CLOSER TO HOME: USING SOCIAL MARKETING
TO STUDY PARTICIPATION IN HEALTH REFORM

by

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Abstract

The concept of broad-based public participation is a fundamental element of health promotion and citizenship. There is a gap, however, between the promise and reality of citizen participation in health reform. The purpose of this study was to describe the experience of public participation in a health reform initiative in one regional district; to elucidate the perspectives of both participants and nonparticipants in a particular health reform process entitled “New Directions for a Healthy British Columbia”; and, to assess the utility of social marketing concepts as an analytical tool for understanding citizen participation.

The study built on diverse literatures including health promotion, citizen participation, citizenship and social marketing in order to provide a new way to conceptualize citizen participation in health reform. The study utilized the data collection methods of participant observation (n=76 meetings), key informant interviews (n=12), focus groups (n=48), street corner interviews (n=5), and a documentary review of the health reform process.

A social marketing framework was used to interpret the data, including the concepts of understanding the consumer perspective, exchange, marketing mix and segmentation. In contrast to the criticism that social marketing ignores the broader context of individual behaviour, the analysis facilitated an understanding of the societal circumstances that inhibited or fostered participation. Specifically, the analysis suggested
that participation was influenced by (1) citizens' perceptions of a sense of belonging to, and equality in, the community; (2) citizens' perceptions of their ability to shape policy; (3) the attainment of a minimum threshold of social and economic well-being; (4) the responsiveness of government to citizens' efforts; and, (5) the ways in which the opportunity to participate was structured.

In this particular study neither the breadth of broad-based citizen participation, nor the ability of participants to shape policy was realized. The findings suggest that reframing the context of participatory democracy is necessary to facilitate citizens acting on their right and responsibility to participate meaningfully. This may be accomplished through (1) understanding, respecting and accommodating diverse citizens' perspectives about participation; (2) providing different opportunities for participation; and, (3) representing the needs and experiences of disempowered groups in health reform initiatives.
TABLE OF CONTENTS

Abstract ii

Table of Contents iv

List of Tables viii

List of Figures ix

Acknowledgements x

Chapter One 1
   Introduction 1
   New Directions for Healthy British Columbia 6
      Purposes of the Study 11
   Research Questions 13
   Statement of the Problem 15
      Participation for Sale 18
      Grounds for Using Social Marketing Concepts as an
      Analytical Framework 23

Chapter Two 26
   Review of the Literature
   Section I Citizen Participation 28
      Who Participates? 32
      Why Foster Participation? 36
      To Participate or Not to Participate? 37
      The Benefits and Costs of Participation 42
      Participate How? 46
         The Opportunity to Participate 47
      Summary 53
   Section II Empowerment, Citizenship and Participation 56
      Empowerment and Participation 56
      Citizenship and Participation 59
         Active and Passive Citizenship 61
         Citizenship as Identity 65
      Summary 68
<table>
<thead>
<tr>
<th>Section III</th>
<th>Social Marketing</th>
<th>71</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Consuming Social Products</td>
<td>72</td>
</tr>
<tr>
<td></td>
<td>Exchange: The Price Must Be Right</td>
<td>76</td>
</tr>
<tr>
<td></td>
<td>Riding the Bus Without Paying the Fare</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td>The Marketing Mix</td>
<td>81</td>
</tr>
<tr>
<td></td>
<td>Market Segmentation</td>
<td>88</td>
</tr>
<tr>
<td></td>
<td>Segmenting Along the Stages of Change</td>
<td>90</td>
</tr>
<tr>
<td></td>
<td>Defining, Designing and Delivering the Product-Market Fit</td>
<td>94</td>
</tr>
<tr>
<td></td>
<td>Caveat Venditor: Why Can't You Sell Participation Like Palmolive?</td>
<td>96</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section IV</th>
<th>Health Promotion Research</th>
<th>99</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Constructivist-Interpretive Paradigm</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Case Study Design</td>
<td>102</td>
</tr>
<tr>
<td></td>
<td>Heuristic Orientational Design</td>
<td>103</td>
</tr>
<tr>
<td></td>
<td>Establishing the Trustworthiness of the Research</td>
<td>104</td>
</tr>
<tr>
<td></td>
<td>Credibility</td>
<td>104</td>
</tr>
<tr>
<td></td>
<td>Transferability</td>
<td>106</td>
</tr>
<tr>
<td></td>
<td>Dependability and Confirmability</td>
<td>107</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter Three Methodology</th>
<th>109</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Population: Sampling Frame, Sample, and Recruitment</td>
<td>110</td>
</tr>
<tr>
<td>Research Timeline</td>
<td>118</td>
</tr>
<tr>
<td>Data Collection Instruments</td>
<td>119</td>
</tr>
<tr>
<td>Participant Observation Schedule</td>
<td>119</td>
</tr>
<tr>
<td>Key Communicator Interview Schedule</td>
<td>124</td>
</tr>
<tr>
<td>Focus Group Interview Schedule</td>
<td>126</td>
</tr>
<tr>
<td>Street Corner Interview Schedule</td>
<td>129</td>
</tr>
<tr>
<td>Use of Documentary Review</td>
<td>130</td>
</tr>
<tr>
<td>Data Collection Procedures</td>
<td>131</td>
</tr>
<tr>
<td>Securing Ethical Review Consent</td>
<td>131</td>
</tr>
<tr>
<td>Administering the Interviews</td>
<td>132</td>
</tr>
<tr>
<td>Procedures for Protecting the Data</td>
<td>134</td>
</tr>
<tr>
<td>Data Management and Analysis Plan</td>
<td>134</td>
</tr>
<tr>
<td>Data Analysis Framed in Terms of Social Marketing Concepts</td>
<td>138</td>
</tr>
<tr>
<td>Concepts of Exchange and Understanding the Consumer Perspective</td>
<td>139</td>
</tr>
<tr>
<td>Marketing Mix</td>
<td>140</td>
</tr>
<tr>
<td>Market Segmentation</td>
<td>141</td>
</tr>
</tbody>
</table>

Data Reduction 142
Use of Data Display Devices 143
Limitations of the Research Design 144
Summary 148
<table>
<thead>
<tr>
<th>Chapter Four</th>
<th>Results-The Participants, Nonparticipants and Their Stories</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Context: Participating in “New Directions”</td>
<td>150</td>
</tr>
<tr>
<td>The Participants</td>
<td>155</td>
</tr>
<tr>
<td>Motivation to Participate</td>
<td>157</td>
</tr>
<tr>
<td>The Opportunity to Participate</td>
<td>159</td>
</tr>
<tr>
<td>The Benefits of Participating: Membership Has its Rewards</td>
<td>167</td>
</tr>
<tr>
<td>The Costs: Membership Has its Dues</td>
<td>170</td>
</tr>
<tr>
<td>Grassroots or Artificial Turf?</td>
<td>171</td>
</tr>
<tr>
<td>The NonParticipants</td>
<td>185</td>
</tr>
<tr>
<td>Summary</td>
<td>194</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter Five</th>
<th>Analysis -- Being Valued as a Citizen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section I</td>
<td>Why Some People Participate and Others Don’t</td>
</tr>
<tr>
<td>Participation: Only the Empowered Participate</td>
<td>200</td>
</tr>
<tr>
<td>Powerlessness and a Loss of Citizenship</td>
<td>205</td>
</tr>
<tr>
<td>Rights or Responsibilities?</td>
<td>213</td>
</tr>
<tr>
<td>Citizenship, Personal and Organizational Empowerment</td>
<td>215</td>
</tr>
<tr>
<td>Organizational Powerlessness</td>
<td>218</td>
</tr>
<tr>
<td>Public-Spirited Active Citizenship?</td>
<td>222</td>
</tr>
<tr>
<td>Summary</td>
<td>225</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section II</th>
<th>Fostering and Sustaining Participation in “New Directions”</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Product, the Place and the Purchaser</td>
<td>231</td>
</tr>
<tr>
<td>Hold a Meeting and They Will Come</td>
<td>231</td>
</tr>
<tr>
<td>Viewing Participation from the Citizen’s Perspective</td>
<td>236</td>
</tr>
<tr>
<td>Viewing Citizenship from the Citizen’s Perspective</td>
<td>239</td>
</tr>
<tr>
<td>A Citizen-Centred Approach to Citizenship and Participation</td>
<td>242</td>
</tr>
<tr>
<td>The Price</td>
<td>244</td>
</tr>
<tr>
<td>Promotion: Closer to Home</td>
<td>249</td>
</tr>
<tr>
<td>A Summary of the “Selling” of “New Directions”</td>
<td>256</td>
</tr>
<tr>
<td>Summary</td>
<td>258</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter Six</th>
<th>Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significance of the Study</td>
<td>263</td>
</tr>
<tr>
<td>Is Participation Such a Good Thing?</td>
<td>265</td>
</tr>
<tr>
<td>The Trouble with Social Marketing</td>
<td>275</td>
</tr>
<tr>
<td>The Contribution of Social Marketing</td>
<td>281</td>
</tr>
<tr>
<td>Reconciling Social Marketing and Health Promotion</td>
<td>285</td>
</tr>
<tr>
<td>Relationship Marketing</td>
<td>292</td>
</tr>
</tbody>
</table>
# TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Sample Information</td>
<td>117</td>
</tr>
<tr>
<td>4.1 Profile of Participants</td>
<td>182</td>
</tr>
<tr>
<td>4.2 Profile of Nonparticipants</td>
<td>192</td>
</tr>
</tbody>
</table>
## FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Framework of Participating in Community Organizations.</td>
<td>31</td>
</tr>
<tr>
<td>5.1 A Flawed System: How the Context of “New Directions” Inhibited Citizenship, Participation and Personal and Organizational Empowerment</td>
<td>262</td>
</tr>
<tr>
<td>6.1 The Flowering of Participative Citizenship.</td>
<td>304</td>
</tr>
</tbody>
</table>
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Thanks kindly, Joan.
DEDICATION

This is dedicated to the love of my life, whose unconditional emotional, spiritual and financial support over the last five years has earned him his own Ph.D.*:

Craig Alexander Wharf Higgins, B.A., M.B.A., Ph.D.

*Perfect husband Doctorate
CHAPTER 1
INTRODUCTION

Health promotion is “the process of enabling people to increase control over, and to improve, their health” (World Health Organization 1984, 4). In health promotion, the concept of health is more than the absence of disease. Health is influenced by social, personal, physical and environmental determinants, and “is seen as a resource for everyday life” (World Health Organization 1984, 4). The Ottawa Charter (World Health Organization 1986) reflected the socio-ecological link between people and health and listed the prerequisites for health as peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity.

Citizen participation is a core component of health promotion (Wallack et al. 1993; Terris 1992). The concept of citizen participation, or public involvement, in planning and implementing health programs has been articulated and supported in various national and international documents for many years (United Nations 1977; WHO 1954; 1978; 1986), and is a fundamental element of both health promotion and community development principles (WHO 1984; Christenson and Robinson 1989; Roberts 1979). (Although as Green (1986) notes, despite the longevity of its popularity, the objectives of citizen participation have changed over the years from seeking public cooperation in the implementation of programs to public collaboration in the decentralized planning and evaluation of, and research in, health policy and services.) Indeed, the concept is considered to be the bedrock of practice (Harris 1992), and continues as an important
strategy in the Canadian government’s objective of achieving health for all (Epp 1986). It is also a crucial component in the governance of regionalized health services (Canadian Public Health Association 1996).

The concept of citizen participation is grounded in the classical theory of democracy (Wharf and Cossom 1992), particularly participatory democracy (Prior, Stewart and Walsh 1995), and suggests that citizens have a right to be involved in decisions influencing their lives and the way they are governed. The ideal envisages not only widespread but equal access to participation opportunities as a mechanism for democratic control (Pennock 1979). This view is captured in Dahl's (1970) "Principle of Affected Interests" under which all those affected by government decisions should have the right to be involved in those decisions.

Representative democracy assumes that, because of the multiplicity of issues of governing, elected officials are required to make the decisions for, and on behalf of, those who elected them to represent the constancy. Where representative democracy has failed is in providing an accountable and accessible structure of governance, and one where the elected differ considerably (in demographic characteristics and life experience) from, and fail to reflect, the citizens they are intended to represent (Phillips 1995; Prior, Stewart and Walsh 1995). One result of the failure of government to represent its constituents is a foundering trust and belief in state administration to be responsive to the needs and interests of citizens (Beatley, Brower and Lucy 1994). One proposed solution is to stimulate active involvement in the policy decisions that shape citizens’ lives.
Notions about the value of participation in public health are not new. Aspects of interest can be traced to traditional healing cultures, the public health movements of the nineteenth century, concepts of community health care (Siepp 1981), and health education principles (Nyswander 1942; Green et al. 1980). The concept has received increasing prominence since the Declaration of Alma-Ata (WHO 1978) with its inclusion in the Health for All by 2000 strategy (WHO 1981).

The Declaration of Alma-Ata (WHO 1978) was based upon the realization that dependency on modern “Western” medicine will neither eradicate disease nor promote health. The Declaration emphasized the importance of community participation in promoting health, underlining the motivating, educating, enabling, and capacity building attributes of the participation process. Through the participation process, community members come to appreciate that health is not only a right for all, but the responsibility of all. The document specifically articulates that “the people have the right and duty to participate in the planning and implementation of their health care” (WHO 1978, 3). Opportunities for public participation are expected to include assessing needs, defining problems and setting priorities, planning and implementing activities, and eventually evaluating the process to identify and remedy difficulties. Further, the Alma-Ata document referred to the necessary roles of government and health professionals in structuring intersectoral coordinating mechanisms, providing information and resources (financial, human, and technical) and engaging in an ongoing, mutual dialogue with the public that would enable communities to make intelligent choices about their health.
The Declaration confirmed a growing international consensus among practitioners that health is not just the responsibility of the medical and health professions, but is influenced by economic development and social policy. These factors are incorporated in the document *Health Promotion Concept and Principles* (WHO 1984), in the *Ottawa Charter* (WHO 1986), and in Canada’s national health promotion framework (Epp 1986). Green’s (1986) review of national and international policy statements about community participation traces the evolution from early notions of participation, which included community involvement in the implementation of centrally-planned and narrowly-defined disease programs, to a more active approach where communities actually initiate and plan decentralized, comprehensive development activities and programs. The success of such ventures, however, requires “involving people in defining their own needs, setting their own priorities, controlling their own solutions, and evaluating their own progress” (Green 1986, 212). This conclusion led later to the development of the social reconnaissance strategy of grantmaking (Green and Kreuter 1991), and to guidelines for engaging citizens in participatory research (Green et al. 1995).

As Mhatre and Deber (1992) acknowledge in their review of Canadian provincial health reform schemes, the concept of citizen participation is not new to Canadian health planners. The 1973 Foulkes report, *Health Security for British Columbians*, recommended regionalizing health services delivery through community health centres run by locally elected representatives. What is new in the 1990s, however, “is that these recommendations finally seem to have percolated into 'common knowledge' and are
receiving more serious attention" (Mhatre and Deber 1992, 663). Achieving equitable access to health care may well hinge on community participation i.e. the ability of community members to make informed decisions in a decentralized and devolved system.

Ideally, community groups involved in health planning will articulate goals, implement plans and evaluate programs, assisted where necessary by governmental and non-governmental support (Madan 1987). However, the reality of citizen participation in health is that citizens are often limited to a consumer role. Rather than being asked to take responsibility for planning, decision-making, resource mobilization and research, or participating in shaping policy that directly affects them, citizens are often, or expect to be, confined to simply receiving benefits and attending programs (Prior, Stewart and Walsh 1995; Rifkin 1990; Cook et al. 1988; de Kadt 1983).

Though the call for greater participation in health planning, policy and promotion is increasing, there is as yet little consensus regarding the meaning, content, process, nature, and necessity of that participation (Freeman, Littlewood and Whitney 1996; Charles and DeMaio 1993; Schwab et al. 1992; Bracht 1991; Oakley 1989; Cook et al. 1988; Muller 1983), nor how to achieve and analyze the outcomes (Kelly and Van Vlaenderen 1996; Charles and DeMaio 1993; Schwab et al. 1992; Altman et al. 1991; Rifkin 1990; Brownlea 1987). Despite the theoretical significance of citizen participation as a national implementation strategy, the actual scope of participation in Canadian health promotion endeavours remains ill defined and misunderstood (Zakus and Hastings 1989; Powell et al. 1989).
Working towards a consensus and enhancing an understanding of the principle of participation requires that academics and practitioners “... develop [different] ways of thinking about different types of participation” (Kelly and Van Vlaanderen 1996, 1236). One approach may be social marketing. In 1971, Philip Kotler and Gerald Zaltman's article “Social Marketing: An Approach to Planned Social Change” introduced the idea of applying marketing principles to planning and implementing social change. The effectiveness of social campaigns, it was suggested, could be enhanced through the explicit use of marketing techniques (Zaltman and Vertinsky 1971), and an especially appropriate strategy for disseminating new information and practices (Kotler, Ferrell and Lamb 1987). The lesson to be learned from business ventures was that products floundered on the market because they failed to satisfy a need or offer a perceivable benefit to the consumer. For Rothschild (1979), this logic was also applicable to the “selling” of social issues. Over the past 20 years, social marketing has provided health educators and health promotion professionals with conceptual tools for influencing behaviour change (Lefebvre 1992), including recruiting volunteers (Andreasen 1995; Lovelock and Weinberg 1989).

“New Directions for a Healthy British Columbia”

Propelled by reduced federal transfer payments, shriveling tax bases, escalating health care expenses and an aging population, eight Canadian provinces have recently commissioned reviews of their health care systems. Hurley, Lomas and Bhatia (1994), Norris (1994) and Mhatre and Deber (1992) note a number of common themes emerging
from these reviews, four of which are relevant to this research: (1) broadening the
definition of “health” with the collaboration of multiple sectors; (2) shifting the emphasis
from a curative focus to promoting health and preventing disease; (3) switching from
institutional to community-based care; and (4) enhancing opportunities for individuals to
collaborate with service providers in making decisions about health choices, priorities and
policies. The latter principle is advocated by all eight provincial reviews and represents a
philosophical shift toward a more democratic process of decision making (Charles and
Demaio 1993). It was also the focus of this research.

Translating the "participation principle into practice" (Mhatre and Deber, 1992,
658) is to be accomplished by devolving the decision-making authority from provincial to
regional authorities, including community members on planning committees, and
increasing consumer education and awareness. However, “there has been more talk about
lay participation in health care decision making than there has been actual change”
(Charles and Demaio 1993, 882), and achieving widespread, meaningful citizen
participation may be the most daunting challenge facing the provinces (Hurley, Lomas
and Bhatia 1994).

British Columbia’s now defunct health reform policy, “New Directions,” evolved
from a 1990 Royal Commission on Health Care and Costs. The Commission concluded
that B.C.’s health care system, although one of the best in the world, was fragmented and
unable to adequately assess the efficiency or effectiveness of its services. The existing
structure had not evolved from an articulated plan, and lacked coherence and logic. There
was enough money in the health care system, but it needed to be more carefully managed. The Commission’s 1991 report *Closer to Home* suggested that the centralized structure for decision-making and resource allocation resulted in poorly planned, poorly managed and uncoordinated health care at the regional and/or community level. In addition, not all British Columbians enjoyed “reasonable” access to the health system. The report focused on the need for local management and decision-making, along with a greater emphasis on health promotion and disease prevention.

Two years later, in 1993, the provincial Ministry of Health released its response “New Directions for a Healthy British Columbia.” Five “new directions” (better health, greater public participation and responsibility, bringing health closer to home, respecting the care provider and effective management) and thirty-eight “priority actions” in these five directions were proposed to guide the implementation of health reform:

1. All determinants of health must be addressed in order to achieve “better health” for British Columbians in a holistic sense. Issues such as housing, education, employment and the physical and social environment, as well as lifestyle, genetics and health services, are factors affecting health. Consequently, health becomes the responsibility not only of the ministry of health and health care providers, but of other levels and ministries of government, the community, schools, and industry -- anyone whose activities directly or indirectly influence health.

2. “Greater public participation and responsibility” is necessary to ensure that services are appropriate and health needs are being met, and to assist individuals to make
informed decisions about their health care. In order to achieve this second direction, opportunities for citizens to participate in local decision-making must be made available, as well as assisting citizens to make informed decisions about their own health care. This second "new direction" is the focus of this research.

3. Local communities and regions should assume control over planning, resource allocation, management and delivery of health care services. By establishing Community Health Councils (CHCs) and Regional Health Boards (RHBs), local communities and regions will be able to "bring health closer to home" and increase public participation in health care decision-making. "Communities will take the lead in developing proposals to establish councils, boards and health centres. Implementation will be at a pace that meets communities’ needs and allows us to learn from experience" (New Directions for a Healthy British Columbia 1993, 16).

4. Acknowledging the unpaid support that volunteers and family care givers provide to the system, and the role that health care personnel play in delivering quality service is critical to health reform. "Respecting the care provider" requires strengthening support for care providers, including respite options for informal care givers, appropriate training and safe working environments. Paid and volunteer care providers should also be involved in the planning of health services.

5. Finally, "effective management of the new health system" is necessary to ensure ethical and financial accountability at every level of the new decentralized system, including professional organizations. "Priority actions" identified to address this fifth direction include the release of an annual "report card" on the health of British Columbians, the development of standards and protocols for the collection of
information and evaluation of health outcomes, and the preparation of a physician resource management plan for the health system. Establishing a closely coordinated system where citizens, particularly traditionally underserved clients (e.g., aboriginal people, persons with disabilities, persons who are mentally ill, youth *et cetera*) "do not fall through the cracks" (*New Directions for a Healthy British Columbia*, 1993, 18) is critical.

Under the direction of these guidelines, British Columbia communities were asked to develop community health plans which reflected the health goals and priorities of their constituents and to ensure that services in the community were appropriate. Community health planning groups, comprised of volunteers, were expected to foster community awareness of, and participation in, the assessment of health priorities as the initial step in developing a community health plan. In doing so, communities were expected to elicit, generate, and document representative input from health care consumers, health care providers and government representatives. The data were then collated and compiled in a report submitted to the ministry of health in the community's formal application for designation as a community health council or advisory committee. By 1996, community and regional boards were to take responsibility for health care planning and resource allocation. Each community health council, or regional health board, would then be responsible for utilizing the information gathered and implementing health reform.
By the summer of 1996 there were approximately 150 community health councils in the province of B.C., and 20 regional health boards. Each council consisted of one-third elected citizens directly elected to the council, one-third municipal councillors, and one-third ministerial appointees of demographically representative community groups (e.g., women, aboriginal, multicultural). Two-thirds of the council members sat on the regional board, with the remaining seats being filled by ministerial appointees. In the Capital Regional District on Vancouver Island, health planning groups that did not apply for or receive designation as community health councils remained as community advisory groups to the Capital Health Board (the Capital Regional District's regional health board).

"New Directions" included an on-going commitment to improve public understanding of, and participation in, health and health services. Given the historical lack of success in fostering broad based citizen participation in health promotion and a variety of other fields, the experience of B.C.'s health planning groups afforded an opportunity to critically explore the participation process. Further, utilizing a social marketing approach to understanding the participation experience may offer new insights into the dilemma "If participation is such a good thing, why don't more people participate?" (Norton, Wandersman and Goldman 1993, 144).

Therefore, the purposes of this study were:

1. To describe the experience of citizen participation in a health reform initiative in the Capital Regional District by documenting and characterizing the processes and activities of local health planning groups.
2. To describe the perspectives of participants in particular health reform process.

Information was gathered from members of health planning groups by inquiring about:
(a) their perceived motivation to participate; (b) what they thought they contributed to the process in terms of skills, knowledge, experience and time; (c) the positive and negative aspects of participation; and, (d) their reflections about the experience.

3. To describe the perspectives of the persons not participating in the health reform process. This included assessing focus group members' awareness of "New Directions," examining their views on health and reasons for not participating, and inquiring about ways in which nonparticipants might like to become involved in the work of the health planning groups.

4. To test the utility of social marketing concepts (exchange, understanding the consumer perspective, marketing mix and market segmentation) as analytical tools in the interpretation of the data and in contributing toward a theory of citizen participation. Would these concepts lend themselves to making sense of the qualitative data? More importantly, would the social marketing approach improve the explanation of why some people participate and others do not?

The dissertation is organized in the following fashion. The next section presents the research questions, and the statement of the problem in the context of health reform in British Columbia. A rationale for using the social marketing framework concludes the introductory chapter.
Chapter two presents a review of the literature in four sections. The first section introduces a multidisciplinary look at the theory and practice of citizen participation. The second section explores the related concepts of empowerment and citizenship, and their relationship to participation. The framework of social marketing and its application to "New Directions" is reviewed in the third section. A selective look at present and emerging research methodologies in health promotion follows in the fourth section.

The methodology chapter, chapter three, describes the sample, recruitment and data collection strategies, and data management and analysis techniques. Chapter four tells the story of health reform in the Capital Regional District through the interviews with participants and nonparticipants, fieldnotes and documents. The researcher's analysis of the data using the social marketing concepts and interpretation of the findings are presented in the fifth chapter. Finally, the concluding chapter offers a critical discussion of the utility of a social marketing approach to fostering and understanding citizen participation, as well as the implications arising from the research for informing theory and practice in citizen participation and health promotion.

Research Questions

The first purpose of the research study was to describe the context of participation in health reform in the Capital Regional District of British Columbia, particularly profiling the members of health planning groups and their work. Secondly, the intent was
to describe the experience of recruited participants in "New Directions." The research questions specific to these goals were:

1. a) Who participates in the health reform process;
   b) What reasons do they give for participating;
   c) In what activities do they become involved; and,
   d) What were some of the perceived positive and negative consequences of the involvement?

The third aim of the study was to investigate reasons other citizens do not participate and explore the perspective of nonparticipants, especially individuals belonging to groups in society that are traditionally underrepresented in the citizen participation process. The second and third research questions appropriate to this purpose were:

2. What needs or conditions do citizens say must be met for them to participate or consider participating in the health reform process?

3. What opportunities to participate are preferred by different constituent groups?

A final intention of the study was to test the utility of the social marketing concepts in the analysis of the qualitative data:

4. Do the social marketing concepts of exchange, understanding the consumer perspective, segmentation and the marketing mix provide an analytical framework adaptable to the data on participants’ experiences and nonparticipants’
perspectives? How do the concepts contribute to the theory and practice of citizen participation in health promotion, if at all?

Statement of the Problem

Kotler and Roberto (1989) define a social change campaign as "an organized effort conducted by one group (the change agent), which intends to persuade others (the target adopters) to accept, modify, or abandon certain ideas, attitudes, practices and behavior" (6). The essential elements of a social change campaign include a cause, a change agent, target adopters, channels for communication and distribution, and a change strategy. Viewed as a social change campaign, the British Columbia health reform policy “New Directions” exhibited all of these core elements:

1. The larger cause was health care reform (“New Directions for a Healthy British Columbia”), an objective that political change agents believed would provide a solution to the problem of a system increasingly characterized as costly, inefficient and ineffective at providing appropriate health care delivery (as identified by the Royal Commission on Health Care Costs). In order to revitalize the health care system, five “new directions” served to guide the implementation of health reform. The second “new direction,” and the focus of this research, was to foster greater public participation and responsibility to ensure that services were appropriate and health needs were being met, and to assist individuals to make informed decisions about their own health care. However, marketers recognize that "even if an individual's attitude toward an action is favorable, he or she may not carry it out because of time, expense,
inconvenience, or plain inertia. For this reason, a change agent in such a campaign must provide rewards or incentives that are perceived to override the costs" (Kotler and Roberto 1989, 19). The success of enlisting citizen involvement in the health reform process depended in part upon the ability of the change agents (e.g., the health planning groups) to positively structure the opportunity to participate.

2. The change agents were primarily government officials responsible for implementing “New Directions.” Community health planning groups, however, assisted in the street level implementation and were responsible for informing residents about opportunities to participate, and persuading them to become involved in assessing priorities and making decisions about local governance structures (e.g., an autonomous community health council or a community advisory committee to a regional health board). Those priorities were to inform the resource allocation decisions made by community health councils or regional health boards.

3. The target adopters were both health care consumers and providers in the community who were the targets of appeals to participate in “New Directions.” Health care consumers were further segmented into socio-demographic groups representing the constituent profile for each community health planning group.

4. The channels were the mechanisms used by health planning groups to communicate and distribute information and to secure commitment for participation from community members.

5. The change strategy reflected the activities and efforts of the health planning groups to solicit citizen participation in the health reform process.
In sum, there were several different stakeholders involved in the implementation of “New Directions” in the Capital Regional District. At the provincial ministry level were the minister and the “New Directions” transitional staff who were responsible for overseeing the implementation of the health reform policy within the stated timelines. The ministry officials, in turn, worked with the staff of the Capital Health Board (the regional health board of the Capital Regional District), primarily to provide technical assistance and the necessary human, financial and material resources. Together with the members of the community health planning groups, the CHB staff worked to develop public awareness of, and solicit participation in, “New Directions,” identify community health needs, establish a community health plan and decide on the appropriate governance structure for each community. Finally, constituents of the seven communities comprising the regional district were invited to participate in the health planning groups, complete surveys, or attend public forums or focus groups, to contribute toward the community health plan and decisions concerning governance.

The challenge that faced the health planning groups comprises the statement of the research problem: How can the opportunity to participate be structured to meet diverse constituent needs and secure broad based participation in the assessment of community health goals and priorities?
The idea of "marketing" tended to be synonymous with "selling" until the mid 1950s when the focus shifted from the selling of products to meeting the needs of consumers (Webster 1988). The selling, or product orientation emphasized developing a superior product and shaping consumers' behaviour to meet the needs of the organization. In contrast, the marketing approach believes that the product is the variable which should be modified and shaped to meet the customer's needs. "Selling focuses on the needs of the seller; marketing on the needs of the buyer" (Levitt 1960, 50). Social marketing has been described as "a way of thinking ... that is fanatically customer-centered" (Andreasen 1995, 33). As in the work of public health practitioners and health educators (Green et al. 1995), marketing's greatest strength is its passionate concern for the consumer (Novelli 1990). The marketing maxim starts where the consumers are, not where the product is: know the target market and how to satisfy it (Andreasen 1995; Kotler and Turner 1983). The marketer knows that it is easier to create products that satisfy existing needs than to alter attitudes and wants toward existing products.

According to Novelli (1990) the concept of social marketing employs theories of consumer behaviour (cognitive, behavioural and environmental) to explain why people make certain decisions to adopt or not to adopt products, and theories of social exchange to explain the willingness of individuals to sacrifice resources (money, time, commitment) for perceived benefits. As Andreasen (1995) notes, "The assumption is made that customers have very good reasons for doing what they are doing" (49) (or not
doing, in the case of participation). Further, social marketing theory holds that the product -- or behaviour -- being offered by the social marketer is not an objective reality; it is only what the customer thinks it is. Effective marketing and implementation of social products relies on research to identify and understand specific consumer needs, wants, expectations, satisfactions and dissatisfactions, in order to understand how the marketing program can best respond to the consumer’s situation. In addition, the research enables the marketer to segment the audience into target markets, and to determine the best means of “positioning” or presenting the cause to each particular market.

The traditional citizen participation experience can be said to suffer from a “selling” standpoint using a market-aggregation approach (Lovelock and Weinberg 1989). The literature reveals that the idea of participation is presented as a standard ‘product’ offered to all and sold to the public from the community organizer’s point of view (Andreasen 1995). The traditional public meeting and forum organized to provide a venue for citizen involvement reflect a selling orientation: “Offer it and they will come” (Andreasen 1995, 39). Rather than recognizing the diverse needs of citizens it is often assumed that the public will respond in droves to public meetings merely because those requesting participation have expressed their needs (George and Compton 1990). Market segmentation, on the other hand, groups citizens according to their needs and preferences for participating, and allows for the development of distinct “marketing mixes” attractive to each target group.
Social marketing concepts are especially relevant to understanding the practical issues of how to design and distribute the idea and practice of participation. Since the focus is on the transaction, whereby something of value is exchanged between the parties (e.g., an individual provides information regarding her health needs and benefits from having her voice heard), a change agent must arrange rewards or incentives that are perceived by the consumer to override the costs of taking part. The marketing process begins with defining consumer needs from the consumer's point of view in order to understand the consumer (Kotler and Turner 1993). This understanding ensures the idea or cause will be developed with its “price”, promotion and distribution organized to attract the client. To be successful, the right idea (the opportunity to participate) needs to be backed by the right promotion (newspaper advertisement, personal selling by a respected community leader, public relations), and be favourably positioned for distribution (survey, focus group, hotline, public forum) at the right social price (minimal effort/cost in transport, convenient, uncomplicated) for each constituent group (“citizen”).

In British Columbia, the application of social marketing to health reform rests on the health planning group's ability to manage and customize these elements.

The health planning groups participating in this study did not explicitly adopt nor even acknowledge a social marketing strategy. Their struggle to increase awareness of “New Directions” and foster participation, however, might usefully be analyzed with social marketing tools. Planning group members repeatedly articulated their concerns about reaching the “grassroots” in the community in order to include traditionally underrepresented voices. As discussed above, “New Directions” can be seen as a social
change campaign organized and conducted by a group (the community health planning
group) which intends to persuade others (citizens in the constituency) to accept the idea
and practice of participating in the assessment of community health goals.

The ample literature on citizen participation across a variety of disciplines
contains demographic and psychological profiles of participants, and accounts of their
activities most often in the form of committee or public meetings. Despite the eclectic
assortment of research in the field, the conclusions to be drawn from the studies are
profoundly similar: all point to the difficulty of enlisting participants from a broad base
of citizens. For all the variety and volume of studies and commentaries written about
participation, there remains little in-depth, evaluative analysis of the quality of
participation and its methods (Kelly and Van Vlaenderen 1996; Wandersman and Florin
1981). Moreover, the comparative success of different techniques in involving a wide
variety of community members have not been fully investigated (Abraham Wandersman,

As a result, scholars of participation in community organization, health promotion
and citizenship have called for further research into the determinants of participation, so
that community organizers can develop more feasible strategies to foster participation and
empower citizens to shape the decisions of the public services they use and pay for (Prior,
Stewart and Walsh 1995; Poulin and Kauffman 1995; Stachenko 1994; Green and
Kreuter 1993; Harris 1992; Bracht and Tsouros 1990; Powell et al. 1989; Cohen and
Uphoff 1980). Of particular importance is studying the organizational, community and
societal conditions which encourage or discourage participation (Wallerstein 1992). Lovelock and Weinberg (1990) suggest that consumer research may help facilitate the search for determinants "...that are realistic in their expectations of human behavior" (14). New models for public participation need to be documented and key lessons extracted from them.

With the exception of Quebec, there have been few opportunities for involving citizens in the health care policy decision making process, leaving it to provincial health ministries, their bureaucrats and provider organizations (Charles and Demaio 1993). Consequently, the documentation of the Canadian field experience in participation, particularly as it relates to describing public involvement in health promotion is sparse (Powell et al. 1989; Zakus and Hastings 1989). In addition, very few of the participation experiences in the literature have been constructed from the participants' point of view (Hume 1993; Rifkin 1990). Scholars have recognized the need in the future to "...combine the insights of community members with more formal theoretical formulations" (Price 1990, 165).

Kotler and Zaltman (1971) acknowledge that planned social change is not often viewed from the consumer's point of view, yet it entails an exchange relationship between the consumer and change agent akin to an economic exchange with tangible products. Perhaps the fundamental difficulty in the theoretical development (reaching consensus regarding the meaning, nature, content and process) of participation and key practical challenge in achieving it is the search for a 'one-size-fits-all' model -- an approach which
can be generalized to accommodate all people in all contexts. Undoubtedly, the meaning of participation varies with different groups of citizens. Understanding the participants' and nonparticipants' point of view may reveal issues accounting for the participation bias. A social marketing analysis offers an approach to furthering our knowledge and understanding of the theoretical and practical evolution of citizen participation.

Grounds for Using Social Marketing Concepts as an Analytical Framework

The extensive research into citizen participation by Wandersman and colleagues' (Norton, Wandersman and Goldman 1993; Chavis and Wandersman 1990; Perkins, Florin, Rich, Wandersman and Chavis 1990; Wandersman, Florin, Friedmann and Meier 1987), detailed in Chapter Two, suggests that arranging an exchange relationship with volunteer participants that minimizes costs and enhances benefits is useful in explaining why some people participate and others do not. This view is compatible with a social marketing perspective where "Marketing is a way of thinking and acting about what we do based on the concept of exchange" (George and Compton 1990, 253). The needs of the participant, as part of the exchange process, have to be recognized more explicitly. Wandersman's research has helped to explain why people voluntarily offer their resources, and in doing so, has provided valuable insights into understanding the participant, including demographic factors, cognitive determinants, benefits sought, and outcomes.
The history of citizen participation also reveals the homogeneous profile of participants suggesting that the most common opportunity to participate -- committee meetings -- encourages the participation of only a narrow group of constituents. Innovative techniques for capturing public input, described in the following section, indicate that a broad base of community involvement may be achieved by focusing on the consumer and better "positioning" opportunities to participate to meet their needs. Conceptually, health promotion meshes nicely with social marketing, for health promotion is also people centred (Catford 1995). As Lovelock and Weinberg (1990) note, social marketing techniques afford a fresh "...perspective and powerful new tools for tackling a range of difficult social welfare problems" (12), challenging health promotion professionals to think in new ways about citizens and methods for engaging their participation.

While the use of social marketing in other health promotion activities has been criticized for its manipulative and prescriptive overtones (Smith 1995; Buchanan, Reddy and Hossain 1994), proponents argue that social marketing has been poorly understood and ineffectively used (Lefebvre 1992). The potential of social marketing to facilitate broad-based community involvement brings it close to community organizing or community development initiatives. Chapman Walsh, Rudd, Moeykens and Moloney (1993) note that social marketing strategies challenge health professionals to design initiatives that are culturally appropriate and accessible, and, in doing so, increase the potential for effectively addressing "perennially frustrating" issues resistant to change. While Chapman Walsh et al. (1993) speak of using social marketing for public health
initiatives such as promoting safe sex practices, the same logic can be applied to fostering public participation. Social marketing may be the tool that can "...isolate those approaches that really do enable individuals and communities to gain greater control over their health and the quality of their lives" (Chapman Walsh et al. 1993, 118). To conclude, the intention in this study was to use a social marketing framework as an analytical tool, to elucidate the standpoint of the citizen participant in community health reform, to better understand how the opportunity to participate can be offered to accommodate diverse citizens' needs, experiences and preferences, and, hence, to facilitate the participation experience.
CHAPTER 2

REVIEW OF THE LITERATURE

There has been widespread embracement and endorsement of the significance of citizen participation to health promotion (and other fields), but far less consensus on how it is to be achieved in practice, and still a further paucity documenting its success. While many proudly proclaim to have achieved ‘public participation’ in health promotion programs and policies, their accounts in the literature do little to further the conceptual or pragmatic development of citizen participation. Similar problems plague the theory of citizenship. Empowerment is an equally popular concept in health promotion, but one that nevertheless remains ambiguous.

The first section of this chapter explores the multi-disciplinary knowledge and research base on citizen participation. It reviews the rationale for participation, the profile of citizens who most frequently participate and how they participate, the benefits and costs to participants, and the opportunities made available to participate. The second section discusses the literature on the concept of empowerment, the theory of citizenship and how these are associated with citizen participation. The second section concludes with a model connecting their shared dimensions. The purpose of the literature review in these two sections is to provide the reader with an evolutionary view of, and the current debates surrounding, participation, empowerment and citizenship.
This chapter then reviews the literature in social marketing, with reference to its application to citizen participation, and includes a discussion of the theoretical concepts used in analysis of the data. Finally, the fourth section of the chapter reviews the approaches to health promotion research relevant to the research design and methodology in this case study.
Section I Citizen Participation

From the diverse and voluminous interdisciplinary literature on the subject it is clear that public/citizen/community participation is a highly touted, valued and idealized concept considered integral to the "health" of a democratic community. Yet it is also one that has been realized only in a limited sense, performing mostly a symbolic function (Prior, Stewart and Walsh 1995; Checkoway and Van Til 1978; Rosenbaum 1976).

The rhetoric of participation acknowledges the importance of recruiting representative input yet the reality is that participants volunteering in community consultation and decision-making activities generally exhibit high levels of wealth, education, confidence and skills that are not representative of the greater community. Moreover, it is clear not everyone participates when given the opportunity to do so. Over 25 years ago, Burke (1968) commented that this paradox stems from the idealized value of participation coupled with the inability to implement it. Burke (1968; 1983) suggested that the gap between what is purported and what is accomplished is a result of miscalculating the conditions requisite for the success of a particular strategy. Others (Rosenbaum 1976; Wengert 1976) cite the tendency of the citizen participation literature to have a "breezy confidence [that] commonly overleaps the nettlesome issues" (Rosenbaum 1976, 363).
In an effort to understand, predict and foster participation, researchers have investigated:

- demographic variables and individual and situational differences that influence participation (Verba, Schlozman, Brady and Nie 1993; Chavis and Wandersman 1990; Henderson 1990; Wandersman and others 1981; 1987; Parkum and Parkum 1980; Wandersman and Giamartino 1980);
- cognitive variables, such as the knowledge and experience that enable successful participation behaviour, perceived consequences of participation, and the perceived importance of those consequences (Zimmerman 1992; Zimmerman, Israel, Schulz and Checkoway; Rappaport 1988; Florin and Wandersman 1984);
- citizens' perception of the community and environment (Perkins, Florin, Rich, Wandersman and Chavis 1990; Oliver 1984); and,
- the effects (costs/benefits) of participation (Prestby and others 1990; Rice 1990; Wandersman and colleagues 1987).

Others (Bracht and Tsouros 1990; Rifkin et al. 1988; 1991) have developed typologies or methods of describing or assessing participation in health-related activities. In addition, catalogues of participation methods review when public hearings, workshops, or other methodologies are likely to be successful (e.g., Advisory Commission on Intergovernmental Relations 1979; Rosener 1978; Heberlein 1976). Other research has led to a variety of conceptual frameworks, notably Arnstein (1969), Green (1986), Brager and colleagues (1987), Connor (1988) and Charles and DeMaio (1993).
Much of the more recent research into public participation in community psychology and planning has been guided by the framework proposed by Wandersman (1981) (see attached figure 2.1, page 31). The framework outlines several interdependent dimensions in participation, including individual participant difference characteristics as influencers of who participates, the parameters of participation, and the effects of participation. If there is an opportunity to participate, individual differences (personality, demographic and background characteristics) influence whether an individual chooses to participate and what level and type of participation they engage in. Parameters of participation define the opportunity to participate and include the setting and scale of the organization, the stage of development the organization is at, the type of participant (resident, helper, government official), types of participation and technique of participation. The appropriateness of the participatory technique used will be influenced by the setting and scale of the organization and its context, stage or phase of the organization, type of participant and type of participation. The effects of participation may be experienced at the individual, organizational or community level, and may affect a person's willingness to participate in the future.

The data from such research has produced the 'participation potential' which identifies cognitive learning variables, community characteristics and other factors whose presence indicates a probability of successful participation (Wandersman and Florin 1981).
As the ensuing pages detail, the reality of citizen participation is that those citizens who have the skill, time and other resources to take part, feel a sense of duty about being involved, and perceive themselves to have the ability to contribute to the process are most likely to do so. For the most part they volunteer on advisory/steering committees which provide the most common opportunity for community members to participate. In contrast, research investigating participation on citizen panels (Kathlene and Martin 1991) and in neighbourhood associations (Wandersman et al. 1987) found these opportunities to bring together a more representative sample of community residents than other traditional participation mechanisms, such as surveys, committees and workshops.
This suggests that how the opportunity to participate is structured may determine who actually participates and what skills and attributes they bring to the participation table.

Who Participates?

In a comprehensive review of citizen participation in community planning and decision making, Parkum and Parkum (1980) found participation and socio-economic status to be positively linked; that is, well-educated people with higher incomes and in professional occupations were more likely to participate than people who were less well-off. They found no regular pattern of participation by gender; rather gender differences tended to be activity or subject specific, with men more active in environmental, economic development, and outdoor recreation concerns and women more involved in educational, anti-crime and urban recreational issues. Not surprisingly, the longer a resident had lived in a community the more likely she or he was to participate in neighbourhood activities. Finally, those persons involved in community efforts were usually engaged in several commitments at once. Other potential influences include population size (although the research is contradictory here), and the maturity of the organization seeking participation.

Similar profiles have been provided by others (Brager, Specht and Torczyner 1987; Oliver 1984; Pennock 1979; Lazar 1971). A PAHO (1984) study of participation in community health found participants generally fell into a narrow class composed of wealthier, more educated citizens and senior community leaders. The citizens most often
underrepresented in participation are women, ethnic minorities, the disabled and elderly (Freeman, Littlewood and Whitney 1996). Kweit and Kweit (1981) suggest that despite growing opportunities for participation, the resources and skills required for participation are not evenly distributed among community members; hence interests of higher status citizens are most often represented. As well, persons in low socioeconomic positions face greater structural constraints to accessing such resources (Wallerstein 1992). Such constraints may preclude involvement due to poverty, limited access to decision-making avenues in societal systems and institutions, and limited educational opportunities. Further, these constraints impede the opportunity to gain experience in public speaking, to understand policy and planning and to become familiar with meeting etiquette (Piette 1990). As such, persons in low socioeconomic positions may feel less confident in participating in a public venue.

Rifkin (1990) and the PAHO (1984) researchers advocate broad representation as a prerequisite for successful community participation efforts. Yet, Winett (1991) argues that community health promotion efforts demanding individual behaviour change may "...be better directed to those persons who do not have to struggle constantly with issues of daily survival" (639). The personal costs of participation are higher, and the share of the collective good lower, for the poor (Oliver 1984).

In summary, social background or demographic factors such as ethnicity, income, age and gender have typically been used to describe who participates and provide an indication of representativeness. Comparing relevant characteristics of the participants
with those of the community is one way to assess representation. "Descriptive" representation reflects the degree to which participants are demographically descriptive or socially similar to the larger public they are intended to represent. Beatley, Brower and Lucy (1994), in addition to descriptive, offer two other forms of representation: opinion (or delegate) and trustee. Opinion representation is based on the premise that the attitudes and opinions of those participating are similar to those in the larger community. Lastly, "trustee" representation assumes that those elected will apply independent judgment and the rational deliberations of parliament, and act on their conscience. The actions are then subject to approval or disapproval by the electorate in the next election.

It is widely acknowledged that those citizens who become involved in participatory processes are quite likely to be dissimilar from nonparticipants. Analyses of such differences, however, remain limited to demographic or descriptive distinctions. Demographic variables have limited utility in explaining and predicting participation, and are difficult to change. While demographic details are salient for planners and policy makers, Hutcheson (1984) notes that there is a symbolic value to descriptive representation. The more relevant issue may be 'whose interests are not being represented'? Representative participation must be assessed in light of the specific objectives of programs, for it is entirely possible to have descriptive representation without opinion-based representation.

Beatley and colleagues (1994) assessed both descriptive and opinion representation in a participatory process intended to develop a comprehensive community
plan. Demographic data revealed that participants were not highly representative of the
general public: they were more educated, wealthier and older than the majority of
residents. Opinions differed on issues of public policy related to compact urban and
business development in Austin, Texas. The study found that the opinions to emerge from
the process of deliberation differed from those of nonparticipants. The authors suggested
that "the process of participation itself may lead almost inevitably to opinions that are no
longer representative of the general public" (Beatley, Brower and Lucy 1994, 194).

Hutcheson (1984) also found that neither descriptive nor opinion representation
was achieved in a traditional neighbourhood planning process. This is in contrast to
Lomas and Veenstra (1995) and Gundry and Heberlein (1984), who found that public
meeting participants provided opinions broadly representative of the relevant community,
despite descriptive differences in representation. In an interesting account of "Citizen
Participation Overplanned," (Paul and Demarest 1984) professionally-imposed concepts
of representation resulted in less rather than more participation and in the demise of a
local health clinic in Guatemala. The researchers conclude their case study with the
advice to "...spend more time learning how the community is organized and less time
trying to organize it" (192).

The latter point introduces the necessity of a third form of representation, active or
experiential representation (Prior, Stewart and Walsh 1995). Electoral or statistical
representation, also termed mirror representation (Phillips 1995), is limited because there
is no guarantee that those who represent citizens share similar constituent gender, ethnic
or socioeconomic status, let alone understand their needs or experiences. Needs are best appreciated when they are shared. Representation, based on shared experiences where needs are actively and subjectively assessed, enhances the legitimacy of representation when economy of time and problems of scale restrict participation by all.

Why Foster Participation?

The literature reveals that public participation in general serves a range of purposes (Younis 1995; Berry, Portney and Thomson 1993; Wallerstein 1992; Prestby, Wandersman, Florin, Rich and Chavis 1990; Rifkin 1990; Littrell and Hobbs 1989; Oakley 1989; Brager, Specht and Torczyner 1987; Sandercock 1987; Palmer and Anderson 1986; White 1983; Kweit and Kweit 1981; Rothman, Erlich and Teresa 1981; Bregha 1975; Cahn and Camper Cahn 1971). Participation may function:

- to market or pilot test services, programs, or tools to the participant as client, consumer, customer or patient. Advice, suggestions and feedback regarding details other than policy are sought to improve the effectiveness, efficiency, appropriateness and utilization of a service delivery system;

- as a mechanism for citizens to voice their opinions or influence decisions in planning or policy making;

- to transform institutions into more effective instruments of democracy;

- to uncover and mobilize a community's indigenous, untapped resources and expertise;
• to reduce alienation, strengthen social networks, foster a sense of community and help people adapt to change by executing public projects;
• to build competence in, and educate citizens about policy-and decision-making processes so that citizens develop the political consciousness and generic skills required to tackle other issues;
• to engender a sense of ownership for, and performance in, programs and projects;
• to encourage self-fulfillment, self-reliance, self-esteem, personal growth, and feelings of personal and political efficacy; and,
• as a means of redistributing political power and increasing equality.

Participation, then is viewed as a means to individual and community empowerment, a means to produce effective policy and program implementation, and a means to achieve individual or collective tangible results or outcomes. Participation is also viewed as a responsibility of citizenship. Empowerment, participation and citizenship are further discussed in Section II of this chapter.

To Participate or Not to Participate?

Wandersman et al. (1980; 1981; 1984), and others (Berry, Portney and Thomson 1993) argue that demographic profiles do little to explain an individual’s decision to participate. In their investigation of participation in neighbourhood block associations, Wandersman et al. (1980; 1981; 1984) found that the value the individual attached to the neighbourhood (especially if they intended to send their children to school there), and
their belief that they could successfully perform the behaviours necessary for participation predicted intention to participate much better than demographic variables alone. Also influential was the perception by residents of an atmosphere conducive to working on problems together, and a sense of citizen duty. Similarly Chavis and Wandersman (1990) found community “connectedness” affected the desire of citizens to participate in local organizations. Unlike age, gender, occupation and race or ethnic origin, these variables are amenable to intervention.

Godshalk and Stiftel’s (1981) investigation of public participation in state water planning found citizen awareness of the participation activities to be an important criterion. This was confirmed in Poulin and Kauffman’s (1995) inquiry into drug prevention activities. People were more likely to participate if they were aware of the opportunities to do so. Citizens’ desire to become involved and the ease of participating (accessibility) were also significant. However, in their path model of participation in drug prevention initiatives, accessibility had direct effects on both desire and knowledge. Poulin and Kauffman (1995) recommended that organizations focus more energy on increasing awareness and knowledge of participation opportunities, and engage in more outreach among members of the minority population.

Participation is dependent on people perceiving that their effort has merit, is within their grasp, and will make a difference (Littrell and Hobbs 1989; Bregha 1975). An individual's perception of efficacy and making a difference is influenced by dimensions beyond and prior to an actual membership decision (Moe 1980). Perkins,
Florin, Rich, Wandersman and Chavis (1990) suggest that a combination of contextual factors in the physical and social environment of communities motivate and enable participation: individual differences initially influence whether or not a person participates, and at what level, and also shape the outcomes of various types of participation. The type of participation will, in turn, influence both the environment and the individual's assessment of that environment and of the value of their participatory efforts. (Coming full circle, this assessment will impact on the environmental, ecological, social and individual variables and willingness for prospective participation.)

Understanding why people volunteer in community life and what they hope to gain from the experience is important to successful recruitment and retention (Lovelock and Weinberg 1989). Reported reasons for initiating participation frequently focus on personal gain and community betterment; reasons for sustaining that participation included personal growth and education (Parkum and Parkum 1980). Oliver (1984) in her study of participants in Detroit neighbourhood associations, found that the most active contributors' reason for participating reflected a pessimism toward the collective spirit: "If I don't do it, nobody else will" (602). On a more upbeat note, the 1987 National Survey on Volunteer Activity (Rice 1990) revealed the following reasons why 27 per cent of Canadians participate in volunteer activities: helping others, supporting a cause, doing something they like, accomplishing something, meeting people, learning new skills, using existing skills and giving something back to the community. Former volunteers reported other competing responsibilities, health problems, disinterest, a negative experience or relocation as reasons for relinquishing their volunteer roles.
Wasting their skills and time were common reasons contributing to an unhappy volunteer experience. Clear role definition, with tasks and responsibilities appropriately assigned to skill and experience level, is recommended by the volunteer management literature. In regard to recruitment strategies, a 1981 survey of American volunteers found that adults and teens became aware of a volunteer opportunity when personally invited to volunteer. Positive evaluations from significant others about the volunteer experience, and prior volunteering experience provided other influential sources of information (Lovelock and Weinberg 1989).

Speculating as to why some individuals do not participate, Brager and colleagues (1987) suggest the theory of relative deprivation, and Lazar (1971) asserts that only those who can invest in issues other than the daily struggle for sheer survival do so. The 1992 guide to Canadian citizenship listed social disadvantages such as racism, illiteracy and discrimination as barriers to participation, in addition to a lack of knowledge of the norms of the community or what is expected of citizens (Multiculturalism and Citizenship Canada 1992). Littrell and Hobbs (1989) cite the inefficiency of democratic processes (e.g., decision-making patterns that are time-consuming and complex), apathy, and the technical nature of problems and decisions in modern communities. Public apathy towards involvement may be a consequence of other priorities or competing interests, but can also result from the distrust and disillusionment with government (Prior, Stewart and Walsh 1995). These challenges may be addressed through use of outside assistance to translate technical questions into broad policy options which can be understood, establishing opportunities for participation which are inviting and nonthreatening, and
inviting participation on issues that are of interest to, and can be addressed by, citizens at
the local level (as opposed to policies that are provincial and national in scope). Baker,
Draper and Fairbairn (1991) encourage investigating the question of why individuals do
not participate, because it may lead to both widening the circle of participation and
respecting those who choose not to be involved.

Lay persons involved in health care decision-making require knowledge of
scientific terminology and technical skills in analyzing epidemiological reports and
impact statements, not to mention knowledge about the health care system and skills in
chairing meetings and writing reports (Brownlea 1987). Advocating participation in
these activities presupposes that community members have the requisite knowledge and
capacity to do so (Pritchard 1986), and may account for the educated and professional
status of the typical participant. Professionals can manage such duties, and are paid to do
so; relegating those tasks to community members may be inappropriate, and may also
explain the low participation of traditionally underrepresented constituents. Indeed, the
Nova Scotia experience documents that lack of professional knowledge and technical
skill undermined consumer involvement in that province’s health reform efforts (Sullivan
and Scattolon 1995).

Mhatre and Deber (1992) are skeptical of health reform plans to increase
consumer input. The authors cite the experiences of Norway’s recent reform of primary
health care services and the Healthy Cities Network which indicate that health care
providers with 'concentrated interests' continue to remain more involved than consumers
with 'diffuse interests'. These results mirror much of the literature in citizen participation. Collins and Green (1994) concur, adding that while decentralization may facilitate public involvement "there is no universal correlation between decentralization and community participation" (465). Thus, Piette (1990) cautions that professionals should function in an adjunct advisory capacity rather than in a representative decision-making role -- they undoubtedly are electorally, statistically or experientially representative, and therefore the decisions made may not reflect the needs or interests of others in the community. This presents a difficult challenge when a professional participates in his or her 'non-professional' capacity (i.e. as a resident in his or her leisure time).

**The Benefits and Costs of Participation**

Despite the popularity of citizen participation in the literature as a desirable activity, research over the last two decades has produced ambivalent conclusions (Kweit and Kweit 1981). Pennock (1979) cites a number of frustrations in fostering participation. Foremost is the basic arithmetic problem of increased participation, with its potential for "interminable discussion and rancorous conflict" (459) and likelihood of accomplishing little. Furthermore, the process of transforming a disinterested public into political beings represents a dilemma, particularly for those who subscribe to a liberal view of citizenship. Libertarians may perceive efforts to foster participation as interference from government or society, infringing upon the individual freedom and rights of private citizens to pursue their own self-interests (Prior, Stewart and Walsh 1995).
At a personal level, the benefits of participation can be classified as material (tangible restitution with a monetary value attached), social (including prestige or recognition), and purposive (e.g., satisfying one's sense of duty or community). Rothman and colleagues (1981) use different terms (material and interim-anticipatory rewards are dubbed "instrumental" and social-interpersonal and symbolic benefits are described as "expressive"), but capture essentially the same components. One interesting material incentive they describe is the elimination of unnecessary meetings. Hawker (1989) lists the positive outcomes of the participation process as an enhanced self-respect and sense of dignity, and the development of individual capacity, skills and rights.

In a study of participation in neighbourhood block associations, Prestby and colleagues (1990) found that higher levels of participation were associated with significantly more and varied benefits and fewer costs. The researchers found benefits (learning new skills) and costs (time demanded of the participant) to be of personal relevance, and of social/communal or social/organizational significance. Benefits at the social or organizational level included improvements in the community, while the costs were associated with feelings of frustration within the group setting. A second finding was that leaders providing higher levels of incentives (particularly, social/communal incentives) and effective cost management significantly increased participant benefits and decreased participant costs. Finally, more effective and frequent incentive and cost management efforts were significantly and positively correlated to organizational viability.
The costs to individual participants have not been identified in the literature as frequently as benefits (perhaps due to the tendency of writers to extol the virtues of participation but not practice it), but Prestby et al. (1990) have identified the following:

- material or personal costs like time, effort and relinquishing time for personal or family concerns, and monetary losses associated with participation (e.g., gas, daycare);
- "solidary" (a term used by Prestby et al. 1990) or social costs of personality conflicts and lack of social/family support or interest; and,
- costs associated with organizational issues including sluggish progress, disagreement with organizational goals and processes, scheduling conflicts and miscommunication.

These authors are also careful to distinguish between the costs of actual involvement and barriers which hinder participation to begin with. Some of the barriers listed by Baker, Draper and Fairbairn (1991) include:

- the timing of the participatory process itself (e.g., in the evening or during the summer when people may lack time to be involved);
- divided interests within the community;
- citizen distrust of professionals;
- naive expectations about inadequate use and dissemination of knowledge and information;
- a preoccupation with present day concerns, contributing to a lack of prospective vision; and,
• a lack of appreciation or understanding of values, needs, structures and the historical perspective of communities.

Politicians and the political process can also serve as barriers to greater public participation (Prior, Stewart and Walsh 1995). Elected officials may fail to grasp the necessity of citizen involvement since it is their mandate to represent citizens, and may feel threatened if sharing the decision-making is construed as undermining their own authority. The time-consuming and supportive nature demanded of citizen participation efforts also runs counter to the political and governing process, and officials may only be interested in public participation that supports their preconceived policy agenda.

Participation, then, seems to be an activity of the educated or informed, who, for a variety of reasons, bring their skills and confidence to the participation table in order to mobilize resources and action within the community. The rewards for participating can, with careful management, outweigh the costs and encourage prolonged involvement. Incentive management requires that organization leaders or staff are aware of the relevant and different benefits and costs to participants and potential participants, and structure the experience to provide optimal positive, and minimal negative (including barriers), consequences.
Traditionally, the most passive form of participation has been the use of the ballot-box (Head 1971). Beyond that, participation strategies or techniques have been categorized in a variety of ways (see, for example, Millbrath 1965; Kidd 1971; Bregha 1975; Rothman, Erlich and Teresa 1981; Brager, Specht and Torczyner 1987; and Oakley 1989). Perhaps the most cited is Arnstein’s (1969) “ladder of participation” developed from her review of the Model Cities and anti-poverty programs in the United States. The eight rungs of her ladder represent the breadth of potential citizen input and control in planning and managing public programs, starting with the lower rungs of manipulation and therapy ("non-participation") through to the token efforts of informing, consultation and placation (where citizen voices are heard but not heeded) and moving upward to partnership (negotiation), delegated power and, finally, citizen control. The upper rungs of Arnstein’s ladder are exemplified by organizations where workers, students, and consumers share in the governing of their workplace, educational institutions and health services.

At the administrative level, Crosby, Kelly and Schaefer (1986) summarized the effects of the "maximum feasible participation" programs in the United States. Those deemed successful lacked a representative participating constituency. Programs in which citizens had the greatest level of participation required the least skills. The majority of opportunities for participation were at the local administrative or delivery level, not at the
decision- and policy-making or agenda-setting levels. Finally, they concluded that the overall impact of citizen groups had been limited.

In an attempt to differentiate between token citizen lobbying and the upper rungs of citizen control, Crosby, Kelly and Schaefer (1986) suggest six criteria for successful citizen participation. These include a fair selection process (to ensure representative participants), sound procedures that promote effective decision making, cost effectiveness, flexibility and utilization of recommendations. Yet complete citizen control is not always feasible or desirable (Brager et al. 1987). In fact, "having 'more' participation is not always 'better' as its value depends on what kind of participation, under what circumstances and by and for whom?" (Cohen and Uphoff 1980, 228).

The Opportunity to Participate

Several researchers across a variety of disciplines (e.g., Anderson et al. 1994; Bermejo and Bekui 1993; Wolf 1993; Syme and Nancarrow 1992; Potapchuk 1991; Sherraden 1991; Hunt 1990; Buck and Stone 1981; Godschalk and Stifftel 1981; Glass 1979; Jackson and Shade 1973) have argued for a number of years that the inaccessibility, intimidating nature and ineffectiveness of traditional participation techniques fail to foster broad-based public input. The basic premise of the argument is that while better educated people tend to participate more, this does not necessarily imply a lower degree of interest among others in the community. It may be that the procedures adopted by those who design public involvement programs are not suitable to the rest of
the community. It may be that, given alternative public involvement techniques, representative samples of the population could be encouraged to participate.

Rosener (1978) suggests that the participation techniques used are often inconsistent with the interests and capabilities of the citizens they are intended to reach: "So while public officials claim apathy, citizens claim inequity" (114). She offers a matrix of techniques and functions so that the methods and purposes can be optimally matched, enhancing the effectiveness of citizen participation. Ideally, this should narrow the gap between expectations and results. The comparative effects of utilizing different participation techniques to reach a wide variety of community members, however, have not been fully investigated (Abraham Wandersman, personal communication 1994; Syme and Nancarrow 1992; Millbrath 1981). Neither has there has been much public involvement in directly shaping the design of participation structures, input which could pay dividends in terms of acceptability and utility (Brieger, Ramakrishna and Adeniyi 1986).

Buck and Stone's (1981) research on public participation in developing a plan for the Yosemite National Park demonstrated that the means of participation (in this case a workbook) determined who participated (educated, knowledgeable and advantaged citizens) and the quality of their participation. They recommend that efforts be structured to accommodate the entire constituency. Urban planners face similar dilemmas. Local government planners in the United Kingdom, attempting to foster citizen participation in sustainability initiatives, found that "the question of who participates ‘most’ or ‘most
effectively' is ultimately largely dependent on the degree and style of participation” (Freeman, Littlewood and Whitney 1996, 67). Sancar (1993) describes how an interactive workshop was used to involve citizens in community design. The 43 participants differed from the demographic profile of the community. They were highly educated, enjoyed above-average incomes and were long-time residents. Thirty-six participants had previous experience with public meetings and planning forums.

Henderson (1990), in her study of citizen participation in U.S. metropolitan councils of government, found task forces to be the most widely utilized device for involving residents, followed by advisory committees. Both of these techniques demand articulate, educated, resourceful and self-assured participants. The typical participant was a white, male, suburban professional between 25 and 50 years of age.

Lomas and Veenstra (1995) wondered if current consultation exercises in Canada involved the general public. They examined who came to rural and urban Ontario town hall meetings to participate in decision making in health and social services, and found participants to be both better educated and three to seven times more likely to be employed in the health and social services field than the general population. They warned readers not to “...pretend that the current consultation technologies really attract the general public” (Lomas and Veenstra 1995, 40). Such formal structures of community participation are likely to involve only a portion of the actual community (Sherraden 1991). O'Neill (1992), in his discussion of community health councils in
Quebec, cites the importance of providing both informal and formal mechanisms for participation that are easily accessible to constituents.

Similarly, others have criticized the design flaws of traditional participation techniques, including the economic and sociocultural barriers that make public forums inconvenient and inaccessible, citizen advisory meetings that require educational and financial resources, and an overreliance on superficial opinion surveys (Syme and Nancarrow 1992; Thomas 1990; Sundeen 1988; Checkoway 1981; Milbrath 1981; Gittel 1980; Heberlein 1976) The circumstances that people face living in disadvantaged environments impose barriers to attending meetings or committing oneself to participating in the first place (Hunt 1990). These impediments, note Kathlene and Martin (1991), are beyond the citizens' control, yet contribute to keeping the traditionally voiceless silent.

A related criticism focuses on the symbolic nature of public hearings for decisions that have been made *a priori*. Such techniques have been described as rituals where government officials go through the motions of citizen participation, but in reality are seeking the rubber stamp of participation rather than building outcomes on community input (Berry, Portney and Thomson 1993).

More recently, studies in public administration have confirmed Rosener's (1978) assertion, suggesting that a citizen interested in participating in local activities might not find the structure or opportunity to participate inviting (Wolf 1993; Farr 1992; Persons
Most meetings, Wolf (1993) notes, are attended by some people who are paid to be there by their employer, while community residents are required to 'volunteer' in order to be represented and participate in the process. Issues of child care, transportation, language and timing of meetings may be irrelevant to the 'professional' volunteers, but without addressing such barriers and employing diverse forms of outreach, initiatives will fail to reach the constituents and address the issues they were designed for. Potapchuk (1991) describes a variety of devices for eliciting citizen participation that have successfully reached and involved non-traditional participants.

An Australian study found that an individual's intention to participate in regional planning for groundwater allocation was largely be a function of their attitude towards the process of public involvement (Syme, Macpherson and Seligman 1991). These researchers found that the ability to comprehend and compose information and the perceived challenge of participating were the primary determinants of attitudes towards the process. It is possible, therefore, that nonparticipants may have an interest in participating if programs are designed more closely to their perceived abilities to successfully contribute. Norton, Wandersman and Goldman (1993) found nonparticipants in a mental health alliance to perceive greater costs to involvement in the organization than participants. This attitude, the authors suggest, may reflect the nonparticipants' opinions of the structure or process of participation. An innovative approach to fostering participation in town planning has been described by Anderson and her colleagues (1994). Using aerial photographs, coloured stickers and a simple questionnaire, the
process attracted participants of all ages, education levels, and occupations, and proved equally attractive to men and women.

Recently, Wandersman (1993; 1994) has suggested that an investigation of the barriers to participation for lower-income and underrepresented groups should begin with the opportunity to become involved. Currently, the American Health Decisions organization is exploring how to involve people in ethnic communities (Crawshaw 1994). Meetings are held in ethnic neighbourhoods at familiar venues (e.g., churches) at various times of day, with child care provided, and are conducted in the language of the neighbourhood in an attempt to reach those who lack the discretionary time, and money to gain access to political power. As well, Smith (1995) in reflecting on his experiences with a community development project with the Simcoe County District Health Council noted that,

Given the multidimensional factors in health the need for a new way of thinking and planning has become essential and must be reflected in the structure of the planning authority. We have accepted the WHO definition of health but the structure of planning does not reflect this holistic view. The community development approach to planning requires this holistic view (102).

It may be that outreach and participant-friendly opportunities to participate may upgrade the attraction of participation. The search for innovative and accessible devices for fostering participation continues (Buckwalter and others 1993; Potapchuk 1991; Kubiski 1990) in the face of "...uncertainty as to how best to encourage active health alliances and community interest in health initiatives" (Macallan and Narayan 1994, 18).
Summary

The literature has shown that relatively few members of the public participate in community initiatives, and those who do are not representative of their neighbours. Why do not more people participate? Why is it difficult for community initiatives seeking public participation to achieve broad-based representation? “The failure to ‘reflect’ the distribution of characteristics through the population as a whole should alert us to obstacles that are preventing equal participation” (Phillips 1995, 297).

Wandersman et al. (1987) suggest that we need to understand more than the "who" of participation, but also the why, when, where and how. The existing literature base in citizen participation has provided a great deal of information about the “who” and the “how” of participation, and the concepts of empowerment and citizenship discussed below offer insights into “why” people become involved in community life. Yet, despite a body of empirical research documenting the failures of citizen participation programs, the literature lacks a consistent message for change (Berry, Portney and Thomson 1993). Just as important as contributing to the theory of participation is further elucidating pragmatic guidelines for fostering public participation. Are there alternatives to committee meetings and task forces that may be more visible, accessible, inviting and utilized, particularly to and by underrepresented segments of the community? What concrete strategies can community organizers and health promoters (and, perhaps, town planners and public administrators) utilize to involve the public?
Bracht and Tsouros (1990) define community participation in health as "the social process of taking part (voluntarily) in either formal or informal activities, programs and/or discussions to bring about improvement in community health services and/or resources" (201). This definition is a useful one: attending meetings, participating in a focus group, answering a questionnaire or giving a presentation in the community would all qualify as participation, albeit at varying rates, duration, types and levels. Yet this is acceptable, because the basic hypothesis is that to foster the practice of participation, it must be tailored to meet consumer needs. Bracht and colleagues (1994; 1991; 1990) suggest that participation in health promotion activities can be assessed, and offer the following measures for doing so:

- presence of participatory opportunities;
- level of decision-making;
- amount and duration of time and contribution devoted to goal activities;
- representativeness of the group;
- satisfaction with the participation processes; and,
- degree of local ownership perceived.

This study examined the first five of these factors as they are reflected in four health planning groups in the Capital Regional District. Berry, Portney and Thomson (1993) offer two broad parameters for assessing a participatory experience which capture these factors -- the breadth and depth of participation -- which are discussed in chapter five. Breadth refers to the extent to which opportunities are offered to citizens to become
involved at every stage of the policy making process. Breadth of participation determines the outreach effort, the representativeness of citizens opting to participate, the effectiveness of information dissemination to community members and the accessibility of the participation opportunities. The depth of participation reflects the extent to which participants' efforts actually influence the policy outcome, and if those decisions are supported by other community members who did not participate. The stage at which this research is being conducted in the health reform process will preclude determining perceptions of local ownership, but suggests an intriguing thesis for a follow-up investigation.
Section II: Empowerment, Citizenship and Participation

This section reviews the research linking empowerment and participation, and citizenship and participation. The intent of this section is to establish a connection between the three concepts by identifying their shared features. The relationship between empowerment and participation has been dealt with in both the empowerment and participation literatures, which are reviewed below. Following is a discussion of the idea of citizenship, and how the notion of full citizenship captures elements of both empowerment and participation.

Empowerment and Participation

Fundamental beliefs about power shape individuals’ decisions about whether and how to participate in community life (Hill 1991). The research reported in the literature demonstrates that citizens who participate in community organizations often feel more empowered (Schulz, Israel, Zimmerman and Checkoway 1995; 1992; Smith 1995) or have a greater sense of control (Chavis and Wandersman 1990) than nonparticipants even before embarking on the participation experience. These citizens have a greater sense of efficacy or belief in their personal abilities and become involved where they believe that the possibility for making a difference exists (Chrislip 1995; Berry, Portney and Thomson 1993). In addition, participation in voluntary organizations is a means of engendering personal empowerment (Zimmerman and Rappaport 1988). People experience feelings of greater control over their own lives, and a deepened competence, following active
involvement in groups (Kieffer 1984), or participation in social movements (Wharf 1990). In light of these findings, Kelly and Van Vlaenderen (1996) note that "it is not surprising that the term 'empowerment' and the term 'participation' are so closely interwoven" (1235).

Further, several scholars have argued that personal empowerment encompasses not only self-perception of power and control, but a sense of connectedness to, and togetherness with others (Sheilds 1995; Lord 1994; McCarron, Tenenbein and Hindley 1994; Wallerstein 1992; Brown 1988; Rappaport 1981; 1987). Riger (1993) criticizes much of the research on personal empowerment as neglecting and overshadowing the importance of connectedness in human life. Her argument is that both connectedness and empowerment "...are integral to human well-being and happiness and to well-functioning communities, and that both ought to be objects of our study. However, little work has been done to integrate the two ideas" (287). A more inclusive model of empowerment should incorporate factors such as sense of community and communion in addition to control (Nelson, Wiltshire, Hall, Peirson and Walsh-Bowers 1995).

Indeed, previous research (e.g., Smith 1995; Berry, Portney and Thomson 1993; Chavis and Wandersman 1990; Davidson and Cotter 1989; Zimmerman and Rappaport 1988; Wandersman et al. 1987; Maton and Rappaport 1984) has suggested that a sense of community or belonging functions as both an antecedent to, and consequence of, participation. Involvement has been commonly viewed as the natural expression of an underlying sense of community (Chavis, Hogge, McMillan and Wandersman 1986). In
contrast, when an individual is “unable to participate, and unable to contribute to the decision-making process that affects his or her life, self-esteem may be diminished with an implication for a lack of full membership within the socio-political system” (Younis 1995, 265). The notion of community does not simply translate as an abstract sense of belonging, “but is the wellspring of democratic values” (Berry, Portney and Thomson 1993, 6).

In addition to encompassing individual strengths, abilities and control, and a sense of connection, personal empowerment has also been thought to embody people’s sense of self-worth (Jackson and others 1996) and dignity (Brown 1988). In exploring women’s experiences of the meaning of empowerment, Sheilds (1995) found the development of self-value and a sense of connectedness to the community to be central themes of the empowerment process. Other scholars speak of individual rights (Jones and Meleis 1993), civic duty and political efficacy (Zimmerman and Rappaport 1988) as important aspects of empowerment. According to Rissel (1994), empowerment acknowledges “...the person as a ‘citizen’ within a political as well as social environment” (40).

Personal empowerment, then, seems to capture an individual’s right and responsibility to partake in the life of the community, as well as a feeling of connection with that community and a sense of being able to successfully contribute to, and assume some control over, its political and social life. As Wallerstein (1992) notes, the WHO definition of health promotion encompasses many of these aspects of empowerment with its emphasis on individuals increasing control over their own health. An explanation of
how this broader understanding of personal empowerment is related to citizenship and participation follows.

Citizenship and Participation

In Marshall’s (1977) famous essay, *Citizenship and Social Class*, citizenship is comprised of three rights: civil and legal rights (the rights of free persons in terms of freedom of thought, speech, and religious practice, and property rights), political rights (the rights to vote and to hold office) and social rights (rights of persons to participate in the economic and social well-being of the community). The basis for these rights is what Marshall (1977) refers to as the equal social worth of all members of society: “...to be accepted as full members of society, that is, as citizens...” (8). Equal social worth demands that there be a minimum level of resources available to everyone, a safety net ensuring a minimum of education, income, health and housing that enables individuals (especially disadvantaged persons) to enter the mainstream of society, and that is necessary for citizens to fully exercise their civil and political rights. As Marshall argued, without the rights guaranteed by the welfare state, gross inequalities of wealth, education and status render civil and political rights largely theoretical (Gorham 1995; Brown 1989). In turn, civil and political rights are a precondition for the development of social rights.

From this perspective the notion of ‘citizen’ implies equality of status and respect as a member of society and being accorded the same rights as every other citizen (Moon
1988; Turner 1986; Walzer 1983). Citizenship is a status unrelated to family background, class, wealth, race or gender (Brown 1989). The most compelling aspect of citizenship is its inclusive, unifying nature (Miller 1995; Fierlbeck 1991) and its embodiment of social justice (Miller 1995). “Citizenship is seen as a refuge from the market -- as rights to which people are entitled not because they work, but because they are human and members of a community that transcends the boundaries of the market” (Gorham 1995, 35). In theory, full citizenship -- civil, political and social entitlement -- enables every person to feel like a full member of society, able to participate in and appreciate community life. The two ideals founding Marshall’s (1977) notion of citizenship were a sense of membership and participation in a community, and these have become the “everyday view of citizenship rights . . . standard in the literature” (Kymlicka 1992, 3).

Regarded for its seminal place in political science, the significance of Marshall’s thesis on citizenship can be found in its relatively apolitical grounds for the provision and growth of state-administered social services in almost every Western democracy (Rees 1995; Kymlicka 1992; Fierlbeck 1991). Marshall’s (1977) view of citizenship still dominates (Miller 1995), however, his theory is now thought to be limited by its evolutionary, analytically vague and ethnocentric nature (Turner 1990). It has also been questioned on the issue of the formal and substantive effects of citizenship (Prior, Stewart and Walsh 1995). The latter distinction is between the status that provides persons with the possession of formal rights and entitlements, and the status that enables persons with the opportunity to realize those rights and entitlements. All citizens formally possess civil, political and social rights, but not all possess the means of realizing, and hence,
enjoying the substantive benefits of citizenship. Finally, Marshall’s (1977) thesis has been criticized for its emphasis on entitlements against the state -- citizenship as a status - over obligations -- citizenship as a practice (Oliver 1991). Indeed, as Kymlicka (1992) notes, people rarely speak of citizenship in terms of duties or responsibilities outside of paying taxes and obeying the law.

Active and Passive Citizenship

Citizenship, Younis (1995) notes, not only comprises the right to participate but also the responsibility to share in decision-making. At its most fundamental level citizenship is an account of the relationship between the individual, the community and the state (Prior, Stewart and Walsh 1995; Fierlbeck 1991; Oliver 1991), and between citizens (Staeheli 1994). It is from this relationship that the ‘active’ (or, citizenship-as-desirable-activity) and ‘passive’ (or citizenship-as-status) sides can be delineated. The phrase ‘active citizen’ became popular jargon of the British conservative governments in their development of local governance systems. The active version portrays citizens as individuals who “stick to the rules of the economic game” (Miller 1995, 433) -- that is they are self-supporting -- while simultaneously fulfilling their obligations by participating in public life. Consequently, the debate over fostering citizen participation may not be restricted to increasing citizen input, but also encompass citizens taking responsibility for decisions (Rhodes 1987). Indeed, the active mode of citizenship is distinguished from volunteerism by the notion of obligation -- the expectation inherent in a person’s claim to membership in the community to contribute. For Oliver (1991) this is
one of the more important aspects of active citizenship: it serves to foster in the participating citizen a sense of belonging to the community, while at the same time contributing toward the common good.

For conservative thinkers, citizenship status is achieved once civil and political rights have been granted; social rights are regarded as an infringement of the freedom of others because of the tax burden required to meet the costs of the welfare state. While people may not view citizenship in terms of responsibilities, Mead (1986) argued that there is a set of social expectations, although not legally enforced, that must be fulfilled for people to be thought of as full members of society, including being employed, supporting one's family and respecting the rights of others. Moreover, the guaranty of welfare rights, it is argued, has produced an impoverished, passive and dependent segment of people, without really enhancing their quality of life. The over protective welfare institutions have prevented people from being economically self-sufficient and supporting one's family. The basis of the argument is that Marshall's (1997) passive mode of citizenship underestimated the degree to which meeting one's obligations as citizen is a precondition for being accepted as a full member of society.

The conservative trend, epitomized in Mead's (1986) work, sought to reform social policy to go "beyond entitlements": access to public benefits would require citizens to meet certain responsibilities, such as in the workfare programs (Marston and Staeheli 1994), thereby including, rather than excluding, recipients in the common responsibilities of citizens. According to the conservative school of thought "failure to fulfill common
obligations is as much of an obstacle to full membership as the lack of equal rights” (Kymlicka and Norman 1994, 356). Social rights then would be guaranteed, not through government intervention (which would be minimal), but by encouraging a more active and responsible citizenry, particularly on the voluntary efforts of the more successful individuals (Prior, Stewart and Walsh 1995). In the conservative view, the extent and quality of one’s citizenship becomes a reflection of one’s involvement in the community (Kymlicka and Norman 1994). Consequently, citizenship becomes a reflection of one’s ability to afford to participate in the community and, in effect, generates market driven classes of citizenship -- the very struggle Marshall (1977) sought to overcome.

The social democrat scholars similarly find the passive nature of citizenship unsatisfactory. Their rationale, however, differs: passive citizens have been prevented from participating in the processes of government, unable to influence the relevance and appropriateness of public services, and relegated to the impersonal decisions of others. Dependency on the welfare state is due to a lack of opportunities to acquire work, education and training, not due to a lack of initiative and self-reliance (Kymlicka 1992).

They also differ with respect to the issue of the sequence of rights and responsibilities. Equality can only be secured once social and economic rights have been acquired. “Where any of these [rights] are withheld or violated, people will be marginalized and unable to participate” (Kymlicka and Norman 1994, 354). Such individuals are those who suffer a particular disadvantage as a result of their circumstances or endowment -- minorities, persons with a physical or mental disability,
and the poor (Kukathas 1995; Kymlicka 1989). As well, the conditions of modern life -- meaningless work and the loss of control over one's life -- have undermined the social ties of citizenship and community. Imposing obligations as a matter of public policy is futile if opportunities for employment, education and day care are not available (Kymlicka 1992). It is inappropriate to demand the fulfillment of responsibilities before the rights are secured (Kymlicka and Norman 1994).

There is nothing wrong with enterprise, initiative, personal responsibility or even the lawful pursuit of private profit. What is incoherent is believing these goals can be achieved without a citizenship of entitlement, without the shared foundation that alone makes freedom possible (Ignatieff 1989, 37).

The social democrats challenge the conservative vision with reference to countries who exhibit low unemployment rates also enjoy extensive and comprehensive welfare states (e.g., Sweden), as well as point out that conservative policies have actually expanded and exacerbated inequalities (Fierlbeck 1991).

It should also be recognized that an individual may participate in community life without possessing legal immigrant status and the right to vote in elections or hold office, although the individual may be enjoying the social rights provided by the state. Pincentl (1994), in documenting the political activism and local government policy decision-making of Latinos in Los Angeles, found large numbers of people who, despite being denied legal status, were participating in their communities as citizens. Pincentl (1994) argues for new ways in which the relationship between citizens and the state are defined. She also challenges the morality of denying legal rights of citizenship to persons who are already fulfilling the obligations of that status. Carens (1995) concurs, noting that if the
concept of citizenship assumes equal moral worth of all, then we cannot exclude those
who want to join.

Citizenship as Identity

Recently, both Kaplan and Cousineau (1993) have suggested that the concept of
citizenship needs to be reconceptualized as "belonging". Citizenship is not just defined by
a set of rights and responsibilities, but also by an expression of one's membership in a
community. The notion of citizenship has emphasized legal, civil and political rights, but
eclipsed social rights. Social rights contribute to the sentiment of solidarity -- the sense of
belonging to a community and shared heritage -- as well as to effective participation as a
member of the community. It is impossible to contemplate a citizen's willing
participation in a collective project of the state unless that citizen feels that he or she
belongs to the collectivity. By promoting commonality among different members of
society, genuine equality of respect and maximum participation will be possible:

In a democracy, we should assume that all those living in the society
are citizens with shared access to the decision-making process. The
thrust of the citizen participation movement must be to guarantee that
such is indeed the case and that there is genuine equality in the exercise
of power within the community (Smith 1995, 63).

Yet confounding the notion of citizenship as a sense of community is the
ambiguity of the term community itself. Traditionally, the concept of citizenship has
recognized citizens as residents of a geographical community and as such suffers from its
assumption that 'community' is an undifferentiated, homogeneous entity, serving to reify
the existing power and powerless relations between persons and groups in the community (Prior, Stewart and Walsh 1995). A more robust concept of citizenship must also recognize citizens as people with different interests (communities of interest who share objective concerns and interests) and as members of different social groups (communities of identity who share subjective concerns and interests).

Equal citizenship is extended to people despite all their differences of birth, education, occupation, gender or race. It is a slippery slope from saying that these differences should not count, to saying that they don't even matter (Phillips 1993, 77).

Yet, “political equality is not guaranteed by the equal right to vote” (Phillips 1995, 293). Many groups in society, despite possessing the shared rights of citizenship, still find that equality and social justice elude them (Phillips 1995; 1993; Kymlicka and Norman 1994; Young 1989). It is not just socioeconomic status that contributes to their feelings of exile and exclusion from full participation but their sociocultural identity and distinctive needs as well (Kymlicka 1992). The problem, Young (1989) suggests, is that the notion that citizenship is the same for everyone translated in practice to demand that all citizens be the same, stripped of any group identification or particularity (Staeheli 1994).

We exist not just as abstract citizens, but also as members of variously privileged or disadvantaged groups. [Yet], abstract individualism imposes a unitary conception of human needs and concerns, and this serves to marginalise those groups who may differ from the dominant norm . . . [which is] so powerful that it obscures the startling fact that most people lie outside its boundaries (Phillips 1995, 298; 293).
As the work of Mansbridge (1980) and Gutmann (1980) attest, when opportunities for citizen participation are defined in the universalistic and unified terms of citizenship they silence the experience and perspectives of disadvantaged groups. Participatory democratic structures tend to perpetuate oppression by assuming that, because everyone has the right to participate in the decision-making process, the opportunity to do so can be identical for all.

Young (1989) dubs this the "paradox of democracy [in which] social power makes some citizens more equal than others, and equality of citizenship makes some people more powerful [and involved] citizens" (259). How does a theory of citizenship accommodate for these 'differences' when the premise is treating people as equals? Young (1989) argues for 'differentiated citizenship' on the basis that genuine equality emerges from affirming rather than dismissing group differences. The demand for distinct rights by disadvantaged and multicultural groups --communities of identity -- Young (1989) suggests, is a demand for inclusion. Hence, the recognition and accommodation of differences does not diminish the integrative function of citizenship but facilitates inclusion in the larger society (Kymlicka and Norman 1994). Young (1989) and Phillips (1995) call for enhancing consultative procedures for those groups who have minimal political influence.

Much like the concepts of participation and empowerment, citizenship is a theory in search of specifics and consensus (Gorham 1995; Miller 1995). Citizenship does not
concern only membership, but also the question of what rights and obligations citizens should possess (Fierlbeck 1991); citizenship is an idea both of being and of doing (Prior, Stewart and Walsh 1995). An adequate theory of citizenship, Kymlicka and Norman (1994) argue, requires a balance of rights and responsibilities, for if the responsibility of participation is to be emphasized how do we ensure that citizens participate for communitarian, rather than out of self, interests? As well, there still exists the tension between the ideology of universal inclusion and the reality of “social, economic, and political structures that perpetuate the differential abilities of individuals to exercise their rights and responsibilities as citizens” (Marston and Stacheli 1994, 844).

Summary

Citizenship, then, can be understood to embrace aspects of empowerment, and vice versa. Participation is integral to both concepts. Citizenship and empowerment embrace the ideas of belonging and rights essential for participation in social and political environments. As Beresford and Trevillion (1995) note, the concepts of participation and empowerment underpin participatory democracy. Ideally, a citizen is an individual regarded as an equal member of the community, accorded the respect and full rights of all other citizens, who actively assumes responsibility for his or her participation. Through participating in community life -- practicing citizenship -- one can achieve a sense of control over one’s life and a heightened sense of belonging and membership (Gorham 1995) -- in essence, a sense of empowerment.
Support for this relationship is demonstrated in the literature. When low-income residents have participated in community activities, they have brought with them the same sense of community and inclusion as more advantaged citizens (Berry, Portney and Thomson 1993). It is not socioeconomic status *per se* that distinguishes participants from nonparticipants, but a sense of full citizenship and the appreciation for their distinct needs. Seeking to understand empowerment and participation from the perspective of the citizen, Lord (1994) found that individuals perceived participation to be both the process of becoming involved in community work, and the sense of being acknowledged and accepted as contributing community members -- aspects of social citizenship. In describing the experiences of marginalized persons, McCarron, Tenenbein and Hindley (1994) conclude that knowing one has a place in society -- a notion of belonging and connection -- empowers individuals to act in the political and social environment. Indeed, collaborative experiences in Los Angeles demonstrate that inclusive participation efforts are successful when the basic human needs of belonging, respect, and a sense of self-worth are satisfied (Chrislip 1995).

It might be speculated, then, that personal empowerment is a result of full citizenship -- accessing one’s entitlements, a sense of identity and cohesion, and fulfilling one’s obligations by participating toward the common good. The experience of participation reinforces or strengthens the notion of personal empowerment.

The focus of this chapter now turns to the social marketing literature. In addition to describing the evolution of social marketing as a social change technology, the
theoretical assumptions and key concepts of a social marketing framework are discussed. The notion of citizen participation in “New Directions” as a social change strategy is integrated throughout the discussion, including an explanation of how the concepts of understanding the consumer perspective, exchange, marketing mix and segmentation are used and applied in the analysis of the research data. As well, the section reviews the criticism and concerns of social marketing in the literature, particularly as it relates to health promotion.
Social marketing, or in Kotler and Roberto's (1989) terms, social change management technology, is one approach to effecting social change. Other means of producing social change include legal, technological, economic and informational approaches. Social marketing evolved from the latter, particularly in the form of social advertising, which influenced attitude and behaviour change. Used in isolation, however, social advertising was often unable to deliver the right message and motivate behaviour, and relied heavily on mass communication to influence change. The approach evolved into social communication, which incorporated promotional efforts beyond advertising such as personal selling, sales promotion, special events and other techniques for getting information to consumers.

More recently, social marketing has succeeded social communication as a social change technology. Social marketing adds four elements to the conventional information-providing approach of social advertising and social communication: market research, product development, the provision of incentives, and facilitating behaviour change.

Market research aids in understanding the composition, size and behavioural characteristics of the market, and in identifying appropriate campaigns for each market segment. The marketer then seeks the best product to meet consumer need. While social communication strategies highlight the advantages or disadvantages of various
behaviours, social marketing includes the use of incentives to motivate change. Finally, the social marketer is concerned with facilitating both the adoption and maintenance of new behaviours, by making change as easy and convenient as possible. More than merely promoting a desired change, social marketing motivates and facilitates individual change by coordinating the product, price, and place variables with the promotional effort; the four "P's" known as the "marketing mix."

The essence of marketing is based on theories of consumer behaviour and social exchange (Novelli 1990). It seeks to explain why and how people make certain decisions and willingly trade resources for perceived benefits. Social marketing offers one approach to understanding why persons buy into the idea of participating or do not, and how their participation might be encouraged and sustained.

Consuming Social Products

Social marketing seeks to enhance the "purchase" or adoption of social ideas or practices. In this context, Kotler and Roberto (1989) identify four types of adoption behaviour: (1) compliance, (2) identification, (3) knowledge-based and (4) internalization. These can be placed on a continuum from fast, short-term adoption to slow, long-term adoption. While it is relatively easy and quick to facilitate compliance adoption, internalized adoption is the most sustained, and hence preferred, form of change.
The processes of adoption have been classified as (1) learn-feel-do, originally labeled the learning hierarchy (Smith and Swinyard 1982); (2) do-feel-learn; and (3) learn-do-feel (the low-involvement hierarchy). The three elements -- learning, feeling, and doing -- reflect adopter cognition, affect and behaviour; the order in which they occur reflects how involved people are with the offering (Lovelock and Weinberg 1989). Consumers may have to become aware of and knowledgeable about the social product, and then develop an attitude or feelings toward it before finally adopting the behaviour. This is the learn-feel-do model. The second and third processes simply transpose the sequence of learn-feel-do that reflects the different emphasis each element plays. The integrated multipath model (Smith and Swinyard 1982; Kotler and Roberto 1989) suggests that the three sequential response chains described above cannot, in isolation, explain for adoption behaviour. Rather, the response pattern is contingent on the information source and may resemble any three of the sequential patterns of the processes of adoption. This fourth model also distinguishes between trial adoption and committed adoption, which may be affected differently by different information stimuli.

Learning about a product can come from personal and non-personal sources of information as well as the experience of adoption. Two factors influence the weight of this cognitive component -- belief strength and message acceptance. Belief strength is the extent to which an individual associates certain attributes or qualities with a particular object. A strong conviction of the link between the two results in a higher order belief; less certainty results in a lower order belief. Belief strength is largely a function of message acceptance: when information is highly accepted, higher order beliefs will result
(Smith and Swinyard 1982). The source of information is a significant factor in message acceptance. Smith and Swinyard (1982) note that advertising, an external information source, usually produces lower order beliefs because of audiences’ inferred partiality about source credibility: knowledge bias (or expertise) and reporting bias (or trustworthiness). Knowledge bias results when the audience believes that the advertiser's knowledge "about external reality is nonverdical, and reporting bias refers to the belief that a communicator's willingness to convey an accurate version of external reality is compromised" (Eagly, Wood and Chaikin 1978, 424). When an advertising message triggers these biases, the source has low credibility, and belief strength is jeopardized.

In contrast, direct experience through trial adoption molds a strong belief base, because an individual rarely doubts the validity of their own perceptions and the problem of conflict of interest inherent in an external source does not arise. The higher order belief resulting from direct experience generates "...a powerful information base for attitudinal development" (Smith and Swinyard 1982, 84). Hence, personal communications and direct experience are more persuasive than mass media, and become more salient as the adoption process progresses.

The development of the affective system is, to a large extent, a function of belief strength. Attitudes toward a social product may derive from an individual's beliefs about the consequences of adoption. This is because beliefs allow a person to associate a product with its attributes or qualities. These qualities are instinctively evaluated by the individual, in effect creating affect toward the product. Lower order beliefs produce
impoverished attitudes and may be ineffective in initiating adoption. Alternatively, higher order beliefs would foster more robust feeling, leading to adoption or other relevant behaviours. Campaigns may also subscribe to consumer values and motivate target adopters to satisfy certain needs, thereby influencing the feeling effect. Values are "the mental representations of our underlying needs, after they have been transformed to take into account the realities of the world in which we live" (Wilkie 1990, 213-214). Kahle (1984) has listed self-respect, sense of accomplishment, being well-respected and a sense of belonging as four of nine basic terminal values. Similarly, Kotler and Roberto (1989) list the need to be loved and accepted among the primary needs of humans.

However, when a person is uncertain about their feeling toward a product, they may engage in trial adoption to gather more information, and utilize that experience-based knowledge to determine their opinions. Knowledge limited to lower order beliefs will not engender positive affect prior to adoption. Adoption behaviour in this instance is an attempt to gather more information on which to base an evaluation. Committed adoption (when positive affect predates adoption) is thus differentiated from trial adoption (the pursuit of more information). Trial adoption allows individuals to assess perceived risks, whether social, psychological, physical, functional or financial in nature, and convey direct facts so that an evaluation can be formed. Once trial adoption leads to satisfaction -- that is when expectations have been met or exceeded -- committed adoption is achieved. Indeed, the greater the perceived risk of the adoption situation, the more a "person's observation and experience becomes the favored information source" (Locander and Herman 1979, 273).
The learn--do (trial adoption)--feel--do (committed adoption) pathway proposes that trial behaviour serves as an information gathering strategy and precedes affect, while committed behaviour follows affect. Higher order beliefs, and thus more potent attitudes, are generated by direct experience. A positive trial experience may substantiate the integrity of the source and enhance message acceptance in ensuing communications.

The integrated multipath model has some pragmatic implications for marketing strategy (Smith and Swinyard 1982). These authors suggest that the focus of marketing should be to respond to the uncertainty of external information sources by furnishing an environment conducive to trial, thereby providing opportunities for personal evaluation, the formation of favourable attitudes and committed adoption.

**Exchange: The Price Must Be Right**

Assessing the consequences of engaging in a behaviour distinguishes the positive and negative aspects of that behaviour (Andreasen 1995). The concept of exchange helps the marketer to concentrate on the question “what benefits do consumers seek to obtain and what costs (of all kinds) they are prepared to incur to get them?” (Lovelock and Weinberg 1989, 11). Social exchange theory (also known as incentive theory) holds that participants contribute resources in exchange for various incentives or benefits. The theory suggests that individuals will participate if the incentives are greater than the barriers or costs. The key to eliciting voluntary exchanges is to offer benefits that are valued as being worth the cost or effort of involvement. This is most difficult in social -
behaviour marketing where the endorsed behaviour may be unappealing (e.g., taking up exercise, eating more broccoli) or is perceived as a nuisance with more costs than immediate pay-offs (e.g., quitting smoking). The real benefits may not only be long-term, but collective in nature, "...reflecting the external economies of compliant behavior" (Lovelock and Weinberg 1989, 13). Social marketers often emphasize the long-term benefits while failing to address the short-term costs (Andreasen 1995).

Benefits and costs have two characteristics: the probability that a positive (or negative) outcome will arise, and the importance that the consumer places on that outcome. Changing the benefits of a behaviour can often be accomplished through changing its attributes (e.g., exercising with a group of friends). It is also important to recognize that benefits and costs are closely linked to needs and values (Bush, Ortinau and Bush 1994). Knowledge of the benefits that consumers seek enables marketers to link those benefits to values (or needs), and help them to understand why specific benefits are important or unimportant to consumers. Moreover, benefits and costs undoubtedly differ in importance to different consumers; thus, knowing the determinative costs and benefits for different consumers is crucial (Andreasen 1995). While social marketing strategies can focus on enhancing benefits or minimizing costs, often it is the combination of benefits and costs that is important to consumers. People may be willing to endure immediate costs if a significant benefit can be realized, or they may be willing to sacrifice a benefit if they can avoid certain costs.
One of the most popular classification schemes for incentives is Clark and Wilson's (1961) trimotivational typology. Under this scheme, financial remuneration or tangible items which can be translated into a monetary value are classified as "financial" incentives. Solidary incentives in contrast, are intangible benefits that arise from being part of a group, such as friendship, socializing, status resulting from membership, satisfaction with belonging to a group *et cetera*. Solidary incentives may be collective (e.g., the sociable climate) or selective (e.g., the status of occupying a position or office). Purposive incentives are also intangible, but are linked to the group's suprapersonal goals or visions "which do not benefit members in any direct or tangible way" (Clark and Wilson 1961, 135) and are thus collective in nature. Purposive organizations rely on the attractiveness of the "cause" to recruit and maintain membership, and may need to provide other types of incentives as well to achieve stability (Salisbury 1969). Clark and Wilson (1961) theorized that an organization may attract participants through a mix of incentives: different members may be attracted for different reasons and have different motives for participating, although one type of incentive may predominate.

Knoke and Wood's (1981) research on commitment in voluntary associations found that purposive incentives were more effective than other types of incentives in attracting individuals motivated by an organization's goals and in retaining their commitment to the group. Commitment was also enhanced by the interpersonal relationships among members, suggesting the influence of solidary benefits. Material incentives were ineffectual in securing member commitment. Participants in the 32 local
chapters of social influence associations studied fit the demographic profile of the traditional participant: they were predominantly middle to upper class.

A number of studies (Knoke and Wood 1981; Wandersman et al. 1987; Prestby et al. 1990; Norton, Wandersman and Goldman 1993) have found a bimotivational adaptation of the Clark and Wilson (1961) system to be more relevant. A simpler bimotivational typology combines some of the original classification schemes (solidary and purposive) with a personal factor related to incentives or barriers which specifically add to or detract from personal needs. Under this scheme, social/purposive incentives (sense of responsibility and contribution, helpfulness, friendship with other members) are cited as reasons for participating. Such incentives must be perceived as outweighing the barriers and as being available only to participants before individuals will become involved. Personal barriers (time, effort, convenience) and social/organizational barriers (conflict, lack of progress, frustration) have been found to be the most relevant in limiting participation (Henry and Basile 1994; Butterfoss et al. 1993).

Social marketers distinguish between monetary, time, psychic and sensory costs (Lovelock and Weinberg 1989). Monetary costs include both the obvious financial expenses of purchasing a product and the associated costs of acquiring it, such as transportation, child care, and taking time off work. Time costs denote the time spent participating, while psychic costs may include feelings of frustration, intimidation, inefficacy, boredom or fear for personal safety. Finally, sensory costs relate to the characteristics of the product or its delivery that are offensive to the senses.
Successful social marketing campaigns improve the ratio of benefits to costs in comparison to alternatives. Achieving this requires one of four strategies: (1) increasing the perceived benefits of engaging in the behaviour; (2) decreasing the perceived costs; (3) adding new benefits; or (4) decreasing the perceived benefits or raising the perceived costs of an alternative behaviour.

**Riding the Bus Without Paying the Fare**

Political economy theory stipulates that to be effective, incentives should specifically reward participants for their individual contribution and be obtainable only by those who actually participate: thus, they are selective incentives. Collective incentives, on the other hand are available regardless of whether or not an individual participates (Hrebenar and Scott 1990). These latter incentives, or public goods, suffer from a "free rider" phenomenon: if the individual can enjoy the benefits of the outcome without incurring any costs, she or he can “free ride” by relying on others to contribute (Coleman 1987).

More recently, Prestby et al. (1990) in their extensive study of the benefits and costs associated with participation in neighbourhood organizations, found support for the value of social exchange and political economy theories in understanding why people participate in voluntary organizations. Higher levels of individual participation in the neighbourhood block associations were significantly related to higher benefits and lower costs, while those who participated the least experienced fewer benefits and more
barriers. Moreover, these researchers found that incentive and cost management efforts on the part of organizational leaders significantly lowered costs for participants, except for personal costs. "This finding suggests an important area for further research since reducing personal costs like time constraints, child care, and safety could greatly enhance participation rates" (Prestby et al. 1990, 141).

Wilson (1973) has suggested that the paucity of participation by lower socio-economic groups may be explained in part by the types of incentives organizations offer. Material benefits may be less salient to upper- and middle-class persons, who can better identify with an abstract concept (community) and an organization's purposive goals. Less fortunate individuals, on the other hand, are more likely to respond to incentives that can be immediately and directly derived from membership. Norton, Wandersman and Goldman (1993) have called for more research into the barriers to participation facing lower income persons.

The Marketing Mix

Lovelock (1991) recounts the story of a Harvard Business academic, Neil Borden, who heard a colleague characterize the marketer's job as "being a mixer of ingredients" (223); finding the right recipe to create the best possible product. This led Borden to originate the metaphor 'marketing mix'. Marketers view the marketing problem as establishing the right product, backed by the right promotion, in the right place at the right price. These elements have been referred to as the four P's (McCarthy 1968) in the
marketing mix. Recently, two additional P's -- potential purchasers and probing for feedback from the consumers -- have been suggested as useful additions to the marketing model (Fine 1990). The marketing mix is an instrumental concept as it reinforces the complementary nature of each of the ingredients in the market ‘recipe.’ The following describes each of these elements and their relevance to this study.

1. *The Product* is that which is offered to the consumer, be it a tangible product, social cause, practice or behaviour change. In “New Directions,” the product is the opportunity to participate as a means of providing input into health priorities, goals and services.

   Several attributes or characteristics of products can influence the relationship between the consumer and the product, and enhance the potential of a new product's success. When a product is congruous with a consumer's affect, cognition's and behaviour, and does not require a shift in values or behaviours, the product is said to be compatible and much more likely to be adopted. Thus, for individuals who have previous experience in community participation, or providing input or opinions, participating in health reform will be compatible with their values or behaviours.

   The extent to which a product can be sampled or used for a probationary period is its “trialability”. A consumer is more likely to test a product if it can be adopted on a trial basis. Experimenting with the opportunity to become involved, such as filling in a questionnaire, may spur on citizens to join health planning groups on a more permanent basis.
The observability of a product refers to its public visibility. Products (or their effects) which are highly observable by consumers are more likely to be rapidly adopted. When observability is low, packaging the design and promotion of the product may be necessary to stimulate action. People witnessing others filling out questionnaires in public malls or at community events, may be tempted to do the same.

The speed with which the benefits are realized is another factor. Products that deliver immediate gratification are more likely to be tried. The tangible benefits of participating in community identification of health priorities will not be experienced for a lengthy period. However, participants may experience an intangible benefit (solidary or purposive) more swiftly.

Similarly, products that are complex or confusing stand a poor chance of being sampled. A simple product is more user-friendly. Hence, surveys or questionnaires that clearly identify the reasons for health reform and use simple language, meetings that are well-run, and focus groups with straightforward directions are more likely to encourage participation.

In the end, the most important attribute of a product in securing adoption is its relative advantage. What are the advantages of involvement relative to noninvolvement? The advantage may come with technological superiority, such as providing easy access to health planning groups via electronic mail. The advantage may be a functional benefit such as learning new skills. Or, it may come with the symbolism of participation.
Symbolic advantages reflect the social or psychological value, image or meaning that consumers attach to products, rather than their functional utility. The value attached to the democratic right of every citizen to have a say in how their health services are organized and governed is such an advantage.

Perceived risk will influence adoption. The risk involved in participating might be financial (costs of transportation, time away from work, or childcare), psychological (fear of speaking one’s mind or losing employment or services) or social (disagreement or conflict). The greater the perceived risk of becoming involved, the less likely a person is to participate. Allowing a trial adoption may be one means of overcoming or decreasing risk.

Finally, the other elements in the marketing strategy may influence the perceived quality, and thus success, of the product. How a product is promoted and the qualities emphasized in that promotion, price and place of distribution can all affect the product’s relative advantage.

2. *The Price* is the cost the consumer must bear in adopting the product, including both financial costs and social prices (such as time, effort, and lifestyle, sensory, place, and psychological costs). Decisions to engage in the marketed behaviour are based on considerations of both benefits and costs (Andreasen 1995). The price of participation is the estimation of a cost to benefit ratio. The strength of the incentive to adopt the product depends on the size of the excess benefit. The marketer must consider how to enhance
the benefits and/or reduce the costs, or to blend the elements of product, place, price, and promotion that will produce a favourable cost to benefit ratio. This may involve selective pricing, or pricing according to market segmentation because the perceived costs of participation are likely to vary between different constituent groups.

For participation, the price may reflect the time involved in providing input (and hence taken away from other activities); the effort required, psychological costs of frustration, boredom or intimidation; financial costs of travel or child care; and physical costs of safety. Health planning groups, then, must reduce such costs to attract participants, yet they are constrained by a paucity of information on, and control over, these prices (Joyce and Morris 1990). Fine (1990) sees participation by consumers in issues of social change (health reform) as “expensive” because it means payment of all types of prices.

3. *The Place* refers to how the product is delivered or distributed to the consumer. Citizens may be able to access health planning groups by attending their meetings, or participate at arm’s length in the form of a questionnaire, electronic mail, or telephone hotline (Lovelock 1983). Effective social marketing acknowledges that behaviours must be easy to do (Andreasen 1995; Lovelock and Weinberg 1989); many adoption decisions are influenced primarily by the handiness of the location. Convenient and accessible multiple distribution channels or venues enhance the likelihood that people will respond to the invitation to become involved. These venues might include a health planning group meeting, public questionnaire, focus group, community outreach presentation or hotline.
4. *The Promotion* is the means by which the consumer is informed about the product, its price and channels of distribution, and is induced to adopt it. Promotion includes, but is not limited to, mass media communication, personal selling, publicity, advertising and sales promotion. Personal selling, or interpersonal communication, may be the most effective means of communication when inducing adoption. Lovelock and Weinberg (1989) describe five types of interpersonal communication, two of which are relevant for health planning groups. Proactive selling occurs when a change agent seeks out consumers and encourages them to participate. An example from "New Directions" is the "Floating Outreach Team" (health planning group members who volunteered to do public presentations equipped with a standard speaker's script and audiovisual aids), who visited community groups, worksites, parent advisory meetings and other community groups, to talk about "New Directions," stimulate interest in participation, and conduct surveys, or focus groups. Personal advice is a more informal communication strategy that ensues when individuals who are not official change agents influence citizens to participate (e.g., health care providers, family members, friends).

It is important that promotional methods deliver consistent messages. This is difficult task when numerous individuals or groups serve as mediating communicators between health consumers and the health planning groups. The Diffusion of Innovations theory (Rogers 1983) suggests that potential adopters are influenced by, and will respond to, different communication-persuasion strategies. The innovation-decision process is similar to the decision-making routine of consumers. Rogers and Shoemaker (1971) define the process as one that begins with an awareness or knowledge of the innovation,
followed by persuasion through which a favourable or unfavourable attitude is formed, a decision to adopt or reject, and a reaffirmation of the decision.

Innovators and early adopters, who can learn vicariously, understand more abstract concepts, can afford greater risk, and respond more readily to early mass media efforts (the learn—feel—do pathway of adoption). Individuals further along in the adoption curve are persuaded by personal communication as well as mass media, and often rely on 'homophilous near peers' to role model the behaviour change. They may also reply on trial adoption, direct experience or personal sources to develop affect, and eventually committed adoption. Laggards resist adoption until regulatory and technological influences persuade them to change.

To reach all markets, a variety of promotional techniques are recommended over the course of the social change campaign. Promoting the opportunity to participate may include newspaper advertisements asking for community input, articles on New Directions, personal selling by health planning group members, or the publicity generated at community events or by local media (e.g., the publicity resulting from the Minister of Health when designating the Capital Health Board as a regional health authority). Key target group leaders will also play a crucial role in promoting participation.
Market Segmentation

Who are the purchasers or potential participants, and what specific needs and wants do they have? Market segmentation identifies the target consumers for which custom-designed participation opportunities are developed. Fine (1990) sees this as the most important step in the marketing process. In the case of this study, the needs of citizens, including the benefits sought, barriers encountered, and variables influencing the decision to participate are unlikely to be the same for everyone. Segmentation enables health planning groups to identify and define different constituent groups and then match appropriate participation opportunities to each sub-group in the community. Designing different participation opportunities in response to citizen needs may involve customizing the components of the marketing mix. Variables used in segmentation might include (1) demographic and socioeconomic variables (age, gender, income, occupation, education, ethnic background); (2) psychographic variables (values, attitudes, interest, motivation); and, (3) benefits and costs (consequences the potential participants wish to achieve or avoid).

Market segmentation for the health planning groups has been delineated in the Ministry of Health document *Processes, Benchmarks and Responsibilities for Developing Community Health Councils and Regional Health Boards* (1994, 5). Health planning groups were to seek representative participation from the following identified constituent groups in their community:
• Aboriginal peoples
• citizen groups - youth, women, seniors, single parents
• labour organizations
• multicultural group service clubs
• business groups
• health care providers, regional health boards, private practitioners
• people with disabilities and anti-poverty groups
• health agencies
• non-profit boards
• municipal governments
• school boards
• parks and recreation departments, community centres
• cooperative and social housing
• homemaker organizations, child development centres

For health planning groups, the market has already been segmented based on these demographic and community criteria. However, this distinction does little to help the planning groups understand how to foster these groups' participation beyond serving as a checklist (Lovelock and Weinberg 1989). A more useful classification would consider benefit segmentation as well, (Lovelock and Weinberg 1989) by assembling groups based on the benefits and costs they seek to achieve or avoid. Benefit segmentation may dovetail with some of the demographic distinctions. For example, low income residents, as a demographic group, may face the same barriers of transportation, inconvenience and financial cost when invited to attend evening meetings. Another useful segmentation scheme is consumer responsiveness to elements of the marketing mix. Convenience might be the most important attribute of participation for one group so varying health planning group meeting times and places might facilitate participation. Reducing a psychic cost -- perhaps perceived inefficacy to write a community health plan -- might be most significant for another group, and thus delegating appropriate roles and
tasks to different members’ comfort levels and skills might encourage involvement in this instance. Finally, Andreasen (1995) offers the stages of change theory as a useful classification scheme for segmenting consumers, based on their readiness to adopt a new social practice.

Segmenting Along The Stages of Change

For Andreasen (1995), consumer behaviour is best understood through the Prochaska and DiClemente (1983) transtheoretical or stages of change model. This model suggests that people do not change their behaviour all at once; rather, they go through a series of progressive stages from ignorance or indifference toward commitment and permanent adoption of a new behaviour. Andreasen (1995) offers complementary social marketing tasks for each stage of change:

1. Precontemplation Stage: With new social issues or behaviours, a great many individuals may not be thinking about making a change. These individuals are at the precontemplation stage due to ignorance, or because the new behaviour seems irrelevant to their lives, or incompatible with their principles. To propel precontemplators to begin thinking about the behaviour, the social marketer must create awareness of the new behaviour (to overcome ignorance) and interest in it (to make it seem relevant), in addition to helping the consumer accept that the proposed behaviour is compatible with their values and beliefs. To accomplish this Andreasen (1995) notes, social marketers “...start by listening to consumers...adjust their messages to what is important to the audience, in language the audience can
comprehend, and through vehicles to which the audience pays attention...they seek natural opportunities that fit with the audience’s lifestyles” (149).

The challenges social marketers face from consumers include selective exposure (avoiding messages) and selective attention (screening out messages when exposed to them). To minimize these effects, social marketers must choose communication channels carefully, create interesting and dramatic messages, employ familiar spokespersons, and link the behaviour with familiar beliefs or established behaviours. The key is to find “apertures” -- the times, places and circumstances when the intended audience is most likely to be exposed to, and pay attention to, the marketer’s message. Since it is crucial that messages be understood by precontemplators, communications for this audience should be pre-tested for readability and comprehension.

Communication and propaganda are important tools, yet the objective is more than getting the message “out” to the public. Helping individuals progress to the next stage requires that social marketers educate citizens and facilitate a value change.

2. Contemplation Stage: For persons who are thinking about making a change, but have not yet done so, social marketers can utilize the theories of exchange and processes of adoption to persuade the individual that it is personably desirable to do so, and to motivate them toward action. Contemplators ponder the benefits and costs of engaging in the new behaviour, as well as their ability to actually carry it out. Getting people to engage in the behaviour requires enhancing the more immediate benefits of actually doing the behaviour, rather than emphasizing the more distant benefits. Reducing the costs of engaging the behaviour is also important. Over the duration of this stage, the
importance of the latter issues shifts. Early in the stage, contemplators focus more on benefits than costs and concerns about their own abilities are not seriously considered. Later, contemplators perceive greater costs than benefits, and begin to seriously assess their abilities to successfully execute the behaviour. Moving contemplators toward action is more of a function of reducing costs, because people are thinking more in terms of the process itself, rather than the longer term outcomes. Andreasen (1995) also recommends using reference groups as influential sources of communication and behaviour modeling for people at this stage.

3. Action Stage: In order for persons to progress to the action stage -- actively engaging in the new behaviour -- they must believe they are capable of successfully executing the new behaviour. This sense of efficacy relates not only to the individual's own repertoire of knowledge and skills (internal, or self-efficacy), but to factors in the environment that will enable the behaviour to occur (external, or action efficacy). A lack of information or skills can lead to self-doubt, while situational factors in the environment communicate societal norms and values, favouring action or inaction. Marketing strategies geared toward individuals in the action stage focus on enhancing self- and action-efficacy in order to create action. Pragmatically, this means marketers must make opportunities for carrying out the desired behaviour as feasible, convenient, easy and painless as possible; simplify the proposed behaviour; minimize the time inconvenience involved; increase the urgency of the commitment to act; and continually remind people to act.

4. Maintenance Stage: Maintaining a behaviour change requires that an individual positively evaluate the actual consequences of engaging in that behaviour. Relapse is a
very real possibility for a great deal of social behaviours for which the benefits are not immediate and personally gratifying. The sources of disappointment, or a negative evaluation, include being dissatisfied with the positive consequences of the experience, perceiving excessive negative consequences, failing to have significant others support the behaviour, or realizing that the behaviour was not as easy to do as initially expected. Social marketers can enhance the probability of people maintaining behaviours by: establishing the reasonable consequences -- positive and negative -- that can be expected; heightening the visibility of hidden benefits; improving the system for delivery if possible; enlisting the support of significant others; and enhancing skill training.

Regardless of the segmentation approach used, dividing groups into distinct target markets would allow health planning groups to tailor opportunities to participate in health reform to a variety of needs. A 'made to fit' marketing mix can be developed for each group by reducing relevant costs (monetary, psychic, time); offering a variety of opportunities to participate (distribution); and employing promotional and communication strategies likely to reach diverse audiences. Customer self-selection and/or controlled coverage strategies can be used to reach diverse targets. A questionnaire printed in the local newspaper and delivered to every door is an example of a customer self-selected technique. Although the product is promoted broadly, residents choose themselves whether to complete and forward the questionnaire. Presentations and focus group discussions are examples of a controlled coverage method.
Defining, Designing and Delivering the Product-Market Fit in Health Reform

How well does the product meet the needs of consumers, both in terms of their interests and in facilitating the adoption process? Such issues are the subject of the product-market fit. Kotler and Roberto (1989) note that many social change campaigns are unsuccessful because target adopters are unaware of a cause or do not understand that a problem exists. Defining the product-market fit requires raising awareness of the cause and persuading constituents to adopt the (previously disregarded) product as a resolution to the problem. Such is the case with participation in health reform. To date, “New Directions” has not received extensive media exposure (particularly not positive exposure) in the Capital Regional District, and does not enjoy a widespread awareness among citizens. Indeed, most media attention has involved local politicians criticizing the idea. Defining the product-market fit in health reform requires generating a public consciousness of “New Directions” and, particularly, of the opportunities for health consumers and providers to contribute to changing of the health system.

The opportunity to participate has no tangible-product base; it is a “social idea” product. Designing the product-market fit, therefore, is a three-fold task involving (1) positioning the product to different target groups so it becomes an attractive and tempting offer; (2) “dressing up” the social idea with symbolic packaging; and (3) designing a reinforcing image of the product. Several designs may be necessary for different target groups (e.g., for youths, seniors, ethnic, economic groups).
Positioning is determined by analyzing the competition, the market and internal (health planning group) resources (Lovelock and Weinberg 1989). Understanding competitor products and their attributes, the organization and make-up of the market, and the resources available for -- and potential constraints on -- success enables the marketer to position the product. Positioning strategies can include delineating the product attributes, highlighting user benefits, associating the product with a particular use or function, and with regard to the competition. Positioning can also occur through the construction and coordination of the remaining elements of the marketing mix. Thus, the opportunity to participate in health reform may be positioned via its qualities (easy, convenient, affordable), the benefits to the user (to create appropriate health services closer to home, fulfilling a sense of duty or community), or by associating participation with the concept of democracy, citizen rights, and government reform. Alternatively, positioning may occur through modifying the price of participation, the venues for becoming involved, and the promotional techniques employed.

Delivering the opportunity to participate includes ensuring the communication message is sent and received, establishing various venues or opportunities to become involved, and "closing the sale" or prompting the adopter groups to participate in assessing community health needs and priorities. In social products that have a tangible-product base (e.g., contraceptives in family planning), social marketers may attempt to attract target markets into the delivery outlet to try or sample the product. For social marketers of participation, "closing the sale" may mean reaching out to individuals who would not be tempted by meetings, newspaper or hydro bill insert questionnaires.
Caveat Venditor: "Why Can't You Sell Participation Like Palmolive?"

Of course, social marketers in health promotion must tackle obstacles that are not relevant for commercial marketers (Bloom and Novelli 1981). Inherent in the latter authors' definition of social marketing is the idea that it fosters change intended to benefit more than just the individual; campaigns to foster public participation in health care reform clearly fall into this category as they ask citizens to participate for the greater good. One difficulty is analyzing the target markets. Knowledge about the determinants of consumer behaviour, and even the characteristics of consumers themselves, is usually complex and hard to capture. In addition, those segmented groups who are the target of campaigns are comprised of individuals typically negatively predisposed to the behaviour change, the antithesis of what commercial marketers face. Community organizers struggle to foster participation among individuals who may have had negative or frustrating experiences and who may not look favourably upon the request to "fill out another questionnaire".

Creating innovative product strategies is a second challenge. Limited flexibility in defining the idea and practice of participation makes it very difficult to effectively communicate and sell the product. Health promoters in particular often have the task of persuading people to modify a behaviour which is more pleasurable than the alternative. Such is the case with participation. The act of participating requires greater effort than not participating.
A third issue is finding innovative ways to assess and then reduce costs, which in the case of participation, are not solely monetary. The time, effort, psychic and convenience costs of participating may demand more thoughtful methods of reducing costs than merely ameliorating financial constraints. Yet knowledge of the perceived costs or barriers is not always accurate or complete. Controlling distribution channels is also a challenge. While community organizations may be able to secure a variety of venues where citizens can become involved in health reform (surveys in newspapers, interviewers or educational displays at public malls et cetera), they are limited in their ability to control the logistics of distribution such as where the survey is printed, whether the newspaper gets delivered at all, or where in the mall the display and interviewers are housed. Bloom and Novelli (1981) note that because social marketers must rely on the attractiveness of the "cause," their ingenuity in recruiting adopters, and the quality of the "brokers" who deliver the product, the distribution scheme is often erratic.

The financial constraints that community groups face in using various communication techniques (e.g., the high cost of advertisements and reliance on free, but competitive publicity) may severely limit their effectiveness in increasing awareness and generating community interest in health reform. Mass media messages must contain a great deal of information, particularly regarding the benefits to be achieved and what action the consumer can take next. "Unfortunately, the need to provide large amounts of information forces many social marketing messages to close with the old standby, For more information, please call or write..." (Bloom and Novelli 1981, 85). Finally, evaluating social marketing efforts can be tricky when the process eludes the "sales"
definition of measuring effectiveness. Social marketers have also faced ethical concerns about 'manipulating' the public, and criticisms of emphasizing individual responsibility for change (Brieger et al. 1986-87).

Despite these caveats, however, social marketing can succeed (Bloom and Novelli 1981), and provide a blueprint from which social and health promotion issues may be confronted (Lefebvre 1992). The final section of this chapter presents the reader with a look at how health promotion issues and concerns have been confronted by other researchers. Specifically, the fourth section introduces the reader to health promotion research relevant to the manner in which this case study was designed and conducted.
As an inter- and multi-disciplinary subject, health promotion draws on a wide range of research methodologies. Recently, a "quiet methodological revolution" (Denzin and Lincoln 1994, ix) has been occurring in the social sciences, and health promotion is no exception. In addition to controlled experiments or survey research done for people, understanding and moving toward social change with people, now counts as science. This revolution brings with it particular assumptions about the ontology, epistemology and methodology of knowledge inquiry. This section reviews some of the approaches and methodologies health promotion research relevant to this case study. It is not meant to be a comprehensive review, nor to suggest that all health promotion inquiry is conducted in this way. Rather this section is designed to place in context the methodology chapter that follows.

Integral to the methodology of much health promotion research is the acknowledgment and acceptance of multiple social constructions of reality, and a valuing of the shared creation of data between the researcher and participants (Guba and Lincoln 1989). Qualitative methods become the preferred mode of inquiry when researchers want to gain insight into the needs of consumers (Lord, Schnarr and Hutchison 1987). In keeping with the "New Directions" articulated by the Ministry of Health (1993), the philosophy of health promotion (WHO 1984), the principles of the Capital Health Board (1994), and research in local government (Blackman 1993) this research study incorporates aspects of Fourth Generation Evaluation (Guba and Lincoln 1989). As
detailed in chapter three, the methodology stops short of employing a full fledged hermeneutic dialogue, although it retains important elements such as achieving stakeholder consensus on the research questions, contextualizing the data, and observing the phenomenon of participation in its natural setting.

Constructivist-Interpretive Paradigm

The ontological, epistemological and methodological assumptions of the constructivist-interpretive paradigm are distinct from those of the positivist and postpositivist paradigms. Researchers working in the latter paradigms search for pre-existing, verifiable and generalizable truths that can statistically express relationships among natural or social variables for the purpose of prediction. Positivism values distance and detachment from the subject under study because positivist scientists assume the existence of a social world external to individual consciousness. Social facts are 'out there.'

In contrast, constructivists-interpretists explore individuals' creations of reality as they interpret a localized and specific experience or phenomenon (Guba and Lincoln 1994). Knowledge is created, rather than unearthed, as the perspectives of people experiencing a social phenomenon are explored. The purpose of constructivist inquiry is to understand the life from the perspective of the participants in the setting under study - the emic point of view (Schwandt 1994). It is best captured through detailed interviewing and observation. Thus, multiple interpretations, or knowledges, can be constructed based
on the unique context and characteristics of each person. The constructivist paradigm perceives facts to be value- and theory-laden, and therefore meaningful only when viewed from a theoretical or value-based framework.

In constructivist-interpretive inquiry the researcher attempts to get close to the participants and share the context of the phenomenon. Together with the inquirer, participants collaborate in the research process. Acquiring knowledge in the constructivist-interpretivist paradigm requires an interactive relationship between the researcher and his/her co-researchers, as well as observing and capturing information in its natural context. The researcher is interested in reducing the distance between the investigator and the 'subject', or as Sandelowski (1986) suggests, "...eliminating the artificial lines between subjective and objective reality" (page 34). Samples of co-researchers are not randomly selected, but are chosen purposively, based on the phenomenon and context. Maximum variation sampling provides the constructivist researcher with the broadest scope for acquiring local perspectives (Guba and Lincoln 1989).
Yin (1984) suggests that the case study inquiry is the design of choice for understanding complex social phenomena. As a research strategy, case studies are useful in refining theory and offering suggestions for further investigation. A case study investigates a contemporary phenomenon within its real-life context to retain the holistic and meaningful characteristics. Stake (1995) distinguishes between three main categories of case studies: intrinsic, instrumental and collective. The research for this study falls into the second category, in which “...a particular case is examined to provide insight into an issue or refinement of theory” (237). The issue in this research is understanding public participation in health reform, and the health planning groups provide the context for the casework.

The case study inquiry uses multiple sources of evidence. Triangulation clarifies the phenomenon by identifying various ways it is being seen. These multiple sources of data are brought together to construct a comprehensive picture of the phenomenon of participation and nonparticipation (Patton 1990). ‘Telling the story’ is a common format in case studies. Both Stake (1994) and Guba and Lincoln (1989) caution that which data actually are included in the story is a decision that ultimately the researcher must address. “Many a researcher would like to tell the whole story but of course cannot; the whole story exceeds anyone’s knowing, anyone’s telling” (Stake, 1994, 240).
The research approach in this case study can be classified as heuristic orientational inquiry (Patton 1990). It uses heuristic methods oriented from the social marketing concepts of understanding the consumer perspective, exchange, marketing mix and segmentation. Heuristic inquiry "legitimizes" the personal experiences and insights of the researcher as s/he comes to an understanding of the phenomenon "through shared reflection and inquiry with co-researchers as they also intensively experience and reflect on the phenomenon in question" (Patton 1990, 72). Heuristic study enables the researcher to become intensively involved in the local social, political and cultural context. This can be accomplished through what Guba and Lincoln (1989) term "...prior ethnography, that is to live in and experience the context for some time..." (201).

Orientational inquiry is useful for theoretical explanation, confirmation, and clarification. From the outset, it acknowledges and makes explicit the theoretical perspective or framework of the researcher which guides the inquiry. The researcher then interprets the findings from within that framework. "What is required is that the researcher be very clear about the theoretical framework being used and the implications of that framework" (Patton 1990, 87).

The use of social marketing as a theoretical framework provided a perspective from which to analyze the data, and interpret the meaning of 'facts.' However, the researcher did not divulge this theoretical orientation to the participants, and thus makes
no pretense that they were aware of, or acknowledged it, in the data collection and analysis phases.

Establishing the Trustworthiness of the Research

The traditional criteria of validity, generalizability, reliability and objectivity for quantitative research are not appropriate for qualitative inquiry. The ultimate constructivist criterion for a successful inquiry rests on its ability to evince a more informed and sophisticated understanding of the phenomenon under study (Guba and Lincoln 1994). Guba and Lincoln (1989) suggest 'parallel' trustworthiness criteria of credibility, transferability, dependability and confirmability for qualitative inquiry. Others (Miller and Crabtree 1994; Richardson 1994) have suggested similar rules of evidence: the telling of methodologically, rhetorically and clinically convincing stories.

Credibility

Credibility demonstrates the isomorphism between participant input and the interpretation/analysis of the data, and refers to the "believability" of the findings (Leininger 1994). Becoming intensely involved with the process not only facilitated entree into the field, but was instrumental in establishing trust with the health planning group members. The latter privilege is a crucial to establishing credibility (Guba and Lincoln, 1989). Building trust was a fragile undertaking and one that required constant nurturing. The researcher attempted to foster trust by sharing equally in the workload and
not dominating or shirking tasks, attending meetings and events on a regular basis and
commenting on the activities of the different health planning groups to other groups only
when asked.

Credibility of the research was further achieved though a number of strategies.
This study followed the suggestions of Adler and Adler (1994), Baum (1992), Chambers,
Wedel and Rodwell (1992), Gilchrist (1992), Fawcett (1991), Silverman, Ricci and
Gunter (1990), Guba and Lincoln (1989), and Shaffir, Stebbins and Turowetz (1980) by
confirming the data with informants to enhance the validity (reducing the susceptibility to
bias from the observer’s own interpretation of situations).

As noted by Miles (1983), there are pitfalls with validation through feedback
including the "rewriting of history" (128) by informants to portray themselves more
favourably, problems with absolute anonymity, and the added delay in turnaround time.
Confirming informants’ thoughts and opinions at a later date permitted validation,
elaboration and clarification of previously gathered data from other sources, and allowed
factual contradictions to be resolved. Sandelowski (1986) states that “a qualitative study
is credible when it presents such faithful descriptions or interpretations of a human
experience that the people having that experience would immediately recognize it from
those descriptors or interpretations as their own” (30).

The researcher’s consistent attendance at health planning group meetings and
activities over the 11 month period also enhanced the credibility of the research: “The
object of persistent observation is to add depth to the scope which prolonged engagement 
affords” (Guba and Lincoln 1989, 237). The rigour of the observations is further 
enhanced when used in combination with other methods. As ethnographers note, 
“although direct observation may be marred by researcher bias, at least these are 
consistent and known. Direct observation, when added onto other research yielding depth 
and/or breadth, enhances consistency and validity” (Adler and Adler 1994, 382). In this 
study, personal observation was complemented by data obtained through individual and 
group interviews, review of documents and video.

Miles (1983) offers other suggestions for establishing credibility, including 
searching for evidence in support of, or contrary to, preliminary interpretations or 
explanations, and discovering rival explanations; testing propositions; making 
predictions; and looking at extreme-bias cases. Demonstrating a failure to find 
supporting evidence for competing hypotheses helps to support the original explanation. 
Chapters Four and Five report the alternative patterns and data that emerged.

Transferability

Transferability of the research is concerned with the data "fitting" other settings, 
and is accomplished through an information-rich design producing thick descriptions of 
the context, culture and phenomenon under study. Patton (1990) uses the term 
extrapolation to explain how findings can be applied to other similar situations, as lessons 
learned and/or potential applications for future use.
Sample size is critical to the generalizability of quantitative data, and can be contentious issue in the transferability of qualitative research. Purposeful sampling enables "information-rich cases" to be selected that are central to the purpose of the research (Patton 1990). Roche (1991) and Chambers and colleagues (1992) suggest that when similar patterns and themes emerge from the informants, or information becomes redundant, a sufficient sample size has been reached. When sampling to the point of redundancy, or to confirm and disconfirm evidence, Kuzel (1992) suggests a sample size of 12-20. Patton (1990) downplays the sample size liability when he writes "The validity, meaningfulness, and insights generated from qualitative inquiry have more to do with the information-richness of the cases selected and the observational/analytical capabilities of the researcher than with sample size" (185).

Dependability and Confirmability

Tracking and documenting the research process is crucial for establishing dependability and confirmability. Dependability is the criterion for reliability of the data; confirmability is parallel to objectivity (Guba and Lincoln 1989). The audit trail for dependability and confirmability details the process of inquiry (methodology, evolving thematic patterns, interpretations and decisions). It also links data back to their original sources.

Similarly, Altheide and Johnson (1994) talk of "reflexive accounting" a strategy that informs the reader where the author is coming from, a "...version of truth in
advertising" (Altheide and Johnson 1994, 490). Reflexive accounting includes data on the context, participants, activities, routines, significant events, members' perspectives and meanings and basic social rules and patterns. As well, it means accounting for the role of the researcher in respect to the phenomenon, and informs the reader how entry was gained into the research setting, how trust and rapport were established, what the researcher's role was, the type and breadth of information gathered, how information was collected, recorded, coded and analyzed and of any mistakes, misconceptions or surprises.

Chapters four through six provide the reflexive accounting or audit trail for this case study. These criteria enable the reader to follow the research process and make sense of the raw and interpreted data. As Patton (1990) suggests, “The point is to be aware of how one’s perspective affects fieldwork, to carefully document all procedures so that others can review methods for bias, and to be open in describing the limitations of the perspective presented” (482). Limitations are discussed in chapter three.
CHAPTER 3
METHODOLOGY

This is a case study of four health planning groups in the Capital Regional District (CRD). It describes and assesses their attempts to foster public participation in the identification of health priorities and goals for a community health plan from September 1994 to June 1995 and August, 1995. It studies the participant perspective and experience in the health reform process, drawing on the shared experience of the researcher, as a participant in the health planning groups, with that of other health planning group participants. This research also looks at the nonparticipant and attempts to discover the preferred ways in which a variety of citizen groups would like to become involved, if at all, in community health issues. The terms ‘participant’ and ‘nonparticipant’ were selected for ease of reference and have been used throughout the dissertation to reflect persons’ involvement or uninvolve solely in the health reform process of “New Directions.”

This chapter details the method of inquiry, including the population chosen, data collection instruments and procedures, methods of data management and analysis and interpretation of the findings and the limitations imposed by the research design.
The ministry of health’s reform policy for health care, "New Directions," led to the creation of 80 health planning groups throughout the province to begin the work on health reform. These groups represented particular geographic areas and were responsible for planning the establishment of community health councils and participating on regional health boards, as well as planning for the management of health services at the community level. The ministry recommended that groups include a balance of consumers and the public, health care providers and local government representatives. In developing community health plan and community health councils, the health planning groups were encouraged to follow the principles of community development, particularly for addressing the core issues of health priorities (for the health plan) and, governance and management (of the community health council).

Within the CRD on Vancouver Island, seven health planning groups (representing seven communities in the region) have worked since the spring of 1993 to develop a community health plan and establish community health councils. The Capital Health Board (CHB), the regional health board for the CRD, initiated the process with newspaper advertisements inviting citizens to attend health planning group meetings in the seven communities. The researcher’s involvement began in February, 1994, after noticing a newspaper advertisement inviting citizens to attend a regional forum on citizen participation in health reform. At the time, the researcher was a doctoral student studying citizen participation in community-based heart health projects, who went to the forum out
of personal and professional interest. Shortly thereafter, the researcher began to regularly
attend the monthly meetings of the community health planning group (D), hereafter
designated as group (D).

By the spring of 1994, the researcher realized that the context of the health
planning groups provided a rich data source for studying citizen participation and shifted
her research focus to citizen participation in the health reform process. With the CHB’s
commitment to developing a participatory, inclusive process with a grassroots voice, the
implementation of health reform in the CRD provided an ideal context in which to study
and document the experience.

In August, 1994 the researcher approached and received permission from the
CHB to conduct the study, under the conditions that the research did not interfere with
the work of the health planning groups, and that each of the groups were aware of, and
consented to, the research being conducted (refer to Appendix A). The Board staff
provided the names of the chairs and meeting times and dates to the researcher. One
health planning group (designated group G) was eliminated due to its inaccessibility. The
schedule of meetings provided the order in which the health planning groups were
solicited.

Four health planning groups were selected for study as a purposive and
convenient sample (see Table 3.1 for a summary of sample information). These groups
represented (1) the urban core of the region, with a high transient population (hereafter
referred to as health planning group A); (2) a locale highly populated with senior citizens (hereafter referred to as health planning group B); (3) a large rural area with the highest population of young families (hereafter referred to as health planning group C), and (4) an affluent community whose population is predominantly middle-aged (hereafter referred to as health planning group D). The researcher had been a member health planning group (D), in her municipality, for seven months prior to approaching the other three groups.

As a result of participating in region-wide forums with all seven health planning groups, and as a member of the regional communications committee, the researcher became familiar with the work of the other health planning groups and their members.

In the fall of 1994, the researcher approached three (designated groups A, B, C) of the seven health planning groups with a request to participate as a non-voting member in order to document and research public participation in the health reform process. After contacting the chair of each group and requesting inclusion on the next meeting's agenda, the researcher explained the purpose and scope of the study to the members of the health planning groups and any questions or concerns from the members were answered. Each of the three groups agreed to be part of the research study. The researcher's own health planning group (D) also consented to the study. However, due to the difference in member status (i.e., voting versus non-voting) of the researcher, data were not collected from members or former members of this health planning group. Health planning group (D) data (fieldnote observations) contributed to providing the researcher with the experience of being a citizen participant in the health reform process. The remaining two health planning groups (designated groups E and F) were not
approached for involvement in the study due to the fact that their meetings were held on identical evenings as groups (A), (B) and (C).

Maximum variation was used when sampling for citizens to interview so that the broadest range of information and perspectives about citizen participation could be obtained. Nine key communicator interviews were held with health planning group members of groups (A), (B), and (C). As the groups were completing their applications for designation as Community Health Councils, an open request for interviews was made at their May, 1995 meetings. The researcher asked to have a few minutes on the agenda to re-iterate the purpose of the research and the research questions, and distributed an “Invitation to Participate” (refer to Appendix C) to all the members present. In addition, the invitation was attached to the meeting minutes and mailed to members unable to attend. Two active/regular members of each health planning group volunteered to be interviewed. The chairs of the three groups were also approached for interviews and consented. A total of nine interviews with health planning group members were conducted.

In order to explore the perspective of citizens who were no longer participating in the health reform process, meeting minutes were reviewed to find the names of persons who had attended a minimum of one meeting and had not returned. A letter was then mailed to former participants explaining the research and requesting an interview (refer to Appendix D). Approximately seven days after the letter was mailed, a follow-up telephone call was made. A former member of health planning groups (A) and (C) both
agreed to be interviewed. The first person approached from health planning group (B) declined, with a second drop-out consenting to the interview. A total of 12 key communicator interviews were conducted.

In order to explore the nonparticipant perspective -- the experience of persons who had not been involved at all in the work of the health planning groups -- focus groups were organized and conducted with community groups in the CRD. These groups represented individuals who were, for the most part, absent from the health planning group membership, yet who were recommended to be part of the planning process as outlined by ministry of health documents and who are traditionally underrepresented in community participation initiatives. A total of 48 individuals took part in the focus groups. Krueger (1994) recommends the use of focus groups when there is a gap in communication or understanding between groups of people; particularly between groups who are perceived to have power and others who are not. The researcher received an internal grant from the University of Victoria to finance this portion of the research. The funding enabled a research assistant to be hired for six weeks and basic supplies to be purchased (including food, transportation and day care costs for focus group participants, audio tapes, stationary, postage). The research assistant, who had a master’s degree in adult education, organized and facilitated the focus groups in collaboration with the researcher.

Using the community pages of the local telephone book, the research assistant telephoned community organizations that represented diverse marginalized groups: street
people, youths, single parents, persons with physical disabilities, and persons with mental illness. The research assistant explained the purpose and scope of the research to the manager/executive director of the organization, and followed this up with a letter attaching university ethical consent to conduct the research. Consent from each of these organizations was also secured prior to conducting the focus groups (refer to Appendix A). With each of these community groups, the contact person was extremely helpful in recruiting focus group participants. The instructions provided by the research assistant were threefold: the focus group required six to ten people, who represented the membership of the organization, and who preferably do not know each other. The research assistant made it clear that any costs incurred by focus group participants for transportation or day care would be reimbursed, and that refreshments would be served. The contact liaison for persons with mental illness suggested that an enticement other than food be used. In the latter focus group, gift certificates for ten dollars in groceries were purchased and distributed.

Over a four week period, focus group interviews were held with each of these five groups. A sixth group, an organization representing live-alone seniors, initially agreed to participate in a focus group discussion, but due to circumstances of logistics, schedules, and weather conditions, the research team was unable to finalize and conduct the discussion. After conducting five focus groups it was apparent to the researcher that thematic patterns had emerged across the groups.
Finally, street corner interviews of citizens who had neither participated as health planning group or focus group members were conducted by the researcher and the research assistant on a weekday morning, June 29, 1995, outside a grocery store in each of the three municipalities of health planning groups (A), (B), and (C). Using a page of random numbers from the text *Social Research Methods* (Hessler 1992), the first digit (n) of a blindly selected number served as the nth person to approach. The number 12234 was randomly selected, and therefore the first person of each gender was approached for an interview. After receiving permission from the store manager, we requested to speak with the first man and woman to approach the entrance to the grocery store in each municipality “about health issues in the community.” It was decided at the outset that the researcher and research assistant would accept a maximum of ten rejections (per gender) before leaving each site.

Another important role the research assistant filled was that of peer debriefer. At the beginning of her contract, the research assistant read the research proposal, including the theoretical and methodological sections. After each focus group and the street corner interviews a debriefing session was conducted, enabling the research team to discuss what had worked well, what had not worked well, and the extent to which responses in the focus group were applicable to the theoretical orientation.
### Table 3.1 Sample Information

<table>
<thead>
<tr>
<th>Participant Observation</th>
<th>Key Informant Interviews</th>
<th>Street Corner Interview</th>
<th>Focus Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPG* (A) - 9 meetings attended</td>
<td>HPG* (A) - 1 chair, 2 active/regular members, 1 former member</td>
<td>HPG* (A) - 2</td>
<td>street youth n = 9</td>
</tr>
<tr>
<td>HPG* (B) - 12 meetings attended</td>
<td>HPG* (B) - 1 chair, 2 active/regular members, 1 former member</td>
<td>HPG* (B) - 2</td>
<td>high school youth n = 6</td>
</tr>
<tr>
<td>HPG* (C) - 14 meetings attended</td>
<td>HPG* (C) - 1 chair, 2 active/regular members, 1 former member</td>
<td>HPG* (C) - 1</td>
<td>single parents n = 4</td>
</tr>
<tr>
<td>HPG* (D) - 23 meetings attended</td>
<td></td>
<td></td>
<td>First Nations (two focus groups - one reserve, one off-reserve) n = 17</td>
</tr>
<tr>
<td>region wide - 6 meetings attended</td>
<td></td>
<td></td>
<td>persons with a physical disability n = 6</td>
</tr>
<tr>
<td>regional communications committee - 12 meetings attended</td>
<td></td>
<td></td>
<td>persons with a mental illness n = 6</td>
</tr>
</tbody>
</table>

*HPG denotes Health Planning Group*
The Gantt chart outlined below maps the timeline for the research study.

### Time Schedule

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Feb/94 - April/95</th>
<th>May/95</th>
<th>June/95</th>
<th>July/95</th>
<th>Aug/95 - Dec/96</th>
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</thead>
<tbody>
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<td>observer and member of health planning groups</td>
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<tr>
<td>confirm research questions with health planning group members</td>
<td></td>
<td></td>
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<td>X</td>
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<td>key informant interviews</td>
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<td>X</td>
<td>X</td>
<td></td>
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<td>focus group interviews</td>
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<td>street corner interviews</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>interview transcriptions &amp; feedback</td>
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<tr>
<td>analysis, interpretation &amp; write-up</td>
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<td></td>
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<td>X</td>
</tr>
</tbody>
</table>

Research Timeline

The Gantt chart outlined below maps the timeline for the research study.
Data Collection Instruments

Participant Observation Schedule

By attending the groups' meetings, workshops, focus groups and outreach efforts the researcher witnessed and participated in the health reform process and spoke with participants. Specifically, the participant observation/researcher-as-member schedule included monitoring of:

1. The timeline of major activities and events. This included the variety of opportunities that exist for community input, as classified by Rosener's (1978) typology (distribution channels), such as health planning group meetings, focus groups, presentations, and health forums. The date, time, location, roles and activities of key players were noted and described. In addition, casual conversation or remarks concerning public participation were recorded for each activity or event.

2. The physical environment, location, and setting of each activity or event.

3. The social environment, including the individuals who participate (target markets), and their (researcher estimated) socio-demographic characteristics (age, gender, education, occupation and health consumer classification). The verbal language of individuals was noted, particularly any jargon used by participants. As well, observations were recorded about activity levels of participants (i.e. what participants did, how often, for how long).
4. Insights, hunches, concerns and revelations regarding participants' perception of the features, benefits and costs/barriers to participating. Participant satisfaction with the participatory process and reasons why they dropped out or continued to participate were documented. Any items that should be followed-up on were also noted.

5. The relationship between the researcher and participants, and the opportunities for, or barriers to, gaining social entrance or continued involvement with the health planning groups. The status of the researcher's group membership and level of intimacy achieved, in terms of both working and trusting relationships, were documented through the amount and nature of the information which the groups were willing to disclose. Challenges to the researcher's role definition and responsibilities were explored, and consequences of the researcher's actions and mistakes of unanticipated events, were recorded. For example, in the development of a public survey, questions formulated by health planning group members were poorly stated, leading and ambiguous. The researcher struggled with the research role: should the researcher use knowledge and edit the questionnaire, or stand back and let the process evolve? Choosing the former almost cost the researcher her hard earned trust with other members. Other participants who had shared in the development of the questionnaire were upset that their ideas had been usurped and replaced without consultation. They did not take ownership of the survey and were hesitant to administer it during community events. The researcher noted this error in judgment for further collaborative activities.
This participant observation schedule was developed after reading the literature on ethnographic fieldwork, and was tested and refined by the researcher during the seven months prior to the formal start of the study, as a member of health planning group (D). The original schedule had included monitoring the body language of the health planning group members, but this proved challenging to interpret. Photography augmented the written participant observations and public events, meetings and presentations were captured on camera film.

During September, 1994 to June, 1995\(^1\) the researcher spent 175 hours attending a total of 76 meetings and events. Specifically, the number of health planning group meetings/events attended was: group (A) - 9; group (B) - 12; group (C) - 14; group (D) - 23; region-wide meetings/events - 6 and regional communications committee meetings - 12. The health planning group meetings lasted an average of two hours and included discussions concerning public participation, identification of health issues, planning for the establishment of the community health council and reviewing drafts of their designation document. Different events were used by the health planning groups to engage constituents: (1) staging public forums/meetings to which community residents were invited to contribute to the work on the health plan; (2) attending existing community groups’ meetings and making a presentation about the health planning group; (3) conducting focus groups with targeted segments of the community to determine their

\(^1\) Although the researcher ceased to attend health planning group meetings in June, 1995 with the submission of their designation documents, included as data are observations and fieldnotes from a region-wide meeting on August 24, 1995.
health issues and needs; and, in the latter stages, (4) public elections to vote citizens to interim community health councils. Regional forums were longer in duration (usually held on Saturdays), and functioned to bring all seven health planning groups together to address regional issues of communication, governance, management and delivery. Fieldnotes were taken with a pen and paper, and later inputted onto computer disk at the researcher’s home. All meeting minutes and other communication were kept in a dedicated file folder for each health planning group, the CHB, the regional communications committee and regional forums.

The mandate of the regional communication committee (which the researcher is secretary to) was to increase community awareness of and communication with the health planning groups and CHB. Representatives from each health planning group sit on this committee which has produced a speaker’s kit, regional newsletters and public information sheets, as well as sharing information among and between health planning groups.

The researcher’s role can be classified according to Adler and Adler (1994) as the complete member researcher. Complete member researchers “...study scenes where they are already members ... in order to grasp the complete depth of the subjectively lived experience” (Adler and Adler 1994, 380). Membership in the researcher’s community health planning group facilitated entree into the other three groups, and enabled the observations and participation to be “... the least noticeably intrusive of all research
techniques" (Adler and Adler 1994, 382). In fact, the naturalness of the observer role is verified by the fact that all of the health planning groups, in their application for designation as a community health council, included the researcher in their list of active members. It was not until the researcher reminded the groups she had non-resident status, and was therefore not a ‘legitimate’ member in the eyes of the ministry of health, that she was removed from their lists.

The primary limitation of the participant observation tool is that the researcher herself is the “instrument.” Observer bias cannot be eluded by using the instrument to insulate the research from the researcher’s preconceptions. Candid accounts of what assumptions guided the data collection process must then become an inherent part of the conduct of the study. Observations are also limited by the unknown effect(s) the presence of the author may have on those being observed, and are further constrained by the limited sample of events actually observed. The ten month observation period of this study helps to minimize the reactivity or observer effects (Patton 1990). As well, it is important to note that observation only captures the external behaviours of participants.
The purpose of the interview schedule was to capture the perspective and experience of each participant and former participant who had been involved with health planning groups (A), (B), and (C). In dialogue with individuals the researcher explored

1. The needs to be met in order for the individual to participate in health reform. Directly or indirectly, the researcher probed regarding: attitudes and beliefs toward health reform and citizen participation in health reform; how participants became involved and their reasons for participating; what they believed they could contribute (perceived self-efficacy); and preferred opportunities for participating.

2. The perceived selective and collective benefits of becoming involved, and the costs/barriers to participating.

3. Individuals' self-reported levels of involvement; including the amount, duration, rate, and form of contribution; and their level of satisfaction with the participatory process.

4. In addition, personal data were gathered on individuals (e.g., occupation, experience, education, and length of residence in the community), as well as information regarding their involvement in other community participation efforts.

The interview schedule was based on knowledge of the literature and the variables previously found to be significant for citizen participation, and incorporated aspects from other studies of community participation (e.g., Prestby et al. 1990). Interviews resembled unstructured conversations rather than structured interviews (Mishler 1986). The initial key communicator interview served to pilot the questions and test for face validity. The
transcripts revealed that the questions were not posed in an identical manner each time, however, the respondents' answers provided the type of information that was sought. The interviewing style can be classified as active interviewing, where the interview guide was used as "more of a conversational agenda than a procedural directive" (Holstein and Gubrium 1995, 76).

A field note reporting form was used for each interview (refer to Appendix E). The date, location, and time of interview was noted as well as the code number used for the key communicator on the form. The interview questions were also printed on the field note reporting form.

Interviews ranged in length from 45 to 90 minutes and were audio taped. The interview was most often conducted at the key communicator's home or office (one interview was conducted in the researcher's office; a second was conducted in a public restaurant) at a time convenient for the key communicator, as arranged earlier by telephone. Key points or phrases were written down on the field note reporting form, but the researcher relied mainly on the audio-tape to record the interview. There were two exceptions to this data collection format. In one instance, the tape machine failed to record the interview, and the field notes, memory of the conversation, and feedback from the key communicator were used to reconstruct the data. A subsequent interview was also not tape recorded due to the locale in which the interview was conducted (a public restaurant). However, extensive field notes were taken, and the key communicator reviewed the notes to confirm their accuracy.
While interviews enabled the researcher to explore beyond the external behaviours observed in health planning groups, interviews are also a limited source of data. It is acknowledged that participants in the interview could only talk about their perceptions and perspectives, and as such, the data from interviews might have been limited by recall error, reactivity to the interview and the potential for respondents to portray themselves in a positive light. In some instances, data from observations were used to corroborate what was reported in interviews (e.g., participant reported levels of activity were verified by participant observation notes and meeting minutes).

Focus Group Interview Schedule

The purpose of the focus group interview schedule was to capture the nonparticipant perspective on participating in “New Directions”.

Focus groups consisted of four to nine persons and were scheduled for 1.5-2 hours. Focus group participants were recruited from various community organizations and agencies in the CRD that represent traditionally underrepresented sectors of the community: single parents on income assistance (Single Parent Resource Centre), homeless young adults (Victoria Street Community Association), youths (Void Cafe), persons with physical disabilities (Victoria Recreation Integration) and persons with mental disabilities (Victoria Mental Health Centre). The focus groups were conducted at the respective organization offices with the exception of the youths, who came to a classroom at the University of Victoria.
The agenda for the focus groups and the questions to be asked were developed following the format used at the First Nations focus groups discussion that had been organized and delivered by two consultants under contract to the CHB. The consultants were hired to explore the native perspective on "New Directions" and to understand why First Nations citizens had not participated with the health planning groups, and how they might want to become involved in the health reform process. The researcher had attended two of these focus groups as a representative of health planning group (D). Participant observation fieldnotes from these focus groups were also used as part of the non-participant data set.

The focus group meetings were to begin with the researcher presenting a ten minute overview of "New Directions" and the work of the health planning groups in the CRD summarized on flipchart paper. Questions about "New Directions" and the community development process were then to be entertained. This was to be followed by posing six questions to focus group participants, and recording their answers on flipchart paper: (1) What does the word 'health' mean to you? (2) What has been your awareness or experience with "New Directions" up to now? (3) Why have you not participated fully, or at all, in "New Directions" so far? (4) What do you see as some of the questions, concerns or issues that (single parents/persons with disabilities/youths/seniors et cetera) may have about "New Directions"? (5) What can be done to encourage or make it easier for (single parent/persons with disabilities/youths/seniors et cetera) to participate in "New Directions"? (6) What are the most affordable, convenient and "citizen-friendly" ways to participate in the health reform process? Basic demographic data were also
gathered from each focus group member (see Appendix F, “Information Sheet”) in order to assemble a general profile of focus group respondents.

The first focus group to be conducted was with the street youths at the office of the Victoria Street Press. The research team quickly abandoned the prepared agenda and use of the flipchart when they discovered the setting for the focus group (an attic four feet in height). Instead, the research team used the field note reporting form (refer to Appendix F) as a guide to asking the questions and noting the details of the focus group. During the course of the discussion with the nine street youths, and subsequently with each focus group conducted, the original agenda was reconstructed to meet the needs of each group. The flipchart was used only with the single parents, who expressed a keen interest in the details of “New Directions.” It also became apparent that discussing health issues needed to be dealt with closer to the beginning of the focus group. This information often came out when respondents defined what health meant to them. Focus group members found it difficult to articulate how and where they might like to participate until their health concerns, often recounted through experiences that spoke of isolation and alienation, were aired. They had voices that needed to be heard. On average, sixty minutes were spent dealing with the health issues. Questions five and six from the original agenda combined to become one question: In what ways would you like to become involved or participate in “New Directions”?

Focus groups have limitations as a technique for gathering information. Some of the limitations are related to the shared discussion and dynamics of the group: reactivity
to the other participants, as well as the presence of the interviewer and the setting in which the discussion takes place. It is possible for the group climate to interfere with individual expression, or that one or two persons dominate the group discussion. The quality of the data gathered, then, is limited by the skill of the interviewer. Audio tapes of focus groups are also more difficult to transcribe, due to more than one person speaking at once. The potential to omit some data because of poor sound quality must be considered as a limitation. Finally, it cannot be assumed that the perspectives of the individuals who participated are representative of the community organization or group to which they belong. Indeed, the very act of participating in a focus group about “health”, may introduce viewpoints concerning the health issues and experiences of these individuals, and may be different from other ‘nonparticipants’ in the community.

Street Corner Interview Schedule

The purpose of the street corner interview schedule was to capture the perspective of individuals who had neither participated in “New Directions” nor the focus groups. The field note reporting form outlined the following script, and provided space for the researcher and research assistant to record answers and comments.

*May I ask you a few questions about health issues in your community?*

1. “New Directions in Health” is the Ministry’s plans to reorganize the health care system. What has been your awareness or experience with “New Directions” up
to now? (Have you participated in any of the local public meetings or answered a
survey about “New Directions”?)

2. Would you like to be involved in some way to contributing to the identification of
health issues and priorities?

3. What do you see as some of the questions, concerns or issues that you may have
about health in your community?

4. How would you like to be involved? What can be done to encourage or make it
easier for you to participate in “New Directions”? (What would be the easiest
and most comfortable way for you to participate in making decisions and offering
ideas?)

“Thank you for your time and participation”

The data gathered from the street corner interviews are limited by a number of
contextual issues including the time, location, and conditions under which the interview
was conducted. Moreover, the viewpoints of respondents who agreed to be interviewed
may not be representative of those citizens who declined the invitation to be interviewed,
or of those not approached.

Use of Documentary Review

The use of documentation as a source of data can be limited by the quality of the
information included and its content. In this research, meeting minutes from the health
planning groups, as well as their draft designation documents, CHB, Ministry of Health
and health planning group correspondence, and a CHB and local cable company produced video "Where in Health Are We Going?" were used as sources of data. Health planning group meeting minutes, designation documents and correspondence were employed to corroborate participant observation notes taken by the researcher, and to verify comments from key communicator interviews. CHB correspondence and the video were used to substantiate key communicator and participant observation data about the perceptions of participants regarding community health council designation. Ministry correspondence was used to represent the perspective of government officials and the minister of health. Meeting minutes and other correspondence from the CHB and health planning groups were mailed to the researcher's home, and kept in the appropriate file folder.

Data Collection Procedures

Securing Ethical Review Consent

Ethical consent was received from the Human Subjects Committee at the University of British Columbia to conduct the entire study in August, 1994, and by the University of Victoria for conducting the focus group interviews in May, 1995. Refer to Appendix A for copies of ethical consent from these institutions.
Administering the Interviews

The key communicator interviews occurred during the months of June, July and August, 1995. The focus groups were conducted in May and June, 1995. The street corner interviews were completed on one day, June 29, 1995.

Prior to beginning the key communicator and focus group interviews the consent form was reviewed with each participant (refer to Appendix B), and any questions about the study answered. Each participant was provided with a copy of the consent form to keep. Consent forms from each community organization were also collected (contained in Appendix A), awarding the researcher permission to conduct the focus group. In the focus groups, demographic data (age, gender, education, occupation, and marital status) about the participants were collected on an information sheet prior to the start of the group interview (refer to Appendix F). Focus group participants were instructed not to identify themselves when completing the information sheet. Refreshments were also served at the focus group interviews (coffee, muffins, and cookies for the adult participants; pizza, chips and cola for the youths).

After the consent form(s) had been signed, the tape recorder was turned on and the interview formally commenced. Field note reporting forms that provided the interview questions (as well as space for writing) guided the discussion, although the exact order of questions asked, and who asked them, varied from situation to situation. No participant names were written on the field note reporting form. Focus group notes were identified
only by the segment of the community that the participants represented. Key communicator interview notes were identified by a code number, from 01 to 12. At the completion of the individual and group interviews, participants were asked to write down a mailing address if they wished to receive a copy of the transcript to review and provide feedback on. A stamped envelope, addressed to the researcher, was included with the transcript for easy return. Focus group participants were also asked if they had incurred any transportation or day care costs. No transcripts from focus group participants were returned; seven key communicators returned transcripts in which they had corrected their own grammar.

On June 29, 1995, the researcher and research assistant traveled to three grocery store outlets, owned by the same chain, in the communities representing health planning groups (A), (B) and (C) to conduct the street corner interviews. Verbal permission from the manager of each store was secured prior to the conduct of the interviews. The interviews ranged in duration from two to five minutes. The first man and first woman to enter the grocery store was approached and an interview requested. The research team persisted until a man and a woman agreed to the interview at each site, or until ten persons of each gender denied their request, whichever came first. Five out of 23 persons approached agreed to speak with the research team. Both wrote down key words and phrases from the interview on the field note reporting form, which were inputted onto disk that same afternoon.
Procedures for Protecting the Data

All participant observation notes, meeting minutes, signed consent forms and completed field note reporting forms were stored in the researcher's home in a locked filing cabinet. Audio tapes of the key communicator and group interviews were transcribed onto disk (identified only by a code number or community organization). A copy of the interview was printed and mailed to each participant, and a hard copy of the transcripts retained. Audio tapes are to be erased following the completion of the dissertation. In the interim, tapes are locked in a filing cabinet at the home of the researcher. Computer disks containing the interview data are stored at the researcher's home.

Data Management and Analysis Plan

The transcripts of the key communicator and focus group interviews were tape-based (Krueger 1994), transcribing verbatim the responses of the participants. Italics were used to represent exaggeration or emphasis of a word or syllable; pauses in speech and laughter were also noted. Respondents were not identified on the transcript. In order to distinguish between participant comments and those of the researcher or research assistant, the latter were highlighted in bold on the transcript. The researcher transcribed all the key communicator interviews and the first two focus groups conducted. The research assistant transcribed the remaining three focus group discussions. On
completion, the transcripts were reviewed by the researcher and/or the research assistant for sentence comprehension, and any errors corrected, prior to sending copies to participants.

Focus group transcripts were accompanied with a covering memo, summarizing the group's discussion and requesting respondents to review the transcript for accuracy. In addition, the memo invited respondents to make any clarification to the transcript they deemed necessary, or to add or delete any comments they felt might identify themselves. A personalized, hand-written thank you note, signed by the research team, also accompanied the transcript. A self-addressed, stamped envelope was included to facilitate the return of transcripts.

Key communicator transcripts were accompanied with a covering memo thanking respondents for their participation in the interview, and requesting them to review the transcript for accuracy, and make any additions or deletions they deemed necessary. A self-addressed, stamped envelope was included to facilitate the return of transcripts.

The process of transcribing and reviewing the interviews was actually the first step in analysis, enabling the researcher to get close to, and familiar with, the data. It facilitated the identification of preliminary themes across interviews. Once all the interviews had been completed and transcribed, the data were translated into ASCII format for use with the analysis software MARTIN (Diekelmann, Lam, Schuster 1991).
MARTIN uses the Microsoft Windows' graphical environment to create a metaphorical desktop. Passages from original documents can be opened to electronic similes of index cards and annotated. Notes can be freely attached to the text. As cards accumulate, they can be moved around the desk top and stacked with other, similar cards. As patterns begin to emerge from these informal associations, related cards can be linked more formally by moving them into a hierarchy of folders and folder groups. MARTIN is a program designed to aid the coding and retrieval of data, as well as acting as a code-based theory builder (Weitzman and Miles 1995). The mechanical tasks of coding, classifying, enumerating and assembling thematically associated sections were done with the MARTIN software.

The bulk of collected data for this research were tape recorded interactive personal and group interviews, and participant observation notes. The approach used here has been termed “editing analysis” of the transcriptions and field notes (Crabtree and Miller 1992). The analysis blends four cognitive processes that, for the purposes of description, can be delineated as (adapted from Morse 1994):

1. Comprehending/Understanding - having in-depth knowledge of the phenomenon of participation. This was achieved by reflecting on the researcher’s own experiences, reading the literature on citizen/community participation, empowerment and citizenship and engaging in dialogue with community citizens to obtain their experiences. These conversations and observations were transcribed, analyzed for descriptive words, idiomatic phrases and "bibbits" (Kirby and McKenna 1989) that can
add to the understanding of the experience, and coded into thematic or patterned categories. Categories were analyzed and sorted to identify the characteristics or properties of a concept, and taxonomies developed that reveal the components of the phenomenon of participation. This process continued until little new was learned, and there were enough data to be able to write a complete, detailed, coherent and rich description.

2. Synthesizing - continues the categorizing process. Data sources were merged to find common themes. Synthesizing can be thought of as sifting the insignificant parts from each data source, leaving only the common, but significant features (similar to factor analysis). Synthesizing was accomplished initially by analyzing the themes from transcripts of each participant, and secondly, analyzing categories (sorted by commonalties) between or across participant transcripts. Synthesis was achieved when no new categories emerged, and thick description resulted.

3. Theorizing - attempts to connect the data to theory. This began by establishing etic (literature/researcher) and emic (participant) distinctions, by identifying beliefs and values, and by linking these with established theory. Concepts about participation and citizenship were identified, analyzed and compared with those existing in the literature. Theorizing also involved constructing alternative explanations for the data and testing them against the data, until the best fit (explanation) emerged. The best fit is the one that provides a comprehensive, coherent and simple model that links diverse and unrelated facts in a useful, pragmatic way. Just as the null hypothesis provides a rival explanation in quantitative analysis, the search for rival explanations to account for the data is done in qualitative analysis.
4. Recontextualizing - continues reframing the issue in terms of established theory and practice. Existing theory may provide (1) the context in which the emerging theory links the new findings with existing knowledge, and (2) the mechanism for demonstrating the utility and implications of the findings.

Each source of datum (for participants, non-participants and fieldnotes) was treated as a separate ‘project,’ and coded and classified independently, producing three sets of thematically clustered information. As patterns and themes began to emerge across data sources, each data set was revisited, several times to make connections between the excerpts from interviews and fieldnotes. The researcher also returned to the citizen participation and citizenship literature to see what the significance of the data might be in light of previous research and where gaps occurred. The next step was to begin to make sense of these themes and patterns, by developing a story and storyline (Strauss and Corbin 1990).

Data Analysis Framed in Terms of Social Marketing Concepts

The orientational nature of the research dictates that the analysis and interpretation of data be mapped from a specific theoretical framework. There are four fundamental and interconnected concepts in social marketing which provided the framework for analyzing the data (e.g., when coding thematic/pattern categories, or clustering): the concept of exchange; understanding the consumer perspective; marketing mix; and market segmentation. Although these concepts were introduced in chapter three,
a brief description of them is presented below to illustrate how each was used in the analysis stage.

Social marketing has been suggested as a framework or structure in which to approach health and social problems (Lefebvre 1992). Entering the marketing world requires abandoning the expert's mind-set that the idea of citizen participation is intrinsically good, so that if it fails to sell, the defect must reside in uninformed, apathetic or unmotivated citizens who need shrewder instructions or louder exhortation to become involved. Using a marketing lens, the researcher is invited to view participation from the citizen's perspective. Several examples in the community organization and community psychology literatures suggest that relatively few people actually participate when given the opportunity. If participation is such a good thing (the expert's mind-set), why do not more people participate (Norton et al. 1993)? Why and how do people make decisions to participate? How do we motivate them to participate? The answer(s), when we stumble on it, then defines how we structure and cultivate the exchange environment so we are successful in recruiting citizens to participate -- that is, defining the product-market fit so that the opportunity to participate matches citizens' needs, interests and purchase-adoption procedures.

Concepts of exchange and understanding the consumer perspective

In approaching an understanding of why people participate, and why more people do not, the concept of exchange is a useful one, and at the core of understanding any
transaction. Understanding the needs of the consumer is especially relevant when intangible products are difficult to define and their associated costs less amenable to measurement. This is particularly cogent when citizens are asked to take actions that benefit the community as a whole much more than they do the individual (Lovelock and Weinberg 1989). Effectively fostering public participation requires a knowledge base that enables proponents of citizen participation to understand how and why people decide to participate or not. Previous research in elucidating the participation experience reveals that the notion of balancing benefits and costs for participants -- incentive management -- is relevant. The concept of exchange is used as a way of approaching the data to understand why someone does or does not participate. What needs are to be met in order to facilitate (for non-participants) or sustain (for participants) involvement? What benefits do citizens seek to obtain from the participation experience, and what costs are they willing to incur to get them? To achieve this, the analysis also demands examining participation from the citizen’s standpoint.

The marketing mix

Once we know what people are willing to exchange, we can shape or design the participation opportunity to meet their needs and tailor the product-market fit. This is where the concept of the marketing mix is useful in making sense of the data. It is an axiom in marketing, according to Lovelock and Weinberg (1989), that a product offering will not meet its full potential unless it is appropriately priced, its availability is convenient and accessible, and the information promoting its attributes and availability is
effectively communicated. The health planning groups' efforts to facilitate citizen participation require that decisions be made in four broad areas, known together as the "marketing mix": (1) the characteristics of the product (idea and practice of participation) being offered; (2) the price of becoming involved; (3) the place or distribution channel (where, when and how citizens participate); and (4) promotion of the product to the community (how citizens become informed and persuaded to participate in the health reform process). All four elements must be tailored to match the needs of the target markets, suggesting that different opportunities to participate will have to be offered for various groups to achieve broad-based participation. The opportunities made available to the citizens of the CRD lend themselves well to analysis along these lines.

Market segmentation

The needs of citizens, including the benefits sought, barriers encountered, and variables influencing the decision to participate are unlikely to be uniform for everyone. Segmentation enables the health planning groups to identify and define different constituent groups (based on variables that characterize citizens and on factors that predict their response to participate) and then organize a differentiation strategy matching appropriate participation opportunities to each sub-group in the community. Designing different participation opportunities in response to citizen needs may revolve around customizing the components of the marketing mix. The segmentation variables used in this analysis to delineate citizen characteristics are demographic and socioeconomic (age, gender, income, occupation, and education). Citizen responses to the idea and practice of
participation were also subdivided based on how they behaved relative to the opportunity to participate (frequency, duration and type of participation; perceptions about, and knowledge of, and readiness to engage in the participation opportunity/experience). Finally, the readiness of citizens to engage in "New Directions" is useful to consider in identifying the participants and nonparticipants. The idea of market segmentation (demographic/response segmentation) is also useful to distinguish the target markets, and their associated needs in terms of exchange.

Data Reduction

These social marketing concepts provided the analytical tools for making sense of the data. Analyzing qualitative data involves three concurrent activities: data reduction, data display and drawing conclusions (Miles and Huberman 1994). Data reduction is a process that simplifies, condenses, and abstracts the data from transcriptions. Coding, patterning, and other forms of reducing the data are also analytic choices that organize the data for presentation and verification. To reduce the bulk of data, a number of strategies or devices were used:

1. Noting patterns and themes: the codes or categories assigned to "chunks" of data summarize portions of the interview transcript, document or fieldnotes. Pattern coding is a method for grouping those summaries or pulling together diverse sections of data into smaller analytic units.

2. Clustering: another tactic for forming categories similar to coding and pattern coding. Clustering relies on aggregating and sorting similar and dissimilar concepts.
Clustering can be done early in the analysis, and at later stages when clustering involves subsuming specifics into a general class. The essence of the strategy is always grouping and conceptualizing items that have similar patterns or characteristics.

3. Making metaphors: a way of reducing data (taking several particular instances from the data and making one generality of them). Metaphors are a form of partial abstraction, and can aid in linking findings to theory.

4. Counting: enables the analyst to get a quick idea of what distributions are in a large data batch. Counting actually is part of coding and identifying patterns when an idea or event happens consistently or repeatedly.

5. Factoring: the process that allows themes or constructs to subsume even bigger chunks of data. The metaphors or pattern codes represent a "factor" -- bits of common or like information that can be lumped together -- and are often called first-order factoring. Second order factoring takes the data to a higher level of abstraction and generates fewer overarching themes.

Use of data display devices

Traditionally, display of qualitative research has been in the form of narrative text. The use of matrices, networks and diagrams can convey information in an accessible, condensed form. Data displays are also a data reduction and analytic activity. The primary devices for displaying data in this study are conceptually clustered matrices. A matrix displays items that "go together." *A priori* ideas (research questions) and
empirically generated ideas can both be included in the matrix. For example, a conceptually clustered matrix that provides information about participants and non-participants organizes data describing a profile of participants (status, occupation, motivation, benefits and costs), and nonparticipants (group, occupation, perceptions of health, quotes about experiences in society and preferred modes of participating). As well, models that graphically illustrate the concepts emerging from the data analysis are used.

**Limitations of the Research Design**

Some of the limitations associated with the data collection strategies have been discussed earlier. The structure and design of the study also imposes limitations on the applicability of the data, constrained primarily by the citizen perspectives presented. The scope of this research study and the findings are restricted to the stories of participants and nonparticipants who agreed to be part of the inquiry process. As such, the findings must be viewed in terms of these select constituents only. Other than the correspondence, the data do not represent the perspectives of the provincial ministry of health staff. This case study provides a glimpse of citizen participation at the community level.

As well, it is important to point out that most of the focus group members who comprised the 'nonparticipants' (with the exception of street youth and persons with a mental illness) were involved with at least one community organization or association, or members of their First Nations band, and thus were 'participating' in community life in one form or another. This may have confounded the findings and contributes to the
difficulty of distinguishing between 'public' and 'citizen' participation. Powell et al. (1989) note that both terms are used interchangeably in the literature, however, public participation can also refer to individuals participating in social and recreational activities, as well as in community groups or associations. Citizen participation refers to collective efforts to influence government decision-making.

In addition, the study follows a defined window of time during the beginning stages of the health reform process in four communities on Vancouver Island. The timeline in which this study was conducted, during the initial stages of regionalization, may have not permitted a developmental understanding of citizen participation in health reform. The results are reflective of the participants' and nonparticipants' perspectives within this context and do not represent other British Columbians' experiences with "New Directions." Therefore, conclusions and recommendations cannot be transferred beyond the context of health reform in the Capital Regional District during September 1994 to August, 1995. While the transferability of the findings for understanding participation beyond health reform can only be speculated, it can be enhanced by providing the reader with as much information about the setting as possible. Chapter four attempts to offer the reader a "thick description" of the "New Directions" experience in the Capital Regional District so that they can draw their own conclusions about the usefulness of the data to their situation.

The use of social marketing concepts to frame the analysis also restricts the interpretation of the findings to understanding participation through a social marketing
lens. The interpretation of data has been filtered through the perception of the researcher and the use of these specific theoretical concepts. The limitations of this approach as they relate to the findings are discussed in chapter six.

The thematic analyses of the interview, fieldnote and document data were the researcher’s interpretation, and were not corroborated by all of the research participants. Chapter four was reviewed by the former chair of the Capital Health Board (although not one of the health planning group participants interviewed) who found the researcher’s description and analysis to make sense in light of her experience. In addition, the author presented the findings and analysis to members of health planning groups (A) and (C) who found the results, and the author’s interpretation of them, “to hit the nail on the head.” (It should be noted, however, that group members had no opportunity to express their reactions confidentially.) As such, whether the researcher’s interpretation of the participants’ experiences and nonparticipants’ perspectives captures their understanding remains speculative.

However, as Martindale notes, “...theory has one function: to illuminate. The difference between one theory and another is in comparative candlepower” (Martindale 1960, vii). The theory offered in the subsequent chapters is presented in the Martindale spirit: with the hope that there is sufficient strength in its candlepower to enlighten the participation and citizenship knowledge base.
In addition to the limitations discussed above, Guba and Lincoln (1989) describe some of the risks associated with using a naturalistic approach to research, beginning with the tenuous nature of long-term and close relationships that make these relationships susceptible to "...violation[s] of trust, to shading the truth, to misunderstandings regarding the purposes or relationships with other respondents on site" (132). As mentioned previously, the researcher has taken pains to establish trust between herself and health planning group members, and has continuously restated her position as a member interested in researching community participation (i.e. at every meeting, participants usually introduced ourselves, and the researcher's tag line became: "Hi, I am Joan Wharf Higgins, working with four health planning groups doing research on public participation in the community development process—who participates, who does not participate, why, and how we can involve more people").

A second risk concerns confidentiality, and the vulnerability that participants may feel when their words and thoughts, once transcribed onto paper, can be attributed to them, and thus reveal their identity. In order to alleviate this concern, as well as to engender a feeling of collaboration in the research process, editorial power was granted to each individual and group interviewed. The only changes to returned transcripts were grammatical in nature.

A third risk applicable to this research is the framing of the case study, and what information is included or excluded. Guba and Lincoln (1989) advise that this question can only be answered "...on the basis of what is needed and appropriate in this setting, in
this place, in this time, and for these stakeholding audiences” (137). The researcher promised from the outset to return the data to the groups for their use. A shorter, less academic written version will be made available to each participating health planning group, as well as to the Capital Health Board. An oral presentation of the research was given to two of the health planning groups in July, 1996.

Summary

Despite the limitations inherent in this research design, it is compatible with the principles of health promotion, participatory research, community development, and social marketing. In the context of health reform in British Columbia, it was also in keeping with the guiding principles of the Capital Health Board, and the health planning groups. Given the purpose and the context of this study, using a survey approach to capture a snapshot glimpse of citizen participation would have been inappropriate. The paradigm shift occurring in health promotion and health promotion research supports a naturalistic inquiry into the multiple realities of citizen participation; similarly, the method of inquiry in this study values the collaboration of citizens in the creation and collection of data. Data collection strategies used were the researcher’s own observations and participation as a health planning group member for eleven months, twelve key communicator interviews, five focus group interviews, and five street corner interviews, as well as documentary review. Participant feedback from the interviews was also used as a form of data collection.
CHAPTER 4
RESULTS -- THE PARTICIPANTS, NONPARTICIPANTS
AND THEIR STORIES

This chapter introduces the reader to the participants of health planning groups (A), (B), and (C), and their experiences with participating in the health reform process. It provides the reader with the information about 'who' participated in health planning groups, their motivation for becoming involved, the positive and negative aspects of their involvement, and why some participants opted to discontinue their involvement. This chapter also captures the work and activities of the health planning groups during the community development process. The bulk of the data is derived from interviews with the nine participants and three former health planning group members, but fieldnotes and documents (written and video) were also sources of information.

This chapter also acquaints the reader with selected nonparticipants, primarily through transcripts from the five focus group interviews, as well as through fieldnotes from the focus groups with First Nations on-reserve and off-reserve individuals conducted by the Capital Health Board. Exploring the nonparticipants' perspective of "New Directions" included discussing their awareness of "New Directions," their perceptions of health and pertinent health issues, and ways in which they might like to become involved in the health reform process.
This chapter begins with a description of the regional context in which people participated (or did not participate in "New Directions"), provides the stories of the participants and nonparticipants, and concludes with a summary of the findings. Tables 4.1 and 4.2 present condensed profiles of the participants and nonparticipants. The numbers in brackets after participant quotes reflect their interview code number, and are cross-referenced in Table 4.1.

The Context: Participating in "New Directions"

In March 1992, the Victoria Health Project, a pilot project designed to improve regional collaboration in the planning and delivery of health services to seniors, came to the end of its three-year term. In its final report the Project recommended that a regional health board be established to consider ways of improving planning between all sectors of health care. The Minister of Health accepted the recommendation and appointed the Capital Health Council Society which became operational in April 1992. The mandate included developing effective processes to improve coordination, integration and communication across the full spectrum of health services, from acute to community care and health promotion. The Council was to develop an open and inclusive process for involving community members in health planning, and in doing so, ensure broad, balanced and diverse participation.

With the introduction of the provincial government's health reform initiative,
"New Directions for a Healthy British Columbia," the Capital Health Council Society was re-named the Capital Health Board (CHB) in order to ensure consistency with the provincial policy. It was officially designated under the Health Authorities Act as a regional health board on September 8, 1994.

Under the guidelines of the five "New Directions for a Healthy British Columbia," communities throughout the province began restructuring the health care system. Local Health Area (LHA) boundaries were to be used as guidelines indicating where community health councils were to be developed. Regional health boards were to be established in each of the 20 regions of the province. The CRD is comprised of four LHAs. In the spring of 1993, the CHB initiated and facilitated a community development process in order to implement "New Directions." Six local planning groups were established through consultation with local municipal councils, existing community groups, local service providers and the general public. A liaison was also established with a seventh group already working on a community health plan on the Southern Gulf Islands. Unlike other regions in the province, where Ministry "New Directions" transitional staff assisted volunteer health planning groups, the CHB hired (and seconded from other health care institutions) community development staff who nurtured the community development process in each of the region's seven geographical clusters. The community development staff facilitated the early health planning group meetings, as well as providing administrative and technical support throughout the process. Each health planning group provided two representatives to sit on the CHB to contribute toward the regional health planning process, and to maintain the flow of communication.
In the developing community health plans and governance structures, the health planning groups were to create community awareness and foster broad-based participation. The process was outlined in two Ministry documents *Processes, Benchmarks and Responsibilities for Developing Community Health Councils and Regional Health Boards*, and *A Guide for Developing Community Health Councils and Regional Health Boards* which included a checklist of various groups and organizations within the community that health planning groups were to contact:

Traditionally underrepresented groups such as aboriginal peoples, persons with disabilities, youth, seniors and women may need to be actively sought out so they too, are heard. Participation should reflect the cultural diversity of the community (*A Guide for Developing Community Health Councils and Regional Health Boards*, 11).

The documents also advised health planning groups to provide a variety of ways for citizens to participate, noting that people participate in situations where they feel comfortable. Suggestions ranged from traditional surveys and public forums to kitchen table discussions, meetings with already established citizen groups, and going "to where the people are such as schools, senior citizen facilities, food banks, hostels, etc." *A Guide for Developing Community Health Councils and Regional Health Boards*, 11). The documents encouraged health planning groups to evaluate their efforts at communicating and reaching out to the public, including identifying the successes and challenges.

The Capital Regional District (CRD) encompasses several communities from Port Renfrew to the Southern Gulf Islands, covering almost 1000 square miles on the southern
end of Vancouver Island. The 1994 population was estimated to be 321,580. When compared to other metropolitan Canadian areas, the CRD has the largest percentage of residents over 65 years of age. The average 1991 family income was $45,941. With 9.8 per cent of the regional population classified as low-income families, the CRD has almost 2.5 per cent fewer low-income households than the rest of the province, despite the fact that three municipalities in the region are above the provincial low-income family average. CRD residents are slightly better educated than the rest of British Columbians, and the region is also characterized by small households with an average size of 2.6 persons. With Victoria being the capital city of the province, the government is the largest employer in the CRD, followed by the retail trade and the health and social services industry. In the CRD, public, acute and long-term health care services have been regionally organized and managed for many years.

Advertisements in regional newspapers publicized health planning group meetings, and invited interested citizens to attend the evening meetings. The meetings were held on Tuesday for groups (A), (B), on Wednesday for group (C) and Thursday for group (D), from 7:00-9:00 p.m. in the evenings every two to four weeks. The meeting locations varied, and included regional public and mental health unit offices, community centres, the CHB office, a fire hall, an adult day-care facility, and a library. Occasionally food and beverages were served, but these were on rare evenings when meetings began during the supper hour. Coffee and tea were available at a few of the meetings of groups (A) and (D), but not on a consistent basis. Parking was free, but available only on the street. There were no facilities or services available for child minding.
Meetings were informally conducted, although some aspects of Roberts' Rules remained, such as approval of meeting minutes and the agenda, the making of and voting on motions, and the chair's responsibility for ensuring orderly discussion. The majority of decision-making was done by consensus, with the exception of matters of finance when voting took place. The meetings usually began with a round-robin introduction, including participants' formal affiliation or representation. Attendance was recorded on a sheet that was circulated during the meeting, on which participants were requested to log their name, address, phone/fax numbers, and any affiliated organization or agency. Meeting minutes, dates of upcoming meetings and agendas, and any pertinent correspondence or documentation were mailed to participants on average ten days following the meeting.

Attendance at the four health planning groups meetings ranged from a minimum of nine persons to a maximum of fifty-four; the average participation rate per meeting was fourteen persons. At least one, and in most cases two, CHB staff persons attended each meeting. By the fall of 1994 all health planning groups received $35,000.00 from the Ministry to help finance their work. Each group contributed $6,000.00 to fund secretarial support for the recording and dissemination of meeting minutes, correspondence and other administrative duties. According to fieldnotes and meeting minutes, a Ministry of health “New Directions” staff representative attended a total of twelve health planning group meetings during this time. By the fall of 1994, all the groups had elected chairs or co-chairs who were responsible for setting the agenda and conducting the meeting.
The Participants

A review of the membership roster from the designation documents and meeting minutes of the three health planning groups reveals that they were well represented by health professionals (e.g., nurses, social workers, hospital and long-term care facility managers, public health officials, and mental health administrators), individuals with political and planning expertise (e.g., municipal counselors, community planners, social policy researchers, and public administrators), and persons experienced in working in community organizations (e.g., municipal Social Planning Councils, Capital Families Association, United Way, Seniors Serving Seniors, et cetera). Of the twelve health planning group members interviewed, five were employed health professionals, three individuals recently retired from health professions, three had previous and present volunteering experience in the health field, and one was an air traffic controller. All of the participants interviewed had experience in previous or concurrent volunteer community initiatives or professional endeavours. These experiences endowed them with a repertoire of skills and knowledge that they could draw on to effectively contribute; they could "logically analyze concepts" [02], "pull together different ideas" [01] and "articulate well" [09]. These skills enabled them to run a meeting, write briefs, speak in public, facilitate group discussions, interpret research and absorb a great deal of written material.

Participants also brought with them knowledge of the health care system and other service industries. They knew the identity of key provider and community players, and had a great deal of tacit knowledge from previous professional or community work.
"I do bring a knowledge of the system from both a city and a rural aspect, as well as working in various different departments within the health system." [05]

Two of the participants with volunteer experience viewed themselves as representing the physically disabled and mentally ill consumer, respectively. They, too, had an extensive resume of volunteer community work, including the "Shutterbugs Club," Kiwanis Club, and neighbourhood associations. Most importantly, however, they brought to the group the perspective of the user of the health care system, and their 'insider' knowledge.

*I bring the experience and perspective of being a consumer of the health care system that has not received closer to home support services. I know from personal experience that all energies go into surviving -- you can get pretty depressed. I know. I have seen a lot of people that haven't survived. I've worked with the disabled a lot, and have seen them go down the tubes. It's pretty frightening and totally unnecessary.* [07]

*I just think through life experience, I'm valuable. Because, I've been there, I've been on social assistance . . . something comes up, I can just say it in plain language. I've been there . . . do you want to know what it's like?* [04]

Only one participant had no experience in the health field. Yet, his past involvement with the municipal planning council, and other community-based organizations (including little league), endowed him with the aptitude to become chair of health planning group (B), as well as vice-chair of the CHB.

*I would estimate that the amount of time I have contributed would be about 40 hours/month, although I can't believe how really easy all this stuff is. It's mostly a matter of being organized. Also, I am fortunate in that my work schedule rotates, and my colleagues are usually cooperative in switching shifts when I need to be at meetings.* [06]
Participants' estimates of their time contribution ranged from six to seven hours a month to forty hours a week, although their assessments did not account for "the time it takes to dig through the volumes of material we are sent. It takes an awful lot of time and energy. Going to the actual meeting is minor." [07]. Most meeting locations demanded the use of a vehicle. From the dialogue at meetings, it seemed that familiarity with health jargon was also a prerequisite. Although the groups operated on a consensus model of decision making, being familiar with meeting protocol and etiquette was definitely an advantage.

The Motivation to Participate

The reasons why participants were motivated to join the health planning groups included professional and personal interests, as well as a belief in their ability to contribute to the process. In one interview, this was articulated very clearly by the chair of health planning group (A):

When I originally looked at who I thought were involved, and why there were involved, it was because of an active care about health care. But, there are a lot of people who have an active care about health care who are not involved. And, when I look at it, I think the issue that really stands out is personal power. It's not just the interest in the field, but how much personal power a person feels they have in terms of making a change and making a difference. [01 ]

One participant believed health planning group members were involved for purely professional self-interests or to protect their 'turf': "The people who were involved [in the health planning group] were people in the health care industry" [12]. Others were
motivated out of professional and personal concern to see the health care system change—
- "As a citizen, concern for my children and what kind of system we're going to have in
place for them" or because the ideology of "New Directions" appealed to them.

... so, the ideas behind "New Directions" really appeal to me. And, if we
manage to make it happen, I'll be delighted because there things that have
never happened in all the years that I've been working in the medical field. [03]

I went to see what they [health planning group] were doing, because I have
an interest for my own family about the health care changes. Plus, I went to
see what I could get -- what I could learn, and what I could offer, how I could
fit in. [11]  

Some were galvanized out of a sense of duty: "My parents instilled in me a
personal philosophy of giving back to the community" [06]. One participant, who dubbed
herself the ‘token mental health consumer,’ was spurred to participate because

I voted this government in, so I'd like to see something done. Everything
I touch . . . I see it through the community health plan aspect. I'm living it
. . . I can't explain it . . . but I am actually living this whole "New Directions"
thing. [04]  

Similarly, the participant with a physical disability, believed her involvement was
necessary to ensure some equity in the decision-making power. The mayor of
municipality (B) recommended that she join the health planning group.

I like my voice to be heard. I have a valid perspective of what's being
needed. . . I'm adamant that people have a right to complain about the health
care system, with no fear of reprisal. It's not an entirely level playing field
if you need help from the health care system. [07]  

Regardless of their individual reason for participating in "New Directions," all of
the participants interviewed, including former participants, had been personally invited or
referred to join the health planning groups. The invitation or referral came through a personal connection (friend, relative) or professional link (colleague, community organization).

The Opportunity to Participate

The health planning groups engaged in traditional forms of participation, such as evening meetings, organizing public forums/meetings, and distributing surveys. In health planning group (B) members were concerned that too many citizens participating would disrupt and retard the process, and debated what constituted a ‘member.’ This feeling was articulated despite having included in their draft designation document a statement indicating that the group had “... a role in actively advocating and facilitating the participation of all members of the community, including those who do not normally have a voice in the decision making.” It was decided that those individuals who had attended meetings on a regular basis from the beginning of the process would comprise a ‘steering committee.’ Other interested citizens, who might receive meeting minutes and occasionally partake, would be considered part of the larger group membership. Only steering committee members had decision-making authority. Despite this concern for mass numbers flocking to meetings, the average participation rate in health planning group (B) was 12 persons.

The response rates for other methods of engaging the public were disappointing at best. In a series of six public forums in one community, only 48 persons out of a
population of 58,100 attended. This same community received only 122 completed surveys from a mailout of 22,000. The chair of that health planning group acknowledged that “... I don't think there’s a whole lot more people that want to participate”. [09]

Another health planning group organized a Saturday public forum to assess community health concerns. Attendance at this forum represented less than 0.2 percent of the population. Health planning groups had a much better response when volunteers with questionnaires approached residents at a series of summer events, a region-wide health fair, and at the local mall; activities and venues that provided a ready-made audience.

The local elections to select community appointments to the CHB and fledgling CHCs were also poorly attended:

It was very disheartening at the elections meeting that we had such a poor turnout. I didn't expect a lot of people ... maybe 50 out of a population of 77,000 which is pretty pathetic. But in the end result we had 25 people. This is just ridiculous. [01]

In some instances, health planning group members presented information at existing community network and organization meetings. At times, however, the health planning groups anticipated that representatives from other community groups would join them. In health planning group (A), for example, there were thoughtful deliberations about health planning group members attending local neighbourhood association and community groups' meetings as a means of tapping into existing networks. The final decision, however, reflected one of reaction rather than proaction. Citizens were welcome to address the health planning group with their ideas or concerns. A letter to each
neighbourhood association invited representatives of the other organizations to attend health planning group meetings.

A few health planning group members were cognizant of the elite status of their membership and their lack of community representation. The chair of group (A) attributed this, in part, to the insular nature of the group’s meetings.

And, there should have been a lot of more people involved and I think even though we had given a lot of talk to involving the neighbourhood associations and made sure they got reports of our meetings and stuff; we haven’t really gone out to them. We haven’t made presentations, we haven’t done that outreach work . . . we could have done a lot of going out to church groups and going to neighbourhood groups and actually going out to them. Instead we were kind of depending on people to come to us. I think there has to be a lot more outreach. I really do. [01]

Others agreed, realizing from the outset that meetings precluded citizen attendance by the very nature and logistics of the meeting structure,

Darkness, driving, [lack of] daycare are all barriers to coming to a meeting [like ours]. Meetings are difficult to attend sometimes . . . the change of meeting locales has been difficult, too. We probably lost a few people in the shuffle. You’re almost preselecting certain kinds of people by virtue of a meeting schedule. [07]

Participants were cognizant of the time and financial barriers, and were also critical of the complexity and packaging of information in prohibiting inclusive participation. “What was available was the Ministry kind of documentation people just don’t read”. [08] Commented the administrator of a long-term care facility

Most of the things that have been produced have been far too complex for the general public to understand. What does “FTE” [full-time equivalent] mean to Joe off the street? It doesn’t matter how well educated you are unless you are in the system, you don’t understand it. [05]
For one health planning group member, participation could not be defined as simply attending a meeting, but included other means of enlisting involvement. "From my perspective, I don't believe that going to the meetings is the only way to participate."

Similarly, others suggested a variety of ways people could become involved: "electronic bulletin boards," "kitchen table or front porch discussions," "speaking to existing community groups," "listening posts at local malls." Most participants recognized that their groups included "a healthy dose of providers," while a few perceived the group’s membership to be a representative blend of the community. Each participant interviewed, whether a chair of the group or a former participant, admitted that the group floundered in its efforts to garner broad-based participation, but they were divided as to whether the group membership reflected the diversity of their constituency.

The participants in health planning group (A) were particularly aware of the gaps in their membership.

*What I see on the health planning group, almost exclusively, is white Anglo-Saxon Protestant. It's the power group -- the same power group all the time. Not that as individuals we tend to be a power. But, the rest of the community is not involved, and I think we've failed. I really do. When I look at who's on the proposed community health council -- who's interested in being on it -- it's the same scenario. And, from that point of view, there's a lot of work we need to do.* [01]

*I don't think we've met tribal councils and Indian bands. We have quite a few nurses and health care providers. Single parents, people with disabilities are people I particularly want to contact. So, you know, there is a whole list of people there that we need to contact.* [03]
For one member of health planning group (B), the membership reflected the vested interests in health care, particularly acute health care.

So, talking about a community group, in fact we haven’t got the community. We’ve got only a very few people, with some fairly major limits in their understandings about the reality of providing services in this area, and [who are attending the meetings to preserve] what they want . . . They’re coming with their own bag of tricks. And, power. You go to the meetings and there is not a lot of youth or younger people. As I say, I get really panicky when I start thinking about it. [05]

Former participants agreed with this assessment of the health planning groups’ membership.

What is obvious from our group is that it represented people with special interests in the health care industry. I didn’t think anybody was there that wasn’t totally somewhat involved in the health care industry. [12]

And, participants were also well aware of the difficulties they might encounter in attempting to consult with the public:

No. I think we’ve tried [to get representative membership]. We’ve done our best. I’m not sure what . . . or how you could be representative. I think the danger is that we will get frustrated by trying to mobilize the public and just give up on it . . . they don’t want to participate, screw ‘em, we know what’s better for them . . . get into that kind of [attitude]. [08]

In contrast, chairs of health planning group (B) and (C) had a more optimistic account of the groups’ membership,

I think that the work of the health planning group is reflective of and represents the community, and that our group has been lucky in attracting the right mix of participants. [06]

Yes, I think given the lack of public participation in all the different things that we tried to involved the public in, I still feel that we’ve got a good cross-section, so I think it’s representative. We were very, very lucky in [this community] that our group that came together, for whatever reason, tended to be a very broad based group. It wasn’t all providers, if wasn’t all citizens
that knew nothing about health. It was a real mixed bag And, that gave us an advantage from day one. [09]

A related and oft-repeated concern of the health planning group members, and of the participants who were interviewed, was the need to include the grassroots community voice, despite a lack of consensus on how to achieve it. The discussions around the health planning group tables often revolved around the means by which interest and participation in the health reform process could be generated. The debates resonated between two camps: those who recognized the inherent limitations of meetings as restricting participation to the elite few, and those who felt the burden to participate was an individual responsibility. For those who sided with the latter argument, the lack of broad based participation was attributed to a general apathy toward health, and the fact that the obligation for decision-making had traditionally resided with government.

_I think not being sick matters, or not hurting matters. But, health, in its broad context, I think an awful lot of people take for granted, and don't see a need to do anything proactively about. [09]_

_Occasionally, you'll run into an average person that I think would be interested in going to a group like that, but for the most part people are into themselves, and aren't interested in health until it's an issue that affects them. [11]_

_People in the community have not had to make the effort to come together because the government has traditionally done [health care] for us. [12]._

Health professionals, in particular, were cynical about individual responsibility toward health. Remarked a retired physiotherapist,

_One of the things you learn when you've been in the health field for years and years is that people are not interested in health until they are sick. The average citizen isn't going to come to meetings. They
don't give a damn about health until they need a hospital bed. It's very hard to interest them. [03].

Participants felt somewhat deserted by the provincial government when they found themselves trying to foster participation in relative obscurity. Participants felt burdened with the responsibility of raising public awareness about “New Directions,” without sufficient expertise, funds and resources to do so. A common lament was summed up by one participant as,

I don't believe that the Ministry has done their part in promoting “New Directions”, what the process is. I think they have been very, very lax in their responsibility [for] that part of the process. Councils and boards don't have the financial resources to do things like a media blitz. That's what should have been done a year ago. Little, thirty second spots on t.v., radio, in the newspapers, whatever. That's how you reach people. [09].

The problem was compounded by the fact that a lack of media attention to “New Directions” contributed to the public’s low level of awareness. In fact, most of the publicity generated in the local media was negative, led by the official opposition party interested in making political gains, and emphasized cuts in patient services and increasing levels of bureaucracy.

I think that public communication is a crucial component of implementing “New Directions,” and I'm upset that we didn't do more. The press sensationalizes the issues of “New Directions” which influences the public to fear it, because they do not know anything else about the process. Part of it is people -- if they are not personally involved they just don't want to think about health. [07]

Former participants also explicitly referred to the need to use health issues to
stimulate citizen interest and involvement effectively. A former member of health planning group (C) suggested that,

_They need to use [health] issues more to attract people. There are a lot of issues that they [health planning group] could focus on and get people out. They need to market themselves a bit better [because health planning group meetings] are not really open to the public. So, I think if they just advertised -- I don't see the group advertised in the public, or any encouragement [to participate]. [12]_

Participants also commented on how the groups’ might attract and engage citizens in the health reform process, strategies that reflected use of the media as well as the personal touch:

_I think it requires almost headline news about the kind of impact and decisions that could be made in this area in the next six months to a year, without their [public] input. I think we have to do our best to encourage people to come [to meetings] and be friendly to them. [05]._

Participants suggested ideas such as neighbourhood discussions around the kitchen table or on the front porch, phone-in talk shows, computerized bulletin boards, and using existing community committees and agencies to tap into their members for input.

_And, I think that a lot of people have this sense that if they aren't at these meetings they haven't participated. I don't believe that at all. I think there 's all sorts of different ways, and not necessarily, formalized ways. I would quite happily get on the phone, knock on doors, and walk up and down the mall and talk to people on the street and explain what the health council is, what the board is, what “New Directions” is about. Part of my vision down the road is things like an electronic bulletin board in the community. That is terrific participation. Phone-in shows, talk shows. That's participation! [09]_
In contrast, one participant interviewed felt that the health planning group had done more than an adequate job of informing the public and inviting their participation.

*I think of the community forums that [were] organized, and the lack of participation the community had. The advertisements in the Gazette, some radio announcements of what was going on, [the co-chair] did some stuff with Shaw Cable, PSAs, a news reporting kind of community report kind of thing . . . I certainly think the community has had ample notification of the process and ample opportunity to participate.*

The Benefits of Participating: Membership Has its Rewards

Despite the wealth of skills and knowledge that participants entered the health reform process with, when asked to reflect on the benefits of their involvement participants reported gaining additional skills, knowledge, experience and personal insight.

*I learned a lot about the values that people have. I probably learned a little bit about myself. I learned a lot too about the cynicism and suspiciousness of people toward government, and again my own value of seeing what I think that the government is trying to do, what the politicians are trying to do, and how that is different from what the bureaucrats are willing to give us. It causes me to ask whether it is the politicians we need to be suspicious of or the bureaucrats?* [02]

*I have done things in the last year and a half that I never could of imagined doing. Never. [Like] facilitating workshops. I had never facilitated anything in my life before. I've learned a lot about my own community. And, the other real special piece for me, anyway, is making the connection to the native community. That's a really, really important connection to me. And, I've gotten to know people in the community that I might not otherwise have ever met. I also found myself going to council meetings that I had never gone to. So, that has to be a plus.* [09]
Participants also commented on achieving a greater understanding of, and respect for, different citizen perspectives. Others spoke of learning more their community, and of achieving a sense of control over some aspect of their life.

*For me, I think there is a tremendous amount of personal power which I don't see in other people that I work with who haven't been involved with the process -- they just feel victimized [by "New Directions"]. Other nurses or doctors. Their sense of personal power about it all is very low. So, being involved certainly gives me a different point of view from that.* [01 ]

*I'm less scared. I feel safer. I don't know how to describe that. [Other things I've learned], well, not so much legal stuff; but I know enough to know where to go. I can tell you where to go. If I don't have the phone number or if I don't have the information, I know where to get it. Even though it might be in a round about way.* [04]

A sense of accomplishment was also a reported benefit: “And, I do get satisfaction from doing something and getting it done. Once we've gone to a certain phase and reached what we said we were going to do, I get a feeling of satisfaction.” [03]. Overwhelmingly, participants also spoke of the pleasure they received from the social aspect of their involvement, including meeting new people, finding a sense of solidarity or belonging as part of the group, and having their contributions appreciated.

*It's been enjoyable. I always felt myself to be very much a member of the group, a member of the community. And, I've gotten that out of being there. It's one of the things that might have made it enjoyable is that sense of membership. I think that is important to people, and their well-being.* [02]

*I've found that a lot of people in the health group I like, I can relate to them very easily. 'Cause I can kind of stand in their shoes. It's not just understanding the jargon, I like a lot of the people. I really genuinely feel that they're trying in their own way, and that they're very dedicated to health concerns and reform.* [04]
I think it utilizes a lot of my background. It's nice to be able to use all of that and find I'm in a group that appreciates my being part of the group. I feel these are good working colleagues, and people I enjoy working with. And, I have found it quite rewarding I feel that I gain knowledge and skills all the time [during the process]. [08]

One woman, a Registered Nurse, despite dropping out, reported she learned more about group dynamics and “. . . how to chair meetings . . . and you can draw from that experience without going to a workshop itself for that.” On a personal level she was able to

. . . overcome the tendency to be shy. I'm not really a shy person, but everybody has shy feelings. I had to overcome that fear. Now, if I went back, I'd have to overcome the fear of being judged, 'cause I went for a while and gave up. That's always beneficial. You go to those things, and you do become more comfortable with people the more that you go. [11 ]

A drop-out from health planning group (A), after attending just two meetings, reported some benefit from her brief alliance. “Yes, what I got out of it was a couple of the people were very encouraging of my idea, so I guess a couple of personal contacts that I appreciated. Just some affirmation of something that I feel is valid, valuable.” [10]
The Costs of Participating: Membership Has its Dues

The negative aspects to participation, or the costs, included the time and effort demanded of health planning group members, as well as the expected problems with group dynamics or process. Participants felt frustrated by "the plodding pace" of the community development process, particularly when "we were waffling, and a lot of time went over stuff that we'd already gone over. Somebody would ask a question and you think you've just answered that. And you start all over and do it again. I got irritable about that."[03]. One former health planning group participant had dropped out of the process because she felt unwelcome by the group,

I found them to be a very cold group. I didn't feel useful. I think you need to feel useful and part of the group. I felt like it was their group, and [I] was just visiting. [11]

Moreover, she sensed her contribution, to serve as a liaison to the medical community, was not valued by the group because, "... they never followed up on my work." A second person, a mental health provider decided not to return after two meetings because she saw the process as futile, believed her efforts to affect change would not be realized. A third drop-out (a long-time volunteer in an adult day care centre) after devoting almost a year to the process, came to the conclusion that the process was flawed and refused to return: "I didn't see that anything we did was worthwhile or useful." [12]
However, the more frequently cited costs concerned the participants’ perceptions that they were losing control to affect change. “New Directions” might well be described as a top-down provincial directive to reorganize the health care system from the bottom-up. Complained a former health planning group member, “It is a ministry organized and directed initiative [New Directions], but it is being sold as a grassroots reaction; there wasn’t anything grassroots about it.” [12]. That sentiment summed up much of the experience in the CRD.

The next section chronicles the challenges and frustrations participants faced in their efforts to effect change. It begins with the events that occurred and the comments aired at one particularly emotional meeting of health planning group (B) in the early spring of 1995.

**Grassroots or Artificial Turf?**

A ministry of health employee (“New Directions” transition staff occasionally sat in on health planning group meetings) had earlier distributed to health planning groups a document outlining a model for regional governance that prohibited health planning groups from gaining CHC status, requiring them to remain advisory bodies to the CHB. The members of health planning group (B) authorized the chair to write a letter to the Minister

...questioning if this was in fact the model that would be thrust upon the capital region, making the last two years of work a waste of time. Let’s ask him if things are predetermined and if not, get your people
out of the scene and let us do our thing. If the thing is predetermined [i.e. set number of CHCs] what is this community development farce? [fieldnotes, April 11, 1995]

In reply to the letter, the chair reported back, "The ministry's response was on previous occasions repeated: the ministry will NOT be making any decisions on management policies -- it is a community decision."

At that same spring meeting, the chair also reported on a governance model that had been developed for the CHB by a former assistant deputy minister of health. Prior to the ministry contracting this individual to develop a governance model, the CHB trustees, in consultation with health planning group members and health providers, had decided against the ministry recommended 'superboard' model of governance. The superboard model proposed merging the major acute- and long-term care facilities in the region as a cost reduction and downsizing administrative move. The CHB, in deference to the thousands of volunteers that support and govern health care organizations, opted to amalgamate only limited services, such as laundry and financial, and advocated a model of affiliation between the major service providers. The model submitted by the contracted for deputy minister was perceived as a "Mini-ministry of health. Two years of community participation would be down the toilet. There were no avenues for CHC input at all. It is the superboard we have all said we don't want". [fieldnotes, April 11, 1995] The steering group to whom the model was presented, composed of providers and health planning group representation, roundly rejected the proposed governance structure.
Another contentious issue raised during this time concerned the appointment of community members to the CHB. One-third of the CHB membership was to be produced by citizens electing their representatives to community health councils, two-thirds of whom, in turn, would sit on the regional health board. However, municipal elections were not scheduled until the fall of 1996, and so health planning groups had been instructed to hold mini-elections within their community and health planning groups for interim appointments. The minister, however, retained the authority to accept or reject the community’s preference, in order to ensure some demographic breadth of membership on the CHB. Indeed, the minister had exercised this authority when he appointed his own selection of citizens, and ignored those elected to Upper Vancouver Island regional health boards. Participants wondered aloud why “He [minister] is asking us to do this work if he's going to make up his own mind anyway?”. [fieldnotes, April 11, 1995]

Similarly, with respect to the provincial government overriding a decision that the local health planning groups had “painstakingly” made about funding community health programs, one participant said,

*We were all very annoyed and wrote a letter to the ministry of health. If they're not going to listen to your recommendations, why ask you to do it, why ask you to go through the exercise? This committee had worked conscientiously on [recommending] that list.* [03]

Looming large over the entire implementation of “New Directions” was an upcoming provincial election, a prediction that a new party would be elected, and the uncertain implications for the future of the health reform process. Some participants recalled the lip service paid to citizen participation by political elite’s during the U.S. War
on Poverty (Berry, Portney and Thomson 1993), and the provincial government reform of health and social services in the 1970s (Clague, Dill, Seebaran and Wharf 1984), and feared that provincial staff might sabotage health planning group efforts. Thus, a common perception was that bureaucrats uncommitted to “New Directions,” intolerant of decentralization, and fearful for their jobs, were wary of sharing their authority with others.

*What I fear is that the minister and deputy minister have demonstrated that they’re so incapable of managing the people down below who are not happy with all of this, and are very skilled at fighting their own kind of battles, will put the whole thing at risk.* [08]

These series of events in the spring of 1995 began to take their toll on the morale of health planning group members.

*The ministry of health is determined to have its own way -- they wouldn’t know community development if they fell over it. The two years of community participation is in jeopardy.*

Participants were determined to be “*true to the principles and philosophies of Closer to Home,*” and in mid-June, 1995 the health planning groups went forward with their original plans. Six health planning groups submitted applications for designation as community health councils. Only one health planning group (D) opted to remain an advisory body. Some participants relinquished their own personal view that six CHCs in one region was too many, in deference to the greater consensus. Participants repeatedly voiced their concerns about “*balkanizing services,*” however, they felt that the communities were distinct enough to warrant their own planning and governance structure. In addition the CHB reiterated its position that it would be a policy-setting and
fund-allocating agency, and would not take on the management or delivery of regional health services.

The chair of the CHB requested a meeting with the minister to explain the process that had been followed to arrive at these decisions. It was anticipated that the minister’s concerns would be discussed at this meeting. The minister indicated that it was important that the capital region follow the same process that was taking place in the rest of the province, namely, that the documents be submitted to ministry of health staff for review to ensure their compliance with the legislation. After three weeks, the minister’s office was contacted to ascertain if there was any other information required.

On August 17, 1995, the minister of health met with CHB trustees regarding the health planning groups’ applications for designation as community health councils. The CHB and planning groups’ chairs understood that the purpose of the meeting was to hear the minister’s concerns so that the issues could be discussed and a mutually satisfactory solution to any concerns could be reached. Instead, the minister rejected five applications, granting only one (health planning group G), and appointed two individuals (a local member of the legislative assembly, and the former assistant deputy minister of health who had previously been contracted to develop the governance plan for the CHB) to recommend a restructured CHB in the form of a co-terminous regional health board/community health council.
Further, the participants felt insulted when the minister used, as his rationale for denying designation, the very criteria (geographic situation and local service capacity) that had been used to support designation of other community health council areas that did not match local health area (LHA) boundaries. Indeed, "New Directions" documents distributed to health planning groups at the beginning of the health reform process offered guidelines for the development of community health councils (Community Health Council Boundaries, New Directions Development Division, February 25, 1994). The guidelines recommended using LHAs as "starting points for planning CHC boundaries" (the CRD was comprised of four LHAs) but that health planning groups could propose community health councils at the sub-LHA level. Such proposals must address the rationale for a separate community health council, the potential improvement of access to health resources or the improved ability to plan or administer resources, and an evaluation of options. In applying for community health council designation at the sub-LHA level health planning group and CHB members felt that they had addressed these concerns in their designation documents. Participants felt that it had become painfully obvious that neither the minister nor his staff had read the designation documents: "We always suspected that the ministry of health staff was so busy covering their asses that they didn't have time to inform the minister what was going on."

A week following the minister's refusal to designate the five community health councils an "extraordinary" emergency meeting was called by the CHB. The meeting was open to all health planning group members, interested citizens, and CHB trustees to discuss options for responding to the minister's directions. One hundred and seven
people, plus CHB staff, attended the August meeting. Board trustees and health planning group members were “insulted and infuriated by” the minister’s decision which they considered to be “a slap in the face.” Participants summed up the sentiment of health planning group members when they remarked,

_We’ve just seen two years of community involvement trashed. It was obvious that the briefing of the minister was poor. It appears that [the] preconceived notions of some staff held the day with the minister._

_Both Cull [former Minister of Health] and Ramsey [Minister of Health] knew how the CHB and health planning groups were proceeding. We had two consultations with them each before the submission of the designation documents. They had a full understanding we were taking, but now the direction has been changed unilaterally._

_I’m just furious. It became so clear [at the meeting with the minister] that the minister’s briefing notes didn’t reflect the content of the designation documents. I doubt he even read them._

_Let’s refuse to accept [the decision] and let democracy prevail. They wanted our input, so let’s give it to them and refuse to go away. I can’t believe the contempt with which the [bureaucrats] hold community input._

After the August 17th meeting, several CHB trustees, who had volunteered for the last two years, interpreted the minister’s comments as “impugning the integrity of Board members,” and resigned in protest. In her letter of resignation from the Board, the chair of health planning group (D) wrote to the minister that “... if you didn’t plan on using the people’s advice, why did you ask for it? “. Likewise, a member of health planning group (B) wrote to the minister to “... strenuously object to this cavalier treatment and the resultant confusion”._
On August 30, 1995, in a letter to the minister of health, the chair of the CHB articulated her "sincere disappointment" at the minister's decision, and offered the community's take on the issue. In her lengthy correspondence she wrote,

... It is true that you and your officials expressed concerns about some aspects of the directions that the community has been going in its plans, and we have listened to those concerns, discussed them and attempted to address them in our plans. At the same time, you and your officials have consistently stated in public meetings and in writing that you would not decide the governance structure for this region. You have repeatedly stated that the community would make those decisions.

Indeed, the chair's perception that the community had ultimate authority for governance decision making is supported in an excerpt from a local cable video production about "New Directions" in the CRD entitled "Where in Health Are We Going?". The three segment video was produced by CHB and Shaw Cablevision to inform viewers about the changing health system and its progress in the CRD. The first segment depicted a "kitchen table" discussion about health care reform featuring the minister of health, the former minister of health who had initiated "New Directions," the chair of the CHB and a moderator. At one point the moderator makes a comment that public participation is a "messy process" and posed the question,

What happens if the community makes a mess of it [planning for reform]? What happens if you're [minister of health] not happy with the results? Community organizers [like the Chair of the CHB] might be concerned that government will come swooping down one day and say 'sorry guys, game over, we're taking it [authority] back?"

A former minister of health was first to reply. In the video she remarks

Well, they [community] may make the wrong decisions, but if we're being honest sometimes bureaucracies and government don't do the
thing that's right for the community either and I don't think that the people in the community are any less well equipped to be able to figure out what their needs are and to be able to develop the right plans to deliver the needs. In fact, they're probably better equipped.

[Elizabeth Cull, Minster of Health November 5, 1991 to September 15, 1993]

To which the then current minister of health added

*It was a conscious decision that that's the way we should go [with public participation]. Other provinces have done regionalized governance structures for health and they didn't make it messy. They said 'one size fits all, government knows best, we're going to tell you what to do'. And, we in this province say communities know best, and they need to get involved... governance decisions must be made by ordinary citizens.*

[Paul Ramsey, Minister of Health, September 15, 1993 to June 17, 1996]

Regarding CHC designation in the CRD, the perspective of the ministry of health is revealed in a letter dated September 12, 1995 to the then chair of the CHB. It offered the minister's response to the August 30 letter from the CHB chair. Signed by the minister of health, it stated

*As we have discussed many times in the past, granting the applications of all planning groups would have resulted in a proliferation of CHCs within the region which did not meet ministry criteria.*

*As Minister of Health and Minister Responsible for Seniors, I am accountable for the planning and delivery of health services throughout the province. While I clearly advocate the importance of community participation in health care, it is imperative that in order to meet my responsibilities to the residents of British Columbia, the devolution of services must occur within prescribed guidelines.*

*My staff and I have imparted this information to you on many occasions. We have already agreed that a regional structure best serves the Capital Health Region and that community structures under the CHB should serve this regional structure, rather than result in fragmentation of services. You can understand my concern when I received designation documents which ignored our guidelines... I appreciate the considerable efforts expended*
by members of the planning groups and the Board for community development activities. However, I have considered this matter at great length and my decisions stand.

Not only did the minister’s decision stand, he acted on it immediately. In September, the minister disbanded the CHB, firing all but four of the existing CHB trustees, restructured its membership, and forged ahead with plans to merge health care institutional and organizational services. On October 4, 1995 the minister announced the appointments of the new chair and chief executive officer of the CHB. The positions of the three community development officers, and four other CHB staff were not renewed; two CHB staff were retained and one new staff member added. The four health planning groups representing the core municipalities of Victoria have been merged into one community health planning and advisory committee (CHPAC); health planning groups (B) and (C) have each formed their own CHPAC. Subsequent to the minister’s decision the members of health planning groups (A), (B), and (C) have asked the provincial Ombuds office to review the situation.

Not surprisingly, interviews with participants revealed that the most negative aspect of their involvement stemmed from what they felt to be government opposition to their efforts. This sentiment was evident despite the fact that interviews occurred one to two months before the final designation decision by the minister. Wearied by their perception that the ministry was changing the rules mid-stream, participants were left with a sense of powerlessness over the outcome. One participant remarked that this tendency left her with a "haunting feeling about the process—did it manipulate us to
come to where we are, or did we arrive where we are because we were remaining true to a community development process?" [07]

These implementation challenges contributed to the frustration that hinged on the participants’ sense of losing control over the process, creating a sense of futility about, and causing them to question the value of, their efforts.

*I think there is a certain cynicism, which I tend to feel myself occasionally, that we’re spinning our wheels. You’ve probably heard people at the meetings saying that. We’re going through all of this and doing a helluva lot of work, and is anybody going to take any notice? ... Is this just an exercise in futility? [03]
Table 4.1. A Profile of The Participants

<table>
<thead>
<tr>
<th>Status</th>
<th>Occupation</th>
<th>Personal Invite/Referral</th>
<th>Motivation</th>
<th>Perceived Benefits</th>
<th>Perceived Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair [01] Health Planning Group (A)</td>
<td>Registered Nurse</td>
<td>√ Colleague</td>
<td>Personal/professional commitment to see health promotion at the community level</td>
<td>Meeting others; learning about community structures and politics</td>
<td>Sense of frustration with plodding process; personal assault on involvement as a professional</td>
</tr>
<tr>
<td>Chair [06] Health Planning Group (B)</td>
<td>Air Traffic Controller</td>
<td>√ Friend</td>
<td>“My parents instilled in me a sense of giving back to the community”</td>
<td>Meeting others</td>
<td>Sense of frustration over government interference</td>
</tr>
<tr>
<td>Chair [09] Health Planning Group (C)</td>
<td>Former Ministry of health employee; currently on disability leave</td>
<td>√ Health organization</td>
<td>Personal interest in health (recovering from a car accident and depression), as well as an occupational interest in seeing Ministry better managed</td>
<td>Meeting others; learning new skills and about the community</td>
<td>Frustration with lack of health planning group control over outcomes</td>
</tr>
<tr>
<td>Active/regular member [03] Health Planning Group (A)</td>
<td>Retired physiotherapist</td>
<td>√ Former colleague</td>
<td>Personal and professional interest in health reform</td>
<td>Meeting others; learning about health care system</td>
<td>Frustration with plodding pace and government interference</td>
</tr>
<tr>
<td>Status</td>
<td>Occupation</td>
<td>Personal Invite/Referral</td>
<td>Motivation</td>
<td>Perceived Benefits</td>
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<tr>
<td>Active/regular member [04] Health Planning Group (A)</td>
<td>Consumer; “token mental health consumer”</td>
<td>√ Neighbourhood Association</td>
<td>To advocate on behalf of mental health</td>
<td>“I’m less scared, I feel safer.” Meeting others; learning about civil rights.</td>
<td>“Dealing with the system... it’s like getting put through hoops or something.”</td>
</tr>
<tr>
<td>Active/regular member [05] Health Planning Group (B)</td>
<td>Long-term care provider</td>
<td>√ Colleague</td>
<td>To represent interests of long-term care in health reform</td>
<td>nil</td>
<td>Government abrogating responsibility for health to community level</td>
</tr>
<tr>
<td>Active/regular member [07] Health Planning Group (B)</td>
<td>Consumer - physical disability; former Ministry of health employee</td>
<td>√ Mayor</td>
<td>“To ensure equity in community decision-making”</td>
<td>Meeting others; learning about the community</td>
<td>Feeling manipulated by government as it “changes the rules midstream”</td>
</tr>
<tr>
<td>Active/regular member [02] Health Planning Group (C)</td>
<td>Social worker</td>
<td>√ Chair of Health Planning Group (C) and supervisor</td>
<td>Professional duty and responsibility</td>
<td>Meeting others; sense of belonging</td>
<td>Time commitment</td>
</tr>
<tr>
<td>Active/regular member [08] Health Planning Group (C)</td>
<td>Retired Ph.D.; former coordinator of Healthy Community Project</td>
<td>√ Colleague</td>
<td>To facilitate community integration and coordination of services</td>
<td>Having ideas, work valued by group; sense of camaraderie</td>
<td>Frustration from bureaucratic roadblocks</td>
</tr>
<tr>
<td>Status</td>
<td>Occupation</td>
<td>Personal Invite/Referral</td>
<td>Motivation</td>
<td>Perceived Benefits</td>
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<tr>
<td>Former Participant [10] Health Planning Group (A)</td>
<td>Mental health professional</td>
<td>√ Colleague</td>
<td>To voice idea about consumer health information centre</td>
<td>Validation of her idea</td>
<td>Sense of futility with group’s power to affect change</td>
</tr>
<tr>
<td>Former Participant [12] Health Planning Group (B)</td>
<td>Volunteer - adult day care centre</td>
<td>√ Colleague at day care centre</td>
<td>To represent adult day care centre interests in health reform</td>
<td>Learning about health care system; value in volunteering</td>
<td>&quot;I didn’t see anything we did was worthwhile or useful&quot;</td>
</tr>
<tr>
<td>Former Participant [11] Health Planning Group (C)</td>
<td>Registered Nurse</td>
<td>√ Colleague and relative</td>
<td>Personal and academic interest in community health reform</td>
<td>Learning new skills</td>
<td>Feeling useless; not belonging to group</td>
</tr>
</tbody>
</table>
The Nonparticipants

Some of the suspicions that participants held regarding low participation rates were corroborated in discussions with nonparticipants. Most nonparticipants in the focus groups were only vaguely, if at all, familiar with “New Directions.” Members of the First Nations bands who participated in the focus groups, and the street and high school youth, did not have any knowledge of “New Directions.” Among the other groups, there was a mixture of awareness and ‘wariness.’

"I've heard something, but I don't really know too much about it [New Directions]. It seems to me, that, one minute they are talking about Closer to Home and the next they are talking about cutting back.

The information they had gleaned through the press and media was negative,

Occasionally, it gets stuck in the papers. It's [press about “New Directions”] the negative things. It's the cuts, what's wrong, not what we can do to create something better or not what is available. Just what's not going right.

The majority of nonparticipants defined health in a holistic sense. In all focus groups a broad vision of health was articulated, including pleas for alternative and health-promoting forms of health care:

One thing that I find frustrating is that you can go to a doctor all you want - and they are the most expensive - but what ever you need to maintain good health -- like physiotherapy -- is limited to twelve [visits] a year. There should be more emphasis on prevention and health maintenance instead of always fixing acute problems.
First Nations, in particular, viewed the determinants of their health in socio-political terms: "Our health issues are related to colonization—racism, mental, physical and social elements; health is a community responsibility." Nonparticipants also spoke of health in terms of control. As one of the single parents remarked,

*I may not be able to do something about my situation right now, but I can do something about my health, and that may make a difference about my situation. Just having that control to be able to do something for myself is really important.*

An individual with a mental illness echoed the importance of personal control: "*Health to me just means being balanced . . . it means not feeling scared.*" For persons with mental illness, their status in the system (as recipients of mental health services) often exacerbated this loss of control.

*What I don't like about the system is that there is no accountability built in. Accountability for when you, as a consumer, want access to your records, you want to have it without all the rigmarole. Without having a doctor to say you don't need to know that . . . the whole system doesn't have it [accountability]. You have no way of trying to ground the giver of care in some sort of [your own] reality.*

Persons with mental illness also spoke of the stigma attached to their mental health status: "*People still have that stigma for the mental health part of it . . . we see [the] stigma [of being mentally ill] in several places . . . mental illness doesn't automatically mean -- what is his name[Hannibal Lecter] -- in Silence of the Lambs!*".

For both the street and high school youth, good health was rooted in their sense of self. Lacking a valued sense of identity provoked risk behaviours and dependence on illicit, or licit, drugs.
I think that one reason why there is so much medication out there is because they are not really dealing with actual issues. I mean the issues are that as children we grew up feeling lost, sad, depressed because we didn't do well in school, we didn't have the money that all the other kids had. We grew up with less confidence in ourselves, and then people become depressed and then that's when they get on the medication.

There should be self-esteem workshops [at school] - ways of feeling better about yourself or people you can call and talk to. Like for alcohol problems and things like that there are lots of people you can call but there is not a phone line to deal with the effects low self-confidence and low self-esteem -- because that is what alcoholism and anorexia and all that stuff can stem from. But you have got to look at the root causes. I don't think a lot of people think of that as being healthy but it is a big part of feeling healthy.

Perhaps due to their experiences as recipients of social services, persons with a physical disability argued the need for an integrated and coordinated system.

The other thing that I think is a good idea and I think in some provinces that they do is have health centres where you don't have to be traipsing around from here to there to everywhere because I find that's the difficult part.

Despite this apparent view and understanding of health in broad terms, and the recognized need for integrated, coordinated and alternative health services, focus group members did not participate in the work of health planning groups or “New Directions.”

Through exploring health needs, focus group members recounted stories of their experiences in society. The single parents and youths referred to the medical community's disdainful treatment of them as patients ("they think we are so dumb"). The single parents, in particular, were frustrated by the lack of authority they had over their own health care decisions. "[Doctors] wouldn't give me a referral for massage because they didn't believe in it. [Therefore] I shouldn't believe in it. Why is it someone else's
choice? I made the decision and I want it followed through.” The stories from persons with physical disabilities, those with a mental illness and First Nations were particularly haunting.

It's [going to social services] a very demeaning experience. Sometimes they are incredibly mean. They opened up my kitchen cupboards and said, 'oh you have enough food for the week'. And away they went. It makes you feel like you are a beggar . . . I shouldn't say anything wrong because they are helping me financially, but I am scared to go there if I need any extra help.

Getting social services to help me is very, very hard. I have made about half a dozen calls and don't get them returned. What do you have to do to get the respect, to get the help that you need? I just find it [dealing with social services] very, very frustrating. This has been going on for months now. It is like talking to a wall. I feel like I'm not being heard, and this is a really big issue for me.

There is never an opportunity to voice our own concerns -- people think we just don't care -- we think we will be judged and criticized. We are taught not to have expectations, not to make trouble.

The street youth felt misunderstood and oppressed by fellow citizens and the government:

I sat for four hours down on Government [street]. I was reading my book and had my hat out and I got a quarter. Everyone else stepped over me. I really don't pan anymore. I don't need to ask people [for money] and get my self-esteem run down and get cursed at and sweared at. Sure, I put a hat out with a sign saying 'donations accepted'. And, then they [City of Victoria] put on programs to teach people how to say no to panhandlers.

When queried on ways in which nonparticipants might like to become involved in the health reform process, focus group respondents revealed their need to have health planning group members experience their world.

Come join us, walk with us. If you want a real insight into how we are, go put your grubbies clothes on, grab yourself a backpack and spend
maybe a day on the streets . . . it would give them [health planning group] a better idea of what we're going through to sit with us and pan one day and see how many people step over you and look at you and go Ugh. People don't understand how bad it is.

Somebody share with us. Give him [health council member] his $529.00 and say - OK, get out. Live for a month. Get out there and find out what you can have and what you can do. And also here's your symptoms and see what you can find out in the way of getting help for those. Get the minister of health down here and put him on one of the electro-shock couches and repeat treatment until he catches on. Flexibility. Accessibility. He'll get the message. He will probably start actively lobbying.

It has got to be more involved -- where they come and spend a bit of time. If they are in the position, if they are spending the money, if they want to be on that health board, then there should be a bit more commitment to it. They have got to experience it. They have got to be more experiential attitude when making their decisions. They should learn exactly what they are going to suggest spending or not spending money on . . . participation for them so they can see what is going on and at the same time consumers immediately there will be able to give some immediate feedback. Someone coming in and saying it to them, in front of the board, is [not] going to be the same thing. They don't really see what happens.

Survey them [health planning group members]. If they are making the decisions. Let them understand more about what they are doing. What their decisions [to fund] may take away or help.

Interaction during class time was particularly attractive to high school youths,

Have them [health council members] be in person [at the school]. It is the only way to do it. They can hear your opinions, and you can hear theirs. It is not like writing a letter that they are never going to read. Or they give you one back that they never even wrote. You are actually knowing that they [health planning group members] are hearing them [youths' ideas]. You have to make it interactive. You can't just have someone standing up there going blah, blah, blah.

The focus group participants also recommended a variety of ways in which participation could occur in the context of their everyday lives, opportunities that are
closer to home. "It needs to be visible. Point of purchase, promo people, health fairs, people to talk to." The opportunity to provide input, make decisions, and receive information should "seep in at you from different places, places where people go anyway... to get information for something else and there [information about "New Directions"] is". It should be available in places like day care centres, drugstores, grocery stores, at worksites, community centres and organizations and on public transportation, in addition to the newspaper, television, radio and existing organizations' bulletins and newsletters. For single parents,

*The drugstore would work for me. It's a common place. It's a place that everybody goes, and supermarkets - that's a reality for everyone it doesn't matter [who] they are.*

The creation of an ombudsperson or advocate office that could liaise between citizens and the health planning groups was recommended by persons with a physical disability.

*If there was some sort of central place where you could phone or talk to somebody. We have to have somebody - an advocate at a telephone number -- to get information. Somebody that you could write to but also telephone for issues that should be brought up at the [health] council. Somebody who will really return your call and acknowledge, answer [your request].*

Such an office could be accessed through a number of routes: electronic mail, faxes, a hot line, in-person visits or mail. It could validate citizens' concerns by the simple act of returning phone calls and providing feedback. Knowing that their ideas or input was at least attended, if not acted on, was very important to nonparticipants: one youth commented, "If it was something where you talked and
nothing ever came out of it, I wouldn't go back [to participate].” A single parent concurred on the significance of receiving feedback for her efforts: “Validation of my opinion is very important.”

Focus group members went on to advise how information could be communicated most effectively. “The general public who buy the newspaper do it on Friday. Friday -- the day the newspaper comes out with the TV guide -- that’s a good day for inserts. I know a lot of people who buy the newspaper on Friday.” The need for simple language and visual information was also emphasized:

*Translate this [“New Directions” materials] into everyday language. This information is too jargony. It’s too complicated. I’d probably use it to start a fire in the Big House. The more simple and visual the information is, the better.*
Table 4.2 Profile of Nonparticipants

<table>
<thead>
<tr>
<th>Group</th>
<th>Age Range</th>
<th>Occupation</th>
<th>Perception of Health/Health Issues</th>
<th>Comments re: Experiences in Society</th>
<th>Comments re: Preferred Ways to Participate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Youth (n=9)</td>
<td>15-25</td>
<td>some part-time, irregular restaurant work</td>
<td>&quot;energy&quot;; &quot;part of it's the surrounding environment&quot;; &quot;power of the mind&quot;</td>
<td>&quot;[People] are taught by their parents and everyone else that you're shit if you don't work and pay taxes&quot;</td>
<td>&quot;Come join us, walk with us... come spend a day on the streets with us&quot;</td>
</tr>
<tr>
<td>High-school Youth (n=6)</td>
<td>15-18</td>
<td>Part-time, irregular restaurant and retail work</td>
<td>Recognition that more than lifestyle behaviours affect health, especially self-esteem.</td>
<td>Youth spoke of their desire to be trusted and accorded the same rights as adults, as well as the difficulties they faced in feeling connected and included.</td>
<td>&quot;Have them be in person [at the school]... it's the only way to do it.&quot; &quot;Everybody will get involved if you get them out of class.&quot;</td>
</tr>
<tr>
<td>Single Parents (n=4)</td>
<td>25-54</td>
<td>Part-time, irregular and volunteer work</td>
<td>Recognition that control over one's life is crucial; system needs to emphasize prevention: &quot;[doctors] definitely practice medicine not healing.&quot;</td>
<td>Commented on the frustration of a lack of control over their health care decisions, as well as the disdainful manner in which they were treated.</td>
<td>&quot;One way to reach single parents is through day care centres, and at Zeller's store because almost everyone can afford the stuff at Zeller's&quot;</td>
</tr>
<tr>
<td>Group</td>
<td>Age Range</td>
<td>Occupation</td>
<td>Perception of Health/Health Issues</td>
<td>Comments re: Experiences in Society</td>
<td>Comments re: Preferred Ways to Participate</td>
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<tr>
<td>First Nations (n=17)</td>
<td>22-54</td>
<td>Some full and part-time employment on and off reserve</td>
<td>Holistic models of healing, with an emphasis on spiritual aspects and natural resources; poverty and racism implications for health need to be acknowledged.</td>
<td>Suspicious of government initiatives due to struggle with self-government and history of colonization.</td>
<td>Prefer gatherings held in their own communities conducted by Aboriginal facilitators, and attended by elders, giving voice to their unique identity, culture and needs.</td>
</tr>
<tr>
<td>Persons with a Physical Disability (n=6)</td>
<td>36-65</td>
<td>not employed</td>
<td>Preferences for alternative health services and health centres “where you don’t have to be traipsing around from here to there to everywhere”</td>
<td>Frustrations dealing with social and government services “Unless you are really well known, they won’t give you any respect.”</td>
<td>Emphasized accessibility: “It is not always easy getting to meetings, so if there is some way to communicate with the group” like “a crisis line”.</td>
</tr>
<tr>
<td>Persons with a mental illness (n=6)</td>
<td>27-52</td>
<td>not employed</td>
<td>Emphasis on wellness and control: “emphasize prevention instead of fixing acute problems.”</td>
<td></td>
<td>“If they are going to be in charge, make decisions, they have to experience it.”</td>
</tr>
</tbody>
</table>
Summary

This chapter has described the participants in the health planning groups (chairs, active and regular members, and former participants) and their experiences, as well as the nonparticipants' perspectives of participating in "New Directions." The participants were well equipped with skills, experiences and discretionary resources, which enabled them to participate in "New Directions." The majority worked (or volunteered) in the health field. Their motivation to participate was rooted in their perception of themselves as valuable contributors, and ratified by a personal invitation or referral to take part. Some sense of personal empowerment was achieved through the participation process as evidenced by the benefits participants spoke of obtaining. The primary structure for participation was evening meetings, although some public forums were held on weekend afternoons and weekday evenings. These structures demanded articulate, resourceful and self-assured individuals.

Most participants recognized the lack of broad-based public participation, but the reasons attributed to the low rates of participation differed. Participants provided suggestions toward reducing the barriers to participation, such as simplifying the language, reaching out into the community, and providing informal mechanisms for participating. Public apathy toward health, poor media coverage, and the barriers inherent in attending meetings were also cited by various participants as possible explanations. Nevertheless, the traditional evening meeting prevailed as the most common form of participation.
The negative aspects of the participants' experiences centred around their frustrations with group dynamics and sensing their efforts were futile. The participants' impressions occurred both on an individual level and on a collective basis, with similar consequences. Whether disenchanted by the chilly climate of health planning group (C), or disillusioned by the pretense of community control, not being valued (for their presence or contributions) jeopardized lasting citizen participation. While participants felt they had been promised control in the beginning, and certainly perceived themselves to have control over the decision-making authority, the final result smacked to many of tokenism. In the end, participants' perceived that, despite the advice and efforts of health planning group members, the government did what it deemed best.

In contrast to the views that some participants held of those who did not participate, nonparticipants were not apathetic. They spoke of a holistic understanding and caring of their health. They were, however, only vaguely, if at all, aware of “New Directions” and the work of the health planning groups. When asked about their health needs, the stories of their experiences as members of society emerged. While the experiences of each group varied, a common theme prevailed: feeling like a second class citizen. Each group spoke of their lives in terms of feeling alienated, stigmatized, or disrespected.

There was also a prevailing theme to the nonparticipants' preferred means of participating in “New Directions”: they extended an invitation to health planning group members to become involved in their world experiences and realities. Nonparticipants
defined participation as activity that would reflect, and be closer to, their daily lives. Nonparticipants also spoke of the need for health planning groups to communicate to the public in a variety of ways, in language that was understandable and inspiring, and in ways that were visible and easily accessible in their day to day existence. Finally, receiving feedback and validation of contributions was viewed as a significant criterion for sustaining participation.
CHAPTER 5

ANALYSIS -- BEING VALUED AS A CITIZEN

The purpose of utilizing the social marketing concepts of understanding the consumer perspective, exchange, marketing mix and segmentation was to tell the story of participation in health care reform from the community standpoint, in order to better understand why some people contribute time and energy while others do not, and to explore how the participation experience could be made more inclusive. Most significantly, adopting a marketing approach to making sense of the data dictated that the analyst "understand and empathize with" (Hastings and Haywood 1991, 137) the participants' and nonparticipants' needs and wants, and that the interpretation emanate from a consideration of their perspectives.

In short, the social marketing concepts provided a window for approaching the key issue underlying this study: if participation is such a good thing, why do not more people participate? Tackling this question requires approaching the data from different perspectives, so that one can ask: (1) Is participation the same thing for all people? (2) Are there different perceptions of what is positive or good about participation? (3) And, if so, do these differences reflect the differences between various groups in the community?

The first section of this chapter presents an analysis of the data as seen through the lenses understanding the consumer perspective and exchange. In order to understand how participants perceived their experience in "New Directions," and why they chose to
belong to the health planning groups, as well as why some individuals did not become involved in health reform, the author interpreted the data from the point of view of health planning and focus group members. Understanding the consumer perspective means emphasizing and presenting the experiences, feelings and needs of the participant and nonparticipant from their standpoint. This approach was particularly useful in interpreting the nonparticipants’ stories about their experiences with the social services system and as members of society generally. It meshed well with a constructivist approach to research, where the ‘findings’ become the creation of the inquiry process (Guba and Lincoln 1989). It also enabled an understanding of the nature of the transaction involved in participating. Rather than using the idea of exchange in purely economic terms, it is employed as a means of thinking through what it is that is exchanged in the participation encounter. That is, what is demanded of people in order to participate, and what do they seek to receive in return for their efforts? Exchanges are being made even if the benefits and costs are intangible and subtle (George and Compton 1990).

In the second section, more tactical social marketing concepts come into play when the participation experience is analyzed in terms of the notion of the marketing mix. The product is what “New Directions” has offered to the residents in the way of opportunities to participate in health reform. Analysis of the product also means asking what participation means to citizens, and what opportunities to participate should be offered. The place or position examines how the opportunity to participate is distributed to residents — where should participation occur? The price reflects the exchange transaction. It includes the citizens’ assessment of the importance and probability of
consequences (positive and negative) from their involvement. *Promotion* helps to explain the awareness and knowledge level of "New Directions" in the community, as well as how citizens were recruited to participate. Finally, the segmentation aspect of social marketing can be included under a fifth "P", the *purchaser* or for whom the offer is intended. Is the entire constituency treated as one group, or are different segments identified and approached according to their needs and interests?

The bulk of the data discussed in this chapter represent the experiences of the researcher (fieldnotes), interviews with participants and the focus group interviews. The street corner interviews yielded less volume and quality of data, and did not prove to be as useful a research tool as originally anticipated. It was difficult to capture the attention of shoppers or engage them in a dialogue about participating in "New Directions." The method and timing of data collection -- the researcher and her assistant approached shoppers outside a grocery store on a hot afternoon before a long weekend -- may have been the primary obstacle to achieving a rapport, and creating a discourse with the five shoppers interviewed. The methodology precluded an adequate collection of data, let alone understanding and representing the citizens' perspective of not participating in "New Directions." As a result, the data collected through street corner interviews were inferior to the observations and interview data, less amenable to analysis with the social marketing concepts and are not included in the presentation or discussion of the findings.
Section I  Why Some People Participate and Others Don't

In analyzing the experiences of participants empowerment emerged as a key concept. This was not surprising. The literature tells us that empowered individuals tend to participate in more community life (Schulz et al. 1995; Smith 1995; Chavis and Wandersman 1990), and that those experiences further enhance their sense of personal empowerment (Zimmerman and Rappaport 1989). Another concept that surfaced in the analysis of the participants’ and nonparticipants’ narratives was the importance of notions of citizenship -- the equality of status, respect and rights theoretically accorded constituents that enables them to participate, and the attendant responsibility to do so. In particular, support for the postliberal view of citizenship emerged suggesting that the entitlements of citizenship must precede its obligations, and an absence of full citizenship renders participation unlikely. The following analysis demonstrates how the words of both participants and nonparticipants inform, support and extend our understanding of these concepts and their relationship to participation.
Participation: Only the Empowered Participate

To a great extent the membership (and work) of the health planning groups mirrored the findings of the citizen participation literature. Previous experience has found that citizens involved in health promotion, health governance, and other public administration and planning initiatives, are not typical of the community at large; such experiences have been found to be more common to health professionals and suburban residents with above average incomes (Sullivan and Scattolon 1995; Sancar 1993; Henderson 1990; Piette 1990). In this case study, most health planning group members, if not active or retired health or health-related professionals, volunteers or providers, possessed the discretionary financial and personal resources necessary to attend evening meetings and weekend forums, and to devote a large amount of time and effort to the process. Participating in their ‘leisure time,’ confirmed Bracht and Tspoors’ (1990) observation that citizen participation endeavours attract only ‘professional’ volunteers. These findings are compatible with the bulk of other citizen participation research: participants were well educated, well spoken and well off (Lomas and Veenstra 1995; Beatley et al. 1994). The data also support Young’s (1989) contention that the universal nature of citizenship “makes homogeneity a requirement of public participation” (257).

As with experiences documented in the literature, involvement was attractive to the participants because, to some degree, it served their needs and interests (Kelly and Van Vlaenderen 1996), including those of the researcher. “Let’s face it. I’m here to protect the interests of the hospice. We’re all here to look after our own turf,” admitted
one health planning group member. Analogous to participation experiences in Healthy Cities (Mhatre and Deber 1992), Healthy Communities (Wharf Higgins 1992), and other municipalities implementing "New Directions" (Communities Putting New Directions Into Action, 1993) those with 'concentrated interests' -- the professionals and providers -- were more involved than those with 'diffuse interests' -- the general public. The motivation to participate reported by health planning group members was also reminiscent of the volunteer literature: participants were responding to a desire to support a cause, accomplish something, or give something back to the community (Rice 1990).

The large numbers of participants who received a personal invitation or referral to join a health planning group confirms the potency of such a recruitment strategy as recommended in the marketing literature: 'personal selling' is thought to be one of the more persuasive forms of facilitating action (Andreasen 1995). In a survey of volunteers in the United States, the majority of adult and youth volunteers became aware of the opportunity when asked to volunteer for it; a mere six percent responded to a recruitment advertisement (Lovelock and Weinberg 1989). Certainly most of participants in "New Directions," and all of those who were interviewed, were not motivated to attend health planning group meeting solely, if at all, by a newspaper advertisement, but were influenced by the extension of a personal invitation.

In addition to the relevance of socioeconomic status, the findings also confirm the importance that an individual's perceived control (Chavis and Wandersman 1990) and
confidence in their ability to make a difference (Chrislip 1995; Littrell and Hobbs 1989) plays in the decision to participate. Empowerment expresses itself “at the level of feelings, at the level of ideas about self-worth, at the level of being able to make a difference in the world around us” (Rappaport 1985, 17). These ideas were explicitly addressed by some participants. In addition to their wealth of experience and skills, participants enrolled in the health planning groups with a sense of confidence about their ability to contribute:

\begin{quote}
\textit{It's not just the interest in the field [that motivates people to participate], but how much personal power a person feels they have in terms of making a change and making a difference.} [01]
\end{quote}

Other reasons cited for involvement implied aspects of citizenship. When asked to sum up her thoughts on why she became involved, one participant remarked, “\textit{I think it has got a lot to do with human rights -- health and human rights.}” [04]. This individual had experienced years of living in mental health institutions and was struggling to become an advocate for others in the same plight. Dubbing herself the “\textit{token mental health consumer}” of health planning group (A), she felt that participation was one way in which she could exercise her political rights in order to advocate for social and civil rights. Similarly, a participant in health planning group (B) who had experienced and witnessed the powerlessness of health care consumers became involved to try to bring some equity to the decision-making process.

\begin{quote}
\textit{It is crucial that people with disabilities are involved because for too many years able-bodied people having been making the decisions about health . . . Once you go through those doors at extended care, your rights go out the window.} [07]
\end{quote}
Despite their consumer status indeed because of it — these two participants felt that they could make a contribution to the work of health planning groups: "just through life experience I think I'm valuable" [04].

For some others a sense of community both motivated them to join in the first place ("my parents instilled in me a sense of community" [06]), and became part of the benefits reaped ("... and that's something else I've got out of this is a sense of belonging and sense of community" [02]). Their experiences were empowering in other aspects as well. They spoke of learning new skills ("I have done things in the last year and a half that I never could of imagined doing... like facilitating workshops" [09]), acquiring knowledge, and gaining insight from their experiences with the health planning groups. Former participants also acknowledged that their brief alliance had some beneficial aspects. One former participant noted that she learned valuable skills such as facilitation skills ". . . and you can draw from that experience without going to a workshop itself for that." [11]

Overwhelmingly, participants mentioned the benefit of meeting others ("I've met a lot of nice people" [03]) and sharing with them a vision for better health, denoting a sense of belonging and enjoyment gained from the personal relationships among participants. "I think it [participating in the health planning group] utilizes a lot of my background. It's nice to be able to use all of that and find I'm in a group that appreciates my being part of the group."[08] Previous research has identified the benefits of belonging, and self-esteem as important to volunteer acts (George and Compton 1990), as
well as indicating that such solidary benefits serve to sustain the participatory act (Norton, Wandersman and Goldman 1993; Prestby et al. 1990). As well, the data provided by the participants support the contention that communion and connection, in addition to a sense of mastery and control, are integral components of personal empowerment (Riger 1993). Here, the data corroborate the literature: empowerment functioned as both an antecedent to, and consequence of, participation. The empowered got more empowered.

Powerlessness, Marginalization and A Loss of Citizenship

It is the poor, adolescents and women -- as well as individuals seen as different from the majority because of ethnicity or physical impairment -- who are the politically and socially marginalized, the second class citizens of Canadian society (Brown 1994; McCarron, Tenenbein and Hindley 1994; Wharf 1992). The marginalized are those who suffer injustice and inequality (Kirby and McKenna 1989); those who may be unemployed, who have little control over their lives, or who are stereotyped at the same time that their experience and situation is invisible in society (Young 1989). Health planning group members explicitly referred to the homeless, broken families, teenage parents, the disabled and ethnic persons as the “marginalized groups in the community”, both at their meetings and in documents (Communities Putting New Directions Into Action, 1993).
While the narratives of health planning group members reflected experiences of personal empowerment and active citizenship, the nonparticipants told decidedly different stories. Rappaport (1985) suggests that empowerment is difficult to define but easy to recognize, and more easily understood in its absence (Jones and Meleis 1993; Wallerstein 1992). Lack of empowerment is expressed through powerlessness, alienation, and loss of a sense of control over one’s life, concepts evident in the voices of nonparticipants. The First Nations groups spoke of their long history of colonization, their struggle for self-governance, and their subsequent mistrust of the government:

*We've been hurting now for 150 years. They [government] haven't followed through with any of their promises. I'm very leery of anytime we're offered something and wonder what they'll [government] take.*

For some, this meant feeling abandoned and alone; as one street youth remarked, "*We don't have nobody telling us it is going to be okay.*" One individual with a mental illness commented: "*You go through life where there are times you feel that you've lost control and you don't know why.***

"*Democracy implies equality, but when it is superimposed on an unequal society, it allows some people to count for more than others*" (Phillips 1995, 289). Going beyond the powerlessness reflected in their words was another dimension: these individuals did not feel equal as citizens. They felt in some way mistreated by, disenfranchised from, and forsaken by society. While the literature is replete with discussions of the gendered and cultured nature of discrimination and poverty, the underlying theme emerging from these data describes a lack of citizenship, in spite of gender or race, that defined focus group
member experiences. Male, female, Caucasian and aboriginal nonparticipants alike echoed a desire to be valued as citizens.

Respect, Walzer (1983) argues, is a crucial component of equality as a citizen and one missing from the lives of focus group members. "We need to be approached as First Nations governments and to be treated with respect." Respecting others, according to Goodin and Wilenski (1984), means not depriving people of their self-respect. "Primary among [the impediments to self-respect] are things like poverty, joblessness, and the denial of human rights" (Goodin and Wilenski 1984, 515).

The loss of citizenship was reflected in the stories of nonparticipants. Indeed, focus group members' accounts of the treatment they had received from government services and society generally chronicle consistent disrespect, and suggest they are being recast from citizens to recipients of services (Hoatson, Dixon and Sloman 1996): "At Social Services I feel like I am begging" commented an individual with a mental illness. Similarly, a person with a physical disability, in describing his frustrations with social services, pleaded "What do you have to do to get the respect, to get the help that you need?". To deny the users of public services the feelings of being respected and valued, as a result of their encounter with the service, is to diminish their status as citizens:

Citizenship, as well as being a principle which should underpin the organisation and management of public services, should be viewed as a desired outcome of quality services: public services should be delivered in a way which promotes citizenship by encouraging and enabling people to feel and act like full citizens. This means, as well as services responding to individuals in ways that enhance self-esteem, that services should be delivered in a way that treats individuals as responsible persons and encourages individuals to take control over their own lives
(with appropriate support where necessary). (Prior, Stewart and Walsh 1995, 151).

Yet, evidence in the literature about government provided services suggests otherwise. McKnight (1992) goes as far to say that such services “... tend to be pathways out of community and into the exclusion of serviced life” (62). Many of the services designed to enhance life for disadvantaged individuals have unintended iatrogenic effects (Rappaport 1985), including dehumanization, oppression (Merzel 1991), and humiliation (Sen 1994) -- in effect, harming the people they are supposed to help. Lord and his colleagues (1994;1993), Younis (1995), and Culpitt (1992) discuss the consequences of prolonged dependency on social service systems, including low self-esteem and limited practice in decision-making. The role of “expert” adopted by service agency workers and bureaucrats reinforces this minimization of citizenship. Taking decision-making away from citizens and putting it in the hands of professionals who tend to slot people into client categories, “robs citizens of their democratic standing in relation to the bureaucrat and the state” (Brown 1994, 890).

The institutions and professional practices created to “care for strangers” have all too often achieved special kinds of estrangement between themselves and their clients, the estrangement of stigma, of arbitrary power, of patronizing expertise and of dependency (Roche 1987, 377).

Further, Pateman (1988) argues that employment has become the key to citizenship: good citizens support themselves and their families. “Self-supporting” means that an individual is a citizen of equal worth to, and deserving of respect from, other employed citizens. In Mead’s (1986) view, employed persons have met the social
expectations of citizenship. Linking the right to work with the rights of citizenship creates a context in which economically dependent persons are restricted in their access to the rights of citizenship, in turn, limiting their claims to work and to assistance (Marston and Staeheli 1994). Citizenship then no longer reflects one’s political and social status, but one’s economic standing in the marketplace (Kymlica and Norman 1994). Ignatieff (1989) has commented on this vicious circle,

> Without property, a citizen cannot be independent; without the income of property, an individual will not have the leisure necessary to be a good citizen. Without property, the citizen is passive, a ward of the state, a dependent on the benefit cheque, [and] social services (34).

Those excluded from the market are denied citizenship value (Gorham 1995). The street youth were well aware of their status: "people are taught that you're shit if you don't work and pay taxes." Some nonparticipants, particularly those with a physical disability or mental illness, and to a lesser extent the single parents and street youth members, were unable to be self-supporting, and depended on government social or human services for survival. Yet the very act of depending on welfare and social services can be stigmatizing in and of itself, despite the legal right of citizens to receive such benefits without any loss of status (Moon 1988; Mishra 1977):

> It's [going to social services] a very demeaning experience. They ask you 'well, why are you here?' I had enough problems on my plate at the time to have to go through that as well. It is scary just to ask for help.

Stigma not only stemmed from receiving government services, but from the personal attributes as well: "We still see the stigma of mental illness all
over the place.” In 1964 Goffman, writing on the management of spoiled identity, noted that:

The stigmatized individual tends to hold the same beliefs about identity that we do; this is a pivotal fact. His deepest feelings about what he is may be his sense of being a “normal person”, a human being like anyone else, a person, therefore, who deserves a fair chance and a fair break. Yet he may perceive, usually quite correctly, that whatever others profess, they do not really “accept” him and are not ready to make contact with him on “equal grounds”. . . The central feature of the stigmatized individual's situation in life . . . is a question of what is often, if vaguely, called “acceptance” (Goffman 1964, 7-8).

People feel stigmatized when they perceive themselves as unequal, unaccepted and unimportant as human beings in society (Rappaport 1985).

For the high school youth, the sense of alienation and loss of control stemmed not from their use of social services, but from their perception of disrespectful and unequal treatment from, and lack of freedom in, adult society: “Society is totally not fair. How many times have you been down at the beach, doing absolutely nothing wrong and had police officers come up to you and ask you to leave -- for no reason?”. Again, this is reflective of other work describing youth. In a series of youth forums on recreation and wellbeing (“SCY Youth Forums on the Recreation Needs of Youth” 1996; Rutman 1995), youth across British Columbia spoke of their desire to be trusted and accorded the same rights as adults, as well as the difficulties they faced in feeling connected and included. The youths felt discriminated against by adults and police, and alienated from the community.
As such, the marginalized person -- the second class citizen -- has received an "undeserved exile" from society (Moon 1988; Pateman 1988). The irony is that receiving services from the very institutions established to help these individuals erodes their confidence and confirms their sense of stigma. Relying on social services that, as citizens, they have the legitimate civil and political right to access ("a socialized system is supposed to help everybody" commented a street youth), erodes personal dignity and independent living skills (Bryson 1992). As such, it is disempowering (Gorham 1995). At the same time that the disadvantaged access their rights they are, de facto, not recognized as equal. Yet recognition of equality is basic to democracy and to participation in that democracy. While, in theory, all citizens are created equal, some are more equal than others (Brown 1989), generating two classes of citizenship (Gorham 1995).

Just as a sense of community is a dimension of both empowerment and citizenship, its absence is suggestive of powerlessness and nonparticipation. Citizens must feel they are part of the community before they will be willing to participate (Smith 1995). Cousineau (1993) suggests that

It is an essential condition of any well-functioning community that its members sense that they belong. As a community, we should be prepared to do what we can to ensure that our institutions encourage the sentiment of being a valued member of the collectivity (150).

Individuals derive a sense of belonging or not belonging from the actions of the state or of the citizens around them. When people feel that they belong or do not belong in a collectivity, it is because the larger group has done something to engender the sentiment: "Somehow [the health system needs to be] set up so that the consumer has
some tool. Because as it is set up right now, the consumer has no tool. That is why I really felt disenfranchised -- very much on the outside." Lacking a sense of belonging breeds feelings of disconnection and alienation, and is disempowering (McCarron, Tenenbein and Hindley 1994). The importance of connectedness and belonging was not lost on focus group members, nor was the importance of actions by the larger group to foster interest and respect:

*I think that what is fundamental to humans is we live in communities. You have to promote that sense of community in everything. If you start doing that in some way -- by having the leaders - as that is who the community health board is in a sense -- they are looked at as leaders of your community health program -- come and look to see what is going on [in mental health], you get this feeling they are not a faceless board.*

As well, the idea of community was more than just a sense of belonging, but as Berry, Portney and Thomson (1993) eluded, “a wellspring of democratic values”(6). Continued the same focus group member,

*Perhaps more people will start saying, ‘Perhaps I would like to be on that board’ or ‘I am interested in [doing] this’. [Focus group member]*

Exploring participation in a South African community health project from the participants’ point of view, Kelly and Van Vlaenderen’s (1996) were led to “believe that the nature of participation is strongly determined by existing relations within the society and these are interpolated into participatory processes within projects” (1243). Young (1989) concurs, noting that “people necessarily and properly consider public issues in terms influenced by their situated experience and perception of social relations” (257). These statements substantiate Moe’s (1980) assertion that a person’s perception of their ability to make a difference is influenced by dimensions beyond and
prior to the actual membership decision. Thus, if focus group members perceived
themselves to be less than equal to other citizens, as a result of their experiences in
society, they may have correctly anticipated that similar circumstances would occur
within the health planning group structure. (This assessment of the participation
experience is also discussed in the second section under "Price".)

Rights or Responsibilities?

It might be argued that the experiences of nonparticipants appear to support the
conservative view of citizenship: the social safety net of entitlements has created a
culture of dependency and passive citizenship. The conservatives' hold that a welfare
policy must "include recipients in the common obligations of citizens rather than exclude
them [because] to obligate the dependent as others are obligated is essential to equality,
not opposed to it" (Mead 1986, 12-13). Were focus group members 'free riders'
(Coleman 1987) benefiting from, and relying on, the contributions of other citizens? The
absence of equality and empowerment in the lives of focus group members, therefore,
might be accounted for by their lack of involvement in community activities and
fulfillment of their obligations to the state. Yet, if all members of society are extended
equal citizenship rights, including the obligation to participate, why has this not led to
social justice and equality?

A closer look at the experiences of nonparticipants provides a stronger
confirmation of the social democratic (and feminist) thoughts on citizenship. If
participation is both a virtue and an obligation of citizenship, then provision must be made that permits everyone to become involved (Fierlbeck 1991). The obligation falls to the government to provide every member with an equal opportunity to participate in citizenship by providing a core of social rights.

These [rights] should protect citizens from the homelessness, poverty, bad housing, unemployment, physical and mental disability and ill health which prevent citizens from participating in society (Oliver 1991, 170).

Yet, while possessing such formal rights and entitlements focus group members found them relatively meaningless when unable to act on them in practice. The rights they were guaranteed did not prevent them from being homeless, unemployed, poor, or physically or mentally disabled. These impediments to self-respect “clearly, are the conditions which it is within government’s power to alter” (Goodin and Wilenski 1984, 515). As a result focus group members’ experience of citizenship was undermined, deepening their sense of exclusion. Focus group members may not have contributed to “New Directions,” but neither did they benefit from the provision of health services as a public good to the same extent as their more advantaged, respected and empowered neighbours.

Furthermore, if, as an obligation of citizenship, participation is contributing skills and resources for the greater good, why would the marginalized be expected to be involved? These data support the notion that active citizenship can only be expected of people after their rights to participate are secured and realized (Prior, Stewart and Walsh 1995; Kymlicka and Norman 1994; Oliver 1991).
In contrast, the participants -- self-supporting, respected members in the community -- enjoyed the formal and the substantive status of citizenship, in addition to the education, skills and experience that made them confident of their ability to make a difference. The two exceptions, 04 and 07 (who are mentally ill and physically disabled, respectively) despite being unemployed recipients of services, certainly viewed themselves as valuable and contributing members: "I have a valid perspective of what's being needed." [07]

The sense of belonging and being able to effectively contribute -- at the individual or group level -- was missing for those individuals who dropped out of the health planning groups. "It was like it was their group and I was just visiting." [11] "I didn't see anything that we did was worthwhile or useful." [12] Thus, if we accept that these individuals enjoyed full citizenship (two were employed and the third was a wealthy, active volunteer in the community) and were sufficiently confident to participate at least once, the absence of communion and a sense of contribution at the group level precluded their ongoing involvement.

One dimension of citizenship -- being respected as an equal -- also lends itself to understanding the costs of participant involvement. The inventory of costs in the participation literature range from personal costs of time, effort, and relinquishing other
obligations, to those associated with group and democratic processes -- personality conflicts, sluggish progress, and disagreement over goals (Prestby et al. 1990; Littrell and Hobbs 1989). These costs were evident in the experiences of participants. Yet a more profound and potent price also took its toll on many health planning group members: a loss of social worth and respect. For some, this loss stemmed from a personal assault on their contribution to the work of the group as an equal and respected member. One health planning group member recalled such an assault on her personal value as a professional:

"the times that I felt the most 'oh I just want to quit this . . . what am I doing here?' weren't the times the process just seemed to be going on and on, it was the times when people were actively confronting me in a very negative way saying 'health care professionals are out to make their money -- why do we want to survey health care professionals or why do we care about what they think; we're out to make the health of the community better -- they don't know anything about it, they don't want to deal with it . . . they're just out there to make their money and after all it's in their best interest to keep us ill' -- that sort of stuff. And, I just thought, 'I don't need this' [01]

For the majority of health planning group members, however, the most significant cost to their involvement was the erosion of their sense of value as an equal and respected participant in the process of health reform. This loss came at the hands of the minister of health and his staff, in what was perceived as a belittling and premeditated dismissal of the participants' efforts: "The government has carefully orchestrated us to be herded. I feel that we have been blindsided." During the two years that participants worked to implement "New Directions," subtle and seemingly inconspicuous actions by the provincial government began to add up to what participants felt was a conspiracy against their work. At the heart of the participants' uneasiness with their relationship to the
ministry of health was the designation of community health councils in the CRD and the fate of the health planning groups. Despite applications for six community health council designations in the region, the minister designated only one, the group that had been negotiating for self-governance prior to the birth of "New Directions." The remaining six health planning groups were restructured into three community health planning and advisory committees, with no legal authority for decision-making. In addition, the minister ordered the CHB management and governance structure revamped, its membership replaced, and its mandate revised. In short, the participants' perceived the ministry to disavow two years of work, and with it their committed beliefs.

The "New Directions" experience in the CRD has been different from that in other parts of the province, due in part to the CRD's history with the Victoria Health Project (the predecessor to the CHB) and, possibly to the provincial government's physical presence in the region. The latter distinction was important for participants. Bardach (1977) suggests that social policy implementation frequently takes the form of 'games' -- strategies administrators employ to defer, deflect or dispel policies in an attempt to protect their interests and assert control. His notion of a 'fixer' suggests that preferred outcomes can be covertly, and often coercively, manipulated. Brown's (1994) account of the savvy of municipal and provincial bureaucrats to redirect resources for AIDS in Vancouver underscores the power bureaucrats have to redress policy. Health planning group members accused local ministry bureaucrats of playing the implementation game, changing rules mid-stream, and manipulating the process to rig the outcome of community health council designation.

One of the things that worries me a little bit is that I think the ministry of health have got a stake in this -- the people who are working there may
lose their jobs if they're going to be [decentralizing] and transferring [to other regions of the province]. They'll be pretty reluctant to give up their little bailiwicks. [03]

Participants felt that the bureaucrats were protecting their own self-interests: decentralized decision-making in the CRD would require fewer civil servants in Victoria. Were ministry staff reluctant to embrace the change that “New Directions” would involve for administration at the provincial level? The consequence of increased public participation is a decrease in government authority. Did the minister not want to diminish his own authority by sharing it with others? Or, was his decision to retain regionalized health governance simply good public administration? Participants may have forgotten that in a democracy citizens frequently must accept political decisions that do not serve their direct interests (Prior, Stewart and Walsh 1995).

Organizational Powerlessness

The participants’ inability to make a difference in how health services were managed and delivered in their community also influenced empowerment at the health planning group level. In addition to personal empowerment, the construct is also thought to function at the organizational and community level (Labonté 1989). Organizational empowerment is characterized by providing opportunities for individual growth, the pursuit of mutually defined goals, and access to shared decision-making processes, as well as influencing the policies and decisions in the community that would redistribute power and resources (Israel et al. 1994; Wallerstein 1992). Organizational and
Community empowerment may arise from participation in voluntary groups, but only when participants have actual control and not merely perceived control -- to make decisions and effect change.

In the CRD, participation in health planning groups appeared to demand a sense of identification with the community as a valued member. Participants certainly viewed themselves as such. Participants also shared common goals, strategies and decision-making authority within the group, and perceived themselves to have both the individual and collective competency to establish five community health councils in the region. Yet to be truly empowered organizations, the health planning groups needed more than to be populated with efficacious members; they had to be successful in their bids for change. One indicator of successful participation is an outcome that reflects a shared vision and ownership of that vision (Freeman et al. 1996). “People must be able to see themselves in the governing process if they are to feel connected ... [government] must reflect [the] voices in the community” (Chrislip 1995, 22). The participants’ vision of the future of health delivery was not shared by the ministry of health. By dismissing the recommendations of health planning group and CHB members, participants perceived the ministry to challenge their notion as equal citizens and threatened their ongoing involvement.

It is difficult for ordinary citizens to know in any objective sense who won and who lost in most public policy matters. However, their perception of who won and lost affects their sense of whether government is fair and open to all . . . Moreover, such perceptions affect individuals’ calculus as to whether or not it is worth their while to become involved. (Berry, Portney and Thomson 1993, 102).
Following the minister's decision to deny community health council designation to five of the health planning groups, participants were calculating the price of their involvement. As well, it influenced participants' sense of whether government was fair and open to all. As one participant from health planning group (C) remarked, "What trust do I have in the system now? I don't know if I can continue working on [health reform] under these circumstances." Thus, while most participants individually emerged from the health reform experience feeling empowered at the individual level, collectively their ability to influence the implementation decisions of "New Directions" in the CRD was negligible.

Participation in "New Directions," when viewed from the health planning group perspective can be labeled as tokenistic (Arnstein 1969). Citizens provided their input but their advice was not heeded; the depth of participation (Berry, Portney and Thomson 1993) was found to be shallow indeed. In Charles and Demaio's (1993) terms, participation was consultative only. Without the redistribution of decision-making power and resources participation proved to be a frustrating process (Younis 1995; Arnstein 1969). As O'Neill (1992) has documented with respect to the Quebec experience with health care boards, community participation in health reform does not guarantee community empowerment.

While the rhetoric of citizen participation in "New Directions" created the illusion of democracy (Woelk 1992), the potential cost of sharing the decision-making power may
have outweighed the benefit of community input for ministry bureaucrats and undermined the authority of health planning groups.

Government officials rarely have to confront the dilemma of whether they should give up their own power in the name of good government . . . administrators can undermine citizen participation programs if they are not committed to them (Berry, Portney and Thomson 1993, 212).

Did the government truly understand the consequences -- the benefits and the costs -- of using citizen groups in health reform? The benefits of government promoting a responsible and active citizenry have been identified in the literature to include enhanced popular support for government and its services, greater acceptance and easier implementation of policy (Prior, Stewart and Walsh 1995). It is more likely that the ministry underestimated the costs: the need for fundamental changes to the system and practice of government that translate formal rights into substantive ones, and that significantly alter the nature and distribution of power. Did “New Directions” just pay lip service to the virtues of citizen participation? As previous accounts in the literature suggest, the vogue for community participation has been driven not by an empowerment or democratic agenda, but rather by a managerial one (Lupton, Buckland and Moon 1995). Progress toward full participation in public health (Levin, 1995; Hunt 1990), health reform (Charles and Demaio 1993), tenant housing management (Peterman 1996) and public administration (Tulloss, 1995; Younis 1995) has been plagued by governmental and official resistance (Prior, Stewart and Walsh 1995) where opportunities for participation have precluded citizens from making decisions and shaping policy about the present and planning for the future (Peterman 1996; Crosby, Kelly and Schaefer 1986).
However, there is hope that the ideals of participation can be realized. The recent British Columbia Commission on Resources and Environment (CORE) demonstrated that a shared decision-making process can enhance the value and utility of public participation in the eyes of government:

Through the process, the government officials gained a respect for the volunteer efforts and wisdom of the different perspectives brought to the process by members of the public, and came to appreciate the value of public participation as an empowering force for the government as opposed to a threat to their authority (Owen 1995, 23).

Another example in the literature is the “Citizens First!” movement in Florida, where government acts as a partner with citizens “... giving back to the people a sense of ownership and responsibility” (Chapin and Denhardt 1995, 213).

**Public-Spirited Active Citizenship?**

Conversely, it might be argued that participants were inexperienced in the arena of provincial public policy and administration. Was “New Directions” simply “... an invitation for the ignorant and irresponsible to muck around in government? Are average citizens really capable of governing themselves in a wise and conscientious manner?” (Berry, Portney and Thomson 1993, 196-197). Health planning group counsel recommending the number of local governance structures may have simply been poor advice in the broader context of provincial health services. Was it reasonable to assume that the government would designate six community health councils in a region that had a successful history of delivering health services on a regionalized basis? Would the public...
want to reduce the role of competent, nonpartisan trained health policy makers so that their neighbours could have a say? Is not the minister of health, elected by the whole population, in a better position to make the health decisions for the whole province?

Indeed, one of the objectives of “New Directions” was to establish equitable service delivery and achieve uniform health status for all British Columbians. The idea of a local health governance authority was initially conceived to ensure rural districts had more accessible and responsive health systems. Community health council structures are less suited for core urban areas. As well, residents of the CRD consistently rank among the healthiest in the province. Were health planning group members motivated primarily by a desire to serve their own local interests and get the best deal possible for themselves, thereby forsaking a more effective, efficient solution for the greater good? Active citizenship requires individual contribution in the public spirit toward the common good, so one may question whether health planning group members were, in fact, truly fulfilling the obligations of citizenship.

Some members of health planning groups (B) and (C) even failed to see the need for each other’s respective bids for community health councils, and, together with group (D), lambasted the three groups representing the urban core. How could they possibly rationalize the designation of three community health councils in such a small geographical area? The decision of health planning group (D) -- the community with the largest population and most central access to health services -- to remain advisory to the CHB was also viewed as suspect by groups (A), (B) and (C). “It’s [the decision of health
planning group (D) to be the only community to not apply for designation] *all about local politics gone mad and it will blow 'Closer to Home' to hell in a hand basket'* remarked one member of group (B). The experience in the CRD is similar to other participation initiatives: local groups tend to promote the interests of their own community as a top priority (Berry, Portney and Thomson 1993).

In spite of the lack of regional consensus on the issue of governance structures, all health planning groups agreed in principle to respect the others’ decisions based on the criterion that community health councils would neither increase overall administrative costs nor add another level of bureaucracy. Was this naive thinking? Some participants had at least a superficial knowledge of social policy and policy implementation. The CHB, staffed and governed by educated and experienced citizens, assisted the health planning groups in organizing, writing and submitting the designation documents. Was it a case of groupthink or merely a set of misguided but well meaning intentions?

The participants' felt the government, in denying their applications for designation, had not been responsive to their interests or efforts. Yet responsiveness is not simply giving people what they want *carte blanche*, but balancing the trade-offs between differing interests to accommodate the needs of the wider community (Berry, Portney and Thomson 1993). The minister of health, in upholding the trustee model of representation, valued the promotion and protection of the broader and uninvolved interests of his provincial constituency to a greater extent than responding to the opinions represented by health planning groups (Beatley, Brower and Lucy 1994).
In the end, the accountability for the health planning groups' decisions ultimately fell into the lap of the minister of health and his staff. Health planning group members were neither directly elected from the populace nor appointed by the ministry. Until the municipal elections occurred, scheduled for the fall of 1996, participants would be held virtually unanswerable for their decisions that would affect the health services in their communities and, in turn, province-wide. The minister, on the other hand, was accountable to both the electorate and the premier. How much authority should be given to citizens and how much should be retained by government officials? This fuels the debate about the desirability and practicality of participatory democracy, and what issues should be left in the hands of representative democracy.

Summary

This section has suggested that the concepts of citizenship and empowerment are useful in explaining why some individuals engaged in the work of the health planning groups and others did not. The sense of full citizenship -- enjoying the formal status and substantive effects of civil, political and social rights as an equal member of the community -- distinguished participants from nonparticipants. The concepts of citizenship and empowerment were also useful in understanding the decisions of some people to no longer participate in the health planning groups and the feelings of those who remained as the groups failed to effect change.
Empowerment is a complex, multi-level construct said to be both a process and an outcome. Indeed, the immensity of the concept and the ambiguity surrounding it are “a major stumbling block for the field” of health promotion (Rissel 1994, 39). Viewing the decision to participate in terms of citizenship rights and responsibilities, rather than solely in terms personal empowerment or sense of community, adds a new perspective to understanding citizen participation. Orthodox citizenship holds that everyone is entitled to equal and unassailable rights: rights which nonparticipants perceived to be withheld or violated. Nonparticipants’ powerlessness was rooted in their fragmented sense of citizenship which left them unable to fulfill their obligations to society and participate in its decision-making. As the voices of the nonparticipants chronicle, despite its ideology of inclusion and unifying function, in practice “citizenship, like another favourite, community, shuts people out as much as it welcomes them in” (Rees 1995, 361).

It appears that the benefits sought in exchange for participating in community life are respect, a sense of belonging, a sense of accomplishment, and most significantly, a sense of full citizenship. These benefits were not present for focus group members within the existing format of health planning group meetings, and were perceived by participants to be taken from them subsequent to the denial of community health council designation. Participation in community organizations requires, at a minimum threshold, a sense of full citizenship, of being accorded the rights that define one’s equal status in, and relationship to, the state. This perception enables one to participate in community life, with the potential to experience aspects of personal empowerment such as mastery, control and a sense of community.
Being valued as an equal citizen -- and being able to act on it -- not only has the potential to mobilize participation among the marginalized constituency, it also serves to sustain involvement for health planning group members. The obligations of the state to the citizen go beyond provision of entitlements to include respecting and responding to the collective contributions, needs and aspirations of the citizenry.

Yet how does being valued as a citizen -- or a full sense of citizenship -- account for the remainder of CRD constituents who did not participate, but neither represented the disadvantaged or marginalized groups? If rights are a prerequisite for responsibility, why did not the majority of residents fulfill their obligations of citizenship? Social marketers might speculate that these individuals possessed internal efficacy -- a belief in themselves that they could successfully contribute to the health reform process -- but lacked external efficacy -- a belief that the government would be responsive to their input (Andreasen 1995). Should this be the case, citizens of the CRD would not be alone. Citizens’ declining confidence in government has been noted elsewhere (Prior, Stewart and Walsh 1995; Beatley, Brower and Lucy 1994; Pincentl 1994; Staeheli 1994). Although enjoying full rights of citizenship, most citizens skirted their responsibility to engage in the life of their community (in health reform anyway) perhaps due to a sense that their efforts would carry little weight in relation to government actions.

It must also be noted that the citizen participation system is unappealing and intimidating to a great deal of people; people may not participate simply because they find other pursuits more compelling (Berry, Portney and Thomson 1993). Inviting
participation in a flawed and ineffective system is sure to further alienate citizens from participatory democracy (Morone 1990). When real policy making authority is not offered to citizens at the grass roots, people may perceive (and often accurately so) it is not worth their while to become involved.

Finally, it can be argued that the entitlements of citizenship have been emphasized over the obligations. Many citizens happily receive public services yet, beyond paying taxes -- and often grudgingly so -- may not fulfill even the basic responsibility of good citizenship: voting. This is not meant to lay the blame squarely at the feet of citizens: the system of government sustains the passive nature of citizens. The terms of involvement are dictated by government, not the citizen; “there is a need to work with the grain of how citizens behave” (Prior, Stewart and Walsh 1995, 88). How is a responsible and virtuous citizenship created? How can citizenship promote a sense that citizens belong to the state and that the state belongs to them? The next section continues the analysis of citizen participation in “New Directions” in light of reinventing both citizenship and participation.
Section II  Fostering and Sustaining Participation in "New Directions"

Social marketing and stages of change theory tells us that focus group members were not roused to participate in “New Directions” for one or more of three reasons:

1. Citizens may have simply been unaware that it was possible to participate in “New Directions.” This was confirmed by many of the focus group participants and raises concern about the promotions aspect of the marketing mix.

2. While some may have heard about “New Directions,” even if during the focus groups, they believed that it was not relevant or appropriate for them to participate. This was a result of the “product” or “selling” orientation of “New Directions,” which failed to understand the citizen’s perspective. Nonparticipants found health planning group meetings, and the attributes of those meetings, personally irrelevant and offering far fewer benefits than costs for their involvement. For First Nations, the belated invitation to participate in “New Directions” was immediately suspect. They had difficulty seeing the relevance of the existing structures for health reform, or how they would fit in because the system did not attend to their distinct needs and differences:

   There is nothing that really addresses the uniqueness of First Nations people. No sense of how our community works, so there's no trust in the process. We didn't have anything to do with these structures [health planning groups]. It's after the fact . . . we should have been involved right from the beginning.

3. Nonparticipants perceived participating in community life to be irreconcilable with their current beliefs of, and experiences as, a citizen in the community.
Changing the incompatibility of how one experiences citizenship versus how it is defined presents the most difficult challenge in encouraging people to contemplate participating.

The process of adopting social practices or ideas incorporates three elements: cognitive (learning), affect (feeling) and behaviour (doing). The relative importance and order of these elements differs from behaviour to behaviour. The primary values and needs to be satisfied in the affective domain include respect, acceptance, a sense of belonging, and a sense of accomplishment (Kahle 1984).

It was argued in the preceding section that being valued as a citizen (possessing the formal rights of citizenship and empowered to act on them) was a primary determinant of participation. The data from this study suggest that individual decisions to participate in community life might be reflected in a feel-learn-do pathway. Values or feelings of belonging and being valued and accepted as equal citizens must be satisfied first, followed by an awareness or knowledge of the opportunity to participate and, eventually the act of participating. The lack of a sense of full citizenship -- of belonging and respect -- precluded participation in “New Directions” for focus group members.

Feelings of second class citizenship status may provide an understanding of why some people do not participate, but short of a revolution, how can the situation be remedied? Social marketing tells us that encouraging people to begin thinking about and participating in, “New Directions” requires modifying how the opportunity to participate is defined, designed and delivered, and ensuring that the positive consequences of
participating outweigh the negative ones. An argument will be made in this section that
the concept of citizenship also needs rethinking, and it is from such a reconceptualization
that the appropriate processes for participatory democracy will emerge. Data from
participants and nonparticipants, when considered in terms of marketing concepts, offer
promising ideas for addressing these issues and for promoting the citizenship, inclusion
and participation of everyone. This section explores how social marketing theory is
relevant to understanding the recruitment and retention of citizen participants in “New
Directions.”

The Product, Place and Purchaser

Hold a Meeting and They Will Come

The findings strengthen the assertion made at the outset of this paper that
participation in “New Directions” has suffered from the use of a “product approach” or a
selling orientation, rather than a marketing perspective. The former assumes the product
offered is so inherently superior that the only task is to advertise the product and
its benefits. Characteristic of purposive organizations, health planning groups relied on
the attractiveness of “New Directions” to recruit and maintain membership. Such
“marketing myopia” prevents the marketer from seeing beyond the product. “It is a
mindset that says ‘Offer it and they will come!’” (Andreasen 1995, 39). Some
participants suffered from this shortsightedness: “... if they are interested they [public]
will come.”
This approach was particularly evident in the way in which the opportunity to participate was structured. The work of the health planning groups more closely resembled a social planning orientation than a community development one (Rothman, Tropman and Erlichman 1987). Opportunities for public involvement followed the traditional approaches typical of public participation experience (Wolf 1993; Syme and Nancarrow 1992; Henderson 1990). Primarily, the opportunity to participate in “New Directions” was offered in the form of the health planning group meetings. There were also opportunities for residents to respond to mailed, in-person and newspaper surveys, and to attend public forums. On a few occasions, participants conducted presentations at meetings of existing community organizations. However, the opportunity to participate most often demanded that the community gravitate toward the health planning groups, or participate on their terms, rather than the health planning groups reaching out into the community. The chair of planning group (A), and a former member of health planning group (B) recognized the limitations in their expectations:

To really involve the community -- be open to the community and really be open to how people view health, how they deal with health ... [we] really have to get out and spend the time and listen to them. And, that's something that we haven't done enough of. We really expected everybody to come to us. [01]

So, I think that it has to be more loosely organized than 'we decide the dates and then advertise and you come.' I think it has to be more organic. [12]

As with other experiences in the literature (Chrislip 1995; Gilbert 1987), the structure of participating in “New Directions” was such that it discouraged many in the community from participating. Health planning group meetings and public forums were
simply announced and held for whoever chose to attend. Typically, the mix of attendees resembled "the usual suspects . . . who are the most vocal and have the most resources" (Chrislip 1995, 26, 28). As Phillips (1995) notes, those who go to public meetings tend to be "... a pretty unrepresentative bunch!" (295).

Lomas and Veenstra (1995) caution against pretending "that current consultation methods really attract the general public" (40), a caveat not always heeded by the health planning groups. Citizens must be able to see some reflection of themselves in the participatory endeavour in order to trust the process and participate (Chrislip 1995). The images visible in the health planning group membership failed to mirror the diversity of the communities they represented. It can be argued, however, that it was not necessary for health planning groups to be representative of their constituency if they understood the needs and experiences of those they represented. Yet such 'active representation' required an on-going relationship between the participants and the citizens in the differing municipalities; a relationship health planning groups foundered to establish. "If those who represent citizens have no understanding of their needs drawn from experience, then can they be regarded as capable of acting as representatives?" (Prior, Stewart and Walsh 1995, 73).

Similarly, the reluctance on the part of some participants to increase group membership and their desire to confine 'voting membership' to regular attendees speaks volumes about their penchant for selling, rather than marketing, opportunities to for involvement. Instead of creating a variety of participatory opportunities to meet the needs
of all citizens, most participants preferred that citizens adapt to the group's existing means of involvement.

Other participants recognized the need to adopt more of a consumer-centred approach because “... there's all sorts of different ways [to participate], and not necessarily formalized ways.” [09]. O'Neill (1992) in his discussion of community health councils in Quebec, identifies the importance of easily accessed informal and formal participation mechanisms in order for participation to be empowering. “Hold informal meetings like this [in the Native Friendship Centre] and you'll get your community response, and information and voices. People will begin to feel that their opinions matter.” Forging a sense of belonging for these individuals requires structuring participation in ways that are safe and comfortable for them, and in ways that restore a sense of value.

A selling orientation also tends to ignore the presence of other opportunities that compete for citizen's attention, and blames the lack of response on consumer ignorance or apathy. Some participants accused the general public of being uninterested in health, and suggested this as the reason for low participation; a 'blaming the nonparticipant' mentality. “The average citizen isn't going to come to meetings. They don't give a damn about health until they need a hospital bed. It's very hard to interest them.” [03] Yet, “such an attitude both misses the point and is patronizing” (Andreasen 1995, 48). Focus group members certainly articulated an holistic understanding of health and argued for integrated, coordinated and alternative health care services. Health mattered to the
nonparticipants. This consumer interest echoed other experiences with British Columbia health reform:

The consumer is as well informed about what services should be delivered as the providers . . . Consumers know what they want, and a lot of people would like to let someone know what they want out of their health system. *(Communities Putting New Directions Into Action 1993, 32).*

Finally, the selling of participation opportunities in “New Directions” treated CRD constituents as an undifferentiated mass. Neither benefits-based segmentation nor readiness to participate were considered when recruiting individuals to become involved. As a result, health planning group membership was relatively homogeneous across the region (attracting individuals in the action stage, according to the stages of change theory). These individuals were motivated to participate for personal or professional reasons, and took action because they felt confident in their abilities to contribute successfully.

Nonparticipants, on the other hand, might be categorized primarily as precontemplators, and to a lesser extent as contemplators. In addition to obvious differences in awareness and knowledge levels of “New Directions,” nonparticipants also perceive greater costs and fewer benefits to becoming involved than do participants. The strategies used by health planning groups to create awareness and persuade citizens to participate were simply louder exhortations to sell the existing participation opportunities.
Viewing Participation from the Citizen’s Perspective

A consistent theme emerging from the focus group discussions was that citizen involvement in the form of committee meetings, public forums, meetings, and surveys was not part of their reality. Such techniques catered to the advantaged citizen. Rather than merely refusing the invitation to participate in committee meetings or public forums, however, focus group members invited members of the health planning groups to participate in their reality; to experience the lives of those the participants represented; “to spend more time learning how the community is organized and less time trying to organize it” (Paul and Demarest 1984, 192):

Come join us, walk with us . . . sit with us and pan one day.

They [health planning group members] should learn exactly what they are going to suggest spending or not spending money on . . . participation for them so they can see what is going on and at the same time consumers immediately there will be able to give some immediate feedback.

It [health planning group members’ involvement] has got to be more experiential.

When understanding participation from these citizens’ perspectives, it becomes clear that there are multiple realities in which the opportunity to participate exists. Relying on a shallow repertoire of participation techniques imposes a pattern of participation convenient to health planning groups (Prior, Stewart and Walsh 1995). The demand for attendance at public forums and meetings only make sense for, and is only relevant to, a select few. Surveys, questionnaires and, presentations to advisory committees are convenient and accessible means of participation for the
socioeconomically advantaged citizen because the community comes to them. The same logic needs to be applied to individuals for whom being valued, not to mention surviving, is a daily major struggle. In order to participate in 'traditional' structures, these individuals would have to be treated as 'traditional' citizens, with the full citizenship rights and respect accorded the more advantaged participants. Clearly, the focus group members perceived that they were not regarded as equals.

The biggest challenge that the health planning groups face in fostering broad-based citizen participation is not apathy, or inadequate awareness but, as Rosener (1979) suggested, the problem of inequity. The participation opportunities offered by the health planning groups were inconsistent with, and also irrelevant to, the interests and capabilities of focus group members. The design flaws included more than meeting locales and times -- the very idea of a meeting was itself meaningless for many nonparticipants. Focus group members can also accuse the power group of being uninvolved, uncaring -- even egocentric and smug -- in their view of participation so nonparticipants, too, can ask, if participation is such a good thing, why do not more people participate? The question is one of whose reality sets the context for participation. Did the health planning group members have a responsibility to participate in the life of the focus group members? Schambra (1995) suggests that a truly compassionate and caring society is one in which citizens engage intensively and immediately in the lives of the disadvantaged -- “a genuine suffering with” (111). As well, Beresford and Trevillion (1995) found that consumers of British social services placed great importance on
practitioners' learning about their first-hand experience and the understanding and empathy which came from such experience.

The suggestions from focus group members also support Smith's (1995) contention that new ways of thinking about health planning and structuring participation in that planning require an holistic view. The narrow parameters of participation are not surprising given the fact that most health planning group members were professionals or providers; as Fabricant (1985) has noted, the practice of public service has become industrialized, hampering the ability of professionals to consider problems holistically.

Kelly and Van Vlaenderen (1996), in their case study of community participation in South Africa, found the nature of participation to be differently understood and experienced by different participants. These researchers found that local community 'experiential' knowledge and professional knowledge represented two distinct frames of understanding. Kelly and Van Vlaenderen (1996) recommended that,

Through closer interaction of these frames of understanding in the context of [a] project, a third, shared perspective may have emerged. Such a perspective could conceivably have incorporated the contributions of both community and professional knowledge, an intimate understanding of the realities and needs experienced in the context, and an understanding of specific professional competencies and possible services (1243).

Acknowledging that other domains for participation exist does not discount the contribution of the health planning group members nor their conventional structures for participation. What experiential knowledge would bring is the understanding, experience, attitudes and views of citizens, gained in the social life of communities, to the health
planning groups. It is the knowledge that works with the grain of citizens and constitutes a new kind of active (as opposed to passive) representation based on an experiential relationship (Prior, Stewart and Walsh 1995).

Viewing Citizenship from the Citizen’s Perspective

A look at the evaluative research in citizen participation suggests that how participation efforts are structured does not, in and of itself, guarantee the success of the project in recruiting a wide breadth of citizens (Freeman et al. 1996; Poulin and Kauffmann 1995; Berry, Portney and Thomson 1993; Checkoway, O'Rourke and Bull 1984; Berry, Portney, Bablitch and Mahoney 1984). Merely offering a menu of opportunities to participate does not bring people out of the woodwork. Berry and colleagues (1993), in their study of effective participation in American cities, found that urban centres with strong structures of ‘local democracy’ were no more effective at recruiting their disenfranchised citizens than cities lacking such systematic structures for involvement. The daily burdens of marginalized citizens are a powerful force that contribute to a sense of inadequacy and alienation; feelings that can not be ameliorated simply by providing easier avenues for participation.

It might be argued that it is the assumptions grounding the structure and process of local democracy -- the nature of citizenship itself -- that contributes to the feelings of exclusion and alienation (Prior, Stewart and Walsh 1995). The universal ideal of citizenship serves to exclude disadvantaged and diverse groups in society by assuming
that, because differences are discounted in an attempt to provide equal status for all, differences no longer matter (Phillips 1993). For Young (1989) a universal, one-size-fits-all notion of citizenship that transcends sociocultural differences unjustly oppresses historically excluded persons. In addition to guaranteeing individual civil, political and social rights, a notion of citizenship that promotes social justice

... should attend to rather than be blind to group difference in awarding benefits or burdens, in order to remedy group based inequality or meet group specific needs (Young 1995, 166).

Genuinely universal citizenship is differential: it embraces the diverse perspectives that people derive from their distinct experience and position in society and views these as a strength. “Attending to difference is necessary in order to make participation and inclusion possible” (Young 1989, 273).

Rethinking what participation means for a variety of constituents, and restructuring the opportunity to participate so that it is ‘closer to home,’ begins to acknowledge the distinctive experiences and needs of citizens and their equal social worth as members of society. As such, it may also bring the idea of citizenship ‘closer to home’ for individuals who feel on the outskirts of society. Rethinking participation may also encourage the development of an experiential relationship between the disadvantaged groups in society and health planning groups. This relationship would enable health planning groups to appropriately and confidently represent the disadvantaged citizen’s health needs and issues if, in an absence of substantive citizenship, disadvantaged citizens were unable to participate in the work of the health
planning groups. As such, active representation may lead to better opinion representation even when participants are quite different demographically from the members of the wider community.

In turn, restructuring participatory democracy may begin to instill the sense of community, and belonging that seems fundamental to both citizenship and participation, as well as engendering a feeling of respect. We respect people's needs and wants because we respect people (Goodin and Wilenski 1984). As other scholars note (Lord 1994; Lusthaus 1986) it is important for isolated and powerless individuals to be able to make a contribution to their communities; such contributions are unlikely to be realized in contexts that hold little meaning or relevance for marginalized people. Having access to valued social roles is also part of the empowerment process (Wolfensberger 1983), as it can function to reduce isolation and heighten feelings of self-worth.

It may be that citizens are interested in health and do wish to influence the quality of health in the community (Beresford and Trevillion 1995), but do not feel they really can (Kubiski 1990), or have not had the chance (Berry, Portney and Thomson 1993) in contexts that are meaningful to their lives. In short, reframing opportunities for participation may "enable people who are citizens in theory [to] become citizens in fact" (Prior, Stewart and Walsh 1995, 144).
A Citizen-Centred Approach to Citizenship and Participation

The notion that there are multiple realities in which the opportunity to participate exists is compatible with the constructivist perspective of research -- that inquiry into participation must take into account the subjective reality of those being asked to participate. Participation can best be understood within the context of a subjectively constructed world (Culpitt 1992). It is also compatible with the human development-potential perspective (Kimiecik and Lawson 1996), and universalistic approach (Wallack, Dorman, Jernigan and Themba 1993) which challenge the way social problems are conventionally defined and solutions determined. A universalistic perspective also assumes that "... as citizens, people share the responsibility for the conditions in society as well as a strong obligation to the collective good" (Wallack et al. 1993, 15). Rather than laying the fault at the feet of the focus group members, attributing their nonparticipation to apathy and laziness, health planning group members, in redefining the opportunity to participate, can demonstrate their commitment to changing the conditions in society and their obligation toward the collective good.

The results also confirm the potency of a citizen-centred approach to understanding participation. Effective social marketers realize that the behavior being promoted, the offer, is not an objective reality; it is only what the customer thinks it is . . . sometimes the perceptions of reluctant or antagonistic customers are deadly accurate and changing the offer requires the marketer to make fundamental, real changes (Andreasen 1995, 55).
The traditional “selling” approach to participation in “New Directions” -- health planning group meetings, public forums and community surveys -- was simply unable to accommodate and reflect how people in the community view and understand their lives and their role as citizens. The opportunities to participate only met the needs of the well-heeled (and perhaps well-healed) citizen. In contrast, becoming involved in the lives of the traditionally underrepresented citizen -- as a form of participation for health planning group members -- turns the table on conventional participation. It is a marketing approach. The findings argue against a one-size-fits-all concept of participation and citizenship, and in favour of opportunities that are developed in, tailored to and respectful of, specific contexts and persons.

A citizen-centred orientation “may serve as a refreshing antidote to the application of positivist social scientific research to health promotion problems” (Buchanan, Reddy and Hossain 1994, 50). By applying marketing concepts to health promotion principles, health promotion professionals may begin to discern the narrowness -- indeed arrogance -- of their own views as what actually constitutes participation (Hastings and Haywood 1994), and develop more sophisticated understanding of, and respect for, the participatory experience.
The Price

Attitudes toward participating can influence public involvement, and may be derived from beliefs about the consequences (positive and negative) of participating. Lower order beliefs produce impoverished attitudes and low participation rates. Alternatively, higher order beliefs foster more robust feeling, leading a person to participate. An individual’s decision whether to participate in “New Directions” can be understood through a consideration of benefits and costs. What would be the positive consequences of devoting themselves to health reform? What would it cost them to do so?

Weighing the benefits and costs includes assessing the likelihood those costs and benefits will occur, as well as their relative importance. Such an assessment can be seen in the following statements. When asked if she would continue her involvement with health planning group (B), one participant responded, “I need a clearer picture of what's involved. I don't want to spend all those hours meeting if nothing comes of it.” Similarly, a First Nations citizen wondered aloud “What's the use of getting involved? What good is it going to do us? What are the benefits? What's one good reason to participate?”

As noted earlier, participants entered the participation arena armed with skills, resources, and a sense of confidence that they could make a difference to the health reform process in the CRD. This expectation was affirmed within the group environment,
where participants' notions of self- or internal efficacy enabled them to write community health plans and designation documents.

The costs participants paid for their involvement included a great deal of time, energy, skills, knowledge, and ideas for improving the system. They anticipated these outcomes, but did not attribute a great deal of importance to them and were quite willing to exchange them for being welcomed and valued as a worthwhile member, and having the government honour their efforts. These benefits were also expected but were of high importance. This estimation of the costs and benefits was the anticipated price of their involvement.

Participants also enrolled in the health planning groups expecting they would be able to affect change at the community level of health care delivery (external or action efficacy). This perception persisted until the groups’ efforts were thwarted by political and bureaucratic barriers. "Sickened” by the Minister's decision to designate only one community health council in the region, CHB trustees and health planning group members considered the government’s action “a slap in the face” of citizens who had contributed more than two years’ work to “New Directions.” Several resigned in protest. Participants expected that the government would follow community recommendations and placed high importance on this outcome. When the expected positive consequences of community health council designation did not materialize, and the excessive negative consequences of being disrespected and dismissed arose, participants questioned the likelihood of maintaining their participation. Thus, the
government's failure to meet those expectations resulted in less participation (Berry, Portney and Thomson 1993); the price turned out to be higher than participants wanted to afford.

For the former participants, their decision to not return to the health planning groups was also due to unsatisfactory positive consequences and excessive negative consequences (the costs had been underestimated or unexpected ones arose). One former participant did not receive the communion benefit she had anticipated. "I never felt part of it [health planning group]. It's sort of like it was 'cliquey'."[11] Similarly, an important factor in fostering and sustaining participation for focus group members was seeing the results of their contributions. As one of the single parents noted, "validation of my opinion is very important." And, a high school youth remarked, "if it was something where you talked and nothing ever came out of it, I wouldn't go back [to participate]."

From their experiences with public participation in sustainability planning, Freeman and others (1996) note the importance of clearly reflecting public input in the ongoing process and final product.

Attitudes toward participation may also be derived from associating the opportunity to participate with its attributes. Attributes can provide benefits or costs. Some attributes of health planning group meetings were the time (evening), location (which required personal transportation), mode of conduct (familiarity with Robert’s Rules) and language. Health planning group meetings favoured articulate and knowledgeable persons. The professional jargon commonly used at health planning group
meetings reflected the education level and experience demanded of participants: "balkanization of services" and "palliative care" and "health outcomes." Even participants recognized that such phrases meant little "...to Joe off the street." [05] Perceived attributes also influence an individual’s belief in their abilities to successfully contribute to the process itself, even if they feel they cannot affect the longer-term consequences.

In the CRD, the attributes associated with public participation processes did not satisfy the needs of persons in the focus groups, generally persons with a fragile sense of being valued and of belonging in the community. Commented one individual with a physical disability, "I would love to become involved except that I find it [process] very frustrating... everything's planned and set up before you even get there." In fact, Poulin and Kauffman (1995) found that citizens' cost/benefit calculations about participating in drug prevention activities to be linked to their sense of community: for those who felt a tie and connection to the community, the cost of participating was reduced. Citizens with a sense of belonging also had a greater awareness of the drug prevention activities.

Based on their previous experiences with services and systems, nonparticipants assessed the costs of disrespect and inequality as both important and likely to occur. One youth reported that she would go to meetings if health planning group members "...are listening to you... [where] you actually know they are hearing [your ideas]. Not just telling you." Participation without a two-way flow of information -- without the
opportunity to provide feedback and influence decision-making -- amounts to tokenism (Hart 1992; Arnstein 1969). Persons with a physical disability stressed the importance of returning phone calls and providing feedback; a common courtesy they found wanting in government structures and services. "And, have someone who will really return your call. Somebody who will acknowledge [you], answer [your concern]. And, maybe not a year from now. Don't laugh." Providing prompt feedback to concerns and contributions was found to be an important aspect of making participation a worthwhile experience for consumers of social services in Britain (Beresford and Trevillion 1995).

In addition, issues of self-efficacy influence the decision to participate in the first place. Citizens ask themselves whether they can actually perform the requisite behaviour? Despite a new found awareness and interest in health reform, one nonparticipant with a physical disability feared he lacked the qualifications to become involved in the existing structure of "New Directions". "I would love to participate in some way, but my problem is not having the skills and tools . . . how smart do you have to be to be on a board?" His sense that he lacked the required knowledge and skills precluded his involvement.

Finally, dependence on professional services has rendered most citizens inexperienced in making their own decisions about health. "The general public are totally uninterested, partially because this is a service that the government has provided all along, and they expect it." [12]. As Charles and Demaio (1993) point out, in a publicly financed system such as Canada's responsibility for health care has not traditionally rested with individual consumers. The universality of Canada's health
system attempts to ensure equal access to health services, but makes little demand of us to be accountable for our own health. Thus, citizens who may feel empowered in other respects of their life lack the knowledge, skills and expertise to participate in a venue dominated by health professionals. It is possible, therefore, that nonparticipants may have an interest in participating if the structure and its attributes of participation opportunities are more in keeping with their life experiences. Before focus group members and other citizens on the margins of society can be expected to take some responsibility for their own health "they need to gain some self esteem, to achieve some measure of control over their lives, and to have a decent environment in which to live" (Hunt 1990, 184). In other words, they need to be accorded the full rights of citizenship before they are able to exercise the concomitant duties. This suggests that Marshall (1977) was correct in his assessment of the interdependent and reciprocal nature of civil, political and social rights.

Promotion: Closer to Home

Promotion is the communication element of marketing; it informs and persuades people to adopt a product. The promotion of "New Directions" was ineffective due to the financial and resource constraints of health planning groups, intermittent communication in mainstream media, and poorly designed and targeted messages. The messages often conveyed information, through both substance and style, that sustained exclusive participation. Both health planning group and focus group members mentioned that promotion of "New Directions" inhibited participation.
"Informing" is one of the early rungs or stages of participation identified by Arnstein (1969) and Wilcox (1994). The lack of awareness among focus group members about "New Directions" corroborated participants' concerns about an uninformed public. Health planning group participants recognized the necessity of promoting "New Directions" to community members: "I harp back on sell it, sell it, sell it. We need a catchy slogan" [09]. Suggestions included more and diverse promotional efforts by "New Directions" and the health planning groups. Yet marketing is more than mere communications. It requires understanding different consumer needs, wants and perceptions and treating consumers uniquely, rather than as a mass. Perceived personal relevance is necessary for persons to shift from a stage of unawareness and precontemplation to one of contemplating participation (Andreasen 1995). It is also necessary for people to have an effective voice in decision-making (Freeman et al. 1996), and to clearly communicate to the public that they can make a difference.

In the packages they give to new people, they need to have something more clear on goals of the planning group, and what that new person's role could potentially be. Because then a person will feel more relaxed and know what they can do -- feel more accepted. [11].

Health planning group members certainly felt a personal connection, either to protect their professional 'turf' or for personal interests such as a belief in the ideology of "New Directions": "I'm living "New Directions" [04].

It's easy to forget that there are literally thousands of issues and services competing for public attention, and that the great majority of citizens may not consider any given activity relevant to their own situations -- if, indeed, they are even aware of it (Lovelock and Weinberg 1989, 7).
Promoting "New Directions" thus required overcoming the barriers of selective exposure (avoiding exposure to a message) and selective attention (not paying attention to a message) that commonly plague advertisers. How were the health planning groups supposed to attract participants if the public failed to see the promotional messages, or neglected to pay attention to them? It might be tempting to assume that a PSA or newspaper advertisement announcing meeting dates and locations would suffice to attract interest, but as Lovelock and Weinberg (1989) caution, the competition for the public’s attention is fierce as they are "bombarded all day long with sophisticated messages" (7).

One former health planning group member recognized this challenge and recommended the social marketing strategy: connecting the message to a familiar theme or value (Andreasen 1995). She suggested that highlighting different health issues may spur participation by acknowledging consumer differences, and making individual contributions relevant in a context that is meaningful: "... they [health planning groups] need to use [health] issues more to attract people. Often to motivate people, it has to be an issue that is important them. As it is now, they [public] don't see a personal connection" [11]. Not only was the participation venue not geographically close to home, the idea of becoming involved in making decisions about health was equally distant. The failure to personalize health issues and to communicate the relevance of citizen participation in "New Directions" resulted in a lack of connection between "New Directions" and CRD residents. Participating in "New Directions" was not emotionally close to home.
You can get people in their fifties if you talk about the lack of long-term care beds and the direction of nursing in the home. [For example] come and find out what homemaking services there are. So, me who has a 75 year old mother with a heart condition, will I end up having her in my home? If I've got the potential to have my mother in my house or in a nursing home, I might [participate]. [11]

For persons not yet aware of the opportunity to participate, Andreasen (1995) stresses that the message must be easily understood. This is confirmed by community work researchers Beresford and Trevillion (1995): information must be clear, accessible, appropriate and not patronizing in order to reach and stimulate interest among social service users. Yet, nonparticipants in the CRD found the descriptions of health reform in government and CHB publications to be loaded with jargon, perplexing, and most telling of all, written as if the intent were to ensure health planning groups to preserved control:

It's like they want to make it [New Directions] so hard you can't get it -- the control thing -- don't want them to know too much. And, write it in a different language, then they [general public] really won't understand. [Focus group member]

The importance of linking the topic of participation to established values was also confirmed by nonparticipants. Dimensions of citizenship -- belonging and equity -- need to be reflected in the promotional messages to persuade people that their participation is important, and to make them want to take part. The substance of the message, focus group members noted, needed to be revised. Rather than informing the public about the infrastructure created to implement “New Directions,” communications should address the affective domain and foster a sense of belonging. Commenting on a CHB newsletter designed to inform community members about “New Directions,” one First Nations man remarked,
I'd be blitzing the philosophy and guiding principles of the Capital Health Board to inspire and give [people] a vision, make them want to take part . . . they need to create ownership, the touchy-feely stuff.

Selective exposure and attention can also be overcome through the use of dramatic design elements (Andreasen 1995). Here, too, nonparticipants provided recommendations on style. Visual information should be accompanied with cartoons and bright colours that make it interesting and fun to read, because "somehow these days the way the government packages information seems to turn people off." Knowing which communication media citizens use is crucial for reaching nonparticipants. As one First Nations person said, "I don't read the newspaper, personally, because it's all bad news for me."

"New Directions" product or selling approach is evident in the communication strategy used. Simply getting the message out was thought to be adequate: "I certainly think the community has had ample notification of the process and ample opportunity to participate." [02] Nonparticipants, however, recommended in addition to different substance and style, different communication vehicles altogether -- natural opportunities that meshed with their everyday reality. Overcoming nonexposure and inattention, and encouraging citizens to contemplate participating, requires the use of 'apertures' (Wells 1989) where as one nonparticipant noted, the messages " . . . seep in at you from different places, places where people go anyway . . . to get information for something else and there [information about "New Directions"] is". Places like day care centres, drugstores, grocery stores, worksites, community centres and on public transportation, as well as
newspapers, television, radio and existing organizations' bulletins and newsletters. Apertures serve to bring the promotional messages closer to home and encourage the person thinking about participating to become involved.

*I think that any promotion of anything you have to reach people where they regularly receive information. I think with anything you really have to make the effort to get the stuff out to where people go which is the grocery store or pharmacy - those sorts of places where people will pick up information without going out of their way.*

The provision of early, relevant, accessible and clearly comprehensible information about the participatory process and the potential impact of citizen involvement were found to be salient features of successful participation efforts in the literature (Poulin and Kauffman 1995; Berry, Portney and Thomson 1993; Hawker 1989). Information enables citizens to learn about their relationship to government and to encourage a more active development of that relationship (Prior, Stewart and Walsh 1995).

It is also important to notice the difference in the recruitment of participants and nonparticipants. Scholars have previously noted that the recruitment process does little to encourage minority or working class citizens to participate on community committees and boards (O'Neill 1992). All of the participants interviewed had received a personal invitation or referral from a colleague or acquaintance to attend a meeting, reinforcing their sense of being able to make a difference to the health reform process. Interpersonal
communications were important channels for forwarding messages about participating in health planning groups.

Nonetheless, some members expected a simple newspaper advertisement, or Public Service Announcement would entice other citizens to attend. One active member, a long-term care provider, saw the need to personally recruit community residents: "I think the only way we're going to get more public involvement is if we personally go out and get people." [05] Lord's work (1994; 1993) corroborates this assertion: Being invited and welcomed were significant first steps to participation in community life for physically disabled persons. Initiatives seeking broad-based participation need to extend a personal invitation to participate to diverse citizens in the community. While this may present logistical challenges, having a community organization or agency extend an invitation on behalf of the health planning groups may be more effective. The diffusion of innovations theory (Rogers 1983) tells us that interpersonal communication, between like individuals, positively influences a person to adopt a practice. Participation efforts "...cannot succeed by relying only on those who can be expected to show up. There must be an active process of invitation and recruitment" (Chrislip 1995, 28).
A Summary of the Selling of "New Directions"

Participation in "New Directions" did not reach its potential for attracting broad-based involvement as recommended in "New Directions" materials. While some health planning group members recognized the need to adopt a marketing approach, the overall strategy reflected a product or selling orientation to participating in health reform. The Diffusion of Innovations theory (Rogers 1983) suggests that certain attributes of the opportunity to participate influenced the narrow scope of citizen participation in "New Directions."

There was little relative advantage to participating as a member of a community health planning group and attending evening meetings for the majority of citizens not employed in health or related professions. Relative advantage is the extent to which an innovation is thought to be better than the idea it follows. It does not matter whether an innovation has a great deal of "objective" advantage; the key is whether an individual perceives the innovation as advantageous. Convenience, satisfaction, and social-prestige, as well as economic factors, are important considerations in assessing the degree of relative advantage.

Alternative means of participation that might have accommodated persons with little leisure time, or those unfamiliar with health and meeting jargon or hampered by transportation or daycare barriers were not provided. Nonparticipants might see the advantage of health planning group members visiting their turf, but they were not anxious
to revisit the experience of being devalued, a feeling that permeated much of their daily routine. For such individuals, there was little, if any, symbolic value to attending health planning group meetings, which demanded a degree of psychological risk that they were reluctant to tolerate. Former participants, who questioned the utility and value of their efforts, admitted to experiencing a few functional benefits from their brief liaison, yet were unable to see the advantage of continuing their involvement. Lastly, for some active and regular participants there was little to be gained from continuing their involvement after the ministry declined their applications for community health councils.

Compatibility is the extent to which an innovation is thought to be consistent with the existing values, past experiences and needs of potential adopters. Certainly the compatibility of becoming involved was not apparent to the nonparticipants in the focus groups as it was irrelevant to their experience as second class citizens. If the core rights of citizenship were not realized for focus group members, why would they consider fulfilling their obligations as citizens?

"It's all very abstract and airy fairy for most people" [08]. The complexity of the participation experience is the degree to it is perceived as difficult to understand and use. Participants readily grasped the idea of meetings. Some of the nonparticipants perceived the opportunity to participate as requiring skills or a knowledge base that exceeded their own, if indeed, they could decipher health planning group promotional material to sufficiently ascertain potential roles and contributions.
Compounding the complexity problem was the lack of opportunity to shape the participatory behaviour of citizens by offering a foot-in-the-door approach (Andreasen 1995). The trialability characteristic refers to the extent to which an innovation can be experimented with on a limited basis. The trialability of participating, in anything other than the health planning groups' meetings and surveys, was minimal for nonparticipants. The perceived risks of attending meetings for persons unfamiliar with meeting protocol and health issues -- venturing beyond their own 'psychic' backyard -- diminished the likelihood of even considering participating. Moreover, the observability or visibility of the participatory opportunity was negligible. Meeting locations, dates and times were not widely advertised beyond inclusion in meeting minutes. Recalled one former member of health planning group (C),

*I phoned to ask who could go to the meetings and stuff; because by then I thought it was a closed shop. I didn't realize that the public could go. It's not very well advertised . . . I didn't see anything about it in the papers, I only knew about it through work.* [11]

Summary

Through the voices of the participants and nonparticipants, one can begin to understand why some members of society do not feel like citizens, and why a sense of full citizenship is a prerequisite for participating in community life. This section has interpreted the participation experience through the marketing mix lens, and once again the notion of citizenship emerged. Specifically, the analysis suggests that
the opportunity to participate was not structured and delivered to accommodate constituents with diverse needs and experiences nor with a fragile sense of belonging or self-respect. Thus, while Andreasen (1995) argues that social marketers must change the values of those not yet thinking about participating to propel them towards contemplating and ultimately participating, it would seem that the participatory and community environment required altering as it failed to provide the benefits of respect and belonging that focus group members sought. The nonparticipants did not need to change their values; in fact they felt excluded accessing the very rights that supposedly guaranteed their inclusion. What was flawed was the context -- the manner in which nonparticipants experienced life in society, the system and structure of participatory democracy in the CRD, and how the opportunity to participate was distributed to citizens. “A democratic public should provide mechanisms for the effective representation and recognition of the distinct voices and perspectives of those of its constituent groups that are oppressed or disadvantaged within it” (Young 1989, 261).

• the benefits and costs associated with participating related to dimensions of citizenship, specifically belonging, respect and equality; and,

• the promotion of “New Directions” failed to address issues of personal relevance and belonging, nor to effectively reach diverse audiences with appropriate communication messages. The messages were neither geographically nor emotionally close to home. That is, messages did not reach citizens in places that were convenient and frequently accessed, and the message itself did not convey a connection that focus group individuals sensed was significant to their lives.
In the end, the lack of diversity of participatory opportunities, the ineffective promotional strategy, and the homogeneity of health planning group representation resulted in a narrow breadth of participation. This would not alone be sufficient to deem public participation in “New Directions” a failure, for many such endeavours succeed on the parameter of depth. “They tend to fail here too, however, in one key area -- the ability to be taken seriously in the broader policy development and implementation process” (Berry, Portney and Thomson 1993, 56). Of course here, too, public participation in “New Directions” fell short. The perceptions of participants have been presented and the analysis offered two interpretations: citizen participation as token and consultative exercise or as one steeped in professional self-, as opposed to the collective, interest.

Regardless of the perspective one aligns with, it is clear that the implementation of “New Directions” was plagued by ambiguity of goals and communication, problems of administrative control, the complexity associated with multiple layers of implementation, and disagreement over goals (Morah 1990). The obligations of the ministry of health to the citizens of the CRD in enabling responsible participation were not fulfilled. Meaningful participation must “. . . occur within an environment that values people, cares for them, perceives the enhancement of their powers and capacities as a goal of society”(Smith 1995, 51). For the majority of citizens in the CRD, especially the disadvantaged, the status of citizenship and its practice in “New Directions” was not ‘close to home.’
The analysis in this section has begun to piece together an understanding of the multi-dimensional relationship between the concepts of citizenship, participation and empowerment. Figure 5.1 returns the relationship proposed in chapter two between the concepts of citizenship, participation and empowerment, and, from the findings, summarizes the problems in “New Directions” that precluded a sense of full citizenship, public-spirited participation, and personal and organizational empowerment. It is toward a revitalized theory of citizenship and participation that the focus of the next chapter turns.
Figure 5.1: A flawed system: How the concept of "New Directions Towards Citizenship, Participation and Personal and Organizational Empowerment" reduced the active contributions of citizens and their subservience to the structure of democracy.
CHAPTER 6
CONCLUSIONS

In a recent edition of the *Annals of the Royal Canadian Physicians' and Surgeons' College*, Singer (1994) wonders if the public should be involved in setting health-care priorities and, if so, can the public’s participation be attained? He answers a qualified yes to the first question, but feels unable to answer the latter question as it reflects "...the lack of an accepted methodology to assess the public’s view" (277). He goes on to conclude that since "public involvement in health-care decision-making has been adopted as a principle by provincial governments, it is critical that suitable methodology be developed to accurately sample public views and values" (278). Despite a body of empirical research documenting the failures of citizen participation programs to achieve their goals, the literature lacks a consistent reform message to improve the practice of citizen participation (Berry, Portney and Thomson 1993). A similar problem plagues the institution of 'citizenship.' The return of the concept to the forefront of political debate has not been accompanied by further elucidation or consensus concerning what constitutes a theory and practice of citizenship, nor even an accepted definition of 'citizen.' If it is to become a useful and accepted concept, citizenship must become a much clearer and more developed one (Oliver 1991).

This case study has described one aspect of public participation in “New Directions” -- including active and regular involvement, short-term participation, and
nonparticipation -- from the experiences and perspectives of citizens in the Capital Regional District. The key findings from the experience of participation in “New Directions” suggest that no singular methodology to engage citizens in health reform, nor any single reform message for enhancing citizen participation is likely to be found. The solution for rethinking the concept of citizenship and its practice may lie in a citizen-centred approach to create conditions which enable participation to flourish closer to home.

The following paragraphs discuss the key findings and the significance of the study for learning about citizen participation. A discussion of the controversies surrounding social marketing, and the contribution of social marketing to health promotion, citizenship and participation follow. The chapter concludes with some suggestions for further inquiry, and an update on the fate of “New Directions.”
Key Findings and Significance of the Study

Is Participation Such a Good Thing?

If participation is both a virtue and an obligation of citizenship, then equal opportunities for everyone to take part must be provided; if the ability to participate is a good thing for a citizen to have, then it follows that it is also a good thing for all citizens to enjoy (Fierlbeck 1991). But is participation such a good thing? Clearly, the ideology which underlies participatory democracy makes it an attractive and virtuous activity. In particular, health promotion professionals' quest to empower disadvantaged groups and to bring about social justice suggests that the principle of participation is a highly plausible strategy. However, the lack of an operational definition and strategy of what is realistically feasible indicates how utopian the notion of citizen participation really is (Berry, Portney and Thomson 1993). And, if it is an obligation, upon which other rights depend, then again it must be made accessible to all.

It has been suggested throughout this dissertation that the rhetoric and the reality of participation are at odds. It is the gap between expectations and results that has led to the debate about the value of participation (Rosener 1978). In a democracy, participation is at once an option for, and an obligation of, citizens. The right to participate is not necessarily seen in terms of a responsibility to do so.
As the findings from this research suggest, community functioning and the actions of the community’s institutions are responsible for residents’ sense of belonging in the community and value as citizens, and may predispose a person toward participating. Kelly and Van Vlaenderen’s (1996) findings with respect to public participation in South Africa led them to “believe that the nature of participation is strongly determined by existing relations within the society and these are interpolated into participatory processes within projects” (1243). In this case study, the vast majority of regular participants were well educated, well spoken and well off. They brought with them skills, experience and resources to the health planning groups, and the formal and substantive rights of citizenship that encouraged and facilitated their involvement. Typically, these participants believed it was possible to shape health policy to better suit their community needs, despite the fact that they lacked an electoral mandate to represent their constituency. They reported a sense of belonging, professional or personal connection to “New Directions” as motivating forces to participate. Life within the health planning groups closely resembled what participants experienced on a day-to-day basis.

Further, because of their homogeneous and insular membership, they were neither demographically representative nor did they share the life experiences of all members of the Capital Regional District. Demographic or electoral representation, also termed mirror representation (Phillips 1995), is limited because there is no guarantee that those who represent citizens share similar constituent gender, ethnic or socioeconomic status, let alone understand their needs or experiences. Needs are best appreciated when they are
shared. Experiential representation, based on shared experiences where needs are actively and subjectively assessed, enhances the legitimacy of representation when economy of time and problems of scale and access restrict participation by all.

The nonparticipants' feelings of a lack of belonging and equality arose from their experiences with societal institutions, experiences they had reason to suspect would be revisited in the traditional structure of health planning group meetings. Clearly, participation was not meaningful for focus group members. They believed that they were substantively prevented from acting on their rights; rights which were necessary to protect and promote the conditions of securing individual liberty and autonomy through social participation (Skinner and Viroli 1990). As such, the experiences of focus group members with societal institutions failed to create a context conducive to participation for those not already comfortable with traditional forms of participation nor who possessed full citizenship.

As well, the act of participating in community life needed to be seen as more than volunteering by both constituents and government officials (Kymlicka 1992). It needed to be recognized as a valuable component of citizenship, as a responsibility toward the collective good, rather than as an act of altruism and charity (Peters 1993). The system of governance did little to encourage active citizenship; in fact, if often seemed foreign to the lives of most citizens and far from their experiences in daily life.
In their review of citizen participation across the United States, Berry, Portney and Thomson (1993) found that state-supported community outreach and communications, the facilitation of face-to-face interaction and discussion, and provision of specific instructions and mechanisms for policy input were crucial for effective and valued participation. While acknowledging that different opportunities to participate enable greater numbers of citizens to become involved in ways that best meet their needs and perspectives, Berry and colleagues (1993) concluded that the value of participation, as a desirable and legitimate activity of citizenship, must be enhanced and acknowledged by both citizens and government officials.

Only the naive would assume that simply creating new opportunities for participation will lead to expanded political activity, more knowledgeable and capable citizens, enhanced public confidence in government, or any of the other benefits promised by advocates of participatory democracy (Berry, Portney and Thomson 1993, 21).

Similarly, British scholars of local government discuss the urgency and importance of reinventing structures of participatory democracy and government services as a means to strengthen citizenship. Prior, Stewart and Walsh (1995) offer conditions for ‘opening up government’ to nurture decentralization, symbolize change, and enhance citizen participation as mutual learning activity between the state and its citizens: processes that ensure accountability of public services; opportunities for involvement in shaping policy, management and evaluation of public services; provision of regular, comprehensive and accessible information available to all citizens about the decision-making process; access to services for all citizens that is unimpeded by social, cultural or
economic criteria; providing the public with choice about public services so that citizens can make their own decisions about how their distinctive needs should be defined and serviced; and, securing a system for redress both within and independent of the service provider. The authors go on to delineate different and multi-dimensional levels of decision-making for health services that will be appropriate for, and relevant to, different groups in the community.

Wandersman (1981) suggests that individual differences of demographic attributes, cognitive abilities, and discretionary and skill resources account for individuals' decisions to participate. The findings from this study demonstrate that, in addition to these individual differences, dimensions of citizenship were also found to be important. The sense of value and equality in the community, and sense of belonging to the collectivity, not only enabled participants to engage actively in community life, but made them believe they could participate. They also had a sense of personal connection or meaning to participate in “New Directions”; the issue was emotionally ‘close to home’.

As well, the findings from this case study argue that the parameters or structures of participation that define the opportunity to participate (Wandersman 1981) must reflect the multiple realities and opportunities to participate of a variety of citizens, as part of their everyday lives, rather than imposing structures on citizens. In addition to individual attributes, the very structure of the participation technique itself influenced who participated, and vice versa; a sentiment that has been articulated by multi-disciplinary
scholars of participation (Wolf 1993; Norton, Wandersman and Goldman 1993; Farr 1992; Kathlene and Martin 1991; Syme, Macpherson, and Seligman 1991; Persons 1990). Meetings attracted health professionals who felt comfortable participating in such a structure because they understood how they might contribute. It was part of their everyday world. In turn, this collective familiarity shaped the manner in which the opportunity to participate occurred.

For focus group members, the opportunity to participate was not meaningful nor relevant, and served only to heighten their sense of disenfranchisement. The ways in which nonparticipants would have preferred ways to participate reflected their life experiences and daily lives, and were markedly different from the structures established by participants. Yet, because no youth were members of health planning groups to suggest that discussions occur in schools and classrooms, participants continued to meet in the evening, in locations rarely frequented by youth, resulting in no youth participation.

The invitations extended to health planning group members to experience other realities, to understand and appreciate the health needs of physically disabled or mentally ill persons, displaced youth, Aboriginal persons or single parents, reinforced the idea of experiential representative. Moving the participation venue ‘closer to home,’ requires meeting people on their own terms and on their own ground where they feel comfortable (Beresford and Trevillion 1995). “The only way to show a person or group that they are
Lord's (1994) research lends credence to the notion that listening to, and observing the lives of, disempowered citizens provides them with the sense of being valued as a respected member of the community which is critical in the transition from powerlessness to power. Accommodating non-traditional requests for participation may help to achieve experiential representation and commence the journey toward personal empowerment.

As well, participation structures helped to determine who participated in terms of language, financial and social barriers. The opportunity to participate in “New Directions” was either unknown, unappealing or inaccessible for disadvantaged citizens. Nonparticipants, and even some former participants, were unaware of the roles they could occupy and the contributions they could make to the process. Undoubtedly, the parameters of participation affected who participated in “New Directions” and whether citizens felt like an equal member of the community. Continued reliance on traditional participation techniques undermined both the legitimacy of different citizens’ needs, and citizen participation.

The voices of both participants and nonparticipants spoke to the importance of validating and honouring citizen efforts and of recognizing individual contributions. As such, these are potent mediators (Wandersman 1981) in effecting personal and organizational empowerment and ongoing involvement. People must not only feel that they can make a difference, they have to be able to believe that they have made a
difference. Again, this is something that is not exclusive to the findings of this case study. Arnstein (1969) and others following her (Chrislip 1995; Wilcox 1994; Charles and Demaio 1993) have emphasized the tokenism of informing or consultation that does not give those consulted any opportunity to influence decision-making. The experience of participation itself becomes a mediating factor between feeling valued as a citizen and empowerment.

At the personal level there were both negative and positive effects for participants. Effects of participation, according to Wandersman (1981), may occur at the personal, organizational and community levels and can influence a person’s willingness to participate in the future. The costs included frustrations with group dynamics and the community development process, as well as a sense of isolation within health planning groups for persons who dropped-out. The primary cost for many participants who remained involved until the applications for designation were submitted, was the dismissal of their efforts by the ministry of health, highlighting the poor relationship that existed between the provincial government and the local community groups. The participants’ perception of their inability to influence change, as well as one of perceived disrespect as an equal citizen, threatened their ongoing involvement. Despite the participants’ eventual failure to effect change in the Capital Regional District, and the former participants’ perceived inability to contribute at the group level, both groups nonetheless experienced aspects of personal empowerment as a result of their involvement.
The "participation potential" (Wandersman 1981) is a combination of variables that contribute to a person becoming involved in community organizations. The combination includes an individual's sense of duty, the knowledge and experience that enable them to successfully participate, the perceived consequences of participating and the value attached to those consequences, as well as facilitating community characteristics. In addition to these variables, this research has identified that citizenship is an important and enabling factor for participation that helped to explain why some people participated and others did not.

In the end, the results confirm that there is no one ubiquitous, sweeping and one-size-fits-all remedy for enhancing citizen participation. Nor should the expectations of citizens to fulfill their obligations be identical. The notion of a differentiated citizenship suggests that the purpose of, opportunities for, and level of involvement in participation should be tailored to the interests and capabilities of citizens. The conservative view that the 'active' citizens should be those who are successful in the marketplace may well be useful after all. The health planning group members occupied above average socioeconomic status and possessed the knowledge and skills that enabled them to contribute a great deal of time and energy to the health reform process, in activities that mirrored their professional and personal experiences in society. Participants could, literally, afford to be involved.
Nonparticipants, on the other hand, possessed neither the financial resources nor the life experience to be able to participate in health planning group meetings. What they could offer, however, was insight into the delivery and appropriateness of health care services that the participants lacked. The focus group members' experience of citizenship was shaped largely by their relationship with the regional health and other social services. It was based on these experiences that the focus group members expressed their preference for better quality services, improved accountability and respectful interaction. It was the focus group members who proposed and promoted the idea of participants sharing in their daily experiences. Where demographic representation was not possible, the potential for active and experiential representation, on behalf of citizens absent from health planning group membership, may have existed.

Therefore, the more appropriate opportunities for disadvantaged and powerless citizens might be to provide input and feedback about the quality of public health to those who make funding and service decisions, as well as to identify needs in the planning of appropriate delivery of services. Through participating in this way, disadvantaged citizens may influence the services they access, bring some control into their lives and begin to claim the full rights and responsibilities of citizenship. At the very least, participating at this level may enable community health councils and/or regional health boards, in the absence of broad-based demographically representative participation, to achieve some level of active and, therefore, opinion representation about health issues and concerns.
The vogue for participation has not met its anticipated results. There may be (and probably are) many reasons why the reality of participation in health promotion and other fields rarely achieves its lofty goals of broad-based participation, an empowered citizenry and responsive government. It is unlikely that most constituents in a community will be intensely involved regardless of how convenient, nurturing and empowering the process may be. However, the findings from this study point to the need for a citizen-centred orientation so that the option, opportunity and obligation to participate is 'closer to home' for all citizens. In this way, the efforts of all citizens can be respected.

The Trouble With Social Marketing

The study also highlights the controversies and contributions of social marketing to health promotion and understanding citizen participation. For some health promotion professionals, social marketing concepts and practices raises a number of ethical and philosophical concerns. This section discusses some of the contentious issues in this debate. Without negating these concerns, the author then offers a position that adopts and adapts the concepts in a way that is philosophically compatible with health promotion. The theoretical contribution of social marketing to health promotion, participation and citizenship is also discussed.

From an ethical standpoint, social marketing may be seen as suspect by health promotion practitioners and the public if they perceive that the government is
downloading the difficult financial and policy decisions around health care to the
community level. One participant, a long-term care provider, was particularly cognizant
of the potential danger of decentralized decision-making:

*I think it's going to be very tough for the community health [council] to
make decisions that affect their neighbours or their children. It's easy to
point your finger at the Ministry of Health and say 'ain't it awful?'. It's
quite a different ballgame when that person lives down the street. When
we start deciding about handicapped kids and whether we're going to give
them lungs, and all of the rest of the stuff that somebody else would get, or
deciding about whether someone's old and whether we should continue to
plug in certain services, it's going to be really tough. And, don't think the
Ministry isn't loving the fact in lots of respects that it's not going to be them
who has to face this.* [05]

In effect the province may be seen as stepping back from taking responsibility for
health care delivery and direction under the guise of fostering local control over health
care planning and decision making. Under "New Directions," the ministry's role was to
be restricted to setting broad health goals, monitoring standards and outcomes and
delivering provincial programs such as ambulance service and "911." As the province
retreated, the link between citizens and an accountable public body would become more
obscure. While regional health boards were to be saddled with the most critical decisions
respecting health services within their region, they would have no authority to levy taxes.
Only one-third of regional health board members will be directly elected from the
community. How was a new level of government, with only one-third of its members
elected at large, and no taxing authority, to be held accountable?
Some critics have cautioned that emphasis on local autonomy may abrogate government responsibility -- obligations of the state to citizens -- rendering local efforts ineffective where provincial and national strategies are required (Labonté 1990; Wharf 1989; Allegrante and Green 1981). Under these circumstances, participation is not such a good thing, and encouraging citizen participation becomes a form of 'buck-passing' with a transfer of responsibility without resources. As well, there are doubts whether 'more' public participation translates into effective decision-making, and in what contexts participation is appropriate (Charles and Demaio 1993). Similar suspicions have been articulated about active citizenship, namely that it would be a cheap surrogate when attempting to compensate for the deficiencies in the cut-backs to state-administered health and social services (Fierlbeck 1991). “Active citizenship should be regarded as a supplement to, not as a substitute for, the citizenship of entitlement” (Oliver 1991, 169).

Equally disturbing for health promotion professionals is that the nature of public health service and health promotion are thought to be fundamentally at odds with the marketing model. The philosophy of health care services in Canada is based on equality of rights to receive social benefits and goods, equity of need, and fairness: values which are seen as incompatible with the marketing context, where goods are sold only to those who can pay for them (Severijnen 1994; Wallack et al. 1993; Walsh 1989). Health services are intended to distribute health care equitably as a 'social good'. Health care in Canada is seen as a basic social right of citizens rather than one to be earned in the
marketplace. "One deserves health care because one is a member of the community for which health is an important value" (Wallack et al. 1993, 14).

Social marketing concepts, then, cannot be directly applied to health promotion contexts because the product and the promoter, and their relationship with the user, are different from those of the market. Marketing efforts tend to seek business from only those in the community who can afford to pay to look after their self-interests and frequently reinforce inequities among community members. Health promotion initiatives, however, often serve community-wide interests, or those in poor health, in an effort to promote the common good and reduce inequities in health. As Walsh (1989) notes, basic public goods and services "should not be treated like soap powder, reducing fundamental social choices to politics of the supermarket" (15).

The concern about the "commodification" of health (Chapman Walsh et al. 1993) may be rooted in the fact that the notion of consumer or customer does not capture the reality of the multi-dimensional relationship between the citizen and the administration of social services. In the marketplace the consumer enjoys high status: the customer is always right; satisfaction is guaranteed or money refunded. Moreover, consumers act out of self-interest, and most buyers can beware, as the saying goes. Yet 'caveat emptor' is a dangerous philosophy for health care (Mintzberg 1996): as a recipient of public service the citizen/consumer has low status (Stacey 1976). Unlike consumers in the marketplace, the consumer of public goods does not hold the balance of power with his or her
Consumer sovereignty may be viewed as incompatible with the goals of the public service organization (Lovelock and Weinberg 1989). The accounts of focus group members’ experiences with public services tell us they ‘get no satisfaction’ (Marini 1993). Lupton (1994) concurs, noting that “health promotion activities do not represent the public as authoritative; rather they routinely position members of the public as ignorant, apathetic, and passive, needing guidance from state agencies to conduct their lives wisely” (115). Ironically, for McAlister (1995) the primary concern with the use of marketing in health promotion is the “presumed imbalance of power” (417) that would-be health promotion practitioners might hold over those whom they seek to influence; a situation which exists even without a marketing approach.

Neither does the essence of the exchange transaction transfer appropriately. The prolonged realization of being valued as a citizen belies the *quid pro quo* of the exchange transaction (Buchanan, Reddy, and Hossain 1994). Without the resources to ensure that a compromise is reached, the promise of balanced power -- the ‘win-win’ situation (Andreasen 1995) that the idea of exchange proclaims -- may be hollow. Health planning group members felt strongly that in exchange for their efforts, local input should be honoured by the government. While acknowledging the effort of citizens, the minister made the ultimate decision on “New Directions” policy, determining not only the number of community health councils, but who was appointed to sit on the CHB and its governance structures. Likewise, focus group members articulated their need to be respected and valued as citizens in order to participate in health reform, and the need for that
participation to reflect their experiences and reality. Regardless, as Hastings and Haywood (1994) warn, "... if the powers that be go ahead anyway [and override community input or dismiss the considerations of the marginalized] they [citizens] have little recourse" (61).

Critics argue that, with its emphasis on individual behaviour, social marketing forces broader issues to recede into the background, deflecting attention from the social environment and society (Buchanan Reddy, and Hossain 1994; Wallack et al. 1993), and renewing the problem of victim-blaming (Brieger, Jayashree, and Adeniyi 1986-87). While the research data enable us to understand more fully how to encourage individual participation, the capacity of social marketing to address the broader circumstances that stripped focus group members of a sense of citizenship remains dubious. The suggestion that opportunities to participate be moved closer to home for nonparticipants can be criticized for suggesting a simple solution to a complex social problem (Wallack et al. 1993). The social conditions that engender a loss of citizenship and make it improbable that disempowered people will participate are difficult ones to transform.

Similarly, the participants felt that the conditions leading to the defeat of their applications for community health council designation were largely out of their control. As with other experiences of social policy implementation documented in the literature (Morah 1990), problems of administrative control, unfavourable dispositions of bureaucrats, the complexity of joint action, and the ambiguity of policy goals and
communications plagued the implementation of “New Directions.” Facing such effective barriers to action Andreasen (1995) advises that “social marketers might do well to shift their definition of the target market from the individuals to the community” (265). Yet restructuring the delivery of social services to be empowering, and enhancing the government’s capacity for clear communication and implementation policies, require almost herculean social change.

The Contribution of Social Marketing

The most significant contribution of social marketing to this research is its compatibility with a relativist ontology, which provides unique insights into the participation phenomenon.

Health practitioners are looking for tools and techniques that will enable them to understand their clients’ social worlds and the range of social forces that shape their activities. Social marketing is developing “sense making” techniques to convert communication from a process of transmission to a process of dialogue, something health educators are increasingly eager to do (Chapman Walsh and others 1993, 118).

By empathizing with and trying to understand the nonparticipants’ experiences -- essentially examining participation from their perspective -- the importance of being valued as a citizen emerged, drawing attention to the circumstances in society that these people faced and helping the researcher understand the focus group members’ social worlds. The social marketing concepts furthered an understanding of how participation in
"New Directions" was structured to reveal the victim-blaming attitude toward nonparticipants that existed in the absence of a marketing approach. Simply exhorting people to 'take more responsibility' without addressing the environment in which people are expected to participate, raises the ethical concern of manipulation: emphasizing individual behaviour change while ignoring the broader context.

Moreover, the use of social marketing as an analytical framework not only reaffirmed the earlier contention of some scholars (e.g., Hawker 1989; Rosener 1978) that there is no one general style or form of participation suitable for all circumstances, it revealed that participation is perceived differently by, and its pursuit must be tailored to suit different groups in the community. As such, social marketing strengthened the shift toward a notion of differentiated citizenship. Lincoln and Denzin (1994) encourage "trying to live ever closer to the lives about which we write" (582): highly compatible with the social marketing approach.

Social marketing provides a lens, a framework through which to address problems (Lefebvre 1992) that is perfectly suited to the heuristic orientation of research inquiry. It is a customer centred "... way of thinking" (Andreasen 1995, 33). The findings from this study demonstrated that incorporating elements of social marketing, particularly the concepts of exchange and understanding the citizen perspective, is useful in constructing research from the citizen's standpoint. As well, the social marketing concepts contributed
toward understanding why a solitary approach to fostering diverse citizen participation in health reform has failed to generate successful participation experiences.

Segmentation is traditionally used to target different publics based on demographic characteristics, psychographic variables, or benefit-based distinctions. This study revealed that citizenship was a key variable separating participants from nonparticipants. Community members who felt disenfranchised and disconnected from society could not contemplate participating; indeed they were usually unaware that the opportunity existed at all. Delineating such a distinction furthers our understanding of how to foster citizen participation and, unlike demographics or even benefits, it is a condition which can be changed (albeit not easily).

The comprehensive theoretical foundation of the social marketing framework made it an attractive model to use in this study. The theories of social exchange and stages of change were helpful to interpret individuals’ decisions to participate or not participate. As well, the diffusion of innovations theory contributed to understanding how the idea of participating was ineffectively spread throughout the community, via inappropriate communication channels that failed to capture citizens’ attention and interest in participating. Finally, aspects of implementation theory proved useful when making sense of the different perspectives of community members and government officials who implemented the health reform policy “New Directions.”
Admittedly, accepting the citizen perspective may have obscured a more holistic grasp of the health reform process in the CRD. The views and experiences of government officials responsible for implementing “New Directions,” beyond written and video documentation, were not considered as part of the study. The bureaucrats’ side of the story would have undoubtedly added to a fuller understanding of the process. Lacking this information, the social marketing concepts created their own myopic vision of citizen participation in “New Directions.”

Nevertheless, such a citizen-centred approach emphasizes that “standpoint epistemology” (Punch 1994, 89) addresses some of the ethical concerns of deception and exploitation that can afflict research, particularly conventional inquiry. (It may also introduce yet others, some of which remain to be discovered.) A counter argument to the detractors of social marketing who allege its manipulative intent can be that, rather than duping research ‘subjects’ about the intent, method and results of the inquiry, the researcher and her assistant ensured that focus group members and key communicator interviewees were aware of the research questions and data collection procedures. All twelve individuals interviewed, as well as the focus group members, were provided with the opportunity to control, in reference to the interview transcripts, what constituted data. Lastly, the findings and interpretation have been confirmed by some of the individuals who participated in the research study as accurately capturing their experience.
As Lefebvre (1992) notes social marketing is often erroneously characterized as a ‘top down’ approach. Yet, because of its overwhelming concern for understanding the citizen perspective (at both the individual and ecological levels) and working with the citizenry to determine and address their needs, social marketing’s affinity to a bottom-up, community development approach is irrefutable (Chapman Walsh et al. 1993; Lefebvre 1992). As such, it is also participatory. Health promotion practitioners have embraced the theoretical, methodological and ethical aspects of community development, as well as participatory approaches to research and program evaluation that engage citizens in a process of investigation-learning-action. The health promotion discipline’s respect for social marketing will emerge when the approach is no longer defined solely as a communication strategy to encourage individual behaviour change, but seen as an approach to social change -- a way to empower people to take control of their own health. The essence of the provision of health services, and of the rationale for citizen participation in decision-making with respect to those services, is “the respect and dignity of all parties and empathetic understanding of needs, expectations, and perceptions -- as well as professional skill and know-how” (Marini 1993, 172).

Reconciling Social Marketing, Citizenship, Participation and Health Promotion

It would be foolish to suggest that a marketing approach could simply be taken over from the private sector and grafted onto community health promotion structures (Novelli 1990). However, there are valuable ideas from social marketing that can be
adapted to the health promotion context. Admittedly, there is difficulty in knowing what language to use. Lovelock and Weinberg (1990) note that, for marketing to be embraced by the nonprofit sector, "the marketing of marketing itself" (12, emphasis in original) is required, reframing the concepts and strategies in ways that are comfortable for health promotion practitioners. The words used in marketing to describe the relationship between the provider and the user are inappropriate for health promotion because the ‘consumer’ can carry for some connotations of a passive recipient with no responsibility or duty to act (a citizenship of entitlement), and the ‘customer’ implies one who pays for services rendered. Walsh (1989) offers alternatives such as user, recipient, beneficiary, or client that may be appropriate in different contexts, but will not be so in all.

On the other hand, a consumerist citizenship may transform the passive citizen -- the recipient of public services -- into an active consumer. The marketing goal of ‘getting closer to the customer’ can be compatible with citizens’ entitlements to complain (Prior, Stewart and Walsh 1995). Citizens as consumers in a context of public health services can be seen as empowering because citizens are given specific rights to ensure their satisfaction. This can be accomplished with a system that facilitates citizens to voice their complaints about public services.

Thus, accountability becomes directly linked to the process of consumption, not separated from it in time and space as it is through the traditional mechanism of citizen empowerment, representative democracy (Prior, Stewart and Walsh 1995, 16).
However, it is not semantics alone that need to be modified. The notion of consumerism itself is not enough. Hawker (1989) comments on the need for community development to pay much closer attention to the relationship between citizens as consumers of their own democracy. This demands “a realistic approach to the political forces at play in any society and the enhancement of the power of the individual - as a consumer - in that system” (291). Yet, the analogy of citizens as merely consumers of, instead of contributors to, the state undermines the reciprocal relationship that citizens share with one another and society in general. Furthermore, it neglects the role of citizens in shaping policy decisions through which services will be provided to them. “We must also encompass a broader notion of the consumer with power [rights] and with obligations [duties] and the collective and community aspects of consumption” (Walsh 1989, 10). One need not pit the ideas of citizen and consumer against each other. In fact in Walsh’s (1989) definition the idea of consumer parallels that of citizen. Public administrators are beginning to explore the relationship between the concepts of customer, client and citizen (Marini 1993) and the need for the perspective of citizen as consumer (Hawker 1989). Perhaps the word citizen would be a globally appropriate substitute less offensive to community health promotion professionals.

If one substitutes the word ‘citizen’ for ‘consumer,’ the social marketing strategy of understanding such different perspectives aligns more closely with the principles of participation and concept of health promotion. The idea of understanding and respecting diverse experiences and viewpoints is a useful and intuitive one in health promotion. One
need not discard the essence of the social marketing concept -- merely its label. It would seem that health promotion would benefit from embracing, rather than brushing aside, the core marketing idea of adopting the client or public perspective. As one former participant remarked, “I think that the health care system really hasn’t focused on the users of the health care system.” [12] The same can be said of the participation system in “New Directions.” Social marketing, although of assistance in strategizing the communication element of health issues, provides its greatest contribution to the way problems and issues are approached and understood -- by ensuring they are seen from the citizen’s view.

The term ‘citizen,’ with its implications of rights and responsibilities, also meshes nicely with the concept of participation defined in the Declaration of Alma-Ata (WHO, 1978): that people have not only the right Green (1986) but the duty to participate in the planning, implementation and evaluation of health services, policies and programs.

The conceptual compatibility of the ideas of consumer and citizen can be found in the client orientation of much recent public administration research and practice (Marini 1993) and in the concept of a public service orientation explored by Dutch and British managers in their search for a new approach to designing and delivering community public services (Severijnen 1994; Walsh 1989). One goal of public social service practice is to be ‘closer to the community’, which Beresford and Trevillion (1995) suggest, can be achieved through a pro-active understanding of service users’ experiences.
The mission of local government, Rhodes (1987) suggests, is not only the provision of public services, but the strengthening of citizenship. Rhodes (1987) unites the concept of consumer with those of caring and citizenship. The values of caring (respect for persons and their wants) and citizenship (stressing entitlements and obligations to contribute toward the common good) provide the rationale for, and can be enhanced by, consumerism (a focus on community members as consumers of public service that will result in a more accountable, efficient and effective delivery of service to meet distinct needs). The combination of caring and consumerism highlight the obligations of the state to the citizen, and may work toward achieving the goals of marketing, public administration of social service and democracy: bringing the government closer to the consumer, the community, the citizen. The “3C’s”, as Rhodes (1987) refers to the interlinked concepts of caring, citizenship and consumerism, provide an “ethic for local government which both enhances the standing of that institution and contains the potential to motivate all who participate in it” (69).

Walsh (1989) further suggests that other core marketing concepts -- exchange, marketing mix and segmentation -- can also be useful as an approach to the provision of local government services. Clearly, citizens have duties as well as rights. Using the idea of exchange can help to clarify these duties and responsibilities. A marketing analysis can be used to examine what costs and benefits people perceive to accompany their responsibilities as citizens, who does and does not exercise their vote or become involved
in the community in some other manner, and generally why individuals behave as they do.

In this manner, social marketing concepts can also contribute to encouraging citizens to take responsibility for health issues. A social marketing strategy would create a superior exchange -- compared to the competition -- that is socially desirable and easily done (Andreasen 1995). To accomplish this, incentive management is important, as is the improving the citizen's ability to act. Citizens must believe that they have the knowledge and skills to participate effectively. Lacking self-efficacy may contribute toward the decision to not participate, and so the strategy becomes one of increasing citizens' skills in public speaking, or preparing briefs, or chairing meetings or other desired capacities.

Social marketing also points out the importance of recognizing the alternative activities that compete for citizens' time, energy and commitment. Often social marketers must demarket, or reduce the desirability of the competition, as a means of facilitating the proposed behaviour change. Mobilizing the significant social pressures influencing citizens constitutes a fourth strategy. The use of respected and familiar opinion leaders and role models in the community often serve to trigger adoption. Particularly when the benefits of participating may be long-term, or occur only in the absence of something else (e.g., a two-tiered health care system), the use of extrinsic rewards or added benefits, in addition to managing costs and incentives, may help foster participation.
The marketing mix is a useful mnemonic device that serves to remind programmers that marketing is more than promoting or communicating an activity or message; the mix incorporates other factors that influence the overall success of the marketing strategy. More importantly, the marketing mix encourages health promoters to think about what they are offering -- the product -- in terms of the (different segments of) citizens they are targeting and their respective needs. Again, if the terms are distasteful, one can affix new labels. From the perspective of the citizen, health promotion practitioners need to ask: what is (the perception of) the initiative or opportunity being offered? What are the (perceived) expectations of citizens, and what can they expect to receive for engaging in the opportunity or adopting the initiative? Where can the public find the opportunity, and in what ways is awareness and knowledge of the opportunity most appropriately generated?

Indeed, market research techniques are wholly suitable for assessing the public’s needs and wants. Such techniques as focus groups and consumer panels provide a means through which local government can learn from citizens, and provide a useful balance to the political and professional voices that traditionally dominate and influence public decision-making (Prior, Stewart and Walsh 1995; Severijnen 1994). The emphasis on citizen perception is useful because of the temptation for providers to believe that they have a better understanding of what is required than does the user (Beresford and Trevillion 1995; Marini 1993). “We cannot assume that professionals necessarily know what is good for people never mind what they think their needs are” (Walsh 1989, 17).
Enabling effective participation requires that as consumers, citizens are seen to have rights and thought of as equal with providers (Hawker 1989). The principle of participation (Green 1986) reminds us that citizen involvement in directly shaping the design of the participation opportunity can 'pay off' in terms of utility, acceptability and ownership.

George and Compton (1990) recount the introduction of marketing to a Red Cross organization. While initially suspicious of marketing as "crass and unprofessional" (253), health care personnel reported positive experiences using and understanding the marketing concepts six months after the training session. Particularly notable was the shift in thinking toward the blood donor perspective. Other research demonstrates the applicability of the marketing approach in the search for more accessible and acceptable health services (Brieger, Jayashree, and Adeniyi 1986-87; Finau 1983).

**Relationship Marketing**

A recent shift in marketing theory is relationship marketing -- establishing, developing and maintaining successful relational exchanges. Gundlach and Murphy (1993) argue that successful relational transactions -- fair and open exchanges -- must be founded in the ethical precepts of trust, equity, responsibility, and commitment. Smith (1990) found that perceptions of inequity or unfairness reduce the satisfaction of, and trust in, exchange relationships. Similarly, Morgan and Hunt (1994), found dimensions of
commitment and trust to serve as important mediators in the development of cooperative relationships. Relationship marketers suggest that commitment and trust are developed when partners attend to relationships by (1) providing resources, opportunities, and benefits that are superior to those offered by alternative partners; (2) maintaining high standards of values and partnering with those who have similar values; (3) communicating valuable information such as expectations and evaluations of the partner’s performance; and (4) avoiding malevolently taking advantage of their partners (Shelby and Hunt 1994, 34).

The ethical dimensions discussed in establishing relational exchanges seem applicable not only to relationships among business partners, but to the relationships between government administration, community organizations and individual citizens as well. In this study, the participants’ perceptions of an unjust and unsatisfactory ending to their participatory efforts are not surprising given the shaky ethical foundation of their exchange relationship with the ministry of health. Indeed, their sense of lack of equity stimulated health planning groups to present their case to the provincial Ombuds Office; a common retaliatory act in the absence of equity (Gundlach and Murphy 1993).

“To respond to new demands for participation in problem definition and planning, public health advocates will need to rethink their relationship with populations they seek to serve” (Wallack et al. 1993, 16). As Staeheli (1994) has observed, there may be a public desire to create the conditions for active citizenry in the context of a
responsive government and a caring and respectful community. Relationship marketing may provide a promising framework to rethink citizenship practice and provide a means to improving the context of citizen participation.

Citizens need to learn the skills and knowledge necessary for participation, and they need to be given opportunities and incentives to participate. Skills, knowledge, opportunities and incentives are not innate, but must be developed, often by government policies and institutions (Kymlicka 1992, 43).

Citizenship, then, requires a relationship of mutual learning, openness and trust between and among local government and citizens (Prior, Stewart and Walsh 1995; Berry, Portney and Thomson 1993). Relationships rooted and nurtured in trust, commitment, equity and responsibility may well serve to promote a citizenship culture where there is an appreciation for the limitations and potential of government. (A relationship that would have facilitated the health planning groups and the ministry of health to understand the perspectives and decisions of each other: the communities’ desires for local health councils and the government’s responsibility to act in the best interest of the rest of the province.) As such, citizenship would be regarded not merely as a set of rights or a burden of obligation, but as a partnership in which there is “an opportunity for self-fulfillment and a reciprocal relationship between citizens and the state” (Oliver 1991, 165).

Relationship marketing between the state and citizens ideally begins at the level of community health councils or, in its absence, regional health boards. A large part of one’s experience as citizen is shaped by such community levels of government and its
services (Beresford and Trevillion 1995; Prior, Stewart and Walsh 1995). Community health councils and/or regional health boards are uniquely positioned to serve as an intermediary, local level of government between citizens and the provincial government. It is also a context through which many of the rights (particularly social) and obligations of citizenship are exercised, and as such, is the logical place to begin reframing the structures of participatory democracy. Although the findings from this case study confirm the contention that decentralization does not necessarily correlate with community participation (Collins and Green 1994), community health councils and/or regional health boards nevertheless represent a level of government that is familiar and close to the lives of people. Further, it is a setting that holds the potential for interpersonal interaction between citizens and the local health governance structure; interaction “which lies at the heart of the theory of participatory democracy” and leads to a trustful and cooperative relationship (Berry, Portney and Thomson 1993, 10).

Members of the councils and boards might seek to establish an equitable and trusting relationship with both the provincial health officials and the constituents, but it is particularly with the latter that the strengthening of citizenship can begin. In order to establish a process of mutual learning and dialogue, as well as build trust, members might begin with extensive outreach and innovative participation opportunities with community members as a means of achieving active or experiential representation. Building trust also requires enabling citizens’ involvement right from the beginning of an initiative, clarifying the responsibilities and benefits citizens can expect from their involvement, as
well as accommodating multiple perspectives (Beresford and Trevillion 1995). Incentive and cost management is also an important task for community health councils and regional health boards to assume in order to foster and sustain the participatory relationship.

In addition, as a body accountable for the provision and quality of public health services, community health councils and/or regional health boards would want to ensure that services are delivered in ways that enhance self-esteem and encourage people to be dependent and responsible; to be empowering rather than disempowering. A local level of government that encourages constructive feedback through a complaint system is an important mechanism for mutual learning (Prior, Stewart and Walsh 1995). In this way, the experience of citizenship can be strengthened for disadvantaged constituents.

A Citizen-Centred Approach to Health Promotion, Participation and Citizenship

Figure 6.1 depicts the shared dimension of the concepts of social marketing, citizenship, health promotion and community development: a concern for the citizen and his or her involvement in the decisions that concern his/her health. This figure illustrates the unanimity of these concepts or frameworks, and how no one approach excludes any other. Social marketing may actually complement a community development approach or other health promotion initiative (Lefebvre 1992), and certainly is thought to enhance the public administration of services (Severijnen 1994; Walsh 1989). As with the
experience in the CRD, labeling a project as 'community development' may be the politically and financially expedient thing to do in order to satisfy granting agencies' increasing demands for more local involvement in research and intervention. However, it often belies the dominance of professional involvement and the origin of the issue.

Labonté (1990) has commented on the tendency to label community-based programs, such as heart health and smoking prevention, as community development initiatives when in reality they are professionally driven and delivered. Community (or locality) development as defined by Rothman, Erlichman and Tropman (1987) calls for community self-determination of problems and solutions. Ensuring a program involves, understands and respects the citizen perspective may bring it more in line with a true community development model and away from the social planning-in-community development-clothing version that is currently so prevalent.

Similarly, the health promotion principle of participation, and the discipline's slogan that advises professionals to "be on tap, not on top," argues for a citizen-centred approach to planning and delivering health services. The discipline's temptation to label a professionally initiated and provided health education (predominantly a disease or health issue related) program as 'health promotion' suggests that health promotion practice can also benefit from emphasizing the patient or client (usually a socioenvironmentally related) view. In describing an empowerment education approach to practice, Wallerstein (1992) encourages a process that fosters independence, a curriculum that emanates from a
dialogue with participants, incorporating their "personal experiences into an analysis of societal forces and an understanding of people's role to challenge those forces" (204).

Understanding and respecting citizens' perspective, as well as developing a trusting relationship between the citizens and the state, is compatible with participatory research in health promotion in which shared decision making and responsibilities between researchers and community members is encouraged. Health promotion, participatory research, empowerment and community development share an emphasis on the participation of people in the development and operationalization of policies and programs to shape the decisions that influence their health (Hamilton and Bhatti 1996) and, thereby "increase control over, and improve, their life conditions" (Green et al. 1995, 18). Allison and Rootman (1996) discuss the compatibility of community participation in health promotion research. In reviewing the influence of public participation in the activities of the North York Community Health Promotion Research Unit, the authors found a participative model to reduce the researchers' control over the content and process of research, yet this did not necessarily compromise the rigour of the research. What a participatory approach does require is additional "time, patience and the ability to negotiate with community partners" (Allison and Rootman 1996, 338). Green et al. (1995) concur, and while endorsing the strengths of participatory research, note that some policy issues and research problems demand more expedient and efficient methods than participatory research, as well as attention at provincial and national levels.
The Healthy Communities movement is an example of citizen participation at the municipal government level where citizens have shared in the responsibility and decision-making and profoundly influenced their local life conditions (Wharf Higgins 1992). Many of the hopes for the community health councils and regional health boards to serve as venues for local democracy were pinned on the successes of the Healthy Communities initiatives in British Columbia.

Finally, there is the potential for a consumer emphasis to enhance the theory and practice of citizenship, although this in no way is meant to endorse the conservative view of active citizenship. Citizenship is not meant to be earned nor privatized (Fierlbeck 1991); if the entitlements of citizenship are conditional on the performance of the legal and moral obligations of citizenship -- particularly the active obligation of service -- it defies the very core of citizenship: its principle of inclusion and equality. "If we try to privatize the provision of goods that are not in the core, in other words, to pare down the rights of citizenship to the minimum, the effect may be to weaken people's sense of citizen identity, and to erode the core itself" (Miller 1995, 443).

A consumer flavour to citizenship, however, may serve to clarify the muddy waters where civil, political and social rights, the legal and moral duties of citizens and the duties of the state tread uneasily. A consumer perspective highlights the obligations of the state to the citizen, so that in the wake of funding cuts to public services a resurgence of active citizenship does not replace the core of entitlements. The key aspects of
consumerism are choice (Prior, Stewart and Walsh 1995) and a citizen-centred approach to citizenship and participation. Much like Wallerstein’s (1992) empowerment education approach, citizen-centred participatory democracy necessitates a mutual dialogue between government, public services and citizens, experiential representation as well as accountable public services that engender citizen independence and control. The administration and delivery of public goods and services in a manner respectful of citizens’ civil and social rights and needs creates an environment in which citizens feel they belong, can and want to contribute.

A consumer emphasis may also contribute to a differentiated understanding of citizenship in which the distinct needs of historically oppressed groups are recognized and accommodated. The findings also support the work of Kymlicka (1992; 1995), Phillips (1995) and Young (1989; 1995) in their argument to recognize the differentiated rights of minority cultures and oppressed groups. Citizens have different needs and interests according to their circumstances and experiences in society. In light of their different situations and experiences, citizens will bring with them distinct assumptions and experiential knowledge. This demands varied and tailored opportunities for participation to facilitate meaningful decision-making (Prior, Stewart and Walsh 1995).

The rhetoric of citizen participation promises to transform institutions (particularly social service institutions) into more effective instruments of democracy and provide a mechanism for citizens to voice their opinions or influence decisions in
planning or policy making. The discourse also suggests citizen participation can build
competence in and educate citizens about the political process, and especially reduce
alienation, strengthen social networks and foster a sense of community. Yet, if the
rhetoric of citizen participation is to be realized the status, practice and context of
citizenship must be reframed closer to home.

In chapter two, one definition of community participation in health was cited as a
way to conceptualize the phenomenon for the purposes of this study. Bracht and Tsouros
(1990) defined it as

the social process of taking part (voluntarily) in either formal or
informal activities, programs and/or discussions to bring about
improvement in community health services and/or resources (201).

The findings of this research suggest that an amendment be made to the above
statement, particularly to the voluntary aspect of the definition. The findings argue for an
extension of the definition of consumer in social marketing to ensure participation in
democracy. As such, participation becomes both a right and a responsibility of
citizenship, not merely an act of volunteerism. As well, participation becomes a political
process. The formal and informal distinction of the definition is a good one, as it provides
flexibility as to how, when and in what capacity citizens can choose to be involved.
However, all types and forms of participation must be respected as equal contributions,
and not valued based on duration, sophistication, expertise etc., or participation will
become a market-driven activity once again.
**Participative Citizenship**

Blending citizen participation with the notion of consumer proposes a new definition of citizenship: participative citizenship. The notion of consumer germinates both the right and the responsibility to participate. Citizenship is not just about one's legal standing, but, perhaps more importantly, as the research of Pincentl (1994) and this case study suggest, reflects one's economic and social well being, and a sense of community and involvement in that community. It is social rights which nurture one's sense of personal empowerment and respect, as well as one's responsibility to collectively engage in the life of the community to self-determine problems and solutions.

More than being a good neighbour, citizenship must also increase a sense of ownership in the political and governing process (Kymlicka 1992). A participatory context that nurtures a trusting relationship between and among the state and its constituents by respecting and representing diverse citizens' perspectives, offering diverse opportunities for involvement and responding to citizens' input and efforts, may facilitate organizational and community empowerment.

Participative citizenship (a term introduced by Prior, Stewart and Walsh 1995) provides one suggestion to reframing the status, practice and context of citizenship closer to home. The findings from this research argue that a participative citizenship is grounded in the disciplines of social marketing, citizenship, health promotion and community
development. Rights, responsibility, respect and responsiveness plant the seeds for participative citizenship. In particular, Figure 6.1 illustrates that participative citizenship blossoms with:

1. A government that understands, respects and represents diverse consumer perspectives of needs and experiences, one that accommodates the multiple realities in which the opportunity to participate can occur, and one that is responsive to the efforts and inputs of citizens. The context of citizenship becomes strengthened when a relationship of commitment, trust and mutual learning is established;

2. Individuals who possess the formative and substantive rights of citizenship and thus are empowered to fulfill their obligations and responsibilities as citizens to engage in collective action;

3. The opportunity for citizens to participate in every stage of the planning, delivery, management and evaluation of health programs, not only in consuming services or resources; and,

4. A system which facilitates residents' self-determination of problems and solutions, rather than government or professional pre-determination.
Figure 6.1: The Flowering of Participative Citizenship

1. Social Marketing - understanding, respecting and representing the consumer perspective

2. Citizenship - the right and responsibility to engage in collective action

3. Health Promotion - principle of participation

4. Community Development - residents self-determine problems and solutions

Participative Citizenship
Concluding Thoughts

Despite its continuing ambiguity, empowerment has become a cornerstone concept in health promotion and health (Sheilds 1995; Jones and Meleis 1993; WHO 1986), associating participation in decision-making (Wallerstein 1992), control (Schulz et al. 1995) and connection (McCarron, Tenenbeiri, and Hindley 1994) with positive health status and quality of life. Citizen participation has been understood to be an empowering process in itself, as well as a consequence of an empowered constituency. In addition, an involved citizenry is a prerequisite to a high quality of community life (Chapin and Denhardt 1995).

Community-based services that facilitate meaningful participation may influence individual perceptions of control and belonging, and, in turn, improve health. The findings from this case study can inform health promotion practice that is “designed to enhance access to opportunities to participate [in] and [to] influence [policy], particularly among members of the community who have been traditionally denied access to decision-making processes” (Schulz et al. 1995, 325). Fostering broad-based participation requires new ways of thinking about participation (Kelly and Vlaenderen 1996); ways that are organic and holistic (Smith 1995), and which respect and reflect diverse citizen perspectives.

As a person of social privilege, I am not likely to go outside of myself and have a regard for social justice unless I am forced to listen to the voice of those my privilege tends to silence (Young 1989, 263).
Young's (1989) comments certainly capture the experience of this researcher. By listening to the voices of focus group members, persons whose lives were far more disadvantaged than the author's, and for more than just the obvious reasons than having money, one's physical and mental health, a job and being Caucasian, and even a sense of personal empowerment, could explain. It seemed that the one thing citizens should all have in common, despite and because of differences, was missing from the lives of these people. Rights are at the heart of participation; rights which can provide some safeguard and trust and legitimacy for people to make their own choices about how they live. The story of health reform in the Capital Regional District points to the importance of a differentiated concept of citizenship and of a citizen-centred approach to understanding, fostering and sustaining broad-based participation. Further, the story also suggests that a new idea of citizenship, a participative citizenship, is founded on four "r's": rights, respect, responsibility and responsiveness.

Further Inquiry

Almost twenty years ago, Judith Rosener (1977) noted that citizens, government officials and professionals each [view] participation from a different vantage point, [have] different participation goals, different organizational and economic constraints, different time horizons and different participation needs (58).
This research enhances and extends the literature on participation from the citizens’ perspective. Some suggested areas for further inquiry include:

1. A greater understanding of the relationship between citizen expectations, perceptions, and satisfaction/dissatisfaction of public health services, may help to determine the appropriateness of a consumer emphasis for strengthening citizenship (Rhodes 1987). “The relationship among such notions as “customer”, “client”, and “citizen” is worth our concern” (Marini 1993, 172). Is local government a context in which democracy and citizenship can be restored?

2. An understanding of the bureaucratic perspective of citizen participation. What do government officials seek in exchange for establishing a relationship of commitment, trust and mutual learning with citizens?

3. Exploring the use of, and implications from, a participatory action research methodology when studying citizen participation in health promotion research. Exploring the utility, relevance and application of these findings in health promotion practice. As well, the results from this study may well be transferable to other initiatives involving citizen participation. Can these findings be applied in practice to enhance citizen participation in health promotion and other contexts, such as urban planning, public administration and volunteerism? Specifically, can The Participation Experience be redesigned to meet a variety of constituent needs, and flexible in how it is delivered in the community? For marginalized residents, can the experience be viewed from their perspective, acknowledging the multiple realities in which participation can occur? By repositioning the opportunity to participate and moving it
into the "backyards" of citizens -- environments that respect the diverse experiences and realities of citizens -- will the sense of value and belonging absent from the lives of many disenfranchised constituents be restored?

In *exchange* for participating in health reform, individuals seek to be valued as equal and respected members of the organization and community. To strengthen the experience of citizenship, and the potential for people to practice it, there must be societal support for people to achieve their basic needs as healthy and autonomous members of the community. Is it possible for public services to be delivered in ways that enable people to feel and act like full citizens -- ways that enhance, rather than detract from, self-esteem, and that encourage people to take control over their lives and the decisions that affect their lives?

In order for citizens to believe that they can make a difference and be motivated to participate in community activities, they need to have trust in the process. For disadvantaged groups, trust may only be possible if some experiential representation is achieved. Will participation in the experiences of a variety of citizens, to learn about the issues and problems people face in everyday life, achieve representation that is reflective of the community?
Will ensuring that the *Place or position* of the participation opportunity is close to home, and in the context of citizens’ everyday lives, facilitate participation? Are personal invitations or referrals successful in recruiting broad-based participants?

Can the *Promotion* of the participation opportunity, if written clearly, free of jargon and visually appealing, pique citizens’ interests in participating? Will simplifying and personalizing the message serve to convey the value of citizen participation, emphasizing that ordinary citizens have the abilities and skills to contribute and make a difference? How effective are promotional efforts that reach citizens in their daily routines? Interpersonal channels of communication, especially face-to-face communication between homophilous individuals (‘near peers’), influences the decision to adopt a new practice (Rogers 1983). Are promotional efforts most effective if accompanied or followed by a personal invitation to participate?

**Postscript**

In May 1996 the electorate of British Columbia re-elected the New Democratic Party. A new minister of health was appointed in June and within a short time she put regionalization “temporarily on hold” (“New Minister Outlines Priorities for Health” 1996). While her acting deputy minister noted that the minister had “no intention whatsoever of moving backward with respect to the objectives of regionalization” (“MLA Review Team Appointed” 1996, 2), a review process of “New Directions” was initiated.
The minister assembled a team of four members of the legislative assembly, supported by a three person “reference group” -- a vice president and executive director from two regional hospitals, respectively, and a senior member of the Vancouver Health Board. The review team and reference group were asked by the minister to conduct a “candid assessment” (“MLA Review Team Appointed” 1996, 1) of how well the regionalization process was meeting government objectives, in light of the five “new directions”: better health, greater public participation and responsibility, bringing health closer to home, respecting the care provider and effective management.

The review focused on the concerns expressed about “New Directions” including infrastructure costs, the roles of community health councils and regional health boards, duplication of services, the participation of existing volunteers, and the increasing fiscal pressure facing the health care system. During the interim period, a moratorium on regional health board and community health council activity was in place until the review team announced their recommendations. The moratorium forbade councils and health boards from finalizing any amalgamation or affiliation agreements with health providers and organizations, staff transfer agreements or bylaws, establishing advisory committees, or employing of administrators and other staff.

In light of this news, the Capital Health Board decided to await the outcome of the minister’s review before reconvening regular meetings and other activities of the Board. The CHB office remained open and operative during the transition period. The Greater
Victoria Community Health Planning Advisory Committee opted to continue its meetings over the summer. Early in July the chairs of the three Community Health Planning Advisory Committees in the CRD met with the chair and staff of the CHB to discuss the roles and relationships between the CHB and the advisory committees. The advisory committee chairs expressed concern about their relevance during the review period. “They were assured community involvement continues to be a cornerstone of health reform” ("MLA Review Team Appointed" 1996, 5). For six months, the prognosis for “New Directions” remained uncertain.

In November 1996, and based on the review team’s report, the minister announced a more “streamlined approach to health care regionalization: Better Teamwork, Better Care - Putting Services for People First” ("Changes to Health Plan Put Services for People First" 1996, 1). The successor plan to “New Directions” was initiated to in order address the perceived and real flaws both in the model and in the way it was being implemented around the province. There is no question New Directions started with some great ideas and a worthy objective to take health care decision-making out of Victoria and Closer to Home . . . But, the roles of the players were confusing . . . Somewhere along the way the original plot line began to get lost, and despite all the hard work and dedication that was poured into it, at the end of the day the process itself became too unwieldy ("Address of the Honourable Joy K. MacPhail Minister of Health and Minister Responsible for Seniors, November 29, 1996, 1-2).

As a result, the new plan reduces the number of regional health boards to 11 from 20 and 34 community health councils from the 82 established under “New Directions.”
Unlike the "New Directions" model, the responsibility for local health care decision-making and management will rest with either a regional health board of community health council, not both. All RHB and CHC members will be appointed by the minister, people who represent "a broad range of skills and experience in their region or community" ("Address of the Honourable Joy K. MacPhail Minister of Health and Minister Responsible for Seniors, November 29, 1996, 4). The ministry will take responsibility for establishing performance guidelines, as well as tracking and auditing the quality and accessibility of health care, patient satisfaction and waiting time for treatments province-wide. These results, as well as the activities and progress of RHBs and CHCs will be available to the public in an annual report.

Notably absent from the new "Better Teamwork, Better Care - Putting Services for People First" policy is mention of ongoing citizen participation. There will be no democratic processes to elect members to RHBs and CHCs. The reconstituted RHBs will have a maximum of fifteen members, six fewer than those under the predecessor "New Directions." The membership will include one physician and one health care union representative, and the remaining members will "reflect the population distribution and diversity in the region" ("Better Teamwork, Better Care Facts", 1996, 4). The chair of the CHB, the first regional health board to be appointed in the province, is president and chief executor of Centra Gas and chair of the Greater Victoria Hospital Foundation. While the appointments are to be applauded for achieving gender equity and including a First Nations representative, it seems that the remaining eleven appointments of the CHB,
representing the following ‘interests, experiences, and population distribution’, have failed again to mirror the diversity of citizens in the CRD:

- two retired nurse-administrators with previous experience as executive members of various nursing and hospital organizations;
- a former federal minister of Indian and Northern Affairs, Public Works and the Treasury Board;
- a former mayor of one of the CRD municipalities;
- the health co-ordinator for the Saanich Peninsula Tribes;
- a professor of law at the University of Victoria;
- a bookkeeper and executive member of several community organizations;
- chair of one of the regional hospital societies;
- a retired federal deputy minister of Energy, Mines and Resources; and
- a former business manager of a labour union.
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# Appendix E

## Interview Fieldnote Reporting Form

**Date & Time:**

**Location:**

**Interviewee Number:**

**Consent Form**

*Turn the Tape Recorder On!*

**Q. 1** Please tell me a little bit about yourself: age, education, employment, family, hobbies, other community activities, experience with the health system, how long you have lived in the CRD

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<th>Brief Summary/Key Points</th>
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Q. 2 Please tell me about your involvement with New Directions and what influenced you to become involved—when you started, why, in what ways/activities you prefer to become involved.

- attitude/belief about participation in community-based health
- what you expect as a result of participating
- confidence that you can make a difference to the process, strengths, expertise
- how/in what ways you prefer to participate

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Q. 3 What do you see are the personal and community benefits of participating? What about costs? Are there any barriers that you encountered to becoming involved?

- self-development, learn skills, use skills, meet people, sense of community, ownership of activities etc.
- time, frustration, boredom, time away from family/friends/hobbies, fear, intimidation, personality conflicts, not seeing outcomes, etc.
- transportation, money, scheduling, lack of education etc.

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Q. 4 *Tell me what you do with/in/for the health planning groups, and how satisfied you are with your involvement in the process.*

- chair meetings/attend meetings/organize focus groups/ write surveys/ write DD etc.
- what skills/knowledge/expertise do you use?
- duration/rate of involvement; number of hours volunteered
- are you happy with the process to date? What would you change?

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Q5. If you were to use a metaphor or slogan to describe your participation in the work of the health planning group, what would it be?

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Q. 6 From your position as a citizen, and as a professional, do you think that the work of the health planning group has represented the community? Who is missing?

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APPENDIX F

FOCUS GROUP FIELDNOTE REPORTING FORM, INFORMATION SHEET, AND FEEDBACK FORM

Date & Time: _____________________________________________________________

Location: ______________________________________________________________

Number and Description of Participants:

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________
Responses to Questions:

Q1. What the word “health” means to you/What are some health issues for you?

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Q2. What has been your awareness or experience with New Directions up to now?

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Q3. *Why have you not participated fully or at all in New Direction so far?*

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Q4. What do you see as some of the questions, concerns or issues that you, as single parents/persons with disabilities/street youths/youths/persons with mental illness may have about New Directions?

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**Q5. What can be done to encourage or make it easier for single parents/persons with disabilities/street youths/youths/persons with mental illness to participate in New Directions?**

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Q6. What are the most affordable, convenient, and people friendly ways for you to participate in the health reform process?

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Information Sheet

Please tell us a little bit about yourself! The following questions will give us information that will help us to understand your comments from the group discussion.

Please circle the answer that describes yourself:

1. I am... 13-18 years of age 19-24 years of age 25-35 years of age
   36-49 years of age 50-65 years of age 65+ years of age

2. I am... Male Female

3. I am... Single Married Divorced Widowed

4. I have... no children 1-2 children 3-4 children 5+ children

5. I am currently working... Yes No
   If Yes, do you work full time? Yes No
   or
   Do you work part time? Yes No

What kind of work do you do? ________________________________

6. I am currently in high school/technical school/college/university...
   Yes No

I have completed grade________

I have attended technical school/university/college for ________ years
Feedback Form: Your ideas and opinions are important to us. We welcome your comments about today's discussion.

If you would like a copy of the focus group discussions to read and give us back comments on, please put your name and how we can contact you below (mailing address, or organization address/phone number). We will send you a stamped envelope for you to return your comments in. THANKS!

________________________________________
Name

________________________________________
Address/Phone Number