Influence of health promotion bureaucracy on community participation: a Canadian case study

WILLIAM F. BOYCE
Social Program Evaluation Group, Queen’s University, Kingston, Ontario, Canada K7L 3N6

SUMMARY
The purpose of this paper is to illustrate, through a Canadian case study, the bureaucratic support and obstacles for community participation in health promotion. The paper begins with a brief history of the development of a participatory health promotion programme in Canada. The role of bureaucracies on participation of communities is highlighted.

Secondly, the paper describes how a variety of bureaucratic factors affected grassroots community participation efforts of local projects in one province. Finally, discussion focuses on how community participation is constrained in a bureaucratically mediated activity such as health promotion.

Key words: bureaucracy; Canada; community; health promotion

INTRODUCTION
The Canadian federal government has played a significant role in the development of health promotion principles, strategies and, to a lesser degree, programmes both nationally and internationally (Pederson and Signal, 1994). From the 1970s to the 1990s, the federal government demonstrated its commitment to the principle of community participation in health promotion primarily through the Health Promotion Directorate (HPD) of the federal health ministry (Pederson and Signal, 1994; Pinder, 1994). The purpose of this paper is to illustrate, through a case study of HPD, the bureaucratic support for principles of community participation in health promotion. This is part of a larger project that studied structural influences on community participation in a series of health promotion projects for disadvantaged groups in Ontario (Boyce, 1997).

Development of a health promotion participation programme in Canada
Major Canadian social trends in the 1970s and 1980s influenced calls for community participation in health. These trends included the emergence of new social movements, especially feminist critiques that challenged traditional authority, doubts about the efficacy of the medical model, and the fostering of democracy by supporting disadvantaged groups in the public policy process (Labonte, 1994). Federal governments were increasingly involved in funding social development programmes for disadvantaged groups such as women, ethnic minorities and persons with disabilities to aid, in part, the national unity effort (Ng, 1990; Pal, 1993; Phillips, 1994).

In the health sector, Marc Lalonde, the Liberal federal minister, supported a new vision of health, which he outlined in A New Perspective on the Health of Canadians (Lalonde, 1974; Laframboise, 1990). In this early report, individual community members were essentially limited to being passive recipients of services or to being responsible for personal health choices.

In 1980, the Health Promotion Directorate of Health and Welfare Canada launched the Health Promotion Contribution Program (HPCP) as a means of implementing the government’s
community participation strategy. The HPCP was essentially the funding and supervision of a series of health promotion demonstration projects at the local, regional and national levels. The HPCP contributed, in a cost-sharing sense, to the funding of health promotion projects organized by citizen groups for terms of up to 3 years, with the possibility of extension up to a maximum of 5 years. Thus, the HPCP was initiated to provide financial resources to certain community groups for projects to help them to identify and solve their health problems. Early HPCP projects, which were organized around individual behavioural changes in areas such as smoking, alcohol and nutrition, reflected a lifestyle view of health promotion (Pinder, 1988; Pinder, 1994).

In the next decade, there was a shift in emphasis with respect to structural effects of community participation in health. In *Achieving Health for All* (Epp, 1986), Conservative health minister Epp suggested that community participation was a strategy for ‘… helping people to assert control over factors which affect their health … and enhancing people’s capacity to cope’ [(Epp, 1986), p. 9], albeit with their current situation. Epp cited self-care groups and mutual aid voluntary associations as prime mechanisms for community participation that were intended to enhance coping skills in disadvantaged persons, although these mechanisms also emphasized individualism (Iannantuono, 1997).

The World Health Organization’s *Ottawa Charter for Health Promotion* (WHO, 1986), of which Canada was a signatory and prime contributor, represents a further shift in emphasis towards a social structural perspective of health, although biomedical and lifestyle considerations were not completely discarded. The charter also marked a shift in emphasis in the discussion of community participation in health promotion by noting that people were the main health resource, not the government or health services (Raeburn and Rootman, 1989). This orientation required that the latter two groups ‘… share power … with people themselves’ [(Raeburn and Rootman, 1989), p. 4]. The community was expected to assume an expanded role of ‘… setting priorities, making decisions, planning strategies and implementing them’ (p. 3).

Soon, the Canadian government’s views on community participation in health promotion moved in a similar direction. In another discussion paper, *Mental Health for Canadians: Striking a Balance*, Epp extended the earlier understanding of environmental influences on health to include structural factors related to social, cultural, economic and regulatory conditions (Epp, 1988). Health inequities were to be addressed by public participation which gave ‘… a greater voice to those who, for such reasons as age, sex, socioeconomic status, disability or ethnicity, have historically had little or no say in shaping the policies and systems that affect their lives’ [(Epp, 1988), p. 14]. However, Epp’s new characterization of the community member was one of a marketplace consumer who influenced the design and choice of health services. Disadvantaged members of communities were now addressed in health promotion, but how participatory principles were to be implemented without compartmentalizing the community into competing interest groups was not clear (Labonte, 1994).

Thus, subsequent to the 1986 Ottawa Charter, public participation in HPCP projects received an increased focus of attention in line with the new “social” model of health (Raeburn, 1987). The HPCP was now intended to support disadvantaged groups in controlling their own health conditions and projects (Law, 1989; Pinder, 1994).

However, an internal programme evaluation in 1989 indicated that, in a sample of 100 HPCP projects, sponsors reported the involvement of community members in project activities to be quite modest: only 41% of projects had public involvement in planning; 29% had involvement in implementation; 19% noted public attendance at meetings; and only 11% had participation in evaluation activities (Health and Welfare Canada, 1989). These estimates were quite low for a programme whose primary strategy was intended to be community participation. In addition to questions related to disadvantaged community members’ motivation and capacity to participate, these data raise the concern of how community participation is fostered or inhibited by bureaucracy.

The role of bureaucracies in support of community participation by disadvantaged groups has not been well studied. There are numerous papers describing how the bureaucracy interacts with mainstream health advisory bodies such as district health councils. These studies largely conclude that the bureaucratic structure supporting such community participation legitimizes citizen involvement and taking responsibility (Abelson, 1995; Lomas, 1997). However, in less formal health
venues, ordinary citizens do not assume responsibility beyond advising programme staff and prefer to rely on traditional bureaucratic, professional and political decision makers (Singer, 1995; Anderson, 1996). Little is known of the effect of bureaucracies on the participation of disadvantaged persons in health promotion projects.

METHODS

This research utilized a comparative, multiple case study of community participation in five projects funded within the HPCP (Boyce, 1997). The projects addressed were: STDs and street youth; substance abuse and persons with disabilities; mental health and ethnic youth; women’s health; and community living for those with disabilities. Cases were selected according to the primary role (board of directors, advisor, volunteer, employee, client) that community members played in the project. The researcher conducted 31 in-depth interviews with staff and community member respondents. Nine additional interviews were conducted with HPD officials, knowledgeable academics and health promotion practitioners. Qualitative analysis of data yielded bureaucratic factors that were linked to the community participation process. Case studies and a comparative cross-case analysis were written to describe the characteristics of the community agencies and the mechanisms by which bureaucratic factors affected participation. A complete analysis of structural influences on community participation is reported elsewhere (Boyce, 2001).

The bureaucratic influences on community participation can be categorized into structural, priority-setting, resource and administrative factors.

HPCP organizational structure and staff background

The HPCP was administered to local and regional groups through Health and Welfare’s five regional offices. Regional directors met four times a year to exchange information about the HPCP, as well as about other HPD programmes. O’Neill et al. (O’Neill et al., 1994) and Raeburn (Raeburn, 1994) have noted that HPD regional offices played key roles in stimulating and supporting health promotion activities in most provinces and territories. In Ontario, however, the HPD was not a major player due to the large number of other organizations active in health promotion; for example, the provincial Ministry of Health, city and regional governments, and health units (Pederson and Signal, 1994). However, the HPD staff were key facilitators of local health promotion projects. A total of 41 programme officers were assigned to specific HPCP projects in regional offices, as well as to manage other operational projects of the HPD. Programme officers also met once a year to set target group priorities. HPD staff came from diverse backgrounds. One group represented older federal health educators who were transferred to the new Health Promotion Directorate (PHD) in the 1970s and were instrumental in developing the initial lifestyle health promotion activities (Palko, 1982). Another group represented younger staff who had worked in the Non-Medical Use of Drugs Program which had administered small grassroots projects with community groups (Pinder, 1994). Significantly, many of the Ontario-based staff had been involved in local community development and social movement groups for women, persons with disabilities and the poor, prior to, and even while working for, the federal government.

The formal roles of programme officers in HPCP projects were: to assist with information requests; to solicit project proposals; to suggest revisions to proposals; to monitor projects; and to negotiate extensions and funding supplements. However, an informal but crucial role of programme officers was also to advocate for particular community groups to be placed on the HPCP funding agenda. In essence, this advocacy role stimulated the creation of groups representing disadvantaged persons. This role was achieved through annual internal HPD meetings and policy reports, which were used to establish programme eligibility for certain groups, such as street youths and groups representing persons with disabilities. In the Ontario regional office, for instance, idealistic staff from community development backgrounds worked directly to facilitate the development of community groups. According to a senior HPD manager, idealistic motivations influenced programme officers’ orientation towards community work: ‘We had almost an instinctive wish to view it (HPCP) as a popular approach to health’. One respondent observed that programme officer influence in health promotion was due to their being ‘outsiders on the inside’.
In the grander scheme, this is a response by the health sector, professionals and institutions to the challenges of social movements that were raised in the 1960s and 70s, which were making demands for that kind of participation. The bureaucrats in Ottawa could have been deaf to that but weren’t. One of the reasons why they weren’t was that people who were part of those social movements were moving through the institutions, chipping away from outside and creating those spaces. The primary motivation was from a critical mass of people in the Health Promotion Directorate who wanted to do good and had some grounding and awareness of social movement issues, and awareness of political issues coming out of the 1960s and 70s and tried to see how they could put some of that into place in their own language, institution and sector. This view emphasizes the crucial role that HPD staff perceived they had taken in supporting community participation in health promotion.

However, senior HPD managers reported that the federal government, through its five regional offices, had neither adequate organizational linkages nor supervisory capabilities to manage a large locally delivered programme. This was particularly notable in the area of evaluation, which was almost non-existent, and resulted in little feedback to local groups on their community participation strategies.

Setting priority goals: target issues and target groups

HPD developed funding priorities for demonstration projects utilizing two distinct strategies—the target issue and target group approaches—which had different implications for community participation. In the 3 years prior to the establishment of the HPCP, the HPD operational programmes focused on six areas (tobacco, alcohol, drug use, nutrition, safety and mental health). Groups that were eligible for funding included universities, service institutions, provincial and local governments, and voluntary associations that were capable of developing and conducting health promotion projects (Health Promotion Directorate, 1982). HPD respondents observed that community participation was minimal in these projects since professionals either directly initiated them, or became heavily involved due to their specific knowledge base and expertise in the target issues. When these ‘target issue’ projects failed to incorporate many community members, the HPD established the HPCP in 1980 to include ‘target groups’ (children, youth, women, elderly, natives, persons with disabilities, and low-income persons). A number of these groups were in the traditional Liberal ‘welfare constituency’ (Phillips, 1994).

Priorities for funding in both strategies were supposed to be set on an annual basis by HPD staff (Health and Welfare Canada, 1985). By 1987–1988, systematic prioritization of target issues had taken place and a special funding stream for priority target issues (Seniors’ Independence Program, National Drug Strategy, Driving While Impaired, Child Sexual Abuse, Family Violence, AIDS) was initiated in the HPCP. Interestingly, elderly persons and children were the only target groups from the traditional welfare constituency to be moved to the new funding stream. Simultaneously, a national Healthy Communities Project and a Strengthening Community Health Project were funded to take a broader ‘locality’ approach to health problems by utilizing community networks and partnerships (Hancock, 1994). The target issue projects appeared to be well established with support from different federal ministries such as Transport and the Solicitor-General. The new arrangement appeared to allow complete flexibility for Ottawa bureaucrats to initiate, or to delegate to community organizations, a wide variety of target issues. However, there was little opportunity for bottom-up initiation of target issue projects by community groups.

In contrast, priorities for the remaining target groups (children, youth, women, natives, persons with disabilities, low-income persons) were not well established by 1987. Without such systematic prioritization, HPD respondents reported that there were many opportunities for lobbying activities from within the Ottawa bureaucracy, from political staff, and from external advocates to influence funding for particular community organizations. These respondents noted that the interests of HPD bureaucrats and ministerial political staff diverged as the HPCP funding opportunities became more well known by community organizations. In particular, respondents perceived that prioritization became influenced by the Progressive Conservative Cabinet. While there is no direct evidence from this study that pressure extended to actual project selection, similar political influence has been claimed to occur at the same time in project funding in other federal ministries, such as the Secretary of State,
and has been attributed to the political confidence achieved by a second Conservative majority government (Pal, L., 1993; Phillips, 1994).

Overall, the programmatic overlap between target issue and target group projects that were encouraged by senior bureaucrats, and the lack of systematic prioritization of target groups encouraged a narrow group of organizations to access HPCP and eliminated a broader spectrum of groups.

**Resources for community participation**

The level of financial resources available for community participation programming did not match the government’s rhetoric about its importance in the health promotion field. While full details of HPD budgets were not available for review in this study, summary data were derived from HPD respondents, from records of Ontario projects, and from the 1989 evaluation report of the Health Promotion Program (Health and Welfare Canada, 1989). However, the lack of separation between funding streams prevented internal evaluators from assessing whether the programme was spending appropriate amounts on its priorities [(Health and Welfare Canada, 1989), p. 12].

On the whole, target group projects for disadvantaged persons did not fare well in the priorities of the HPD, as was reflected in the division of resources. In its early years, the HPD had an annual operating budget of approximately $12 million (Canadian), which excluded HPD staff salaries. The HPCP itself operated with an initial project budget of $2.1 million in 1980–1981, which increased to $4 million over the next few years. Thereafter, the combined HPCP budget for both target group and target issue projects remained relatively stable, varying from $3.6 million to $4.2 million per year. Overall, however, the cumulative funds from 1981–1987 dedicated to HPCP projects ($26 million) accounted for only 38% of the Health Promotion Directorate’s non-salary expenditures, and did not represent a large sum of money when spread across five regions of the country (Health and Welfare Canada, 1989). In comparison, 31% of the HPD budget was allocated to the costs of surveys, evaluations and development of policy papers.

By 1987–1988, the Cabinet recognized the HPD as having sponsored an innovative HPCP programme (Health and Welfare Canada, 1989). As mentioned previously, HPD established a special, centrally directed funding stream for priority target issues with a total budget of $146 million over 5 years. This new funding allowed additional local projects to be launched for special target issues, such as AIDS and impaired driving initiatives, but not for target group projects which HPD staff claimed were oriented more toward community participation. Furthermore, regional staff levels to administer all project streams were increased by only 15%.

Overall, funding of important political and public health issues (an ageing population, increased awareness of child abuse, a deadly disease) took precedence over funding the participation of traditionally disadvantaged groups in health promotion activities. During the period of this study, there was significant expansion of the HPCP budget for target issues, while the target group portion of the HPCP budget remained essentially the same. Thus, resource allocation to participatory projects for disadvantaged groups was only modest and indicated an ambivalence on the part of the senior bureaucracy and government toward the grassroots target group approach to health promotion.

**Programme administration**

HPD staff developed informal guidelines for community participation. By 1986, the HPD emphasized the involvement of community groups in developing and managing HPCP projects.

In particular, project selection criteria emphasized that organizations with target group membership were preferred:

Organizations that ensure target population involvement such as consumer-based groups will receive preference for funding. Other types of organizations will need to establish decision-making and management structures for the project that ensure significant target population participation (Health Promotion Directorate, 1986).

HPCP did not require specific organizational structures to ensure community participation, but traditional methods were strongly recommended to project applicants. For example, programme officers recommended to applicants that community members should form the majority of elected board members in an incorporated non-profit organization. HPD staff claimed that adhering to this recommendation would protect community members from personal financial responsibility for the project, as well as ensure formal organizational bylaws. In addition, HPD
staff stated that incorporation would improve accountability for project commitments and help to build the capacity of the community organization. However, this recommendation for traditional legal incorporation also ensured a rigid hierarchy of officers and members, with set terms of office and unfamiliar roles for inexperienced persons. Additionally, formal incorporation of organizations did not allow the full participation of children or youths in projects, due to legal age restrictions on holding office. Finally, undertaking the lengthy process of incorporation was a time-consuming process for small groups that received financial resources from HPD for only a few years.

In addition to incorporation methods, HPD staff also recommended that projects have an advisory committee that would include target group members to ensure representation of various community interests. However, this advisory committee could also be eliminated by consumer organizations that were assumed to have target group members managing and directing their own projects. Unfortunately, there were no guidelines on the roles and responsibilities of advisory committees vis-à-vis boards of directors.

Finally, guidelines for HPCP did not automatically allow expenditures for travel costs, nor for participant honoraria and child care (Health Promotion Directorate, 1982; Health Promotion Directorate, 1986). These items had to be negotiated with HPD programme officers and administrative staff prior to project approval. This practice made the inclusion of financial supports for community participation uneven across projects and ensured that less experienced groups had fewer resources for community participation.

Thus, through a series of recommended legal mechanisms and informal advisory structures, HPD attempted to shape the ability of community organizations to plan and manage their activities, and to incorporate community membership into them. However, the practical supports that were necessary for participation of disadvantaged persons were inconsistent.

**DISCUSSION**

Overall, the HPD’s mandate and capacity in health promotion programming which could encourage community participation was limited on economic, jurisdictional and administrative grounds. First, the HPD did not intend the HPCP to be a long-term funder of local community health promotion activities due to the economic requirements of funding an increasing number of projects as the idea became more popular. Long-term financial commitment to local health promotion initiatives was not a possibility in the economic environment of the 1980s. Secondly, federal bureaucrats and politicians were sensitive to provincial governments’ responsibilities and jurisdictions in health and did not want to compete excessively with them to fund local groups. Nonetheless, HPD wanted to demonstrate its new conceptual tools in health promotion. However, the absence of a formal priority setting for target groups ensured that HPD staff engaged in a constant lobbying process for groups to be prioritized and funded. Thirdly, despite the reputation that HPD had for championing community participation in health promotion, there was a number of administrative barriers to its implementation of the HPCP strategy. The top-down hierarchy of the HPD and regional offices ensured that distant bureaucrats made the final decisions about project selection. Although HPD staff had experience of and commitment to local target groups, they appeared to have little expertise in project management, especially with respect to evaluation. Guidelines that recommended the incorporation of local organizations were promoted without regard for their feasibility or impact on project activities and the roles of community participants. In sum, restrictive factors in the Canadian health promotion bureaucracy limited any demonstration that the federal level could join the movement for community participation and take the initiative in an area of local health that was usually beyond its mandate.

This paper illustrates the difficulties that are inherent in federally driven health promotion programmes that attempt to emphasize community participation of disadvantaged groups. Two conclusions about community participation are evident from this case. First, health promotion in Canada was a bureaucratically initiated response to broader social change. Any hesitancy to commit to a transformational style of public participation should be viewed in terms of these bureaucratic roots (Pederson, 1988). In explaining problems in community participation in health promotion projects, analysts have tended to criticize the motivations of individual community members, or the negotiation process between different interests, as being deficient rather than
examining the basic organization and structures that inhibit or support the process (Anderson, 1996).

During this historical period, the leadership of certain federal politicians and bureaucrats re-invigorated public health concepts in Canada. However, in the establishment of a federal health promotion presence, there were also other economic, political, social and bureaucratic imperatives at stake. This view of a temporary, although important, role for the HPD is supported by the lack of Canadian federal leadership in health promotion since 1990. Fiscal and political crises, loss of key HPD staff, lack of an effective political spokesperson for health promotion in the federal government, and the strengthening of local and provincial health promotion programmes and leadership have all contributed to this demise (Hancock, 1994; O’Neill et al., 1994; Pinder, 1994). The recent re-organization of the health functions of Health and Welfare Canada (including HPD) into Health Canada, and the separation of social welfare programmes into a new federal Ministry of Human Resources Development may also indicate that the vision of an integrated health and social policy approach in Canadian health promotion has diminished.

Secondly, the participation of disadvantaged community members is fundamentally different from that of privileged community members with more resources. Financial and social support mechanisms are necessary adjuncts to community participation by disadvantaged persons. However, this is rarely achieved. For example, in the Canadian North West Territories, participation on community health committees was limited due to a lack of honoraria for aboriginal community members, in contrast to the situation for professional members of other sectoral committees (Yazdanmehr, 1994). Farrant points out that participation is supposed to be a key strategy in health promotion but there is little resource support for it in practice (Farrant, 1991). Health promotion projects are often understaffed and limited in their funding terms. These limitations preclude public involvement in needs identification, skill development and ongoing participatory activities.

The emergence of a population health perspective in Canada indicates that determinants of health for at-risk subpopulations will receive more attention than community processes that affect health (Labonte, 1995). A population health approach does not intrinsically expect community participation, except though a pluralistic interest group strategy that can set priorities. The ability of disadvantaged groups to participate meaningfully in such a strategy seems unlikely.

Address for correspondence:
William F. Boyce
Social Program Evaluation Group
Queen’s University
Kingston
Ontario
Canada K7L 3N6
E-mail: boycew@post.queensu.ca

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