effort was made to consider health
needs in broad terms, not merely in terms of existing programs
or services, and to establish a specific goal or objective
in each of the areas of need;

- the criteria to be used as weighting factors when placing
needs in à priority order. A compendium list of the criteria
includes:

> - the DHC's ability to affect the situation
> - the level of public and consumer support
> - the lack of organizational complexity in
>   terms of the number of agencies involved
> - the necessity for DHC involvement to
>   ensure action
> - the cost-benefit and cost-effectiveness
> - cheapness in terms of total investment involved
> - numbers of people (consumers) affected
> - comprehensiveness throughout the district
> - availability of technical knowledge and data
> - importance for health status of the community
> - urgency
> - poltical acceptability
> - possibility of evaluation.

In one of the DHCs all the Council members then individually
assessed the goals against the criteria and the resulting
ordering of the priorities, albeit rough and ready, was then
used by the Council in its decision making and in redesigning
its committee structure.

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* An ambitious and sophisticated approach to planning was
developed under the auspices of the Ottawa-Carleton Regional
DHC - see Ottawa-Carleton Regional District Health Council
Planning Program, Long-Term Strategic Evaluation of Health
Services in Ottawa-Carleton. August 1979.

This kind of approach was generally found to be helpful in developing a systematic and self-critical approach to planning. Certainly from the researchers' point of view, the approach opened up the organizational questions in a way that somewhat sterile discussions on the difference between operational, strategic and comprehensive planning did not. It was then possible to consider organizational changes, particularly the arrangement of committees and working groups, so that the structure facilitated rather than impeded planning.

One of these changes has already been hinted at in the foregoing discussion of the optimum basis for operational committees. In the early days, most Councils were faced with immediate issues, coming either from their local communities or from the Ministry of Health, which they had to address if they were to gain credibility. The organization structures that they developed to meet this kind of need were not necessarily suited to the long-term planning function. For example, some Councils responded by delegating the planning function to a committee or executive group. In fact, one of the organizational models suggested to the original DHCs involved primary committees based on just such generic areas of work as planning and coordination.

The research findings suggest that it is a mistake for the Council to delegate these fundamental activities to a sub-group since the Council then loses the ability to pull together all the activities within its organization. Decisions concerning the planning or coordination of health services on a district wide basis give the Council its raison d'être and should not be delegated to a subordinate, non-representative group.

A second relevant principle, perhaps procedural rather than structural, was introduced by one of the DHCs. The Council meets every two weeks (instead of once a month), alternately sitting as the Council and as the Planning Committee of the Council. There is a determined effort to keep the Planning

Committee agenda free of immediate problems or administrative
minutiae so that members can concentrate on the long-term
planning process. At the same time, seminars and working sessions
were organized to familiarize members with the particular
planning process that had been developed in the district. These
changes were found to improve attendance at both types of meeting,
the members reported greater satisfaction in their work and
planning came more to the forefront of the DHC's operation.

It was also clear that the ability of the Council to grasp
the planning function was largely predicated on the level
and style of operation of the executive director and staff.
Long-term planning is essentially concerned with quite abstract
ideas about health needs in the district and about creative
ways of meeting those needs. If the executive staff of a DHC
are unable to, or prevented from, working at this level, it is
likely that the short-term, topical matters will dominate.
The next chapter explores this issue in greater detail in the
context of the working relationship between the Council and
its staff.

CHAPTER 6   THE DISTRICT HEALTH COUNCIL AND ITS STAFF

One of the continuing themes of the research project was the
role and duties of the DHC Executive Director and other staff.
The issue was analyzed in two of the three intensive research
settings, in seminars held for other DHCs, in discussions
with Ministry staff, in presentations to the Metropolitan
Toronto DHC Steering Committee and in a research conference
organized as part of the project in June 1980. (See
Appendix III for the Working Paper that resulted from this
conference).

The concerns, and the need for clarification, arose in
respect to various aspects of the role of the DHC staff:
- the nature of the work carried out by
  the Executive Director (ED) and staff
- the size of the executive staff and the
  skills required to do the work
- the relationship of the ED to Council
- the relationship of the ED to the
  Ministry of Health.

A 1980 study identified the characteristics of DHC staff.
In general, they were young, well educated, had been in their
present jobs for about two years and remained in the same
job classification for which they were hired. For about half
of the staff, the DHC post was their first working experience
in health care. The majority of DHC staff were 39 years of
age or younger. Unlike the staff as a whole, the EDs were
relatively experienced in the health care field, 40% of them
having more than 15 years previous experience. However, a
surprising 20% of the EDs reported that their present job
was their first in the health care field. Over half of the
staff had at least a baccalaureate degree and about 60% of
those in executive roles were completing or had completed
graduate studies. Staff with post-secondary education had
taken programs in social sciences, health, administration or
management.[1]

THE WORK OF THE STAFF

As DHCs have developed, the executive staff have come to be
seen more as sophisticated health planners than as
administrative secretaries. In 1975, it was possible for
an Ontario Council of Health report to describe the duties
of the ED as:

> ...leadership to the district health council
> to identify needs and to provide enough
> technical expertise so that solutions are
> found to the problems identified. In addition,
> there are innumerable duties of minutes, and
> reports, and the creation of paper on which
> organizations depend today.[2]

A quite different and far more technocratic emphasis appeared
in the 1980 report of the Metro Toronto DHC Steering
Committee:

> The primary duties of the staff secretariat
> should be:
> - To provide the Council and its supporting
>   organization structure with the necessary
>   research, report-writing and secretarial
>   assistance.
> - To provide professional services for planning
>   studies, research activities, policy analysis
>   and program reviews to be used by the Council
>   in developing positions, setting priorities
>   and reaching decisions.
> - To use existing sources and to develop and
>   maintain a comprehensive data base and
>   information network on health care services
>   and programs, health legislation and policies,
>   and new developments in health care delivery
>   programs and technologies.
> - To service the Council's liaison and
>   communication function with community
>   development groups and agencies, health care
>   providers and all levels of governments
>   through direct staff contacts, publications
>   and reports.
> - To provide a focal point for communications
>   and contact with the Council.
> - To perform other secretarial, administrative
>   or professional duties and assignments as
>   directed by the Council.
> - To be available as a resource to the people
>   of Metropolitan Toronto.[3]

This research project came to an end before the Metro Toronto
DHC was in operation so it has not been possible to study
the largest and arguably the most complex of the DHCs. But
it was possible to analyse in some depth the work undertaken
by some of the other DHCs and their staff. As has been
shown in previous chapters, different Councils emphasize
different aspects of their role and this obviously affects
the range and nature of the work undertaken by staff.
Nevertheless, in one of research papers in January 1979 a
fairly representative description of the specific tasks for
which the ED is accountable was given:

- carrying out the administration associated with the
  Council's work (arranging meetings, preparing materials,
  coordinating members, recording decisions, taking follow-
  up action, etc.);
- preparing the annual DHC budget for Council approval,
  maintaining the Council's accounts and reporting on them
  to Council;
- maintaining links with a wide variety of health organizations,
  community groups, professional bodies, other DHCs,
  universities and social agencies;
- obtaining and providing to Council and its committees such
  information and data as are required;
- developing policy proposals for Council approval and
  implementing approved policies;
- guiding the Council to issues for consideration and advising
  on the implications of various alternatives;
- identifying organizational needs and problems and proposing
  solutions;
- maintaining links with the Ministry of Health particularly
  through the Area Planning Coordinator;
- developing detailed plans on specific topics for submission
  to the Council;
- investigating developments or programs elsewhere which have
  relevance to the Council's activities;
- helping to induct and educate the new Council or committee
  member;
- recruiting, selecting and managing the other Council staff.[4]

Many aspects of the above tasks are delegated by the ED to
other staff but because of the small size of the staff in
most of the DHCs the ED needs to be able to deal with many
of these tasks personally.

The Council members generally see the ED as accountable for
making sure that all major issues come before Council and
that members have sufficient information on which to make
decisions. The ED is also seen as the coordinative link
between Council and its subordinate committees as well as
a link to the broader health care community and the Ministry
of Health. Indeed, one of the characteristics of the staff
roles is that the tasks come from many sources - the Council,
the executive committee, other committees, the chairman and
external groups. Consequently, the staff have to balance
activities and judge priorities all the time in the
knowledge that the effectiveness of any one member group
or committee is largely predicated on the amount of staff
support available.[5]

SIZE OF THE STAFF

Until the emergence of the Metro Toronto DHC in 1980, the
consistent policy was that DHC staffs should be kept small.
This appears to have been a response to the general emphasis
on cost constraint and that most feared - and most facile -
criticism that the organizations would become homes for
tired bureaucrats.[6] On the question of staff size, the
1975 Ontario Council of Health report stated:

> An administrator plus a secretary-bookkeeper
> will be the minimum staff required. Additions
> beyond that number should be made by the
> district health council with extreme caution
> because one can envisage a formidable
> hierarchy of such executives developing with
> inevitable additional demands upon
> available health dollars.[7]

In September 1978 the Ministry of Health sought the views
of the DHCs and chairmen in order "...to attempt to determine
the optimum number of employees required to serve the needs
of District Health Council members in fulfilling their
mandate...".[8] At the invitation of Ministry staff, a

response was sent, based on research findings at that time,
which made the following comments on the size of DHC staff.

...At Council level there seems to be general acceptance of
the policy to keep the executive staff reasonably small.
There is recognition of the fact that a large staff would be
perceived as 'another layer in the bureaucracy' and would
adversely affect the Council's credibility with local
agencies and communities. Comparison is made with HSAs in
the USA whose large professional staffs are sometimes seen
to dominate health planning at the expense of community
involvement.

Nevertheless, there is a dilemma here since the size of a
Council's staff seems to be one of the major limitations on
the range and nature of activities that the Council can
undertake. Perhaps the most precise statement that can be
made about optimum size of staff is that it should not be so
large that it is perceived as another bureaucratic hierarchy
but should be large enough to carry out effectively all
tasks delegated to it by Council. To be more precise than
this is difficult for a number of reasons:

- The relatively broad mandate for DHCs
  means that different Councils emphasize
  different aspects of the role. Some of
  the Councils have become more involved
  in what might be called basic data collection
  than others; some have been drawn into the
  implementation of plans at the local level;
  some have concentrated on developing a
  specialized planning capability. Clearly
  the different emphases that the Councils
  have chosen have implications for the size
  and type of staff required;
- Staffing needs are much affected by
  particular local circumstances - the
  existence of a health sciences centre, the
  geographical size and remoteness of the
  district, the number and complexity of
  local health and social service agencies
  and so on;
- To the extent that Councils can seek and
  obtain outside help on a temporary basis,
  so the permanent staff can be kept reasonably
  small. If such external consultants are
  not available, for financial or other
  reasons, the permanent staff would presumably
  have to be larger.

All of these factors mean that there is probably no ideal size
of staff. The needs will differ from place to place and
according to the stage of development of a particular Council.
However, it is clear that, because of the voluntary, part-time
nature of Council membership, the Executive Director and staff
do have to deal with most of the detailed work. They very
directly affect the amount of work and decision making that
Councils and their subordinate structures carry out. Hence

policy decisons to increase or reduce the size of DHC
secretariats would have a profound impact on the level of
Council operation.[9]

In November 1979, the Ministry issued guidelines on size of
DHC secretariat which specified four full-time or full-time
eauivalent staff for DHCs serving a population of less than
400,000 and six staff for DHCs with a population of more than
400,000 or a district that includes a health sciences centre.

These guidelines were hardly consistent with the 1980
recommendations of the Steering Committee, Metropolitan
Toronto DHC, which envisaged a fully developed staff secretariat
of 25 to 30 individuals and suggested that during its first
year of operation the Council would require the services of
approximately 15 members of staff. (In fact, there are ten
staff at present). The proposed mature staff organization
included an Executive Director and 4 Assistant Executive
Directors heading up divisions in planning and program evaluation,
research and analysis, community development and agency liaison,
and finance and administration.[10]

It seems then that the notion of an optimum size of staff
is an elusive one. This is not to say that the guidelines
applying to DHCs are at all unusual. In many health systems,
indicators such as size of population served, or the number
of beds, or the presence of a university teaching centre,
are used as proxies in establishing levels of staffing and
pay. But as has often been demonstrated, these indicators
do not seem to be particularly helpful in establishing the
number of jobs required or the type and complexity of
decisions to be taken in those jobs. Could it not be, for
example, that it is easier to relate to a large, urban
population with an established network of social agencies
and political organizations than to a small but heterogeneous
rural population with few social or political institutions?

LEVEL OF WORK

In its enquiry, the Ministry also sought views of the level
of expertise required in the executive staff roles. As
mentioned already, the existing EDs came from a wide variety
of backgrounds (although most of them had experience in the
health care field) and their educational qualifications
covered a wide range. The advertisement for the post of
Executive Director, Metropolitan Toronto DHC (The Globe and
Mail, Thursday November 20 1980) described the role and the
skills required as follows:

> As the first Executive Director, you will face
> the unique demands of a start-up situation.
> Your initial mandate will be to provide
> guidance and assistance to Council in developing
> and prioritizing a broad range of goals and
> objectives. Almost simultaneously you will
> have to use your executive and managerial
> skills to develop the administrative structure
> and build up a secretariat. Your interpersonal
> and communicative skills will be utilized to
> forge relationships with a host of private and
> public organizations involved in all aspects
> of health services.
>
> As a senior executive your administrative and
> facilitative skills will be finely honed.
> Ideally, you have a knowledge of health services,
> programs and planning. You must be familiar with
> financial administration, formulation
> of policies and have a working knowledge
> of community and media relations,
> preparation of briefs, research and
> communications. An understanding of the
> operation of voluntary organizations and
> the working processes of various levels of
> government would be added assets.

Even allowing for advertising hyperbole, this role bears
little resemblance to the administrator/committee clerk
envisaged in the mid-70s. The ED is seen as being at a
"senior executive" level, justified partly by the inherent
complexity of the job, partly by the requirement that the
individual in the job should be able to command the respect
of the professionals, senior executives in other organizations

and senior government staff. This latter argument - about
the need for equivalence and comparability with other
senior roles in the health and social services systems -
was put forward strongly in the deliberations of the Steering
Committee and Advisory Group.

Although apparently as arbitrary a criterion as size of
population or presence of a university teaching centre, the
notion of equivalence was generally felt to be a more useful
way of trying to establish the kind of work and level of
responsibility in the ED role. On the other hand, size of
population is an objective, measurable criterion whereas
level of responsibility is a much more nebulous and
subjective concept.

To try to resolve this dilemma, a model of work stratification
was applied to the ED role.* This model, first created by
Jaques in terms of 'time-span' measures of levels of work[11]
and developed by Rowbottom and Billis as a descriptive
theory,[12] posits the existence of a natural stratification
of the work to be done in organizations. Rather than
attempt to paraphrase the essence of the theory, a summary
is quoted below.

> In essence the thesis was this:
> 1. that the work to be done in organizations
> falls into a hierarchy of discrete strata in
> which the range of the ends or the objectives
> to be achieved and the range of environmental
> circumstances to be taken into account both
> broadens and changes in quality at
> successive steps;
> 2. that the work at successively higher strata
> is judged to be more responsible, but that
> significant differences of responsibility are
> also felt to arise within strata; ie. that
> these qualitative strata form stages within
> a continuous scale of increasing levels of
> work or responsibility;

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* Because this issue arose towards the end of the research
project, it was not possible to test the application of the
model in other than a limited way. Unlike most of the other
propositions in this report, therefore, these ideas have not
been tried out or absorbed into executive action in the DHCs.

3. that at least five such possible strata
can be precisely identified in qualitative
terms; in successive order and starting from
the lowest: prescribed output, situational
response, systematic service provision,
comprehensive service provision and comprehensive
field coverage;
4. that these strata form a natural chain for
delegating work and hence provide the basis for
constructing an effective chain of successive
managerial levels within the organization; and
5. that the understanding of these strata can
also provide a practical guide to designing new
organizations (or part-organizations) according
to the kind and level of organizational
response required in relation to the social
and physical environment in which the
organization is to operate.[13]

(The main features of each stratum of work are summarized
on the following page).

It is the fifth point in particular which has the potential
for opening up the question of the requisite level of ED
(and DHC) work. What kind and level of response is required
from a DHC and its Executive Director in relation to the
Ministry, the community and the numerous organizations and
agencies with which they must work?

It is clear from the previous analysis of the DHC that it
is expected to operate at a high level - to undertake
long-term planning and to envisage new solutions to the
problems encountered. Indeed, much of the frustration
reported by Council members and staff arose from the
apparent inability to break out of the constraints of
existing situations and systems into more significant and
higher levels of decision making; (See page 122); or, to
express the same idea in terms of the work strata model,
to move away from work at stratum 2 and stratum 3 and deal
with issues demanding a response at the higher levels.

Summary of work-strata

Stratum	Description of work	Upper boundary
5	<u>Comprehensive field coverage</u> making comprehensive provision of services within some general field of need throughout some given territorial or organizational society	Not expected to make any decisions on the reallocation of resources to provide services outside the given field of need
4	<u>Comprehensive service provision</u> making comprehensive provision of services of some given kinds according to the total and continuing needs for them throughout some given territorial or organizational society	Not expected to make any decisions on the reallocation of resources to meet needs for services of different or new kinds
3	<u>Systematic service provision</u> making systematic provision of services of some given kinds shaped to the needs of a continuous sequence of concrete situations which present themselves	Not expected to make any decisions on the reallocation of resources to meet as yet unmanifested needs (for the given kinds of services) within some given territorial or organizational society
2	<u>Situational response</u> carrying out work where the precise objectives to be pursued have to be judged according to the needs of each specific concrete situation which presents itself	Not expected to make any decisions i.e. commitments on how future possible situations are to be dealt with
1	<u>Prescribed output</u> working towards objectives which can be completely specified (as far as is significant) beforehand, according to defined circumstances which may present themselves	Not expected to make significant judgements on what output to aim for or under what circumstances to aim for it

Work at stratum 4 (so-called comprehensive service
provision) would be characterized by systematically taking
into account the need for services as it exists in the
district. But the identification of the need to be met,
often only discovered by the collection of data on needs
and services, would be limited by the prevailing conception
of the kinds of services conventionally provided. An
example of work at this level might be the development and
implementation of a plan to amalgamate hospital resources
to provide a more effective service.

The qualitative difference at stratum 5 is that "the scope
is broadened by moving from a framework of accepted,
specified and sanctioned kinds of service on offer to a
framework which simply defines some general field of need...
In health services the question changes from 'what sorts of
hospital, general practice, and public health services are
needed throughout this district?' ...to 'what are the basic
health needs of this district, group by group, and how may
they best be met in any combination of old or new services?'"[14]
Work at this level tends to involve staff spending a lot of time
outside the immediate operational area of the organization and
requires considerable interaction with directing and
sponsoring bodies of various kinds.[15] An illustration of DHC
work at this level might be the development of a comprehensive
plan for the care of the elderly in the district.

There are examples where a DHC has been able to tackle an
issue at this level but they are relatively few. If DHCs
are to fulfill their promise, it seems that they will
have to develop the capacity for this comprehensive field
coverage work.

It has already been demonstrated that the capacity of the
Council itself is greatly affected by the capacity of its
Executive Director and other staff. If the staff present
options and proposals to the Council exclusively in stratum

3 or stratum 4 terms, there is little likelihood that the
members will have the time or the information to construe
the issues in innovative and challenging ways. Therefore,
the capacity of the ED to operate at stratum 5 seems to be
a prerequisite for the effective functioning of the DHC
as a whole.

THE EXECUTIVE DIRECTOR AND THE COUNCIL

It was generally agreed that the ED is accountable to the
Council as a whole but the question of how this relationship
works out in practice came up frequently in the research
project.   The usual starting point for the analysis was
concern, most frequently expressed by the EDs themselves,
that their position vis à vis the Council was potentially
too powerful. The concern is illustrated in the following
two extracts from research pepers.

...The role of the Executive Director and staff was
discussed, particularly in relationship to the role of
members. Due to the voluntary, part-time nature of the
membership, the Executive Director must inevitably handle
most of the day-to-day issues, often in consultation with
the Chairman, and must take a major part in deciding which
issues come to Council...But it became clear that the
boundaries of authority for the Executive Director have not
been made explicit and that this should now be undertaken
alongside the clarification of the role of members.[16]

...(one) view is that the Executive Director and staff have
too much influence on Council, in effect predicting many
of the decisions by the information they bring forward and
their interpretation of issues. This view of there being
too much delegation of authority to staff was voiced both
by members and the Executive Director. It is appreciated
of course that the amount of authority carried by the
Executive Director is largely dependent on both the way
in which a particular chairman chooses to operate and the
degree of involvement members are willing to assume in
general.[17]

These situations were not seen as intentional grasping of
power by the EDs but rather as an intrinsic problem in
the relationship. The Council members meet relatively

infrequently and might or might not have specialized
technical knowledge of health services planning and
management. Although the EDs do not have large staffs, the
staff inevitably become the repository of knowledge and
information. Combined with these factors, the complexity
of the work, the expectations of clients and the community,
and the ED's relative continuity of tenure compared with
the members all tend to increase the possibility of the ED
arrogating decisions which should be taken by Council itself.

This situation is not unique to DHCs of course. There are
many other public service organizations (and some private)
where the position of the chief executive officer in relation
to the board has a similar character. For example, the
relationship between ED and Council has many of the same
characteristics as the relationship between the hospital
chief executive and the board of trustees.[18] But unlike a
hospital, the DHC is not a legally incorporated body with
required activities and functions. Nor are the DHC's
major activities, as they are in a hospital, directed to
the operational management of services. Consequently, the
relationship is a more freewheeling one, less constrained by
institutional requirements and precedent.

In the research conference for EDs held in June 1980 (see
Appendix III) there was discussion of the amount of discretion
that the ED should have in carrying out the work of the
DHC and, by implication, the amount of control or authority
which the Council should exercise over the ED. It was
suggested that the ED's style of operating can be characterized
in one of three ways:
- prime mover: the ED is the central figure
  in DHC activities, in effect deciding what
  the Council should be doing and how it
  should be doing it;

- consultant/advisor: the ED is an active
  professional resource to the organization
  who exerts influence, upon request, on
  what the Council should do and how it should
  be done;
- skilled servant: the ED does not decide what
  the Council's objectives and priorities should
  be, nor influence the Council greatly in its
  decision making, but rather acts on the basis
  of directions from Council.

The conference participants discussed the relative merits
and consequences of each of the styles and agreed that there
is a natural tendency for the ED to be allowed, or even urged,
by Council to slip into the prime mover role. It was generally
felt that this is inappropriate and that continual effort is
required to make sure that major policy and program decisions
remain with the Council. There was a general sense that a
productive and satisfying relationship between a DHC and its
ED is probably in the consultant/advisor mode and is
dependent on the ED's role being clearly defined in terms
of the limits of discretion and authority.

In order to push the analysis a little further, the
relationship was compared with the normal manager-subordinate
relationship[19] and it was argued that the components of the
two relationships are essentially the same. Like an
individual manager, the Council should carry the authority
to veto the selection of candidates for the ED's post, to
direct and instruct the ED, to assess the ED's performance
and to initiate the removal from the role of an individual
who is judged to be unsatisfactory. It was agreed that
theoretically Councils do have the potential to exercise
all of these components of authority but that in practice
they have found it difficult to do so:
- veto on selection: each Council hires its own ED with
the involvement of the Ministry of Health and the Area
Planning Coordinator. It was felt that Councils do carry
authority to reject candidates that they consider unsuitable;

- <u>directing the ED</u>: the amount of detailed direction which
a Council gives its ED is the major determinant of the style
he or she adopts. The 'prime mover' ED is given little if
any specific direction whereas the 'skilled servant' would
expect to operate with quite specific directions from
Council;

- <u>assessment of the ED</u>: there was general concern that the
mechanisms and criteria for assessing the EDs' performance
are unclear so that if performance appraisal is done at all
it is a perfunctory and superficial exercise. There was
agreement on the need for more thorough appraisal of EDs
against clearly defined criteria so that the accountability
of the ED to the Council can be reinforced. It was felt
that if Councils do not see assessment of the EDs' performance
as part of their role, the Ministry may be drawn into the
appraisal process. (This point is developed more fully in
the next section of this Chapter).

As mentioned in Chapter 4 , it does seem appropriate and
necessary for the Council to delegate much of the supervision
of the ED to the Chairman but this relationship must not
become so exclusive that the members are unaware of important
decisions regarding staff and their effectiveness.

The timespan of the research project did not allow further
analysis of this important organizational question but a
number of the DHCs have continued to analyse and refine
their understanding of the Council-staff relationship by:
- clearer definition of the role of ED
in terms of the discretionary limits
within which the Council expects him/her
to operate
- greater involvement of the members of
Council in detailed investigation of issues
and analysis of the findings.

THE EXECUTIVE DIRECTOR AND THE MINISTRY OF HEALTH

The ambiguous nature of the relationship between the DHCs
and the provincial Ministry of Health was described in
Chapter 4 , as was the ubiquity of this kind of organizational
tug-of-war between the centre and the periphery. The centre
will wish to retain control over the local agencies so that
minimum standards of effectiveness can be assured; the local
agencies will wish to be as autonomous as possible in order
to respond to the demands of their communities. Hence the
paradox of decentralization.

The paradox reappears in the relationship of the ED to the
Ministry of Health. During 1979 and 1980 the DHCs began to
express concern that the accountability of the EDs to the
Councils was becoming blurred by interventions from the
centre. The concern focussed on particular initiatives
taken by the Ministry of Health to establish uniform manpower
and compensation policies for the DHCs. Inter alia, these
policies established that the Area Planning Coordinator
must take part in the appointment of an ED as a voting member
of the selection committee and that an appointment must
receive the prior approval of the Minister. Some of the
DHCs saw this as undermining their authority and independence;
the Ministry no doubt saw it as a legitimate step to ensure
effective management within the DHCs. The DHCs' worries
were not quelled by suggestions that the ED has an indirect
responsibility to the Minister, through the Council, for
ensuring that budgeting and financial reporting are carried
out consistently with Ministry policy.

There is clearly no easy resolution of this kind of problem
and it can in any case be argued that these skirmishes
serve to create a healthy and critical atmosphere in the
relationship. A certain amount of territoriality on the
part of the DHC is to be expected, as is a certain amount
of 'interference' on the part of the Ministry. But it is

clear that there is a point beyond which the vying for
authority cannot go if the relationship is to remain a
viable one. With regard to EDs, this point seems to be
the ability of the DHC to hold its ED accountable for the
work of its staff and to exercise sanctions on the basis
of judgements about the quality of the ED's performance.
It therefore seems vital that the Council should be allowed and
prepared, to exert the authority that goes with this
accountability - to exercise a veto on the appointment of
the ED, to control the amount of discretion which the ED
has in decision making, to assess the quality of the ED's
work and to use appropriate sanctions.

This authority would be quite consistent with the requisite
authority of Ministry staff, in particular the Area Planning
Coordinators, to monitor and coordinate DHC activities;
(see page 90).

This consideration of the level of work and effectiveness
in the Council-staff relationship leads naturally to the
issue of the effectiveness of DHCs generally. In the next
and concluding chapter, the numerous themes in this report
are brought together in a discussion of how DHCs might be
evaluated and the major organizational and political factors
involved.

CHAPTER 7   EVALUATION OF DISTRICT HEALTH COUNCILS AND
            IMPLICATIONS FOR COMMUNITY BASED HEALTH PLANNING

Throughout the research project, interested observers would
ask - But do DHCs work? If this report has done nothing else,
it should have demonstrated that there is no straightforward
answer to this question. The DHCs are in a focal position in
a highly complex situation and are dealing with sensitive
issues. Their role can only be understood in the context of
their relationships to the Ministry of Health, to provider
agencies and to the community. These three groups are the
major sources of the varied and sometimes conflicting demands
upon the DHCs and it is in mediating the interests of these
groups that the Councils must attempt to strike a balance.

Reflecting these three crucial sets of relationships are the
Councils' three main areas of work - planning, coordination
and community involvement. Judgements about the overall
effectiveness of DHCs will inevitably be made on the basis of
how well they fulfill expectations in each of these three areas.

THE EVALUATION PROCESS

As shown in Chapter 2, the critics of DHCs often commented
that they had not been evaluated and that their success had
not been demonstrated. Apart from the fact that this is
often an excellent example of the pot calling the kettle
black, this line of criticism also makes the questionable
assumption that there are evaluative techniques which could
identify a causal relationship between the existence of a
DHC and particular outcomes. Nonetheless, the need for
some kind of evaluation has been stressed by provincial
government, health agencies, professional bodies and the
DHCs themselves. In 1979 the Ministry of Health engaged
independent consultants to study the feasibility of evaluating
DHCs and they reported in 1980.[1] After consideration by the

Ministry and the Ontario Council of Health, it was decided
that a 'developmental assessment steering committee' should
be formed to review the performance of the DHCs. The ten-
member steering committee was set up in September 1981 and
includes representatives of the Ontario Hospital Association,
the Ontario Medical Association, the Registered Nurses
Association of Ontario, District Health Councils, the Ontario
Council of Health, the Ontario Public Health Association and
the Ministry of Health. The committee will oversee the
work of independent consultants who will conduct the review.
Administrative management is by the University of Ottawa and
the steering committee is expected to report to the Minister
of Health in 1983.[2]

There are two broad approaches to evaluation which might in
principle be applicable to DHCs:

- outcome evaluation: the identification of
    (measurable) changes which have resulted from
    the activities of the organization. In the
    case of DHCs, these changes might be in the
    health status of the population, in access
    to services, in redistribution of resources,
    in increase (or reduction) of services
    available, and so on;

- process evaluation: assessment of the extent
    to which the organization has established
    processes, internal and external, which
    enhance the possibility of achieving desirable
    outcomes. These processes could be organizat-
    ional, political, financial, technical,
    procedural, and so on.

The research findings suggest that in the case of DHCs there
is no possibility of doing meaningful outcome evaluation.
To trace a causal relationship between DHC activities and any
one outcome would require the identification and control of
all the other significant variables involved in that

situation, a task which is clearly beyond the current state
of the evaluation art. To illustrate, how can we know that
the failure of a DHC to achieve, say, better services for
mothers and children is not a result of poor social conditions
and high unemployment rather than any inadequacy on the part
of the DHC? Or, to take a positive example, how can we know
that the development of a new service would not have happened
anyway, without the involvement of the DHC?

The same intractability does not apply to the processes
whereby the DHC tries to achieve the outcomes. Indeed, this
whole research project was concerned with evaluation of the
organizational processes established within DHCs and in
relation to other organizations. The point was made in a
position paper prepared by one of the Executive Directors.

...Objectives cannot, at this stage, be set in "health status"
terms but more reasonably must be seen in the context of
local organization and process for planning, coordination and
priority setting; shorter term objectives related to ration-
alization or redistribution of resources; and the building
of local relationships.[3]

If we go back to the original terms of reference for DHCs, it
is significant that these are almost exclusively expressed
in terms of process - identifying district health needs,
considering alternative methods of meeting those needs,
planning a comprehensive health care program, establishing
short-term priorities, coordinating all health activities
and working towards cooperation in social development
activities. The only phrase that is in outcome terms concerns
the DHC's responsibility "to ensure a balanced, effective and
economical service, satisfactory to the people of the district",
a daunting objective which it is quite clear that DHCs as
presently constituted are in no position to achieve.

Apart from the question of what is to be evaluated, there are
also certain factors which are crucial to an understanding of
the functioning of DHCs:

- The varying age of DHCs and the dynamic nature
  of their development: a snapshot kind of

approach to evaluation could not capture the
significance of the changes and adaptations
which DHCs have made, nor could it identify
the underlying developmental trends;

- The actual nature of the role of the DHC
and its relationship to other organizations:
the arguments put forward in Chapter 4
suggest, for example, that it would be quite
legitimate to assess DHCs' success in identifying
health care needs and deciding their own
priorities since they have sufficient authority
to carry out these activites. But they do not
carry sufficient authority, nor could they be
held accountable, for example, to ensure that
there is a reallocation of resources away from
acute services to long-term care;

- The inter-dependence of DHCs and the other
organizations and agencies with which they work:
the 'success' of DHCs is largely a function of
the effectiveness and attitudes of these other
organizations. Recognition of the essentially
open system in which DHCs operate means that
the scope of an evaluation would have to extend
well beyond the boundaries of the DHCs
themselves.

However, this is in no sense an apologia for DHCs. It is
rather an attempt to direct attention and future investigation
to those areas of the Councils' work which are amenable to
judgements about effectiveness and more important, which can
be the subject of change and development.

If we take the three main areas of DHC work - planning,
coordination and community involvement - the question
raised by the research is whether it is reasonable to
expect the DHCs to perform equally well in each of these
areas. As has been repeatedly demonstrated in this report,
even in those DHCs that were the most self-critical and

where detailed analyses of structure and function were
undertaken, there was still concern that they were not
achieving the right balance in the three main areas of
work. Some of the Councils have developed relatively
sophisticated approaches to planning but felt that this
tended to be at the expense of establishing real links
with the community. Others devoted a geat deal of effort
to community development activities but were experiencing
difficulty in converting these activities into formulated
plans. The ability to coordinate the activities of many
diverse agencies was a central aspect of both other areas
of work and here again the Councils experienced difficulty
to a greater or lesser degree.

Is it then the case that however carefully a DHC analyses its
role, sets its priorities and adapts its organization to fit
those priorities, there is an underlying problem inhibiting
its effectiveness? Is it expecting too much of a single
organization to ask it to develop the specialist, technical
orientation required for long-term planning while also acting
as an agent for community action and development? And how
effective can the planning be when the organization has no
accountability or authority for the management of the services
being provided? [4]

PLANNING AND COMMUNITY INVOLVEMENT

The first of these fundamental questions was explored in one
of the research conferences in October 1979. (See the
Working Paper in Appendix II). The discussions showed clearly
that DHCs have adopted very different styles and emphases,
reflected in different organization structures, skills of the
staff and relationships to the community. There was no
suggestion that this kind of variation is undesirable; on the
contrary, potential for variety was seen as essential for the
Councils to accommodate to local circumstances.

But a problem was seen in combining in the one body the function
of community development and the technical, relatively abstract
orientation required for long-term planning. Council development
tended to be based on building up the community linkages first
then moving into program development and planning, or the
reverse. The tendency to go the technical route seemed to be
strongest in those districts that had hospital or health
planning councils before the DHC was created. In these DHCs,
as in some others, the Council and its committees were often
dominated by provider members and the staff often saw themselves
as specialist planners rather than as agents for community
development.

One response to this dilemma was the proposition that the
attempt to combine these two basic functions in one body may
be unrealistic since they are basically incompatible and require
separating in different organizations. [5] The planning function
might be carried out by individual agencies or groups of
agencies, relating directly to the Ministry of Health.
Alternatively, planning might be carried out by regional offices
of the Ministry of Health which would be outposted extensions
of the Ministry organization. The community involvement
function would then be placed with a quite separate body,
locally appointed or even better locally elected, which would
affect health care development and planning as an independent
pressure group.

This 'separation of powers' theory was not supported by most
of those involved in the research. The more typical response
was that community development and long-term planning are
not fundamentally in opposition; rather the one informs the
other. The challenge is to devise an organization structure
and methods of working which enable both these functions to
be carried out in the same body.

The research findings suggest that clarification is needed in
a number of areas if this is to be achieved, the first being

recognition that planning is a primary function of the DHC
and community involvement is secondary. To put it another
way, for a DHC community involvement is a means to an end,
not an end in itself. That this is the case is confirmed by
the realities of the Councils' position as outlined in
Chapter 4 - accountable to the Minister of Health, a non-
elected membership, a responsibility but no accountability
to the community at large.

Supporting evidence for this view comes from a number of
DHCs involved in the research which were making specific
efforts to increase the involvement of local people in their
activities. Where this was pursued as an end in itself,
rather than in relation to a specific project or community
concern, the efforts were singularly unsuccessful, regardless
of whether they took the form of publicity through the media,
public meetings, talks to clubs and associations, or other
public relations events. In one of the research settings,
the situation was described as follows.

...Concern has been expressed that there was not sufficient
awareness of the Council and its work in the communities.
The purposes of improving this awareness would be to avoid
some of the misunderstandings which arise in the community,
to create a source of membership, to gain political support
for the Council's actions, to prevent agencies and groups
short-circuiting the Council by going directly to the
Ministry and to increase consumer input in Council's work.
...The possibility of increasing the Council's public
relations activities was discussed. But the consensus was
that public awareness is best, and perhaps only, created
by the Council working on specific problems with people
and agencies in the different communities. It is through
such activities that the public is motivated to learn about
the work of Council and to take an active part in it.
Public relations exercises were felt to be relatively
ineffective if unrelated to a community's particular
concerns.[6]

In another research setting, the same kind of concerns led
to the creation of a community liaison committee with the
special and only purpose of improving community involvement.
The committee was disbanded after a year as it had been
unable to change the situation. The Council used other

methods, such as advertising for members to serve on committees and working groups, to involve a wider range of people in the on-going work of the DHC.

This view of community involvement as a secondary, enabling function is not the conventional one. It is more commonly assumed that, of itself, "consumer participation as a component in the planning and management of health services will promote innovation in the delivery of health services and increase target population utilization by improving the acceptability and acessibility of care".[7] But in the context of DHCs, if community involvement is seen as a means rather than an end, it is possible to be far more precise about the degree of involvement required. In discussion of this issue in the research work, several degree or levels of involvement were identified:

Information ⬇	A one-way flow of information from the DHC to the community; no channel provided for feed-back and no power for negotiation.
Consultation ⬇	Attempts to ascertain community views in order to assess acceptability.
Mediation ⬇	A negotiating relationship with those interest groups in the community which have the power to block DHC decisions if they are not acceptable.
Joint decision making ⬇	A sharing of planning and decision making through the inclusion of (elected) community representatives in the governance of the DHC together with representatives of providers.
Community control	Governance totally in the hands of elected representatives of the community.

It is clear that DHCs as presently constituted cannot be accurately regarded as joint decision making bodies, even less as agents of community control.* (It is interesting to

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* There is considerable evidence that, for structural reasons, even joint decision making bodies - for example the consumer based boards of health centres - do not allow community members to achieve an effective voice in the direction of health care organizations.[8]

note, however, that the Indian health councils or commiittees
mentioned in Chapter 2 (page 38) are an example of the
community control model). But linking back to the earlier
discussion of the DHC member in Chapter 4, it seems that in
order to fulfill its primary planning function, the DHC
cannot merely inform or consult with its community. It
must achieve the position of mediation and negotiation with
interest groups in the community and this implies represent-
ation of relevant sectional interests in appropriate areas
of Council's work. The purpose of such involvement is
not to satisfy some ideological imperative but to ensure
that acceptable and implementable decisions are made.

(This functional approach to community involvement is open
to the criticism that organized interest groups do not
represent the whole community. Deliberate efforts may be
needed to seek out those sections of the community that
have no organized group to put their case and which are
effectively 'disenfranchized'.[9] However, this may be a
counsel of perfection for most DHCs since it is difficult
enough to ensure the participation and commitment of even
the most powerful and visible interests in the community.)

If the analysis above is accurate, there is an obvious
consequence for any evaluation of DHCs. Planning is a
primary function of DHCs; community involvement is secondary.
The appropriate evaluative question is not therefore 'Has
the DHC been effective in involving the community in its
work?' but rather 'Has the DHC achieved sufficiently
comprehensive community involvement to mediate the development
of implementable plans?'. This does not mean that community
participation is an insignificant or unimportant phenomenon.
It does mean that DHCs as presently constituted cannot be
seen primarily as agents of social change through community
involvement.

PLANNING AND COORDINATION

The other area of work in which the effectiveness of DHCs is
likely to be assessed is their capacity to coordinate the
activities of other organizations which affect the provision
of health services in their districts. These organizations
are of two major kinds:

- those concerned with the planning
  and/or delivery of health services;
  for example, boards of health, hospitals,
  voluntary agencies of various kinds;
- those concerned with the provision of
  other services which have an impact on the
  health of the community; for example, social
  services, education, housing, environmental
  control.

DHCs frequently encounter problems in attempting to coordinate
their work with that of other health organizations and
coordination with non-health agencies seems to be even more
difficult. One of the DHCs described the problem as follows.

...There has already been discussion in Council about the
difficulties of achieving coordinated action in the area and
various possibilities have been considered. It seems that,
at the local level, coordination can be achieved around
particular programs or activities but that it is much more
difficult to establish continuous mechanisms for coordination
between the numerous agencies involved. At present there is
seen to be considerable overlap in the different agencies'
mandates and activities as well as gaps or omissions in
services because of unclear accountability. As part of the
consideration of the DHC's future role, there is need to
consider the whole issue of coordination and the part that
the DHC might play in a coordinated network of services.[10]

It has been suggested previously in this report that the
capacity of a DHC to coordinate other health service agencies
is predicated on its recognized authority to monitor and
coordinate in its relationship with those agencies. The
relationship can be sustained through the appropriate
involvement of the provider agencies on Councils and committees
and through developing mechanisms for continuous consultation

with advisory groups of various kinds. It would be unreasonable
to expect a newly-formed Council to have these processes in
place immediately but the more mature Councils could be
assessed from this point of view.

This argument still leaves open the basic question raised
earlier in this chapter - how effective can the DHC be in
achieving coordinated planning when it has no accountability
for the management of health services? Evidence from else-
where suggests that accountability for planning and for
executive action should not be separated and that the planners
and the managers should be, if not the same people, at least
in the same organization and reporting to the same point in
the system. Thus the planners' flights of fancy are moderated
by the practical day-to-day realities of providing services
and the managers' concerns about efficiency and cost contain-
ment are leavened by the planners' insistence that they look
to the future and try innovative solutions. Some writers
have gone as far as suggesting that if planning is not seen
as part of the total process of management, it is likely to
fail.[11]

This is not to question the fact that planning goes on in
the individual hospital or public health department. But the
task of the DHC is to produce a coordinated and comprehensive
plan which is more than the sum of its individual parts. The
ability of the DHC to do this, even when its monitoring and
coordinating authority is well developed, must be questioned.
As long as DHCs are advisory with respect to the health
system at large, the only reasonable expectation is that they
eliminate the more obvious inconsistencies and gaps in the
system. To expect them to achieve radical change is clearly
unrealistic.

The DHCs are in an even more uncertain area when they attempt
to coordinate the activities of non-health agencies. In the
research project, collaboration and coordination with social
services was the problem most frequently raised, no doubt

related to the fact that one of the terms of reference for
DHCs is to work towards cooperation in the social development
activities for their districts. The relationship with social
services will therefore be used here as an illustrative
example of the wider issue.

Since the mid-60s there has been quite consistent emphasis
in Ontario, as elsewhere, on the need for closer collaboration
and coordination between health and social services. This
pressure has come about partly as a result of the efforts of
both health and social service agencies to respond to policy
initiatives - for example, the policy of deinstitutionalization
of social services and health programs with an increased
emphasis on a comprehensive home care and placement strategy.
The pressure has also arisen from recognition that the
jurisdictional boundaries between health and social services
are acts of organizational convenience which bear little
relation to the actual problems experienced by individuals
and communities.

At the provincial level, the creation of the policy fields,
each with a Provincial Secretary, to oversee a number of
ministries, marked an effort at governmental level to
coordinate and cut across boundaries. The Provincial
Secretariat for Social Development now includes four ministries -
Community and Social Services, Health, Education, and Culture
and Recreation. Other provincial initiatives include the
emphasis on joint planning and operation of health and social
services in the regional development strategies for the
Province. But it is probably fair to say that there is a
certain amount of scepticism about the effectiveness of these
and other inter-ministry mechanisms for coordination. In
1977, the Ontario Council of Health commented that DHCs
should identify specific areas where local cooperation is
hindered by conflicting priorities or practices in different
ministries and that these problems should then be considered
at provincial level.[12]

Perhaps the most tangible evidence of collaboration has occurred at the regional or sub-regional levels through the provision of collaborative programs and attempts at coordinated planning. The two district social services/resources councils in Waterloo and Sudbury created in 1977 are working alongside the respective DHCs. In the Waterloo Region, the possibility of a combined health and social services development council was originally explored but it was eventually decided that a single planning body for both health and social services would be premature.

Existing DHCs have had varying success in working towards cooperation in social development activities. Some DHCs have worked closely with social planning councils and social service agencies in their districts from the start. Others have had difficulty in identifying appropriate linkages or have been hampered by administrative and organizational barriers. The potential for achieving coordination seems to lie in two areas:

- Program development: the sponsorship and development of joint programs, ranging from basic agreements between health and social service agencies to provide their separate services on a coordinated basis, to programs that are administered from a single organizational setting but involve staff and resources from both sectors;

- Planning: the development of long-term plans that respond to the health and social needs of the population. Collaborative planning can range from simple information sharing in the planning process to the development of joint plans to which the relevant health and social service agencies are committed.

The DHC is not, of course, the only point of coordination. Joint programs and plans have been achieved at the local

level and attempts are being made to produce more general
collaboration in particular services - for example, children's
services. But to the extent that the DHC provides a
coordinating focus for health services, so it provides a
natural point of reference for collaboration with social
services.

In the absence of any DHC authority to affect the social
service community, there seem to be three important
preconditions for achieving coordination:

- The recognition that health care and
  social services are closely related and
  that 'health' planning must therefore
  take into account medical, social and
  environmental factors;
- The existence of a coordinating body or
  bodies which can speak for the numerous
  and varied social service agencies in relating
  to the DHC;
- The building in of explicit organizational
  linkages between health and social services
  when a DHC is first set up. To graft these
  relationships onto an already established
  DHC organization seems to be difficult.

But even where these preconditions exist, it must be
recognized that when attempting to achieve joint planning,
the DHC is primarily a negotiating, consensus forming body.
Although the following comments were made about joint planning
bodies in another system, they apply equally well to the DHC.

> Any executive powers which do exist
> (in a joint planning body) will be no
> more than the aggregate of the executive
> powers (such as they are) of individual
> members...individual members will continue
> to represent their own employers and continue
> to be accountable to them for what they
> propose or agree. Again, the outcome of
> joint planning can be no better than the
> willingness and combined abilities of all
> parties to it.[13]

CONCLUSION

It is not possible to encapsulate the research findings in
a list of recommendations for future action since the nature
of the research collaboration was essentially analytic and
problem solving, not prescriptive. Furthermore, to make
recommendations for change would imply that the DHCs are
dealing with particular and relatively simple issues which
could readily be resolved given sufficient perseverance.
The abiding message from this research is quite to the
contrary. The most intractable problems in DHCs are general
ones which are being experienced in many other settings.
Experiments of this kind in community based health planning
raise some quite fundamental questions of social organization,
the answers to which will only come step by step.

Related to the contents of this report, these questions
concern:

- the paradox intrinsic in schemes for
  decentralization - the desire to allow
  decisions to be made at a local level
  while retaining central control and
  accountability. (Chapter 1).

- the essentially political nature of the
  decision making process, portrayed in the
  debates about the natural health district,
  relationships to local government and
  relationships to the public. (Chapter 2).

- the feasibility of combining in one
  organization the functions of long-term
  planning and community involvement. (Chapter 7).

- the practicality of placing accountability
  for coordinated planning and for management
  with different parts of a service-providing
  system. (Chapter 7).

On a more optimistic note, it is clear from the research
that the local planning bodies can do much to improve the
effectiveness of their organization and thus to increase the
satisfaction of those involved in the work. Matters such
as the structure and composition of the body itself
(Chapter 4), the organization of its infrastructure
(Chapter 5) and the roles and relationships of the staff it
employs (Chapter 6) are all amenable to productive change.

But in the final analysis, unless such change can be rooted
in a more profound understanding of the political and
organizational forces at work, it can only be ameliorative.

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This appendix describes a particular approach to the studies of health and social service organization. It is an approach which has been developed in a number of different settings but which has its roots particularly in work done in the industrial setting and in health and social services.

Field of study

The work is concerned with the organizational features of health care systems - the roles played by individuals and groups and the working relationships between them. This entails an analysis of the work that individuals and groups have to do, what authority they carry to make decisions, what impact this authority has on others and who is accountable for the results.

The field of interest is potentially the health care system as a whole and all the professional and occupational groups within it. Because health services are so closely related to the provision of other social services the work also encompasses this aspect, particularly the relationships between health services staff and staff in other social service agencies. The place of the health services in the community and the involvement of the public is an additional important dimension.

If the field of study is organization a legitimate question is - which organization? Is it the organization as seen by the individuals working in it? Or is it the organization which it is hoped exists? Or is it the organization which is assumed to exist as a result of statutory requirements? There are these differing perceptions of an organization and it is necessary to distinguish between:

i.   the organization as described on paper, the formal or manifest organization;

ii. the individual's assumptions, as exhibited in his behaviour in the organization, the assumed situation;

iii. the organization as it in fact works, the extant situation;

iv. the organization as it might be after changes, a more workable and satisfactory form, the requisite organization.

Aims of the Research

The first aim of the research work is very much concerned with change. The researcher's job is to help the people in the organization to clarify how it really is operating and how it might be adjusted to produce better results. The method used to try to ensure the necessary conditions for this process of clarification and change is described later.

But there is another and equally important aim - to develop
concepts or theory about the organization of health services.
To be of any general use, these concepts must be based on sound
empirical evidence and must be tested and re-tested by
application to the health services field. It seems that the
more traditional organization or management theory is not capable
of analysing most health services organizations. The large number
of different professional groups, the multi-purpose nature of the
enterprise, the unusual devices which have been adopted to
accommodate clinically autonomous medical staff in the system,
the multidisciplinary approach to decision making - an organization
which has these and other complicating characteristics needs
specific and sophisticated theory to help it evolve.

The development of concepts, using the collaborative research
method described later, follows a general pattern. The first
step is to identify the activities which the health services,
or part of them, are expected to carry out. Next is the analysis
of roles which people occupy in carrying out these activities
and the structure of the work or organization which links them.
At this stage the wide range of different working relationships
that are built into health services organization begins to emerge.
Then the task is to identify which particular role relationships
or organizational models produce the best results under particular
circumstances. If the concepts can be sufficiently tested in
a large number of field-work situations, it becomes possible
to use them predictively in discussions about changing organization.

So the research has two major aims - to assist those in health
organizations to devise and implement planned change, and to
develop a body of theory competent to explain health services
organization. The two aims are inextricably linked; the research
method used is designed to allow the complementary pursuit of both.

Method

If there is to be any hope of achieving the research aims, the
researchers need to have a particularly close and continuous
relationship with the people in the organization. The relationship
must be sufficiently deep to allow analysis of the actual problems
and last sufficiently long to allow the analysis to be worked
through and thoroughly tested.

A further condition necessary for successful analysis of this
kind is a realization on the part of the researchers that they
cannot take the decisions for the people in the organization. If
clarification and change are to have any permanence, the decisions
must be taken by those in the organization. It is easy for the
researchers to believe that they see what the difficulties are
and to suggest solutions. But any such approach overlooks the
fact that it is only those responsible who are fully aware of the
situation; they must decide what to do if the solutions are to

be practical and if the people in the organization are to
be committed to the solutions - or even, indeed, to solving
the problems. The role of the researcher must therefore be
to assist those in the organization to clarify what the problems
are and to see what possible solutions exist in order that they
can decide whether to change and what to change.

So the research method is intended to achieve a collaborative
relationship between researchers and the organization, which
gives access to the real problems, which is long term and which
places responsibility for decisions about change firmly
within the organization.

The first step in achieving this relationship is the voluntary
participation of the organization and individuals within it.
The researchers respond to requests from members of an
organization to work with them rather than initiating the contact
themselves. Once such an invitation is received, a number of
general meetings are held at which the researchers explain
their role and field of work.

After the general meetings, discussions are held with the
individuals who indicate that they wish to take part in the
project. The discussions are between one researcher and one
such individual and may be quite lengthy; or a series of
meetings may be needed. As a result of these discussions a report
is produced giving the individual's view of his role and how
it relates to others in the organization and perhaps to staff
in other organizations with whom that individual works. This
report is amended and improved until it is accurate and is
approved by the individual for use in the project in general.

With a number of such reports available, the inconsistencies
and gaps in the organization become apparent. For example, it
may emerge that accountability for an area of work is not clear,
or that two individuals who need to relate closely in their
work have different conceptions of the relationship. This kind
of problem is fed back to the group concerned, in discussions
and in written form, and there is further working through of
the difficulties.

The products of this kind of analysis are not always the same.
At a minimum, the people in the organization become clear about
how they are actually working together. They may decide that the
problems are too challenging and choose to leave matters as they
are. Or they may decide that further clarification is needed
and then opt to change a part or parts of the organization.

Since the research relationship is a long-term one, the research
staff continue to be available to help with further discussion
and clarification. Change in one part of the organization cannot
be handled in isolation; other consequential changes may prove
to be necessary or groups of staff who have not previously been
involved may decide that they want to look at their part of the

organization. The professional responsibility of the researchers to continue work as long as there is demand allows the dynamic nature of the organization to be taken into account.

The maintenance of confidentiality throughout the process is vital. At each point, the researcher is unable to use information more widely in discussions unless specific permission to do so has been given by the individual or group involved. This strict rule of confidentiality is essential to the creation of confidence and trust in the relationship. Without it, the research results are superficial and the research workers are not allowed anywhere near the real organizational problems.

This social analytic approach to large-scale organizational change is different from the more familiar social survey approach. In the survey, the intention is to derive valid and reliable data about the behaviour of populations. In social analysis, there is no possibility of producing statistically valid statements about the organizations being studied. But generalizations of a different kind are possible. As mentioned earlier, it is these generalizations that allow the extension of the experience in individual organizations into theoretical formulations about health organizations in general. To illustrate this point, let us take a familiar situation in health services - that of the individual who appears to be accountable to two or more people for different aspects of his work, a situation of dual or multi-accountability. Social analysis cannot discover the incidence of such roles, but it can help to discover under what conditions the dual accountability situation is likely to work and what alternatives there are if it is not working.

The Research Conference

In addition to the approach to field-work, another method of collaboration that has been developed is the research conference. These conferences, usually but not inevitably held away from the organization's home site, are closely related to the field-work in their aims. In bringing together a group of people from health services in the conference situation, the aims are to convey the research findings to a wider group and to subject the research findings to further testing in group discussion. It has been interesting to find that these conference discussions have provided an invaluable check in the development of the organizational concepts, and led to a refining of existing concepts and to the emergence of new ideas. It is important for the individual researcher to be involved in both field-work and conference activity, so that the one informs the other.

Evaluation of the Method

In this kind of research evaluation poses particularly difficult problems. It is impossible to show a direct cause-and-effect relationship between research in an organization and better - or worse - provision of services by that organization. Too many

other factors are at work to make this kind of link. Nevertheless, there are ways in which evaluation of the research can be carried out.

The first method of evaluation is the assessment made by the people in organizations with whom the researchers work. They have views as to whether this kind of collaborative relationship enables them to work more productively. There are really two levels at which this kind of judgement can be made – by the individual in judging whether clarification of his role and his relationships with others enables him to operate more easily and with better results, and by all the members of an organization in judging whether social analysis facilitates the development of organizational policies and practices.

Two aspects of the research method itself allow the evaluation to be more real than it might otherwise be. Firstly, the researchers' commitment to be available over a long time-scale means that the consequences of research do come home to roost during the collaborative relationship. Secondly, since those who take part in the project do so voluntarily and on an understood basis, they are equally free to withdraw from the project if they do not find it useful.

A more philosophical evaluation argument which the social analytic approach can evoke is posed by the questions: Why does structure matter? Is it not a question of personality? This argument denies the value of clarity about organization and the impact of organizational structure upon individual behaviour, and usually implies that specification of requisite organization inhibits the freedom of the individual. Certainly, the personality factors in any work situation are extremely important. A really serious personality conflict can wreck any organization, however well structured. But the real point in analysing and setting up an organization on a clear basis is to provide a generally understood framework within which people can work together freely, exercising as much discretion as possible. Where organization is unclear, there is much experience to show that it can both inhibit individual freedom of action and produce conflicts between individuals that need not have arisen.

Extensions of the Research

There are important linkages to be made with other more quantitative approaches, with social policy formation and with sociological and psychological studies. But these theoretical developments must be measured by the same criterion as the rest of the work – that they should lead to a clearer understanding of the ways in which health services for a community can best be organized.

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APPENDIX II   TESTING AND GENERALIZATION OF RESEARCH FINDINGS

The concepts and models which result from the research
approach used in this study, even from a single research
setting, are inevitably generalizations - general statements
about particular experiences. Once these initial generalizations
are made, there arises the question of how widely applicable
they might be to other situations. In order to broaden the
field of application, the research findings were tested in
a variety of settings and with a number of audiences, as listed
below.

1976

October (to Sept- ember 1977)	- Technical support to Ontario Council of Health Task Force on Planning Function of DHCs

1977

May	- Presentation at Central West Regional Conference of DHCs in Niagara.
July	- Attendance at American Health Planning Association Annual Meeting.
September	- Meeting with Area Planning Coordinators, Ontario Ministry of Health.
October	- Discussions at Action Centre III Conference. - Meeting with staff of University Teaching Hospitals Association and Hospital Council for Metropolitan Toronto. - Meeting with City of Toronto Aldermen and staff.

1978

January	- Presentation to Long Range Planning and Assessment Committee, Faculty of Medicine, University of Toronto.
February	- Report prepared for DHC Chairmen and Executive Directors on Coordination of DHCs.
March	- Presentation on DHCs, University of Toronto Refresher Course. - Data/Planning Seminar for DHCs, Toronto. - Seminar on DHC Research, Department of Health Administration, University of Toronto.
April	- Weekend Seminar for Durham Regional DHC.
July	- Visit to Québec to study Regional Councils.

1978 (cont)

September	- Weekend Seminar for Manitoulin-Sudbury DHC.
October	- Weekend Seminar for Grey-Bruce DHC.
November	- Action Centre IV Conference. Joint paper with Executive Director, Kenora-Rainy River DHC.
December	- Presentation to Assistant Deputy Minister and Area Planning Coordinators, Ontario Ministry of Health.

1979

January	- Submission to Executive Coordinator, DHC Program, Ontario Ministry of Health, on DHC Secretariats.
	- Presentation to Department of Epidemiology and Biostatistics, McMaster University.
June	- Meetings with Health Services Organisation Research Unit, Brunel University, England.
July	- Meeting with Consultant to the Ministry of Health on evaluation of DHCs.
August	- Presentation to the Social Planning Council of Metropolitan Toronto.
October	- Submission to the Steering Committee for the Metropolitan Toronto DHC.
	- Two-day Research Conference on the Organization of DHCs in Ontario for DHC members and staff at the University of Toronto; Working Paper prepared and distributed.
	- Submission to the Executive Coordinator, DHC Program, on Eligibility and Appointment of Members.
November (to February 1980)	- Technical advice to Steering Committee for the Metropolitan Toronto DHC.
	- Presentation on social services and a Metropolitan Toronto DHC at conference convened by the Social Planning Council of Metropolitan Toronto.
	- Paper prepared and presented at meeting of DHC Executive Directors on coordination and sharing between DHCs.
	- Presentation at Action Centre V on Organizational Issues in DHCs.

1980

| April | - Presentation to Select Committee, North York Department of Public Health, on establishing priorities in health planning. |
| | - One-day Research Conference on the Role of District Health Council Chairmen at the University of Toronto; Working Paper prepared and distributed. |

1980(cont)

June   - One-day Research Conference on the Role of
             District Health Council Executive Director
             at the University of Toronto; Working Paper
             prepared and distributed.

July   - Presentation on evaluation of District Health
             Councils to the Health Services Committee of
             the Ontario Council of Health.

RESEARCH REPORTS

The following research reports have been produced during
course of the research. Those reports which were prepared for
individual DHCs or other client organizations (marked *) are
confidential to those organizations and can only be released
by them.

Title	Date	Document Number
Digest of the presentation and discussion on organization of District Health Councils. Central West Regional Conference.	June 30, 1977	77.1
Paper for the Ontario Council of Health Task Force on the Planning Function of District Health Councils.	Sept. 1999	77.2
Ottawa-Carleton Regional DHC. Alternative Models for Secondary Care Board.	Oct. 1977	77.3 *
Kenora-Rainy River DHC. Report on DHC Seminar, Quetico Centre, April 29 - May 1, 1977.		77.4 *
The Quetico Conference: a Problem-Solving Approach. Paper presented at Action Centre III Conference.	Oct. 1977	77.4a
Kenora-Rainy River DHC. Notes on the formation of a Committee on Services for the Elderly.	Nov. 1977	77.5 *
Organization of Adult Mental Health Services in the Kenora-Rainy River District.	Nov. 22, 1977	77.6 *

APPENDIX III RESEARCH CONFERENCE WORKING PAPERS

Three research conferences were organized as an integral
part of the research project. This appendix contains the
working papers that resulted from the conferences:

Organization of District Health Councils
October 1979

The Role of the District Health Council Chairman
April 1980

The Role of the District Health Council Executive Director
June 1980

WORKING PAPER

ORGANIZATION OF DISTRICT HEALTH COUNCILS IN ONTARIO

REPORT ON
RESEARCH CONFERENCE
UNIVERSITY OF TORONTO

OCTOBER 11 - 12 1979

CONTENTS

INTRODUCTION

1. A Research Conference was held at the University of Toronto
    on October 11-12, 1979. The Conference was organized by
    Professor Maureen Dixon as an integral part of a three-year
    research project on the organization of District Health
    Councils (DHCs) in Ontario.[1] The research project, now in
    its third and final year, is aimed at identifying optimum
    organizational models for DHCs.

2. The Research Conference, attended by five members and sixteen
    staff from fourteen DHCs and three Area Planning Coordinators
    from the Ontario Ministry of Health, was designed to allow
    the participants to work with researchers on critical
    organizational issues. The Conference was simultaneously
    a research tool, a means of testing research findings and
    an opportunity to develop the analysis of DHC organization.

3. The Conference participants represented a wide variety of
    Districts -- urban and rural, heavily and sparsely populated,
    with and without a health sciences centre, etc. The DHCs
    represented also ranged from those earliest established to
    ones more recently created.

4. This Working Paper reports on the major issues identified
    and the formulations developed at the Research Conference,
    and is intended for those working in the DHC field and for
    others interested in organizational development in DHCs.
    The Paper has been prepared by the researchers and does not
    necessarily represent the views of all individuals in
    attendance at the Conference.

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[1]Funded by Ontario Ministry of Health Demonstration Model Grant
#332. Principal Investigator: Professor Maureen Dixon.
Research Associate: Ann Kirkland.

TOPICS

5. The focus of the Conference was organizational aspects of DHC operation: the basic role and function of DHCs, the composition of Councils, the role of members and their relationships to the community, the Councils' committee structures, the Councils' relationship to health and other agencies and the relationship to the Ministry of Health.

6. The agenda was structured by the Conference participants as follows:
      - the role and function of DHCs
      - the accountability of DHCs
      - the authority of DHCs
      - organizational structures and styles.

   At each point in the Conference, there was an attempt to distinguish between what DHCs are and what they optimally should be. Another objective of the analysis was to identify those principles which appear to be generally applicable and those which seem to be situation-dependent.

ROLE AND FUNCTION OF DHCs

7. The first topic examined was the role and function of DHCs -- what they are doing and what they should be doing. One Council reported that research had shown that their members held different views on the DHC's role, including:
      - an objective, neutral advisor to the Minister
      - an advocate for community health needs, involving lobbying on behalf of the community
      - an agent of the Ministry of Health, ensuring that Ministry policies, especially on cost containment, are carried out
      - a mediator between the Ministry and the community
      - a mediator between agencies in the community, helping the Ministry to bring competing interests together.

8. Each of these views has different implications in terms of accountability and authority, and it was argued that some of them are mutually exclusive. For example, some argued that a DHC could not combine the roles of agent of the Ministry and advocate for local health needs. Others argued that a DHC can carry all these roles at different times and with respect to different issues.

9. There were also different views on the desirability of specifying the DHC role more precisely.
   9.1 Some felt that the time is ripe to put more definition on the DHC role than is implied by the 'advisory' designation and by the 'black book'[1] terms of reference. If a more precise definition could be achieved, it would both simplify the DHCs' work and reassure independent agencies and institutions. The more precise mandate would not rigidify the Councils, but rather enable them to work freely within legitimized boundaries;
   9.2 The opposing view was that more specification would restrict the DHCs in carrying out different activities and allow them less individuality. There was concern that Councils should not be all the same, but be able to have different roles and functions according to the needs of their Districts. The mandate should, therefore, be left vague and unspecific.

10. Discussion then focused on the functions which the DHCs are, and should be, carrying out. The basis for discussion was a model developed by the Executive Directors at a recent meeting which places activities in a hierarchy, with the least complex activities at the top.

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[1] The District Health Council: Action Centre in Ontario's Health Care Delivery. Ontario Ministry of Health. Issued 1975.

ADVICE-GIVING	Collecting and forwarding information to the Ministry
↓	
NETWORK-BUILDING	Creating linkages, getting people to talk together
↓	
NEEDS ASSESSMENT	Identifying high risk groups and directing attention to them
↓	
PROGRAM DEVELOPMENT	Rationalization and coordination within the present system
↓	
PLANNING	Planning health services for the future
↓	
IMPLEMENTATION	Monitoring the implementation of plans
↓	
ALLOCATION OF RESOURCES AND MANAGEMENT	Financial and managerial responsibility for programs

The expectation is that as a Council moves to more complex activities in this hierarchy, the requirement for staff work increases.

11. There was considerable discussion of the level in the hierarchy which DHCs should be reaching. It seems that many Councils have reached the program development level but are having difficulty in moving into the planning phase. The reasons for this difficulty are many -- small staff, lack of time, expectations in the local community, the 'fire-fighting' which Councils must undertake, lack of expertise, structural problems and lack of explicit approval by the Ministry that Councils should be involved in planning. Consequently, a Council may have to refuse to do many of the less complex tasks if it is to undertake planning on any sort of long-term basis. The age of a particular DHC also clearly affects the activities being carried out; a new Council has to undertake the less complex tasks before it can move into program development and planning.

12. Although some hold the view that definition is undesirable, as mentioned previously, it was generally held that there should be an explicit recognition of the legitimate functions of a DHC. i.e. the level in this hierarchy to which DHCs should penetrate. If this is left unclear, the DHCs have no power to press for resources to do their work. The general view was that:

   12.1 DHCs should <u>not</u> be involved in the allocation of resources and management of programs;

   12.2 as they gain experience and local credibility, DHCs <u>should</u> be involved in planning and monitoring the implementation of plans. If DHCs are prevented from involvement at this level, the motivation for DHC members to do any of the preceding tasks will be substantially diluted.

13. The question of the freedom of Councils to choose which issues they want to become involved in was also discussed. The Ministry clearly defines many of the issues for Councils and there are many issues which are apparently judged to be outside the scope of DHCs. e.g. opting out of OHIP. But the general sense was that DHCs should be allowed to judge their own priorities, recognizing nevertheless that there are certain issues, predominantly in the area of medical care activities, which the Ministry will continue to expect the DHCs to work out in their communities.

ACCOUNTABILITY OF THE DHC

14. The second item on the agenda, the accountability of DHCs, followed naturally from the earlier discussion. There was consideration of whether the DHC is accountable, in the sense of being held to account for its actions, to the Minister/ Ministry, to providers, and to the community. The consensus was that there are forms of accountability to each of these three groups but that they differ radically in kind.

14.1 The accountability to the Minister/Ministry has been given substance, in the absence of legislative accountability, by precedent. There is undoubtedly accountability to the Minister to carry out the institutional review process (new or expanded programs in hospitals) and the recently established review of new or expanded programs in public health. Outside these activities, the Councils have discretion to decide their own priorities. But the overall accountability to the Minister nevertheless remains, so that the Minister could, presumably, require that DHCs carry out other 'delegated' activities in the future;

14.2 It was agreed that there is no direct accountability to provider agencies and individuals in the District. The Council is responsible for ensuring that providers' views are accomodated in their decisions but not for ensuring that the views are upheld;

14.3 Similarly, the Council is responsible for taking community concerns into account in its decision-making. Within this community responsibility, a Council may decide that local needs are not best met by a particular policy and so attempt to have that policy changed. But in the final analysis, a Council cannot be said to be accountable directly to the community.

15. In summary, the analysis was that DHCs are accountable to the Minister but that this accountability is limited and is not an 'executive' relationship. i.e. the DHC is not simply a regional office of the Ministry. The DHCs' responsibility to the providers and the community gives them discretion to interpret policies, to make their own judgments and to challenge central decisions.

16. Some Councils have received funding from ministries other than the provincial Ministry of Health and from local government. It was agreed that this does not imply accountability in the same sense to these funding bodies. A Council is, rather, in the position of a contractor, fulfilling the terms agreed to with a particular funding body. In the event of dissatisfaction with the Council's use of the funds, the only recourse is for the body concerned to withdraw the funding. There is no overriding accountability established between the Council and these other agencies.

AUTHORITY OF THE DHC

17. The discussion of accountability necessarily involved a discussion of authority, that is, the legitimized ability to affect the behaviour of others. What authority can, or should, the DHCs have with respect to local agencies and institutions?

   17.1 The picture at present is that the Minister does have limited authority over the Council members. Although it has not been tested, it is assumed that the Minister could dismiss a Council that was judged to be incapable of fulfilling its role. He also has authority to veto the appointment of particular members, although this sanction has rarely been employed. But the authority is limited to these areas. Greater authority, for example overriding direction to a Council to do certain things, was judged to be unacceptable since the Council might thus be unable to meet commitments to its community;

   17.2 The Ministry staff, and particularly the Area Planning Coordinators, do not and should not carry the same direct authority with regard to the DHC staff, since the line of accountability and authority is between the Minister and the Council;

17.3 These relationships can be represented as:
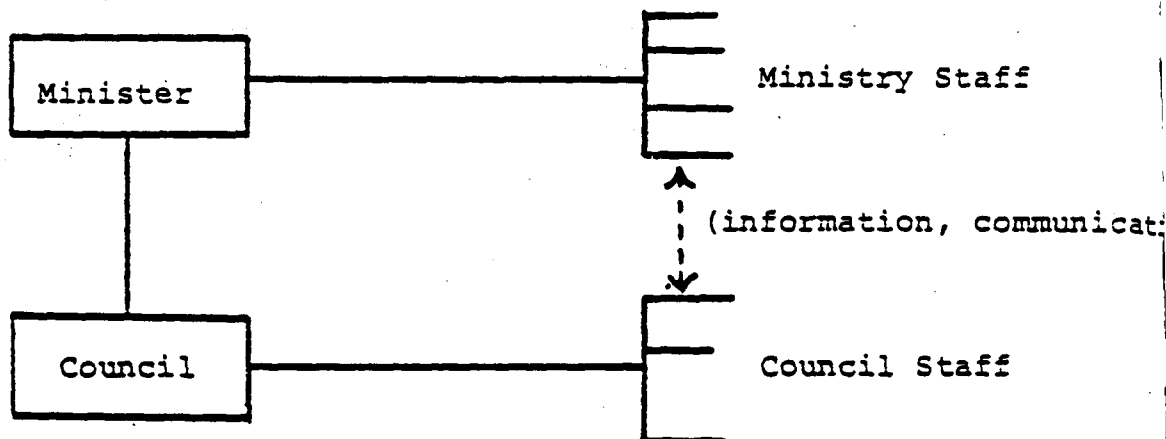
18. The relationship of the Council to the provider agencies
and institutions is again a subtle one. Terms like "power"
and "influence" may describe the relationship more accurately
than "authority". Nevertheless, the Councils can be seen
exerting influence in some fairly definitive ways -- veto
power on certain decisions affecting local institutions,
asking for information from providers/agencies, and so on.
It seems that if a Council is to fulfill its role, its
requisite authority with regard to provider bodies is:
- the authority to monitor the implementation of
agreed plans
- the authority to coordinate the health planning
activities of agencies and individual providers.
The authority does not extend beyond these limits. A
Council cannot direct providers nor can it directly employ
sanctions if a provider body chooses to reject the efforts
to monitor and coordinate.

ORGANIZATION OF DHCs

19. These formulations about the authority and accountability
    of DHCs have implications for the organization of Council
    itself, committees and staff and for the style which DHCs
    use in their work. In all these aspects, DHCs differ
    enormously. Some have one-third of their membership drawn
    from local government; others involve local government in
    the nominating process but have no elected local government
    members on Council. Some accept members appointed by external
    groups; others require nominations on which the Council makes
    the decision. Some Councils have an extensive committee
    structure involving many people; others have few, if any,
    subordinate committees. Some Councils stress the technology
    of data collection and planning; others pursue local issues
    on a more political, pragmatic basis.

20. This kind of variation was felt to be desirable and
    acceptable within the general framework of role, activities,
    accountability and authority defined above. The organizational
    principles to be identified, therefore, must be ones which
    enable a Council to function effectively while responding to
    particular local needs and circumstances.

The Nature and Composition of Council

21. Regardless of local considerations, the Councils all
    appeared to have a common quality -- the mediation of the
    varied and sometimes competing interests in their Districts.
    Members do bring their local affiliations and concerns with
    them into the Council deliberations and they are not, nor can
    they reasonably be expected to be, completely objective or
    disinterested if these concerns are under discussion. It is
    the Council as a whole, not the individual member, that must
    attempt to reach the most utilitarian decision.

22. It was suggested, therefore, that if a Council is to fulfill
    its accountability with its limited authority, it must have
    the support of the major interested parties in the community.
    These interest groups can include geographical localities,
    local government(s), providers of health care services,
    consumers, distinct ethnic or religious groups, industry
    and trade unions. Since the power and development of these
    groups differ from place to place, the Councils must be
    free to decide their own particular membership mix. A
    uniform composition for all Councils would not permit this
    reflecting of local characteristics.

23. The concern in appointing members, therefore, should be
    less whether they are formally described as providers or
    consumers and more whether they can be said to represent
    a significant aspect of the District's socio-political
    character.

Role of Chairman

24. There was brief discussion of the role of Chairman and the
    varying styles adopted by different Chairmen. It was agreed
    that the Chairman should requisitely be more than simply a
    chairman of meetings. The Chairman must take action on
    behalf of Council between meetings, report back to Council,
    coordinate the members' activities in general and maintain
    a relationship with the Minister of Health.

Committees of Council

25. It was clear that the committee structure created by a
    particular Council is influential in determining how its
    work will be carried out. The principles which emerged
    were as follows.

25.1   There is research evidence that if committees are based
        on a number of different types of task definition -- for
        example, function and programs and agency groupings --
        the likely result is confusion and overlap, with a
        consequently heavier work-load for the Council itself.
        The committees need to be defined as far as possible
        on the same basis;

25.2   If powerful external groups are limited to membership
        on committees and cannot have representation on Council
        itself, those committees tend to become highly independent
        in their work and Council becomes a rubber stamp on their
        activities;

25.3   There seems to be a difficulty in creating a committee
        structure which can both cope with the technical
        planning function and provide a realistic basis for
        community involvement. Councils have tended to go one
        way or the other. They then find it hard to switch the
        emphasis or to provide for both functions within their
        structure. The tendency to go the technical route seems
        to be particularly strong in those Districts which had
        hospital or health planning councils before the DHC
        was created;

25.4   Irrespective of the emphasis embodied by the committee
        structure, there is a tendency for Councils to lose
        control as their committee structure becomes more complex
        and attenuated. Having Council members on committees
        can help to prevent this loss of real accountability to
        the Council, as can limiting the number of committees to
        the minimum. Although the Council cannot do all the work
        itself, many Councils are now reducing the number of
        decisions which are delegated to committees and are
        working through recommendations in detail themselves,
        either in full meetings of Council or as a committee of
        the whole;

25.5 An over-powerful executive committee of Council can also lead to the Council becoming a rubber stamping body. Where executive committees are used, it seems desirable to ensure a regular change of membership to guard against this possibility.

26. The general formulation was that there is clearly no blue-print for committee organization. The principles outlined above may help a Council to structure its committees in keeping with demands on it but the resulting structures will differ greatly from place to place.

DHC Staff

27. The organization and style of a Council are strongly affected by the Executive Director and the other staff. Since the Council is a volunteer body, much of the detailed work must be carried out by staff and yet the danger of the staff leading the Council must be avoided. The relationship between the Chairman and the Executive Director is clearly crucial in this connection.

28. It was argued, therefore, that if the Executive Director is skilled predominantly in the technology of health planning, other staff should be selected with the community development or educative function in mind. Alternatively, an Executive Director whose skills are primarily in the area of community development and education will need the support of staff oriented towards research and planning.

29. The staff needed for a particular Council will also be affected by the availability of external resources. Some Councils are surrounded by resource groups which can be tapped as consultants or as members of committees and task forces. Other Councils are isolated from such assistance and have great difficulty in locating appropriate external advisors. In discussion, it emerged that the position would be much improved by:

- development of an inventory of university and other
  resources which could be relevant to DHCs
- more sharing of information and results of studies
  between Councils
- greater recognition by the Ministry that extensive
  research and data collection is not always possible
  or indeed appropriate.

Style of Operation in DHCs

30. The Conference discussion showed clearly that DHCs have
adopted very different styles and emphases, reflected in
different organization structures, skills of the staff and
relationships to the community. There was no suggestion
that this kind of variation is undesirable; on the contrary,
potential for variety was seen as essential for Councils
to accomodate to local characteristics.

31. But the final topic of the Conference, returning to the
opening topic of the DHC's basic role, concerned the apparently
general problem of combining in the one body the functions of
community development and the technical, specialist orientation
required for long-term planning. Council development has
tended to be based on:
    - building up the community linkages first then moving
      into program development and planning
                          or
    - building up the program development, operational
      and long-term planning capacity, then moving into
      development of community linkages
                          or
    - trying to develop all these functions simultaneously.

32. Whichever the developmental route selected, there seems to be real difficulty in achieving a balance between the community demands on the one hand, and the technical and planning demands on the other. Two approaches to this problem were identified.

    32.1 One position is that community development and long-term planning are not fundamentally in opposition; rather the one function informs the other. The organizational challenge is to devise a structure and a method of working for the DHC which enables both these functions to be carried out;

    32.2 The other position which was discussed proposes that the attempt to combine these two basic functions in one body may be unrealistic. The proposition was considered that the two functions are basically incompatible and require separating in different organizations. The planning functions might be carried out by individual agencies or groupings of agencies, relating directly to the Ministry of Health. Alternatively, planning might be carried out by regional offices of the Ministry of Health which would be fully and clearly accountable to the Ministry. The community and consumer involvement function would then be placed with a quite separate body, locally appointed, which would affect health care development and planning as an independent pressure group.

33. There was no consensus on this issue, the sense being that the Councils have insufficient experience as yet to provide conclusive evidence one way or the other. There was agreement, however, that this will be a critical area for analysis and research in the future.

WORKING PAPER

THE ROLE OF
DISTRICT HEALTH COUNCIL
CHAIRMAN

REPORT ON
RESEARCH CONFERENCE
UNIVERSITY OF TORONTO

APRIL 23 1980

CONTENTS

INTRODUCTION

1. A Research Conference on the role of District Health
   Council Chairman was held at the University of Toronto on
   April 23, 1980. The Conference was organized by Professor
   Maureen Dixon at the request of the DHC Chairmen and as an
   integral part of a three-year research project on the
   organization of District Health Councils in Ontario.[1]
   The research project, now in its third and final year, is
   aimed at identifying optimum organizational models for
   DHCs.

2. The Research Conference, attended by twenty-eight Chairmen,
   Vice-Chairmen and Council members soon to take on those
   roles, was designed to allow the participants to work with
   the researchers on critical organizational issues. The
   Conference was simultaneously a research tool, a means of
   testing research findings and an opportunity to develop
   the analysis of DHC organization. Eighteen of the twenty-
   two DHCs in Ontario were represented.

3. This was the second research conference to be held as part
   of the research project. The first, held in October 1979
   and attended by DHC members, staff and Ministry of Health
   staff, resulted in a Working Paper which was distributed
   to all DHCs and to other interested individuals and organ-
   izations. A third conference is planned for June 1980 for
   Executive Directors of DHCs.

4. This Working Paper reports on the major issues identified
   and the formulations developed at the Research Conference
   and is intended for those working in the DHC field, parti-
   cularly Chairmen and Vice-Chairmen, and for others

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interested in organizational development in DHCs. The
Paper has been prepared by the researchers and does not
necessarily represent the views of all the individuals
who attended the Conference.

TOPICS

5. The focus of the Conference was the role of DHC Chairman.
Those attending were asked to submit in advance a list of
topics they wished to consider and from these the follow-
ing agenda was distilled:

- Activities of Chairman
- Accountability of Chairman
- Authority of Chairman
- Relationships among Chairmen and DHCs
- Long-term planning.

At each point in the Conference there was an attempt to
distinguish between how DHCs and their Chairmen are oper-
ating at present, and how the operation might be changed
to achieve a more satisfactory working situation. Another
objective of the analysis was to identify those principles
which appear to be generally applicable to DHCs and those
which seem to be situation-dependent.

ACTIVITIES OF CHAIRMAN

6. There was general agreement that the activities of DHC
Chairmen extend far beyond the conventional one of chairing
meetings. Although there is considerable variation, Chair-
men spend up to twenty hours a week on DHC work. The
following activities were identified which are normally
part of the Chairman's role:

- Chairing Council meetings and ensuring that
  follow-up action is taken;
- Preparing and/or approving agenda for Council
  meetings, usually in cooperation with the
  Executive Committee and Executive Director;
- Reviewing the performance of Council and
  committee members and providing opportunities
  for members to develop their skill and knowledge;
- Assisting in the recruitment and nomination of
  new members for Council and committees;
- Recruiting, directing and supervising the
  Executive Director;
- Acting as a member of the Executive Committee
  of Council;
- Acting as a member of other Council committees,
  as required by the Council's constitution or as
  judged necessary;
- Representing the Council in relationship to the
  Minister and Ministry of Health;
- Representing the Council in relationship to local
  health agencies and institutions, to local and
  provincial government and to social service and
  other related agencies;
- Representing the Council in relationship to the
  public and the media;
- Carrying out preparatory reading and study in
  connection with any of the above activities.

7. Although most Chairmen are carrying out most of these
   activities, there is considerable variation in the total
   time spent on the work and in the emphasis given to part-
   icular activities. In general, this variation was felt to
   be desirable. The consensus was that the role of Chairman
   is not amenable to precise prescription and that Chairmen
   should be permitted to engage in activities and to develop
   styles of operating which suit the needs of both themselves
   and their Councils.

8. Chairing Council meetings: This activity was seen as
   important but not the most onerous part of the Chairman's
   role. There was general agreement that the Chairman
   should be impartial when chairing meetings of Council and
   should attempt to create an environment for thoughtful,
   thorough and uninhibited debate of the issues before
   Council.

9. Agenda planning: Planning agenda seems to be a relative-
   ly small part of the Chairman's duties. The Executive
   Committee and/or the Executive Director often take on
   the task. But most Chairmen would expect to see the agenda
   for approval prior to the meeting.

10. Reviewing members' work: There were different views on
    the appropriateness of Chairmen reviewing the performance
    of members. Some felt that there is little they can do
    to affect individual members since they are externally
    appointed and unpaid volunteers. Others felt that there
    is an implicit expectation that the Chairman will assess
    the performance of members and that these assessments will
    be taken into account in the nominating of individuals to
    the Executive Committee or other roles in Council. (See
    discussion of Chairman's authority on page 9).

11. Relating to Executive Director: There was agreement that
    the Executive Director is accountable to the Council as a
    whole but that the Chairman must take special responsibility
    in the process of recruitment and supervision of the
    Executive Director. (See discussion of the Chairman's·
    authority on page 10).

12. Executive Committee: All the DHCs represented at the Conf-
    erence have an Executive Committee. Most of the Chairmen
    also act as chairman of the Executive Committee although
    in one case the Executive Committee selects its own chair-
    man who, by custom, is subsequently elected as Vice-Chairman

of Council. In this particular case, the Council Chairman
is on the Executive Committee ex officio. This arrangement
has been adopted to lighten the workload of the Council
Chairman and to provide a training and development opport-
unity for the Vice-Chairman.

13. Other Committees of Council: In order to maintain a
manageable workload and to provide opportunity for the
development of the Vice-Chairman and other members, it was
seen as desirable that the Chairman should not be heavily
involved in other committees of Council. Also, the danger
of by-passing Council is avoided if the Chairman is not
personally involved in committee work.

14. Relationships with the Minister and the Ministry: An
activity which the Chairmen consider central to their role
is the representation of Council in negotiations with the
Minister of Health. A distinction was drawn between the
accountability relationship of Chairman to Minister, and
the information/communication relationship between the DHC
and Ministry staff. (This distinction is analyzed further
on page 6).

15. Relationships with agencies, local government and the public:
It seems that the older the DHC, the greater the demand for
the Chairman personally to undertake various public relations
functions and inter-organizational functions. These activities
require that the Chairman be well-informed, not just on broad
issues but also on the 'technical' content of Council's work.
The importance of the relationship between Executive Director
and Chairman was emphasised in this connection.

ACCOUNTABILITY OF CHAIRMAN

16. Discussion then turned to the issues of accountability of the
Chairman -- to whom he or she is accountable for carrying out
the activities identified above. Four different forms of

potential accountability were analyzed:
- to the Minister of Health
- to the Area Planning Coordinator and other
  Ministry staff
- to the Council
- to the district community.

17. Chairman-Minister of Health Relationship: The Chairmen
regard themselves as accountable to the Minister of Health
for ensuring that the Councils work effectively within the
terms of reference specified in the black book[1] and within
other policies specific to DHCs which have been promulgated
by the Minister. The reflection of this accountability is
the recognized authority of the Minister to affect who is
appointed as Chairman, to assess the performance of those in
the role and, theoretically, to initiate the removal of some-
one from the role. However, this accountability is limited
and is not an 'executive' relationship in the sense of the
Chairman being a managerial subordinate of the Minister.
The accountability of the Chairman to the Council as a whole
and to the community (see below) are countervailing pressures
on the Chairman and mean that he or she must exercise wide
discretion in interpreting policies, making judgements based
on the local situation and, when necessary, challenging
central decisions.

18. Chairman-APC and Ministry Relationship: There was a general
and strongly-held view that the Chairman and the Council are
not accountable to the Ministry staff in the same way as they
are to the Minister. The APCs and other Ministry staff are
not seen to carry any formal authority over the Chairman,
members or Executive Director. Rather the relationship is
one of mutual information and advice giving, in which either
side can choose what use to make of the information and advice.

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[1] The District Health Council: Action Centre in Ontario's
Health Care Delivery. Ontario Ministry of Health. 1975.

19. There was general concern that this distinction between accountability to the Minister and non-accountability to the Ministry staff, notably the APC, has become blurred recently. A number of factors or practices were identified which have led to this situation:

- By-passing, albeit infrequent, of the DHC -- by the Ministry dealing directly with local health agencies or by the agencies dealing directly with the Ministry -- on issues which the DHC has been asked to coordinate;

- Announcements of new policies or plans by the Ministry before the Chairman has been informed;

- Involvement of the APC in the appointment of Executive Director;

- No opportunity for the DHCs to be involved in developing the generic personnel and employment policies affecting DHC staff;

- Monitoring of the DHC budgets by the APCs;

- Wide variation in the way different APCs interpret their role and carry out their functions.

20. It was recognized that it is impossible for the Minister to conduct all the business with the twenty-two DHCs on a personal basis; he must clearly work largely through his staff in the Ministry. Nevertheless, it was felt that the accountability of the DHCs to the Minister could be reinforced by the development of various components in the relationship, some of which already exist:

- The ability of the Chairmen to have direct access to the Minister and to meet with him on a regular basis;

- Informing Chairmen and DHCs before public announcements are made which affect their districts;

- Allowing the Councils discretion to decide who should be nominated as new Council members;

- Audit of the Councils' financial status by provincial auditors;

- The ability of the Councils and staff to
  contact relevant branches of the Ministry
  directly, not solely through the APC;
- Development of coordination among DHCs on
  a regional basis;
- Clearer definition of the APC role;
- Closer working relationships between the DHCs
  and Ministry staff.

21. <u>Chairman-Council Relationship</u>: The Chairman is seen as
accountable to the Council as well as to the Minister. Few
Councils have defined the Chairman's role precisely but there is
a general expectation that the Chairman should be held acc-
ountable by other members of the Council for carrying out
the activities in a satisfactory manner. Although there is
variation in the DHC constitutions, they all have available
the sanction of election of a new Chairman or the decision
to re-appoint an existing Chairman who has not completed the
maximum term of office.

22. So the Chairmen have dual accountability -- to the Minister
on the one hand, and to their Councils on the other. The
potential conflict in this situation can surface from time
to time but it seems that adaptation and compromise have
dealt with these instances. On balance, the Chairmen have
to judge their actions on the basis of the Councils' expect-
ations since no Chairman would be in a tenable position
without the support of Council. It was felt that the inherent
conflict in carrying this dual accountability could be reduced
by more specific statements of Ministerial expectations of
DHCs and by the Councils themselves developing role descr-
iptions for their Chairmen.

23. <u>Chairman-Community Relationship</u>: It was agreed that there is
no direct accountability of a DHC or Chairman to the community
at large, nor does the community have any direct authority
over the DHC. But the Council is responsible for taking

community concerns into account in its decision-making and
the Chairman has a special responsibility to ensure that
community interests are identified and represented in
Council and committee work.

AUTHORITY OF CHAIRMAN

24. If the Chairman is to be held accountable, it follows that
he or she should have matching authority. Two areas of
authority were identified:

24.1 With respect to Council and committee members,
the Chairman carries coordinating authority.
This form of authority is limited in that the
Chairman's actions must be within the limits
of generally agreed policy; hence the require-
ment that any action taken by the Chairman
between Council or Executive Committee meetings
be reported at the next meeting for ratification.
As coordinator, the Chairman carries authority
to:

- make firm proposals for action
- arrange and preside over meetings
- obtain first-hand knowledge of progress
- decide what shall be done in uncertain
  situations.

But in the case of sustained disagreement, the
Chairman does not have authority to issue over-
riding instructions to Council members.

24.2 As mentioned on page 4, there are differing views
on whether the Chairman should carry authority to
review and assess the performance of other Council
members. In general, the sense was that such
authority should not be formalized but left to
the personal influence and style of the Chairman.

24.3 With respect to the Executive Director, the general view was that, although the Executive Director is accountable to the Council as a whole, the Chairman has a special responsibility to give the Executive Director direction, to assess the Executive Director's performance and to report back to Council on a regular basis. It was agreed that, in manifesting this relationship, the Chairman should not become the sole 'manager' of the Executive Director but should rather act on the Council's behalf and with the Council's specific mandate.

24.4 There was a suggestion that most Councils have not been sufficiently precise in establishing the criteria against which the Executive Director's performance is assessed. There was concern that these aspects of the relationship between Chairman and Executive Director should be clarified within individual Councils in order that the accountability of the Executive Director to the Council not be undermined.

25. The term of office of the Chairman was discussed in the context of requisite authority in the role. The terms of office vary among Councils -- one to three years -- and many Councils permit the re-election of the Chairman for a second term. But since the Councils have a six year limit on Council membership, and because Chairmen are almost invariably recruited from the existing Council membership, most Chairmen are effectively limited to a relatively short term of office. It was felt that the DHC bylaws should permit the Chairman to serve for a reasonable period, including preparation as Vice-Chairman and a period as past-Chairman, in the interests of continuity and development of on-the-job skills and knowledge.

RELATIONSHIPS AMONG CHAIRMEN AND DHCs

26. The issue of coordination and linkages among DHCs and Chairmen was considered at length. The existing mechanisms include:

    - ad hoc contacts as necessary between Chairmen
    - regional groupings of DHCs/Chairmen for the purposes of educational events, developing regional policies, etc.
    - the Chairmen's meetings with the Minister of Health and the prior meetings of the agenda committee
    - regular meetings of the Executive Directors
    - joint research and study projects such as the seven-DHC consortium Research Program.

27. Some felt that these mechanisms are adequate and that more formalized arrangements are not required. Others encouraged the development and strengthening of coordination around regional groupings of DHCs. But the notion of a province-wide association of DHCs was considered premature; the resources to support such an association are not available, nor are there yet sufficient common concerns among the DHCs.

LONG-TERM PLANNING

28. Although the issue of long-term planning is a general one affecting the whole DHC, there was concern that it should be discussed by the Chairmen and Vice-Chairmen. All felt that long-term planning is one of the DHCs' primary purposes but many reported difficulty in moving into this area. Factors which have led to this situation include:

    - the inevitable emphasis on achieving credibility with local organizations and the community by concentrating on short-term, operational issues at the expense of planning for the future
    - the limitations of the DHCs' line by line budgets which make it difficult to budget for long-term, generic work

- the demoralizing effect of carrying out the
  institutional review process when there is little
  likelihood of even the high priority items being
  funded
- the difficulty Council members have in developing
  the technical knowledge required to interpret data
  and produce long-term plans
- the practice in some Councils of delegating the
  planning work to a committee, thus encouraging the
  Council itself to forget this function and concen-
  trate on short-term, immediate problems
- the tendency for additional staff and resources to
  be made available to DHCs for specific special
  projects with a limited duration
- the absence of clear provincial guidelines and
  policies to which DHCs' plans can be related.

29. The outcome of this discussion was a request to one of the
Chairmen to organize a seminar for Chairmen in the Fall on
long-term planning. The seminar will use existing specialized
resources in this area, including the planning work developed
in the Ottawa-Carleton Regional DHC. It was also agreed that
there should be further discussion with the Minister and
Ministry on ways of eliminating the obstacles to long-term
planning.

WORKING PAPER

THE ROLE OF
DISTRICT HEALTH COUNCIL
EXECUTIVE DIRECTOR

REPORT ON
RESEARCH CONFERENCE
UNIVERSITY OF TORONTO

JUNE 13, 1980

CONTENTS

INTRODUCTION

1. A Research Conference on the role of District Health Council Executive Director was held at the University of Toronto on June 13, 1980. The Conference was organized by Professor Maureen Dixon at the suggestion of the Executive Directors and as an integral part of a three-year research project on the organization of District Health Councils in Ontario.[1] The research project, now in its third and final year, is aimed at identifying optimum organizational models for DHCs.

2. The Research Conference, attended by 16 Executive Directors and one Assistant Executive Director, was designed to enable the participants to work with the researchers on organizational issues of particular concern. The Conference was simultaneously a research tool, a means of testing research findings and an opportunity to develop the analysis of DHC organization.

3. This was the third and last research conference to be held as part of the research project. The first, held in October 1979 and attended by DHC members, staff and Ministry of Health staff, addressed general organizational issues common to DHCs. The second, held in April 1980, was attended by DHC Chairman, Vice-Chairmen and Council members soon to take on these roles. It addressed issues around the role of DHC Chairman. Both conferences resulted in Working Papers similar to this one. They were distributed to all DHCs and other interested individuals and organizations.

4. This Working Paper reports on the major issues identified and the formulations developed at the Research Conference

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[1] Funded by Ontario Ministry of Health Demonstration Model Grant #332. Principal Investigator: Maureen Dixon Research Associate: Ann Kirkland

and is intended for those working in the DHC field,
particularly Executive Directors, and for others interested
in organizational development in DHCs. This Working Paper
has been prepared by the researchers and does not neces-
sarily represent the views of all the individuals in
attendance.

TOPICS

5. The focus of the Conference was the role of Executive
   Director (ED) of a District Health Council. Those attending
   had been asked to submit in advance the topics they
   wished to consider and from this list the following agenda
   was distilled:
   - Relationship of ED to DHC.
   - Relationship among EDs.
   - Relationship of ED to Ministry of Health.
   - Tools and resources available to EDs.
   At each point in the discussion, there was an attempt to
   distinguish between how Councils and their EDs are operating
   at present, and how the operation might be changed to
   achieve a more satisfactory working situation. Another
   objective of the analysis was to identify those principles
   which appear to be generally applicable to all DHCs and
   those which seem to be dependent on the local situation
   or the stage of maturity of the DHC.

RELATIONSHIP OF EXECUTIVE DIRECTOR TO DHC

Relationship of Executive Director to Council

6. The participants decided not to explore in detail the
   various activities they undertake as EDs, but they
   considered at length the nature of their relationships
   with Councils. There was general agreement that the ED
   is accountable to the Council as a whole, although this

accountability may be manifested particularly through
the relationship with the Chairman and the Executive
Committee.

7. There was discussion on the amount of discretion which the
ED should have in carrying out the work of the DHC and, by
implication, the amount of control or authority which the
Council should exercise over the ED. It was suggested that
the ED's style of operating can be characterized in one
of three ways:

- **Prime mover**: the ED is the central figure
  in DHC activities, in effect deciding what
  the Council should be doing and how it
  should be doing it;
- **Consultant/advisor**: the ED is an active
  professional resource to the organization,
  who exerts influence, upon request, on what the
  Council should do and on how it should be done;
- **Skilled servant**: the ED does not decide what
  the Council's objectives and priorities should
  be, nor influence the Council greatly in its
  decision-making, but rather acts on the basis of
  directions from Council.

8. There was agreement that all three of these operating styles are
evident at present among the EDs; indeed an individual ED may
have to shift from one style to another. The participants
discussed the relative merits and consequences of each of the
styles and agreed that there is a natural tendency for the ED to
be allowed, or even urged, by Council to slip into the prime
mover role. The reasons for this exist in all DHCs and include
the ED's access to information, the complexity of the work,
heightened expectations of clients, the part-time, voluntary
nature of Council membership and the ED's relative continuity of

tenure compared with Council members. But it was generally felt
that the role of prime mover is inappropriate for the ED and
that continual effort is required to ensure that major policy
and program decisions remain with the Council. There was a
general sense that a productive and satisfying relationship between
a DHC and its ED is probably in the consultant/advisor mode and is
dependent on the ED's role being clearly defined in terms of the
limits of his discretion and authority.

9. The involvement of the ED in the work of the Nominating
    Committee of Council was discussed as an illustration of this
    range of authority in the role. If the ED does more than advise
    the Committee on generic matters such as membership composition
    and balance, it might result in the ED having too much influence
    on the appointment of Council members.

10. The Council-ED relationship was compared with the familiar
    manager-subordinate relationship and it was suggested that
    the components of the two relationships are essentially the
    same. Like an individual manager, the Council should carry
    authority to veto the selection of candidates for the ED's
    post, to direct and instruct the ED, to assess the ED's
    performance and to initiate the removal from the role of an
    individual who is judged to be unsatisfactory.

11. The participants agreed that theoretically Councils do have
    the potential to exercise all four of these components of
    authority but that in practice most Councils have not found
    it easy to do so.

    11.1 Veto on selection: each Council hires its
         own ED, with the involvement of the
         Ministry of Health and the Area Planning
         Coordinator. It was felt that the Councils
         do carry the authority to reject candidates
         that they consider unsuitable;

11.2 <u>Directing the ED</u>: as already mentioned, the amount of detailed direction and instruction which a Council gives its ED is the major factor in determining which style he adopts. The 'prime mover' ED is given little if any specific direction, whereas the 'skilled servant' ED would expect to operate within quite specific directions from the Council;

11.3 <u>Assessment of the ED</u>: there was general concern that the mechanisms and criteria for asessing the ED's performance are unclear, so that performance appraisal, if done at all, is a perfunctory and superficial exercise. Those present agreed on the need for more thorough appraisal of EDs against clearly defined criteria, so that the accountability of the ED to the Council is reinforced. It was felt that if the Councils do not see assessment of the ED's performance as part of their role, there is the danger that the Ministry, via the Area Planning Coordinator, will be drawn into the appraisal process, thus undermining the Council-ED relationship. With regard to the criteria against which the ED should be assessed, it was recognized that these will differ from Council to Council. Nevertheless, the criteria should include skill in developing links with the community and other aspects of the DHC process, as well as technical, analytical skills primarily related to outcomes.

<u>Relationship of Chairman and Executive Director</u>

12. Just as the potential exists for the ED or the APC to slip inadvertently into too powerful a role, so the Chairman can

take on too much authority. It was felt that, to the extent that the real power and authority of Council is allowed to reside with any of these three positions, so the Council can lose control. Although it is appropriate and necessary for Council to delegate much of the supervision of the ED to the Chairman, this relationship must not become so exclusive that the Council itself is excluded from important decisions.

13. Beyond this general formulation, it was thought unwise to delineate precisely the working relationship with the Chairman. EDs who have worked with more than one Chairman have found that style, personality and availability differ widely. Apart from a few general principles pertaining to the respective role of the Chairman and the ED[1], the relationship tends to be highly individual and dependent on the people involved.

RELATIONSHIPS AMONG EXECUTIVE DIRECTORS

14. Among the DHCs generally, there are pressures for forging closer relationships as well as pressures to maintain relative autonomy. On the one hand, the sharing of information, methods and data can expand the capabilities of individual Councils. But both EDs and Councils are in competition with one another for scarce resources, creating disincentives to collaboration. Moreover, early efforts of Councils to provide collective advice to the Minister on policy issues were discouraged; it was emphasized that the Ministry staff and the Ontario Council of Health are the sources of collective policy advice.

15. Many arrangements for closer association among EDs have been discussed and tried over the years. Regional meetings are becoming more frequent in some parts of the province and this development was seen to be useful. The results of the Continuing Education Project may suggest new ways for EDs

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[1]See Working Paper, The Role of the District Health Council Chairman Report on Research Conference, University of Toronto, April 23, 1980.

and Councils to work more closely together. It was emphasized
that the Minister's joint meetings with Chairmen, EDs and
Ministry staff should not be expected to provide an ongoing
mechanism for DHC and ED collaboration, since they occur
infrequently and are large, formal meetings. The regular
meetings of the EDs were generally seen as useful in providing
a working forum for the discussion of matters of mutual concern
and benefit.

RELATIONSHIP OF EXECUTIVE DIRECTOR TO MINISTRY OF HEALTH

16. With regard to the Ministry of Health, the EDs agreed with the
    proposition put forward at the previous Conference on the role
    of the DHC Chairman - that the line of accountability between
    the Minister of Health and the DHC is becoming blurred by the
    increasing authority taken by Ministry staff, notably the DHC
    Program branch. It was felt that the appropriate relationship
    of Ministry staff to DHC staff is one of information and advice
    sharing. A number of possible reasons for the changing
    relationship with the Ministry were identified:

    16.1 Although the APCs are seen as being advocates
         within the Ministry of DHC activities and
         recommendations, the job of the APC has evolved
         from one of a partnership with a local steering
         committee to establish a DHC, to one of
         information gathering and monitoring for the
         Minister and Ministry. In their current role,
         the APCs are inevitably judged to some extent
         on the degree of congruence between Minister's
         policies and the advice being issued by Councils;

    16.2 The organizational structure of the Ministry of
         Health does not complement the DHC system in two
         respects. First, the DHC Program branch in which
         the APCs are located is the only discrete hierarchy
         within the Ministry structure organized on a
         generic, geographical basis; the other sections of

the Ministry tend to be organized on a
functional or professional basis. The Area Team
structure, which cuts across the separate hierarchies,
is designed to achieve coordination on a geographical
basis. But the APC still has a major coordinative
task on any DHC matter which crosses the functional
divisions. The second problem is the obverse of
the first. The DHC Program branch within the
Ministry is under the Assistant Deputy Minister,
Community Health Services; but the DHCs and EDs
frequently need to relate to Institutional Health
Services as well;

16.3 The EDs experience difficulty as a result of the
wide variation in the way different APCs interpret
their role and carry out their functions. This
difficulty has been exacerbated recently for some
EDs by a rapid turnover of the people in the APC
roles and the areas to which they are assigned.

17. The lack of clarity in the relationship between DHCs
and the Ministry was felt to be symptomatic of a more
fundamental issue - whether it is possible to achieve
real community input to decisions through an appointed,
voluntary body accountable to government. The dual
accountability which this model inevitably creates for
DHCs and their staff is a continuing source of tension
and potential conflict.

TOOLS AND RESOURCES AVAILABLE TO EXECUTIVE DIRECTORS

18. The general problem of limited resources was discussed,
particularly in the context of the ED, the other staff
and external resources. It was suggested that there
could be more exploitation of Ministry resources and
information if data could be collected and presented
in a way that is more consistent with DHCs' needs.
The Data Users Committee, comprising DHC and Ministry
representatives, is currently addressing this problem.

19. The other source of resources which should be further
    developed is in the DHCs themselves. Joint projects,
    such as the DHC consortium project, may prove to be a
    useful form of collaboration. There remains for EDs
    the conflict between trying to get the best for one's
    own Council and joining together to get major change
    in the health system.