Community participation in action: an analysis of the South Australian Health and Social Welfare Councils

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SUMMARY
This paper presents an analysis of a health department’s efforts to introduce a mechanism to increase community participation into a bureaucracy’s decision-making, planning and operations. In the 1980s, South Australia adopted a Social Health Policy and a Primary Health Care Policy. These documents were intended as a means of implementing the state’s commitment to ‘Health for All by the Year 2000’ and the Ottawa Charter for Health Promotion. A key plank of each of these policy statements is the strategy of involving community people who are not professionally involved in the health sector, in the process of promoting health and tailoring health services to the needs of the local people. In South Australia, one of the means by which participation was encouraged in the health system was through the establishment of four pilot Health and Social Welfare Councils (HSWCs) in 1988. This paper describes and analyses the data that were collected for an external review of the HSWC program, conducted in 1991. Data collection was through telephone and self-completion questionnaires administered to key informants and HSWC members. The evaluation data show that the Councils mobilised people to take action on a range of issues and three key themes related to the HSWCs as models for community participation: the structural preconditions for success; issues of representativeness; and the differing power levels between stakeholders. The study points to some important lessons for a successful model of participation. These include: (i) participation is difficult when organisations are restructuring and frequently changing staff; (ii) the need for community participants to set their own agenda; (iii) the need for resources, support and quality leadership; (iv) recognition of the competing demands of bureaucracy and community; and (v) allowing the voice of the marginalised to be heard is a more valuable objective than accurately representing all views. The paper describes the progress of the Councils since the review and notes that they were defunded in December, 1995. Some members of the Council viewed the defunding as one indicator of their success in challenging bureaucratic practices.

Key words: community; health promotion; participation

INTRODUCTION
In the 1980s, South Australia adopted a Social Health Policy (South Australian Health Commission (SAHC), 1988) and a Primary Health Care Policy (SAHC, 1989). These documents were intended as a means of implementing the state’s commitment to Health for All by the Year 2000 (World Health Organization (WHO), 1978) and the Ottawa Charter for Health Promotion (WHO, 1986). A key plank of each of these policy statements is the strategy of involving community people, who are not professionally involved in the health sector, in the process of promoting health and tailoring health services to the needs of the local people. Experiences around the world suggest that the rhetoric of community participation is far easier than the practice (Oakley, 1989; Yeo, 1991; Labonte, 1992). In South Australia, one
of the means by which participation was encouraged in the health system was through the establishment of four pilot Health and Social Welfare Councils (HSWCs) in 1988 (SAHC/Department for Community Welfare, 1988). This paper describes and analyses the key findings from a review of these Councils, which was carried out in their third year of existence. The analysis led to insights that will be of value to health workers in other settings who are grappling with the task of making community participation meaningful. The eventual defunding of the Councils has highlighted the dilemma of being funded by a bureaucracy to critique its policies and practices.

**METHODOLOGY**

During 1991, surveys were conducted (see Table 1 for details) to collect data for the external review of the pilot Health and Social Welfare Council program (Shannon and Worsley, 1991). The review was set up to determine whether the Councils had met their objectives as set in the Program Statement (SAHC/Department for Community Welfare, 1988) and to advise the minister on whether the program should be expanded to other areas of the state.

Five categories of respondents were surveyed using questionnaires with scaled responses and open-ended questions predominating. Respondents were asked about:

- the type and level of their involvement;
- the extent to which the HSWCs had met their objectives;
- the extent to which the objectives were possible in the time frame;
- how successful support and resources had been in development of the Councils;
- the main strengths and weaknesses of the program;
- an appropriate outcome for the pilot program.

The rest of this paper describes the Councils’ activities and presents the evaluation data relating to each of the key themes identified in the analysis.

**THE SOUTH AUSTRALIAN HEALTH AND SOCIAL WELFARE COUNCILS PROGRAM 1989–1991**

The commitment to participation and the development of innovative human services has been a hallmark of South Australian politics since at least the early 1970s. An Australian Labor Party government was in power for most of the 1970s (Parkin and Patience, 1981) reforming health and welfare services and leaving a tradition of innovation. The HSWC model fitted this tradition. However, by the time the Councils were established, in the late 1980s, the times were more turbulent for South Australia’s human services. The Councils had to struggle to find their place in a field made perennially insecure and cynical by ceaseless reviews, reforms and reorganisations. The Councils themselves were to be reviewed just over 2 years after they were established. In this period the driving forces in most decision-making seemed to be the Labor government’s deference to principles of economic rationalism and managerialism, contradicting its own political rhetoric about commitment to social justice and participatory decision-making (Yeatman, 1990).

<table>
<thead>
<tr>
<th>Informant category</th>
<th>Number</th>
<th>Response rate (%)</th>
<th>Administration method</th>
<th>Sample selection</th>
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<td>97</td>
<td>telephone</td>
<td>named by Executive Officers from specified categories</td>
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<tr>
<td>Central key informants</td>
<td>17</td>
<td>74</td>
<td>telephone</td>
<td>by central unit, having key position</td>
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<td>59</td>
<td>self-completion</td>
<td>all current and past executive members by Executive Officers</td>
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<tr>
<td>Community group and individuals</td>
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<td>self-completion</td>
<td>systematic sampling of 25% of total membership</td>
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<tr>
<td>Current members</td>
<td>65</td>
<td>38</td>
<td>self-completion</td>
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Four HSWCs were set up, two in metropolitan areas and two in rural areas, as a forum for community members to have input to planning and decision-making about health in their local area. The Councils were intended to:

- increase community participation in decision-making;
- increase accountability of the health and welfare systems;
- [promote] community education and awareness;
- strengthen local action to promote health and prevent social and health problems.

Membership was free and open to anyone who lived or worked in the geographical area covered by the Council and who supported the aims of the Program. The Councils were charged with special responsibility to include those groups of people relatively disadvantaged in health and welfare participatory processes.

Each Council was located in an office within its area, with a staff complement of one full-time executive officer and a half-time assistant project officer. A Central Program unit was responsible for providing support, co-ordination between the four Councils and training for members. The Councils were given a small budget to cover running costs. There was a large reliance on the commitment and time of voluntary workers for the executive committee and issues groups, which were established to work on specific tasks.

FINDINGS OF THE EVALUATION

The Councils in operation

Each of the Councils was able to set its own local agenda which resulted in differences between them and the types of issues they tackled. The data collected in the evaluation made it very clear that the Councils had to perform a number of roles which were generally difficult to juggle. They can be broadly defined as:

- being both independent and part of ‘the system’;
- being broadly representative, but also targeting their efforts towards involvement of those otherwise least able to participate in health and welfare issues;
- being locally driven and focusing on issues of concern to local people on the one hand, and on the other, being responsive to the issues and priorities of the bureaucracy and being available to provide formal input into health service decision-making at every level (from the local agency right through to the Commonwealth);
- educating and supporting local people to be effective advocates of their own health concerns, but also convincing planners and providers of health services about community participation and encouraging them to develop their own systems to make participation happen;
- being ‘untidy’ and loosely structured to support local participation, but responding to bureaucratic demands to be ‘tidy’ and formally structured;
- encouraging communities to be involved whilst constantly under threat of funding insecurity.

The HSWC Program Statement suggested, in the spirit of the new public health, that they should be free to take on issues relating to health and welfare in virtually any portfolio area at any level of government and to deal with private or public or non-government sectors. Such a bureaucratic carte blanche was useful in relation to individual issues, but also overwhelming in its implication that the HSWCs should be all things to all people.

In describing the work of Community Health Councils in the UK, Winkler (1986) identified four main approaches:

- bureaucratic;
- health educator;
- user advocate;
- community health pressure group.

Winkler argued that the last two approaches were most likely to increase ‘user power’, whilst the first two are the most politically acceptable. It is also clear that this typology implies an increasing capacity of organisations to set their own agenda; the ‘bureaucratic’ organisation is fundamentally reactive, while the community health pressure group is largely locally driven. Legge (1990) makes a similar distinction between participation which is instrumental, i.e. passive and related to previously determined agendas, or developmental, i.e. ‘about people taking control over their own health’.

Each of the kinds of approach described by Winkler was used at various times by the HSWCs and a diverse mix of strategies and activities flourished. The majority were related to ‘user
power’ rather than the more politically acceptable responses to bureaucratic demands and health education. While the Councils were under some pressure to act as consultative bodies to a centrally controlled agenda, they put most of their efforts into more developmental participation activity.

Key themes

The above description of the Councils demonstrates that they were given an extremely difficult brief and were expected to achieve it with minimal resources. Such over-inflated expectations are not uncommon in relation to community-based health programs. It is not surprising that the Councils, in their first 2 years, were unable to do more than scratch the surface of the range of issues and strategies implied by their original objectives. These objectives were wide-ranging and ambitious, and the resources given to the Councils in the whole period of their life (1989–1995) never came anywhere near to matching them.

Three key themes—structural preconditions, representation and power—emerged from analysis of the evaluation data. These issues are common to many other new public health initiatives that attempt to implement participative strategies.

Structural preconditions for success

The structural preconditions needed for success in this type of community participation program are identified as: organisational features, resources, support and leadership.

Organisational features. The HSWCs were never secure in their staffing or funding. In the review (Shannon and Worsley, 1991) the authors made several recommendations aimed at stabilising the Councils and making them more secure. These were never implemented, but argued for a substantial increase in the number of HSWCs so that the program could cover the whole state, a change to funding arrangements so that funding was less vulnerable to being ‘lost in the system’, increased central support for the program, and a developmental strategy to increase the independence of the program. These views were shared by some of the survey participants:

for Councils to be incorporated—wouldn’t have to struggle with someone looking after their money. Need some sort of autonomy from central office. There needs to be more of the Councils. (Central key informant on how operation of the Councils could be improved)

Another destabilising feature was the frequent turnover in staff on the Councils:

Communication becomes very difficult with the change of officers, as you no sooner get used to talking with one person, then someone else seems to be in charge. (Member)

The fact that the Executive Officer changed frequently probably reflects the high demands that these jobs made on the staff. They typically needed to have multiple skills, be capable of dealing with community people, bureaucrats and health and welfare professionals, and juggle the multiple roles described above.

The pilot areas were not chosen in response to local community demand, and some people doubted the need for another consultative health group in their area, considering it to be a duplication of existing structures. The role of the Council also was unclear to some people, as this quote exemplifies:

HSWC is a duplication of the community health services role. I see the community health services could be expanded dealing with the consumers. (Local key informant)

There was, however, no other body that was independent of service provision interests and this was recognised by some respondents:

I see the North West Council as a valuable forum for the community, assisting particularly disadvantaged residents and groups in coming to grips with complex issues and in providing support, and community education and significantly, advocacy for residents concerns and needs. (Community member)

There was also the feeling that the Councils were sometimes used as placating and consultative bodies which might detract from their ability to develop their own agenda. Dwyer (1989) maintains that participation will be encouraged when the issues that are being dealt with have emerged from community concerns rather than being those established by health professionals and bureaucrats. The problem of the Councils following someone else’s agenda was neatly put by this respondent:

The continual changing [of health and welfare priorities] has pre-occupied their focus to attempting to put out fires rather than addressing community issues. (Local key informant)
Resources. The rationalist policies and economic restraints which have developed since the Councils inception resulted in the level of resources being cut, particularly support from the Central Program Unit:

We’ve got lots of things—computer and software but not enough staff. Huge barrier for us to being more effective. We’ve got a reasonable budget but getting tighter as we get more active. (Local key informant on level of resourcing from SAHC)

Support. People in the community, particularly those disadvantaged groups for whom the Councils were expected to take special responsibility, are generally not in a good position to exercise control in their daily lives and participate actively in decision-making structures (Brownlea, 1987; Dwyer, 1989). Consequently, if those participating are not to be an elite group, atypical of their local community, strong support from the staff of the Councils would be important. Bracht and Tsouros (1990) have made the point that studies on participation highlight that those participating are inevitably a very small proportion of the local community and meaningful participation does not guarantee representation. Support and encouragement for local people not experienced in dealing with bureaucratic organisations has to be weighed against the danger of professionals taking over the program and driving the agenda. The facilitating role requires a delicate balance, as this respondent noted:

I am cynical about too much active involvement from the SAHC, as decisions made by HSWCs should be free from Government pressure. They should be able to ‘bite the hand that feeds them’ if needed! (Member)

Leadership. When a community participation program is initiated through a central bureaucratic organisation, the style of leadership is critical to the development of the program. The Executive Officers were in the unenviable position of being employed by the Health Commission but expected to serve a community which might be highly critical of their employer. On the whole they seem to have juggled this conflict well:

The early staff were excellent. The Executive Officer knew the area, had excellent communication skills and had background work in health. Was very successful in reaching the local people. (Local key informant)

The general opinion from the data was that the chairperson should be a respected member of the community and have the trust and support of that community to take on both a leadership and representative role:

The program and its structure expect an enormous amount of the chairperson to keep agencies out of taking control—big responsibility. (Local key informant)

Representativeness of the HSWC

Most of the criticisms of the Councils related to their ability to be ‘truly’ representative of their local populations. This is a common theme in the literature on participation (see, for example, Oakley, 1989). Yet this expectation that any small organisation can ‘mirror’ the community appears to have little face validity. Marmor and Morone (1980) present a useful analysis of the way ideas of representation have been used and misused, in the context of a US program for consumer involvement in planning health services; in particular, they identify the common fallacy of descriptive or ‘mirror’ representation, and ask who specifies those characteristics of a community which should be represented. Although the idea of a participatory organisation as a ‘microcosm’ of the community is attractive, it is neither logical nor feasible, yet this idea of representation is at the heart of many of the criticisms of HSWCs. After 2 years the HSWCs had not yet involved a large proportion of their local communities, nor had they always been able to mobilise a large proportion of their actual membership. What they had tried to do was to make their resources available as freely as possible to support local people’s involvement in health or welfare issues of their own naming and to provide them with a forum and a ‘way in’ to the system. Their activities showed other groups what is possible. They attempted to link individuals and groups with each other, and to gather knowledge based on the experiences of individuals and groups. As one respondent summarised:

The Council is the only forum I know of which is able to respond to the complex social, environmental, health and other issues in a cohesive way, allowing local residents to manage initiatives, and promote consensus between sometimes disparate interests. (Community member)

The reviewers (Shannon and Worsley, 1991) consider the issue of equity, representation and openness within the HSWCs, noting that this question was frequently raised in their discussions with ‘outsiders’. In responding to this concern, they noted that there had been some success in attract-
ing the involvement of people from relatively disadvantaged sections of the community and were impressed with the demographic composition of the executive committees in this regard. However, at a more fundamental level, they argue that the issue is not as simple as this—rather, a distinction needs to be drawn between participatory and representative democracy, and the locality base of HSWCs means they had the potential to develop participatory democracy, which is not possible when dealing with larger social aggregations. Respondents were well aware of these issues:

The Council members must always remember that they are spokespersons or representatives for the whole community. Executive Officers need to listen to their consumers and encourage their views all the way through their meetings. It is not a place to push your own opinions. (Local key informant)

A further question is whether or not it matters that the Councils might have been unrepresentative. What is meant by the concept of representation in this context? Did their legitimacy and power rely only on their representativeness? It seems that it probably did not and the idea that they could, with their limited resources, become genuinely representative is unlikely. What they did achieve in their 6 years of existence was to give a voice to some people who otherwise would not have been heard.

The current rhetoric of community participation in bureaucracies is often tokenistic (Dwyer, 1989; WHO, 1994), but effective mechanisms for community participation do mean that non-professional agendas are more likely to be sought and possibly heard and acted upon:

The major strength is the people on the Councils have been empowered—they’ve felt they’ve been taken seriously—people who wouldn’t usually seek out higher up people. (Central key informant)

The influence of bodies like the HSWCs is, inevitably, subtle and not easy to detect but can, none the less, be effective. Their lobbying may change policies and practices in ways that are not openly recognised by bureaucracies:

The initial threat to the health professionals is decreasing and the health professionals are channelling questions through the HSWC because they’re more aware of the role of the community and power of community at a ministerial level. (Local key informant)

The experience of the HSWCs has been that they had to fend off the continuous bureaucratic imperative to comment on policy and structural changes that were happening in the health system. These policy and structural issues were rarely of vital interest or significance to members, although in the long term they could prove significant to the community.

Often, involvement in broader issues only makes sense within an agenda that is firmly based on an acceptance of the collectivist strategies of the new public health which sees health promotion as primarily an issue of policy and adaptation of social, economic and physical environments (Baum, 1993). There is, however, a tension between this collectivist perspective and the reality of working with individuals whose interests are shifting and fragmented and who do not, necessarily, share the collective ideological perspective on which the Councils are based. In some cases, individuals who want to work with the Councils may have values that are at odds with the central principles of the new public health. Inevitably, a program such as the HSWC program, which was established on the basis of a core set of values (in this case the principles of social justice and primary health care), will exclude those people who do not subscribe to those principles and the actions they imply or who do not understand their relevance to their own health status. To this extent, the rhetoric of community (implying inclusiveness) may conflict with political values which, inevitably, tend to be more exclusive (Young, 1990). This conflict is common to most community development and community action work. It is never easily solved. Some commentators on the new public health have suggested that one of its central challenges is to deal with this seeming contradiction in working with communities. Kelly et al. (1993), for example, argue that the Healthy Cities movement will have missed its role in history if it sticks to a modernist agenda and stresses rational, professional solutions. They believe this movement will need to grapple with ‘the values of locality and community, aestheticism, relativism and private behaviour’ if it is to make an impact on the understanding of health. The evaluation and review of the Councils suggest that they and their staff have had some success in juggling these contradictions. It seems that this juggling should be seen not as a barrier to the work of the Councils, but as a central part of their function and role: mediating private problems into community perspectives so that collective action can be taken, and vice versa, so
that collective issues can be read by participants in relation to their own experiences and needs. Certainly, this respondent saw that the Councils were playing a role in promoting more effective community involvement:

People in communities have been previously denied a say in the development of programs which met their needs. The Councils are a much needed service in communities simply because they assist in promoting and thereby enabling community cohesion and well being. (Member)

Inevitably, not all those interviewed as part of the evaluation process were positive about the impact of the Councils in terms of their ability to represent their local communities. The vast majority of the respondents, however, accepted the constraints under which the Councils operated and considered that within these constraints the Councils were able to expand marginally the representativeness of input to health service decision-making. The evaluation had a clear lesson for those setting up programs such as the HSWC program in endorsing the fact that very parsimoniously funded programs cannot be expected to answer all problems of representation and community participation. Participation, particularly if it is to involve those who are the least powerful and most marginalised in our society, requires substantial input of resources to support the process of providing people with the resources and skills they require to participate effectively. The evaluation also suggests that the term ‘community’ cannot be used uncritically. The criticism of the Councils as a form of representation of the whole ‘community’ stemmed from a notion that there is such an entity as ‘the community’. Petersen (1994, pp. 109–110) has discussed the problematic notion of ‘community’ in terms of representation and suggests that it masks many competing interests. Each of the areas in which the HSWCs were operating were, like all communities, made up of diverse interest groups. This raises the question of whether it would ever be possible to represent all these interests. The post-modern perspective has acknowledged the problems and politics of representation as crucial to understanding contemporary society (see, for example, Franzway et al., 1989; Young, 1990). To date, however, there do not appear to be any clear answers to guide those trying to implement programs. Perhaps the clearest message from this experience is to encourage more sophistication in the use of the term ‘community’ and to be suspicious of bureaucracies and others who claim to have consulted ‘the community’ or to be speaking for ‘the community’.

Power: the heart of the matter

It is a pity that the Council doesn’t have more ‘teeth’—so that it has more importance and credibility at the South Australian Health Commission and Family and Community Services Executive level, and so that Community/consumer participation can move beyond placa
cion/consultation toward genuine partnership. Hopefully with it will come a shift of power to the consumer/community. (Executive)

This quote sums up the desires of many of the respondents who were directly involved with the running of the HSWCs. While much of the discussion about participation is wrapped up in cozy statements that imply a consensus view of community, the reality of communities is that they are structured according to patterns of factors such as gender, class and ethnicity. Yeo (1993) has pointed out that images of cohesive communities are romanticised and ignore power as the crucial reason for increasing participation. He claims that successful participation should result in empowerment of people within communities who previously had least power. The HSWCs were not powerful bodies: they had meagre resources, frequently worked with people who were accustomed to having their issues and experiences marginalised, and often found themselves challenging the practices of powerful professional and bureaucratic groups. The respondents were aware of the limited power of the Councils despite the hard work that had been invested in them:

I’m not convinced that we made much of an impact at all. However, after all the hours and work I and others committed, I would like to believe that we have made them more considerate of the community needs. (Executive)

The breadth and extent of their original objectives contrast with this. They suggested that the HSWCs would be powerful organisations that had the potential to bring about significant change in the health and welfare system. What power the Councils did have derived from two sources: the bureaucracy which funded them and provided program support; and local people who became involved in the Council. It is not at all unusual for the interests of these two groups to be in conflict. Once again, the Councils had to walk a tightrope. The staff are public servants who
depend on the bureaucracy for the continued existence of their organisation. In this context, Councils’ attempts to bring about change are frequently based on consensus, rather than conflict, approaches. This fits well with the Ottawa Charter (WHO, 1986) which stresses enabling, collaboration and alliance building. Yet, the Councils knew their futures would be in jeopardy if they trod over the invisible barrier and offended those within the system. This may have led to Councils steering clear of some issues that were seen as too controversial. Certainly respondents to the survey were aware of this:

Members had little quality input. They were put through the bureaucratic motions. If an issue was controversial they were told to back off. (Executive member on increased community participation in decision-making)

The threat of interference from a funding body is a direct limitation on the power of bodies such as the HSWCs. Yet, some power is gained from the basic political reality of being able to appeal to a popular constituency which provides an external source of power. This was not lost on some of the respondents:

One of the strengths of the HSWC is that it has ‘one foot in the door and the other outside’—i.e. it is part of the structured health and welfare service delivery but has enough ‘cutting edge’ to comment from a community and consumer perspective. (Executive)

It appears harder for bureaucracies and governments to ignore lobbying from groups such as the HSWCs when they clearly have ordinary community people involved. Here the issue of representation is less important than the ability to appeal to experience and local knowledge. The Chairs of the Executive met directly with the Minister of Health and so were able to exercise this power to lobby and bring issues directly to the Minister’s attention. The evaluation suggested that the power of the Councils was derived from this kind of informal influence rather than from any formally endorsed power they had been given by the health and welfare bureaucracies.

THE HEALTH AND SOCIAL WELFARE COUNCILS SINCE THE REVIEW

Since the completion of the review in 1991, the four original HSWCs continued to develop ties with their local constituencies and relationships with government and non-government organisations, but no more Councils were established. The Councils each evolved to reflect their members’ interests and concerns at local and state level. Some of the more recent activities include the production of resources such as: directories of general practice; raising awareness in mainstream health services of issues for non-English speaking people and consumers of mental health services; and taking part in a national research project on community pharmacy. Members also were involved in numerous committees and planning groups, making representation to government and providing a consumer perspective on health policy and structures. The recent work of three of the Councils is documented in: Bell (1995), Murray and Tatzyo (1995) and Sullivan (1995).

During 1995, major changes to the state health system in South Australia included the introduction of a funder/provider split, a large reduction in health service budgets, and amalgamation of community health services. The HSWCs were informed in August 1995 that their funding would cease at the end of the year. Some members of the Councils believe their effectiveness as advocates for social justice and reform within the health sector contributed to the withdrawal of support for their activities.

CONCLUSION

The analysis suggests that three factors were key to the success or otherwise of the Councils: the existence of favourable pre-conditions; issues of representation; and the central role of differing levels of power held by different stakeholders, which undermines the impact they can have on policy formation. Other work on community participation also has isolated these issues as very significant in determining the impact of participation.

This paper has presented an analysis of a health department’s efforts to introduce a mechanism to increase the opportunities for participation in its decision-making, planning and operations. The HSWC program had many successes but, from the start, suffered the burden of being in a position of having continually to criticise the body which was funding it. Certainly this highlights one of the dilemmas of the modern democratic state: how to incorporate voices of dissent into policy and practice discourse. A fundamental tenet of the ‘New Public Health’ is
a belief in the value of participation. Community participation will, inevitably, lead to expression of a variety of opinions and views. Policy-makers and politicians should welcome such expressions of democracy.

We would suggest the following advice for those interested in establishing participatory mechanisms that have the potential to allow voices of dissent to be heard.

**For policy-makers and politicians**

Wide participation is an important aspect of a democratic society. It is the responsibility of health policy-makers and politicians to encourage and support alternative voices. Doing this requires resources and health departments should be prepared to provide these.

An important evaluation criterion for mechanisms of participation should be the extent to which they give voice to the concerns of the marginalised and to views that challenge the mainstream. Requiring bodies such as the HSWC to be ‘representative’ of their communities is not necessarily desirable and certainly was not possible on the limited budgets they had at their disposal.

Policy-makers and politicians should be sympathetic to the tightrope of competing demands that is walked by advocacy bodies such as the HSWCs. This means accepting that they will not always hear the views that they would want to. Respect for alternative views needs to be granted as they are a legitimate part of democratic and open policy-making processes.

This study suggests that when health departments reorganise their structures (and their personnel), the effect on community groups is confusion and added difficulties in relating to the bureaucracy.

**For advocacy and consumer participation groups**

The story of the HSWCs suggests that these groups are unlikely to follow a smooth path. More typically, they will have a bumpy and often uncomfortable ride as they negotiate the perils of bureaucracy and the legitimate demands of the community people they work with. Consequently, leaders that facilitate and encourage community people and are able to advocate to policy-makers and politicians are important. Working for an advocacy group is demanding and likely to be personally draining. Funding bodies should ensure people receive adequate support and training.

**General issues**

Communities are not homogenous. The power, class, gender and ethnic differences within them are important in understanding the dynamics of communities and the complexities of increasing participation, so that these multiple voices are heard. Groups like the HSWCs do not usually have any formal source of power. They represent the least powerful and often marginalised sections of the community and exert influence, rather than power derived from their social and economic position. If the views and opinions of community advocacy groups such as the HSWC are to be heard, then policy-makers and governments must have a commitment to empowerment and redressing imbalances of power.

Like most community participation, the practice is much more of a challenge than the rhetoric. The evaluation of the HSWCs in South Australia confirmed this, but also showed how much, in terms of input from different interest groups in the community, can be achieved in return for a small investment from a health department.

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