Developing Approaches to Health and Social Service Planning in the Inner City

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The Institute of Urban Studies

THE UNIVERSITY OF WINNIPEG

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The Institute of Urban Studies is an independent research arm of the University of Winnipeg. Since 1969, the IUS has been both an academic and an applied research centre, committed to examining urban development issues in a broad, non-partisan manner. The Institute examines inner city, environmental, Aboriginal and community development issues. In addition to its ongoing involvement in research, IUS brings in visiting scholars, hosts workshops, seminars and conferences, and acts in partnership with other organizations in the community to effect positive change.

DEVELOPING APPROACHES TO

HEALTH AND SOCIAL SERVICE PLANNING

IN THE INNER CITY

A Report to the Honorable S. A. Miller

Chairman, Cabinet Committee

on Health, Education and Social Policy

Government of Manitoba

Prepared by

Institute of Urban Studies
University of Winnipeg

February 1973

INTRODUCTION

This report represents the summary of the work requested of the Institute of Urban Studies by the Provincial Government in June 1971. Since that time your department has received two interim reports from the Institute (December 1971, May 1972) and an initial draft of this paper was discussed with members of your implementation group in December 1972.

The Institute accepts the desirability of citizens being involved in the planning and renewal of their neighbourhoods, and much of our work has been concentrated to this end in the inner city of Winnipeg. Small but significant advances have been made in encouraging residents and neighbourhood institutions to take self-responsibility for development and in all cases a citizen-based organization has been formed for this purpose. The case of a local church is an interesting example, where both members and community residents are working together on a new development program. These types of self-help service programs do not exclude planning activities by governments: in fact they often represent responses to government initiatives in areas such as housing, renewal planning, social services, and job training. But they do represent the need for planning interventions of all kinds to take into consideration the needs of particular communities and the abilities of residents of these communities to engage in planning and direct service roles. Simply put - people must have a hand in saving themselves; they cannot and will not be saved from the "outside".

Your request to the Institute to initiate a consideration of health care in the inner city and particularly in Urban Renewal Area II must be seen in this light, and not necessarily in the context of organizing a group of citizens to request a community health centre. The initial agreement between the provincial government and the Institute placed an undue emphasis on the health centre concept, and led to a clarification of the contract early in 1972, wherein the perceptions of health needs and health services on the part of both consumers and practitioners was included, as well as the continued support of citizens concerned with improving health services in the area.

The Institute's report represents a modest contribution to the current debate on health care in Manitoba, a debate for the most part dominated by the government health planners and the professional associations in the health care field, in particular, of course, the Manitoba Medical Association. The description of our report as modest is used deliberately. As your 'White Paper on Health Policy' points out, the health care enterprise in Manitoba is a large and complex one, representing some 180 million dollars annually.[1] The sizeable nature of this service is clearly evident in the area of the city in which the Institute was engaged, where the Health Sciences Centre occupies a central position, with a large medical clinic close by and a concentration of similar medical offices in the nearby downtown area. Beyond the eastern boundary of the area (Main Street) is the Mt. Carmel Clinic, which draws people from the Urban Renewal Area No. 2

neighbourhood. At the same time there are many social agencies (some primarily concerned with health matters) which are located in this central Winnipeg area. Thus, the service utilization patterns of the health and social service network of the inner city is worthy of study in its own right, particularly since some of its components have a mandate to provide services on a city-wide and even province-wide basis. The Institute did not engage in such an undertaking but rather talked with administrators and staff of these various organizations to get some understanding of what services were provided, and to whom, and some of the problems involved in meeting the needs of the inner city.

A second area of needed major study involves the health activity of this inner city population. We are referring to the whole complex of factors relating to health status, health practices and behaviour, health utilization patterns, and the impact of the community itself upon health activity.[2] Of these four interrelated factors, most studies are concerned with utilization patterns, i.e. whether or not one goes to a private doctor or to the outpatients department. With Medicare, the question of accessibility of services, in this inner city area at least, does not appear to be as important a question as that of the style or manner in which these services are provided.

This is particularly important in an area as heterogeneous as inner city Winnipeg, an area bounded by the CPR tracks to the North, Portage Avenue on the South, McPhillips on the West, and Main Street on the East.[3] The population of this area totals some 40,000 and is composed of many different ethnic groups and newcomers to the city. There are high concentrations of single-family households, particularly elderly, while the income levels, although generally lower than the average for the city, vary considerably between those at the very bottom of the income scale and those earning close to the Winnipeg average. A large percentage of families are below or near the poverty line. The environmental conditions of this area also vary considerably from pleasant, tree-lined streets and good houses to blighted areas close to railway tracks and industrial premises with dilapidated houses and buildings. From a social environmental point of view, there is evidence of social disorganization in high rates of alcoholism, illegitimacy, venereal disease, family breakdown and mental illness. It is generally accepted that these various social, economic and environmental conditions impact on each other and affect the health status of their populations.[4] However, before health and social services can make any fundamental decisions about the style of services best suited to this area, considerably more data in the area of health status, health behaviour and community diagnosis will be required. Such studies on population morbidity and health behaviour are generally conducted by public health authorities and/or the community or

social medicine departments of medical schools, while for the community diagnosis research, a team comprised of the foregoing departments, plus additional urban specialists from the universities would be required. We see the initiation of such investigation as important to the whole question of providing good health care to inner city populations.

These two studies, therefore, can begin to provide the on-going data base for health care planning in this inner city area. Five categories at least could begin to make up the health information system: 1. status of community health; 2. utilization of health services; 3. general population and housing characteristics; 4. inventory of health facilities and health services, manpower, and; 5. status of community environment.[5]

METHODOLOGY

It is in the light of this necessary information for health planning in the inner city that we describe our contribution to the health debate as modest. Our findings are the result of working with a group of area residents who both conducted interviews and held meetings to talk about health matters, and who eventually set up their own organization called the Health Action Committee* and established a store-front operation to provide

*Note: The Health Action Committee has recently secured the services of a CYC worker to direct the community organizing aspects of the project and has received a LIP grant to hire seven people as neighbourhood health workers.

information on health services and on occasion to make home visits as a follow-up to referrals. Institute staff both assisted with the interviews and meetings, as well as reviewed a wide variety of literature pertaining to health matters, some of which provided ideas and methods for health planning in the inner city.

Why a university-based urban institute with professional and student resources worked with a group of inner city residents in an investigation of health care is a question which is often asked of us. The reason has already been briefly outlined in the beginning of this report. It concerns the practice of planning with people, and the method used has normally been that of action research. Action research aims not only to discover facts, but to help in altering certain conditions experienced by the community as unsatisfactory.[6] Action research thus involves a level of action and a level of analysis. In the area of action the practical preparation of a group of citizens is often involved. Besides training the group to function as a group, training in action research methods is also imperative. However, one of the inherent dilemmas facing an organization adopting this research strategy is the tendency to over-emphasize either the service-practical or the research side of the agenda. The solution of this dilemma is not made any easier by the fact that action research as a method is meant especially for the ordinary citizen in his attempts to undertake constructive social change. Thus, this method

is well-suited to the Institute's aim of enabling communities to accept self-responsibility for their development.

In retrospect the Institute's emphasis in this health study has been on the service-practical side of the agenda. This is reflected not only in the process adopted by the Institute but also in the presentation of our findings. In this a series of summary statements are made that take into account the four research activities of household surveys and neighbourhood meetings, interviews with providers of health and social services in the area, the health information office operated by the Health Action Committee and the literature analysis conducted by the Institute. Had the research side of the model been stressed much more precise data could have been presented, particularly from the household surveys, as, for example, the report of a "Survey of Medical Care in the Core Area of Winnipeg".[7]

However, in the case of the survey initiated by the Institute, the survey instrument was used primarily as an organizing tool, both for the interviewers themselves as they designed the questions, worked out the sampling process and reviewed the data, and for the residents of the community who were encouraged to express their opinions about certain personal and community issues, as well as afforded opportunities to meet with other residents who possibly shared similar interests or concerns. The area was divided into eight sectors, with survey and public meeting activity

concentrating in one sector at a time. Different questionnaires were used in each of the first five sectors before the group finally adopted a satisfactory research instrument. Thus, the data cannot speak to the inner city area as a whole. Three sectors were surveyed using the same questionnaire, with one of the sample areas located in River Heights for comparative purposes. This data, therefore, in a very rudimentary fashion, gives some initial indicators of health care in urban neighbourhoods, but lacks the rigour necessary for more analytical purposes in the field of health research.*

Public meetings were held in each of the inner city sectors to give interested people an opportunity to share their experiences about health care and in the earlier public meetings to discuss the government's proposal for community health centres. As one of the interim reports pointed out, these neighbourhood meetings were not that well attended, despite the time and effort that went into publicizing and arranging them. This situation was not unique to Winnipeg, but in fact occurred in several instances in the United States where health planning efforts attempted to involve the residents of low-income communities.[8] These communities like Winnipeg, at first rated health a low priority item in comparison to housing and lack of jobs, although other problems, such as alcoholism and drug abuse, which were also highly rated, were not seen as health problems. Despite the difficulty of interesting and involving residents in health matters, the

*For a more detailed breakdown of the information, see Discussion Paper on Health Care, IUS, December 1972.

American experience in establishing neighbourhood health centres suggests that the most successful centres have included citizens in their planning from the very beginning.[9]

The highlight of the Winnipeg public meeting activity was the community conference in March when about forty residents of Urban Renewal Area No. 2 met to discuss ways of improving health service for their community. The residents who had been conducting the survey and who had formed the Health Action Committee, arranged the meeting, spoke about their work and invited guests from the then Winnipeg General Hospital,* the City of Winnipeg Public Health Department, and the Manitoba Medical Association to address the meeting. The small group discussion that followed suggested that what was lacking was a program that would begin to connect people to the health and social services available in the area. The Health Action Committee subsequently picked up on this idea.

The second aspect of the research program involved a series of interviews with the providers of health and social services in the area. Thus, interviews were conducted with personnel from the Outpatients Department, Emergency Department and Psychiatric Services of the Winnipeg General Hospital, the facilities for free dentistry service in the community, the Winnipeg Children's Hospital, the Manitoba Clinic, the Children's Aid Society of Winnipeg and Care Services. At the same time, interviews were also held with officers of the Manitoba Medical Association, while senior

* Although the Winnipeg General Hospital, the Children's Hospital, the Sanatorium Board of Manitoba (The Rehabilitation Hospital) and the Cancer Research Foundation formed one Health Sciences Centre on February 1, 1973, names of the separate institutions will be used to describe events prior to this date.

administrative staff of the Winnipeg General Hospital participated in several discussions regarding their services and community needs. Members of the Health Action Committee also took part in some of these discussions.

This aspect of the health study was most important in that it not only gave the Institute and the Health Action Committee information on the range of services available to the public, but also an awareness of some of the problems inherent in delivering these services. Some of the on-going plans for improving the services were discussed as well as the general attitude of the service-providers towards the reorganization of health and social services as suggested by the Provincial Government. Thus, both community residents and agency personnel had an opportunity to learn from one another in the sharing of problems and ideas about the delivery of services to the community. For the Health Action Committee these discussions not only introduced them to the people who are responsible for health and social services in their community, but also made them aware of some of the processes and difficulties inherent in health and social service planning.

The community residents also gained an entre to the senior staff of these organizations where both complaints about the services and ideas for their improvement could be discussed. At the same time those responsible for providing services to the inner city had the opportunity of obtaining

feedback from the community as to how these services were being used, what sorts of difficulties were being encountered and what suggestions for their improvement might be made. The exchange of information and ideas therefore between service-providers and residents on improving health and social services to the community was the primary outcome of this aspect of the health research, although the establishment of contacts for future discussions on community health matters was no less significant.

The third research activity referred to earlier concerned the operation by the Health Action Committee of an Information and Referral Office on Isabel Street in the centre of Urban Renewal Area No. 2. In the course of conducting interviews with community residents and talking about health matters during the neighbourhood meetings the interviewers would often be asked for information on what services were available to them, or to which agency they should go with particular problems or complaints. This need for information and advice on health problems was further emphasized at the community conference in March. Thus it became increasingly clear to the Health Action Committee that this service was needed in the community and that they were in a position to assist.

With the information on various aspects of health care in the inner city gained as a result of the discussions with agency personnel referred to above, the members of the Health Action Committee proceeded with their plans

for a health information and referral service in the community. They opened a storefront office and made arrangements with the Social Service Department of the Winnipeg General Hospital to take a weekly orientation program of three months duration at the hospital, outlining the services and eligibility procedures of the various hospital departments and social agencies. Thus, personnel from departments such as Outpatients, Social Services and Psychiatric Services which have a critical relationship to the inner city community began to give support to a group of community residents engaged in a self-help effort to connect people and available services.

The Health Action Committee not only provided information to residents on health and social service matters, but they also visited people in their homes, referred problems to public health nurses and hospital departments (often calling back to see if the service was given) and held informal discussions with staff from Psychiatric Services, Children's Hospital and the Children's Aid Society of Winnipeg on various plans for community outreach services. Members of the Committee were also invited to sit on the planning group for the General Hospital's Ambulatory Care program. This combination of activities might therefore best describe the members of the Committee as informal neighbourhood health aides. The neighbourhood health aide concept has been mostly discussed in connection with the community health centres operating in the United States[10], where the community residents have been trained to work with the health team in a

variety of tasks, including home visiting and homemaker services, education of patients in preventative health techniques, instruction and assistance for clients in following the direction of the physician and information gathering of pertinent histories and problems. Neighbourhood aides have also worked closely with social workers in these centres and have been able, with supervision, to carry their own caseloads. Aides have also been able to assume the role of patient advocates whereby they have combined their sensitivity to patients' opinions and needs and their knowledge of the health system to enable them to intervene on behalf of consumers.

In Winnipeg, the People's Opportunity Services employed community case aides, while the idea of "lay health workers", as part of a community health care system was proposed in a symposium sponsored by the Winnipeg Clinic on the home care aspect of community medical services.[11] The importance of these various references is to indicate the wide variety of tasks and situations in which community residents can be involved in providing health and social services to their neighbourhoods. The members of the Health Action Committee, therefore, on their own initiative and with the support of the Institute, hospital departments, and local social agencies, began to perform tasks as neighbourhood health aides, particularly in providing a linkage function between people and services.

The fourth research activity was that of a review of health planning literature. Of particular interest in this regard was data on health and low income neighbourhoods, health survey research, neighbourhood health centres, utilization and health behaviour studies, health planning models, new types of health personnel and studies of the organization of medical services. (see bibliography). The Institute had already acquired data on the process of involving citizens in planned change, and the subject of change and innovation in both organizational and policy terms was one of its major areas of interest.[12] Although much information was acquired in this way, the primary benefit of the literature review in this context was to provide a reference point on the issue of health planning in the inner city. A supplementary paper analyzing the literature on community health centres is also forthcoming. Thus the literature itself can be used as a planning tool, providing both ideas for the organization of health and social services and correctives in the application of such ideas.

These four activities therefore -- household surveys and neighbourhood meetings, interviews with providers of health and social services in the area, the health information office operated by the Health Action Committee and the literature analysis conducted by the Institute -- constituted the Institute's research program in the area of inner city health care. Some of these activities overlapped, particularly with the development of the Health Action Committee. The findings which follow, therefore, do not isolate

the specific research activity involved, but are a summary analysis of the data provided through this period of study, discussion and service activity. The overall process demonstrates the utility of the action-research model in its dual function of acquiring information on the change area (in this case health) and encouraging the development of a group of community residents informed about certain aspects of the health care system and (with support) able to negotiate for improvements and innovations in that system.

SUMMARY OF FINDINGS

There are five major findings from our health care study that have implications for developing approaches to health and social service planning in the inner city.

1. The data from the program of household interviews, home visiting and community meetings suggest that people in the inner city do not visit a doctor regularly in order to maintain their health, nor do they seek medical attention as soon as they experience a problem. Instead, they delay seeking medical care until it is absolutely necessary and their condition is acute.

There is an obvious need for community education on the use of health services as a preventive and health maintenance activity: at the same time,

some of this reluctance to use the medical facilities may be a result of poor experience with that system in the past. Therefore, a response on the part of the health system must also be developed that can encourage this pattern of personal health care.

The two major sources of medical care for this population are doctors in private clinics, and the Outpatients Department at the Winnipeg General Hospital. Residents from the lowest socio-economic areas of the inner city made greater use of the Outpatients Department than doctors in private clinics. The data from the nine sectors in which interviews were conducted is indicative of this pattern, with over thirty per cent of the respondents in four sectors attending Outpatients. In the remaining five sectors, the percentage use of Outpatients ranged from 2% to 25%. Many of those who used Outpatients complained about the long waiting times and the impersonal service, but they used it despite these complaints because they can get medical attention the same day, and in some cases, free drugs. In general, satisfaction with medical services outweighed complaints, although in some sectors, dissatisfaction with services was recorded by 40% or more of respondents.

With regard to the health status of this inner city population, the data from the interviews, meetings and discussions with providers of services would indicate that sickness and ill health problems are serious problems in this area. It is difficult to give precise figures about such health

problems, and it is even more difficult to state an 'illness level' in comparison to some other area of the city or even some average for the city as a whole.* Our discussions indicated that most health problems in the area are related to such socio-environmental problems as poor housing, poor nutrition and hygiene, lack of information about available medical services, loneliness, and lack of a family or social life. Both the Children's Hospital and the General Hospital's Psychiatric Services are concerned about the number of multi-problem families in the community, while the Psychiatric Services Department also indicated that a significant portion of their caseload of people with emotional and psychiatric problems are people who are lonely, especially senior citizens, adult single males and 'deserted' wives living alone. The high levels of alcoholism and drug abuse are further elements of a complex community health problem.

The health care investigation also talked with people about the government's proposed community health centres. The response of the residents to this idea was basically a pragmatic one: they would use the services if they thought they were worthwhile, but they had little desire to be involved in setting one up. This finding is consistent with our earlier remarks about the small numbers who attended the neighbourhood meetings to discuss health matters. Until there is an understanding that health and

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*Note: This does not refer to the index of vital statistics published by the Department of Health and Social Development.

other community problems are somehow related, most people will likely continue to leave health care to the professional planners. It must also be realized that there are more avenues for participation in planning activities than simply attending meetings or planning conferences.[13] The activities of the Health Action Committee aptly demonstrate this point.

2. It was pointed out earlier in this report that the neighbourhood is perhaps better endowed than any other in Winnipeg from the point of view of facilities and manpower. However, the overwhelming general problem identified in our study is that agencies are presently structured to serve acute emergency needs and have neither programs nor resources to catch early signs of problems or to do preventive work. In spite of the presence of outpatient services, walk-in clinics, emergency-casualty departments, psychiatric services and others, the hospital's primary function is in the area of acute-care treatment. Thus, techniques and arrangements need to be worked out by those involved in a variety of treatment areas to develop approaches to outreach and prevention in the community.

A second pervasive problem is that services operate in a highly fragmented and at times isolated way. This results in the need for additional staff to play a 'liaison' role while for the person desiring treatment, it results in his 'making the rounds' to obtain help. Part of the rationale for the community health centre is to co-ordinate as much care as possible for the patient in one place.

A further problem has to do with priority setting and resource allocation, such that it almost totally excludes new program development, particularly where community services are concerned. One of the major difficulties in any organization is planning a strategy for innovation or change. Most large scale operations are not designed to develop new approaches, especially in the area of social service delivery, and resources are not allocated for that purpose. Thus, the change usually derives from an outside stimulus. However, it is important to note that many of the medical practitioners in the hospital complex and middle-management personnel are very aware and desirous of developing a more intensive service to the surrounding community. What is now needed is a similar awareness and desire on the policy-making level. What is needed is to develop a clear policy by the Health Science Centre on how best to serve inner-city residents and their particular kind of health needs.

With particular reference to the Health Sciences Centre, the most salient finding of the household survey and the community meetings for the members of the Health Action Committee was that although the hospital complex is located no more than one mile from most of the community, people were not utilizing the services of various hospital departments. Many people just didn't know about the various services available, the hours, eligibility requirements for the service or a person within the department to contact for help. In response to this need, therefore, the Health Action Committee's health information office was set up.

In the light of the pressure on the various hospital departments by people from all over the city it might seem foolhardy for the Institute to claim that the services of the Health Sciences Centre can be better utilized by people in the community. However, we feel that this is an important consideration as the Health Sciences Centre plans its Ambulatory Care program and as its Community Care Committee begins to relate to the community.

3. The third major finding concerns the potential of the neighbourhood health aide role as demonstrated in part by the members of the Health Action Committee. Through their health office the Committee handled requests of both a health and social service nature, and in a small way helped to 'guide' people to the appropriate service, thus saving them from 'making the rounds'. The Committee also provided part of that necessary community contact to which we have referred in (2) above between the hospital departments, social agencies and people who needed service. At the same time, there was a helpful liaison between the public health nurses and the members of the Committee. This relationship could be particularly useful if the City of Winnipeg decides to integrate and decentralize its public health and welfare services in city neighbourhoods. Two other functions are important to this health aide role. The first involves the concept of patient advocate which was earlier referred to, and this requires not only knowledge of the health and social service systems and a sensitivity to the needs of residents, but an independent position from which to operate. Thus

it is important that the health aides don't get 'pulled in' as it were by the major agencies in the community.

The health aides can also perform a valuable 'research' function in the inner city by utilizing the potential to learn about the health needs and the health behaviour of residents in the maintenance of case records of their work.

A further benefit from such a program is the new occupational opportunities it opens for inner city residents, providing both income and the development of skills and a sense of confidence that they can actively help to achieve beneficial change in their own area.

In summary, the Health Action Committee's efforts as informal neighbourhood aides have demonstrated to the providers of services in that area that a 'community arm' can work.

4. An important finding from our study is that while various agencies in the community, including the hospitals, have shown a willingness to attempt new directions in providing community health care, no-one seems to be responsible for co-ordinating approaches to health care in the inner city. Decision-making within the health field is traditionally of a de-centralized nature: it takes place at the individual facility, at the individual practitioner level.[14]

With the formation of the Health Sciences Centre, however, there is the possibility of determining some objectives for meeting health needs in the inner city, and using the considerable resources of the Centre to that end. At the same time, both the provincial government and the City of Winnipeg seem to be favouring a type of single-unit delivery of health and social services at the neighbourhood level.

The creation of a coalition of interested parties, involving the different levels of government, the medical profession and administrators, social agency people and community residents would appear to be an important first step in the developing of new forms of neighbourhood health care, such as a community clinic. Any initiative towards neighbourhood health centres taken unilaterally, not employing the groundwork already laid and building upon the apparent willingness of the different parties to seek new forms of community medical practice, would not be in the best interests of securing better health care for inner city residents.

5. As the introduction to this report pointed out, there is a serious need for a health information system that would begin to lay the data base for the planning, implementing and evaluating of health and social service programs in the inner city.

These five summary findings are hardly conclusive with respect to recommending significant changes in the health care system, as for example,

the developing of a community health centre. However, the research process identified enough of a 'gap' in the services to the inner city to allow us to begin to press for incremental changes in the health care system that could build a firm base grounded in support by the community and medical personnel upon which new enterprises might be developed.

RECOMMENDATIONS

The Institute became involved in that health system, in collaboration with residents from the inner city, and through this activity we have learnt something of the way the system operates, some of the gaps and weaknesses in the services and some of the needs for health care in the community. At the same time we have seen the important work done by the Health Action Committee, not only in identifying the needs, but also in attempting to link the needs to available services. Staff of health and social service agencies have indicated a willingness to attempt new directions in community health care, while the professional associations of doctors, nurses, hospital administrators and social workers, not to mention government planners, have also suggested the need for testing innovative programs in community care. Given the need for much more information about health in the inner city context, the immediate need for serving that area as identified, and the openness to exploring new programs of community health care, the Institute of Urban Studies recommends to the Minister, that A Working Group on Inner City Health Care be formed

by representatives of the:

- Health Sciences Centre, including the Medical College
- Manitoba Medical Association
- City of Winnipeg Public Health and Welfare Departments
- Province of Manitoba, Cabinet Committee on Health, Education and Social Policy
- Manitoba Health Services Commission
- Manitoba Association of Social Workers
- Manitoba Association of Registered Nurses
- Community members, including the Health Action Committee

for the purpose of initiating a developmental program of community health care, with the following objectives:

1. To establish a training program for neighbourhood health aides as well as develop a community health organization in the inner city that can participate in the planning of neighbourhood health programs.

2. To encourage the Health Sciences Centre and other health and social service agencies in their approaches to community health care, especially in the planning of effective multi-lateral service strategies.

3. To develop a health information system as outlined earlier to enable better planning and evaluation of health care to the community.

4. To investigate the health needs of the inner city community, plan a specific program for health services in the inner city, and initiate new forms of health programs.

The tasks of this working group would be delineated according to the particular interests of each participating group. Thus, for example, the Health Action Committee could take responsibility for developing the training program for neighbourhood health aides and would be able to use the resources of the Working Group to this end, as well as determining the best use of the aides on completion of their training. The Medical College could decide to undertake the determination of health status in the inner city, while all members would be able to co-operate in the preparation of the health information system. The Working Group format would permit the development of some form of community health centre on an experimental basis, with input from a number of interested groups. One of the advantages of this type of operational group is that work can progress on a number of parts simultaneously.

The authority for this Working Group is requested of the Minister under Section 16 (1) of the Department of Welfare Act. Thus, the Minister would set up the Working Group, give it particular functions for a period of time and authority to both delineate and initiate programs.

There are obviously many details in this recommendation that still need to be worked out. The Institute believes that this approach to health planning for the inner city community would permit your government, the providers of health and social services and community residents concerned for health matters, to develop the best possible health program for this area. The Institute realizes that structural changes alone will not bring better health care, but that an orientation to the community which is sensitive and responsive to the needs of people will begin to lay the groundwork for the development of an improved community health care system.

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