The Real Business of Health Care Reform:

Community Participation or Local "Production"?

by

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ABSTRACT

Reviews of Canada's health care system have demanded improved management, accountability, cost-containment, evaluation of effectiveness, and flexibility in services to meet local needs. Many provinces have responded to these calls for health care reform with regionalization models which intend to shift control over the delivery of health care services into the hands of community representatives. This ethnography studied one model in practice from a constructivist perspective. The research question — How will the discourses of health care reform enter and affect the decision-making work of governance volunteers serving on community health care committees as established in British Columbia's regionalization process? — held the purpose of revealing the social practices that affect the particular ways this decision-making work is constituted and enacted. In this critical analysis, the move from a "community oriented" to a progressively "business oriented" approach to the management of health care is explicated. Discourses of "production" and "cooperation", which are located in the modern management technologies privileged in this "business oriented" approach, reveal a modified version of classic Scientific Management at the core of health care reform. Introducing management methods from the business world denies any fundamentally different conditions operating in health and social services and assumes business solutions best address issues of management, cost, and effectiveness in health care. In this decision-making setting, community participation in health care governance has not risen beyond the level of "tokenism" .

TABLE OF CONTENTS

LIST OF TABLES

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INTRODUCTION

The introduction of universal medicare in the early 1970's has lead to a health care program in Canada that is a source of national identity and pride. Yet ever since universal health insurance was introduced, governments "have been concerned with cost savings, efficiency of service delivery, equity in service provision, enhanced citizen participation, and increased accountability of decision-makers" (Church & Barker,1998 p. 467). As a result of these concerns, health care reform—which for the purposes of this study is described as governments devolving authority for health care decision-making to the community or regional level—is occurring in many provinces in Canada (Hurley, Birch & Eyles,1992; Lomas,1996a), a trend also underway in several other countries.

From a national perspective, Canada's health care system is already a "decentralized system" in that the federal government devolves responsibility for service provision to the individual provinces. Within health care reform, provinces are further decentralizing the management of their respective health care systems through various versions of regionalization models. With such a move afoot, the concept of health care reform has entered into everyday discussions about health care delivery and signals a progressive, modern approach to providing health care services. This move is progressive in the sense that it has shifted the focus from the initial goal of removing the financial barrier for those needing health care services to "reorganizing and revamping" how services are delivered, something that was not addressed in government—health care professional—community negotiations when the national program was being advanced (Decter,1994; Church & Barker, 1998)

Regionalization refers to the community governance models commonly being used in health care reform in Canada. These models define new "partnerships", or formal arrangements, between various levels of government, and the communities and people over which they preside. Within most of these new partnerships, governance—or the ability to make decisions—is to be shifted from a centralized authority to the population most directly affected by the outcomes of decisions made on their behalf (Dorland & Davis,1995). Regionalization models in use vary, but generally are comprised of community representatives who are either appointed by the provincial government, elected locally, or a combination of the two options. The intention is for the provincial government to delegate responsibility for the delivery of local health care services to community governance groups. This concept sounds reasonable in theory, but both nationally and provincially this transition has been rocky and it continues to be fraught with conflict.

In the research setting, British Columbia, health care reform began February, 1993 and continues to evolve today. Despite being well into the process, however, within the literature and the discourses of health care reform there has been little discussion about the nature of the relationships upon which the success of regionalization is dependent. Specifically, these relationships include: 1) how the linkages between governance volunteers, the Ministry of

Health, and the various health care professionals will function as decision-making is shifted to the community level; 2) how governance committee members will access community input and participation that will allow them to adequately reflect the whole community's health care needs in their decision-making; and 3) how decisions will ultimately be made.

With these concerns in mind, the purpose of this inquiry is to reveal the social practices that affect the particular ways the decision-making of governance volunteers acting as community representatives in health care reform is constituted and enacted. My research question is: How will the discourses of health care reform enter and affect the decision-making work of governance volunteers serving on community health care committees as established in British Columbia's regionalization process? This question will be taken-up from the perspective that all governance committee activity is being produced and reproduced through daily practice which becomes evident within privileged discourses. In answering the research question, the following related questions will be considered: how is the decision-making work of governance volunteers represented? How is this work determined? What are the social rules that generate and support this decision-making work?

By intervening at the level of discourse it is not my intent to discredit different perspectives, as these are revealed in the discourses, but rather to question the conditions that allow particular perspectives to dominate over others with their language and methodology. In conceptualizing this inquiry, I first offer an introduction to those who are engaged in this decision-making activity, people

I call governance volunteers. Following this, a brief historical review of the development of the Canadian health care program is offered as background to the system being "reformed".

Chapter One then explores several concepts relevant to health care reform. These include how health care reform is a restructuring of the governance system, why community governance appears to be a popular choice in this restructuring, and whether these models increase community participation. Decision-making, power, and community are discussed as concepts important to the reform process. The question—Is reform possible?—is posed in light of historical resistance in organizations to change of such magnitude. This leads to a consideration of the effects of bureaucracy, management, and management theory on how reforms are taken-up in well established health care organizations.

Chapter Two presents the methodology of the inquiry. This research draws on an ethnographic study of one group of community representatives doing the decision-making work of a governance committee within British Columbia's regionalization model. The research is grounded in a constructionist perspective and critically analyzes the language or "discourses" in, and around, the group's activities and documents. When taking a constructionist theoretical perspective, the world is observed as socially created, thus the social relations within it are seen to be made or constructed, as opposed to being taken-for-granted, or as naturally occurring. Individuals functioning in society are seen to be constantly participating in social relations, and in their recursive reproduction, as is evident in daily routines.

When focusing on discourse in research, it is assumed that through language we organize and understand ourselves in the world, and that our actions, or our daily activities, are only thinkable through language. It is also assumed that language used purposefully in a particular social setting gives rise to "discourses", or sets of ideas and viewpoints which are experienced in and through a series of communications, either verbally or in writing (Mills and Simmons,1995). Discourse intersects with power circulating in society, thus creating systems of meaning that dominate in everyday social relations. In this ethnography, data were gathered by observing meetings, by reviewing both information the committee members received in the course of their work, and the documents they produced as part of their work, and lastly, by interviewing individual committee members about their decision-making process. In the critical analysis of the data, discourse is seen to communicate to the committee members, and ultimately to the community, what is "important", what decisions to make, and how to make them. The intention of the analysis is to explicate how community governance decisions are made in practice as these are revealed in discourses.

Chapter Three reviews for the reader some provincial and local context. As noted, health care reform has only been underway in British Columbia since 1993, but it already has a history of substantial change. Local community context is also offered in an attempt to describe some of the unique characteristics of the organization this group of community representatives is governing. During data collection, two local issues were particularly relevant. First, the organization the volunteers governed was under considerable scrutiny by the Ministry of Health due to ongoing deficits in its hospital budget. Under the direction of Ministry of Health staff, the administration of this organization had developed an “action plan” to balance this facility’s budget over two years. Secondly, appreciable conflict existed between the governance committee/administration and the local health care professionals—particularly the medical group—due primarily to the health care practice implications of the agreement to balance the hospital budget over two years.

Chapter Four begins the analysis of data collected. In this research, the move from a “community oriented” health reform process to a progressively more “business oriented” approach to the management of health care manifests in the contradictions governance volunteers experience as they try to do their decision-making work. From this standpoint, the “new” health care management setting that is taking form through this application of business principles, or a discourse of “production”, is explicated by reviewing both the documents organizing the work of governance volunteers, and the activities privileged in their day-to-day governance work. This discourse of production is shown to hold a primary focus of increasing efficiency and cost-effectiveness of health care services. In the analysis, however, the community representatives, who express a sense of powerlessness working within this “new” health management setting, are found to have taken-up the very powerful modern management technologies which are instrumental in sustaining and furthering this shift to the production of health care.

Two modern management technologies, strategic planning and Continuous Quality Improvement, were taken-up by the governance committee as was required by the Ministry of Health. In Chapter Five, critical organizational/management literature is drawn on to argue that these management technologies are implemented through a discourse of "cooperation" which intends increasingly to control behaviour of individuals working in organizations through disciplinary practices. Disciplinary practices requiring "cooperation" are discussed in light of their intended effects of suppressing conflict and increasing productivity in health care services. A fundamental concern raised is that the conditions operating within health and social services are very different from those operating in a business organization that produces a "product". In light of this concern, introducing methods of management practice from the business sector, in a way that denies these differences and instead expects health and social services to adopt a business mode of operation, is considered problematic.

From this critical analysis of the decision-making work of a group of governance volunteers functioning within health care regionalization, it is clear much effort is going into "reorganizing and revamping" the way health care services are delivered in Canada. The findings of this research include that discourses of "production" and "cooperation" are located in the modern management technologies being taken-up by the overseeing government body, the Ministry of Health. The Ministry of Health is, in turn, requiring health care governance committees to implement these same methods of management which then privilege their discourses in the decision-making work of community representatives. As a result, business solutions are applied to problems in health and social services without accounting for the fundamentally different conditions operating in these settings. This research challenges government, managers, health care professionals and community representatives to reflect on the taken-for-granted notion that leadership should be sought, and blindly taken, from the business world when addressing issues of management, cost, and effectiveness within health care.

My Interest in Decision-making Committees and Governance Volunteers

Over the last dozen years I have been an active participant in various "decision-making committees", either in relation to my work as a nurse manager, or as a student representative in my nursing undergraduate and graduate programs. I gained an increased sense of the potential for committees to fulfill the functions they are in place to do, and a heightened awareness of the barriers that often limit or restrict their activity. The way committees quickly sort themselves out, and how it is that their members establish consistent patterns of functioning, or awareness of the implicitly understood social relations, was always of interest to me.

As I continue to observe and acquire "committee experience" I have a growing mindfulness of the consistency in the workings of decision-making groups regardless of their location and make-up. Increasingly, I am conscious of limitations placed either on individual members, or on a committee as a whole, as they attempt to carry out their responsibilities. I find myself frequently questioning: 1) the extent to which all members of a committee actually carry out a decision-making function within the group; 2) the extent to which committees make meaningful decisions within the entity they "govern"; and 3) what conditions support decision-making processes?

More recently, two projects in my undergraduate program drew my interest to the type of individual who volunteers time to decision-making, or governance committees, these being people I call governance volunteers. Although decision-making committees are frequently made-up of volunteers, volunteerism "is an area where little knowledge has been established" (Chappell & Prince,1997 p. 336). My general impression of volunteers fits with the findings of some research that these individuals are motivated to volunteer because they enjoy "helping others and working for a cause they believe in" (Chappell & Prince,1997 p. 339). In my experiences, however, it is clear that "governance volunteers" are different than those individuals who volunteer to provide direct services or to do fundraising for example. As volunteers, they prefer the task and responsibility of decision-making and take this enterprise on in a very committed way.

As many provinces in Canada move to "reform" their health care delivery by restructuring their overall management systems, it is volunteers who are interested in decision-making activities that will be involved in community governance models engaged to that end. Although I support the theory of increased community participation through such mechanisms, I wonder about the feasibility of community governance in health care, what factors direct the decision-making of governance volunteers, and about how this method of decision-making and governance will affect both the health care services available to the citizens in my community, and my everyday work as a nurse.

Health care is a public policy area all Canadians take interest in at one time or another. As a social program it has become a taken-for-granted part of our society; however, as a national system it does not have a long history. Nonetheless, it is a system that is undergoing "sweeping organizational change" in response to calls for reform (Hurley, Lomas & Bhatia, 1993 p. 1). Understanding the reforms underway requires understanding the system that is being "reformed" and why the calls for change are being made in the first place. To this end, following is a brief historical review of the Canadian health care system and some of the conditions within it that resulted in the many demands for radical reform.

Canada's Health Care System: A Cultural Icon

The Canadian health care system is often touted as Canada's most cherished social program (Begin,1988; Armstrong, Choiniere, Feldberg and White,1994; Fuller,1998). This program's genesis is described as a "transition from a system in which health was viewed as a private affair to one that entrusted government with the responsibility for ensuring that all Canadians, regardless of how much money or what kind of illness they had, obtained access to medical care" (Fuller,1998, p. 12). But this cultural icon's origin was neither smooth, nor simple. "Its history is fraught with false starts, difficult and sometimes acrimonious federal/provincial relations, and numerous confrontations between governments and health care providers and suppliers" (National Forum on Health,1997 p.11).

Canada's health care program history can be traced back to the British North America Act of 1867—which gave responsibility for health to the provincial governments, but allowed the federal government to retain control over financial resources (Armstrong et al,1994)—but Canada lagged behind other developed countries in establishing a national system (Fuller,1998). In the 1940's and 1950's serious public debate about the kind of health care Canadians wanted resulted in public funding for hospitals through federal legislation, the Insurance and Diagnostic Act in 1957. This was followed by the extension of public funding for physician and medical care through the Medical Care Act in 1966 (Fuller,1998; Armstrong et al,1994). Although both of these events were steps toward a universal system of health care, they are often criticized as having established an unfair emphasis on hospital and physician's services, a bias that remains with the system today (National Forum on Health,1997a), and one that has significant consequences for any attempts to relocate health care governance into the hands of local communities. In 1972, after many years of federal-provincial negotiations, all provinces and territories in Canada had established a public system of health insurance and "medicare" was finally born (Decter,1994).

Most of what was accomplished in the name of "health care" at the provincial levels, however, remained dependent on federal funding. Within a few years of seeing provincial public programs established coast to coast the federal government began measures to curtail federal spending on social programs

(Fuller, 1998). After passing the Established Programs Financing Act in 1977, which heralded both change in funding arrangements between the provinces and the federal government, and some delegated control over use of the funds to the provinces (Fuller,1998), the actual federal dollars transferred to fund social programs diminished over several years.

Predictably, changes in funding perpetuated changes in services. The resulting public concern in the 1980s that "provincial policies and physicians' practices" were slowly eroding health care lead the federal government to "introduce legislation designed to maintain a 'free' health care system" (Armstrong et al,1994, p. 21), and so the Canada Health Act was passed in 1984. The intention of the Canada Health Act was to reinforce the principles of medicare—universality, accessibility, comprehensive coverage, non-profit public administration, and portability—as criteria for provincial funding. This allowed the federal government to withhold cash transfers if a province failed to maintain these principles, and to eliminate "extra-billing" by health practitioners, mostly physicians (Fuller, 1998; Armstrong et al,1994).

The Canada Health Act was very successful in "virtually eliminating extra-billing and demonstrating the importance of the federal transfers in maintaining a national health care scheme" (Armstrong,1994, p. 22); however, further changes to federal/provincial financing arrangements resulted in continued erosion of federal transfer payments. These funding changes include the federal government announcement in 1995 to combine two transfer payment plans which supported social programs into one plan, the Canada Health and Social Transfer

(CHST). With this announcement came social program cuts of six billion dollars, or a forty per cent overall reduction which was implemented over three years (Fortier,1996).

Changes in funding have had a deep influence on provincially administered social programs, and on health care specifically. Public officials argue that in addition to federal funding cuts, health expenditures have risen rapidly over the years (Church & Barker,1998). As a result, provinces have for some time focused on ways to cut costs, "efficiency and productivity have become critical concerns" (Armstrong et al,1994, p. 19). All of this is culminating in a public sense that the health care system is in crisis. "Critics say Canada can no longer afford universal, publicly funded health care" (National Forum On Health,1997a, p. 9) and there is increasing pressure from the private sector who want access to the system on a for-profit basis, something previously denied (National Forum On Health, 1997a).

True, the system is burdened with a "complicated legal framework and funding relationships" that few Canadians understand (Fuller,1998 p. 70), but it is also argued that there was no evidence that social program spending was spiraling out of control thus necessitating the ongoing budget cuts of recent years (McQuaig,1994, Armstrong et al,1994). Those who oppose the "spending beyond our means" argument believe that governments were pressured by, and are succumbing to, the private sector's insistence for federal and provincial debt and deficit reduction. As a result, social program erosion has become the means to this end. Where this action is felt to be unfair, and inappropriate, is in the argument that government debts and deficits are primarily the result of federal monetary/economic policy since the late 1980s which increased interest rates in the name of zero inflation targets. (McQuaig,1994, Armstrong et al,1994). In this argument it is claimed by critics that such monetary policy drastically increased interest payments on government debts. Increased interest payments, in turn, contributed greatly to growing deficits, hence it was not social program overspending, but rather huge interest payments that benefited members of financial communities were the major cause of provincial and federal deficits. From this perspective, social programs were seen as little more than a scapegoat in the name of deficit reduction.

In offering a different framing of health care fiscal problems, Jonathan Lomas reminds us that in the beginning of medicare there were autonomous hospitals and autonomous physicians, both independent and "their own boss" (CBC,1994b p. 3). Over the very bumpy road to a universal system, both the hospitals and physicians were provided with the capacity to essentially negotiate with the government for money to provide services.

> What we had then, after we finally finished the full introduction of our health-care system in the early 1970's, was both hospitals and physicians as independent, private, autonomous organizations, and governments committed to paying them all the money that they needed to operate their physician's offices and hospitals—and no right or capacity for management within those provincial governments (CBC,1994 p. 4).

Lomas contends that health care costs were escalating, that escalating costs were the consequences of the absence of management, and that costs became increasingly concerning with the economic downturn in the 1980s. Since that time, provincial governments have tried, and continue to try, to impose management and fiscal constraint in medical and hospital care, mostly in the form of funding reductions in recent years.

Regardless of how one describes the problem, what is generally accepted, and deeply vaunted, is the broad public support for a health system that will be there for all Canadians when they need it (Fuller,1998). It is also assumed that dismantling such a program would be a "perilous undertaking for governments at every level" (Fuller,1998 p.70). This assumption is not lost on politicians and traditional managers within the health care bureaucracy. As such, it offers an interesting backdrop to the extensive activity in and around this "cherished program", activity that is the culmination of considerable pressure from the conflict of opposing positions—government fiscal constraint, broad public/labour support, professional interests and private sector pressure for profit-making opportunities—to reform the way Canada does health care.

CHAPTER ONE

Conceptual Framework: Health Care Reform

Health care reform is an important topic in Canada with all provinces now well into reorganizing the way they manage health care delivery. Direction for this reorganization was taken from the many provincial Royal commissions done in the 1980s which found health care systems to be "fundamentally sound and adequately funded" (National Forum on Health,1997a p. 11); however, it was consistently noted that not all Canadians have equal access to health care services, nor were all Canadians equally healthy. Furthermore, these reports routinely "emphasize the following themes: containing costs, increasing efficiency and effectiveness in health care, enhancing the responsiveness and accountability of the system through decentralized decision-making, and facilitating citizen participation (Church & Barker,1998 p. 469). These concerns, coupled with a political atmosphere that supported cost containment, have sparked much in the way of reform plans. Following is a detailed review of the concepts central to the health care reform movement across Canada and how these reflect intended change to the decision-making process in the management of health care resources and in health care governance.

Re-structuring the Governance System

Health care reform—which is frequently described as governments devolving authority for health care decision-making to the community or regional level—is underway in most provinces in Canada and in several other countries (Dorland & Davis,1995). The criticisms in the provincial reviews that preceded the reforms were consistent in noting the "absence of management mechanisms that might attain cost containment, improved health outcomes, flexibility and responsiveness, and integration and coordination" of health services (Lomas,1996a p. 29). It is not surprising then that the general rationale, wherever and however health care restructuring is occurring, mirrors these issues in the fairly standard goals of cost containment, improved health outcomes, increased flexibility and responsiveness of programs, and for better integration and coordination of services (Ministry of Health and Responsible for Seniors,1993). As these goals are being pursued at provincial levels through "regionalization initiatives", or the implementation of community governance models, politicians and traditional health care managers across the country are looking to communities to make rationalizing decisions as reforms forge ahead.

In Canada, the terms devolved authority, community governance, regionalization and decentralization are frequently used interchangeably (Dorland & Davis,1995). Although each of these terms might have a model that looks slightly different, they are all "organizational devices to shift governance—by definition, to govern is to make choices—from the centre to the regional populations which are most directly affected by the outcome of setting priorities and making choices accordingly" (Sinclair,1996 p. xv). Generally this "shift" is accomplished by provincial governments organizing their province into geographical regions and designing a structure for the delegation of some level of decision-making power. Within each region either appointed or elected community representatives, or a mix of the two options, then take responsibility for the delivery of health care services and do this within the established structure. The frequently cited overarching goal of such change is to make health care "more responsive to the local needs, values, and preferences" (Hurley, Birch & Eyles,1992 p.2). Frequently appended comments such as "in addition, it is suggested by some that decentralization can improve efficiency by better adapting the services to local circumstances" (Hurley, Birch & Eyles,1992 p. 2) allude to the underlying economic issues that accompany these ostensibly benevolent goals.

As noted in Eyles (1993), those who stand in opposition to decentralized control argue that management through devolved authority is time-consuming, inefficient and cumbersome. A further argument against regionalization as an organizing principle is that it may actually represent a "centralization of governance" from the perspective of institutional boards who governed locally in the past, and who felt they had to give up control to regional authorities (Dorland & Davis,1996). Members of the National Forum on Health (1997b) were very concerned with the growing use of decentralization mechanisms such as community governance models. This federal advisory committee described regionalization initiatives as a form of "political decentralization" which made local health boards less accountable to the national standards of health care. This group felt there "is a great deal more that can be done to improve resource allocation through integration and allocation mechanisms without creating another layer of government and an additional layer of bureaucracy" (National Forum on Health,1997b p. 28).

Research by Lomas (1996a) with early community governance board members, all of whom were appointed, articulated a similar concern about the lack of accountability of regional boards to the national principles of health care. If provinces move as many plan to fully, or partially, elected community governance committees, "most of the concern centers on either the potential for boards to become captured by single interest groups or the likely preponderance of what respondents often called 'representational politics'" (Lomas,1996a p. 33). The concern here being that in representational politics, elected individuals would "feel accountable to identifiable interest or geographic groups rather than to local citizens in general" (Lomas,1996a p. 33), thus defeating the said purpose of devolving authority to the community level. There are, however, also arguments for the use of such mechanisms in a system described in the many Royal commissions as "inflexible" and "unresponsive to local issues and health care needs".

Why Use Community Governance Models?

When reviewing community governance as a structure or model, the various interpretations as to why such an arrangement might be useful is striking. For example, supporters of reform suggest that "one way to radically change our institutional arrangements is to switch from a model of health care funding based on institutions to one organized geographically by region" (Rachlis &

Kushner,1994 p. 255). In this opinion, the potential to move health care services away from the "stovepipe" mentality, or the propensity to operate in isolation from other institutions and services, is considered a benefit. Regionalization is proposed as offering decision-making with attention to all health services in a community, thus it is possible to identify duplication and inefficiencies.

Those who stand in opposition to huge bureaucracies, and their often rigid hierarchies, believe that community governance is a means to creating organizations that are more flexible and responsive to the needs of those they serve. Many of these individuals infer this change may be achieved via flattened reporting structures which encourage both a hospitable client environment, and collaboration between administrators and service providers (Fainstein & Fainstein,1976; Wharf & McKenize,1995). This view is supported by Hancock (1991) who believes that although advancing public policy may be difficult in any setting, healthy public policy is often easier to develop at the community level because there is local intimacy with the issue, the policy makers live where they work, and because smaller bureaucracies are easier to work with than large ones.

Others caution that "decentralization" itself does not ensure the extinction of extremely rigid hierarchies (Plant & Plant,1992), or of isolated and intolerant communities with a narrow definition of acceptable behaviour (Wharf & McKenize,1995). When discussing the decentralization taking place nationally within Canadian health care, Michael Rachlis also cautions that when you establish regional health authorities you could "simply be establishing mini ministries of health within a particular region of a province" (CBC Radio Works,1994b p. 28).

Whether or not decentralized decision-making mechanisms merely foster a new authoritarian elite, or truly offer a means of real community participation, there is currently an apparent willingness within political systems and health care bureaucracies to involve citizens in decision-making. A prominent theme in the Royal commissions in the 1980s was the criticism of programs at the provincial levels for being highly centralized in their decision-making, and for being "insensitive", "inflexible", "unfair", and discouraging of the people they fund and those they serve (Church & Barker,1998; Province of British Columbia,1991a). The consistency in these themes across the country perhaps did not allow for anything but a "willingness" for increased citizen participation on the part of politicians and members of the health care bureaucracy.

When considering the "new" role of citizens in health care decision-making that has emerged with the move to regionalization initiatives, Eyles (1993) accounts for the willingness of politicians and bureaucrats to engage in these mechanisms as stemming from broad public "perceptions that governments are now less competent, trustworthy, and useful than [they were] in the past" (p. i). In this, Eyles argues that such perceptions in the general population lead to questions as to "what is being done (decision-making and agenda-setting frameworks), how things are carried out (procedural questions), why things are done in the ways that they are (accountability) and who is responsible for getting things done (representation and the roles of bureaucrats and experts)" (p. i).

In addressing these fundamental questions, politicians and their bureaucracies have little choice but to look to "increased democratization of decision-making procedures through citizen participation" (Eyles,1993 p. i). As a means to reinforce public trust and confidence in their government, in other words, for "reasons of both legitimacy and accountability, the role of the citizen in health-care decision-making is now visible in the public policy arena" (Eyles,1993 p. 1). As a result of this political tone, mechanisms such as regionalization have, for the time, publicly reinforced the legitimate place of community participation in health care decision-making. Moves to democratize decision-making, however, while intended to address the above, quickly become enmeshed in arguments about power-sharing between groups that have operated differently in the past—these being politicians and bureaucrats and the citizens they "govern". As community governance models are put in place, attention must be paid to underlying power structures, and how these will be different than in the past, if true delegation of power is intended as part of citizen participation mechanisms.

Community Governance: Citizen Participation in Decision-making

A populist disposition—one that "celebrates the wisdom of the ordinary citizen" (Johnston,1996 p. 179)—informs community governance models. Populism, as such, questions the basis of authority and expertise in health care systems and requires a redistribution of power historically held by those in positions of authority and by health care experts. (Eyles,1993). Charles & DeMaio (1992) argue that demands, expectations, and aspirations for community and citizen involvement in modifying health systems to be more sensitive to the preferences of citizens as "consumers" of the services are a growing feature of our society, and further that an "inclusive" approach is required if health care reforms are to be acceptable to the general public. With this increased attention to citizen participation in health policy reform, it is interesting to note that "citizen participation" is a well-worn principle, yet it is "still by no means routine or systematic" (MacFarlane,1996 p. 31) in decision-making structures.

Community governance generally refers to new "partnerships", or formal arrangements, between various levels of government, and the communities and people over which they preside (Dorland & Davis, 1995). As noted previously, within these new partnerships, governance—or the ability to make decisions—is said to have shifted from a centralized authority to the population most directly affected by the outcomes of decisions made on their behalf (Dorland & Davis,1995). Given the actuality that the advantages of community participation in decision-making are well understood, but the practice of this remains the exception rather than the routine, one must consider why this contradiction remains typical of most organizations.

If we step back briefly to 1969, it was Sherry Arnstein who very aptly said

> the idea of citizen participation is a little like eating spinach: no one is against it in principle because it is good for you. Participation of the governed in their government is, in theory, the cornerstone of democracy—a revered idea that is vigorously applauded by virtually everyone (Arnstein,1969 p. 216).

What then is the hold-up? Arnstein (1969) and others argue that governments and those that control organizations are also capable of "creating the appearance of increased participation" (Grinspun,1996 p. 15). Activities for the sake of appearances, however, do not address underlying power structures in groups, or decision-making processes which pose barriers to any meaningful participation of community members. Putting "new" mechanisms in place without attention to the historical social relations of those involved will have significant implications for the "responsiveness of the expert or provider system [and] the chances of power remaining in administrative hands (i.e. the potential of [citizen] representatives to be coopted)" (Eyles,1993 p. 11). The plausibility of old patterns of "doing business" reemerging, and directing, relationships within new mechanisms is high. Democratization of systems means citizens will be involved and will be heard; however, the extent to which this actually happens has proven to be a major challenge to those lobbying for greater participation (Eyles,1993). Arnstein's (1969) metaphorical "ladder of citizen participation" continues to offer a useful way to discuss the potential continuum of community involvement in processes such as community governance.

At the "bottom" of Arnstein's ladder, modes of "non-participation" are described as manipulation and therapy. As one progresses further up the ladder, activities involving community consultation, placation and informing are considered "degrees of tokenism"—or participation without authority (Labonte,1989). And finally, toward the top of the ladder, partnership, delegated power and citizen control are felt to offer opportunities where there are "degrees of citizen power"—or meaningful community participation in decision-making processes. The question that is relevant to this discussion is: although the health care reform literature and discourses are full of terms denoting "citizen power", will the underlying power structures and decision-making processes actually allow for the delegation of decision-making power, or does the extensive attention being given to methods for community participation in health care reform merely represent a great deal of work for the creation of appearances?

Representativeness in Community Governance

As health reforms forge ahead under the community governance models established in most provinces, questions of who should participate arise. Such questions are inevitable in a complex, mass society which must move beyond individual polling to methods of citizen representation if decisions are to be made "in a reasonable time, at a reasonable cost" (Eyles,1993 p. i). Mechanisms for participation have been criticized in the past by academics and community activists who study community development practices and participation processes. These individuals question how representative people on these committees are of their broader community (Wharf-Higgins,1996; Eyles,1993; Bracht,1991).

Although the research is limited in this area of volunteerism, there is some evidence that "organizing activity", such as sitting on governance or decision-making committees, is volunteer work more likely taken-up by middle-aged and older adults, particularly men; that seniors are less likely to volunteer in this capacity and are more likely involved in activities that provide direct services to people; and that young people are less inclined to volunteer for this work than older people (Chappell & Prince,1997). This finding reinforces the likelihood that individuals traditionally appointed/elected to such decision-making bodies are there because they have the time, experience, resources, social standing, and education to perform the duties as defined by the institutions governed, and by those devolving authority (Wharf-Higgins,1996; Singer, 1995; Eyles,1993; Gastil,1993; Bracht,1991). Representation of this type is felt to be inadequate if its intention is to offer a "demographic mirroring" of communities (Eyles,1993).

Additionally, these patterns in volunteerism continue to result in an under-representation of the individuals with the more pressing health and social challenges at decision-making levels (Wharf-Higgins,1996). Examples here would include representatives of seniors, youth, women, and those from both non-Caucasian and lower socioeconomic backgrounds (Elyes,1993). Indeed, some have rather bluntly said of community governance that "the average citizen (as opposed to the self-interested patient, the [health care] provider or the manager) has so far shown little interest in contributing and rarely has the requisite skills for most of the tasks asked of him or her" (Lomas,1996b).

And even if individuals from groups underrepresented in the past are "at the decision-making table" through mechanisms intended to address this equity dilemma—appointment processes for example—the question of whether they have a meaningful decision-making role, or if their presence is merely token, must then be considered. Decisions made by community representatives are inevitably questioned then as to whether they represent primarily the interests of those who have greater power and influence in a community—including members of the health care bureaucracy and professionals—an outcome that would be contradictory to the stated purpose of community governance and the broader intentions of health care reform.

Decision-making and Power

Concepts of decision-making and power are included in much of the commentary on health care reform and community participation. The ability to govern, or to make local health care management decisions, is inextricably linked to the delegation of power from government. To discern the processes committee members may engage to make decisions when given the authority to do so, models which embrace traditional, highly logical, or "scientific" processes, and more progressive decision-making methods must both be considered.

From a traditional perspective, decision-making is presented as a rational process, or as an activity encompassing mathematical, logical, and philosophical theories and which is carried out by rational individuals—either alone, in competition, and/or in groups (Resnik,1987; Open University,1983). These views of decision-making support a somewhat linear process which progresses through something akin to a) definition of the problem, b) clarification of all options, and c) selection of the apparently "best" solution. Predominantly rational (rule-based) methods have a long history in health care decision-making, both within the health bureaucracy, and within health care disciplines. It is not surprising then to see these methods being taken up by most, if not all, community governance groups.

Alternative styles of doing "committee business", such as consensus, shared decision-making, or collaboration are criticized for being time-consuming in our fast-paced, results-oriented society. They are, nonetheless, important perspectives to consider when exploring decision-making in the context of community governance. Gastil (1993) and Chinn (1995) both propose highly democratic practices—methods in which all citizens have a voice in decisions that affect them—for groups working toward common goals. Within these methods, open discussion of the decision-making process being undertaken raises individual and group consciousness of what is transpiring in the group. A key area of focus within each of these perspectives is individual awareness of roles, contributions, and conduct in the group. Gastil offers a broad range of decision-making methods (majority rule, consensus, proportional outcomes), and all are carried out in an environment that works toward valuing inclusiveness, differences, relationships and listening. Gastil also advocates equal speaking rights, listening responsibilities, and full access by all committee members to information and agenda setting.

Chinn's (1995) version of decision-making encompasses all of these principles, but also takes this line of thinking further by placing value on unity, shared responsibility, cooperation and collective action, and on diversity. Within Chinn's framework, all decisions are made by consensus after full participation in open discussion on issues. The tone of these decision-making processes contrasts to traditional methods, such as Robert's Rules of Order, where participants must make a formal motion on an issue for it to enter into the discussion, members then must "gain control of the floor" to speak to, or against, the "motion currently on the floor", and the decision is ultimately made on a majority rule basis only (Patnode,1989). The obvious question here is how do community members, particularly those representing groups who may not have had access to the discussion and processes surrounding traditional decision-making methods, participate as equal "partners" with members of both health care bureaucracy and professional groups?

Power

In the health reform literature, the power to make decisions is frequently discussed in terms of control over resources and services and, as being either delegated downward from the government, or upward from local groups who previously governed institutions in their community. Across the country, the scope of authority being delegated to community governance boards is noted to "vary from very limited power over hospitals (New Brunswick) to extensive resource allocation and other powers over a combined budget for community services, welfare, housing, corrections and almost all health care (Prince Edward Island)" (Lomas,1996a p. 26-27). Clearly, there are many versions of regionalized health care systems; however, "all visions share the desire to shift the locus of decision-making power to local or regional levels" (Hurley et al,1992 p. 1).

Within most references to "power", "authority", and "control" in health care reform, it is taken-for-granted that a "re-allocation" of power will be a good thing. The implicit assumptions being that someone has too much of it (probably members of government or health care bureaucracies and professionals) and that someone will benefit from more of it (members of communities and recipients of health care services). Within this conception of power, there is a sense of a fixed nature of the new relationships that will follow this "re-allocation". Within this, it is taken-for-granted that a more equitable decision-making environment will result within the models organized for community governance. In this research, however, rather than assuming that power is a fixed possession, or something that violates the rights of others, or is defined primarily in economic terms (Mills,1997), power is conceptualized in a way that draws on Foucault's "analytics of power" (Dreyfus & Rabinow,1982 p. 184) which he proposed as being different than a "theory" of power.

Foucault saw power as being "everywhere and nowhere…not possessed by individuals, groups, or functions but always a relationship that involves positive as well as negative outcomes" (Mills & Simmons,1995 p. 114). In this way, power is explained as a complex range of social practices which is dispersed throughout our everyday activity and which "produce[s] possible forms of behaviour as well as restricting behaviour" (Mills,1997 p. 20). Foucault perceived power as operating through "strategies" or "the networks, the mechanisms, all those techniques by which a decision is accepted and by which that decision could not be but taken in the way it was" (Anderson,1995 p. 42). In this analysis, the relationship between power and knowledge becomes evident, something Foucault concerned himself with a great deal, and saw as being expressed in discourses circulating in society.

Discourse, or what is both intentionally written and said on a topic, is therefore also inseparable from power as it is "a process of definition and exclusion" (Storey,1993 p. 92). As such, discourse is always rooted in power. From this perspective, we all participate in, and "contribute to practices and discourse which bestow different elements of power (and powerlessness) on each of us" (Mills & Simmons,1995 p. 221). It follows then that even at the level of the individual, there is a role in recursively organizing the social relations that play out in groups, in the broader community, and ultimately in the society to which we belong. The questions arising here are first, how will individuals in the health care system, who historically have had greater access to power circulating in society, respond to different patterns in its circulation? Secondly, how will members of communities, who have had less access to power in decision-making in the past, take it up in their new role as participating citizens?

Community

The term community is also problematic in the health reform literature. "Community" appears to be used primarily to refer to a population organized within a determined physical territory, and for the purposes of defining where and how health care resources are distributed. Governments may believe that in the instance of resource allocation, this definition is sufficient; however, communities are anything but homogenous, and proponents of community participation would argue that this definition is simplistic (CBC Radio Works,1994a).

This said, it is surprisingly difficult to find a clear and widely accepted definition of community. When asked "how would you define the word community" (CBC Radio Works,1994a p. 2), community organizer John McKnight replied

> you know, if you go to a sociology department and you ask that question of the faculty, you'll never leave....you ask me the question: what is the community?, I probably listen to it: where is community? And there the answer is: in your mind. And in the mind of every other person in Canada it's a different place. To some people it's a feeling, to some it's relationships, to some people its a place, to some its an institution...(CBC Radio Works,1994a p. 2)

The implications of this description can be considered from at least two perspectives. First, it may pose a major challenge to a government who wants to delegate power to a group of people who are reasonably representative of a community as defined by geographical boundaries. Alternatively, the complex and ambiguous nature of the notion of "community" may offer governments considerable advantages in that not being able to define it easily allows a great deal of mobility in its interpretation. As such, it is more difficult for governments to be held accountable for not attending to specific health issues of communities, particularly if these will require greater resource allocations. I suggest that if the intention of health care reform is to involve citizens, or representatives of those citizens who are affected by decisions, in the decision-making process in a meaningful way, communities must also be understood by the consistent social relationships or interactions that constitute the many smaller communities—or sub-communities—that cohabitate within a geographic space.

Proponents of community participation advocate that an essential prerequisite for understanding a "Community" defined by geography is the development of a social profile which offers rich detail about one's constituency (Conner,1994). Such a profile should delineate the basic demographic groupings (age, ethnic background, socioeconomic classes etc.) and then move on to outline the many "communities" within the Community which are defined by specific health issues and social relations (for example—members who are functionally illiterate, individuals with addictions, seniors living in poverty, Aboriginal people with disabilities, homeless people, single parents, grassroots organizations, advocacy groups...). When considered this way, one might argue the possibilities are innumerable, and therefore capturing a "complete" picture of the make-up of a community is impossible. On the other hand, if broad community representation and participation in community governance are central to health care reform, a greater understanding of a Community's overall composition can only assist the process toward its declared goals of developing different relationships between community members and members of health care bureaucracies and professionals.

Is "Reform" By Way of Community Governance Possible?

Much of the literature on devolved authority reflects an assumption that community governance will result in a democratic system in which citizens, health care professionals, and government are equal partners in the provision of services. As community governance structures are introduced, and as responsibility for service provision shifts to community representatives, tensions are inevitable given the limited discussion on what this new relationship between the organization, or agency, the health care managers and providers, and the community looks like, or how it manifests in practice. In order for this process to function as it is described in the literature, and in the "talk" or discourses that surround it, employees of organizations and health care providers—those generally viewed as the experts in our society—and members of the community (or their representatives) must work together differently. Although this is an easy statement to make, historical resistance to such change within organizations speaks to the pitfalls of this issue. In such a critique, questions emerge about the organization and construction of society, and the social relations within it, that challenge the possibility of the changes proposed within the health care reform literature.

Health care reform, with community governance as a means for its achievement, proposes a social re-ordering of the way things are done in an area that has a history of domination by health professionals, or the understood "experts" in society. Proponents of critical management studies argue, however, that the decision-making authority historically held by these experts is being progressively relocated to the disciplines of management (Alvesson & Willmott, 1992). Thus there is another level of potential conflict as these groups negotiate changing power relations.

If considered from a Foucaultian tradition, any discipline's authority becomes known through the discourses, or the "talk" which embodies each discipline's "accepted concepts, legitimized subjects, taken-for-granted objects, and preferred strategies" (Dreyfus & Radinow,1982 p. xxiv). Discourse is understood as what is purposefully spoken and written and also plays out in human actions that occur in the context of the discourse. Foucault argued that the "historically produced, loosely structured combinations of concerns, concepts, themes, and types of statements" (Marshall,1994 p. 125) that construct our language are embedded in our discourses, and emerge and re-emerge in our everyday lives as discursive practices. Thus social relations are understood as recursively organized in a manner that does not allow for the rapid adjustments in historical relationships required in radical events such as health care reform.

In light of this line of thinking, the absence of both discussion on how this social "reordering" will occur and on the role of power in the "new" decision-making processes, is troublesome. So too is the fact that one does not have to look far to discover extensive discussion and literature on organizational and social "resistance to change", and various "change theories", or ways to get past, around, or beyond the taken-for-granted problems of implementing changes in organizations and in society (Bridges,1991; Weisbord & Janoff,1995). Given the contradictions between discourses promoting the progressive notion of "making change", and the abundance of information on resistance to the same that will be encountered within organizations, one must also consider concepts integral to the "sites" of proposed health care reforms—these being the institutions of the health care system and those who "run" them.

Bureaucracy, Management and Management Theory

When reviewing the topic of organizational "reform" within a system as large and complex as health care, discussion must include the organization, or bureaucracy, within which reform is occurring; the role the discipline of management has in these organizations; and the issue of how managers attempt to bring about change in organizations, or the place of management theory. Within organizational theory, bureaucracy is understood as a "large and complex formal organization, which is organized through an elaborate division of labour, under a hierarchical structure of authority, and which operates according to explicit rules and procedures" (Mills & Simmons,1995 p. 35). A mainstream definition would attach bureaucracy to government and public administration, and describe it as a "system of authority, people, offices, and methods that government uses to achieve its objectives" (Kernaghan & Siegel,1995 p. 25). Regardless of how people feel about these organizations, "the dilemma is that without bureaucracies the processing of a number of services would make life more difficult and cumbersome for many of us (Mills & Simmons,1995 p. 35).

In his studies of bureaucracy, Weber "suggested that most organizations adapt to the pressures for greater efficiency by introducing bureaucratic principles of organization" (Mills & Simmons,1995 p. 37). These principles are defined as "a high degree of routinization, specialization, formalization, and standardization" (Mills & Simmons,1995 p. 35). As noted, in the 1980's the provincial health programs were depicted in several Royal commissions and other reviews as being very inefficient and costly for what they delivered in services

(Lomas,1996a). Given the history of the haphazard development of health care as a national "system", it might be argued that the drive to remove the financial barrier between those providing health care services and those receiving them was of primary importance, and how the service was delivered was secondary, an issue that soon came home to roost (Decter,1994).

Health care bureaucracies, like many bureaucracies, are criticized for being rigid, resistant to change, secretive, anti-democratic and self-perpetuating (Ministry of Health and Responsible for Seniors,1993; Mills & Simmons,1995). The relentless pressure within the current social and political climate to become more efficient in a system apparently designed, at the central level at least (as opposed to the local or institutional level), to be efficient poses some major challenges to those who manage the system overall. In organizations, the discipline of management has accrued the power necessary to bring about change in how organizations function as a whole, and in the work processes which are in place to accomplish the organization's function. As such, the role of management in health care reform requires discussion.

Management

The twentieth century could be called the "age of the professional manager" with the emergence of this relatively new discipline accompanying the growth of larger and more complex organizations (Mills & Simmons,1995). In the public sector, enormous expansion in the activities of Canadian governments, particularly since the beginning of the Second World War, saw a similar growth in professional managers within the ranks of bureaucracy (Kernaghan &

Siegel,1995). Roles central to the management of an organization are generally understood to include some combination of the following: planning, organizing/coordinating, motivating, and controlling the activities of an organization (Mills & Simmons,1995).

Within management theory, management activity is usually described in ways that construct an ambience of harmony ("bringing together resources", "coordinators of human effort"), and little reference is made to undesirable elements in organizations such as power, conflict, manipulation and inequality (Mills & Simmons,1995). Indeed, it is as though once you step into an organization, these things do not exist. In most organizations management is also "seen as the only agency which is capable of bringing together all the different elements of the organization....[as though it] alone can rise above the particular interest of each constituency" (Mills & Simmons,1995 p. 60). This image of management as the "carriers of rationality and initiative" is being challenged in a way that "questions the wisdom of taking the neutrality or virtue of management as self-evident or unproblematical" (Alvesson & Willmott,1992 p. 1). Although modern management theories are typically developed in, and for, the private or business sector, their emergence in public institutions in response to calls for improved efficiency and system reform requires attention as business organizations are different than health and social services. In considering management theories, however, one cannot simply look at the present, but must also consider their roots in the past.

Management Theory

When reviewing early, or classical, management theory, Scientific Management is commonly understood as one of the first systematic methods of management and is often referred to as "Taylorism" after its founder, Frederick Taylor (Mills &Simmons,1995). In this theory of management, Taylor viewed organizations as a machine (his background was engineering) and attempted to develop a universal and standard set of principles of management for application to any organization.

Essentially, Taylor's management theory held 1) that managers should control the conception of work, workers were only responsible for performing the work; 2) that scientific methods should be used to analyze and design the most efficient way to do the work; 3) that detailed instructions of each job were required and workers should follow these exactly; 4) that management must fully train the "best" workers for the job; and 5) that managers should routinely monitor the performance of workers at work (Mills &Simmons,1995).

In this description, it is obvious that Taylor's work bestowed an extreme emphasis on efficiency and taking a scientific view to management. The highly rational approach seeks to study work in an organized way, to analyze it into its simplest processes, and to systematically improve the performance of workers in each of these processes (Drucker,1986 as cited in Mills & Simmons,1995). Overall, the purpose of this approach is to render the organization and its processes amenable to management supervision and control (Mills & Simmons, 1995). In critiques of Taylor's work, it is argued that his methods of routinization and standardization of work resulted in early deskilling of workers and the loss of traditional craftsmanship, a criticism not widely noted in management theory texts (Mills & Simmons, 1995).

In Scientific Management theory, clearly management is meant to hold the balance of power in organizations and therefore defines, through the use of discourses, acceptable, or "good" behaviour in those that work in organizations, and in the same way, excludes undesirable, or "bad" behaviour. As such, Scientific Management does not allow for variability in meanings of "work" and "productivity", nor for the possibility that variations in meaning reflect a different distribution of power. By not accounting for variability in meaning in any way, Scientific Management seeks to displace the possibility that power is constantly negotiated within the social relations of organizations. Such recognition would reveal power's more ubiquitous nature, as opposed to propagating the sentiment of power as a possession controlled solely by management.

After Taylor, there was a great deal of interest in developing a scientific theory of organization, or "broader theories about the ideal structure for any organization" (Kernaghan & Siegel,1995 p. 49). This work focused on proper alignment of organizational functions and span of control—or "the number of subordinates who report to one supervisor" (Kernaghan & Siegel,1995 p. 49)—and gave rise to the organizational charts and clearly defined hierarchies that remain with organizations today. Through mechanisms that seek to establish "reporting relationships" in this way, management of organizations map out very specific processes workers must follow in order to resolve problems they have within the context of their work. In this way, responsibility for resolving problems becomes that of the individual. When individuals "fail" in problem resolution, a "chain of command" is established as it is to be followed, should one have the confidence to engage with such a confrontational process. Mechanisms such as these contribute to the suppression and invisibility of conflict and power inequities within organizations.

Over time, management theory began to take into account the human aspect of organizations and moved away from obviously authoritarian styles of management toward proposing more cooperative methods. Early versions of these more humanist approaches, however, maintained a "very paternal view of the worker, embracing Taylor's view that workers are not capable of making their own decisions" (Kernaghan & Siegel,1995 p. 63). These human relations theories migrated thinking toward a more positive view of employees—as being something more than a fragment of a greater "machine". Worker "participation" in decision-making began to be seen as "therapeutic" and useful as the worker had a common interest with management which required cooperation to achieve, this being the successful operation of the organization.

If one recalls Arnstein's (1969) ladder of participation, "therapeutic" involvement in decision-making was at the bottom of this and was considered a mode of "non-participation". Human relations theories eventually fell under criticisms that the "common interest theory" on which they depended did not exist, and that they were first and foremost manipulating "employees to behave in the interests of management" (Kernaghan & Siegel,1995 p. 68), as opposed to their own best interests. In this manipulation, these theories are also criticized as having added the notion of increased productivity to that of the overriding principle of efficiency of work processes (Mills & Simmons,1995). Ironically, there was also the opposite criticism, that these theories focused too much on the needs of the employee. The necessity to account for both of these perspectives resulted in various "new" management theories which can be grouped under the term participatory management (Kernaghan & Siegel,1995).

Participatory, or modern, management theories vary in their methods. Their distinguishing quality is proposed as the acceptance of the tension and conflict between management and employees as a given in the workplace. This tension and conflict, however, is viewed as something that can be directed and controlled in the best interest of the organization. According to Kernaghan & Siegel (1995) participatory management methods range from joint goal setting between employer and employees which are then used as guiding principles for operations (managing by objectives); to a focus on problems in organizations as reflecting more serious underlying issues that must be addressed if change is to be implemented (organizational development); to broader approaches aimed at changing the "organizational culture" in a way that all employees are focused on establishing and maintaining high standards of quality (Total Quality Management). Many health care organizations in Canada have adopted a version of Total Quality Management—Continuous Quality Improvement—a method in which organizations establish interdisciplinary "self-management teams" which are to set goals and identify and solve problems in cooperation with management (Decter,1994).

Participatory management methods are generally criticized for requiring a huge commitment of organizational resources and for causing lengthy disruptions in the workplace as they represent much apparent change in management-employee relationships (Kernaghan & Siegel, 1995). More harshly it is argued that, yet again, the goal is manipulation of workers through "new" work processes which are intended to replace overt forms of control with control that is "based around the manipulation of symbols and discourses rather than panoptic surveillance and direct supervision" (Gerlach,1996 p. 432).

When considering how readily participatory management methods are being taken-up in government bureaucracies, and in local health and social service institutions, Kernaghan & Siegel (1995) offer some interesting comments on the limited success of participatory management in the public sector. The "particular set of problems" encountered in this area include first, the contradictory principle of top-down ministerial responsibility for activities in parliamentary-based public organizations; and secondly, the difficulty of involving people affected by the service in the decision-making as, from a political point of view, they constitute a "special interest group". These opposing principles highlight the contradictions of government versus community interests. As such, these conflicting interests propose a complicated setting in which leadership and management of health care reforms resides. How will these contradicting interests be addressed, or accounted for, as reforms—such as community governance or regionalization—are implemented? Perhaps reluctantly, Kernaghan & Siegel (1995) contend that "few government agencies give more than lip service to participatory management" (p. 79), a reality that has significant implications for changes such as health care reform. How is it that organizations, which apparently practice a type of participatory management theory, can ultimately pay only "lip service" to it?

When reviewing management theory broadly, it is often presented in texts as linear, with ideas having moved over the years from highly rational, authoritarian methods to more democratic ideals. Early Scientific Management, and the ideas that followed its development, are not understood in this inquiry, however, to be "consigned to the scrap-heap of history in favour of more enlightened and more humanistic forms of management" (Mills & Simmons,1995 p. 72). Rather, Scientific Management is seen, in many ways, to have "established the domain for all later systems of management, and its principles and practices are still [seen to be] embedded in the management systems" of modern management theory (Mills & Simmons,1995 p. 72). From this perspective, the social relations of Scientific Management are understood as continuing to have a significant impact on the organization of health care bureaucracies, on their day-to-day management, and on health care reforms as they are moved ahead.

In this chapter, health care reform was discussed as a proposed re-structuring of health care governance through the use of community governance in regionalization models. Community governance models were noted to offer governments both a mechanism for citizen participation, as was consistently called for in the most recent Royal commissions on health care, and a means of legitimizing the role and actions of both governments and their staff. The issues of who should participate, how representative community governance committees are, and how to define the notion of community were also raised given their contributions to established social relations and discourses that hold the potential of recursively re-creating old patterns of managing health. From this perspective, the possibilities of "reform" by way of community governance are questioned.

A review of bureaucracy, management roles, and management theory reveal governments as engaging modern management theories—as are notable in participatory mechanisms such as regionalization—to implement sweeping changes in how we organize and deliver health care services in Canada. Given the history of management theory, one must consider the extent to which decision-making power will be delegated to the community groups that governments are involving in the management of health care resources, and the reasons for engaging with communities in this way. With all of this as background, the question of this research is—How will the discourses of health care reform enter and affect the decision-making work of governance volunteers serving on community health care committees as established in British Columbia's regionalization process?

CHAPTER TWO

Research Methodology

In light of the many discussions on health care reform, the pressures being exerted from political and economic fronts, and the probable challenges the reforms will encounter as they are attempted within the established health care system, one must view with interest how "reform" will be brought about. Health care reform is said to be underway for a number of reasons. The prominent motivation at this time may be economic conditions and beliefs that support the need to share rationing decision-making with the public. Examples of rationing decision-making might include health service cuts or decisions to prolong surgical or therapeutic waiting lists. Such a tactic could be seen as desirable by government and health care bureaucracy staff as it dissipates responsibility for unpleasant decisions by "sharing" the process of making them with communities (Hurley et al,1992).

More desirable reasons for health care reform include developing responsive, flexible systems which are better able to meet the needs of local people toward improved health over the long-term, as opposed to short-term absence of disease, a goal consistently encouraged in provincial Royal commissions. Another motivation would include the desire of government and their bureaucracy staff to gain greater control over the management of health services and health care professionals, something that has alluded them in the past due to how the national system was initially negotiated. As reforms move ahead, the various motives will impact how change emerges in social relations of health care organizations. In an effort to distill how health care reform is playing out in practice, the research question—How will the discourses of health care reform enter and affect the decision-making work of governance volunteers serving on community health care committees as established in British Columbia's regionalization process?—was taken-up by conducting this inquiry with a group of community governance volunteers doing their health care decision-making work.

A research question such as this holds and arises from certain assumptions about how the world is organized and the role of individuals and groups as participants in that organization. Theories of Giddens (1984) and Foucault (Dreyfus & Rabinow,1982) are drawn on when considering the world as a socially organized place. Within day-to-day activity, routine—or whatever is done habitually—"is the grounding material of...the recursive nature of social life" (Giddens,1984 p. xxiii). By recursive nature, Giddens refers to social activity, or social relations, that are "constantly recreated out of the very resources which constitute them" (Giddens,1984 p. xxiii). In other words, social relations are constantly reproduced by the individuals engaging in them.

Social relations within a society are communicated to other members of that society who also engage in their recursive reproduction. Language, as the basis of communication, is elemental to social organization. Language organizes our world, but is itself an organized system. As such, "language is not a tool, it is a way of being. In a fundamental way, one is one's language" (Allen,1995 p. 177).

Discourses embedded within social relations are evident in our language and further organize our world through the expressions of power that operate within them. In a world viewed as socially organized in this way, that is with full participation from those living in it, the challenge of bringing about a "new" way of doing things is not to be underestimated. However, "when a 'new' object [in this case health care reform] is imported into an already ordered system an opportunity is created to study how old signs are transformed and new signs created to order and bring the new object into play" (Purkis,1993 p. 2). With the goal of determining how the discourses of health care reform, as part of a new object, enter and affect the decision-making process of governance volunteers, an ethnography was carried out with a group of individuals engaged in this activity.

Ethnography

This research is an ethnographic study of governance volunteers doing committee work within the regionalization structure organized in British Columbia health care reform policy. In an ethnography, the researcher observes, and then describes a group doing their routine work or activities. Overall, this research is grounded in a constructionist perspective and focuses on the language or "discourses" in, and around, the group's activities and documents. In this ethnography, data were gathered by observing meetings, by reviewing both information the committee members received in the course of their work, and the documents they produced as part of their work, and lastly, by interviewing individual committee members. In analyzing the data, discourses were seen to define for the committee members, and through them to the community, what is "important", what decisions to make, and how to make them. The purpose of the analysis is to explicate the conditions underlying community governance decisions, thus revealing the social practices that affect the particular ways the decision-making of governance volunteers is constituted and enacted.

A Constructionist Perspective

When taking a constructionist theoretical perspective, the world is observed as socially created, thus the social relations within it are seen to be made or constructed, as opposed to being taken-for-granted and as naturally occurring. Drawing again on social analysis offered by Foucault (Dreyfus & Rabinow,1983) and Giddens (1984), when acting in society, people are not seen as victims of external forces. Rather, people are seen as accessing social rules, or sets of practices, in a knowledgeable manner, which combine to control how they view the world and behave more productively through it.

As social actors in such a society, "all human beings are highly 'learned' in respect of knowledge which they process and apply, in the production and reproduction of day-to-day social encounters" (Giddens,1984 p. 22). In this inquiry, social action, such as day-to-day governance committee decision-making activities, is considered to be constituted by knowledgeable governance volunteers who are "positioned, in 'multiple' ways, within social relations conferred by specific social identities" which are constantly recreated within a broader social context (Giddens,1984 p. xxv). "Positioning" here refers to how one is positioned in relation to others involved in immediate circumstances—in this situation other governance volunteers or the Ministry of Health staff for example. Positioning is also understood as being in relation to where one is in the "flow of day-to-day life", in relation to past experiences, and in relation to broader surrounding experiences—in this case examples might include provincial or national health care issues or the current economic environment (Giddens,1984). Therefore, being positioned in a "multiple" way is taken-for-granted in all social activity.

Constructionism, as a mode of thought, can also be understood in comparison to the more dominant research perspectives, positivism or post-positivism, which are also referred to as "scientific method". In scientific method, a single reality is assumed to exist. The purpose of research conducted from this world view is to predict and control the natural phenomena within that reality by establishing enduring cause and effect relationships (Guba & Lincoln,1994). Toward this end, there is an emphasis on the researcher and the object of research being independent entities. Ideally, the researcher is seen to be capable of studying the "object of interest" without influencing, or being influenced by it, thus carrying out "objective" research. Although maintaining objectivity remains the ideal, increasingly the single reality is seen as "only imperfectly apprehendable because of basically flawed human intellectual mechanisms and the fundamentally intractable nature of natural phenomena" (Guba & Lincoln,1994, p. 110). In ongoing comparison, scientific method as a research strategy holds many fundamental differences with the view undertaken in this constructionist inquiry.

In contrast to a scientific world view that presents a "single reality", constructionism proposes multiple, competing and changing realities, or "constructs" (Guba & Lincoln,1994) which cannot be viewed and described "objectively", nor specified in terms of unchanging cause and effect relationships. Within this perspective, the researcher is not seen as separate from what she researches. Rather the researcher is considered to be functioning within the same set of broad social relations as the individuals and groups being studied. Thus the researcher is inextricably linked to that which is being investigated. As such, the researcher must be mindful that research findings are created through the interaction of the researcher and the social conditions which she is exploring (Guba & Lincoln,1994). In this way, the researcher encounters the socially organized world from a stance of reflexivity that seeks to undertake observations more systematically than her research participants, remaining open to the "flow" of power operating and organizing encounters.

The aim of this research then is "understanding" which "takes the interpreter's present participation in history into account in a central way" (Linge,1976 p. xvi). Linge's interpretation, which is drawn from the work of Gadamer, differs from that of Guba & Lincoln (1994) in that "understanding" is not simply a "reconstruction of the constructions that people (including the inquirer) initially hold, aiming toward consensus but still open to new interpretations as information and sophistication improve" (Guba & Lincoln,1994 p. 113). Rather, understanding is "essentially a mediation or translation of past meaning into the present situation" (Linge,1976 p. xvi) from the researcher's reflexive stance.

In sum, the intention of an inquiry within a constructionist perspective is to explicate how particular understandings of what is being researched—in this case the work of governance volunteers—are organized. In this approach, it is taken that no social circumstances exist in isolation from others, that the social conditions manifest in one setting are seen as related and relevant to another. For example, although "reformed" health care governance in a smaller, northern community will have some local contextual issues, what is playing out in the broader social relations will have much in common with health care governance activities in the provincial capital. In this inquiry, these consistencies in social relations will be captured by focusing on the "discourses" of health care reform produced by them and observing how these enter and affect the decision-making processes of governance volunteers.

Discourse Defined

Through language we organize and understand ourselves in the world. Our daily activities are only thinkable through language. Language is not only useful in helping us organize our world—it is "organizing"—but, it also represents an organized system itself—it is "organized". It is also assumed that language used purposefully in a particular social setting gives rise to "discourses", or sets of ideas and viewpoints which are experienced in and through a series of communications, either verbally or in writing (Mills and Simmons,1995). A further assumption holds that "discourses structure both our sense of reality and our notion of our own identity" (Mills,1997 p. 15).

Drawing again on theories of Foucault, "the general domain of all statements'; that is, all utterances or texts which have meaning and which have some effects in the real world count as discourse" (Mills,1997 p. 7). An example of this from the health reform publications in British Columbia is drawn from the Ministry of Health announcement to shift reforms from the New Directions initiative to one called Better Teamwork, Better Care. In the announcement of this "new" initiative, the Minster of Health said "all of us must focus more on people, not process; on services not structure" (see Appendix D - D-32). In this announcement, these comments were a thinly veiled attack on the previous initiative, New Directions and its "consultative, developmental approach" (D9-16), and marked a significant shift away from the "community participation" approach the Ministry had been taking in health care reform. In this example, the utterance was made purposefully, had meaning to those involved in health care reform, and had real "effects" on how health care reform proceeded from that time on. In this, this example offers evidence of the extent to which meanings are constructed (through language systems) in opposition to other meanings.

In this theory of discourse, there is no "one discourse", rather groupings of utterances or statements separate into several discourses. Defined this way, discourse is understood as "a set of sanctioned statements which have some institutional force, which means that they have a profound influence on the way that individuals act and think" (Mills,1997 p. 62) in particular settings within society. As discussed in the previous chapter, Foucault argued that this ability of discourses to have “effects”, or institutional force in the world, arises from the certainty that embedded within the discourses of any particular field are “unwritten rules”, or the “historically produced, loosely structured, combinations of concerns, concepts, and themes” (Marshall,1994 p. 25) which attempt to regulate what can be written, thought, and acted upon in a particular field (Dreyfus & Rabinow,1982). These unwritten rules, also referred to as “discursive practices” or “discursive formations” (Dreyfus & Rabinow,1982; Storey,1993), are seen both to constrain, and make possible, in particular ways, the social relations of those practicing in the field by allowing some modes of thought and denying others. In other words, discourses have effects because they are embedded in, and expressed by, social practices and routines. The concern that arises from this characteristic of discourses is the relationship between discourse and power in regulating practice in any field.

The ability to influence the behaviour and thinking of people involved in social practices is powerful activity. “In this sense discourse is inseparable from power” (Storey,1993 p. 92). Power is understood as operating through discourse because discourse communicates and represents embedded orders of knowledge which are enacted by people complying with the social routines that discourses construct (Storey,1993). As noted earlier, however, in this inquiry power is not known to be a “simple imposition” owned by one group. Rather power is understood as circulating through society and in constant negotiation (Mills,1997 p. 39).

In a connected way "a discourse is not a set of utterances which are stable over time" (Mills,1997 p. 26). This may seem surprising, because although easily distilled in everyday conversations, and therefore often presumed familiar at present, discourses have a history of shifting and lurching in their development as opposed to the seamless narrative progression one might more easily be persuaded is the case (Mills,1997). In this way, discourse "is seen as 'dialogical', in dialogue and potential conflict with other uses of languages" (Storey,1993 p. 92). Thus discourses, which do not exist in isolation, become a potential "object and site of struggle" (Mills,1997 p. 16), or a place where power may be negotiated time and again. When data were collected for this ethnography toward addressing the research question—How will the discourses of health care reform enter and affect the decision-making work of governance volunteers serving on community health care committees as established in British Columbia's regionalization process?—as researcher, I was constantly mindful of details which spoke to how the social practices I was observing and recording appeared to be constructed, what was the language that contributed to that construction, and how was power circulating through the social relations evident in the decision-making work of a group of community governance volunteers.

Data Collection

After clarifying my area of research interest, and that I could investigate this by observing a governance committee doing their decision-making work, I approached the Chairperson of the Community Health Council in my home community with a proposal to do the research with that group of governance volunteers. I was greeted with much interest in the project and support for the idea of investigating the seemingly vague nature of decision-making processes. At that time this Community Health Council (the "Council" or the "CHC") was just being designated, or "recognized as officially operating", by the Ministry of Health under the latest reform initiative "Better Teamwork, Better Care. The Chairperson communicated the Council's interest in "doing things differently" than how governing groups might have been seen to do them in the past. This person supported having their work assessed systematically and the findings reviewed with them in a manner that encouraged discussion about "how we do things" as a way to assisting them to be a "different board".

With this support, I submitted a letter to the Council as a whole, outlining my research interest and the proposed methods for investigating decision-making in this context (see Appendix A). This request was placed on the agenda of the Council's October, 1997 Executive sub-committee meeting by the Chairperson. A motion supporting the research project came out of that meeting. From the beginning the Council was very public about participating in this research, including notes relevant to it in public minutes, and introducing me at meetings in this capacity.

While awaiting University Ethics Committee approval for the project, I began attending the monthly public meetings of the Council on a routine basis for two reasons. First, it allowed me to become familiar with the workings of the group and the topics they were dealing with, or the "language" around their activities. Secondly, it allowed the members participating in the project to become more comfortable with my presence, and to move away from feeling that they were being scrutinized in some way. From early on, the group of governance volunteers appeared quite comfortable and welcoming of my presence.

Ethics Committee approval came in January, 1998 with the condition that informed consents be obtained from all people routinely participating in the Council's public meetings. This expanded the research "group" to include the eleven Council members, five senior management staff, one medical chief of staff, and one charitable group organizer, for a total of eighteen participants. Within the group of eleven Council members, two were appointed by the Ministry of Health—one to provide a medical perspective and one to provide a labour or union perspective. Some details on the remaining nine Council members, the "community representatives" include: 1) seven were Caucasian with the remaining two being from different ethnic backgrounds; 2) one member was under the age of twenty-five, two were retired citizens and the remaining six members more "representative" of middle-aged than older adults; 3) seven were professionals and the two retired citizens had backgrounds in community development/activist work; 4) the professions of the seven professionals included two members working in education (one currently a manager and the other in accounting), one member from nursing (in education/public health management), three members from the private sector (a manager, an entrepreneur and a lawyer), and one community development worker with a background in journalism; 5) all but one of the members had substantial "committee" experience either through their professional work or from volunteering in other capacities in the community; and 6) seven of the nine representatives were involved with health care reform locally from early in the process.

The individual consents that were signed by all participants outlined in detail the methods for collecting data, what would be included as "data", and a request for individual interviews to review two decisions that were made by the Council as a whole (see Appendix B). In total, data collection from the participants was completed over a seven month period, from February to August, 1998. Ministry of Health documents that were part of the data continued to be collected until January, 1999. During the data collection from the participants, I attended all public meetings of the Council as a whole, one "special Council meeting", various in camera meetings, and was invited to attend the Council's strategic planning sessions that were underway. Additionally, there were other "in-house" organizational meetings/events that I also attended. Over this period, one participant, a Council member appointed to represent medical staff, resigned this position and left the community.

In this inquiry, there were five methods of data collection. The first method was observation of regular public and in-camera meetings, and of other Council and organizational activities, with the researcher routinely taking field notes for a total of twenty-two meetings between February and June, 1998 (see Appendix C for a comprehensive list). Secondly, monthly public meetings of the Council as a whole were audio-taped and the audio-tapes transcribed so that these data could be treated as text for analysis. Data collection from these meetings was completed between February and June, 1998 during which time there were five regular public meetings and one special meeting taped.

The third method of data collection was the review of documents the Council members received in the course of their activities; collection and review of those documents they produced as a result of their activities; collection of any Ministry of Health publications, some dating back to the beginning of this province's announcement of health care reform; and review of texts on activities they were involved in, specifically on strategic planning and quality improvement processes. Although the documents produced from the group's strategic planning sessions are included in the data, these sessions were not audio-taped as per prior agreement. Sources of documents included information the Council members received from the Ministry of Health, professional groups, community groups, sub-committee work, internally produced documents, local newspaper articles, and board member journals and newsletters (see Appendix D for a list of documents used in analysis).

The fourth method of data collection was individual interviews with the participants. From the beginning of the research, the intention was to continue data collection until two "significant" decisions were made by the Council. These two decisions were then to offer concrete examples for discussion in the individual interviews. The analysis did not, per se, focus on the two decisions in isolation. Rather the two "significant decisions" offered the governance volunteers something specific to "talk" about as we discussed their decision-making process. For the purposes of this research, a significant decision was defined as a decision in which there was the following: 1) involvement of all committee members; 2) both wide support and difference among committee members; and 3) direct local effects on health issues, services, and/or needs. In the individual interviews, a final question was posed which allowed the participants to make any general comments they felt were important, or relevant to the decision-making process within the health reform structure they are working in.

In June, 1998, after two significant decisions were made that could be reviewed specifically, individual interviews were scheduled at a place and time convenient to the participants. All Council members (excluding the one member who had resigned) participated in an interview. Additionally, the three senior management staff and one medical staff who routinely contributed to the public meetings were asked for, and agreed to, individual interviews for a total of 14 interviews. All interviews, except one, were audio-taped with permission from the participants and then transcribed so that they could also be treated as text in analysis. The individual interviews were completed by August, 1998. The fifth and final method of data collection was the observations and notes I kept in the form of a journal. Overall, data collection was completed in January, 1999.

The Researcher's Place in this Inquiry

In the constructionist perspective taken-up in this inquiry, the researcher is not seen as separate from what she researches. Rather the researcher exists within the same broad context of social relations as the research participants and, in this way, is inextricably linked to that which is being investigated. This reality could not have been more evident than it was in this research and, as such, it provided extensive terrain for much introspection on the data collection process (that is, what constitutes data) and on the craft of interpretation.

When considering my place and connections in the research setting, important information to share include that the group who participated in this inquiry are from my home community, a smallish northern town where one cannot help but to know many people in the community. Additionally, I was a casual employee in the organization this group governed, although not financially dependent on that work. During the data collection phase, however, I was working in a temporary part-time position in the hospital which actually improved my access to information produced by the Council as this filtered through to the staff levels. Working in the hospital also allowed me access to the local and staff "talk" around general issues of contention, of which there were many. These are discussed in more detail in the next chapter which offers "local context".

Finally, my partner is a member of the medical group in this community, an issue that became suddenly relevant early in data collection. As data collection began, the Council, in support of their management staff, and the local physicians as a group, took up strongly opposing positions over some operational issues within the local hospital. This created a tension that was most poignant between February and May, 1998, an atmosphere which caused me considerable turmoil in my capacity as researcher as I was hearing, rather loudly, the contested issues from several perspectives. During this time, foremost in my mind was the concern of how to remain receptive to the many interpretations of events as they were unfolding. In addressing this issue, I spent extra time journaling happenings and reflecting endlessly on my interpretations, or how and why I might come to understand various versions of events in the way I did.

My thesis committee was invaluable at this point. As a group outside of my home community, and not emotionally connected to the health care upheaval that was playing out locally, they were able to offer comment on my journal notes which facilitated my openness to the various positions taken up. Most importantly, they assured me it was possible to live through what was transpiring, a prediction that quickly enough became apparent.

After a time, the local climate seemed less volatile, and I regained a level of comfort with listening to the various issues in different contexts. Although I was very cognisant of the perspective of the medical staff on a personal level, the relationship I had developed with the members of the Council, and my favorable perception of "governance volunteers" as very community-oriented, altruistic individuals, maintained my accessibility to what they might be thinking or trying to do around an issue. I was also fortunate to have past management experience in a hospital setting to draw on when issues of management practices were at the centre of the controversies. In all, this experience proved to be a cogent exercise in finding a place of balance as researcher within that which is being researched, and one that contributed greatly to my ability to critically examine the data gathered, and to make some sense of it, as I explicated the social relations embedded in it from a constructionist perspective.

Discourse as Analysis

In describing the decision-making of those participating in the research, this analysis focused on the language used to organize the work of governance committees. This language is seen to be socially constructed, specifically within the discourses of health care reform, and generally within broader societal discourse of "democracy" and respect for individual differences. With this focus on discourse, the aim is to provide an account which renders a description of practice—practice being community governance decision-making work—from a constructionist perspective.

Discourse was described earlier as purposeful speech acts that have an effect, or that produce something else, "rather than something that exists in and of itself and which can be analyzed in isolation" (Mills,1997 p. 17). As such, discourses are more than merely language or speech, but are "practices that systematically form the objects of which they speak" (Foucault,1972 p. 49), hence, the aim is to analyze discourse as producing knowledge in a regulated, rule-governed and internally structured manner.

According to Foucault, analysis would not entail simply noting the health reform discourses which are circulating in our society at present, but would include reflecting on the "arbitrariness of this range of discourses, the strangeness of those discourses, in spite of their familiarity" (Mills,1997 p. 26). Drawing further on theories of Foucault, the intention of analysis is not to determine "which discourse is a true or accurate representation of the 'real',...[rather, it is to consider] the mechanics whereby one becomes produced as the dominant discourse, which is supported by institutional funding, by the provision of buildings and staff by the state, and by respect of the population as a whole, whereas the other is treated with suspicion and is housed both metaphorically and literally at the margins of society" (Mills,1997 p. 19).

In doing analysis the researcher must interpret the text. To any interpretation we bring our "background", or common sense knowledge, which defines our pre-understanding about reality (Linge,1976). Our "background" is embedded in our language and constantly informs our interpretation of everyday activities (Hiraki,1992). Because each person has a distinct background informing their interpretation, misunderstandings are assumed to arise routinely. Interpretation, in this context, proposes that each individual interprets language from their "horizon" — the limits of what they know from past and present knowledge — and within the confines of their "prejudices" — the biases that limit their openness to the world (Linge,1976). According to philosophers such as Gadamer, we can gain critical awareness of our "prejudices" and correct them in our effort to hear what is communicated to us (Linge,1976). Within this, understanding the subject of interpretation for the purposes of analysis becomes a deliberate product of reflection. In interpretation, the relationship between power and interpretation is central and we cannot ignore our own participation in it (Hiraki,1992), nor the influence of our past understandings on it (Linge,1976).

In this inquiry, analysis of all texts began with the selection of "serious speech acts" (Dreyfus&Rabinow,1982 p. 59), or the phrases, statements, and utterances which as ethnographor, I observed to be purposeful, or intended to have an effect. Close attention was paid to how language was used, and how language use articulated with other social practices. Alertness to language use in this way makes evident consistencies in speech acts as these are revealed in their effects. Consistencies were then grouped and it was these consistencies across texts which emerged as discursive formations, subject to critical interpretation and analysis. Reflected in the consistencies are the everyday practices that recursively reproduce, rather than form, the wider trends in social relations of health care reform.

Important to this process was the assumption that the dominant meaning in the text was not the only meaning; that knowledges excluded by discursive formations operating in the text were equally important (Mills,1997). "What is analysed is not simply what was thought or said per se, but all the discursive rules and categories that were...assumed as a constituent part of discourse and therefore of knowledge, and so fundamental that they remain unvoiced and unthought" (Young,1981 p. 48). Necessarily, the intention was to look beyond the "surface", thus uncovering the rules for making sense of the work this Council was to do.

As analysis progressed, data were coded by source for researcher reference in the analysis documentation. The coding was as follows: 1) The public meetings were numbered and the transcript pages from each meeting were subsequently numbered. Data from public meetings were coded in the analysis as PM-meeting number-transcript page number. 2) Transcript pages for the individual interviews were numbered beginning with the first interview consecutively through to the last page of the last interview and were coded in the analysis as I-page number. The interviews were coded this way, as opposed to by interview, to further camouflage the comments of individual participants. The concern being that although identifying data were removed from individual comments, to the greatest extent possible, coding by individual interview would offer a means to group a number of comments made by an individual. This posed the prospect of exposing the owners of comments when there are a relatively small group of participants. 3) Each of the remaining documents used in the analysis were numbered, and if a document had multiple pages, that number was included in the reference as well. Data from documents were coded as D-document number-document page number. 4) Lastly, my field notes as researcher were coded as FN-date. The coding of data is provided here to assist the reader in determining the sources of data as the references appear in the analysis chapters.

In sum, analysis of discourse is useful "in that it can allow us to analyze similarities across a range of texts as the products of a particular set of power/knowledge relations" (Mills,1997 p. 23). From this interpretation, the discourses of health care reform were demystified and revealed how everyday practices of community governance volunteers reflect, and continue to form, wider trends in social relations. Before presenting my interpretation of the text analyzed, the provincial and local context of this site of inquiry are offered to afford the reader as broad a background as possible within which to consider the findings of this research.

CHAPTER THREE

The Provincial and Local Contexts

In offering the reader some context for the findings of this inquiry, a history of health care reform in British Columbia is outlined as background to the research site (also see Table 1). Additionally, I offer are some of the unique details about the organization this group of volunteers governs and the manner in which these relate to the activities of the governance committee.

A History of Health Care Reform in British Columbia

On February 2, 1993, Elizabeth Cull, the NDP Minister of Health at the time, officially launched a health reform campaign that included profound changes to the "governance" of health care in British Columbia. Taking-up a regionalized community governance model as health policy, or "bringing health closer to home" was one of five strategic "New Directions" to be implemented in this reform package. Other reforms included: a broader definition of health, greater public participation and responsibility, respecting the care provider, and effective management of the new health system (Ministry of Health,1993).

As a mechanism for reform, regionalization greatly affected health care providers, the Ministry bureaucracy, and the communities they serve. Given this, it is not surprising that it became the focus, if not the Achilles heel, of the five New Directions to be implemented in the overall reform plan. Indeed, at one time, many considered the two terms (regionalization and New Directions) to be synonymous. Investigation of the development of this health care reform policy revealed that regionalization, a policy proposed to the British Columbia Government a number of years ago, was not entirely a new idea.

In 1972, after twenty years of Social Credit reign, British Columbians elected a New Democratic Government. During the period the NDP held office (1972-1975), many social initiatives were undertaken with themes of "service decentralization, coordination across services, and citizen participation at the community level" (Prince,1996 p. 251). Most relevant to this research was the work done at that time by Dr. Richard Foulkes. Foulkes was appointed special consultant to the health minister early in the NDP's tenure. Within this new position he completed a major study of health care in British Columbia (Clague, Dill, Roop, & Wharf, 1984).

In the report from this study, Foulkes recommended a very detailed regionalization model for the governance of health care services, a proposal he cautioned would not result in reduced costs for health care, but rather was aimed at improving the health of the population over the long-term. Unfortunately, Foulkes "cited the social goals of the New Democratic Party in British Columbia as the philosophical influence" for his recommendations (Clague et al,1984, p. 131), a move which politicized the intentions within and caused his Minister considerable embarrassment. A combination of government discomfort, resistance in the Ministry of Health bureaucracy and from the medical community, and time constraints all ensured any plans for regionalization in health care did not get on the political agenda before the NDP lost power to the Social Credit Government at the end of 1975 (Clague et al,1984).

British Columbia's health system was not reviewed again in this way until March, 1990. At that time, with an election drawing near, the Social Credit Government announced the Royal Commission on Health Care and Costs. The converging factors cited as impelling this study include "significantly rising costs of acute care; political pressure placed on the Social Credit Government by the opposition to attend to the lack of direction in the health care system; and growing knowledge of the results of Royal Commissions done in other provinces and the reforms they were undertaking" (E. Cull, past Minister of Health, personal communication, December 6, 1996). Initially, the Social Credit Government appointed five commissioners—four men and one woman. Their backgrounds included a health economist, a past municipal politician, a community volunteer, a senior manager in acute care, and a lawyer. In November, 1990, nine months into the investigation, a doctor/retired university professor was also appointed to the Commission.

In brief, the Royal Commission's terms of reference included: examination of the structure, mandate, quality, accessibility, affordability, utilization, efficiency, and professional personnel requirements of the health care system in British Columbia (Province of BC,1991b). The commission proceeded with this mandate and carried out the first extensive study to be done since Foulkes's in 1973. After 20 months of research, the commissioners released their report in November, 1991 to a newly elected NDP government who had been arguing for the democratization of the system in their role as opposition.

The Royal Commission's final report, called Closer to Home, had several themes and many recommendations. The theme relevant to this research was a call for "decentralized management" within the Ministry of Health bureaucracy. Within this theme, the report criticized the current centralized management system for being "insensitive to local and regional questions, inflexible in its programs and policies, and unfair in its distribution of resources" (Province of British Columbia, 1991a p.15).

The Royal Commission's recommendations addressing these issues outlined a very specific overall policy direction. Specific directions within this included: 1) divide the province into several health regions, each with a regional general manager who will be responsible for setting regional goals, will oversee regional health care personnel plans and budgets, and will allocate resources; 2) assign each region a funding envelope which contains all health care dollars for that region; 3) support the creation of local and community boards to advise the regional general managers; and 4) leave province-wide standards and programs under the authority of the Ministry of Health in Victoria (Province of British Columbia, 1991b).

As is evident in these recommendations, the Royal Commission on Health Care and Costs did not recommend devolved authority through the regionalized community governance model now embodied in the Health Authorities Act and Amendment Act (Government of British Columbia,1995 & 1997). Rather, the commissioners advocated a traditional organizational model with a focus on geographical redistribution of the management structure which would allow for decentralized decision making "closer to home". Given the likely standpoints of the commissioners, and the political philosophy of the government who commissioned them, this is not particularly surprising.

Table 1
Overview of Health Care Reform in British Columbia

Event	Date of Event
Review of British Columbia's health care system by NDP consultant Dr. Foulkes, regionalization first proposed	1972
Announcement of the Royal Commission on Health Care and Costs by the Social Credit Government	March, 1990
Release of the Royal Commission's report "Closer to Home" to newly elected NDP Government	November, 1991
Announcement of health care reform initiative: "New Directions for a Healthy British Columbia"	February, 1993
Review of the progress of "New Directions" by re-elected NDP Government	July, 1996
Announcement of new health care reform initiative: "Better Teamwork, Better Care"	November, 1996
Designation of participating health authority under the Better Teamwork, Better Care regionalization model	July, 1997

A Response to the Royal Commission: "New Directions"

After receiving the commissioner's report, the new NDP government, having recaptured political power after sixteen years in opposition, proceeded to study the study. After eleven months of Ministry of Health review and consultation, the Royal Commission's recommendations were used extensively in the health reform document New Directions for a Healthy British Columbia (D-9) which was released in February, 1993. The Ministry of Health did, however, redefine the "decentralized management" recommendation into one of "regionalized community governance" with "two-tiers" of community authority. This regionalization model proposed Community Health Councils (CHCs) at the local community level which would report to Regional Health Boards (RHBs)—authorities comprised of representatives from all CHCs within a region. RHBs, in turn, were to be regional "overseers" accountable to the Ministry of Health. The composition of these committees was a mix of elected and appointed members as a means of ensuring they both broadly represented their respective communities and remained accountable to their communities .

In the design of this regionalization model, considerable attention was also paid to another of the new directions—"respecting the care providers", or the health care professionals. In attending to this issue, the Ministry of Health required RHBs and CHCs to establish at least three advisory committees. These included a Health Care Service Providers' Advisory Committee, a Medical Advisory Committee, and a Union Management Advisory Committee. The chairs of these committees were also eligible for appointment to the RHB or CHC they were advising. Thus the Royal Commission's health care management recommendations were re-framed and headed for major reforms not unlike those advocated by Faulkes in 1973—obviously ideas whose time had come.

When asked about the transformation of the Royal Commission's recommendation for decentralization of the bureaucracy into a community governance model, Ms. Cull acknowledged concerns that the recommendations which called for several "regional manager positions or 'super managers' could create almost 'czars of health care' who were not accountable in any way to the public" (personal communication, December 6, 1996). After the announcement of the health care reform strategies in 1993, much energy went into developing workable relations between the regionalization model's major participants, these being members of communities, governance volunteers representative of their community, health care professionals, local health care management staff, and the Ministry of Health. Despite these efforts, however, government officials and governance volunteers felt this process made few gains in 1994-95 and, if anything, the relationships between some of the major participants were rapidly deteriorating (E. Cull, past Minister of Health, personal communication, December 6, 1996; Anguish & Briggs,1995). The pervasive level of conflict was often discussed in terms of "resistance to change" at both the local institutional levels and at the Ministry, or provincial level.

The participants in this research, who were involved in the early reforms, saw this conflict particularly evident in two areas. First, between communities who were supposed to be working together through representation on RHBs, but who were individually taking much direction from local health care management staff and professionals. This was described as "turf wars". In other words, community representatives being primarily concerned about retaining whatever services and budget they had prior to the announcement of health care reform, rather than considering what might be best for the region as a whole. The second area of conflict was seen to be between communities and the Ministry of Health. In this area, at least four community governance committees were "dismissed" by the Ministry of Health between 1995 and 1997 for "not cooperating" with the planned reforms. Each of these dismissals were covered extensively by the media. As a result of this coverage, the dismissals became common knowledge of anyone involved in health care reform, thus offering clarity around the consequences of not "cooperating" with planned reforms.

Reforming the Reforms: "Better Teamwork, Better care"

In July, 1996, a newly appointed Minister of Health announced that the regionalization process was "too unwieldy", "focused too much on governance", and was "muddled". It is not completely clear who assessed it as such; however, in light of this appraisal, a task force of "caucus colleagues" was organized to review the progress of regionalization in this province (Ministry of Health, 1996b p.2). In November, 1996, further health care reforms were announced as a result of this review. These were to proceed under the initiative "Better Teamwork, Better Care". The proposed changes were focused on "peeling away the layers of bureaucracy and administration" (Ministry of Health, 1996b p. 5) by reducing the governance structure to a single layer of authority. This meant that a community would have either a CHC (in rural and geographically separated communities) or a RHB (in urban areas) responsible for health care service delivery, never both.

A major repercussion of this change in the governance structure was that it removed the requirement for geographically isolated communities in a region to work together. In the previous design, the CHCs in each community had a representative on their RHB who was responsible for participating in overall regional planning, and each CHC reported to that group of governance volunteers. Removing that structure placed these communities in relationships with one another where they were all "competing for the same health dollars" (I-200), but had no governing group responsible for considering what might make the best sense for the region as a whole.

Intentions to accelerate the process for transfer of authority to the community groups, and downsizing and reorganization of the Ministry of Health were also announced with this initiative. It was also decided to continue with an appointment process only for governance volunteers on these committees, thus removing the one third elected concept of the previous plan. And finally, the requirement for RHBs and CHCs to have the three advisory committees that represented health care professionals was also removed. In lieu of this, a physician and a union representative were to be appointed by the Ministry of Health to each governance committee.

With the Better Teamwork, Better Care initiative came a new emphasis on efficiency and cost-effectiveness and on local accountability for services delivered. In this announcement, the emphasis on greater efficiency and cost-effectiveness was notable in the plans for "improvements and reductions in administrative operations within the Ministry [which] will result in at least 28 million dollars in savings next year" (D-33-4) and in "cutting" the number of local governing bodies "by more than half" to reduce bureaucracy and management at the local levels (D-33-5). Accountability was to be achieved by setting "specific performance guidelines for the new boards and councils" (D-32). It is also argued that the Better Teamwork, Better Care initiative shifted the goals of health care reform away from New Direction's "broad focus on the health of the population to a more specific focus on the health care services" (Auditor General,1997 p. 7).

On a final note, in the spring of 1997, just as the process for transferring authority to local governance groups got underway, it was recognized by the Ministry of Health staff that the revised regionalization model had not considered the coordination of public, community and mental health services in rural areas. As these services were historically managed on a regional basis, the removal of a regional governance body from the structure in areas where communities were geographically separated meant there was no governance group for these services to report to. This recognition resulted in the hasty creation of Community Health Services Societies (CHSSs) in regions in the province that were without a regional governance body, a move that further obscured the modified model. At present, however, all forms of regionalization committees are functioning in a governance capacity.

Some Local Community Context

Under the Better Teamwork, Better Care initiative, the group of governance volunteers participating in this inquiry were transferred authority from the Ministry of Health in July, 1997 (D-47). The governance volunteers were not entirely a new group as most were involved in much of the New Directions activity from early in the reforms. In their governance capacity, the volunteers oversee service provided in an acute care hospital, an extended care facility and in a small residential mental health facility. All of these facilities are located in a northern community with a population of just over 22,000 people. This CHC is funded to provide the above services to their local community with the exception of the acute care psychiatric unit in the hospital which is designated as a regional service and is funded as such. This designation as a local, not regional, facility became a key issue during data collection. Finally, this being a rural area, there is a Community Health Services Society (CHSS) that oversees the public, community and other mental health programs provided in this town, but this Society does this separate from the CHC, and on a regional basis.

What makes the health care in this community perhaps unique is the collection of medical specialists which have accumulated in a relatively small town. This is relevant because, as noted earlier, medical care has dominated the health care system in Canada along side hospital care since the inception of the national program. This particular community is geographically located such that it has become a regional centre in a number of ways not directly related to the CHC's mandate (for example other government programs, head office for the CHSS, a retail centre). The central location may have also contributed to the collection of a core group of medical specialists and they as a group recruited other specialists to provide complementary services. At the time of this inquiry, there were fifteen local general practitioners, and twenty-two medical specialists providing thirteen areas of specialist care. For comparison, a southern rural "peer" hospital had twenty-six general practitioners and nine specialists offering six areas of specialist care, and a northern rural peer hospital had nineteen general practitioners and seven specialists offering seven areas of specialist care (College of Physicians and Surgeons of British Columbia,1998). In all, the collection of medical practitioners in the community involved in the study is a very unusual mix of medical services in a rural, northern town.

This information is pertinent to this inquiry as it directly relates to the situation the CHC members found themselves in as they began to take responsibility for health services delivered in this community. For the past number of years the local hospital budget was in a sizable deficit, most recently of approximately $300,000. This deficit was fairly easily accounted for by the notion that a portion of the acute care services were provided on a regional basis, as opposed to services provided to the local community only. The reason this was happening was directly related to the number of medical specialists practicing locally. The specialists would regularly receive patient referrals from communities in the region and these people would receive care in this CHCs facilities at this CHCs "expense". Again, I reiterate, that from the Ministry of Health perspective, this organization was not designated as a regional facility; therefore it was not funded to provide regional services.

In general, no local people begrudged providing people in the region health care services that were available because of the accumulation of specialists. Most "northerners", who know all too well the experience of having to travel long distances at considerable expense for specialist health care, firmly believe in the principles of "closer to home"—if the service could be safely and competently provided locally, then it was done locally. Throughout this inquiry, it was clear to me that the Council members never lost sight of the fact that they were not keen to forfeit any of the medical specialist services that the community had when they took on their governance role, but this possibility loomed throughout this research.

The "funded for local, but providing regional services" became an administrative issue when the Ministry of Health directed the Council to reduce the hospital's deficit from approximately $300,000 to $178,000 in their first year of governance and to a balanced budget the following year. The Ministry of Health staff assisted the Council and their management staff to develop an "action plan" to this end. Quickly, issues around "who gets what service", and "not accepting referrals from outside the funded community", abounded. Notably, one of the principles of medicare—accessibility—suddenly seemed to be up for discussion. This, amongst other operational issues meant to address the deficit, set the medical community, particularly the specialists, and the CHC/administration at serious odds.

Ironically, during this time another problem was unraveling. The general practitioners had concerns about the only regional service that the CHC was funded to provide, this being acute care psychiatry. Their concerns here included the inability of that program to maintain psychiatrists for consultation in the care of these people, the lack of any consistent rehabilitative programs for those receiving service, and problems with safety and security in the unit for both staff and patients. Due to these concerns, the general practitioners as a group elected to stop accepting referrals from the region until the service was functioning in a way they felt provided a reasonable level of psychiatric care. In essence, the organization was providing regional services it was not funded to provide, and was not providing the only regional service it was funded to provide. Needless to say, this drew much attention from the Ministry of Health staff.

As a result of both the deficit and the lack of regional psychiatric services, during this inquiry the Ministry of Health was reviewing the administrative/financial operations of the hospital on a fairly regular basis. There were designated Ministry staff who would visit every couple of months and review financial statements and statistics that were meant to reflect the hospital's activities, a level of scrutiny not experienced by other CHCs on such a routine basis. The organization was not under "public administration", so the Council and its administration were still "in control"; however, the presentiment that "the Ministry will come in" was increasingly taken-for-granted locally. As an observer, however, it would appear that the Ministry of Health was working very hard to avoid being seen as "taking over", effort that perhaps reflected a desire not to be perceived as "firing boards" who were not "cooperating".

Given the medical locus of the problems, the level of conflict between the CHC/administration and the medical staff gained momentum over the course of my data collection with the participants. This conflict was particularly tangible around a program the CHC and administration were implementing throughout the organization—Continuous Quality Improvement, or QI as it is called locally. The physicians initially agreed to participate in this program on a trial basis as part of the preparation for the accreditation survey the organization was scheduled for in May, 1998, four months into my data collection. Their agreement to participate in the QI process was contingent on a review at six months. The doctors insisted the review should include input from all those involved in the process, as opposed to a review by administration only, a demand that reflected the lack of trust between the two groups.

During data collection, there was also substantial conflict between other groups involved in health care, primarily within the hospital, and the administration. In general, the conflict seemed to be related to major facility changes such as the reorganization of the nursing units into one "amalgamated" unit with fewer beds for inpatient care—something that was causing considerable upset from several groups; budget cutbacks in various areas which were related to the agreement with the Ministry of Health to balance the hospital's budget over two years; and to the perception of some staff and doctors that within the QI process members of the multidisciplinary teams were not allowed any real decision-making power. During data collection I was invited to attend two meetings the hospital staff nurses organized in an effort to synthesize their concerns with patient care in order to articulate them to the administration. Several nursing representatives also attempted to meet with the CHC directly; however, that meeting was not held in the end as they were directed back to their department manager.

Finally, all of this was occurring at a time of considerable unrest amongst rural doctors in the province with several communities in the north without medical coverage after hours in protest of on-call obligations. Other health care professionals were also involved in job action as they negotiated contracts. With all of this, the Government and the Ministry of Health were under growing criticisms that the health care system was "in crisis". The local medical group undertook a sizable media campaign which fueled that concern locally, drawing even more Government attention to the health care in this community.

In all, it was a time of flux for the community governance volunteers as they took-up their governance role within the revised regionalization structure. As I collected data with this group, they were having to respond to the many events and pressures around them and to a high level of scrutiny by the Ministry of Health staff. As will be shown in the next two chapters, these events and pressures shaped how the discourses of health care reform entered and affected the decision-making work of the community governors serving on this health care governance committee.

CHAPTER FOUR

Health Care Reform:

Engaging Communities in the "Production" of Health Care

As the effects of health care reform are playing out at the local level, so are conflicts between the various players involved—community members, governance volunteers, health care professionals and management staff at local and provincial levels. In the following analysis, the move from a "community oriented" health reform process, as is discernible in a review of early Ministry of Health documents and in participant interviews, to a progressively "business oriented" approach to the management of health care first becomes evident in the contradictions community representatives experience as they work at making decisions. These contradictions include the governance volunteers' troubles with inadequate time for the process of governance, inadequate information for decision-making, and in two aspects of their relationship with the Ministry of Health staff—these being the experience of an "undemocratic" decision-making process and a requirement to manage by implicit expectation.

In light of these contradictions, the "new" health care management setting is explicated through an examination of the documents that are now organizing the activity of community governance committees. From this analysis, a discourse of "production" is distilled as being privileged in the health reform documents and in the priority activities of governance volunteers. The sense of powerlessness the volunteers express in this new setting represents a collision between the governance volunteers' understanding of their role as a community representative and the role of "production manager" being applied to them. In contrast to this perception of powerlessness, however, the extent to which community representatives are participating in powerful technologies of competitive business management methods requires discussion.

A Discourse of "Community Participation"

In early provincial health reform documents that were setting the direction for changes to come, a discourse of community participation is quickly evident. True, early Royal commissions and inquiries into the health care across Canada acknowledged the "need to build more management and accountability into our [health] system" (CBC,1994 p.23), and British Columbia was no exception. Comment on efficiency, costs and better management were included in British Columbia's overall reform plans; however, the discourse of "community participation" held a dominant place in documents and discussion (D-9;D-10;D-11). The lead health reform document, New Directions for a Healthy British Columbia (D-9), described "greater public participation" and "bringing health closer to home" (D9-13,14) as central to the changes ahead. In this, communities were to "take the lead" and the Ministry was described as planning a "consultative, developmental approach" with "implementation at a pace that meets communities' needs and allows us to learn from the approach" (D-9→D-16).

In one of the many single "facts" sheets released by the Ministry of Health for public information, reforms were described as moving

> decision making for health care from Victoria and into the communities where it belongs. Services can be planned and customized in a way that suits community needs and priorities. Who better than knowledgeable, local people to plan, integrate and manage services within their own communities and regions. (D-12)

This description frames the process for those involved in community governance in a particular way. In provincial legislation that enabled the planned health care reforms, the Health Authorities Act (D-25), a community governance committee was granted the autonomy to "determine its own procedures", to "provide for the control and conduct of its meetings" and to "elect officers…including the chair" (D-25).

In supporting documents such as A Guide for Developing Community Health Councils and Regional Health Boards (D-29), community governance, or regionalization, was intended to "provide a democratic planning process for the identification of health priorities and allocation of available resources in a way that best meets local needs" (D-29-3). This particular document suggested use of "community development principles" as adapted from the Healthy Communities Program and championed involvement of those who traditionally have been underrepresented in governance (D-29-10). Examples offered of people traditionally underrepresented in decision-making include aboriginal peoples, persons with disabilities, youth, seniors, and women (D-29-11). All of these Ministry of Health documents were clear in their emphasis on community participation/governance early in the reform movement. These same expectations of community participation and autonomy were also easily detected in participant interviews.

In the individual interviews completed, there was an expectation of wide community representation and involvement within the governance process, an impression patterned from most of the participants' early involvement in the health care reforms. This expectation is captured in the following comments:

> "when we were first setting up and I was actually a bit enthusiastic because I thought, you know, compared with the way it was before, we are more broadly represented. And I was happy about that and I thought there was variety at the table in terms of, who knows, all aspects of life, political perspectives, all sorts of ages, some variety in ethnicity—even though it could be better—those types of things, things that have never been there before"(I-42);
>
> "the beauty of this structure is to meet the local needs with the local input and addressing all the local concerns..."(I-95); and
>
> "we are widening the circle of discussion, not so much to make the decisions, but to have an understanding of what decisions get made..."(I-114).

The participants' sense of the intentions of the process to be inclusive of their broader community, and as encouraging local autonomy in decision-making, was consistently clear. During these interviews, and in observations of meetings, the participants communicated an obvious understanding of how the governance structure was intended to work, and that this had much to do with why they were involved in the process. In this community governance structure they thought they would be able to govern differently than groups might have done in the past. It was evident, however, that most were struggling with "making it work" in a way consistent with their understanding. How was it that something that sounded so good in theory, and was well supported in the surrounding initial discourse, could be posing such conflict in practice?

Contradictions Emerging: Signaling Incongruency or a Changing Process?

The participants' struggles with contradictions between their understandings of how the process was supposed to work (as communicated in early reforms), and how it was now working in practice, were notable in the interviews and during meetings. The problems they were experiencing were not all entirely new, for as noted, most of the participants were involved in the health reform process from early on. Although the documents collected for analysis included Ministry of Health publications representing the introduction of the health care reforms, data collection did not include information on how the process worked in practice in the initial stages. Regardless of this, the difficulties the governance volunteers revealed in interviews included a sense of inadequate time to do their committee work, grappling with information needs for decision-making, experiencing an "undemocratic" relationship with the Ministry of Health, and having to manage by implicit expectation on a day-to-day basis.

Time, and more specifically the lack of it, as a trouble was revealed in the conflict between the time needed to be doing the "process", which people considered to part of this type of committee work, and the pressures to attend to "board business". This conflict is captured in the following comments:

> "you need to take time to hear other people, you need to take time to help other people come on board and to make them feel part of the group....but there are these [other] demands and pressures that interfere with getting

> on with that kind of work, these sort of crisis, one crisis after another...(I-42);
>
> "I am not given time to know what the real issues for [names group] are [before we have to make a decision]" (I-71);
>
> "due to time constraints...you never fully deal with any issue, you just sort of gloss over it and get on to the next order" (I-195); and
>
> "it is a very honorable notion that we ask people who utilize the system to partake in its governance, but I think in all truthfulness, in order for those people to do that appropriately and adequately, we need time to seek out perspectives that we may not understand inherently" (I-291).

The volunteers' comments imply that they are not able to do what they understood they were to do in a way that fit with the values they brought to the activity. This reality contrasts sharply with early documents that assured implementation at a "pace that meets the communities' needs and allows us to learn from the approach" (D-9-16). What the governance volunteers valued was having time to talk to other people before having to make decisions, and having time to hear what other people in their community thought about any topic, as this was information they felt would be important to their decision-making. In this, they were taking seriously that they should not assume to understand other peoples' perspectives or the effects their decisions might have on them. They understood community governance was supposed to work in a manner consistent with this kind of environment. Not having time to do their work in this way implies the governance volunteers were being kept very busy with other activities and, of course, the question becomes—what were those activities all about?

The participants' concern with information, and what was needed to make the decisions they were being asked to make, had two components. First, there is the kind of information one gets before meetings in "board packages" and secondly, there is the ability to access your "community" for information. As a group, the Council members asked the administrative staff to routinely share more organizational information with them, a request that was certainly being obliged as was evident in the weighty monthly board packages.

Many of participants expressed difficulty, however, in assimilating that information due to its technical nature and the large volume given to them, often within a day or two of a meeting. As one person put it, "it takes a certain type of person, first of all, to be able to absorb everything..."(I-138). This comment identifies a possible barrier to participation of the broader community, particularly to those noted as traditionally underrepresented in governance in the past, and to community members who may have had less formal education.

Other participants characterized the problem as one where they are "chucked full of information" (I-7); as getting a "pile of information" (I-16); as "getting lots of paper" (I-110), or as the information being filled with "non-accessible language" (I-295). The issue here was the extent to which the information they did get was relevant to their decision-making, as they understood this activity, or was it relevant to another understanding of their work? As researcher, having reviewed the packages prepared for each month's public meeting, the technical information therein is primarily management information intended both to provide an account of the more formal interactions with the Ministry of Health staff, and an account of the organization's activities for the past month. Regardless, this type of information was plentiful, but that which the participants valued, input from their community, proved harder to access.

The difficulty in accessing their "community" for information emerged in a number of ways. The issue, according to one participant, is that when making a decision, there is no means to just say "Stop, I want to talk to these people about this issue because you can't just talk to people about an issue...you don't have a forum for that discussion" (I-100). The general concerns raised from this observation are articulated in similar comments:

> "We are making decisions based on, well, based on how we feel I guess as much as anything" (I-192); and
>
> "I wish I didn't have fifty minutes to make decisions where essentially all that I can bring is my personal perspective....which makes it dangerously disconnected from our community and dangerously connected to our own personal biases and morals" (I-297).

In the meetings I observed, frequent comments were made about the need to "organize our communications better" (PM-2-40→46). These comments were about developing ways to access regular information from different groups within the community, to be active in "soliciting" information, as opposed to being "passive recipients" of information. The frequent solution posed was the development of a network of advisory committees; however, the group was not able to get on with this plan in the first year and half of their appointment, again due to time constraints. The lack of the broader community input constituted a problem for most participants who, although quick to point out that they are not on the committee as an advocate for an "organization or group" (D-43), all took the sentiment of community representation very seriously and found their inability to do this a regular source of frustration.

Within the discourse of community governance so prevalent in early reforms, knowledgeable local people were to "plan, integrate and manage services within their own communities and regions" (D-12). It was assumed in the health reform literature that the process that would emerge from the reforms would be a "democratic" one. In the interviews with community representatives there was no shortage of comments on the failings of this democratic process as they have experienced it to date. The difficulties in being "heard" by the health care bureaucracy when the "bureaucracy" had already made its mind up were clearly articulated in the following few samples:

> "I feel like we are just talking to four walls and nobody is hearing us, no matter how hard we try to let them know that it is needed here [referring to Ministry of Health staff], that if it wasn't needed we wouldn't talk about it..."(I-14);
>
> "I think the Ministry [of Health] is really entrenched in that attitude....and I don't think there is any point in going to the wall if the wall isn't going to move anyway" (I-111);
>
> "We are sitting in a situation where the Ministry, the overseer, just says 'do it or else'" (I-64);
>
> "There seem to be these barriers up where people feel they dare not cross....It seems like it is heavy handed...it doesn't seem to be a very free exchange of ideas and comments between the board and the government..."(I-6);

The confusion participants felt around this issue was striking. In general, the feeling was that early in the reform process there was little direction given by the Ministry of Health as communities attempted to work out their governance process. Practice was perceived as having changed more recently. As one participant said:

> Participant (P): "[I used to think] aren't those guys nice [referring to Ministry of Health staff], putting this wording out for us so we don't have to do all the work."
>
> Researcher (R): And now you see it as not being as flexible?
>
> P: No, it is all propaganda, you know. (I-53)

As these comments reflect, participants felt the relationship with the Ministry of Health staff had changed over the years with the increasing "direction" they now experience as to how things are to be done.

A difficulty the governance volunteers were encountering in this area was that little of this Ministry of Health direction was explicit, meaning it was never "in writing", or told to the participants as a group outright. It more likely came to them, for example, in a decision returned to the committee as not approved, or one that "didn't go through" (I-53), or as verbal information via the chairperson or administrative staff (I-130). The implicit nature of expectations came up, for example, when I asked one governance volunteer how the group goes about making decisions. The following is an excerpt from that interview:

> P: [regarding decisions] given the constraints of the Ministry [of Health], I almost think it is impossible. We don't make any independent decisions. If we make a decision and it is not approved by the Ministry…[indicating the decision is overturned], it is as clear as that, do you know what I am saying?
>
> R: Is that explicitly stated somewhere?
>
> P: Oh no, like this is, yes it is unstated

> R: So it is unstated, but you are all clear about it in the work that you are doing [referring to Council members]? Or how does it come up?
>
> P: I don't know if people were all real clear about it, but I would assume they are now by all the experiences we have had with it.
>
> R: ...so if you made a decision and they [referring to the Ministry of Health staff] didn't agree with you, how would that come back to you? Or how would you know that?
>
> P: Oh, they [referring to Ministry of Health staff] would just sort of communicate to us, they are quite blatant about it.
>
> R: Do they communicate directly with the Council?
>
> P: Oh they do it in a variety of ways, they might communicate with [lists names of Chairperson and CEO], sometimes it's a letter from so and so.
>
> R: And you get told "sorry that is not on, go back and do it again"?
>
> P: Oh yes, sometimes it is verbally...and my perspective is this is just clear cut. Like, we are just simple pawns and that is it. (I-49,50)

In this example, the notion of having to make decisions according to the implicit expectations of the Ministry of Health staff was evident. Contrary to what is said, however, the expectations are not "blatant" in the real sense of the word as most participants had difficulty articulating exactly how this information was communicated to them. They understood the expectations as being "blatant", however, through their experiences with having "the wrong decision" returned to them a number of times, in a number of ways.

As another participant put it, "You have to read between the lines a lot" (I-230). The way this situation was seen to pose a problem is summarized nicely: "you have these bureaucratic people making demands of us that are kind of contradictory to the philosophy of the Government that is in....To me that is kind of interesting. It has made an interesting situation" (I-43). The impression left was one that indicated that, as one participant verified:

> "almost all of what they [referring to the Ministry of Health staff] do is verbal and you find that whenever you do get something in writing, it is very much the political line and...what is in writing very rarely waivers or changes, but the verbal part, which a lot of this is done on, takes on all kinds of twists and turns" (I-265).

Another example of expectations becoming known in less than explicit ways surrounded the use of Robert's Rules of Order to conduct meetings (Patnode,1989). A number of the participants did not support the use of formal rules of order as they felt it limited their ability to engage in dialogue that would allow them to learn from one another (I-9;I-54;I-110). Given that in the Health Authorities Act (D-25) noted earlier, a governance committee has the authority to "provide for the control and conduct of its meetings", technically the group could choose a different, and much less formal, method by which to conduct their meetings. The Ministry of Health's model bylaws, however, suggest use of Robert's Rules and the Ministry staff routinely requested "board approval in the form of a motion and the chair's signature" (D-42-12) on various issues (for example on passing budgets, bylaws, health plans etc.). Within the context created by these implicit expectations, it is evident that the use of a formal mechanism to conduct meetings became less of a choice for the governance volunteers.

As researcher, a number of times I also found it difficult to obtain, in writing, information on various events as they unfolded. This was not, to my mind, at all related to people being reluctant to share information with me. I believe the problem was that there was nothing concrete to share. Interestingly, this situation changed somewhat toward the end of my data collection. In the few months following the completion of my interviews with the participants, documents which reflected what I was hearing in the "decision-making talk" materialized from the Ministry of Health. These documents, which began to define explicit expectations of the governance volunteers, are included in the documentary analysis of the next section.

The governance volunteers' struggles with inadequate time, inaccessible information, not being heard, and having to regularly "read between the lines" for the certain direction hidden therein were worrisome and contrary to what is said to be happening in the regionalization process. Community participation language remains in the discussions of health care reform today, but it is being made less relevant to the decision-making of governance groups. In this analysis, the repetition of these contradictions was striking. What are the conditions that allows such contradictions to continue? This question lead to a review of the documents organizing these reforms since the announcement of the Ministry of Health's most recent plan, Better Teamwork, Better Care. The following analysis was undertaken with a view to determining what discourses hold a privileged position under the Better Teamwork, Better Care initiative, and whether these have changed under this "new direction".

Better Teamwork, Better Care: Launching the "Business" of Health Care

Despite much effort and time, the early reforms engendered by the community participation discourse were assessed by the Ministry task force commissioned by the new Minister of Health in 1996 as making little progress within the "developmental approach" taken by the Ministry of Health. Whether there was movement away from this philosophy as the dominant approach prior to the announcement of the latest Ministry of Health initiative—Better Teamwork, Better Care—is unclear from the materials available to me; however, this announcement provides a marker for change in the discourses privileged in reform health care. With this shift in health policy, and the events that flow from it, the application of business principles as a new way to manage health care becomes visible as it plays out in the everyday activities of these governance volunteers.

From the beginning of the Better Teamwork, Better Care approach, issues central to health care reform were attached to, or couched in, business language. Such references were not new to the health reform discussion, they simply were not prominent, certainly not ubiquitous in early reforms. According to the initial Ministry of Health press releases, the Better Teamwork, Better Care initiative was to offer a "simpler, more streamlined approach", it would "focus more on people, not process; [on] services, not structure" and would provide "innovative, high quality care". Additionally, there was an emphasis on achieving a new level of "team work" and "best practices" in health care.(D-32).

When the new roles of community governance boards were defined under this approach, they were first noted to have the "potential to achieve significant cost savings through consolidation and rationalization of services and economies of scale" and as having the "opportunity to find efficiencies and savings which can be used to improve local patient services" (D-35). Incidentally, within a few months of the announced changes to health reform, a Ministry of Health community development program, Healthy Communities, was also canceled (D-3-44), perhaps further signaling a change in overall Ministry of Health direction. Business language is not, however, limited to fiscal issues as became clear over the two years following the launch of this "new" direction.

Better Teamwork, Better Care was announced November, 1996. Transfer of authority to governance committees began in April of 1997 and was complete by the end of that year. This group of volunteers was appointed, really a "re-appointment" of the previous group, to govern in July,1997. Very early in the Better Teamwork, Better Care reforms, the Office of the Auditor General of British Columbia undertook a review to assess "what mechanisms the Ministry of Health has put in place to achieve effective governance and accountability for performance" (D-57-1) as responsibility for the delivery of health care, and accountability for achieving the objectives of regionalization, were transferred to local or regional governance bodies (D-5-6). The Auditor General felt this was important to assess as approximately four billion dollars, or just over half the provincial health care budget, was being placed in the hands of community governance committees. A review was completed in this case, as opposed to an audit, "because there are no generally accepted standards or benchmarks to compare performance [of the health authorities] against" (D-57-5). The results of this study were released at the very beginning of my data collection with the participants.

The Auditor General's report made a general observation that Better Teamwork, Better Care's goal of "improved health care for people....shifted the system from a broad focus on the health of the population to a more specific focus on the health care services provided to the people of British Columbia"(D-57-7). Overall, the Auditor General concluded that "certain key components of the governance and accountability mechanisms necessary for the ministry to determine whether the objectives of regionalization are being achieved needed to be established" (D-57-6). Among these were the Ministry of Health's need to "communicate a vision and strategic direction", "clarify roles and responsibilities", "review planning processes...to achieve efficiencies", "develop clear performance targets and evaluation measures" and to "reassess accountability reporting needs" (D-57-6).

A key issue picked up in the media from this report was the criticism of "the way the ministry selects and appoints people to health authorities", that this needed to "be improved to ensure that the best qualified people fill the positions" (D-57-6,7). More bluntly, the Auditor General recommended that "the competencies required of individuals to serve on the authorities, as well as the competencies required of the board as a whole" (D-57-12) should be established and as well, that criteria was needed "for selecting members with qualifications to be able to govern effectively" (D-57-12). Apparently gone is the populist notion that celebrates the "wisdom of the ordinary citizen" who can draw on her own health experiences in the role of community governor and in its place another variant of Scientific Management thinking-in-use emerges.

In this review, the assessment of the health care reforms as a system not unlike a business, is demonstrated in the seeking of standards for assessment of performance, in the need for strategic planning, performance indicators, performance targets, and evaluation measures to assess efficiency, and in the clear requirement for concrete means of making people accountable for their responsibilities within the system. Many would argue that none of this is necessarily a bad thing in and of itself. The question of how such demands are taken-up in organizations, and how they materialize in everyday health care experiences and governance, is what becomes relevant to this inquiry.

At the time of release of the Auditor General's report, the Ministry of Health responded to the review's conclusions offering activities that were underway to address the concerns noted in the report. These activities included the development of "performance indictors that will be used to measure and monitor the performance of health authorities in their management and delivery of the health services they govern"; "establishing…eligibility criteria for health authority membership"; an "Accountability System for Health Care in BC"; "standards for acute and continuing care programs"; the "Health Services Management Policy…that defines ongoing conditions of the government's delegation of authority"; "the Health Authorities Governance Policy Manual"; and arrangements for "education and training of health authority members" (D-57-62). And indeed, in the last few months of my data collection with this group of governance volunteers, documents explicitly outlining expectations of accountability and health services planning and evaluation began to emerge from the Ministry of Health, and came to the governance volunteers via their monthly board packages.

In both the Auditor General's review, and the Ministry response to it, the increased reliance on business descriptors is notable. Although it is possible this business tone was becoming evident prior to the launch of Better Teamwork, Better Care, it certainly took-up an increasingly prominent place in the discourse of health care reform in the two years following this announcement. As I will illustrate in the next section of documentary analysis, business terms and the use of scientific means for evaluating and improving "performance" are becoming taken-for-granted activities in the management of health care.

Managing Health Care as a Business: A Taken-For-Granted Mode of Operation

The documents reviewed in depth in this part of the analysis include the Accountability Framework for British Columbia Health Authorities (D-39) and the document it was based on—Enhancing Accountability for Performance: A Framework and an Implementation Plan (D-58); and British Columbia's (draft) Guide to Health Services Planning for Health Authorities (D-42). Other documents informing the analysis include policies from the Ministry of Health's Governance Policy Manual; the governor orientation manual, Governance for

Health (D-43;D-44), and lastly, the revised eligibility criteria for governor appointment. In the review of these documents, the purpose is to demonstrate the shift to a "business orientation" in the information directed to, and now governing, the activities of community governance volunteers. "Business oriented" information is understood in this research to be information that constantly emphasizes financial issues and that privileges logical, or "rational", knowledge above all other ways of knowing.

In the Ministry of Health document, "Accountability Framework for British Columbia Health Authorities" (D-39), the broad purpose was "to support understanding of one important aspect of our new health care system—accountability—in the hope of fostering a health system that is responsive, affordable, and viable for the future" (D-39-2). In the introduction of this document, the "twin principles" of autonomy—"the ability of health authorities to determine how to manage services"—and accountability—"[doing] so within certain boundaries" (D-39-1) are offered as the basis of regionalization. This document intends 1) to clarify the roles of the various players in regionalization (D-39-3,4,5); and 2) to redefine accountability which in the past focused "on the financial results of operations and on specific service sectors", a locus the authors felt was "not sufficient to assess whether a system or organization is performing well" (D-39-8). The goal outlined is to develop a foundation on which it is possible to "set performance expectations, measure results, and ensure that the right people and organizations are held accountable for achieving the desired results" (D-39-8). How the various governance documents mutually reinforce one another and the "accountability cycle" are also outlined.

The "accountability cycle" is described as beginning with the expectations as articulated by the Ministry. These include enduring expectations (compliance with legislation and policy) and those subject to periodic revision such as strategic direction and priorities (now called "Annual Advice" D-39-12). Health authorities are to engage in a cycle which encompasses the following processes: multi-year health planning and annual reporting; managing and improving services; reporting to the Ministry and public as requested; "evaluating performance against intended results"; and finally, "improving performance" through the use of evaluation results. For its part, the Ministry of Health will monitor health authorities to ensure that its expectations are met. Under monitoring, it is noted that if "variances" in a health authority are noted by the Ministry, "a progressive set of consequences will be available to assist in improving performance" (D-39-13,14,15). The consequences outlined range from aiding health authorities with "action planning" to the appointment of a public administrator as a last resort. Between these are options such as "training and resource development", "incentives and penalties", and "expectations realignment". Much of the business language herein proposes a significant and deliberate shift in health care reform discourse. The document this framework is based on, Enhancing Accountability for Performance, is much more explicit in its advocacy of the application of business principles to the management of publicly funded health and social services.

Enhancing Accountability for Performance: A Framework and Implementation Plan (D-58), is an Auditor General of British Columbia publication which lays out a framework to guide "the whole government in reporting more fully on its performance" (D-58-1). In this, accountability for performance is something that is seen as generally lacking in government programs by the Auditor General—guardian of the public purse. According to this Office, "to be accountable, government must be clear about its objectives, explain the strategies it will use to meet those objectives, reveal the full costs of these strategies, and report on its actual results" (D-58-10), thus being accountable for performance. Notably, this definition is very similar to that of a "business plan" which is offered in the document's glossary of terms. There a business plan is "a document prepared for a program or organization that describes its objectives and identifies the activities it will undertake to meet those objectives, the allocation of resources to those activities, and the measures that will be use to indicate progress toward the achievement of the objectives" (D-58-85).

In reviewing this accountability framework, it is noted in the executive summary that evaluation of performance "in the business world...is much simpler. The struggle for survival forces companies to make sure they are offering the right product at the right time for the right price" (D58-9). It is acknowledged that government programs have "no comparable operational consequences....[as they usually] have a monopoly on the goods and services they provide to the public" (D-58-9). The move to "performance-based accountability" as outlined in this document is recognized as "a paradigm shift...and will require a fundamental change in how government does its business" (D-58-11). In the implementation plan that accompanies the accountability framework, Deputy Ministers of government ministries are identified as "having the main responsibility for creating the right environment to make change happen" (D-58-13).

Throughout the Auditor General's accountability framework (D-58), business language abounds—accountability is a "contract" between two parties, there is emphasis on "production of multi-year plans", "performance", "objectives", "strategic direction" and better "costing". Performance is described as being "results oriented" and multi-year business plans are to include "performance measures and targets" as a means of evaluation (D-58-12). Finally, it is recommended that key "cycles" of accountability—budget planning, business planning, and strategic planning—be integrated and synchronized (D-58-64). And indeed, the recently released (draft) Guide to Health Services Planning for British Columbia Health Authorities (D-42) begins to establish that performance accountability cycle for governance volunteers, a tangible sign of the Deputy Minster of Health's efforts to "create the right environment to make change happen" (D-58-13).

The Ministry of Health's (draft) Health Services Planning guide is to be "read in the context of the...Ministry of Health Accountability Framework for British Columbia Health Authorities" (D-42-1). In this document the cycle of planning proposed begins with the development of a three year plan "outlining major system changes anticipated". "Timelines for completion" of these plans are set for the various governance groups (D-42-6). The "planning cycle" will then consist of 1) an annual report on progress and selected performance indicators (these have yet to be defined by the Ministry of Health); 2) amendments to the three year plan (if required); 3) an annual new third-year plan, to complete the three year period; and 4) a Funding and Services Expenditure Plan consistent with the detailed directions provided by the Ministry of Health with the Annual Budget Letter (D-42-7). Also required are details of how the health authority will communicate the plan to "ensure ongoing, meaningful dialogue with the public and maintain their confidence in and support for the change to the health service proposed in your plan" (D-42-11). The Ministry of Health staff will hold a role of reviewer and consultant during the development of plans, particularly when health authorities have "areas of significant change under consideration" (D-42-12).

All of these Ministry of Health requirements are reviewed in a "summary of deliverables" (D-42-11), thus completing the construction of what amounts to a "business plan" for the health authorities in which mechanisms used by the Ministry of Health in "managing" are "passed down" to governance volunteers. Finally, the "consequences of non-compliance", as these are progressively outlined in the Accountability Framework (action planning →training and resource development →incentives/penalties → expectations realignment →public administrator), are again offered rounding out the terms of this "contract" and thereby ensuring there are no misunderstandings of the expectations of governance volunteers.

The consistencies and effects of the language in the Auditor General's initial accountability framework (D-58), and the criticisms in that office's review of regionalization (D-57) which placed public pressure on the Ministry of Health to perform in a more business-like manner, manifest in both the Ministry of Health's Accountability Framework (D-39) and in the (draft) Health Services Planning Guide (D-42). Requiring a mode of operation where everyday activity is increasingly subjected to calculations as a means of eradicating "the mystery, emotion [and] tradition" (Marshall,1994 p.437) in organizations was something that was studied by Max Weber and is known as rationalization. Weber critiqued this propensity of modern organizations to require that all knowledge be expressed in the form of calculations which, although aimed at increasing control of organizational activity, ultimately enslaves individuals to the resulting rules and procedures, thus imprisoning them in the "iron cage" of institutions (Mills & Simmons,1995). In light of this history of organizations, and as well, the relationship between the Legislative Assembly—which the Auditor General's Office reports to—and the Ministry of Health, one must question the extent to which these criticisms of regionalization are suggested improvements, as opposed to demands for evidence of the correct direction taken.

As demonstrated in this document review, business-oriented methods and mechanisms hold a privileged place in the information directed to those governing and managing health care. What is concerning here is the lack of consideration and discussion regarding the fundamentally different conditions operating within health and social service programs compared to a business that provides a telephone service or an electrical service, for example. Regardless of the lack of this important discussion and recognition, much of what was beginning to take form in writing, in these documents, was already being brought into practice. The business-like language contained in these documents was increasingly becoming part of meeting minutes, and the correspondence contained in the board packages, and in this governance committee's activities over the course of data collection. The "business of health care" was, therefore, emerging in the "talk" of the governance volunteers and within the committee activities that received priority.

The "Business" of Governance Volunteers

Dealing with finances, strategic planning, quality improvement processes, and the decision to "move to a corporate structure" are examples of committee activities that speak to the influence of first, an increasingly business oriented discourse and secondly, the organizing documents that followed the elevated profile given to business "talk". Dealing with finances or "accounting for the use of funds", consumed much time and attention of the governance volunteers, partly because of the scrutiny they are under from the Ministry of Health, but also because, as most of the governance volunteers pointed out, without money what can you do? Failure to meet the agreed upon "budget targets" near the end of their first fiscal year resulted in the first significant decision that offered an example for discussion in the individual interviews. A decision was made to close the operating room for one week and to shut down a radiology service, the CT scanner, for two weeks, events that caused much upset and conflict both within the organization and within the community. The decision to "cut services" was made to deal with the large budget "variance" that showed up suddenly in the last quarter of the fiscal year.

"Traditionally, accounting is defined as a technique of quantification or calculation which is an important prerequisite for the smooth functioning of a modern business" (Power & Laughlin,1992 p. 114). Defined this way, accounting is technical "work", is viewed as neutral information, and is taken-for-granted as facilitating decision-making. The economic reality that accounting statements offer is assumed to represent objective information, a perspective increasingly challenged by those engaged in critical management studies (Power & Laughlin,1992). Much governance volunteer time was spent, however, on reading complicated financial statements that few could understand and on trying to account for the organization's activity within a financial context. Attempts to meet "budget targets" without affecting services were a significant focus throughout data collection and the financial statements, as information, held a position of privilege in all decision-making activities . Most of the participants noted the budget as their "greatest challenge", or as one participant said, "we are ultimately accountable to our budget, it strikes me, in a very absolute manner" (I-298).

Another activity that consumed much governance volunteer time during the data collection was strategic planning. Strategic planning is defined as the "process by which an organization plots its future course of direction" (Costello,1994 p. 23) and is a concept of "competition" that is increasingly being attached to management, as in "strategic management" of an organization. At the outset of my data collection this group was just beginning their "strategic planning", something they were expected to do by the Ministry of Health. Over the course of four months, seven sessions, amounting to over twenty hours of direct participation time, were held to do this activity. This time was in addition to the regular committee work and many participants found the overall commitment onerous. At about the same time, the parallel regionalization governance committee in this community, the Community Health Services Society that oversees public/community/mental health programs, reported to the CHC members the completion of their strategic plan as well. Strategic planning, as an activity, was obviously in the air.

A further example of committee activity that flows from applying business and accountability solutions to health care relates to the quality improvement processes that both the national health care accreditation council (Wilson,1992) and the Ministry of Health expect health care facilities to take-up. Continuous quality improvement (CQI) is the health care/social sector adaptation of Total Quality Management (TQM). TQM is the industry-based version of this "management method and management philosophy" (McLaughlin & Kaluzny,1994 p. 4).

In the business world, strategic planning and quality improvement processes have been, for some time, closely linked management proceedings. CQI is defined as "a structured organizational process for involving personnel in planning and executing a continuous stream of improvements in systems in order to provide quality health care that meets or exceeds customer expectations" (McLaughlin & Kaluzny,1994 p. 3), a definition commonly criticized as intended primarily to improve efficiency and cost-effectiveness of work processes (Gerlach,1996). CQI emphasizes analysis of the "whole system providing a service or influencing an outcome" by "gathering and use of objective data on system operation and system performance" (McLaughlin & Kaluzny,1994 p. 6), thus revealing scientific methods as the preferred means toward improving efficiency and cost-effectiveness.

Much work went into implementing CQI throughout the organization, partly in preparation for upcoming facility wide accreditation. In CQI, the lead committee is at the governance level—in this case called the Establishing/Implementing Strategic Direction Committee. These committee meetings were organized on a monthly basis and minutes were forwarded to the board packages accordingly; therefore, the Council members were routinely appraised of activities in that area. In the five months of data collection around public meetings, this was the only committee that contributed minutes to each board package, a consistency speaking to the priority it held in activities of the governance volunteers, or in whoever was organizing these activities.

The last example offered of the effects of the consistencies of the business language converging at the governance level is the decision to move the organization to a "corporate structure", or a reorganization of the CHC's organizational chart. This decision was made in the spring of 1998, around budget time, and as a result of pressure from the Ministry of Health staff to be "seen to change" (I-282) to a more efficient organizational structure. It did not result in fewer people working in the organization, but there was an "implicit expectation for a greater sort of corporate thinking" (I-282). Greater corporate thinking was described as eliminating the need for two or three people to make a similar, but independent decision around a work process. Rather, the work was reorganized so that only one person would make such a decision, and with this increased efficiency is assumed. In undertakings such as these, the discourses borrowed from the world of business were easily traced to everyday committee work of governance volunteers.

The business management discourse of "production" dominates in the documents now organizing governance committee activity. This information, in tandem with the large amount of technical information given to governance volunteers in "board packages" at committee meetings (D-1→D-6); Ministry of Health policies which define in detail the "conduct of health authority members" (volunteers are required to sign this); revised appointment eligibility criteria which is attaching importance to the "competency (knowledge, skills, abilities)" of community representatives (D-43); and plans for "educating and training" health authority members (D-57-62; D-45) are all explicitly altering the "work" of governance volunteers. Business management as a taken-for-granted way of organizing this work increasingly requires a governance volunteer to have the skills of a "manager" for entrance to a board position.

A Discourse of "Production": Inculcating Governance Volunteers

Given the increasing volume and the ubiquitous nature of the business language swirling around governance volunteers appointed to the health authorities, it is readily understandable that this "talk" is permeating their discussions and decision-making activities. From the individual interviews, some of the more obvious examples include:

> "[you have to] remove all the fat and inefficiencies and the system will be leaner and meaner and good for everybody" (I-92)
>
> "you have to start running this place as a business now" (I-234)
>
> "they [referring to the Ministry of Health] don't want to be involved in the delivery of health care anymore, yet because of their fiscal interference they are intimately involved" (I-81)

Additionally, in governance meetings, the activities of the group are routinely referred to as "board business" and intrusions into this (like people wanting to talk to the group who have not requested this in advance) resulted in a "fairly strong feeling that our business was being...hijacked" (I-36).

This business orientation also manifests in more subtle ways. The increasingly visible image of "competition" within the discussions and activities of the Council members is another manifestation of this underlying force within health care reforms. This is notable in different ways in the following participant comments regarding the group's disappointment in the budget increase for the year 1998-99:

> "[Lists nearby communities], we are all competing for the same health dollars" (I-200)
>
> "we got [states budget amount], that was more than anybody else got" (I-229)

These comments indicate a knowledge of what other health authorities are doing, what their funding levels are, and how this one is faring in comparison. The presence of competition between health authorities is also revealed in attention given to "being ahead" of other regions in getting together with other health authorities to begin regional planning and coordination of services and in dealing with budget issues. Ministry of Health approval of this competitive behaviour is communicated to the group, often by way of administrative staff, and appeared to be valued by the participants.

The emphasis on establishing a strategic plan and direction is also a manifestation of the increasing role of competition in public services. The word "strategic" invokes images of military campaigns for achieving victory. This activity's roots in "battle" and "army" language are readily acknowledged in texts on the subject where it is described as "a disciplined effort to produce fundamental decisions and actions that shape and guide what an organization (or other entity) is, what it does, and why it does it" (Bryson,1988 p. 5). Another mainstream text on the topic describes the foundations of strategic planning and management as including "the concept of strategy, the process of strategy formulation and implementation, and the transition from plans to actions" (Lloyd-Jones & Simyar,1994 p. 3). These authors caution that "Canadian health services providers should fully understand the strategic planning process before adopting a corporate planning tool that emphasizes economic competition" (Lloyd-Jones & Simyar,1994 p. 3).

The conceptualization of these management techniques as business oriented solutions which emphasize efficiency and cost-effectiveness first and foremost is certainly not a secret. I would argue that in their presentation to governance volunteers and health care professionals, however, this predominant motivation is routinely minimized in favour of more palatable incentives such as "improving care", and increasing professional and public "participation in decision-making" as offered in popular publications like "Healing Medicare" (Decter,1994). In this text, new ways of working together, as described in methods such as "self-management teams", are contrasted to authoritarian "hierarchical organizations" (Decter,1994 p. 99) and are intended to appeal to health care professionals who value the notion of autonomy. The contradictions between what these business solutions propose, and how they play out in the practice of governance, is further articulated in the prevalent frustrations of the volunteers as they try to govern within these new conditions.

A Perception of Powerlessness

A frequent sense of powerlessness and frustration were perceived in the comments of the governance volunteers when they reflected on their routine decision-making activities. These frustrations are grouped loosely under 1) the threat of being "fired" and 2) treading the invisible line between governance and "operations".

There was no mistaking the consistency of the participant statements regarding the limits of their power to act in any way that was seen as contrary to the expectations of the Ministry of Health. If these expectations—both implicit or explicit—were not met, the group was quite clear they would likely be "fired". When this comment was made in the interviews, it was often accompanied by a list of other communities where governance committees were dismissed, and public administrators appointed since the beginning of the health care reforms.

In this same vein, various metaphors used by the governance volunteers to describe the role of a governance committee within regionalization included "a paper tiger" (I-193); "a bunch of puppets" (I-214); and "I don't think it is even a rubber stamp, I think it is a scapegoat for the Ministry" (I-129). Another version of this was "Its a nice exercise in public relations, it means the community thinks it is being represented and in reality, I don't think we have any real gut power" (I-197). As one participant noted, "In the back of your mind, whoever can appoint can dismiss, so when you have been given explicit instructions that you are to achieve a zero deficit by the end of this fiscal year,...they [the Ministry of Health staff] are serious about what they want and they will get it" (I-81).

The implications of comments and perceptions such as these to the decision-making process are significant. The ever present threat of being publicly removed from your appointed position will influence decision-making activities. This was most noticeable in the presence of "The Ministry" at the governance table, and as such this "presence" would influence events. Typically this situation would manifest in comments from administrative staff such as "the Ministry process is..."; (PM 2-16); "the Ministry makes those decisions..." (PM 4-27) or "the Ministry requires a motion on..." (PM 3-10; PM 4-6), and appropriate events would, of course, follow.

The governance volunteers were not necessarily "afraid" of the effects that being "fired" might have on them personally, but rather the "Ministry coming in" was seen as the greater of two evils, and their powerlessness in their governance position as the lesser. As one participant said

> "you reach the point were you say what good am I doing? I am not influencing anything, I might just as well throw the towel in and let the Minister run the place. Then on the other hand, you no longer have influence over the decisions that are made" (I-72).

Another perspective on why people continued to be involved, even if they were disillusioned with the extent to which they had any real influence, spoke to a social aspect of the situation.

> "You...get to the stage [of resigning]...but in the meantime you have developed relationships with the other council members...you develop relationships with administration and that might be part of being a smaller community you know. It is just like a family, you see their good parts, their limitations, all that, but it is hard to jump ship with things so amuck because then you, this is the intent I think, you develop a sense of responsibility..."(I-50).

For the most part people continued to be officially involved in the committee, but the group that was active in their participation got smaller and smaller over the course of my data collection. Frequent references from the participants to a "core group", and that there was "really only 4 or 5 people [who were actively involved]" spoke to this issue (I-30,61,111,224). As an observer of the meetings, this "core group" appeared to be made up of those members most connected to, and able to deal with, management or business activity from their routine experience with it in their professional lives. It was clear that the people who were increasingly absent in the decision-making were those that were least connected to, or exposed to, a business discourse in their everyday lives. Put another way by a governance volunteer, it was as though "the system almost weeds them out" (I-42).

With the regular activities of the committee members becoming more distant from issues of health and health experiences, and more related to the business management of health services, it is plausible that the role of community representative will hold less meaning to representatives from community groups unfamiliar with this discourse, who will then participate less and less. Members of groups traditionally underrepresented in governance, for example, "through the lack of access to education, knowledge and familiarity with information networks and capital, are similarly prevented from having easy access to discourses" (Mills,1997 p. 14). This possibility, combined with the fairly well understood limitations of their real decision-making power, poses significant challenges to the extent to which this example of citizen participation can rise above a level of "tokenism" or "consultation and informing" (Arnstein,1969)

The frustrations inherent in not having a sense of any real power, or security in your place in the process, likely obscure the next area I wish to explore—treading the invisible line between governance and "operations". When asked, the governance volunteers expressed their role was to "govern", something they described as "direction setting", and as dealing with "policy issues"—as opposed to operational issues. As one participant said "We should be worrying about the policy decisions that affect the health of the community…" (I-172).

When the volunteers started in the health care reform process, the popular thinking within the discourse of community participation was that to do this "direction setting", you draw on your own knowledge and experiences with health and health care. These might come to you through personal events or through the stories of other peoples' health experiences. Based on my observation of routine meetings, this type of activity is no longer compatible with the business orientation of meetings as they are organized at this time, and should it emerge it is likely shut down by other committee members in preference for dealing with "board business" and not getting into "operations" or "beyond our mandate" (PM 1-19; PM 2-7; PM 4-17; I-239).

Some of the participants counter this view, that of course "we bring information to the table just by who we are, what else we do, what our past experiences have been, and what our other connections in the community are" (I-41). But the question here is whether one is allowed to include that knowledge, or comments that reflect it, in the decision-making discussion. The response of one volunteer crystallized the more likely situation I observed in meetings:

> "I have heard some, two I think I have heard, [referring to other governance volunteers] who talk about being an administrator in so and so building, but I don't think I have ever heard anyone talk about their own accident or anything, about their own health" (I-26).

In this, the governance volunteers are participating in organizing the content of their meetings by allowing, or including, business-like issues and activities, and by shutting down, or excluding, discussion that might speak to the actual experience of receiving health care in their community.

As this issue plays out in the governance setting of health care reform, drawing on personal experiences compatible with the "business" at hand is becoming the acceptable behaviour, and personal comments directly associated with health care experiences are seen as crossing the line into operational issues, and as such they are "out of order" (I-218). As one participant noted if "the management team begins to see it [discussing experiences with health services] as micromanagement..., then it makes it more difficult to have that kind of discussion (I-106). A situation emerges where governance volunteers who feel they have little real decision-making power are also restricted, in often unspoken ways, from using their personal experience with health to assist in their decision-making processes. Overall, the sense of powerlessness that emanates from these examples resonates with the contradictions the participants experience when their understanding of their role as a community representative collides with the role of "production manager" which is being applied to them in an overt way.

To this point in the analysis, the following arguments have been made: 1) that the majority of the information given to the governance committee members is most applicable to the business management of health care, 2) that the group experiences restrictions on doing the governance activities they are told they have the authority to do within the regionalization model of British Columbia, and 3) that they are, as a group, nonetheless overwhelmed with the amount of work required of them. The governance volunteers are increasingly being pulled into, and kept very busy with some other kind of activity. Add to this the analysis of power offered earlier—this being a complex range of social practices dispersed throughout daily activities—and it is unlikely this group is powerlessly going about whatever activities they are being kept very busy with in their health care reform role.

According to a governance journal called Trustee, "boards respond to the information they are given" (D-56-2), "if a board is given management information, it will manage"(D-56-2). And indeed this governance committee is engaging in management activities, but not of the "micromanagement organizational" variety they work hard at avoiding. Rather, I argue next that governance volunteers are being drawn into, and have taken-up, the very powerful mechanisms of modern management which are instrumental in accomplishing this shift to the "production of health care".

CHAPTER FIVE

Modern Management Technologies:

Accomplishing the “Production” of Health Care

A discourse of production, as the previous chapter demonstrated, is privileged within the health reform documents and activities of governance volunteers. Furthermore, health care reform activities within this discourse are primarily concerned with improving efficiency and cost-effectiveness of health services. The discourse of production, as explicated, is accompanied by powerful mechanisms of modern management, or “management technologies”. Examples of management technologies noted in this inquiry include strategic planning/management and quality improvement processes.

In this chapter, I draw on critical organization/management literature to argue two issues. First, the modern management methods that accompany the discourse of production which is being taken-up by governance volunteers are implemented through a discourse of cooperation which increasingly serves to control individuals in organizations by requiring self-disciplining behaviour. Secondly, these disciplinary practices—which make the need to cooperate known to individuals in organizations, often in unspoken ways—are aimed at suppressing conflict and increasing productivity, thus accomplishing the goal of greater efficiency and cost-effectiveness of health care services. Both of these arguments are made in light of how health care reform activities play out at the governance and local organizational level.

A Discourse of Cooperation: Self-discipline as Practice

When reading about any of the management technologies noted—one could include regionalization itself as a management mechanism here—liberating language about decentralizing decision-making, broad participation of those affected by decisions, delayering organizations, flexibility in responding to constant change, team work, and shared values abounds. The talk of the management of new, flexible organizations is couched in "language of democracy, autonomy and liberation from the oppressive hierarchy of bureaucracy" (Gerlach,1996 p. 425). But are the management mechanisms being taken-up by most health care organizations, as part of health care reform, these things, or are they structures of "subtly enhanced control?" (Gerlach,1996 p. 425).

In understanding which is the case, Foucault's theory of discursive practices, which was considered in Chapters One and Two of this inquiry, is drawn forward. Discursive practices were discussed as the circulating "unwritten rules" that both constrain and make possible the social relations within a discipline, or an organization, by allowing some modes of thought and denying others (Dreyfus & Rabinow,1982). These unwritten rules, or privileged organizational knowledge, are seen to intersect with power in organizations, thus "creating a system of meaning which disciplines/self-disciplines social subjects into economically productive, but politically non-productive, citizens" (Gerlach,1996 p. 426).

When reflecting on strategic planning, quality improvement processes and regionalization, and what is popularly understood about them, notions of participation, teamwork, shared visions and values, democracy, progress, learning, and collective and harmonious problem-solving easily come to mind. If one reviews texts written for managers on strategic planning and quality improvement processes, however, a somewhat mixed bag of concepts emerges.

Strategic planning/management as a management mechanism was defined above in the analysis as a "process by which an organization plots its future direction" (Costello,1994 p. 23). According to texts on the subject, to plot this direction, a "team" of managers clarifies organizational mandates and mission and then assesses the

> impact of all the forces on the organization, as well as internal strengths and weakness, and maintain[s] a delicate balance or congruence among them in order to achieve optimum efficiency and effectiveness in setting goals and in formulating and implementing an appropriate strategy". (Lloyd-Jones, Simyar, Craighead & Caro,1994 p. 12)

This group also develops a "shared vision" of direction—something promoted as "better arming" an organization to face the future (Lloyd-Jones et al,1994 p. 7). "Shared organizational values" are seen necessary as "the successful implementation of any strategy requires that it is perceived by the individuals and groups involved in carrying it out to be compatible with their values (Lloyd-Jones et al,1994 p. 12).

These authors go on the suggest "that one of the best ways to achieve this consensus is to provide for participation in the strategy-making and implementation phases of the process" (Lloyd-Jones et al,1994 p. 16). As a means to broaden "participation", total quality management (TQM) is recommended as it "focuses not only on the classic concept of efficiency and productivity, but also extends the notion of quality to include the entire product or service process" (Lloyd-Jones et al,1994 p. 16). Another text reminds managers, however, that there is a "big difference between giving people a seat on a committee and consulting with them as part of the process. People can supply a great deal of information and advice—and legitimacy for the process—without actually having a vote on a committee" (Bryson,1988 p. 85). Finally, both of these texts are very clear on the need for management to "identify control mechanisms which will ensure that planned activities are not only carried out but also facilitate the movement of the organization toward the attainment of its objectives" (Lloyd-Jones et al,1994 p. 16).

If we move to consider what is written about the health care version of TQM, this being Continuous Quality Improvement (CQI), the need for "total commitment to the concept....from the very top, that is the CEO" (McLaughlin & Kaluzny,1994 p. 28) is what one encounters first in the literature. In this commitment, all of management is charged with the responsibility to "create the climate and culture that support CQI" (McLaughlin & Kaluzny,1994 p. 184). In "walking the talk" management is to

> communicate continuously the positive vision of CQI: that it is a route to success; that people will be energized by the empowerment and the learning that come with it; that it will lead to improved care; that the effort will not be a threat to people's jobs, but an opportunity for personal growth and increased job security; and that it will consciously be made to be not life-and-death serious, but fun (McLaughlin & Kaluzny,1994 p.184).

The need to link CQI to strategic planning is also emphasized as CQI activities are felt to offer many insights for that planning process (McLaughlin & Kaluzny,1994 p.153-155).

"Quality improvement teams" are discussed as being at the core of this management method. "Top management" is acknowledged as having "a great deal of influence over the teams' effectiveness by the way that they signal the significance of the effort, provide feedback and stimuli to the members, evaluate team performance, and provide recognitions and rewards" (McLaughlin & Kaluzny,1994 p. 127). Early "training" in CQI is emphasized as necessary for its success and teams then need to "focus on performance goals associated with some urgency and spend adequate time together to develop collective values, develop work rules and norms, and interpret their own behavior" (McLaughlin & Kaluzny,1994 p. 127). Toward this end, multidisciplinary teams are suggested and the authors comment further that "teams can make a difference, outperforming other types of work units, including individuals" (McLaughlin & Kaluzny,1994 p. 127).

In these texts, although the liberating modern management notions remain to a certain degree, contradictions emerge in how "top-down" these methods are developed and in the extent to which "top management" is meant to maintain tight control of the process. The contradictions noted here reflect those revealed in earlier analysis of the relationship between the governance volunteers and the Ministry of Health staff who hold the place of "top management" in the regionalization process.

If one continues along this line of thinking, the parallels between the CQI process, for example, and the organization and goals of regionalization, as it is shaping up within the discourse of production, are numerous. In regionalization, the Ministry of Health has a number of broadly representative "teams" situated in different areas in the province. The intention of regionalization is repeatedly cited as empowering communities with increased control over their local health care services. In the analysis completed in the previous chapter, however, within the work of this local governance "team"—and one would assume in the work of other "teams"—clearly the top management of the Ministry of Health signals "the significance of the effort, provide[s] feedback and stimuli to the members, evaluate[s] team performance, and provide[s] recognitions and rewards" (McLaughlin & Kaluzny, 1994 p. 127). And it is through this effort that the Ministry of Health is gaining greater control over the management of health services in the province.

In turn, governance volunteers are endorsing the same management methods in their organizations toward an increased capacity for controlling both those that work in health care organizations and the work they do in providing health care to people. Although on the surface of the talk and writing about modern management mechanisms there is an apparent "rejection of hierarchical structure, and thus much of the traditional power imbalances embedded within the organization" (Gerlach, 1996 p. 432), in practice a new level of management control is achieved through "the manipulation of symbols and discourses" (Gerlach, 1996 p. 432).

In achieving this new kind of control over workers and work processes in organizations "competition", as previously discussed, is used to shift responsibility for success from management onto individuals. In CQI language, "competition" provides the means to capitalize on the "intrinsic motivation" of employees (McLaughlin & Kaluzny,1994 p. 35). New levels of individual self-control achieved through competition reduces the need for "panoptic surveillance and direct supervision" of organizational work (Gerlach,1996 p. 432). Indeed, it is suggested in a text on quality improvement that with the implementation of this program "some companies have been able to remove layers of management as work groups have taken over their own processes" (McLaughlin & Kaluzny,1994 p. 35), thus the ultimate evidence of successful implementation of modern management technologies.

Toward this intended effect of employee self-control, or self-discipline, the writing in these texts is prescriptive and concerns of efficiency and performance are "overriding problematics and define what can be legitimately talked about and who can talk about it" (Gerlach,1996 p. 428). The intertextuality of these processes, or their reference back to one another in the literature, leads to a "convergence around a central set of constantly repeated concepts that produce discursive regularities" (Gerlach,1996 p.429). The consistencies and effects across texts results in a new discourse, in this case, one of "cooperation".

Cooperation is required in all the "good" organization behaviour being prescribed in modern management technologies. The repetition and ubiquity of the "liberating notions" that constitute these mechanisms are ensuring they are increasingly taken-for-granted as "good" organization behaviour and, as such, they are being normalized within the social relations of health care organizations. As these "good" behaviors become part of the "unwritten rules" in organizations, individuals apply them to themselves, acts which then discipline individual behaviour in a way that allows management to be less directly involved in achieving this effect (Gerlach,1996; Deetz,1992).

Through methods such as strategic planning and CQI, individuals become "a small version of the organization, having internalized organizational systems thinking and organizational aspirations" (Gerlach,1996 p. 431). As the Council members worked through their budget struggles with the Ministry of Health staff for example, most were clear that they "had to cooperate, to be seen to do that, because we really don't have any other means to get anywhere" (I-102). When opposition was encountered from other groups affected by the budget decisions made by the governance volunteers, the doctors and nurses for example, these groups were seen as "not cooperating", behaviour that emerged as needing to be brought under control(I-16,36,37,227).

Suppressing Conflict: Mechanisms of Social Control

Management as a discipline has long been criticized for continuously minimizing conflict in organizations through the "suppression of democratic values" (Alvesson & Willmott,1992 p. 3). When people "cooperate", conflict is minimized and the organizational ideal is maintained (Mills & Simmons,1995; Deetz,1992). When conflict does emerge, people are perceived as being difficult and as "not cooperating". Of interest in the literature is the prediction of the management response to such "disruptions", or how conflicts are "often routinized, [and how they] evoke standard mechanisms for resolution" (Deetz,1992 p. 25)—or mechanisms that control social behaviour, a prediction that proved fairly accurate in this local situation.

The conflict that surrounded this group of governance volunteers at the beginning of my data collection was discussed in the local context provided for the research setting. Further details on this include that early in data collection Council members agreed to a last minute request from the local medical group for an *in camera* meeting. The doctors requested the meeting to voice their concerns about some of the negative effects on patient care they saw ultimately resulting from the Council's agreement with the Ministry of Health to balance the hospital budget. This meeting catalyzed several events for the Council. These events included a separate in camera meeting with administration and nursing managers who responded to the concerns raised by the doctors, a follow-up in camera meeting with a small group of medical representatives, a meeting with the local city council who were hearing of the medical concerns from the doctors, and a refusal to a request for a joint and open session meeting with the nurses and doctors. During this same time, staff started attending the Council's regular public meetings, something that had not happened routinely in the past, and they "participated" in that they asked questions during the course of the meetings which were felt to be inappropriate and aggressive at times (I-269).

This was a burst of atypical activity for the Council and it had several important effects that flowed either directly from it or in response to it. First, there was a formalization of the internal conflict resolution process, something that became documented and known as "normal process" (D-54). The document developed here outlined in detail individual responsibility in dealing with "issues" as they arise and then a detailed "chain of command" that was to be followed if "individual resolution failed". This written process was widely distributed throughout the organization and "normal process" routinely began to emerge in the governance volunteers' and management "talk" as almost an a priori principle. This written process reemerged approximately twelve months after its initial documentation. This time it appeared in a policy format that included a flowchart of the process to be followed in resolving "issues", and an explanation on how this process intercepts with the internal CQI process, thus contributing to a "central set of constantly repeated concepts that produce discursive regularities" which support cooperative behaviour as the organizational norm (Gerlach,1996 p. 429).

A second event subsequent to the above was the development of a delegation and petitions policy which formalized the process by which groups within the organization and community could access the Council members, although there is an expectation noted at the end of this policy that "normal process" is to be followed prior to approaching the Council directly (D4-70). Within this policy, access to the governance committee has to be requested through the Council's CEO ten days prior to a meeting and with full disclosure "of the issues, questions and subject matter to be discussed" (D4-70). The development of this policy was the second significant decision of the governance volunteers in this research.

When interviewed, the governance volunteers expressed a number of similar reasons for the development of this policy. The most frequently expressed reasons included the sense that people were not being treated equally (the physicians were given direct access to them and allowing that was a "mistake" on Council's part), that issues should not come to them before administration had the opportunity to address them (this was seen as "jumping the queue", or not following "normal process"), and that meetings got disorganized and out of control when people could just "break in" (I-16) and "hijack board business" (I-36). The intention was to bring back some order to their activities through the implementation of the delegations and petitions policy, but in doing that, democratization was quelled (FN-Mar. 24, 1998).

A third event that followed this increased level of conflict was a change in seating arrangements at the regular Council meetings (D5-4). When I began data collection, seating was very informal which resulted in Council members not being able to make eye contact with members of staff or public who began attending meetings and frequently posing questions. From the time this change was made, the meeting room was arranged in a manner that had Council members seated at tables in a U-shape and the rest of the room was set-up theatre style so that the Council members could see anyone "in attendance in the gallery"(D-5-4). Following these events the conflict that was playing out at the Council meetings very quickly diminished and by the end of data collection from public meetings, five months after the first "disrupted" meeting, it had essentially disappeared.

In considering these events in relation to their effects on conflict in the organization this group governs, there are at least two observations to be made. First, with these "interventions" the conflict simply disappeared. There was no obvious follow-up to it, the conflict was just (apparently) gone. Such an effect is evidence of the ability of management interventions, or mechanisms of social control, to silence behaviour that is not considered desirable or productive, or is seen as "uncooperative". The silence "about inequality, conflict, domination and subordination, and manipulation both within orthodox and more progressive accounts of management and organization theory" is well documented and provides a motivation for critical management studies (Willmott,1997 p. 1329); therefore, this effect, while disturbing, is perhaps not surprising.

A second effect of the events flowing from the early conflict was that the Council members who, as previously discussed, had no means of regular communication with their broader community, were now also isolated from the internal community of the organization through the formalization of access to them. This outcome was ironic as many board members, from the beginning of their governance, voiced their intention to be a "different board". Being a "different board" was described as "we are going to be a more open board, we are going to listen to what people have to say, we are not going to be an anonymous face, we want to somehow connect better with the organization..." (I-267). It was noted further in this interview that inadvertently the group had "achieved almost the exactly the opposite, that they seem to be more alienated from the organization than any board that has proceeded them" (I-267). A perhaps unintended consequence of this increasing isolation was that it served to increase the Council members' dependence on the information and perspective of their management staff and the Ministry of Health management staff. The resulting privileged place that management information has over decision-making is not considered unusual in critiques of organizations; however, it is viewed as problematic.

Critical management critiques concede that individuals in organizations do "produce organizations", however, they are quick to remind us that not all people in organizations are equal in this ability (Deetz,1992).

> The advantages given to management [in decision-making] are based on neither rational nor open consensual value foundations nor are they simply acquired through management's own (although often latent) strategic attempts. They are produced historically, and actively reproduced, through discursive practices in corporations themselves....In modern organizations such an advantage is not so much conceptualized as a right or legitimate but is unproblematically reproduced in routines and discourses. As such this privilege is treated as natural and neutral" (Deetz,1992 p. 24).

This unquestioned privilege becomes particularly problematic in a situation where the decision-makers—the governance volunteers—are supposed to be representative decision-makers for the broader community as opposed to being people who merely concede to whatever management, at either the local or provincial level, determines is in the best interest of their community's health care services.

With the assumption that management opinion is neutral or virtuous as taken-for-granted, governance volunteers are being drawn into the discursive practices of organizations and accepting the privileged position of management opinion in the decision-making work within regionalization. Given the increasing focus of health care reform activities on improving efficiency and cost-effectiveness of health care services, it is not surprising that the rational voice of management is proving to be dominant in the methods employed to this end.

Increasing Productivity: Scientific Management Re-emerging

Productivity is “the ratio of output to input” (Marshall,1994 p. 418). Today we hear the expectation of increased productivity commonly referred to in modern organizations in the catch phrase “doing more with less”. When there is a focus on productivity, it is easily argued that the issue of controlling work processes becomes the most basic problem for those engaged in managing health care services. Controlling the behaviour of workers toward achieving greater productivity, however, is not a new management issue. As discussed in Chapter One, controlling the production and efficiency of work processes was the primary focus of early management theory and practice, and was called Scientific Management. In light of this congruency, I argue in this final section that this focus of controlling work processes remains a principal intention, albeit in less obvious ways, of the modern management technologies which propose to engage with the “workers” of an organization in a different way. Thus, a modified version of Scientific Management resides at the core of health care reforms.

If we return our attention once more to what is written in texts on strategic planning and CQI, a common theme to these mechanisms is the use of "systems theory" or systems thinking. This concept is used in scientific analysis to "understand the pattern or structure between any set of parts or units...[and] a system is any structured or patterned relationship between any number of elements, where this system forms a whole or unity" (Marshall,1994 p. 526). This central theme establishes early on scientific method as the perspective taken in these mechanisms. This "world view" was discussed in Chapter Two in contrast to a constructionist perspective taken in this research. Scientific method assumes a single reality exists and attempts to establish enduring cause and effect relationships within that reality, preferably by highly precise measurement. In CQI using a scientific approach is described as "using data to evaluate the current situation, analyze and improve processes, and [to] track progress" (McLaughlin & Kaluzny, 1994 p. 70).

Both strategic planning and CQI texts express a strong preference for the use of quantitative data, or data that can be measured precisely and directly. In this, measurement means "an instrument is used to indicate some value of a concept" (Gray & Guppy,1994 p. 137). In strategic planning, if qualitative goals, or those that cannot be measured directly, have to be used, then indicators are required—indicators being "easily quantifiable results which have a logical relationship to the qualitative goal" (Lloyd-Jones et al,1994 p. 15). Quality improvement theory does not even account for the possibility of using qualitative information; but rather "jokes" that "in God we trust, all others send data"

(McLaughlin & Kaluzny, 1994 p. 70). Finally, both methods require the use of extensive formal decision-making models/diagrams/flow charts, and CQI relies on establishing standards or norms so that variances—"the 'fat' in the system that needs to be reduced"—can be promptly detected (McLaughlin & Kaluzny,1994 p. 70). In this, the highly rational and technical nature of modern management technologies such as these is clear. The use of similar methods within the Ministry of Health was also evident during the reviews that this organization was regularly undergoing during my data collection.

The feedback from these regular Ministry of Health reviews to the governance volunteers most consistently indicated that Ministry staff felt funding received for hospital operations was not being used "efficiently" (FN, April 9,1998; I-101). Those doing the reviews indicated this inefficiency was evident by statistics that show, for example, that "the cost per patient day is on the rise" (FN, April 9,1998). How such statistics were calculated was often not made clear to the hospital management or to the Council members, but the numbers were essentially taken to be "fact". As a result, the governance group was held to their agreement to balance the hospital budget over two years, regardless of what that meant to local health care services. The Ministry of Health would not consider giving them more funding as the assumption was they would spend new funding inefficiently as well (FN, April 9, 1998).

Over the course of data collection, there was constant effort by the Council to be "making the case", and "packaging the statistics differently" (PM 2-21; PM 4-18; I-125), all in the hope of convincing the Ministry of Health that variances in the statistics could be accounted for, that the regional medical work that was done locally due to the number of medical specialists made this hospital different than the "peer hospitals" it was constantly compared to, and that provincial "standards and peer hospital norms" were not fair comparisons given the unique nature of this facility and the work done here. Little was gained in the way of acknowledgment of any of these arguments from the central bureaucracy which, as noted in the participant interviews, does not listen very well when its mind is made up.

Bureaucracy, through the use of management mechanisms such as those discussed above, is a "form of organizing that arises out of, and depends on, a form of rational, calculative thinking" (Mills & Simmons, 1995 p. 103). In this situation, the work of the hospital—or more accurately the work of people in the hospital—was reduced to a calculation, or a series of calculations, meant to indicate "performance". This "roll-up" of performance is measured externally to the organization and the results of these measurements are given the "status of science while rival evidence which might suggest other ways of understanding [the work of people in the hospital] is ignored" (Gerlach, 1996 p. 424). The frustration of the Council members with this unbending attitude from the central bureaucracy was tangible. As a group, however, they cooperated, or more accurately, complied with any direction given by the Ministry of Health staff and continued to consent to measures meant to bring the statistics back in line with established norms, thus reducing their "variances".

What is troubling in this example is that although the governance volunteers and their management staff know the frustration of having "performance" measured in this way, and how the results can be very inaccurate from the perspective of those being "measured", they are nonetheless endorsing methods that will apply the same techniques and principles to measure the work of individual employees in their organization. If these methods prove to be so unjust from the governance and management perspective, will the experience of an employee be any different?

Professional groups, such as nursing, who know the said intentions of management technologies such as CQI, criticize their frequent "misuse" in the workplace. When "misused", these methods are said to "eliminate variation and introduce standardized methods of performing tasks;[replace] multi-skilling with multi-tasking whereby professionals are being replaced with inexpensive, unskilled generic workers, and finally team approaches [are used] to speed up work as a means to eliminate jobs" (Pottins,1994 p. 31). Given the highly rational underpinnings of methods such as CQI, I argue that the above do not represent a "misuse", but rather the emergence of underlying intentions that are implicit in a critical reading of texts on the topics.

In comprehending these texts, the principles of Scientific Management that are embedded in modern management technologies are revealed, and account for the "misuse" effects noted above. Quickly enough, one encounters a comment such as "the fundamentals of TQM are based on the Scientific Management movement developed at the turn of the century" (McLaughlin & Kaluzny,1994 p.

12). Not surprisingly, efforts are then made to distinguish how the "new" methods are different from classic Scientific Management. And granted, there are some differences. What is "new" in these modern methods is the manner in which control of an individual's work is achieved.

"Labour process studies have demonstrated that overt forms of control through management supervision have proven ineffective in inducing employee dedication" (Gerlach,1996 p. 431). The elimination of functional divisions in organizations, and collapsing labour into processes which undergo continuous scientific assessment by semi-autonomous teams, results in work processes placing employees in competitive relationships with one another, creating circumstances which take on the role direct supervision held in the past (Gerlach,1996). Continuous scientific assessment as a means to determine the most efficient way for work to be carried out, or multi-tasking, reduces work processes to calculable activities, thus rendering them available for further organization toward improved efficiency and productivity (Gerlach,1996; Willmott,1997). Approaches such as these then inhibit creative and autonomous thinking of employees, thus achieving what is desired in "greater corporate thinking" (Alvesson & Willmott,1992).

Increasing dependence on rationality inhibits "deeper reflection on means-ends relationships, the current social order, and predominant goals [of organizations]" (Alvesson & Willmott,1992 p. 11). With rationality as the privileged mode of thought, we are quickly coming full circle to the basic principles and effects of Scientific Management as it was conceived by Taylor himself (Mills &

Simons,1995). As discussed in Chapter One, the complete dependence on scientific methods for analyzing work processes produced a level of routinization and standardization of work that resulted in early deskilling of workers and the loss of traditional craftsmanship. Perhaps the level of conflict around the use of these methods in health care organizations is not surprising if it is again considered that the fundamental conditions operating in health and social services are different than those operating in the businesses these management mechanisms were designed in and for. Managers and professionals who note the apparently good intentions of such methods, as long as they are not "misused", are cautioned—it would be simplistic to think we could "import" only the apparently desirable attributes of these mechanisms into the health care setting and set the rest of a model aside (Purkis,1997).

Though decision-making models such as strategic planning and CQI may offer health care organizations some statistical insights, the inability to account for the conditions operating in organizations which care for people as opposed to producing a "product", greatly limits their use. Such models are criticized for "ignoring the complexities of patient-practitioner relationship"; for down-playing "the knowledge, skills and motivation of the practitioner", and for treating "quality as free, [thus] ignoring quality/cost trade-offs" (McLaughlin & Kaluzny, 1994 p. 21). From the perspective of one who "cares for people", these criticisms offer overwhelming barriers to the benefits of such methods in managing those that work, and the work processes, in health and social services.

CHAPTER SIX

Conclusion

We regard those people as leaders who have been able to break out of the existing cast of thought and blaze new trails. That those in power were unable to do so shows that they were poor leaders, not that the task was impossible.—Peter Temin (McQuaig,1998 p.248)

Health care reform was introduced in the context of the national health care system that has been in place in Canada for nearly three decades. Calls for reform of the system have been many, as are the reasons for them. Concerns with the lack of management and accountability in the health care system, rising costs, questions of effectiveness, and user unhappiness with inflexible services and programs were all motivations for change. In response to these criticisms, a prevailing provincial method for implementing health care reform, regionalization, is putting into practice a substantially different method of governing health care services.

In regionalization models, authority delegated to the community level is intended to place control over the delivery of health care services into the hands of local community representatives. A concern reviewed was that as these models of community governance are put in place, little has been determined as to how the relations between the major players will function differently. This is important as the models, as proposed, represent a social "reordering" of relations that have well established histories. These include health care management, at both provincial and local bureaucracy levels, and health care professionals working differently with community members—recipients of health care—who will now be acting in the capacity of decision-maker, or governor.

With these concerns in mind, the purpose of the research was to reveal the social practices that affect the particular ways the decision-making of governance volunteers acting as community representatives in health care reform is constituted and enacted. The research question posed to this end was—How will the discourses of health care reform enter and affect the decision-making work of governance volunteers serving on community health care committees as established in British Columbia's regionalization process? This question was studied in an ethnography with a group of governance volunteers doing their decision-making work.

In data collection and analysis, the perspective taken in this research was discussed as that of constructionism. In this, the world was assumed to be socially organized with all those living in it participating in the production, and recursive reproduction, of its social relations. Language, as an organized system itself, was reviewed as organizing our world further. In this, language used purposefully, and that has effects, was proposed as constituting the discourses evident in everyday activities. Discourses, through their interception with power circulating in society, create and communicate systems of knowledge, or the "unwritten rules" in an organization, a discipline, or in a community. By observing and systematically reviewing the activities of community representatives as they went about governing health care services in their community, the discourses that are entering and affecting their decision-making work were drawn out, thus revealing the social practices that are affecting the ways this decision-making work is constituted and enacted.

The turbulent environment this governance committee was working in during my data collection was discussed to provide the provincial and local contexts of the research setting. In data analysis, a discourse of "community participation" was easily detected in a review of the early health reform documents released by the Ministry of Health. Inversely, this discourse was supported in the consistent frustrations the governance volunteers voiced around not being able to do their governance work the way they understood it was to be done from their early involvement in the process. The contradictions the community representatives were experiencing between their understanding of how the governance process was supposed to work, and how it was working for them in practice, were illustrated as not having enough time to "govern"; not being able to access information relevant to their community representative decision-making role (but having access to large amounts of health care management information); experiencing an undemocratic relationship with the Ministry of Health staff; and in this, being forced to manage by implicit expectation.

This analysis lead to a review of the documents that were now organizing the committee's activities and that were beginning to define explicit expectations from the Ministry of Health, all under the latest reform initiative Better Teamwork, Better Care. This examination offered many examples of the increasingly ubiquitous business language that was being directed to the governance volunteers. These documents were shown to emphasize concepts such as accountability, performance, measurement of performance, evaluation and improvement processes, and long-term strategic and "business" planning. In light of this, reflection on the governance committee's day-to-day activities saw a similarly increasing emphasis on "business" concepts. Examples included dealing with the budget, strategic planning, implementing a quality improvement process (CQI), and moving the organization to a corporate structure. From all of this a discourse of "production", and its emphasis on efficiency and cost-effectiveness, was seen to be increasingly privileged in the decision-making work of the governance volunteers.

The incongruity between how the volunteers understood their role, and how it was playing out within this discourse of production, caused further and consistent frustrations for this group. Most of the community representatives felt powerless in their decision-making role and as constantly having to struggle with treading the invisible line between governance and "operations". From their perspective, they were not afforded the power to "govern"—that is to make choices—nor were they to engage in discussion that might impinge on "operations" (such as their own health care experiences). They were, all the while, constantly enmeshed in health care management information. Thus, the role that was being organized for them, and by them, was increasingly looking like that of "production manager". New selection criteria for community representatives, which began to define "competencies" and "qualifications" for membership, reinforced this new "job description". As the analysis continued, however, it was demonstrated that this group was not engaged in the "micromanagement" they worked hard to avoid, but rather they were being engaged by, and engaging with, very powerful modern management technologies that are privileged in this discourse of production.

Critical management/organizational literature was drawn on to discuss modern management technologies and their implications to health and social service organizations. Borrowed from the business world, these mechanisms were shown to be primarily concerned with improving efficiency and cost-effectiveness of health care services via improved productivity—"doing more with less". These mechanisms were reviewed as attempting to control individuals and their work processes through disciplinary practices which require cooperation and suppress conflict in health care organizations. Example were drawn from the participants' activities which demonstrated the effectiveness of these methods in achieving these two effects through both a discourse of "cooperation" and "standard mechanisms of resolution" (Deetz,1992 p. 25). It was also argued that in the use of these mechanisms, control of work processes is acquired through the application of scientific methods that attempt to reduce all work in an organization to calculations. Reduced in this way, work processes are then rendered available for further reorganization toward increased efficiency and productivity. These methods were made visible as they play out at both the governance and local organization level.

In this analysis, it is not that all notions held within these management methods are necessarily undesirable. Rather, they do raise some important issues that health care professionals and managers at all levels need to address.

It is argued here, however, that organized systems, such as modern management methods, are laden with discursive practices that are not easily separated, nor are their less desirable attributes easily left behind when bringing them into a new setting. A primary concern with "importing" business solutions into health and social services remains that the fundamental conditions operating within these organizations are different than those operating in the businesses these management mechanisms were designed in and for. Health care managers and professionals who focus on the apparently good intentions of such methods are cautioned that it would be simplistic to think we could bring into play only the apparently desirable attributes and easily set the rest aside (Purkis,1997).

In the health care reform community governance setting studied here, although this group of volunteers were working hard for a "cause they believe in" (Chappell & Prince,1997), the factors that continue to restrict their participation from moving beyond that of "tokenism"—or participation without real authority—are demonstrated to be many. Although the regionalization model being used in British Columbia is a relatively new "object" in health care management, obscured discursive practices within established power structures and decision-making processes have not allowed for the delegation of appreciable decision-making power to a group of citizens meant to represent their community's needs in health care governance. The community representatives' response to this actuality, that is the taking-up of modern management technologies in their efforts to "act" in some way, will have many effects on health care in my community and on my everyday work as a nurse. Unchecked, a discourse of production, and the priority it gives to fiscal issues and the perspective of management, will be the primary determinant of what local health services look like and how they will function. Furthermore, the increasing use of a discourse of cooperation within modern management technologies will see my everyday work as a nurse, and that of all other people working in health care, as increasingly subjected to scientific assessment and reduction to calculable dimensions toward increasing efficiency and productivity, regardless of their effects on "quality" of care.

The participants in this study voiced concerns that their work as community governors was being "hijacked", and indeed that is happening. It is not, however, being hijacked by the people wanting to talk to them about health care services in their community. Rather, this dubious honour is held by those that believe the many problems in Canada's health care system will be solved if you start "running [health care] like a business" (I-234). In this research, this increasingly accepted solution is considered to be problematic.

This inquiry made visible how the social practices embedded within the privileged discourses of health care reform, those of "production" and "cooperation", enter and affect the decision-making process of governance volunteers serving on a community health care committee in British Columbia's regionalization process. The critical analysis of this decision-making work challenges government, managers, community representatives acting as governors, and health care professionals to break out of the existing "cast of thought" and to reflect on the taken-for-granted notion that leadership should be sought, and blindly taken, from the business world when addressing issues of management, cost, and effectiveness in health care. Bringing into open discussion that which has been avoided to date—those practices which perpetuate solutions that ultimately ensure citizen participation remains token—may yet excavate options unthought and untried.

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APPENDIX A

Initial letter to participants addressed to chairperson of the participating CHC

Date: October 20, 1997
From : Penny Anguish, Graduate Student, University of Victoria
Subject: Research on the decision-making process of a CHC

Thank you for bringing forward my interest in working with the ___________ Community Health Council. I hope the following offers enough information for the committee to determine if they would be willing to participate in this research. Should you, or other members, require additional information, I can be contacted at my home number _______ most evenings.

My Background

I completed a diploma of nursing in 1982 in Ontario and worked primarily in a small northern community in a variety of positions for 11 years. After moving to British Columbia 4 years ago, I decided to pursue my nursing degree. I graduated from the University of Victoria's Bachelor of Science in Nursing Program in April, 1996. On completion of this program, I promptly applied to the Faculty of Human and Social Development Multidisciplinary Policy and Practice Master's Program. I completed the course work for this program at the end of June, 1997. The research project proposed here is for my thesis and is intended to fulfill, in part, the requirements of a Master's of Nursing degree. Lastly, I currently hold a temporary part-time position with your organization (in the Diabetes Education Clinic in ________ Hospital).

Research Interest

Health care reform and community participation and representation were both areas of focus in my undergraduate and graduate studies. Within the health care reorganization underway in BC, I have concerns that community based decision-making will be restricted by a variety of internal and external forces (i.e. Ministry of Health directives, health care professional and management groups, labour regulating/advocacy associations, community advocacy groups). Although information may be available about how CHC's should function in general, little is documented about how decisions are actually being made, and about what influences, or directs, this process.

Research Proposed

In addressing this lack of research, in my thesis I would like to systematically investigate the factors which affect the decision-making process in one Community Health Council, ideally this would be the __________ CHC. In doing this, I propose to carry out an ethnographic study in which I would follow 2 "significant" decisions as they are being made by the committee. In an ethnography, the researcher studies, and then describes, a group doing their routine work or activities - in this case, committee members doing their usual committee work.

In this research, I propose to gather data by observing meetings, interviewing individual committee members, and by reviewing information the committee receives from other stakeholders and the documents the committee produces. The data would be analyzed using a method called critical interpretive analysis. This method focuses on the language or "discourse" which, in this case, communicates to the committee, and ultimately to the community, what is "important", what decisions to make, and how to make them. The intent will be to describe how decisions are made in practice, and then, if necessary, to discuss how this might be done differently. The study's results would be reviewed with the committee prior to final documentation.

Potential Benefits to Participants

This research project could be an opportunity for committee members to develop a greater awareness of the many factors that influence their decision-making. It also offers the opportunity to openly discuss this process while the committee is a relatively new decision-making body. From this perspective, this research has the potential advantage of clarifying the decision-making process at a time of change and development, thus opening up the possibility of building on what is working well, and of developing ideas about how things could be done differently.

Ethical Considerations

1) The research proposed must be approved by the University of Victoria's Ethic's Department.
2) If the research is to include "in camera" information, the researcher must obtain informed consent from each member of the committee.
3) If in camera information is included in the research, any committee documents that contain client specific information would be excluded from the research process in order to protect client confidentiality.
4) It would be difficult to assure confidentiality around the committee's participation in the research process; however, comments made in individual interviews would by kept anonymous to the best of my ability, and the committee's name would not appear in any written documents unless the committee as a whole preferred this to be noted.

Time-lines

Date collection would occur over a 4-5 month period (Oct-Nov, 1997 - Feb-Mar, 1998).

Data analysis and final documentation would occur in the following 2-3 months.

Researcher's background in health care reform/community participation

Projects and papers I have completed in these areas include the following:

1) A practice placement with Ministry of Health, New Directions office, late 1995 - completed a survey on the impact of regionalization on health care volunteers. The resulting report was sent to all members of British Columbia's CHC's/RHB's in place at the time.
2) A practice placement at the ________ Health Unit - completed a survey on the volunteers supporting health care in ________ , April, 1996.
3) A policy research paper on the policy development process of regionalization in British Columbia, November, 1996.
4) A discussion paper on community governance as a decision-making model, February, 1997.
5) A research project with Elizabeth Cull, consultant to the Capital Health Board, on community participation/consultation mechanisms. Completed the report - "Community Participation: Making it work", Feb - April, 1997.

I hope this is helpful information toward making an informed decision about participation in this research. I would be happy to offer greater detail on any areas that are unclear. Thank you for your time in considering this proposal.

APPENDIX B

CONSENT FORM FOR PARTICIPATION IN THE STUDY ENTITLED:

The discourses of health care reform: How they enter and affect the decision-making process of a Community Health Council

Researcher: Penny Marie Anguish

I, ___________________________________, consent to participate in the study that will examine the decision-making process of a Community Health Council operating under the health care reform re-structuring in British Columbia. I understand that my participation in the study is completely voluntary and that I may choose to withdraw at any point without negative consequences. I understand that should I withdraw before the completion of this research, I may also request that the researcher withdraw any data I have offered to the date of my withdrawal.

I understand the **purpose of the research** is to reveal the social practices that affect the decision-making of individuals who are acting as community representatives in a health care governance committee. It is not the researcher's intent to discredit different perspectives, but rather to question the conditions that allow particular perspectives/paradigms to dominate over others with their language and methodology. The intent is not to be evaluative, but rather to be informative toward a raised awareness about how decisions are made in the committee, what influences/directs members in their decision-making, and how this might be different. I understand that the research data will be used as the basis for the researcher's thesis and for publications that flow from this. Press releases would only be done with full consent from all participants. I understand that when the researcher's thesis is accepted for completion of a master's degree, and on completion of any publications, the data will be shredded.

Disclosure of risks in group and individual data collection: I understand that given the small number of participants in this study, the inclusion of data collection during public meetings, the smallness of the community in which the research is being conducted, and the small number of Community Health Councils in BC, confidentiality may be compromised. Such compromise may include speculation by others about comments made by participants during individual interviews. The researcher will endeavor to limit this compromise wherever possible. Furthermore, although the intent of this research is to benefit participants by raising awareness about the decision-making process of their committee, I understand there may be individual and group anxiety about the potential of the research to uncover negative features of the committee's current decision-making processes. As a participant, I have considered, prior to consenting to participate, any concerns I have that the findings of this research may affect my future appointment to this body by the Ministry of Health or my role within the organization as an employee or physician with admitting privileges.

Research Process: I am aware the researcher will observe and audio-tape public meetings and will observe and take notes in the in camera meetings of the Community Health Council. I understand that any member of the committee may request that an issue not be discussed with the researcher present during in camera meetings if there are concerns about appropriateness of such discussion. I am also aware that I will be interviewed one to two times by the researcher at a mutually agreeable time and place and that I will be asked to share my understanding of the Community Health Council's decision-making process around two decisions which are under study. The researcher will tape the individual interviews only if I am agreeable to this at the time of the interview.

I understand that the transcripts from meetings and individual interviews will not contain names of individuals or identifying information, and that this information will be stored in a locked cabinet and, as a whole, will only be available to the researcher and her thesis committee. I am aware that participants may request to review transcripts of meetings in which they participate and that participants may see the transcripts or notes from their individual interview only. All audio-tapes will be erased on completion of the typed transcripts and all field notes and transcripts will be shredded after completion of the thesis and any professional publications that flow from this.

If I have concerns about the conduct of this research or the graduate student researcher, I can contact the researcher at 635-3552 or her supervisor, Dr. Michael Prince, at the University of Victoria, 250-721-8051.

The above information has been reviewed with me by the researcher and my questions were answered in a satisfactory manner.

Signed: ____________________________ Date: __________________

APPENDIX C

Series of Events in Data Collection

Date	Event	Context
Sept 18, 1997	CHC Public Mtg	member of the public, met the Chair, started discussion of my thesis proposal
Oct 9, 1997	CHC Public Mtg	member of the public, introduced to Board and my proposal shared
Oct 14, 1997	Lunch mtg with Chair	discussed ethics and small town issues (i.e conflicting interests)
Nov 11, 1997	CHC Public Mtg	motion passed for me to do research
Jan 8, 1998	Strategic Planning	invited as observer
Jan 15, 1998	CHC Public Mtg	no ethics approval yet
Jan 22, 1998	Strategic Planning	invited as observer
Feb 4, 1998	Strategic Planning	invited as observer

Ethic approval/individual consents signed - Data collection begins

Date	Event	Context
Feb 12, 1998	CHC Public mtg.	MDs presented during in camera session, CEO absent
Feb 17, 1998	Special Nursing Council	re: board response to MDs concerns
Feb 18, 1998	Special Board mtg.	admin. response to issues raised by MDs (only MD present - Chief of Staff)

Feb 19, 1998	Strategic Planning	invited as observer
Feb 25, 1998	Special Board mtg.	not notified, service closures announced by Board
Mar 11, 1998	Nursing mtg. (BCNU)	re: amalgamation issues
Mar 12, 1998	Joint Conference mtg.	Board responding to MD concerns union reps. attempted to join mtg.
Mar 19, 1998	CHC Public mtg.	many reps. of unions present
Mar 20, 1998	Strategic Planning	invited as observer
Mar 21, 1998	Strategic Planning	invited as guest (all day session)
Mar 23, 1998	Nursing mtg. (non-BCNU)	re: planning committee to assess nurses concerns with amalgamation
Mar 24, 1998	Special Board mtg.	re: receiving delegations – policy approved
Mar 31, 1998	CHC mtg./City Council	observed
Apr 9, 1998	CHC mtg. with MOH reps	re: funding, regional services
Apr 9, 1998	MDs mtg. with MOH reps	re: regional services
Apr 9, 1998	CHC Public mtg.	taped version only
Apr 14, 1998	Nursing Council mtg.	re: amalgamation/nursing issues
Apr 20, 1998	Strategic Planning	after Admin. and a CHC member have “pulled together all the goals”
May 1, 1998	Open forum with Nursing Council	to address nursing issues with representativeness of this group

May 14, 1998	Regular CHC mtg.	taped - not present for meeting
June 11, 1998	Regular CHC mtg.	observed and taped
June 15 - July 17	14 individual interviews on 2 “cases” and general impressions of decision-making process	(10 CHC members, 1 medical staff, and 3 senior managers), taped all but 1 interview

APPENDIX D

List of Documents Used in Analysis

D1 Board package: January 15, 1998 meeting pp1-95

D2 Board package: February 12, 1998 meeting pp1-111

D3 Board package: March 19, 1998 meeting pp1-109

D4 Board package: April 9, 1998 meeting pp1-183

D5 Board package: May 14, 1998 meeting pp1-101

D6 Board package: June 11, 1998 meeting

D8 Our New Understanding of Health, Ministry of Health, 1993

D9 New Direction for a Healthy British Columbia, Ministry of Health, 1994

D10 Fact Sheet: Now is the time to start implementing changes, Ministry of Health

D11 Fact Sheet: If the system works, why fix it?, Ministry of Health

D12 Fact Sheet: New Directions means less bureaucracy, better decision making by communities, Ministry of Health

D13 Fact Sheet: Setting the right pace for New Directions, Ministry of Health

D14 Fact Sheet: Regional Health Boards - Roles and responsibilities, Ministry of Health

D15 Fact Sheet: Community Health Councils - Roles and responsibilities, Ministry of Health

D16 Fact Sheet: Transferring control to communities/better representation, Ministry of Health

D17 Fact Sheet: Amalgamation of Community Boards and agencies, Ministry of Health

D 18 Fact Sheet: Voting and representation on CHCs and RHBs, Ministry of Health

D19 Fact Sheet: The future role of the Ministry of Health, Ministry of Health

D20 Fact Sheet: Regionalization update, Ministry of Health

D21 Fact Sheet: The role of CHC and RHB advisory committees, Ministry of Health

D22 Fact Sheet: Health Advisory Service Providers advisory committees, Ministry of Health

D23 Amendments to the Health Authorities Act, Ministry of Health

D24 Health Highlights from the UBCM convention, Ministry of Health

D25 Health Authorities Act, Queens Printer, 1994

D26 Terms of reference for the health services providers' advisory committee to RHBs and CHCs, and Terms of reference for union management advisory committee, Ministry of Health, 1995

D27 Terms of reference for the medical advisory committee to RHBs, Ministry of Health, 1995

D28 Eligibility Criteria and guidelines of conduct of RHB and CHC members, Ministry of Health, 1995

D29 A guide for developing CHCs and RHBs, Ministry of Health, 1993

D30 News release: Minister outlines process for regionalization assessment, Ministry of Health, 1996

D31 Fact Sheet: Summary of report of the regionalization assessment team, Ministry of Health, 1996

D32 News release: Changes to health plan to put services for people first, Ministry of Health, 1996

D33 Speaking notes of Minister of Health: Better Teamwork, Better Care, the new approach to regionalization, Ministry of Health, 1996

D34 News release: "Better Care" for BC patients as regionalization takes effect, Ministry of Health, 1997

D35 Fact Sheet: Putting services for people first, Ministry of Health, 1996

D36 Questions and answers (Better Teamwork, Better Care), Ministry of Health 1996

D37 News release: Public administrator appointed for North Shore, Ministry of Health, 1998

D38 Health Authorities Amendments Act, Queen' Printer, 1997

D39 Ministry of Health Accountability Framework for British Columbia Health Authorities, Ministry of Health, 1998

D40 Health Care and Epidemiology Alumni Newsletter: Four concepts of accountability, 1998

D41 Governance Policies for Health Authorities, Ministry of Health, 1998

D42 (Draft) Guide to Health Service Planning for Health Authorities, Ministry of Health, 1998

D43 Eligibility criteria for membership on RHBs, CHCs, and CHSSs, Ministry of Health, 1998

D44 Governance for Health, BC Health Association, 1997

D45 Governance for Health, Health Association of British Columbia, 1998

D46 Administrative policies for participant CHC, samples, pp 1-7

D47 Organization presentation for participant CHCs accreditation survey, 1998

D48 Strategic planning, documents produced, 1997-1998, pp 1-77

D49 Bylaws for participant CHC, 1999

D50 Action plan for budget reduction for participating CHC, 1997

D51 Council member orientation, working group paper, participating CHC, 1998

D52 Internal documents gathered over course of data collection "articulating internal troubles", 1998, pp 1-23

D53 Internal documents gathered over course of data collection "responding to troubles", 1998 pp 1-7

D54 Documents articulating "normal process" and "team work", and delegation and petitions policy, participant CHCs administrative staff, 1998, pp1-13

D55 Board Job Descriptions, Trustee Newsletter, 1997

D56 Information and the Effective Board, Trustee Newsletter, 1996

D57 A Review of Governance and Accountability in the Regionalization of Health Services, Office of the Auditor General of BC, 1997

D58 Enhancing Accountability for Performance: A Framework and an Implementation Plan, Office of the Auditor General of BC, 1996

D59 What's all this talk of Community?, L. Duhl, Trustee Newsletter, 1996

APPENDIX E

Interview Questions

Research title - The discourses of health care reform: How they enter and affect the decision-making process of a Community Health Council

SEMI- STRUCUTRED INTERVIEWS - QUESTIONS FOR PARTICIPANTS

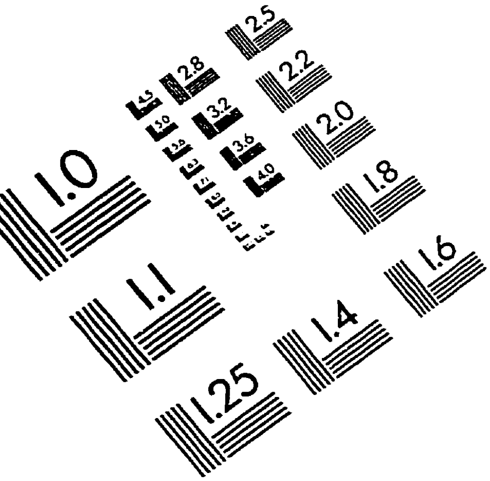
The researcher will review the "significant decision(s)" under study.

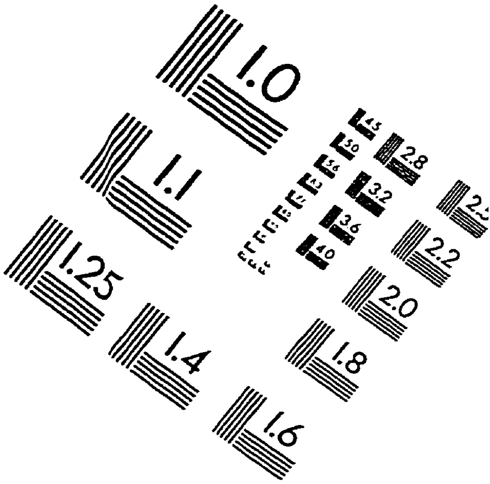
1) In trying to understand how decisions are made in this committee, I will begin by asking participants to tell me be about how they understand the decision under discussion came to be made.

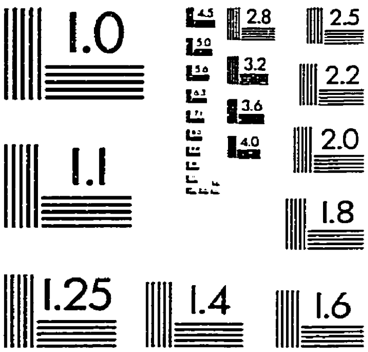
2) Based on what participants say, prompts will be used to have them expand on their comments around the decision-making process.

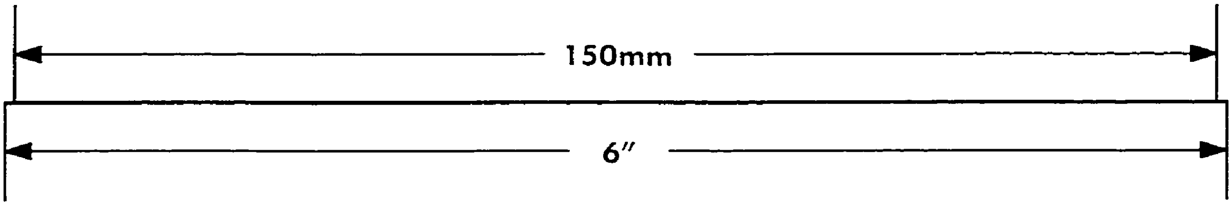
3) Finally, participants will be asked if there is anything further they would like to add about how they understand their role in the decision-making process of the committee, and about the factors which they feel influence or direct the decision-making process within the health care reform they are participating in.

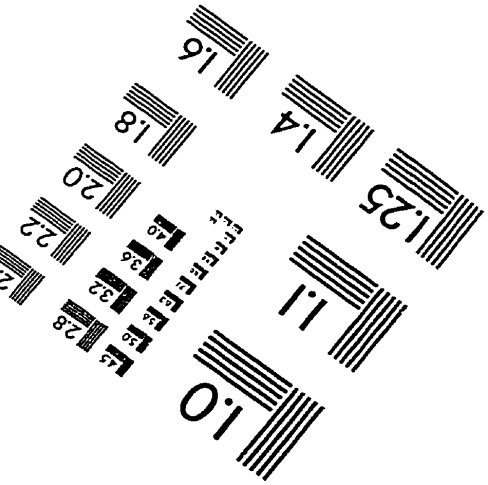
IMAGE EVALUATION
TEST TARGET (QA-3)

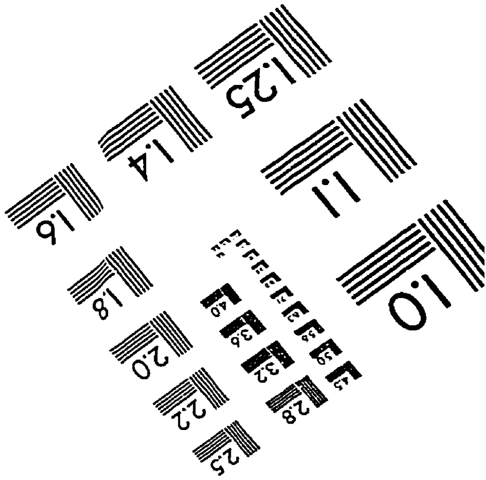












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