The Administration of Participation:
British Columbia's "New Directions" Policy Story

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Abstract

The rational approach to policy-making represents an alternative to politics by offering solutions to complex public issues based on calculated costs and benefits. This instrumental view excludes the knowledge and experience of all but a small group of policy decision-makers. In contrast, a participatory approach incorporates broad-based participation and shared decision-making power. Because this model recognizes multiple perspectives, policy decisions are better informed and therefore more effective. However, recent health reform initiatives in British Columbia show how certain participatory elements are strategically included in the "administration of participation." The central thesis of this study is that policy reform is not possible if the balance of decision-making power does not change. How open, inclusive, and innovative the policy process is depends on connecting active political participation and the redistribution of political power.

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Preface

"They are wrong who think that politics is like an ocean voyage or a military campaign, something to be done with some end in view, or something which levels off as soon as the end is reached. It is not a public chore, to be got over with, it is a way of life." (Plutarch)

Policy decision-making approaches are strategies for structuring relationships in order to achieve something. As the most widely practiced approach, the rational policy model is described as "the systematic application of procedures for assessing the utility of social programs." (Pal:39) Deborah Stone describes this model as a project, characterized by a limited number of actors making calculated policy choices within an administrative hierarchy. The claim of rational decision-making to being apolitical is enhanced by the nearly exclusive use of "neutral" cost-benefit analysis to measure policy initiatives and outcomes. The "rationality project" represents the "common mission to rescue public policy from the irrationalities and indignities of politics through the use of rational, analytical, and scientific methods." (Stone:4)

The contemporary power of the rationality project is derived from a "new" political paradigm in which governments do less, and align their own operations with market concepts of competition and efficiency. (Self:ix) The dominant perception in "government by the market" is that the "market

system is inherently a better method for satisfying human wants than recourse to government, and that the political process is subject to numerous imperfections and distortions." (ibid)

However, the desire to separate politics from instrumental policy decision-making in the rationality project raises critical questions regarding the nature of public policy and democratic governance. The central effect of the rationality project is to streamline the policy process by limiting public participation in the decision-making process. As a result, what is considered "legitimate" policy knowledge, and who holds that knowledge, are also limited. By restricting access to and information in the policy process, the power of decision-makers is sustained. Given their narrow scope of understanding of what the public interest is, and what the needs of communities are, policy decisions in the rationality project cannot adequately reflect the complex and conflictual political society in which we live.

A contrasting participatory approach seeks a broader perspective concerning who is authorized to participate in decision-making, and who gets the benefits and bears the burdens, of a policy decision. In this view, policy-making is a process which must take place outside the administrative hierarchy in communities made up of politically active participants. The enhancement of citizen

efficacy and empowerment in a broadly defined constituency is therefore of critical importance in the participatory approach. (cf Stone; Majone)

As a concept, participation is intuitively appealing because it encompasses two central tenets of democratic politics, assuring accountability both of bureaucracy to government and of government to citizens, and developing the democratic capacities of citizens. (Self) Through empowering participatory mechanisms, all members of society can assert greater individual and collective control over their lives. (Langille: 229) Hilary Wainwright argues that, beginning in the 1970's, governments have at times acknowledged "participation" as a legitimate decision-making tool. (1993:112) Certain aspects of participation, such as "partnership" and "stakeholder" initiatives represent attempts to capture the appeal of participatory governance.

In practice, those with decision-making power "will rarely be willing to share" their influence if it means surrendering control of key resources. (Langille:235) The illusion of equal participation with power-holders is sustained only if people outside the administrative hierarchy "restrict themselves to consultation rather than decision-making, or only deal with matters of marginal importance." (ibid)

This case study on two recent health reform initiatives in British Columbia illustrates how both the "New

Directions" and the "Better Care" policy strategies appear to incorporate some elements of public participation. In 1993, health minister Elizabeth Cull introduced "New Directions for a Healthy British Columbia," which was to be structured on community-driven definitions of health needs and delivery of services. Three years later, this participatory dimension came to be perceived as the primary obstacle to health policy reform. In 1996, the community aspect of health reform was shifted to a regional framework called "Better Teamwork, Better Care: Putting Services for People First." Participation in this new approach would be managed through a smaller and more closely controlled number of appointed health boards.

The policy "story" of New Directions and Better Care reveals a political strategy of control and persuasion by decision-makers in order to reduce conflict over the goals of fiscal and administrative retrenchment. A regional dimension is not necessary in order to accomplish the goal of rationalization. However, under the guise of "new" health reform initiatives which incorporate certain aspects of participatory rhetoric, decision-making was retained by traditional power-holders and authorized by the contractual consent of a limited number of appointed participants.

As a model of social connection and political agency, the participatory framework goes beyond assessing public policy in terms of efficiency, but also in terms of the

contradictions the policy process embodies and sustains. The New Directions/Better Care study reveals contradictions when an "add and stir" approach to participation in public policy-making is used. How the role of ordinary people is perceived within the process, how the gap between policy intentions and outcomes is explained, and whether the state is a site of control or of political mobilization, depend on the ability of the policy approach to accommodate them. The contradictory stories that emerge from this case study show that the rationality project, in which decision-making power is constructed as finite and fixed, cannot facilitate true public participation. Rather, the strategic inclusion of selected participatory mechanisms detracts from the value of true participatory governance, and further disempowers members of the political community.

The experience of participation in the politics of rational management of British Columbia's health policy reforms reveals that when the balance of decision-making power does not change, meaningful policy reform is not possible. How open, inclusive, and innovative the decision-making process is depends on connecting active political participation and the exercise of political power. I conclude this study with a model of the civic community based on collaborative decision-making in the public realm. The infrastructure of the civic community is determined by the process of developing "the networks and norms that

facilitate coordination and cooperation for mutual benefit." (Putnam:3) In this framework, members of the civic community share the responsibility, authority, and accountability for public policy decisions.

Background and Methodology

Background

This project began with a concern regarding the increasing complexity of the policy decision-making process and the (seemingly) inversely proportional decline in political efficacy on the part of ordinary people. In Policy Paradox and Political Reason, Deborah Stone showed me the possibility of a policy model that connects, incorporates, and reflects the needs of the members of the political community. Like Stone, I do not find calculations of "the bottom line" a description of the world I know or want to live in. Rather, it is politics that determines the "common sense" in deciding who counts and who does not, and who gets what. My academic background in Political Science and Women's Studies, as well as being raised in the wildly political hills of rural Alberta, have made me aware that how decisions are made is far more complex, and far more interesting, than simply determining economic costs and benefits.

Methodology

My case study reflects a process of empirical interpretation described by Maynard-Moody and Stull [1] as:

(1) the interplay of observable characteristics in the form of words, actions, and artifacts; (2) the various explanations of these characteristics by relevant actors; and (3) a search for a theoretically useful understanding of these various interpretations. (253) My research is based on a literature review of policy theory and case studies of health policy issues, public document surveys, and conversations with interpreters directly involved in New Directions and/or Better Care.

The literature review included books, journals, and articles from the areas of public philosophy, public policy theory and analysis, and public administration. For example, Deborah Stone's theory of the political community in which an ongoing debate over ideas takes place, and Peter Self's description of the marketization of the state provided considerable critical insight into the (de)construction of the rational approach. Hilary Wainwright made clear for me the connection between knowledge, status, and power in her definition of democratic governance as beginning with "the full development and

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[1] Steven Maynard-Moody and Donald D. Stull, "The Symbolic Side of Policy Analysis: Interpreting Policy Change in a Health Department." in Fischer, Frank and John Forester, eds Confronting Values in Policy Analysis: The Politics of Criteria. London: Sage, 1987.

expression of people's knowledge." (1993:120)

The literature review framed a case study of the British Columbia government's New Directions and Better Care health policy reforms. My research of these initiatives included a survey of government publications, speeches, relevant newspaper reports,and Hansard records from the past four years. As well, I spoke with fifteen people who were involved in some capacity with either or both reform approaches. My goal in contacting these people was to gather their perspectives of the process. They include: four ministry employees, one who was part of the New Directions transitions team, two who are still employed with the Ministry and who worked both in New Directions and Better Care, and one who worked on the Seaton commission before moving to another ministry; two former chairs of regional health boards under New Directions; a member of the Medical Services Commission; an MLA who took part in the legislative debates concerning both New Directions and Better Care; four former members of (now disbanded) community health councils; a former hospital administrator who worked under New Directions; and a current hospital administrator appointed under Better Care. All but one person I spoke with requested anonymity, and only those comments authorized for inclusion appear in the case study chapters.

I was not able to speak with any of the three different

health ministers and deputy ministers involved in New Directions and Better Care, or a CEO of a current regional board. Nevertheless, the benefit of speaking with those who had direct experience with the reform process was invaluable. Through their interpretations I was able to identify a strategy of control and persuasion as a common thread between the two initiatives.

The experiences of the people I spoke to resonate with studies on participation in community-based programs done by Joan Wharf-Higgins, Sharon Hume, and Mary E. Tate. Their analyses greatly enhanced my theoretical understanding and added depth to the intersubjective interpretations in my case study.[4]

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[4] see Wharf-Higgins, Joan. "Closer to Home: A Case Study of Participation and Citizenship in Health Reform." PhD Thesis, Faculty of Education, U.B.C., 1997, Hume, Sharon. Government Sponsored Community Development Initiatives in B.C.: 1988-1993. University of Victoria, 1993, and Tate, Mary E. "The Illusion of Inclusion: An Analysis of Participation. Empowerment, and Community-Based Decision Making in Mental Health Planning." M.N. Thesis, Faculty of Human and Social Development, University of Victoria, 1993.

CHAPTER 1

THE RATIONALITY PROJECT

Introduction

Deborah Stone describes the rationality project as built on three components: a model of reasoning as rational decision-making; a model of society as the market; and a model of policy-making as a bounded and orderly sequence of stages. (Stone:5) As the "systematic application of procedures for assessing the conceptualization, design, implementation, and utility of social programs," (Pal:39) this model represents policy efficiency as the culmination of a politically neutral method in which the "rational decision-maker lays out goals and uses logical processes to explore the best way to reach those goals. (Stokey and Zeckhauser:266) The policy process is presented as a bounded and orderly sequence of stages, moving "as if on an assembly line," from problem definition to the evaluation of policy outcomes. (Stone:7)

The strength of the rationality project comes from fusing growing demands that governments achieve greater economic and administrative efficiency. (Self:ix) Policy making in this approach combines the rational selection of appropriate means for achieving political goals with economic rationality in determining the most efficient use of resources among competing purposes. (Lindblom in

Gregory:213) Majone suggests this model has "considerable intuitive appeal" in which policy making, decision making, and problem solving become "nearly synonymous terms," embodying the same concept of rationality as "maximizing something" and "choosing the best means to a given end." (13) As a result, technocratic policy practices are perceived as critical for mediating the ambiguities and contradictions of political decision-making.

This reflects the principals of management science, in which social scientific laws of human behaviour can be objectively determined and applied to practical problem solving. (Jennings:135; Self:169) The "methodological individualism" used to measure the utility of policy decisions authorizes who policy decision-makers will be. (Self:257) Exclusive problem-solving instrumentality sustains and entrenches the control of traditional "experts" over the policy process. Because policy making in this view is dedicated to the objective pursuit of knowledge, "other" people are viewed as objects of public policies and programs, without the legitimacy or agency to define or represent the public interest.

By merging market economics with political decision-

Stone does not separate out the functions of politicians and administrators in the rationality project, although other critics of the rational approach argue that the "classic distinction between politics and administration cannot be sustained" in a challenge to the concentration of power in the decision-making hierarchy. (see Anderson:23)

making, the rationality project is able to assume broad-based social consent for its values and practices, while at the same time it excludes the possibility of social debate. Technical efficiency "does not tell you where to go, only that you should arrive there with the least possible effort." (Wildavsky:131) Because an instrumental approach discourages recognition by decision-makers of the most difficult social policy problems, the opportunity to expand knowledge about policy issues is limited.

This model is not inherently hostile to public input. Rather, it is that the rationality project derives its authority and justification from political control, rather than in public participation. In the face of technical complexity and rapid change, it promises to solve social policy problems and enhance economic efficiency without shifting the balance of decision-making power. The central claim of the rationality project is that the "amorphous issues of governance can be resolved in a orderly manner and the rationally superior public action for many, if not all, social problems can be discovered. (Byrne:71)
The problem remains, however, that social problems are political problems rising from differences of ideas, opinions, and interests.

I. Assumptions of the Rationality Project

> "We have been discussing the way individual welfare should be measured, and have underscored the ethical principle that each person should be the judge of his own welfare. Nothing beyond this principle is required for market transactions to play their appropriate role." (Stokey and Zeckhauser:266)

In the rationality project, individual actors or groups make informed decisions, among preferences, in order to maximize policy decisions. The basic form of social interaction that generates these preferences and decisions is based on a market theory of resource allocation. Efficiency can be achieved by allocating scarce resources to their most economically productive uses. This is determined by using market value in order to separate it from the "fuzzier" contexts of political or social value. As a central methodological tool, cost-benefit analysis disciplines preferences so that optimum policy choices can be made. By conceptualizing society as a market, rational decision-makers can quantify policy decisions and outcomes so they may be assessed based on the delivery of the greatest net benefits when balanced against marginal costs.

Charles Noble suggests that the liberal political economy generally promotes the notion that rational actors will produce the "good" society. As a result, questions such as equity are treated as separate and secondary political issues within this paradigm. (Noble:268) However, proponents argue that the domination of politics in the decision-making process systematically distorts allocative

efficiency. The practices of the rationality project are therefore justified because they are grounded in "nonarbitrary principles of allocation" which represent the "virtual constitution" of society. (Byrne:74) The Pareto principle of optimal welfare underwrites the unstated and collective agreement that "efficiency" is achieved if a decision results in at least one individual in the group better off, and no one worse off.[3] In the rational approach, the improvement of public policy decisions is based on systematic and calculated choice, thus elevating policy-making above the inefficiencies and irrationalities of politics.

By dispensing with political decision-making, the rationality project is able to treat social problems as independent and bounded in scope, and as solvable through the objective measurement of their economic costs and benefits. Because the narrow framing of problems and solutions eliminates the vexed issue of contentious political decision-making, the problem of convincing people of the soundness of the political values that inform policy decisions is bypassed. John Byrne argues that "[i]nsofar as social problems can be treated as independent and bounded in scope...government by right reason would seem to be within our grasp." (76)

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[3]References to Pareto efficiency frequently appear in discussions of resource allocation. Weimer and Vining describe it as a "concept with great intuitive appeal." (31)

Ironically, the project of rational policy-making is sustained and reinforced because it offers a powerful political opportunity. When traditional elites are able to persuade the public that they have impartially and objectively determined the correct solutions to policy problems, they are not required to justify exclusionary decision-making methods and outcomes. Without debate over policy agendas and decisions, the goal of economic efficiency is assumed not only calculable but also consensual. Social conflict over goals and outcomes is portrayed as the result of a problematic decision-making process. By eliminating ambiguity, conflict, and debate, the rationality project is able to determine the "correct" solutions to social problems.

II. The Science of the Rational Management

> "Perhaps most important,...findings are put forward as judgements above politics, based on scientific data, not organized interests." (Bulmer:176)

The rationality project asserts the need to address social problems in a systematic manner. Policy issues are framed using objective social science methods, in which the use of cost-benefit analysis is the central tool. Accordingly, by adapting the formalized models of the "hard" sciences, "a good" policy model will start with assumptions about individuals and the context of decision-making, and then draw logical policy implications from these assumptions. (Majone:11)

The validity of this approach rests on the assumptions of positivist social science. Jennings argues that "policy as science" embodies four central tenets of positivism: scientific knowledge is based on what is objectively knowable; the purpose of the scientific approach is to produce technically useful knowledge in order to determine optimum solutions; because it is scientifically-based, the production of knowledge, both as a process and outcome, is perceived as value-neutral; and the expectation that "the phenomena of human subjectivity...do not offer any particular barriers" to the treatment of social conduct. (137)

The strength of positivist social science is that it

seems to satisfy the double problem engendered by collective social life. (ibid) By denying a legitimate role for value-laden and competing subjective experiences and interpretations, systematic practices can rise above what Levi-Strauss describes as "the human swamps of experience." On the other hand, the positivist legacy denies that norms, values, and understandings influence the "truth." By excluding "unscientific" human subjectivity, rational decision-making is left to justify itself on its own technical terms.

As an alternative to politics, policy decisions based on the principles of positivist social science can prevent "the systematic ways that government interventions tend to lead to undesirable social outcomes." (Weimer and Vining:13) The science of the rationality project asserts the analytic capability to assess social behaviour by claiming that a political process cannot determine efficient policy decisions. In doing so, however, the calculations of the scientific method must follow a form of "Gresham's Law," in which easily measured criteria drive out those dimensions less easily measured: any criterion to which it is difficult to attach a market value tends to be excluded in the decision-making process. (Weimer and Vining:224) Because politics activates many interests and values, "the denial of any intrinsic worth to these elements in the political process amounts to the questioning of democracy

itself and to rejecting the idea there are significant social values which the market cannot easily satisfy." (Self:214)

III. Governance in the Rationality Project

> "Correcting those premises that distort our understanding of the true costs of public services, or that encourage suboptimal supply of such services should lead to the virtual elimination of social conflict..." (Byrne:77)

In the rationality project, problems of governance are "not those having to do with power and conflict, but with the efficient administration of state actions." (ibid:77) This generates important consequences for the notion of democratic governance. In particular, because the rational approach envisages policy as a calculable instrument of control, it also denies political agency to all but a narrow group of policy decision-makers. When only those rational actors whose actions mediate the "common sense" are recognized as the holders of legitimate policy knowledge, a self-enclosed culture of policy expertise is created.

In the culture of expertise, policy making is predicated on the application of "special" forms of knowledge that inform policy decisions. However, notwithstanding the claims of instrumental reason, when decision-makers maintain a narrow and privileged policy knowledge base, they are employing a political strategy of

exclusion and control. Rita Mae Kelly argues that when the link between the politics of policy-making and what constitutes authoritative knowledge and participation is not problematized, elites or their surrogates dominate. The relatively recent trend towards "partnership" or "stakeholder" policy processes obscures the fact that these are exclusionary practices. (Langille:234) Both terms are borrowed from the discourse of the marketplace, and their use implies that government is business, in which only those individuals deemed as "legitimately" active and competing agents in the policy process may participate. (ibid)[1] The desirability of the displacement of all but a narrow group of policy actors is "seldom addressed," but rather much discussion centers on how effectively such a mode of governance can be implemented. (Byrne:78)

Because rational management entrenches decision-making power a critical consequence is the loss of political efficacy experienced by those excluded from the process. "Other" people from outside the decision-making hierarchy, such as those people and communities directly affected by policy decisions, are "incidental" to the process and are thus denied legitimate decision-making authority.(McHardy:4)

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[1] Langille argues that in the marketplace, power is allocated according to who makes the most investment. "Stakeholders" are managed by those who wield the most decision-making power--traditional elites. (235) As a case in point, Paul Sabatier's article measuring "top-down" and "bottom-up" policy approaches refers to target groups, but in the limited context of those recognized interests competing for scarce resources. (197)

Rosemarie Tong argues that "a culture of policy expertise demoralizes the populace in two ways." (42) First, it contributes to the typical citizen's sense of ignorance and powerlessness. Second, a powerful community of experts can easily erode the citizen's desire to make decisions, especially those who are materially satisfied. The legitimation of particular roles and identities in the rationality project denies that citizenship requires people to engage in a continuing struggle to define themselves, their circumstances, and their political and social agency. The rationality project's claim of economic and administrative efficiency is achieved through the assertion of greater control in the policy process.

In what Dunn refers to as "the politics of information utilization" (45) the inclusion of multiple policy positions works against the goals of rational problem-solving methods and practices. This, however, represents a false and simplistic logic, because "many other factors other than methodology shape the ways that policy information is utilized by policy makers: the structure of political power; the political feasibility of recommended alternatives; time and resource constraints; the form and content of information; and the characteristics of the policy-makers themselves." (Dunn 45-46) The provision of information from outside the traditional decision-making hierarchy is therefore critical, because "inadequate or

faulty information may result in a fatal (and fundamental) error: solving the wrong formulation of a problem..." (ibid)

The rationality project perceives policy problems as largely methodological challenges that preclude the need for public participation. However, if efficiency is determined by how well policy solutions address the needs of members of society, the reliance of the rational management on limited knowledge and experience in the decision-making process is counter-productive.

Conclusion

The presupposition that policy efficiency can be defined and determined solely through the methodology of technical rationality ignores the political nature of public policy. The positivist legacy underlying the practices of rational management privileges instrumental reason over politics as a decision-making approach. Social conflict is thus viewed not as political in nature, but as a problem of finding the "correct" solution.

The market orientation of the rationality project defines the criteria of what constitutes a policy problem, and provides the solution to satisfy those criteria. This exclusionary construction of the policy agenda silences the debate between policy intentions and outcomes, which in turn limits the identification of collective needs and desires.

Most importantly, the subjective experiences of those directly affected by public programs are marginalized or erased altogether.

This brings into question the rationality project as a model for developing effective public policy. It is unclear what a controlled and narrow approach has to do with the social and political dilemmas faced by people in the "real" world. Market theory arguably provides an adequate framework for assessing economic efficiency. However, the use of cost-benefit analysis does not explain when policy decisions work, and when they do not. Therefore, "measurability is no index of importance" because in the politics of policy-making, what is left out is as important as what is included. (Kelly:275)

In offering straightforward solutions, the rationality project presents as a reasoned alternative to complex issues of power and conflict. But the problems of policy decision-making are not a result of loss of political control, but are inherently political and require the exercise of political will and choice. Deborah Stone argues that politics and policy are "beyond the reach of rational analytic methods," (4) As a result, the rationality project fails to capture "the essence of policy making in political communities: the struggle over ideas." (7) If there is no escape from power and politics in the policy decision-making process, then something other than a "managed" cost-benefit

view of the world must be considered.

In Chapter 2 I discuss the participatory approach as an alternative to the rationality project. Based on the idea that problems of contemporary governance hinge on the loss of political agency and efficacy, this model seeks to determine a framework that validates citizen participation in decision-making. At the center of the participatory model is a concept of politics as an ongoing and active struggle within a relational community. (cf Benhabib; Stone)

The toleration of ambiguity and contradiction is a challenge for a political culture persuaded by problem-solving instrumentality. It remains, however, that policy decisions are political claims which must be assessed not only in terms of economic efficiency, but also in terms of the contradictions they embody and sustain. (Stone:9) In a participatory approach, "the adequacy of political justifications is hinged upon the ability to address the multiple complexity of contemporary political communities." (Kahane:33) Thus the debate over who counts, and whose needs are addressed, in the policy process is ongoing and inclusive.

CHAPTER 2

THE PARTICIPATORY APPROACH

Introduction

In the first chapter, I argued that the rationality project recognizes only a limited number of decision-makers engaged in making rational choices. Its claim of political neutrality promises rational solutions to complex social problems. In the rationality project, policy intentions and outcomes are assumed to share the same goal of economic efficiency. Because it obscures the social and political context in which policy decisions are made, the possibility for gaining insight into how policy decisions are reached is limited. The ability to determine whether policy decisions are cost effective or not "simply does not tell us very much about what to do" (Majone:19) about collective problems.

In the participatory approach, people are political agents acting within a political community, "where individuals live in a web of interdependencies, loyalties, and associations, and where they envision and fight for a public interest as well as their own individual interests." (Stone:25) In this model, policy decisions represent political claims, because they are "never simply over material conditions and choices, but over what is legitimate." (ibid) In the political community, policy "efficiency" rests on citizens' ability to exercise their

participative power in determining how to address their needs. Their participatory capacities are developed through the exchange of information concerning the (re)distribution of knowledge, influence, and power resources. As a result, both citizen efficacy and policy effectiveness in addressing collective problems are enhanced.

Participatory democracy is an ongoing and collective struggle over the legitimation of interests and ideas. Indeed, a trend toward greater public participation has appeared widely in government and organizational discourse over the past decade. (Tate:14) Yet there are few examples of community development projects in which participatory frameworks are not constrained by the demands of rational decision making.

In this chapter I explore the three central purposes of the participatory model: legitimating knowledge claims which exist outside the technical-administrative project; determining whose needs are taken into account in policy decisions; and achieving policy change in the political community. By challenging the exclusionary construction of the policy agendas and solutions of the rationality project, the participatory approach promises to connect policy-making with active political citizenship. However, this connection must include a shift in the balance of decision-making power.

I. The Construction of Policy Knowledge

> "Ideas, as a medium of exchange more powerful than money, are at the center of all political conflict. Policy-making, in turn, is a constant struggle over the criteria for classification, the boundaries for categories, and the definition of ideals." (Stone:7)

The construction of dependable social scientific knowledge to demonstrate "lawful regularities of social behaviour" is paramount in the rationality project. (Torgerson 1992:211) In contrast, participatory policy making recognizes that political reality is socially constructed in a "politics of meaning," in which the concepts and indicators used to determine policy problems and solutions define whose values and goals are represented in the policy process. (Kelly:271) Political conflict over differing ideas about what is legitimate and fair determines the boundaries over what and who are included, or excluded, from decision-making. In the participatory approach, the struggle for inclusion is an inherent part of politics.

The critical authority of the participatory model is underwritten by wide-ranging theories identified collectively as "post-positivist."[6] As an "unresolved contention among different approaches to the perplexities of meaning," (Torgerson:267) post-positivist discourse engages "entire forms of oppositional knowledge" in which

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[6] Post positivist theories embody "continuously contentious relations among its hermeneutic, critical, and deconstructive elements." (Torgerson:288)

established authority is drawn into question and contested. (:288) This paradigm supports the participatory challenge to the construction of concepts and practices within the rationality project. In direct contrast with the "culture of expertise" entrenched in the rationality project, post-positivism advances the "democratization of knowledge," which recognizes the importance of forms of knowledge that are generally unacknowledged in traditional decision-making approaches. (Wainwright 1994:81)

Expanding the concept of what constitutes legitimate knowledge serves several important functions: it makes otherwise invisible knowledge to subordinate groups legitimate; it facilitates participation by increasing knowledge about policy trends and decisions; and it makes visible the relation of power and knowledge as it is constructed in the paradigm of technocratic reason. (Wainwright 1994:149-50) Challenge by the participatory approach to traditional decision-making places policy issues "at the crossroads of conflicting political forces." (Dobuzinskis:93) In addition, the increasing complexity and fragmentation of the policy process has altered the terrain of politics and political decision making. As an inclusive and open policy model, the participatory approach argues that knowledge can no longer be considered a "natural" attribute of certain individuals or offices.

At the same time that the participatory approach

expands the realm of political possibility, the stakes for traditional power-holding elites are also increasing. In our contemporary information society, information as a key commodity is essential for the management of political strategies. (Fischer 1987:121) In the struggle for decision-making power, "people will mobilize whatever resources they can, including co-operation with others, or the control of others, to overcome the limits of their knowledge and thereby come closer to achieving their purposes." (Wainwright 1994:107)

Legitimating knowledge and experience outside the decision-making hierarchy is critical to the participatory approach. Benhabib suggests that "not only is knowledge power, but power generates access to knowledge, thus preparing for itself a self-perpetuating basis of legitimacy." (:204) The systemic inequality of access to decision-making knowledge in the rationality project is political, and therefore contestable, because it creates incentives for power-holders to withhold or distort information. The lack of transparency in the decision making process is reinforced because "differential access converts information into the bargaining advantage for the more knowledgeable party..." (Majone:103)

The social construction of knowledge has far-reaching consequences on all aspects of the policy process. In the rationality project, policy analysis begins with a "problem"

which requires the stating of goals, and a strategy for accomplishing those goals. As such, policy decision-makers deal with only those problems that are recognized as "both solvable and worth solving." (Dery:5) Although, for example, policy problem identification is one of the most widely analyzed aspects of the policy model, little attention is actually paid to which policy "problems" reach, or do not reach, the policy agenda. (Dery:3) Unpacking the process of problem definition, and what happens in that process to produce agreement on what a policy problem is, illustrates the production of "usable knowledge" (Dery:119) in the rationality project.

The participatory approach argues that without the expression of many different perspectives, accuracy in identifying policy problems and the search for solutions is constrained. Determining which collective issues are addressed is not an objective description of a situation, but the ongoing expression of people's experiences and interpretations. Problem definition is therefore not simply a matter of defining goals, but is a "strategic representation of situations." (Stone:106) In the political community, recognizing what constitutes knowledge is collective and ongoing. By connecting this knowledge and political agency, determining the agenda of policy inquiry is also an open and dynamic process. When democratic governance is redefined to involve the full development and

expression of multiple knowledge sources, "any social processes by which knowledge is appropriated and society made opaque are inimical to it." (Wainwright 1993:120)

II. <u>Political Membership and Public Needs</u>

> "Public policies are frameworks that do not appear from nowhere, but are created to maintain certain kinds of relations and particular forms of interaction."
> (McKenna:125)

Every policy issue involves the distribution of something. (Stone: 40) In the social construction of "usable" policy knowledge, determining what goes on the policy agenda determines roles and power relations, addresses particular interests, and legitimates policy consequences.By connecting the policy process and political efficacy, the participatory approach raises questions regarding who gets the benefits and bears the burdens of policy actions or inactions. The expression of whose needs are, and are not met, in a policy decision therefore represents a political claim.

The participatory approach argues that because the markey model constructs a false choice between material gain and social justice, it has a limited capacity to recognize and generate what a society needs. Because what is "good" for the community is determined as the net result of all individuals pursuing their self interest, it is assumed that everyone experiences the same access to material and social

goods. Policy logic in view of a universalized "individual without gender, class, race, or community," (Phillips:244) dictates that rational decisions will not have social consequences. This "implicitly postulates that interdependence among individuals does not matter, and that the institutional arrangements determining the policy-making context do not matter." (Landry:288)

The goal of rational decision making is to achieve allocative efficiency in a framework of competition over scarce resources. This means that acknowledging needs outside this frame can only be done at the cost of inefficiency. In this view, political access and influence take place in a zero-sum game and lose their positional value when an increasing number of people possess them. (Plant:48) The politics of rational management thus invoke a "paradox of participation," which reduces participation from a valued goal of decision-making to the level of "efficient means." (Lukes:183) The rational individual will only participate to the extent that participation will have a decisive (and desired) affect on the policy outcome. As more people participate, the probability of influencing outcomes decreases. As a result, the desire of individuals to gain advantage over others in the distribution of policy

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To a large extent, inequalities are legitimized by the assumption of equal access. For example, collective problems are externalized and treated as exceptions rather than the rule. These spill-over policy effects are not included in the market evaluation of the distribution of public goods.

benefits and burdens is reinforced.

In the participatory community, economic rationality is "not competition for, but must be justified in terms of, moral principles like autonomy, equality, and benevolence." (Gilroy:100) The capacity of the decision-making process to meet social needs depends on incorporating the insights of the people who live and interact in the political community. Because the recognition of human needs is central to the political economy of a society, the question of policy effectiveness is "a contestable idea about what constitutes social welfare." (Stone:65) Public needs are what the community recognizes as valid and tries to satisfy, the participation in the political community is fundamentally concerned with validating claims about collective needs.

The struggle to establish terms of reference is central to the political community, because the very act of defining a community of needs and solidarity excludes some practices and discourses. Goals of equity and efficiency incorporate tensions between individual and collective interest: policy decisions in participatory politics are collective action problems because people must be motivated to "undertake private costs or forgo private benefits for the collective good." (Stone:16) Debate over public needs is thus a search for ways to facilitate both private and collective benefits. What this means is "inevitably contestable," thus engendering a "positive view of responsible, active,

citizenship." (Self:232)

III. Linking Theory and Practice

> "It is a long haul from academic theories to actual public policies." (Self:69)

A participatory policy process can only have practical value in a participatory society. There are no "epistemological fixes" for the fact that participatory practices are necessary, but not sufficient, for the legitimation of broad-based participation. (Fischer 1988:950) In the hierarchy of rational decision-making, governance issues do not address the issues of inclusion, equity, and conflict central to the participatory model, but with the control of policy decisions through rational management practices. (Fischer:78) From this perspective, a broader participatory process is conceived as a tradeoff with the "high quality data" (Patton:117) needed to determine rational goals and decisions. Increased input of multiple perspectives does not mean that decision-making power will shift in order to validate and listen to those perspectives.

At the same time, the policy decision-making process and the political need to justify policy decisions are connected. In some instances, decision-makers have "added 'participation' to their range of presentational methods." (Wainwright 1993:112) In this way, knowledge and

experience from outside the decision-making hierarchy can be co-opted, allowing public policy issues to be "organized [in/or] out of politics." (Pross:241) As a political strategy, the transitory inclusion of certain aspects of participatory governance facilitates control of the policy agenda and sustains the marginalization of all but a few interests.

The problem with this "add and stir" approach to policy decision-making is that a conception of participation as a strategic tool fails to explain how the policy process, and policy that comes out of it, can be more inclusive and effective. Self argues that "an acceptable public political philosophy must recognize the legitimacy of groups within pluralist societies, but seek ways of judging group claims by standards of equity and practicability." (258) This can only be accomplished in an open and transparent decision-making process.

The strength and promise of the participatory framework lies in its view that collective problems stem not from a loss of belonging but from a loss of political agency and efficacy. This can be addressed by the politicization of the public realm, which will "bring into the open the contradictions between various demands the political system seeks to meet." (Wainwright 1994:95) Without the understanding that knowledge and experience are contingent and contestable in the political community, the pursuit of

solidarity risks the reification of universalism. In the participatory approach, community is determined not through a notion of social wholeness or through the assertion of special interests, but through ongoing debates over its terms of reference. As a result, "there is always conflict over what goals should be and who its members are." (Stone:13)

What we share in the political community is that all issues of social importance are collective public policy issues. Policy outcomes, even those created by the best of intentions, are frequently ambiguous and possibly unintended. This necessitates an inclusive and ongoing debate over whose interests are being served by policy decisions. Participatory democracy "then becomes concerned with the process by which decisions are implemented as well as the competition of opinions and programs regarding those decisions." (Wainwright 1993:120)

In the link between participation and political practice, political agency is sustained ultimately in a framework of decision-making procedures which recognize conflicting interests and allow them to negotiate openly. (Wainwright 1994:119) The crucial feature for sustaining the connection between facilitative decision-making practices and an open process is shared decision-making power as a collective resource. Charles Lindblom argues this is made possible because "no one individual or group

has the monopoly on truth, information, or analysis. And the power to determine the ends and means of public policy is widely, though of course not equally, shared." (in Gregory:225)

Participating in the exercise of shared political power can be achieved through the formation of political alliances, identified by Stone as the "building blocks of the political community." (25) In this connotation, a debate over ideas about politics brings people together, and the strategic considerations involved in building and maintaining alliances shape the ideas people strive to implement. (ibid) Through alliance formation, the challenge of translating social problems into effective political demands can be addressed, holding out the possibility for participation in the political community.

Searching for collective ways to solve problems represents "the attempt to shift positions, to reposition ourselves regarding our individual and collective identities." (Anzaldua:219) In participatory governance, change is not driven by exchange between self-interested individuals as in the rationality project, but rather by shifting the use and distribution of resources such as knowledge and power beyond the individual, to be fundamentally determined by the community." (Stone:64) This requires a norm of "complementary reciprocity" through which "we seek to comprehend the needs of others, their

motivations, what they search for, what they desire." (Benhabib:341)

Conclusion

> "Public policy is anchored in both a set of values regarding appropriate public goals and a set of beliefs about the best way of achieving those goals."
> (Atkinson:19)

In the rationality project, change is driven by market-based exchanges and motivated by the individual desire to improve one's own welfare. In the contrasting participatory model, the policy process is relational and knowledge-grounded. (Phillips:243) In participatory politics, the differential effects of the policy process can best be understood from the perspectives of diverse lived experiences of individuals and communities. Unpacking how knowledge claims and perspectives are legitimated in policy decision-making offers terms of references for the political community that contrast sharply with those of the rationality project.

An open, inclusive and transparent process reveals the inadequacies of strategic inclusion, in which the consensual agreement of the participants is engineered by the gatekeepers of the rational policy approach. In arguing for a "need for an informed and enlightened citizenry (through) education, discussion, and public deliberation," Dahl suggests that policy decisions should be evaluated according to the opportunities for understanding they offer.

(31) Political agency in the political community goes beyond the temporary acknowledgement of certain actors and actions outside the decision-making hierarchy.

The practical relevance of the participatory approach is that the expansion of knowledge about collective issues and ideas expands the political community's ability to learn from the policy decision-making process. This is hinged on the concept of power as a collective resource, so that the process of decision-making is shifted from the rational administrative hierarchy to the political community. As a response to the limits of markets to organize society, the notion of political alliances opens up the question of who participates in policy decision-making, and points to the interaction of state and societal forces. (Simeon:378)

The chapters that follow provide a case study on two health reform initiatives in British Columbia. This study shows that while participation was strategically incorporated into the reform strategies of New Directions and Better Care, first through community-based participation and then through contracted regional boards, the balance of decision making power was not shifted to the regional boards and councils. Consequently, the opportunity to develop a decision-making resource-base at the community level was circumscribed by the narrow construction of recognized participants. Knowledge generated within the process was therefore also limited, which in turn skewed the debate

over whose needs were to be addressed in the policy reforms. Most critically, the strategic inclusion of participation occluded the fact that reforms were intended to meet the agenda of fiscal retrenchment, while offloading accountability onto community groups and further centralizing decision-making power in the traditional management hierarchy.

CHAPTER 3

NEW DIRECTIONS: A POLICY STORY, PART 1

Introduction

The introduction in 1993 of "New Directions for a Healthy British Columbia" held out the promise of full participation of communities from across the province in the health policy reform process. The policy problem that shaped the New Directions initiative was increasing health care costs and a shrinking health care budget. Because New Directions would determine how health service delivery could be more effective through participating communities identifying their needs and recommending changes to the current system, participants at the local level felt they had been given a mandate to make decisions relevant to their experience. However, in November 1996, the New Directions initiative was cancelled by Minister of Health Joy MacPhail and replaced with a "more streamlined approach to health care regionalization." (Speech, Nov.96) Notably absent from the new directive, called "Better Teamwork, Better Care: Putting Services for People First" was any mention of ongoing community participation as a core value in the decision-making process.

The policy "story" of health reform in British Columbia is actually two stories. Participating communities felt they had an agenda which would empower decision-making at

the local level, and attempted to act accordingly. Frustrated by the lack of response and support from the Ministry of Health in meeting this goal, community councils and boards intensified their demands for action. For them, the promise of full participation in the reform process was illusory. (Tate) For government decision-makers, community involvement was to serve as a tool in a persuasion/control strategy needed to rationalize health care service delivery. Demands by community councils and boards for shared decision-making authority exceeded the boundaries of the community framework as perceived by those in charge of reform.

As a result, community participation came to be perceived as the problem, even though the inertia of the reform process largely stemmed from constraints structured into the New Directions framework. Decision-makers, however, were able to point to the "unwieldy" participatory process in order to justify their decision to end New Directions and reinforce control of the reform process in Better Care.

In Stone's political community, effective participation is reflected in the key dimensions of community, information, and power as shared political resources that

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Devolution is only one way to structure reform. However, decision-makers recognized the strategic value of including public participation in a symbolically important policy sector. (see Maynard-Moody and Stull's discussion on "the symbolic side" of policy making: 248-251)

are enhanced through use. When access to participation in the community is restricted, knowledge about policy issues and process is limited. Because decision-making power is derived from all the participatory elements in the community, the ability to coordinate intentions and actions into collective purposes and results is also constrained.

In this chapter, I compare community, information, and power resources in Stone's political community with how they were conceived in the New Directions participatory process. How "community" and its members were determined in New Directions, how the exchange of information between the ministry and community groups and between groups and the public, and how decision-making power was structured in New Directions shows that although communities were intended to make difficult policy reform decisions, a parallel devolution of decision-making authority would not take place. While the initiative contained some elements of community participation, such as the formation of boards and councils, the reform process was constrained and ultimately overridden by the politics of rational management.

I. New Directions: The Participatory Promise

> "Active citizenship serves to foster in the participating citizen a sense of belonging in the community, while at the same time contributing to the common good." (Oliver:1991)

The introduction of the New Directions policy process formed part of a series of community development initiatives occurring over the last decade in British Columbia. For example, Sharon Hume's 1993 inventory of community participatory schemes cites "literally hundreds of community initiatives taking place in B.C." alone. (Hume:4) A central theme to emerge from these provincial reviews was the need to enhance opportunities for individuals to collaborate in making decisions regarding health choices, priorities, and policies in order to develop more responsive and efficient public policies.

At a sectoral level, the pressures of declining health dollars and rising health care expenses has prompted most Canadian provinces to explore avenues for health policy reform.[1] Accordingly, British Columbia's Royal Commission on Health Care and Costs directly influenced the conceptual framework for New Directions. In his 1991 report Closer to Home, Commission chairman Justice Peter Seaton argued that the traditional centralized structure for decision-making and resource allocation resulted in poorly planned, poorly

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[1]By the early 1990's, nearly every province produced a "blueprint for change for its health care system through a royal commission or task force." (Lomas:372)

managed, and uncoordinated health care. As part of its strategy for change, the report focussed on the need for greater local management and decision-making in British Columbia's health care system: "[d]ecisions should be made as close to the community level as possible; local people must be allowed to shape the local system of health care delivery... If (government) attempts to force local citizens to participate in schemes designed by the Ministry of Health, then the boards will be failures." (A-6) The Seaton report's "Closer to Home" was intended to mean establishing a more direct relationship between the recognition of health needs and health care service delivery at the community level.

The Ministry of Health announced its plans for health reform in February, 1993. "New Directions for a Healthy British Columbia" adopted the Seaton report's call for a community-driven health care system through a network of community councils and regional health boards. The mandate for the new regional authorities under the New Directions policy incorporated five principles the Seaton report recommended for the restructuring of the province's health care system: better health; greater public participation and responsibility; bringing health closer to home; respecting the care provider; and effective management. (New Directions for a Healthy British Columbia 1993)

Of these, the "directions" pertaining to increased

participation, community involvement, and management changes are considered in this case study chapter:

1. Greater public participation and responsibility meant a committment to increasing opportunities for citizens to participate in local decision-making, as well as assisting them in making informed decisions about their own health care. This would be accomplished through a devolution of decision-making authority.

2. Bringing health closer to home indicated that control over health planning, resource allocation, management and delivery of services should go to the local authorities. In July, 1993, a new Health Authorities Act designated 20 health regions encompassing 20 regional boards and 80 community health councils. Roles and responsibilities of the participating groups in New Directions were outlined in <u>New Directions for a Healthy British Columbia</u>, (1993):

*Community Health Councils (CHC's) are responsible for planning and coordinating health services, and identifying local health priorities. Over time, these councils will assume responsibility for integration and management of services now delivered by the Ministry of Health, hospitals and health provider organizations and resource allocation for the health services of the community.

*Regional Health Boards (RHB's) are composed of representatives from community health councils and individuals appointed by the Minister, whose initial role

will be regional health planning and service coordination. This will be expanded in the future to include allocation of a regional global budget. The budget will include funding for services delivered by the Ministry and those provided by hospitals and other agencies funded by the Ministry .

*A restructured Ministry of Health will provide support to regions and communities. It will be responsible for distributing equitable funding to the regions, establishing provincial bodies and plans, setting standards, monitoring outcomes, and carrying out evaluation.

3. Effective management of the new health system would ensure accountability of the decentralized system. While the New Directions model was a "decentralized partnership approach to management," there was also a need for a closely coordinated system. (New Directions:2) Accountability measures included the development of standards and procedures for collecting information and evaluating outcomes. For example, using the new directions as a guideline, community groups were asked to develop health plans which reflected their particular goals and priorities. They would do this by gathering and documenting input from health service users, providers, and ministry representatives. By January 1996, 82 CHC's and 20 RHB's were in place to assume local responsibility for health care planning and resource allocation.

The structure and practices of New Directions reflected

its primary goal of rationalizing the system of health care delivery. The "problem" New Directions was to address was the increasing costs, inefficiency, and ineffectiveness of the province's health care system. The principle agents of reform were those government officials responsible for implementing reform measures. Community health councils and regional health boards would structure opportunities for local participation and input into reforms designed to address the "problem." The target groups of the policy process were identified in the Ministry guidelines as "health care consumers and providers in the community." (New Directions, 1993: 3)

Stakeholders identified in the literature included political decision-makers, ministry officials and the members of the boards and councils. Constituents of all communities were "invited" to contribute to their community health plan through their local health authority. (ibid) These stakeholder groups were connected by a member of the Ministry's transition staff, who attended regional meetings and reported back to the Ministry.

For community groups, the promise of the New Directions policy process originated in the Seaton report's

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This also reflected the Seaton report which states "there has never been an overall plan, and quite naturally, the structure that has evolved lacks coherence and sometimes logic...[h]ow it manages to operate is a mystery, even to the Auditor General, as he pointed out in his 1988 report." (Summary:12)

recommendations for increased community participation in health care decision making. For them, New Directions would empower board and council members to facilitate the health and well-being of their community. As a result, the participatory elements in "Closer to Home" found in New Directions held broad appeal for interested community members.

Over the following three years, board and council members worked to fulfil what they believed was the New Directions participatory promise. For them, the regionalized concept in New Directions meant that citizen input and devolved decision-making authority would be exercised through a diverse and active core of informed participants. Indeed, until the initiative was "put on hold" in 1996, Ministry rhetoric concerning New Directions continued to persuade members of the public that the Seaton report's promise of bringing health care "Closer to Home" remained a primary goal.

However, the practices and structure of New Directions show that participation was regarded by policy decision-makers not as an end in itself, but as a tool needed to meet the goals of fiscal and administrative rationalization. For example, the parameters of the New Directions "community" limited participation only to pre-legitimated stakeholder groups, and perpetuated the exclusion of groups traditionally marginalized in the policy decision-making

process. One former hospital administrator stated that "although everyone was 'invited,' our council was not representative of the community--there were no First Nations people, even though we have a large First Nations population here. Where were the people on those councils who need primary health services the most?"[11] The role that participatory resources such as community, information, and decision-making power would play out in the New Directions process contributed directly to the inertia that eventually frustrated the efforts of community members.

II. Community, Information, and Power

> "It was a conscious decision that that's the way we should go...we in this province say that communities know best, and they need to get involved...governance decisions must be made by ordinary citizens."
> (Health Minister Paul Ramsey, 1995)

Community

Both Stone's model of the political community and the New Directions framework incorporate citizen participation as an essential characteristic of community-based policy making. Both approaches establish terms of reference for determining how participation is accomplished.

Because the political community is the site for ongoing

[11]Unattributed quotes used in this study are from my conversations with people involved in the reform process. They are included with permission and are identified by name only when their comments are part of the public record.

debate about the needs of the collectivity, it is driven by open, ongoing, and inclusive participation. Determining the conceptual boundaries of the community within the community itself is at the core of this debate, because "there is almost always conflict within a community over what its goals should be and who its members are." (Stone:14)

Participation is a community-held value and analogous to citizenship, therefore mechanisms must exist in the political community to facilitate widespread involvement in an informed policy process. Hume suggests that involvement is expanded at the community level when participation is the principle that drives policy change: the policy process is examined in the light of that principle, rather than in achieving a pre-determined outcome. (23) Thus a truly participatory community would "incorporate the results of people experiencing the consequences" of policy (in)actions. (Stone:166) Members are assumed to be their own experts, and are asked to express their concerns; members identify the resources that are available to them; and members of the community are involved at the earliest stages of the process. (Hume:30) Participants in the political community are viewed as key players in the processes and decisions that directly affect their lives.

In the terms of reference in New Directions, "community" was predetermined as a geographically derived, and independent regional decision-making body. Under the

guidelines provided by the Ministry, existing Local Health Area boundaries determined where community health boards and councils would be placed. Alternate views of the community such as "communities of interest" or "experiential communities" were to be addressed within the boundaries of the designated New Directions community. To facilitate this, the Ministry provided a shopping list of various groups and organizations the community groups should contact: "[t]raditionally under-represented groups such as aboriginal peoples, person with disabilities, youth, seniors, and women may need to be actively sought out so they too, are heard. Participation should reflect the cultural diversity of the community." (A Guide to Developing Community Health Councils and Regional Health Boards:11) Communities would have the autonomy to determine the issues and needs to be addressed. For example, community needs surveys were not done by the ministry because that would be done at the community level.

However, the terms of reference used to define "community" and who its members should be were unable to incorporate the mechanisms needed to make inclusive participation a reality. Instead, the participatory experience in New Directions was largely structured by the pre-determination of community as a bounded and localized entity. Within that, the opportunity for community members to participate on councils and boards was also limited. The

bulk of group membership was made up of volunteers who "possessed the discretionary financial and personal resources necessary to attend evening meetings and weekend forums, and to devote a large amount of effort to the process." (Wharf-Higgins:210) Participants were personally invited or referred either through a personal or professional connection to join local groups. (:166) A former CHC member reported their council was made up of "white high middle-class or higher members, most of whom were already active in local politics."

Rather than expanding community participation as a political resource for policy reform, the New Directions community and its members reflected traditional group politics. Because of their socio-economic status and access to the process, members of the New Directions community came already legitimized as participatory citizens.[14] In a traditional pluralist model, all important interests become organized in groups to make effective demands. The New Directions community structure was based on the rationale that empowered individuals at the community level would improve the well-being of the community as a whole. (Tate:19) The interpretation of one former community council member was that she joined "because some people

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[14]A national survey found that board members' sociodemographic characteristics only partially reflected those of the population:members were generally middle-aged, well-educated, and relatively well-off (almost two-thirds had incomes of more than $50,000). (Lomas: 516-517)

believed that my management and people skills and my experience working with government bodies would be helpful." This indicates both a sincere interest in making the process work **and** a belief that access by knowledgeable individuals to the process would result in policy influence. The same participant who felt she could contribute positively to New Directions eventually quit in frustration: "I thought health reform meant community-based services. This is not the direction we were headed in."

The strategy of rational problem-solving that underscored the structure and practices of New Directions determined the structure of community and who the members of that community would be. As such, the ability to address the experiences and needs of those "outside" the New Directions community was difficult, if not impossible, for the community groups to achieve. Instead, the New Directions "community" was made up of only those stakeholder groups recognized within the policy framework. Consequently the autonomy of the groups invited into the process was also bounded.

New Directions attempted to strategically incorporate participation into the reform process without a shift in decision-making control. The limitations of the New Directions community served as a barrier to change that was ultimately used by the decision-makers to justify the cancellation of New Directions itself: "other individuals,

from different areas of the province, expressed the view that the creation of the RHB's and CHC's had not changed the approach to health-care decision making...(Regional Assessment Team Report: 12) The central problem in New Directions policy was that the limitations of its participatory concept failed to expand community resources in a meaningful way.

Information

In the political community, information is socially constructed and contestable. The process of legitimating and exchanging information is collective and ongoing. This participatory view challenges the construction of knowledge in the rational approach by arguing that the determination of what constitutes valid information confers "an indirect but significant form of power on the holders of information...as a system of decision-making geared toward privileged knowledge...only those who can navigate the complexities of the policy issues can have access... (Benhabib:204) By expanding the boundaries of "usable" information, its application to the search for innovative policy ideas is enhanced.

The New Directions policy literature recognized that "informed decision-making, clear accountability, careful spending, and greater public participation all require a comprehensive and responsive information system. " (New

Directions: Feb.93:19) Information was to be gathered and shared between the ministry and the community councils and boards, and between the councils and boards and their larger communities. Between February 1993 and February 1994, the ministry published over 25 resource documents to help facilitate the New Direction's information system. (New Directions Development Division: List of Publications)

Discussions with participants revealed a sense of frustration with the New Directions information system. Interpretations regarding the way information was gathered and disseminated in the process reveal contradictions between participants and the Ministry literature. For example, community groups were given the responsibility for raising public awareness and for gathering input about the process "without any guidance or resources." Information that was available about New Directions for community use was "the kind of government stuff that people don't read." A stated intent of the New Directions information system to facilitate "informed decision making" was constrained by the lack of information resources needed by councils and boards to access the community at large.

The lack of support for information gathering at the community level led to the widely-held perception that information was withheld or incomplete. One former chair of a regional health board stated that "information on population needs was less available than information on how

much services cost, or how they should be used," leading to the conclusion that "decisions were made according to the budget, not to health needs." Another former RHB member was told by a ministry employee that information taken at the group meetings "was never looked at downtown."

Because council and board members, and the ministry were operating under different ideas about the purpose of the information "system," two separate New Directions policy stories were sustained. For example, a meeting between the health minister and a regional health board in August 1995 was thought by group members to be an opportunity to discuss issues and arrive at a mutually satisfactory solution to concerns regarding the process. Instead, the minister attended the meeting in order to "restructure" the region by firing all 21 board members.

The strategic use of information in the New Directions process contradicted the system goal of establishing clear accountability as well. Although community groups had asked for greater clarification of roles and responsibilities, an organizational chart was unavailable through the New Directions period. A hospital administrator reported that despite many meetings, an overall governance structure for New Directions was never developed. The lack of clear guidelines about how the transition to New Directions policy of community-driven reform meant that people working within the Ministry themselves had only limited information about

the process. While acknowledging that shifting policy direction was difficult at the best of times, a former member of the transitions team reported that Ministry employees "feared the change, mostly because they were heading into uncharted territory."[13]

A "Closer to Home" approach was to begin the "Jericho process," (Seaton report:7) in which the administrative walls of the health care system would be dismantled. Instead, participants claimed the "walls around facilities remain, Ministry functions are as stovepiped as ever...deadlines for the transfer of authority have come and gone with predictable authority. With no real funding and no real authority we have been asked to organize a new structure. (Oliver-Osoyoos Health Council, 27 June 1996)

The goal of rational management of system "efficiency," and not the health needs of the communities, was reflected in the information provided and recognized in New Directions. Not only was the exchange of information controlled by the closed circuit of participants in the New Directions community, but the information that was produced was filtered through the agenda of service rationalization. The result was the creation of "disinformation" inimical to the exchange of information that would serve as a community resource, (Maynard-Moody & Stull:251) and the shift to

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[13]This resistance may have, in part, led to some community participants' perception of "turf protection" in the Ministry.

community-driven policy reform could not be realized. How information was gathered and delivered in New Directions shows that the access and legitimation of information is not a neutral exercise. Whoever controls the exchange of key information controls the decision-making power.

Power

In the political community, power is derivative of all the elements of collective decision-making, and is used to co-ordinate individual and organizational behaviour in the pursuit of collective goals. As a shared resource, power "co-ordinates individual intentions and actions into collective purposes and results." (Stone:25)

Who has the decision-making power determines the "common sense" understanding of who and what belongs on the policy agenda. In the participatory approach, structural change is possible when power is used to shift decision-making away from traditional elites to the community, using community-driven and defined resources. Stone suggests that "the impulse to restructure authority in order to solve problems is long standing...variations for effecting policy change include changing the membership and the size of the decision-making body, as well as its location." (289) These strategies each represent "a call for empowering a different set of people to make decisions and to have jurisdiction over something." (ibid) In the political

community, a redistribution of decision-making power embodies a set of "power conferring rules" which authorize the shift.

In New Directions, participation was promised through the restructuring of authority to community boards and councils. A former member of a CHC reported that the devolution of authority appealed to "everyone." However, how that authority was perceived, and how it was exercised, in the process were viewed in very different ways by participants and decision-makers. Participants saw devolution as a way to bring control "closer to home" and to improve the accountability of health service delivery so that the quality of health in their communities could be improved. Decision-makers saw it as a way to streamline the administration of health policy and to reduce health care costs. As a result, New Directions "new" structuring of authority was not accompanied by any rules for transferring decision-making power to the community level.

Hume suggests that "the fact that both community and empowerment have entered the political and bureaucratic vocabularies devoid of any analytic framework or power renders the words almost fatuous." (45) Community groups in New Directions had very little authority, and in fact became further disempowered as the process went on. (Tate; Wharf-Higgins) Several former members of both CHC's and RHB's reported that at the end of four years and hundreds of

meetings, they felt "completely disillusioned" with the process.

Power was not transferred because empowerment of the communities and their members was never the intent of New Directions. Rather than serving as a resource in balancing the needs of communities, government, and health care providers, decision-making power in New Directions was "institutional power," (Tate:25) that was directly competitive with communities over who would define problems, solutions, and services. In 1995, the Robson Valley health council suggested that the New Directions process was foundering because "community development is seen as a threat by the government." (Letter to Joy MacPhail: Nov 5,1995)

By not developing the resources to make decisions in communities, the failure to transfer authority reinforced the "paradox of participation" (Lukes:183) embodied in rational management. From this perspective, as the number of participants increases, the ability to decisively affect political outcomes is diminished. In this way, "the potential cost of sharing decision-making power may have outweighed the benefit of community input..." (Wharf-Higgins:229) As in the construction of the New Directions "community," and in the exchange of bounded information, power was not perceived as a collective resource but rather as a management tool needed to achieve fiscal and

administrative rationalization.

Conclusion

In the participatory approach, opportunities for pursuing mutually defined goals facilitate a redistribution of political and social resources. In this chapter, I have compared this understanding with the participatory approach which was strategically incorporated in British Columbia's New Directions initiative. The gap between the policy's (stated) intention and its goal of "efficiency" shows that while New Directions held out the promise of broad public participation, it sustained the rational management of health policy reform.

Barriers to true participation in New Directions included a disparity between the stated goals and practices of the Ministry and those of the community boards and councils. The "two-storied" construction of New Directions prevented the formation of meaningful community action needed to effectively address health care issues. Instead, the New Directions community embodied the belief that social problems should be engaged in "manageable" units. This sustained the idea that "social problems need not be engaged from the vantage point of the collectivity...but only the individuals and communities affected under a definition of the problem." (Byrne:86) As a result, only a narrow debate within the ranks of disaffected stakeholders over

whose needs were being served by the process could occur. Constrained in this way, policy "changes" promoted in New Directions posed no threat to the existing power structure which could continue on its own terms.

Underlying the reform process was the nature of the New Directions "community" that was constituted by policy decision-makers. Consequently, a lack of representation of diverse community cultures, and confusion over roles and functions of the participants led to widespread frustration with the process. Although the "problem" with New Directions was a failure to build the collective resources needed to effect change, the inertia of the process was used to justify the announcement in June, 1996 that New Directions was "temporarily put on hold." (Newman: A13)

In November, 1996 "Better Teamwork, Better Care" was introduced by Health minister Joy MacPhail in order to resolve the tensions between the competing paradigms of community participation and the rational management of service delivery. In July, 1995 Health minister Paul Ramsey had declared in the House that "stovepipe, top-down, one-solution-fits-all administration of health care is a failure. It's a failure in wise use of tax dollars; it's a failure in integration of health services; and it's a failure in getting the services to people when they need them, where they need them." (Hansard: 16775) Sixteen months later, New Directions was cancelled in favour of a

simpler approach in which "the government's appointment process will ensure health-care decision-making." (News release: "Changes to Health Plan Put Services to People First," November 29, 1996:2) Chapter 4 discusses the political context that further limited the participatory potential of the reform initiative in order to strengthen the goals of rational management through Better Care.

CHAPTER 4

FROM NEW DIRECTIONS TO BETTER CARE: A POLICY STORY PART II

Introduction

On November 29, 1996 Health minister Joy MacPhail announced "a simpler, more streamlined approach to health care regionalization in British Columbia. "Better Teamwork, Better Care: Putting Services to People First" would replace New Directions in order to make it more efficient , cut waste and duplication and ensure precious dollars are spent of real priorities." (Press release: Nov.29, 1996) Changes introduced in the new policy model included reducing the number of boards and councils from 102 to 45; eliminating overlapping membership, and fully appointing all members of boards and councils, and mandating performance guidelines through a service contract with the ministry.

These changes reflect key assumptions about how the health care system should be reformed. In the Better Care strategy, fewer and smaller boards "equal better service integration" and "achieve more effective decision-making;" clearer roles and responsibilities for boards and councils "eliminate confusion over jurisdiction" and "guide new regions and councils as they embark on their new roles and ensure high standards..." (Better Teamwork, Better Care Facts These steps would be taken in order to establish

what Joy MacPhail argued was the only "real" change between New Directions and Better Care, "a better accounting of health care dollars for health outcomes." (Hansard vol.4, no.22, 12 May 1997)

In the shift to Better Care, conflict over the goal of fiscal retrenchment in New Directions was portrayed as a result of a faulty decision-making process. To maintain control, decision-makers had to minimize stakeholder criticism by realigning the contradictory stories in the New Directions community. By shifting to Better Care, the persuasive element of regional participation was maintained, but the reduction of the number of boards and councils and the appointment of their members augmented political control over the process.

The Better Care strategy thus incorporated three main objectives: to gain new allies for health care restructuring; to rationalize service provision by integrating health care services without shifting budgetary control; and to contain conflict in the face of reduced spending on health care.[14] In the strategy of control and persuasion designed to meet these goals, performance contracts with regional boards and councils replace New Direction's community involvement as the policy instrument. In doing so, the decision-makers invoked a form of civil

[14]In their research, Lomas et al found that most provincial health reform plans incorporated these three strategic dimensions. (p.819)

privatism which excluded everyone except for those who were "partnered" into the contractual relationship.

I. The Problem Revisited

> "Victoria will no longer be responsible for our health care system." (Joy MacPhail, Hansard vol.4, no.22)

The cancellation of New Directions and its replacement by Better Care was portrayed as a response to the problems inherent to an unwieldy and complex public decision-making process. After four years and hundreds of meetings at the community and administrative levels, the New Directions process appeared stalled. In announcing the shift to Better Care, the Health minister stated "there is no question New Directions started with some great ideas, and a worthy objective...but the complexities and debate surrounding the model seemed to draw our attention away from that goal. (Speech:2) Certainly, as the process went on, most stakeholder groups were critical of the lack of momentum in implementing New Directions. A former community council member complained that "the New Directions health plan came out years before. It had become so slow a process that it was painful."

While community council and regional board members were demanding a transfer of authority in order to "get on with" implementing change, the Health Minister used their demands to present a strategy that would restructure the

responsibility for health care services down to the local level, without shifting the balance of decision-making power. If this was to be accomplished, the challenge for the new strategy would be two-fold. The first was the need for the government to finalize its plan for regionalization and implement it without delay. The second was getting the community boards and councils to endorse the goals of regionalization.

To do this, the contradictory stories in the New Directions process had to be unified into a "Better" approach. The community-as-stakeholder component in New Directions had not proven effective in accomplishing the goals of reform. By identifying this participatory aspect as the fault line that divided the players in the New Directions process, a shift in policy was justified in terms of creating a more efficient system for managing health services. A current manager in the ministry told me that the community participation process was perceived as a "mess," and because New Directions could not be a "managed process," it had to be restructured.

In the first public indication that a shift would take place, the Health minister announced in June, 1996 that New Directions was "put on hold." On July 5, 1996 the minister appointed a Regionalization Assessment Team of four MLA's to review how well the devolution of health care policy was meeting government objectives. (Update: 1) The team's

mandated "terms of reference...emphasized the need to review the cost-effectiveness of regionalization...as well, the Minister specifically directed that the review be undertaken as quickly as possible so decisions could be made.... (Introduction, Report of the Regionalization Assessment Team:1) [15] Not surprisingly, the Regionalization Assessment Team reported a general sense that "enough time had been spent planning...and that it was time to make decisions..." (RAT:18) However, a ministry employee reported that the decision to cancel New Directions had already come down from the Premier's office to the ministry as early as January, 1996.

II. "Pushing on a String"

The shift in health reform policy represented a shift in political strategy in order to take the potential for decision-making authority out of the community and secure it in the traditional decision-making hierarchy. As a matter of strategy, persuasion was used to argue for the changes in terms of producing decisions that would better serve the public interest. In her speech announcing the new initiative, Joy MacPhail stated that "the previous model had two layers, a regional health board and a community health

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[15] The RAT review was part of the control/persuasion strategy. Councils and boards were given a chance to air their grievances about the process, and the Ministry was able to use this information to justify a restructuring of the process.

council for every community; two layers that were confusing, competitive, and inefficient...in our new plan, Justice Seaton's vision will actually be put in place." (Nov.1996)

As Deborah Stone argues, however, underneath the logic of strategically including participation "is another kind of calculus," in which "a new configuration of participation and authority" allows one particular interest to dominate. (Stone:290) What is at stake is the power to control policy decision-making, and "a call to restructure is always a bid to reallocate power." (ibid) The strategy of persuasion and control needed to implement Ministry goals for health care reform was reflected in the health minister's defense of Better Care: "We'll work closely with our new regional boards and community health councils to ensure that all our health care spending reflects the needs and priorities of British Columbians...that is why we've moved forward with our [BTBC] approach to regionalization...to forge a more co-operative and cost effective relationship..."(Hansard, 12 May 1997)

Lomas suggests that through the geographic location of some authority, provincial governments adopt a "command and control" strategy "under the cloak of devolved authority." (818) The retrenchment of decision-making authority under the guise of rational management thus creates a strategic "centralization of decentralization" (Perrow:5) in which

responsibility for reform is transferred to regional boards and councils, while at the same time control is sustained and reinforced for traditional decision-making elites. The interpretation of a former hospital administrator is that the "streamlining" of Better Care meant the reduction in boards and councils, not in the number, or authority, of the "people in charge;" in this person's region, "there are now nine administrative positions where there used to be three."

Better Care's strategy of devolving responsibility without shifting the balance of power incorporated three main dimensions: the acquisition of allies, the capturing of budgetary control, and the minimization of conflict in the face of spending cuts.

Allies

The dissatisfaction of stakeholders in the New Directions community with the decision-making approach raised the possibility that intended reforms were losing support. As a result, Better Care board and council members would be appointed under a revised Health Authorities Act which replaced the previous formula of 1/3 elected, 1/3 appointed, and 1/3 from local government or board positions.[15] The appointment process was "sold" as a form of quality assurance: "the Minister is seeking the advice of recognized local health leaders in considering potential

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This refers to the Health Authorities Act, R.S.B.C. 1996. The Health Authorities Amendment Act, 1997 proposes further amendments to the structure of boards and councils.

nominees, to ensure the membership reflects the qualities necessary to get the job done." (Questions and Answers:9) Joy MacPhail stated that the qualifications she looked for when appointing board and council members were "experience in the community and experience in managing large sums of public dollars." (Hansard: vol.4 no.22, 12 May 1997)

Changing the mechanism for establishing membership in Better Care's regional structures was also justified by the Minister's claim that the appointment process would "speed up" the devolution of authority to the regional boards and councils. For example, the Better Care literature states "the Minister is adamant that the transfer of authority take place as quickly and efficiently as possible, so in the interest of time, an appointment process will be pursued...(What's Changed...:4) By May, 1997 the Minister had appointed approximately 675 people to 34 CHC's and 11 RHB's. (Hansard:12 May 1997)

The process of choosing strategic allies to support a reform strategy is counterintuitive to true participatory models, in which the community itself initiates who will participate in the decision-making process. (Hume:9) In this way, Better Care's strategy of ensuring allies represents a two-tiered approach to centralizing authority, at the appointed local level and at the Ministry level. Lomas argues that management tactics such as appointing board members are likely to lead members toward meeting the

expectations of a particular interest, and that interest is likely to be the provincial government that created the structure of authority in the first place. (520)

Appointing allies to the local boards and councils therefore reinforces the "management by interest group" that devolved authority, at least in theory, is intended to overcome.[a] The importance of the regionalization approach in the Better Care policy strategy is that it legitimates the policy goals and actions of the "real" decision-makers.

Rationalization of Services

The mandate given to regional boards and councils was to increase the efficiency of service delivery through a rationalization of the system. Once the New Directions community boards and councils were amalgamated into fewer RHB's and CHC's, they would be responsible for establishing needs assessments, determining regional budget allocations, and developing practice guidelines and business plans. Once these were in place, RHB's and CHC's would be able to allocate funds from the Ministry to their community. (Barrett:A3)

The real test of autonomy for these regional groups would lie in their ability to allocate resources according

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[a] The stakeholder approach in New Directions and Better Care implies that the government is a "partner" in the initiatives. This obscures the fact that the government is actually the most powerful pressure group who has captured certain other organized interests.

to the needs and services within their communities. However, under Better Care's regionalization strategy, local boards have resource allocation authority but control is retained by the province. However, amalgamation of the districts was done through orders-in-council which unilaterally cancelled boards and councils and fired their members. The liberal health critic, Sindi Hawkins, suggested that Better Teamwork was an oxymoron, because the Health minister had "fired the team." (Hansard:vol.3 no.6, 27 May 1997)

Despite the way in which amalgamation was carried out, a former CHC member suggested that "amalgamation wouldn't have mattered if the Closer to Home idea of serving community needs had been the goal." A former hospital administrator agreed that the overlapping jurisdictions of some CHC's and RHB's in the New Directions model had to be reduced: "everyone on the council recognized that efficiencies had to be made, but let's not lose sight of why we were there" [on the CHC].

Key to the centralized decentralized approach to regional amalgamation, board and council members, health care professionals, hospital union workers, and the actual health agencies and institutions all become employees of the new health structure. As such they will be expected to adhere to the decisions made by or through the system. A former regional board member pointed out that management

positions for the "new" structure were advertised external to the communities which were part of the health region. As a result, the CEO of that particular area "had little community attachment."

At the time of the shift to Better Care, the literature only stated that "when an RHB or CHC assumes authority, funding for health services in the region/community for which they are responsible will flow **from** the Ministry **to** the RHB/CHC. (Questions and Answers: 2, my emphasis) However, in Better Care's regional governance structure, funding control is retained by the province. Tuohy and Evans suggest that governance of a sector without budgetary authority is akin to "pushing on a string:" those with responsibility but no real decision-making power will be unable to achieve policy change.[16] For example, local boards and councils may not make decisions regarding physician's fees and prescription drug costs. Because these two items constitute the major portion of primary health care resources, it is difficult for any board to integrate services without the ability to negotiate the impact these major fee items have on allocation decisions.

By denying the regional boards and councils fiscal authority, a "down-sized" regionalization strategy served

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[16]cf Tuohy, Carolyn and R. Evans. "Pushing on a String: The Decentralization of Health Planning in Ontario Institutions." in Golembiewski and Wildavsky, eds. The Costs of Federalism. New Brunswick, New Jersey: Transaction Press, 1984. pp. 89-116.

the need to control health care boards and providers. Granting the regional boards the authority to allocate only certain resources gives the provincial government increased power over funding distribution, and therefore reinforces control of the decision-making process. By clearly delineating the powers of the local boards, control was centralized further away from not only appointed boards and councils, but also over previously autonomous groups such as health care providers and institutions. This represents a loss of autonomy that the local hospital societies had before a reform process was introduced. According to a hospital administrator, "in our district, before New Directions and certainly before Better Care, the decision-making structure was in fact local. Care facilities, such as the extended care unit, would submit proposals for increased or changed services to the local hospital board, who would then decide if the services were needed in the community, and then fund the project." Under the Better Care approach, regional autonomy is constrained because the decision-making process emphasizes service rationalization, rather than attempting to meet the needs of the people in the health communities.

Conflict Containment

Fiscal pressure on the efficient delivery of health care services is real. The federal Government Expenditure

Restraint Act of June, 1990 significantly reduced federal cash transfers to the provinces for health services. However, "the provincial governments did not need to devolve authority to reduce expenditures on health care: devolving authority is a convenient way to shift accountability and to place a buffer between provincial governments and community conflict with fiscal retrenchment." (Lomas:821)

Conflict within the New Directions process provided the incentive, and the justification, for a strategy that promised to cut costs while at the same time it down-loaded responsibility for politically difficult decisions onto regional groups. In a speech announcing her "new" approach to regionalization, Joy MacPhail stated that "to ensure accountability is one of the most important features of the Better Care approach. Regardless of where you live, responsibility for local health-care governance and management will rest with either a regional health board or a community health council." (Speech:6) One former CHC member responded by suggesting that moving health "closer to home" actually meant transferring the blame for the failures of the system onto local groups.

The Health minister's assertion that the difference in Better Care is that the real responsibility for allocation of resources has been given to the regional bodies is therefore correct. However, it is a clearly delineated responsibility which is separated from decision-making

authority. In a national survey, regional board members stated "we don't have as much local autonomy as they make us believe we have...the government tells you what you can do, and you take the blame from the community if it is not a popular decision." (Lomas:673) The British Columbia experience reflects this interpretation. In a letter to Joy MacPhail, the Powell River Hospital Society complained that "the appointed CHC's are responsible only to you and accountable to you. If we are not satisfied with their performance--supposedly on our behalf--we have absolutely no recourse. Is this democracy?" (10 April 1997)

While agreeing that Better Care emphasized "better" accountability for local hospitals, the MLA for Shuswap suggested that "to make [accountability measures] work, there needs to be significant change to the system to provide people with an opportunity to have a voice...it is my sense that those elements have been lost in the new model." (G. Abbott, Hansard:15 May 1997) Liberal health critic Sindi Hawkins suggested that "the main reason this government set up RHB's and CHC's was to protect themselves from the consequences of politically sensitive decisions." (Hansard:12 May 1997)

Shifts in health reform policy are linked to broader strategic considerations. For example, the electoral cycle frames much of the timing of both New Directions and Better Care. A former Ministry employee reported that the NDP

opposition "sat on" the conclusions of the Seaton report until the 1991 election campaign. In 1996 with another election pending the government was under pressure to prove they were capable of taking strong action to reduce the deficit. The inertia and cancellation of the New Directions process contributed to the credibility problems of the NDP. At the same time, preservation of the health care system was one of the top policy issues in the country. The Better Care strategy offered a rational and manageable solution to the fiscal problems of the provincial government and a convenient political opportunity to be seen as "doing something" in an important policy sector.

III. The Administration of Participation

The concept of regionalization was incorporated into Better Care rational management approach in order to capture the symbolic importance of public participation, and to strategically shift responsibility onto those public participants. In the administration of participation, collective resources such as community, information, and power become management tools used to achieve pre-determined goals. In this way, the theoretically polarized policy approaches of participation and rationality project are seamlessly merged into a "managed" policy initiative. Tate argues that "the current health policy discourse in British

Columbia continues to make invisible the domination of the traditional paradigm in bureaucratic and professional practice." (5) The "Better Care" reform strategy transfers certain responsibilities to local RHB's and CHC's in what Lomas describes as "a significantly constrained set of centrally determined guidelines and standards." (Lomas:373)

Under Better Care, these parameters were formalized through a contractual relationship between the Ministry and its appointed boards and councils. Generally, contracts employ four main mechanisms:
1. Procedural norms are established in order to appropriate the knowledge accumulated by others; 2. The authority of the principal (dominant) partner is deployed to define the allocation of assets and behaviour of the contracting parties; 3. A monitoring scheme is put in place to assess both the contribution of the contractees and to resolve any conflicts that may occur; and 4. The use of incentives to provide rewards and/or impose sanctions. (Self:163-4; Foldvary:197-8)

As Better Care's central policy instrument, a performance contract with the local groups serves as a tool needed to deliver the health reform agenda. Each RHB and CHC was required to sign a service contract with the Ministry before "a transfer of authority [was] approved." (Questions and Answers:4) The Health minister stated that by setting "clear performance guidelines for boards and

councils... [they can be] monitored and audited to ensure patients continue to receive quality care." (ibid)

The goal of maintaining uniform health care standards is generally supported. However, when performance guidelines do not reflect a collective process in determining what those standards would be, whose values and needs those standards represent are questioned.[19] While acknowledging that RHB's and CHC's are responsible for providing "the best possible integrated care model in their community," Joy MacPhail promised that "at the end of the day, if the services are not being delivered in the way that has been contracted for, change will occur." (Barrett: A3) In the Better Care decision-making structure, contracting the performance of boards and councils is needed to ensure compliance. As a mechanism for strategic co-ordination, once the contracting parties accept the terms and conditions of the agreement, they also endorse the decision-maker's choice of policy goal. (Landry:180)

At the same time, the nature of the contractual relationship is by nature adversarial. The power of the principal contracting party--the Ministry--is perceived to be in competition with communities over defining problems

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[19]While stating that the contracted relationship between the government and the boards and councils would ensure standards, the Ministry was also dismantling its Quality Assurance Branch. This department was closed as of March 1, 1997. A former employee reported that complaints about services would be taken on an individual basis by the CEO of the relevant region.

and providing solutions. It is conceivable that the "practices of ruling" (Tate:30) established under the terms of the contract will generate power struggles between the government and the boards and councils. This runs counter to the motivation to initiate health policy reform in the first place, which is to resolve tensions between vested interests and community needs. Majone argues that the choice of policy instruments is not "merely a technical problem." (143) The faith that contracts are "capable of lifting the entire process out of the morass of political debate and compromise" is therefore naive. (ibid)

When public decisions are made through an exercise of public power via private contractual actors, a form of "civil privatism" is invoked. [20] In a policy mechanism which restricts political debate, the control of the dominant partner is reinforced. As a result, the public and a debate about public needs and interests are almost entirely excluded. Rationalized public decision-making fails to "bring into the open the contradictions between various demands" that the political system must account for. (Plant:51)

Because the terms of reference for policy decisions are not determined within the community, but through a self-

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[20]Because it is based on the neutral and consensual nature of economic exchange between individuals, civil privatism obscures both the asymmetry of power relations in the exchange relationship,and overstates the extent of social unity regarding decisions made by privatized public policy makers. (Plant)

enclosed formal agreement between contracting parties, the net result will be to reinforce the pursuit of self-interest of those parties. In this scenario, citizens become health care "consumers," acting as passive recipients of the interaction between health care administrators and providers. (Tate:15) Their understanding of policy consequences is neither sought nor acknowledged. Because decisions are made according to the goals of rational management, "the needs and perspectives of members of the local community appear to be most poorly represented." (Lomas:520) The administration of participation in the Better Care policy strategy does not leave room for the expectations and needs of community members. Instead, decision-making authority remains a positional good, sustained by the power-conferring rules of the contractual relationship.

Conclusion

British Columbia's Better Teamwork, Better Care health initiative represents a larger "new direction" in public policy which has manifested in varying configurations in the UK, USA, Canada, Australia, and New Zealand. (Self:156) This trend includes downsizing the bureaucracy, asserting greater political control, changing patterns of service delivery, and separating out economic goals from the political process. Together, these measures facilitate a

new managerial philosophy of resource efficiency and expenditure control which largely negates the need or desire for public input. (ibid)

"True" community-based reforms incorporate a process of supporting participants in their identification of important issues, and in their ability to plan and implement strategies needed to resolve their concerns. (Hume) In contrast, health policy structuring in British Columbia has largely been driven by the politics of rational management, in which technocratic practices assume broad-based consent while at the same time they exclude social debate. Ken Fyke, the newly appointed CEO of the Capital Health Board, suggested that "announcements about governance and other technical issues aren't what interest the public. What the average person cares about is the continuation of the health care system." (Lee: A1)

The merging of control and persuasion that separates public perceptions about health care--that they want it to continue--from decision-making practices in which they have "no interest" constructs both the implied consent and the exclusion of almost everyone from the decision-making process. However, exclusive and codified reform strategies do little to alter the traditional terrain of policy decision-making. The most prominent change created by Better Care was the shift in accountability for policy decisions onto local boards and councils away from the

"real" decision-makers without an accompanying shift in decision-making authority.

In Chapter 5 I discuss the impact of rational management on the nature of citizen participation and democratic governance in the public policy process. I conclude with a model of participation and political decision-making that develops collective resources in order to better understand and address collective needs.

CHAPTER 5

THE CIVIC COMMUNITY

> "Rather than proliferating the number of citizens and the sphere of interests, the conservative ruler concerned with governability would diminish their number, encourage their centralization and concentration of authority, grant some privileged monopolistic access, and, above all, extend the sphere of governance by devolving upon them powers to take decisions binding on their members and even their non-members. In this way...governments can collaborate in controlling citizen-initiated protest and in ensuring proper fiscal discipline and management." (Pross:220)

I. Lessons from the New Directions Policy Story

In the first two chapters, I explored the underlying values and assumptions of the rational and participatory models of policy making. In theory at least, the two approaches embody conflicting public philosophies of how society should be organized in order to meet people's needs.

In the rationality project, the ability to make efficient policy decisions hinges on the elimination of political contradiction and ambiguity. As "reasoning by calculation," this approach estimates the consequences of actions, attaches monetary values to the consequences, and calculates which actions yield the optimum results. (Stone:207) Presented as an objective assessment of policy choices based on scientifically determined data, policy making in the rational approach is framed as the determination of "correct" solutions to complex social problems.

"Community" in the rationality project is "an

occupation by two or more persons in a place, divided into public and private areas, according to a system of relations which defines and allocates responsibility for the performance of all activities that might be required for its continuity." (Foldvary:92) In the social construction of the rational community, decision-making is a positional good granted to the holders of legitimized policy knowledge and power.

In contrast, the participatory approach argues that the rational model objectifies knowledge in the pursuit of efficiency, and negates the "reality" of a diversity of knowledge and experience. In this view, a loss of political efficacy is due not to a lack of interest in political decision-making, but to systemic barriers which prevent meaningful participation. Because decision-making is exclusive and formalized in the rationality project, it ignores the "exercise of capacities whose contribution cannot necessarily be formally articulated." (Wainwright, 1994:119)

As a model of social connection and political engagement, the participatory approach hinges on a "politics of the community," (Benhabib:76) in which the assertion of perspectives traditionally marginalized in the politics of rational management is fundamental. The participatory community is based on an understanding that knowledge is both fallible and transformable. This translates into a

collective decision making practice based on the importance of shared reflection and ongoing debate. In this approach, subjective experiences are recognized and validated, which in turn creates the possibility for effective policy decision-making.

My case study of the health reform policy process in British Columbia shows how some aspects of community involvement were incorporated into the New Directions initiative. Even after the community-driven rhetoric was dropped in the shift to Better Care's formalized regional structure, the Health minister was quite correct in claiming that over 600 "ordinary" British Columbians were brought into the decision-making process. However, the fact that participants were appointed to tightly controlled regional health boards and councils illustrates that participation was permitted only in order to gain strategic support in the rational management of a complex policy sector.

The administration of participation in these health policy reforms was built on a twofold strategy of control and persuasion. Construction of the policy "problem" was driven by a need to streamline the system in order to counter rising costs and shrinking budgets for health care service delivery. In Better Care, the goal of cost-effectiveness is managed through a set of formalized relationships, specified under the terms of individual contracts, with selected boards and councils. This

illustrates how managing participation sustains the closed circuit of expertise and denies a legitimate role for competing interpretations and experiences. Self suggests that through documentation, priority setting, and categorization of the reporting hierarchies in a rationally managed policy process, the roles of individuals are also rationalized. (183) The appointment of participants is based on the notion of the empowered individual acting on behalf of the public interest.

In this construction, the "client" of health decisions is not a member of the public, but the decision maker, who, as the principal partner in the contractual relationship, must be satisfied by the performance of the boards and councils. Members of the public become consumers who may "buy into" the decisions made on their behalf. This approach assumes that "the members or customers of the contractual community have an equal legal relationship," (Foldvary:200) and indeed, the sum of [those individual contracts] is at any time the social charter...of the community." (Foldvary:92) So constructed, there is little real opportunity for access or participation for those outside the contracted relationship.

The Better Care policy strategy of control and persuasion assumes that a few can make decisions regarding collective well-being, which is legitimized by appealing to the public on the basis of "better" health service delivery.

In the rational management of health policy, collective resources such as community, information, and power are used as tools to achieve pre-determined goals. Compliance in meeting the goals of fiscal and administrative rationalization is ensured by co-opting appointed public members as strategic allies. Decision-makers are then able to point to the regional board and council members as "public" participants, and consensus from the rest of the public can then be presumed.[21] By codifying procedural norms and power-conferring rules, public debate over the direction of health policy decisions was eliminated.[22]

The degree of inclusiveness built into the reform model reflects the relationship between power and participation in the policy process. By "inviting in" selected participants, policy makers maintained the pre-ordained authority to make decisions. In Better Care, this relationship can be characterized as "integrationist," in which some joint

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[21]For example, Foldvary argues that contractual obligations eliminate the free-rider problem in the provision of collective goods by the contracted association. Uncooperative parties would "suffer the resentment and backlash of the others and thus would not receive benefits." It could be pointed out here that hospital boards and individuals who did not co-operate with the amalgamation process in Better Care suffered more than resentment: they were fired.

[22]According to one former council member, there was little public awareness of the process to begin with, "never mind all the changes" to it. A newspaper survey revealed very few articles on either New Directions or Better Care. The information that did appear in Victoria and Vancouver papers consisted of sensationalized reports of cases of failed service delivery or simply reprints of Ministry news releases.

decision-making may take place, but the final power to make a decision rests with only one party. (Hume:8) Robert E. Goodin suggests that is the "whole point of co-option...is all or most of the interested groups' elites can be seen agreeing on an appropriate pace for reform, then their constituents will suppose that the pace reflects some objective facts fixed in the nature of their world, and will make no complaints." (44)

However, traditional decision-making elites "opt unnecessarily for the quiet life." (Goodin:44) A strategy of control and persuasion is counter-productive to policy reform because conflict containment and creative problem solving are mutually exclusive exercises. The New Directions and Better Care policy models were limited in their understanding of health needs in the community at large, their ability to address these needs effectively was also limited. Lindquist suggests that if decision-makers want to facilitate policy learning "they should resist the natural inclination to dampen conflict and reduce struggles." (22)

In a broad participatory approach, debate over conflicting viewpoints determines policy issues and workable solutions, making conflict a desired and legitimate avenue to policy learning. (Lindquist:3) Because policy making is a collective process built on collective resources, the focus shifts from goal to process. Thus the analytic units

of the participatory approach are who, and what, the social construction of policy knowledge serves in the larger political community. In this framework, policy decisions must connect the way individuals define themselves in terms of how "we" should live together.

The lesson from the New Directions/Better Care policy story is that a "top-down" strategic partnership is not an effective decision-making approach. A true participatory process must address how multiple and conflicting subject-positions interact in complex policy issues, how political agency is legitimized, and how political leaders can facilitate interaction in the political community. I conclude my thesis with a proposal for a theoretical model of the civic community which considers these political dimensions of participation and power.[23]

The validity of the following discussion rests on the belief that politics represents the art of the possible. Patterson et al suggest that the interaction between conflicting ideas and alliances is a dynamic process, and thus reflects a need to focus not on "what's wrong," but on

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[23]It remains a proposed model only, both because another case study is beyond the scope of this project, and because there has been little research and writing about "what works" in addressing public policy issues. (Lindquist; Chrislip) On the other hand, many books have been written for problem-solving in the private sector which focus on, for example, creative leadership, team building, communication, and process-oriented structures. Some of these have been adapted to the public realm including the rather distressing trend towards the need for customer-oriented governance.

"what's possible." (17)

II. <u>The Civic Community</u>

Policy decisions are political claims, based on the notion of the community they represent. The definition of authority structures which recognize legitimate interpretations is determined through a struggle for participation. As members of the political community, the struggle is over how to achieve goals or rules which contribute to the collective good of the community. The implication of this perspective is that in order for politics to work, citizen efficacy must be enhanced within a much more broadly defined and politically active constituency.[24]

In this model, I adapt the term "civic community" to describe the "networks and norms of civic engagement, marked by active participation in public affairs and a steady focus on the public good." (Putnam:87) Central to this notion is not only the importance of public participation but also the dynamic of "civic networks and associations that regularly bring citizens together in constructive ways." (ibid)

Networks and alliances are critical to the civic community, because they provide the forums for addressing issues of governance, and engage citizens in debate over

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[24]Benhabib suggests the legitimation of a "participationist democracy" is found in the interstices of subjective interpretation and political engagement. (77)

policy issues. This corresponds to Pross' identification of the policy community (1986) characterized by a diffusion of authority and expertise, and the increasing interdependence of state and society. Beyond this, Pross also provides insight into the "attentive public" which he describes as those members of the policy community who possess expertise and (certain) influence to affect the policy agenda. Policy communities are "constellations of actors who share common interests in a broad policy domain." (Lindquist:7)

Building on these definitions, I refer to alliance formation in the broadest sense of the word to mean a starting point for the interconnection of people in the political community.[25] This does not suggest that conflict is eliminated, or even that it is desirable to avoid controversy over policy issues. It does mean that the focus of conflict shifts to a different level of interaction, where groups within the community must declare their own beliefs and programs, and acknowledge the salience of other perspectives.

This differs from the pattern of interest group interaction which takes place in an adversarial hierarchy or demands. In traditional liberal pluralism, the most powerful groups are able to force the solution they desire by "capturing" particular interests. The individualism

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[25]This is in contrast with, for example, Hugh Heclo's much more specific "policy" or "issue" networks.

inherent to the mediation of special interests polarizes rather than coalesces those involved, and fails to fully address policy issues, because it must oversimplify both problems and solutions. Langille argues that "those who disparage citizens for failing to participate--for abandoning the field to organized pressure groups--are blaming the victims for what is a natural reaction to modern mass politics." (240)

In contrast, participatory mechanism in the civic community ensure that collective action can have an impact on collective life. The complexity and contentiousness of policy issues contribute to the collaborative process: one criterion for measuring the success of collaborative efforts is whether the policy "problem" is complex enough to require full participation across sectoral lines in the community. (Chrislip and Larson:37)

At the same time, the notion of an inclusive participatory framework must also address accompanying problems of empowerment for all involved. While the dispersal of power may open up new opportunities for participation, it also creates a crisis in leadership. Because institutionalized public participation fails to solve problems and engage citizens, traditional political leadership is largely considered an oxymoron. Yet leadership in the civic community is fundamental to successful collaboration in order to build agreement about

needs, develop relationships among participants, and guide the search for balance between process and content.(Chrislip and Larson:73)

In addition to developing the democratic potential of citizens, the civic community requires the re-politicization of political leaders and institutions in order to bring them back into the public realm. This shift addresses the vexed issue in the participatory approach concerning who is authorized to speak for the collective. In the civic community, leadership is facilitative and employs the ubiquitous differences in power to promote and safeguard the process. Power in this sense is a shared (albeit unequally) collective resource used to debate over the public interest. (Stone)

How people are elected and how government decision-making is structured "can exert considerable influence on the extent and nature of community involvement." (Bens:35) In the civic community, leadership in governance is a mechanism that makes possible a meaningful discussion about the collective good. However, this notion is lost in the practices of rational management. A reassertion of two basic dimensions of representative democracy can reinforce the accountability of elected leaders. The first is that the "winners" in an election are obliged to consider the whole of society, and in particular, the defeated constituencies. The second is that elections are the result

of a complex array of questions that require a process for resolving them. (Saul:A19) Similarly, Langille argues for a "deepening" of representative democracy, so that officials are more accountable in extending "political freedoms" and "citizens are more fully informed of and able to participate in public affairs. (240)

In the civic community, accountability is not a "problem" to be managed within the administration of participation. Neither is it separate from the problem of empowerment. Rather, the accountable exercise of power is "intimately related...[a] more accountable government requires better informed, better organized, and a more demanding public; conversely, an enabling bureaucracy and an empowering government can assist in educating and mobilizing a concerned citizenry." (Langille:230) The electoral process is the mechanism which legitimates political leaders to employ their power in particular ways. In the civic community where the pursuit of the collective "good" depends on the exercise of collective power resources, institutional context matters.

However, electing collaborative leaders is only the first step in the exercise of recognizing and legitimating multiple views and issues in the civic community.[20] Because

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[20]Elected collaborative leaders are a necessary (albeit insufficient) condition for the civic community. To suggest otherwise would let the state off the hook in the search for innovative and workable responses to policy issues.

politics is "necessarily a system of alliances," (Stone:20) all groups are important in a collective community. Even when groups are collective only through formal procedures such as voting, bureaucratic rule-making, or bargaining, they still retain the capacity to be influenced. Policy decision are made by real people in particular roles, using particular procedures, addressing particular audiences. (ibid) Because these roles, procedures, and audiences are socially constructed, they are dynamic, mutable, and generate their own influence. This means that what we know about social issues is "socially transformable by people, including state representatives, who take action--co-operating, sharing, combining different kinds of knowledge--to overcome the limits on the knowledge that they individually possess...this brings human agency and creativity back into evolution." (Wainwright, 1993:118)

The process of collaboration in the civic community has the potential to renew an understanding of democratic representation, and maintain the accountability of formalized decision-makers through politicizing citizens on an individual and group basis. Chrislip and Larson observe two patterns of collaborative process development. One is from "interdependence to interest," in which the pattern involves parties who first recognize they are mutually involved in a problem, and then subsequently experience a shift from low to high stakes in the process as it becomes

more "meaningful" and "real" to them. The other pattern is from "interest to interdependence" where parties went into the process with high stakes and strong vested interests, and then their sense of interdependence shifts from low to high. Participants in this study identified these shifts through changes in language behaviour, in the norms of the group, and the perception of decreased differences in power and status. (102-104)

This stands in stark contrast with the experience of participants constructed in the New Directions and Better Care policy initiatives. In the reform process, participatory rhetoric was intended not to facilitate meaningful participation or to develop community input as a collective resource, but to achieve the goals of rational management which remained unchanged throughout the process. As a result, little change occurred in the patterns of interaction between the stakeholders, and therefore little was achieved in the way of policy reform. Instead, the language behaviour of the decision-makers, based on persuading the public of their actions through the use of participatory rhetoric, did not change, the membership of the stakeholder groups did not expand, and the balance of power and status did not shift away from traditional elites, but was reinforced up the decision-making hierarchy.

In the "rational" society, change is driven by exchange, which in turn motivates individuals to improve

their own bargaining power. Through ongoing exchange, the use and distribution of resources may shift, but the resources themselves never change, remaining fixed and finite within the frame of the exchange transaction. (Stone) In the civic community, change is driven by the interaction of ideas and alliances and measured in terms of the political process that chooses and implements the means of policy decisions. In contrast to a theory of scarce resources, political resources in the civic community expand with use, through interconnections between ideas and people, and the development of political skills and authority. (Stone:22; Lindquist:23)

Empowerment theory has long recognized that positive participation has a "normalizing" effect that confirms differing perspectives as legitimate, and in turn encourages more active participation. In this way, "collaboration becomes more than a tactical and strategic means for resolving problems; it becomes a means of re-establishing oneself as a part of a larger community." (Chrislip and Larson:161) Building a political community thus involves a dual purpose that involves a confirmation of self-identity and a development of a sense of efficacy. (Gardner:5) In the civic community, the dimensions of community, information, and power are relational. Their configuration is dependent not only on the democratization of decision-making practices, but on the formation of communities of

need and solidarity around those processes. (Benhabib:302)

In this framework, a true "new direction" in health policy reform would begin with increasing the democratic capacities of people from the many communities which exist in society. Effective reform means incorporating multiple and diverse interests involved in health issues, beginning with traditionally disenfranchised groups. It also requires dynamic leadership to accord these voices legitimacy. Bringing them in at the earliest stages of the process enhances the informal networks that already exist in complex policy areas. (Lindquist:26) As in any good working relationship between people, leadership is needed to maintain direction, align interests, and inspire them to act. (ibid:28-29)

Envisioning how such a process might work in the civic community offers the possibility for widening the scope of the possible. Stone argues that the effect of trying to imagine the meaning of a common goal, and of trying to fit one's own interpretation into that image is a "centripetal force." (310) In this understanding, the search for shared criteria as the basis for common understanding of collective issues forces and articulation of preferences and positions, and reinterprets procedural norms and institutional practices.

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Personal Discussions

Conversations with participants in New Directions and Better Care took place between 15 January 1997 and 20 June 1997. Because all but one person I spoke with requested anonymity, all comments that arose from these conversations are not directly attributed in the text. Only authorized comments appear. Contacts with participants were made largely through word-of-mouth and were often suggested by the participants themselves. My conversations with them took place one-on-one in an informal setting. Before we began, I explained my research process and my central thesis idea, and encouraged them to ask questions about my work. During our conversation, I took notes by hand. At the end of each meeting, I gave my notes to the participant who then read them over, made corrections and deletions, and marked which information I could use in my thesis and which I could not.

For further information regarding this method, often called subject-participant interviewing, refer to Sandra Kirby and Kate McKenna, Experience, Research, Social Change: Methods from the Margins. Toronto: Garamond Press, 1989.

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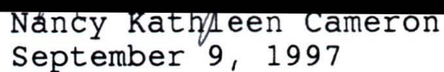
Author 

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