Articles

Barriers to Consumer Empowerment: Implications for Health and Social Services Planning in Ontario

Donna Hardina
California State University, Fresno

Olga W. Malott
University of Waterloo

Résumé: *Après leur accession au pouvoir en 1990, les néo-démocrates de l'Ontario ont dressé un plan visant à impliquer les usagers dans la planification des services de santé et des services destinés aux enfants. Si ce gouvernement semblait faire preuve d'une certaine ouverture d'esprit, son stratagème, en fait, n'a servi, qu'à masquer sa volonté de centraliser les pouvoirs. Les usagers étaient à nouveau opprimés, mais cette fois par un processus en apparence démocratique.*

Naguère, le rôle des citoyens dans le processus de consultation était évalué en fonction de la participation des personnes à faible revenu. Dans le présent article, les auteurs mettent d'abord en lumière les obstacles auxquels s'achoppent les bénéficiaires à faible revenu qui sont désireux de siéger aux comités de planification locale. Puis ils poursuivent en décrivant l'incidence de ces obstacles sur l'intégration des personnes à faible revenu au processus de planification des services de santé et des services sociaux en Ontario.

Introduction

In Ontario, the NDP government elected in 1990 encouraged community-based health and social service planning boards (primarily district health councils and children's services planning groups) to decide what services were needed by the community and determine government funding priorities.[1] Community planning can be defined as a "process of setting commonly shared goals and identifying strategies to achieve them, involving a variety of stakeholders, reflecting the diversity of the community".[2] Often community planning efforts have involved attempts to "coordinate" or "integrate"

social and health services, making programs more accessible for community residents or reducing government expenditures for service delivery.[3] Provincial governments in Canada have established community planning structures designed to encourage participation from consumers of health and social services. One of the purposes of such efforts is to "empower" low-income people and members of marginalized groups. Consumer involvement may, however, merely mask a government agenda to retain centralized control over planning and decision-making. Thus oppression of low-income consumers is maintained under the guise of a pseudo-democratic process.[4]

Often government has utilized consumer participation in local decision-making as a component of a strategy to "reform" social service delivery. Reform efforts in Canada were greatly influenced by the Seebohm Report, published in Great Britain in 1968. The Seebohm Commission recommended that service fragmentation be addressed through the development of social and health services that were centralized for administrative purposes and decentralized for service delivery purposes. Local participation in service decision-making was also recommended.[5] Both Quebec and British Columbia during the early 1970s used the recommendations contained in the Seebohm Report to introduce reform projects that included consumers, service providers, and other community residents in local planning for service delivery; participation was not the primary goal of these projects though. Local Community Service Centres (CLSCs) in Quebec were intended to help communities to respond to social issues through the integration of all health and social service agencies. Community Resource Boards in British Columbia were designed to coordinate and integrate existing programs, and increase accountability to government. Evaluative research indicates that these efforts had limited success in creating structures that could give low-income people a voice in the decision-making process. What this research also identifies, however, are mechanisms that can be utilized to empower low-income consumers.[6]

This paper examines the research literature on consumer participation in health and social service planning decisions in order to assess whether children's services and district health councils in Ontario have the potential to empower low-income consumers. Based on findings from evaluation studies of government-sponsored citizen participation initiatives in Quebec and British Columbia and other small scale consumer and/or community participation projects, structural barriers to consumer participation are identified. The implications of these studies for community planning in Ontario are described.[7]

Theoretical Framework: Community Planning as Social Control

Involvement of service consumers in local planning efforts can be used as a means of alleviating the harmful psychological efforts of poverty by increasing the power of individuals to change those environmental conditions responsible for their problems.[8] Involvement in local planning efforts is thought to decrease feelings of alienation from the dominant culture, helps individuals develop the capacity for collection action, and leads to the development of a sense of "community" or responsibility for and ability to resolve local problems.[9] In order to achieve these results, most recent government-mandated planning efforts identify "consumer empowerment" as a primary goal.

The term "consumer" is often utilized to describe those people who receive free services from government-funded organizations as well as people who purchase services for a fee from either non-profit or for-profit health and social services organizations. It is commonly used as an alternative to the word "client". The terminology is important if one believes that the hierarchical structure of social service organizations renders clients powerless to bargain for the goods and services they need.[10] A consumer is a person "who acquires goods and services to satisfy his [or her] needs." A client, on the other hand, is "dependent upon or controlled by the helper."[11]

Inclusion of low-income consumers on planning boards can be a critical component of social service reform; without specific mechanisms for participation the boards may be dominated by traditional elites, often middle- and upper-income service consumers. While all Canadian residents in theory have equal access to government-funded programs, middle-income consumers have been able to purchase additional heath care and social services to meet their needs; without the power associated with exit from the service system, low-income consumers may have limited opportunities to influence how services are delivered.[12] Although the empowerment of low-income consumers may not have been an explicit goal of early social planning initiatives, these efforts have commonly been evaluated based on whether the planning process resulted in the inclusion of low-income consumers on local boards.[13]

Empowerment can be defined along three dimensions. An individual is empowered when her self-esteem or self-efficacy is increased. At the intrapersonal level, empowerment comes through the construction of knowledge and analysis of social problems acquired through shared experience. At the community level, empowerment occurs through the development of service resources and social change strategies, which in turn help individuals gain mastery over the environment.[14] Community planning is thought to provide opportunities to empower low-income people along all three of these dimensions.

Consumer involvement in planning does not always "empower" consumers, regardless of social class. As suggested by Arnstein, government can structure planning to either control or negate the amount of actual input community residents have in local decision-making.[15] Planning boards that foster high levels of participation are those in which government transfers complete community or consumer control over certain types of decisions to local residents. Alternatively, participants can be limited to an advisory role, "rubber stamping" decisions made by government officials. Government may also choose to use the planning process to "manipulate" public opinion (altering the service preferences of participants) or use participation mechanisms to provide "therapy" (change the behavior or attitudes of marginalized members of society).

Whatever government's rationale for the inclusion of low-income consumers in community planning processes, transfers of decision-making authority often result in increasing the power of middle-income groups, professionals, bureaucrats, and members of traditional élites.[16] It can be argued that government-sponsored initiatives are not actually intended to "empower" low-income consumers, but are utilized by the State to control political dissent. The State mediates competition among interest groups within the élite and relations among the social classes.[17] Although the State may allow opportunities for political involvement of the working class and the poor, consumer participation in social service or health planning at the community level may simply be designed to control the activities of dissident groups.[18] The availability of government funding for such efforts keeps decision-making within the confines of government policies and provides opportunities for political activists to participate in government-sanctioned initiatives.[19] The State, through such processes, fosters the perception that it promotes the interests of all social classes rather than those of private capital. Consequently, government mandates for citizen/consumer involvement in local planning often result in a minimal transfer of power to low-income communities or consumer groups. As Christiansen-Ruffman has argued:

> Because participation often involves struggle and some change in power and decision-making structures, the very existence of state-sponsored participation programs is somewhat of a contradiction. The state structure, which is organized to govern through its authoritative decision-making structures does not normally foster ideals of power sharing, especially in the centre of power.[20]

Despite the difficulties inherent in citizen participation processes, consumer empowerment is not always an elusive goal. Powerful local boards (or constituency group representatives on boards) can be effective in reconciling local needs with government demands.[21] O'Neill speculates that in the case of the Local Community Service Centres in Quebec, consumers were able to

match the power of bureaucrats and professionals in some cases due to their autonomous source of power (mandated seats on the board). He identifies four factors that are essential if consumers are actually to be empowered:

1. A source of adequate information about the service system and agency operations and a means to assess whether the executive director has provided accurate information.
2. A constituency base among residents of the community.
3. The personality or ability to stand up to administrators.
4. Informal or formal processes for getting feedback from constituency groups.[22]

Barriers to Consumer Participation and Empowerment

Information obtained through evaluative studies of previous consumer participation efforts can be used to identify a number of barriers to effective implementation. These barriers, listed below, prevent consumers from achieving full control of the decision-making process and may represent either unintended consequences of government-mandated planning or deliberate efforts to block consumer input in the planning process.

1. *Few low-income consumers are actually seated on local planning boards.*

Although the Quebec government initially recommended a strong citizen participation component in the service reform plan introduced during the 1970s, few low-income consumers were actually involved in decision-making. The final legislation limited public participation to seats on agency boards explicitly reserved for service users and members of "socio-economic groups" representative of the local neighborhood. In agencies, consumers were assigned one quarter to one third of the seats. On the CLSC governing boards, consumers were originally given 50% of the seats, but this was later reduced by "reform" legislation passed in 1982.[23] In British Columbia, local residents were to elect representatives to community boards. Voter turnout varied substantially by community (5 to 43%). Only a few service consumers were elected to the local boards. Most members were male, middle-income professionals: social workers, educators, health professionals, lawyers, and police offices or business leaders.[24]

2. *Government intends to put control of decision-making in the hands of community and consumers; instead service professionals dominate boards and control all decisions.*

In a study of consumer participation in health planning, Christiansen-Ruffman and Catano found that consumers were the last group asked to

participate and were invited midway into the planning process.[25] Planning goals tended to be means-oriented rather than focused on the impact of service changes on consumers. Consumer participants were not considered "experts' and were often excluded from decision-making. Government officials as well as staff members associated with the community planning agency controlled technical information and refused to make such information available to the "non-experts".

In Quebec, representatives on the CLSCs seldom were involved in making crucial decisions. According to O'Neill, service users often felt powerless due to their minority position on the boards and the technical nature of decisions. Service professionals regarded consumers as limiting the efficiency of decision-making and generating conflicts among different interest groups affiliated with the agencies

Domination of the planning process by experts can also be attributed to perceptions of service consumers (and even middle-income board members without technical expertise) that they do not have sufficient knowledge to make technical decisions. Technical language in itself may present a formidable obstacle to the inclusion of non-experts in the decision-making process. Barr describes the impact of negative self-conceptions among consumers involved in negotiating with service professionals toward the developmental of an integrated, client-oriented service unit in a Toronto housing project.

> "We were all scared to death," recalled one. "Here we were, little uneducated people, and they all went to school! How are we going to talk to them — they've all got B.A.'s. We were worried that the agencies would say, flatly 'no' to our proposals!"[26]

The fact that many consumers are members of socially stigmatized groups with few power resources (money, contacts with politicians, social status, professional memberships) further limits their ability to bargain with government officials or professional staff.[27]

3. *Responsibility for funding allocations and decision-making remains with the service professionals and/or government planners.*

In the case of the Community Resource Boards in British Columbia, the government retained control of funding authority and ultimate responsibility for planning decisions. Conceivably, the Minister of Human Resources could override those community decisions with which he disagreed. The separation of funding authority and local decision-making and spending authority is a key problem limiting the effectiveness of community planning.[28] Efforts toward integration of social, health, and education services are also hampered by limited integration of funding authority and decision-making on the part of the various provincial ministries responsible for these services. In

Quebec, restructuring efforts included a system for both centralized planning and government control of service delivery and those staff members providing the service. "Consumer participation" simply provided government with an ally in the process of social reform and allowed the government to appear to be responsive to voters.[29]

In all of the government-mandated efforts described above, most of the services integrated into "coordinated systems" were provided by traditional agencies aiming to change individual behaviour, rather than social change organizations intending to facilitate structural changes in the social environment.[30] Although government social service reforms in the 1970s were intended to alleviate poverty by addressing social problems attributed to structural inequity, the services provided actually focused on the individual as the locus of social problems and attempted to "integrate" members of deviant groups into the dominant society.[31] Reliance on existing service structures required that traditional "medical" models of service rather than community "empowerment" models guide the decision-making process.

4. *Government reduces the power and authority of boards when participants demand more funding or services.*

The Ontario government made several attempts during the 1970s and 1980s to transfer authority for funding allocations and local services planning to children's services councils and then withdrew such authority when local organizations demanded increased funding for services.[32] The Children's Services Division of the Ministry of Community and Social Services had proposed the development of Children's Services Coordinating and Advisory Groups (CSCAGs) in order to pursue the Ministry's goal of decentralizing services. The CSCAGs were intended to act as a mechanism for local management of services for children. Six demonstration projects were to eventually assume responsibility for planning and evaluating local services, establishing service priorities, and allocating funds to voluntary organizations delivering children's services.[33] Service consumers, providers, and elected government officials were members of the CSCAGs.

In 1982, MCSS decided against giving funding authority to the local committees. Instead the CSCAGs were limited to an advisory role for municipal governments and similar advisory groups were established in other Ontario communities.[34] The reasons given by MCSS officials for limiting the authority of the CSCAGs included high administrative costs and opposition from municipal governments who feared that they would have to assume all responsibility for financing children's services. Hurl suggests that the authority of the CSCAGs was restricted when government found that local planning was not cost-effective. Instead local groups identified unmet needs and advocated for more government funding to expand service delivery.[35]

5. *Government utilizes boards for co-optation of dissent or to centralize government decision-making.*

Government funding often turns organizations away from their original advocacy mission as they adopt the government' planning priorities.[36] This has a particularly insidious effect on low-income communities or groups representing the disadvantaged because they seldom have alternatives to government funding. Another consequence of government funding is that the organization becomes accountable to government rather than residents of the local community.[37]

A recent study by Pulkingham revealed the tensions created when a local community development initiative received funding (after substantial lobbying by local politicians) from the only available source, a government program designed to subsidize research on the needs of new immigrants. Local residents were adamantly opposed to any efforts that would bring immigrants into the community. Since the "felt" need of community residents did not correspond with program goals, the project ultimately did not succeed.[38]

Government funding may also result in the co-optation of social-change-oriented organizations. Schreader studied the impact of federal funding on women's organizations in Canada. She concluded that state funding can co-opt radical movements. State representation is structural and hierarchical. Not all interests are represented equally. Funding cutbacks have resulted in rigid accounting procedures and more control over funded groups. The hiring of government staff from among members of the women's movement turned individual staff from advocates into mediators.[39] A number of researchers who have conducted analyses of social service reform in Quebec have argued that one of the purposes of the participation provisions in the service reforms of the 1970s in Quebec was to stifle political unrest (Quebec Liberation Front (FLQ) activities, public employee strikes, organization of Marxist-Leninist groups in low-income communities).[40]

6. *Government regulations limit the types or quality of the decisions made by the community.*

Muller, Walker, and Ng have suggested that community planning is often utilized by government to control the provision of service delivery while offering the appearance of community involvement in the process.[41] Government regulations and accountability requirements alter the administrative structure and client-oriented program goals of community-based organizations and planning groups.[42] Often community groups experience difficulties in working with government officials. Bureaucratic norms are violated (such as hours of work or compensation) when working with community groups. There may also be tensions between experts (government bureaucrats or technicians) and unskilled community residents.[43]

In a study of government-funded services for immigrant women, Ng, Kwan, and Miedema found that state funding may result in reduced capacity for advocacy and increased service capacity in citizen organizations. Record-keeping and intake forms placed an administrative burden on organizations. Funding insecurity and short funding cycles placed the organization in a vulnerable situation. Compliance with funder demands also changed the organization's structure. Organization decision-making moved away from consensual processes with few boundaries between board members and staff and became more hierarchical as the organization changed in response to government demands for accountability.[44]

7. *Use of community boards to make funding cuts or coordinate services "shifts" accountability and costs of service delivery from government to local decision-makers and service agencies.*

Often community-based planning boards are intended to "coordinate" and "integrate" service delivery with the intent that such efforts will not only reduce service fragmentation and increase access to services for consumers, but that these actions will also reduce government expenditures. However, as Clague et al. found in examining the establishment of Community Resource Boards in British Columbia, increased access and consumer input in decision-making will result instead in higher demand and greater expenditures.[45] In some instances, government may respond with increased allocation. In others, costs will be "passed on" to social service agencies, communities, family members, and clients.[46]

McKenzie describes the process of decentralization of child welfare services in Manitoba during the early 1980s.[47] Responsibility for child welfare services in Winnipeg was "devolved" to six non-profit community agencies serving local populations of approximately 100,000. Boards of directors for these agencies were elected from the agency's geographic catchment area. Board members were representative of community residents in terms of both ethnicity and class. Restructuring was intended to emphasize preventative programs and early intervention, improve responses to local needs, and increase coordination with other agencies. It was also assumed that restructuring could be accomplished without new funding from government. Service outcomes included greater access to services, an increase in outreach and prevention programs, more children in care, and increased demand for services. Pressure from community interest groups resulted in greater government expenditures for services, not less. Expenditures did not rise as quickly as demand however. Consequently, staff work loads increased. Funding limitations resulted in a shift to more residual types of services during the fifth year of program implementation.

8. *Community planning results in conflict among local interests and decision "gridlock" as these groups compete for funds.*

Hardina examined decision-making in a Children's Services planning group in southwest Ontario.[48] Although the area Ministry of Community and Social Services office announced plans to place authority for the allocation of funding with members of the planning group, it almost simultaneously announced that there would be little or no new funding for children's services. When funding was available for distribution, the recommendations of the board were ignored. The composition of the board (consumers, "key informants" with no direct stake in the decisions, and representatives of all five children's mental health centres serving the community) served to increase conflict among planning group members, and made the planning group a target of community frustration with the decision-making process. Efforts to coordinate service delivery among area providers were ineffective as the providers attempted to acquire funding for their own agencies. Consumers had virtually no power to influence the decision-making process. The local MCSS office subsequently limited the planning group's authority to identifying priority needs in the community and writing letters of support for agencies that had requested funds for new programs.

Implications for Consumer Empowerment in Ontario

It is questionable as to whether Ontario's current efforts to facilitate community planning for children's services and health care will actually empower consumers or result in improvements in service delivery. Although the province intends to utilize pre-existing structures to facilitate planning, previous decision-making processes have been poorly funded and often lack mechanisms to integrate health or children's services with other social service delivery systems. In addition, as with the Community Resource Boards in British Columbia, these local Children's Services Coordinating and Advisory Groups (CSCAGs) and District Health Councils (DHCs) lack authority to change government policy or to make most allocation decisions.

Children's Services Coordinating and Advisory Groups

Children's Services Coordinating and Advisory Groups would seem to be especially ill-suited to make effective planning decisions. There are currently 18 CSCAGs in Ontario. Although all these groups receive government funding, they have differing orientations (planning, research and/or service coordination) and membership (some combination of service providers, consumers, informed community residents, and municipal representatives). They simply advise area Ministry of Community and Social Service offices on local service needs rather than take a mandatory role in MCSS planning

provincially. The CSCAGs view themselves as "community based, community driven, accountable to the community first and secondly to funders, voluntary in nature, and free of vested interests".[49] Operating without assurances of actual input in government decision-making and no mandatory role for service consumers in the planning process, it is unclear to what degree these planning groups actually "empower" communities to develop service delivery systems that meet local needs. Although MCSS has no established planning process of its own (instead relying on area offices to establish service priorities and allocate decision-making), CSCAGs have been expected to take a lead role in current efforts to "coordinate and rationalize" services.[50] Under the Rae provincial government, MCSS called for area offices to establish a mechanism for planning children's services in localities where CSCAGs do not currently exist.[51] In 1995, however, the Harris government announced plans to terminate existing CSCAGs.

Despite the role these organizations have been assigned in community planning, MCSS has narrowly defined the responsibilities assigned to the CSCAGs. The planning boards have no direct input into funding allocations, but simply determine what services should be a priority for funding and identify gaps in existing services based on analysis of local needs. Government has also narrowed the range of possible recommendations the CSCAGs can make. Although the planning boards are to develop innovative models, a school-based services model, proposed by the advisory Committee on Children's Services, "Children First" has been promoted by the provincial government as the preferred type of delivery system.

District Health Councils

In contrast to the fragmented children's services planning system, the Ontario Ministry of Health has an established network of 32 local health planning groups known as District Health Councils. The DHCs have been operating in some areas of Ontario for over 30 years. Each DHC is mandated to plan health care services for its district, to integrate health and social services as much as possible, and to advise the Minister of Health.[52] The NDP provincial government mandated that each DHC have proportionate representation from consumers (30%), service providers (30%), and community experts (30%). Within the latter two groups, an equal representation of health and social service interests is required, as well as labour and management representation. Consumers have been defined as individuals who have no present or previous contact with the health system other than as end users. Consumer seats on the DHCs are the most difficult to fill and DHC staff often comment on the lack of interest shown by consumers in participating in the DHC process.

One DHC in Ontario is serving as a planning model for the rest of the province. The notion of "total system reconfiguration" dominates the model. Planning is to involve a range of health care institutions including hospitals, community-based health services, long-term care, and social services. A central component of the model is a "citizen board" with members who represent the best interests of the community and are not concerned with the survival of a specific program or service.[53] The Minister of Health in a letter to the DHC describes the composition of the DHC's reconfiguration implementation committee as follows:

> I agree with the principle that the Implementation Committee not be a constituent assembly of stake holders. In support of that principle, I would suggest that 50% of the Implementation Committee be consumers. In addition, it is important that there be satisfactory labour representation, particularly given the positive role that labour has played in the progress of the project. The Committee should reflect a balance of community and institutional interests and ensure a meaningful role for all stakeholders in the process. I would ask that you recommend names to the Ministry for Ministerial appointment.[54]

At the present time, total system reconfiguration is moving forward slowly as those in power (hospital administrators and community program directors) are uncomfortable with giving control to a community-driven approach. Although consumer input is critical to the success of this model, planners have simply assumed that the community is aware and supportive of the planning process. Since solicitation for membership is primarily through newspaper announcements, many members of marginalized groups (the poor or illiterate) are not even aware of the request for new council members.

There are two ways in which government still exerts control over the activities of the DHC and limits the degree of power given to consumers:

1. DHC membership is by appointment through a process known as Orders of Council. The local DHC solicits applications from the community, interviews potential members and forwards a list of candidates and alternates to the Minister of Health for final approval. Approval is not automatic and some or all of the proposed candidates and alternates may be rejected. This process permits political influence to determine appointees, with an increased probability that individuals who are in agreement with the current political direction are appointed.

2. The DHC has no direct control over funding of specific programs and services. The DHC is simply an advisor to the Minister of Health on allocation; the final decision and flow of funds is still from the centralized government. Service providers such as hospitals and long-term care

facilities negotiate their annual budgets directly with the Ministry of Health staff with the result that the final amount allocated may not be in accordance with that recommended by the DHC.[55]

Each DHC has also been mandated to establish a Long Term Care Committee (LTCC) which is to be made up of an equal number of consumers, providers, and others interested in long-term care.[56] The LTCCs are guided in their efforts by the needs and preferences of the community as well as by provincially-established guidelines and standards. The LTCCs are responsible for advising on allocation of local funding, monitoring and evaluating the long term care system and establishing Multi-Service Agencies (MSA). Each MSA is to have its own community board of directors.[57] However, plans to include low-income consumers on these boards were abandoned. In 1994, the Ontario Minister of Health, Ruth Grier announced that consumer representatives to the MSA were to be selected among the ranks of union members.

Once the LTCC has devised a plan for long-term care, it is to be submitted to the DHC for approval. The approved plan is then to be forwarded to the Ministers of Health and Social Services. The final decisions as to the flow of funds rest with the Ministers. In the long term care reform documentation there is little mention of any appeals procedures should the plan developed by the LTCC not be approved in whole or in part at any level. Further, all plans must adhere to the standards and guidelines developed at the Ministry level. Control of funds remains at the Ministry level also. Bill 173 confines planning to specific topics and areas. This legislation describes the composition of the MSA staff, the services it will deliver, and the allocation of operational costs. The MSA notion is causing great concern on the part of service providers as one of its primary goals is to absorb all existing agencies and service providers into one organization.[58]

Implications for Consumer Empowerment

It is clear that the Ontario government, while specifying that consumers should be "involved" in community planning, has restricted the ability of local planning structures to either design delivery systems or allocate funds to meet local needs. The limited role and authority of these organizations suggest that government is using them to achieve fiscal objectives under the guise of community consultation and needs assessment exercises. Legislation and policies which limit the range of planning choices for these organizations suggest that they are utilized as a mechanism to promote government centralization and delivery of services. Thus consumer participation goals become subordinate to government agendas.

Control of decision-making is also limited by the need for consumer members to have technical knowledge. Systematic training of community

board members is not commonly available in most planning groups. Leadership training, training in group facilitation, and communication skills training would encourage "non-experts" to volunteer for community boards and further would allow them to participate as equals.

MCSS has not offered any direction to local planning groups concerning board structure or activities other than to recommend the "Carver Model" of board governance which recommends a narrow role for the board (limited to setting policy direction) and an expansive role for the organization's executive director. Carver advises board members to not involve themselves in organization management. Board members are to simply attend meetings and allow the executive director "to lead". Carver argues for an approach to organizational management that will:

> enable a part-time, possibly inexpert group of persons to lead. They have neither the time nor the ability to control every action, circumstance, goal, and decision. And if perchance they did have both time and ability, the organization would slow to a halt as they carried out their task. The most expensive resource of public and nonprofit organizations, the staff, would be significantly wasted as the official second-guessing process ground on. Boards caught in the trap of being staff better than staff, as well as boards bewildered by unending detail or confused by technical complexities, cannot lead.[59]

This model would seem to be directly at odds with consumer empowerment. It would increase the authority of professionals in the planning process much as the LCSC model did in Quebec and would give consumers almost no formal role in selecting community members or constituency group representatives for seats on the board.

In addition to the explicit bias toward "expert" power, it should be noted that some changes in board composition do little to alter power differentials among board members. Composition of the Ontario boards differs in one important respect from board composition in the British Columbia and Quebec experiments: most of the provider and consumer representatives on these boards are women. In the authors' experience, the main barrier to full inclusion of consumers in the decision-making process is social class; low-income women are rarely treated as equal partners by other women. Female provider representatives often represent male-dominated institutions or community elites; the hierarchical nature of the health and social service organizations represented (as well as the hierarchical nature of the children's and health planning organizations) serves to sustain the power differential between the provider representatives and the consumers.[60]

Conclusions

One of the primary concerns for local planning initiatives in Ontario is the current orientation toward service integration and rationalization. Local planning groups are to make recommendations to either limit expenditure growth or reduce service expenditures. There is a basic contradiction, however, between resource rationing and community empowerment. Fewer resources mean reductions in the voluntary sector's ability to control service decisions. While collective sharing of resources and responsibility for service delivery on the local level is an admirable goal, it does not allow for the expansion of services to address gaps in the existing system or develop programs in response to newly recognized needs.[61] What is likely to happen as government and voluntary agencies scramble to protect scarce resources is that service consumers will face a reduction in the types and quantity of services available and will consequently have little power to choose the services they need or to participate in the development of new systems of service delivery. Can local communities develop plans that adequately address local needs if they do not have control of the purse strings?

One of the ironies of the community planning movement in Canada is that large-scale consumer participation initiatives have been undertaken primarily by social democratic provincial governments. Despite the best of intentions toward service consumers such initiatives may represent attempts to by-pass traditional capitalist elites and win political support or to hold the line on increases in social welfare expenditures (always unpopular with middle-income voters). Community planning also represents an effort to better integrate voluntary agencies and government services. Therefore such efforts, as with government contracting for service delivery with private agencies, may simply be a strategy to centralize (rather than decentralize) decision-making and increase the power of government (rather than private citizens) to make social service or health-related decisions.[62]

It should be noted, however, that not all aspects of community planning are negative. In some areas, local planning has resulted in increased government expenditures for health and social services. In Quebec, consumers have been able to develop sources of power to improve their bargaining position vis-a-vis service providers and government. Social scientists, policymakers, service providers, and consumers need to monitor these planning processes and examine those aspects of the projects that work and those that impede decision-making and empowerment. There may be community development strategies that are helpful for creating partnerships between government and local communities. Local variations in interest groups and power dynamics may alter the composition, the structure, and the balance of power on community boards.[63] Despite implications for co-optation and social control these planning boards do provide a forum for political

expression that can be utilized by community activists to alter oppressive service delivery structures.

NOTES

1. A previous version of this paper was presented at the 6th Biennial Conference on Social Welfare Policy, Memorial University, St. John's, Newfoundland, June 1993.
2. M. Shookner, "Community Planning in Ontario." Paper presented at the 6th Biennial Conference on Social Welfare Policy, Memorial University, St. John's, Newfoundland, June 1993, p. 1.
3. See B. McKenzie, "Decentralization in Winnipeg," *Canadian Review of Social Policy*, 27 (Summer 1991): 57–65; M. Clague, R. Dill, R. Seebaran, and B. Wharf, *Reforming Human Services* (Vancouver: University of British Columbia Press, 1984).
4. M. O'Neill, "Community Participation in Quebec's Health System," *International Journal of Health Services*, 22,2 (1992): 287–301; F. Lesemann, *Services and Circuses* (Montreal: Black Rose Books, 1984).
5. Clague et al., *Reforming Human Services*.
6. O'Neill, "Community Participation" and Lesemann, *Services and Circuses*, describe social service reform efforts in Quebec. Clague et al., in *Reforming Human Services*, evaluated health and social service integration in British Columbia.
7. One of the authors served as a board member of a Children's Services Coordinating Advisory Group (CSCAG) in Ontario; the other author was a staff member for a District Health Council (DHC) also in Ontario. Some of the barriers and issues identified are derived from the authors' experiences in these positions.
8. B. Lee, *Pragmatics of Community Organization* (Mississauga: Common Act Press, 1986).
9. J. Rappaport, *Studies in Empowerment: Steps Toward Understanding and Action* (New York: Haworth Press, 1984).
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50. Shookner, "Community Planning."
51. Ontario. Ministry of Community and Social Services. *Children's Services Policy Framework* (Toronto, 1993).
52. Ontario. Ministry of Health. *Joint Task Force Report* (Toronto, 1993).
53. Essex County. District Health Council. *Final Report of the Essex County Steering Committee on Total System Reconfiguration* (Windsor, 1993).
54. The Honorable Ruth Grier, Minister of Health. Letter to the Essex County District Health Council (December 10, 1993).
55. The DHCs have expressed their frustration that their new role is not entrenched in legislation, but is merely based on an understanding between themselves and the Ministry of Health. The provincial government has addressed this issue by introducing Bill 173 to make a change to the Ministry of Health Act. See Bill 173, *An Act Respecting Long-Term Care*, 35th Legislature, 3rd Session, Ontario, 43, Elizabeth 11, 1994. The Honorable Ruth Grier, Minister of Health, 1st reading, June 6, 1994.
56. Long-term care committees are cumbersome due to their large size (many in excess of 25 members).

57. The Conservative provincial government elected in Fall 1995 is expected to alter NDP-sponsored plans for establishment of the MSAs.
58. Ontario. Ministry of Health, Ontario Ministry of Community and Social Services, and the Ontario Ministry of Citizenship. *Building Partnerships in Long-Term Care: A New Way to Plan, Manage, and Deliver Services and Community Support: A Local Planning Framework* (Toronto, May 1993). Ministry of Citizenship. *Building Partnerships in Long-Term Care: A New Way to Plan, Manage, and Deliver Services, and Community Support*; An Implementation Framework (Toronto, June 1993); Ontario Ministry of Citizenship, Building Partnership: A New Way to Plan, Manage, and Delivery Services and Community Support: Guidelines for the Establishment of Multi-Service Agencies (Toronto, September 1993).
59. J. Carver, *Boards that Make a Difference* (San Francisco: Jossey-Bass, 1990), p. 25.
60. For a discussion of the impact of social class on decision-making among women see Cheryl Hyde, "Commitment to Social Change: Voices from the Feminist Movement," *Journal of Community Practice*, 1 (1994): 45–63. Ng, Kwan, and Miedema, "State Funding and Immigrant Services," also describe the impact of government funding in creating class differences between workers and clients within community-based organizations.
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