THE ORGANIZATION
OF
DISTRICT HEALTH COUNCILS
IN ONTARIO

Report on a research project
funded by the Ontario Ministry of Health
Demonstration Model Grant 332

submitted by F.M. Dixon
for the degree of PhD
of Brunel University
1982
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.
ACKNOWLEDGEMENTS

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.

Ann Kirkland shared the fieldwork and writing throughout the project, including preparation and analysis of much of the material for this report. Other colleagues in the University of Toronto provided invaluable advice and criticism.

The Ontario Ministry of Health provided the research grant without which there would have been no project and throughout the Ministry staff were accessible and constructive in providing information and comment.

Maureen Dixon
London
December 1981
# THE ORGANIZATION OF DISTRICT HEALTH COUNCILS IN ONTARIO

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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 decentralization 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. The Castonguay-Nepveu Report, 1967, recommended a system for Quebec based on regional offices for health and social services with executive authority over institutions. 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. On the other side of the country, the Newfoundland government has been encouraging the decentralization 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.

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. 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. 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. 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.

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.\textsuperscript{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),\textsuperscript{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. 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. 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, 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. In 1975 the government published the basic terms of reference for DHCs in what has become known as the 'black book' 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.

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. (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 COUNCILS IN ONTARIO

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<td>2,572</td>
</tr>
<tr>
<td>23</td>
<td>Lanark, Leeds and Grenville</td>
<td>1977</td>
<td>125,043</td>
<td>2,492</td>
</tr>
<tr>
<td>24</td>
<td>Ottawa-Carleton Regional</td>
<td>1974</td>
<td>546,922</td>
<td>1,064</td>
</tr>
<tr>
<td>25</td>
<td>Seaway Valley</td>
<td>1980</td>
<td>152,647</td>
<td>2,045</td>
</tr>
</tbody>
</table>
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 advisory 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 official 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. 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.

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

<table>
<thead>
<tr>
<th>Activity</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health (apart from program review activity)</td>
<td>8</td>
</tr>
<tr>
<td>Dental health</td>
<td>8</td>
</tr>
<tr>
<td>(Primarily an issue in underserviced areas).</td>
<td></td>
</tr>
<tr>
<td>Health services for Francophones</td>
<td>6</td>
</tr>
<tr>
<td>(An issue in those parts of the Province with a substantial French-speaking population).</td>
<td></td>
</tr>
<tr>
<td>High technology</td>
<td>6</td>
</tr>
<tr>
<td>(In the course of reviewing proposals for sophisticated equipment, several DHCs have analyzed the philosophy and effectiveness of high technology in health care).</td>
<td></td>
</tr>
<tr>
<td>Cardiac care (not only as an aspect of emergency services)</td>
<td>5</td>
</tr>
<tr>
<td>Maternal and child health</td>
<td>3</td>
</tr>
<tr>
<td>Services to Native Indian people</td>
<td>1</td>
</tr>
</tbody>
</table>

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.
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 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. 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. 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. 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. 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. 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. 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. 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, 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".  

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.

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.

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. 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. 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.

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.† 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:

* 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. 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 2½ 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.
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

* 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." 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.  

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.

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 and a resource paper prepared by the National Commission Inquiry on Indian Health, a technical sub-committee of the National Indian Brotherhood. 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.\(^\text{33}\)

**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. 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.

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, 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.
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. Joint administration of health and local government services was considered feasible only if regional government was introduced in England. The subsequent consultative paper came to the conclusion that collaboration between agencies does not necessarily mean common administrative boundaries. 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".
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.

* 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 organizational 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.*

* 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 many 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. 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
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 development 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.

<table>
<thead>
<tr>
<th>Problem Identification</th>
<th>Analysis and Diagnosis</th>
<th>Action</th>
</tr>
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</table>
| 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 DMC 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)
<table>
<thead>
<tr>
<th>Problem Identification</th>
<th>Analysis and Diagnosis</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concern about the DHC-Ministry relationship. July 1978.</td>
<td>Lack of clarity about the relationship, internal and external.</td>
<td>Not an issue which the Council has the authority to resolve; deferred for later consideration.</td>
</tr>
<tr>
<td>Unclear to which Group or committee some issues should be addressed July 1978.</td>
<td>Area Planning Coordinator's role unclear. Ministry organization structure not designed to fit with DHCs.</td>
<td>Other attempts to shift emphasis from hospitals to community health programs and services.</td>
</tr>
<tr>
<td>Members feel unable to make well-informed decisions July 1978.</td>
<td>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.</td>
<td>Decision to continue working with the existing structure since radical change not feasible January 1979.</td>
</tr>
<tr>
<td>Unclear role of Council members including distinction between consumer, provider and local government members July 1978.</td>
<td>None of the Groups set up to consider across the board, programmatic issues e.g. care for the elderly, mental health. 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.</td>
<td>Continuing analysis of Council structure and relationship to sub-groups. Research reports on Council and committees prepared for Ad. Hoc. Co. January 1979.</td>
</tr>
<tr>
<td>How best to establish Group B (community agencies) July 1979.</td>
<td>Different perceptions about actual and desirable 'representativeness' of members. Conflict between requirement that members be unbiased and non-parochial, and selection of members on the basis of external affiliations and interests.</td>
<td>No immediate action taken but related decisions made regarding development of Groups A and B.</td>
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<td></td>
<td>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.</td>
<td>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. Formulation of Steering Group to explore organizational and membership arrangements March 1980.</td>
</tr>
<tr>
<td>Problem Identification</td>
<td>Analysis and Diagnosis</td>
<td>Action</td>
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<tr>
<td>Confusion about distinctive roles within Council's structure: Chairman, Executive Committee, Executive Director July 1979.</td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>Two of major sub-committees unwilling to allow participation of Council member(s) in its meetings Fall 1979.</td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>Continuing concern about lack of clarity in Council's overall role and function Spring 1980.</td>
<td>Need to analyse 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.</td>
<td>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).</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>ACCOUNTABILITY</th>
<th>AUTHORITY</th>
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<tbody>
<tr>
<td>The Minister:</td>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
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<tr>
<td>ACCOUNTABILITY</td>
<td>AUTHORITY</td>
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<tr>
<td><strong>Ministry Staff:</strong></td>
<td><strong>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.</strong></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td><strong>Providers of Health Care:</strong></td>
<td><strong>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.</strong></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td><strong>The Community:</strong></td>
<td><strong>Neither the DHC nor the community carry authority with respect to each other.</strong></td>
</tr>
<tr>
<td>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.</td>
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June 18, 1980
ORGANIZATIONAL STRUCTURE OF THE HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL (as at July 1980)

Key

* The Council has 43 permanent committees and subcommittees in total.

- Permanent groups

- Ad hoc groups
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.  

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.

<table>
<thead>
<tr>
<th>Problem Identification</th>
<th>Analysis and Diagnosis</th>
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<tr>
<td>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.</td>
<td>Lack of sufficiently organized data and no way of setting priorities. Need for clarity on goals and functions before organizational issues can be addressed.</td>
<td>Discussion and analysis with Council members, Chairman and Executive Director (ED).</td>
</tr>
<tr>
<td>Impossibility of addressing all goals simultaneously April/May 1977.</td>
<td>No mechanism for putting goals in priority order.</td>
<td>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.</td>
</tr>
</tbody>
</table>
Problem Identification

Confusion about extent to which Council should decide its own priorities. April/May 1977.

Confusion over whether members should directly represent the interests of their constituent groups. April/May 1977.

Difficulty in accommodating the needs of many communities with different needs in a huge District. April/May 1977.

Lack of clarity about ED's accountability and authority. April/May 1977.

Gaps, overlaps and confusion in organization structure. No obvious place in structure for some Council priorities to be pursued. Summer 1977.

Where to place accountability for functions that do not 'fit' under existing operational committees. Summer 1977.

Lack of clarity about appropriate role of health professionals in committee structure. Summer 1977.

Analysis and Diagnosis

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.

Inevitability of members identifying with their external interest groups when those interests under discussion. The objective, non-parochial member an unrealistic notion.

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. 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.

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.

Need to distinguish between professionals who are involved to contribute technical expertise and those who represent their professional interest group.

Action

Through review of Ministry statements and discussion, further clarification of 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.

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.

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. Organizational statements produced on clarified roles of Chairman, Executive Committee and ED. May 1977.

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. Northwestern Medical Association, Northwest Dental Association, RNAO branches, Hospital Advisory Committee.

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.
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<tr>
<td>Uncertainty about how the Committee for Services for the Elderly (CSE) might most effectively set about its task Fall 1977.</td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>How to develop proposals for a comprehensive mental health service for the District Fall 1977.</td>
<td>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 services for adults.</td>
<td>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.</td>
</tr>
<tr>
<td>Concern that too much detailed work delegated to committees - danger of Council becoming a rubber stamp.</td>
<td>Voluntary board with small staff cannot do all the work itself. It should nevertheless retain control of delegated decision-making.</td>
<td>Decision by Council to delegate in a clearly defined way. Agreement that Council itself must retain planning and coordination functions June 1978.</td>
</tr>
<tr>
<td>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.</td>
<td>Differing perceptions of the DHC's overall role and relationship to the Ministry of Health and to agencies May 1979.</td>
<td>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. No specific action. Issue continues to emerge more strongly as Council advocates on behalf of community March 1980.</td>
</tr>
<tr>
<td>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.</td>
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<tr>
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<tr>
<td>Concern that little or no long-term planning going on May 1979.</td>
<td>No overall picture of needs and services on which to base long-term planning.</td>
<td>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.</td>
</tr>
<tr>
<td>Impact of geographical and demographic factors May 1979.</td>
<td>On Council itself, geographical balance of membership is more important than any pre-determined balance between providers/consumers/municipal representatives.</td>
<td>New members continue to be appointed with geographical representation strongly in mind. Meetings rotated routinely between Kenora, Dryden and Fort Frances.</td>
</tr>
<tr>
<td>Representativeness of members and composition of Council as a whole May 1979.</td>
<td>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.</td>
<td>These issues directed to Committee Structure and Composition Working Group - (See below) May 1979.</td>
</tr>
<tr>
<td>Competence and training of members May 1979.</td>
<td>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.</td>
<td>Policies endorsed. Agreement to hold annual seminar to serve as both an educational event and as a forum for DHC analysis of overall direction.</td>
</tr>
<tr>
<td>Some perception that ED and staff still taking too heavy a coordinative load May 1979.</td>
<td>Need for Council members to take on more coordinative functions themselves.</td>
<td>New relationships established for Council members with committee structure - see below May 1979.</td>
</tr>
<tr>
<td>Anomalies in committee structure identified:</td>
<td>- location of Alcohol and Treatment Services Committee (ATSC) - group studying accidental and violent deaths - tendency for operational committees to become secondary to non-operational committees.</td>
<td>Agreed at Seminar: May 1979 - ATSC should become accountable to Mental Health Committee, not direct to Council - AVD not to be regarded as part of Council's committee structure but as research group - review of committee structure - adequate community representation and real linkages between operational and non-operational committees</td>
</tr>
</tbody>
</table>

Discussion document, Health Resources Inventory, presented to Council by Reasonable Expectations Committee. New members continue to be appointed with geographical representation strongly in mind. Meetings rotated routinely between Kenora, Dryden and Fort Frances. These issues directed to Committee Structure and Composition Working Group - (See below) May 1979. Policies endorsed. Agreement to hold annual seminar to serve as both an educational event and as a forum for DHC analysis of overall direction. New relationships established for Council members with committee structure - see below May 1979. Agreed at Seminar: May 1979 - ATSC should become accountable to Mental Health Committee, not direct to Council - AVD not to be regarded as part of Council's committee structure but as research group - review of committee structure - adequate community representation and real linkages between operational and non-operational committees.
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</thead>
<tbody>
<tr>
<td>- function and location of Institutional Review Committee (IRC) May 1979.</td>
<td>- institutional sector is powerful external group. Only one Council member on IRC, the Chairman.</td>
<td>- additional Council members on IRC to be considered. Chairman of operational committees to be allowed to attend IRC meetings as non-voting participants. More sharing of information between operational committees and IRC.</td>
</tr>
<tr>
<td>Appropriate role for DHC in health planning for native Indian population May 1979.</td>
<td>- 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.</td>
<td>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.</td>
</tr>
<tr>
<td>Relationship and communication with the Ministry of Health May 1979.</td>
<td>Need for more local understanding of how and why Ministry decisions are made; for more advance warning of new Ministry policies or initiatives.</td>
<td>Area Planning Coordinator to attend more meetings.</td>
</tr>
<tr>
<td>Concern that there is insufficient awareness of the Council and its work.</td>
<td>Need to decide whether public involvement is a means or an end in Council's work.</td>
<td>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.</td>
</tr>
<tr>
<td>Difficulty in achieving coordination with other health-related organizations.</td>
<td>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.</td>
<td>Workshop held with McMaster University for health and social service agencies February 1980.</td>
</tr>
<tr>
<td>Lack of knowledge of other DHC's structures and operating methods.</td>
<td>No effective mechanism for sharing of information and experience between DHCs.</td>
<td>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.</td>
</tr>
</tbody>
</table>
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)

Key

- Permanent groups
- Ad hoc groups
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 guideline 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.

### 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.

<table>
<thead>
<tr>
<th>Problem Identification</th>
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<tbody>
<tr>
<td>Initial agreement August 1977 that research should concentrate on: - internal organization and board and committee structure - linkages to the community, professions and agencies.</td>
<td>Hospital Advisory Board (HAB) comprising 10 hospital trustees and 4 community members may not be sufficiently representative of hospital interests.</td>
<td>Discussion and analysis with each major board and committee, Executive Director (ED) and staff.</td>
</tr>
<tr>
<td>Concern about representation of hospital sector in Council's subordinate structure September 1977.</td>
<td>Two boards would create awkward inter-relationship and/or overlap of function. But secondary care is broader concept than hospital care.</td>
<td>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.</td>
</tr>
<tr>
<td>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?</td>
<td>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.</td>
<td>1977 Decision that Board chairman should attend Council meetings as non-voting participants and Council members assigned to attend board meetings as observers.</td>
</tr>
<tr>
<td>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?</td>
<td>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.</td>
<td>1978 Annual joint meeting of Council and boards instituted.</td>
</tr>
<tr>
<td>Communication between Council and boards considered inadequate.</td>
<td>Need for clarity on interpretation of role and functions before organizational issues can be addressed.</td>
<td>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.</td>
</tr>
<tr>
<td>Mental Health Committee (MHC) created as response to community pressure but role and function unclear.</td>
<td>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.</td>
<td></td>
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</table>

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.
Problem Identification

How to ensure continuation of planning function on phasing out of contract planning staff.

Analysis and Diagnosis

Need to examine optimum size of staff and skills and roles of ED and others.

Council to define its own role in planning.

Action

Management consultant employed to recommend ongoing staff organization; reported. Staffing questions still unresolved June 1980.

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.
<table>
<thead>
<tr>
<th>Problem Identification</th>
<th>Analysis and Diagnosis</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concerns about the role of the Executive Committee January 1979.</td>
<td>Different views among members about need for more precise statement of Executive Committee's authority.</td>
<td>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.</td>
</tr>
<tr>
<td>Community pressure to establish Children's Services Committee within DHC structure.</td>
<td>Lack of coordination in children's health and social services and continued delay in establishment of Regional CSC under COMSOC.</td>
<td>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.</td>
</tr>
</tbody>
</table>

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)

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:

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 **overall role of the DHC**
- uncertainty about the **legitimacy of particular DHC activities**
- ambiguous **relationships with other organizations** in terms of both accountability and authority
- inadequate clarification of **'internal' components of organization**: 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 official 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.

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.

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 all 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 within 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:

advisor to the Minister of Health: 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 interpretation 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 dissatisfaction 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 communication 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 differentiation 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.

* 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.
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.
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", 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.
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 implementable, 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:

* 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 committees
- 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.

* 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 disagreement, 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-chairmanship. 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 membership, 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 organizational 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.

*"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.

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 prioritizing 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 decided 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.

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;

*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 jurisdictional 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.
The pros and cons of a geographical 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.

*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. 

B. 

C. 

D. 

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.

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. 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. 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 a 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
  - political 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.

* 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.
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.
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.

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. 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.

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...". 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 decisions 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 equivalent 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 and developed by Rowbottom and Billis as a descriptive theory, 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;

* 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

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<thead>
<tr>
<th>Stratum</th>
<th>Description of work</th>
<th>Upper boundary</th>
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<tbody>
<tr>
<td>5</td>
<td><strong>Comprehensive field coverage</strong> making comprehensive provision of services within some general field of need throughout some given territorial or organizational society</td>
<td>Not expected to make any decisions on the reallocation of resources to provide services outside the given field of need</td>
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<tr>
<td>4</td>
<td><strong>Comprehensive service provision</strong> 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</td>
<td>Not expected to make any decisions on the reallocation of resources to meet needs for services of different or new kinds</td>
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<tr>
<td>3</td>
<td><strong>Systematic service provision</strong> making systematic provision of services of some given kinds shaped to the needs of a continuous sequence of concrete situations which present themselves</td>
<td>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</td>
</tr>
<tr>
<td>2</td>
<td><strong>Situational response</strong> 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</td>
<td>Not expected to make any decisions i.e. commitments on how future possible situations are to be dealt with</td>
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<tr>
<td>1</td>
<td><strong>Prescribed output</strong> working towards objectives which can be completely specified (as far as is significant) beforehand, according to defined circumstances which may present themselves</td>
<td>Not expected to make significant judgements on what output to aim for or under what circumstances to aim for it</td>
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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?'" 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. 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 papers.

...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. 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 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;
- **directing the ED**: 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;

- **assessment of the ED**: 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.
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. 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 organizational, 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 rationalization 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 activities. 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 great 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?

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. 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 accessibility of care." 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:

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information</td>
<td>A one-way flow of information from the DHC to the community; no channel provided for feedback and no power for negotiation.</td>
</tr>
<tr>
<td>Consultation</td>
<td>Attempts to ascertain community views in order to assess acceptability.</td>
</tr>
<tr>
<td>Mediation</td>
<td>A negotiating relationship with those interest groups in the community which have the power to block DHC decisions if they are not acceptable.</td>
</tr>
<tr>
<td>Joint</td>
<td>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.</td>
</tr>
<tr>
<td>Community</td>
<td>Governance totally in the hands of elected representatives of the community.</td>
</tr>
</tbody>
</table>

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

* 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 committees 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 representation 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 'disenfranchised'. 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 elsewhere 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 containment 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.
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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London, 1978
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 September 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.

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Ottawa-Carleton Regional DHC. Note for Executive Committee, Hospital Advisory Board.

Role Analyses of individual members and staff. Hamilton-Wentworth DHC.

The Hamilton-Wentworth Study.

The Kenora-Rainy River Study - Progress Report.

The Ottawa-Carleton Study - Progress Report.


Grey-Bruce DHC Seminar, Meaford, October 14, 1978.

Ottawa-Carleton Regional DHC. Continuing Care Board.

Ottawa-Carleton Regional DHC. Council and Boards.

Ottawa-Carleton Regional DHC. Boards and Committees.


The Organization of District Health Councils in Ontario. Work in Progress Seminar, Dept. of Clinical Epidemiology and Biostatistics, McMaster University.

Hamilton-Wentworth DHC. Council and Committees.
Hamilton-Wentworth DHC. Objectives and Priorities. Jan. 22, 1979 79.32 *


Role Analyses of individual members and staff. Kenora-Rainy River DHC. Feb.-April 1979 79.34-45 *

The Organization of the Kenora-Rainy River District Health Council. May, 1979 79.46 *

DHC Seminar, May 26, 1979 for Kenora-Rainy River DHC. June 8, 1979 79.47 *

The Hamilton-Wentworth Study - Progress Report. Aug. 13, 1979 79.48 *


Research on the Organization of District Health Councils in Ontario. Sep. 27, 1979 79.54


Eligibility and Appointment of DHC Members for Executive Coordinator, DHC Program, Ontario Ministry of Health. Oct. 24, 1979 79.56 *

Conceptual Model and Functional Matrix
for Subcommittee of Metropolitan Toronto District Health Council Steering Committee. Nov. 15, 1979 79.58 *

Social Services and a Metropolitan Toronto District Health Council. Nov. 21, 1979 79.59

DHC Organization and Structure for Metropolitan Toronto District Health Council Steering Committee. Dec. 3, 1979 79.60 *

DHC Cooperation and Shared Services for DHC Executive Directors. Dec. 3, 1979 79.61

Organizational Issues in District Health Councils - presentation at Action Centre V Conference, Nov. 1979 80.62

Operational Committees of the DHC for Metropolitan Toronto District Health Council Steering Committee. Jan. 28, 1980 80.63 *

Analysis of Organizational Change: Ottawa-Carleton Regional DHC. Feb.-June 1980 80.64,64a,b,c*

Analysis of Organizational Change: Kenora-Rainy River DHC. Mar.-June 1980 80.65,65a,b*

Organizational Policies for the DHC. Hamilton-Wentworth DHC. March 31, 1980 80.66 *

What Shall We Do? Establishing Priorities in Health Planning. April 3, 1980 80.67

Research on Organization of District Health Councils in Ontario. April 1980 80.68

Analysis of Organizational Change: Hamilton-Wentworth DHC. April-June 1980 80.69 & 69a *

Notes on Waterloo Region DHC Seminar


(See Appendix )80.70 & 70a

June 10, 1980  80.71 *

(See Appendix )80.72 & 72a
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
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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.

¹Funded 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' 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.

---

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 not be involved in the allocation of resources and management of programs;
12.2 as they gain experience and local credibility, DHCs should 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 accommodated 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:

- 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 blueprint 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 accommodate 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
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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. 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 organizations. 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, particularly Chairmen and Vice-Chairmen, and for others.

Funded by Ontario Ministry of Health Demonstration Model Grant #332. Principal Investigator: Maureen Dixon Research Associate: Ann Kirkland.
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 following 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 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 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, Chairmen 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 particular 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 relatively 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 Conference 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 chairman 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 opportunity 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 emphasized 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 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 someone 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.

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;
21. Chairman-Council Relationship: 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 accountable 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' expectations 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 descriptions for their Chairmen.

23. Chairman-Community Relationship: 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 requirement 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 overriding 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 concentrate 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.

Copies of this Working Paper and the one produced after the October 1979 Research Conference can be obtained from:
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WORKING PAPER

THE ROLE OF
DISTRICT HEALTH COUNCIL
EXECUTIVE DIRECTOR

REPORT ON
RESEARCH CONFERENCE
UNIVERSITY OF TORONTO

JUNE 13, 1980
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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. 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 necessarily 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 Directing the ED: 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 Assessment of the ED: there was general concern that the mechanisms and criteria for assessing 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.

Relationship of Chairman and Executive Director

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

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.