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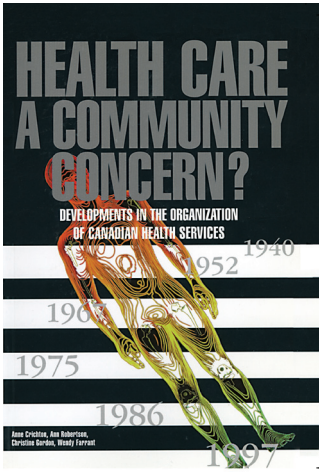

HEALTH CARE: A COMMUNITY CONCERN?
by Anne Crichton, Ann Robertson, Christine Gordon, and Wendy Farrant
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APPENDIX A

Definitions

One of the problems in writing about community involvement in a collectivist society is that the meaning of the terms used is often unclear. There is an inconsistent definition and use of terms. Below are some of the definitions that were found. Since this book is concerned with reviewing the literature, it is likely that the terms used may vary from one person's writing to another, thus the readers must use their own judgement about the definition appropriate for a particular context.

The Biomedical Model of Care

Field (1973) has suggested that medical care has moved through four phases which he has called magical, religious, pastoral and scientific.

By the beginning of the twentieth century the western developed countries were putting their faith in scientific medical care (or the biomedical model) which proposed that the best health outcomes would result from consulting physicians for advice and treatment on the symptoms of disease. As a result of adopting this model, the number of medical specialists grew extensively and the medical profession developed "regional hierarchies" with quaternary and tertiary care specialists and university teachers at the top of the status ladder. Primary care was not so highly regarded.

McKeown (1971) and others have challenged this model as contributing only about ten per cent to the health of populations.

The principles underpinning health insurance in Canada are the provision of universal, comprehensive, portable, publicly administered and equitable medical and hospital care. At the time hospital insurance and diagnostic services, 1957, and medical care insurance, 1966, were brought in, Canadians wanted to have unlimited access to high quality biomedical services, and the guarantee of universal, comprehensive and portable care ensured this.

Collectivism

The *Concise Oxford Dictionary* defines a collective as "of [or] from many individuals, common."

"Collective ownership for land, means of production etc. [is] by all for the benefit of all."

Collectivism is used in the text to describe the shift from an individualistic form of social organization to a state in which resources are shared by all as equitably as the government can arrange to do so.

Community

There are many ways of defining this term. Robichaud and Quiviger (1990) base their definition on geography, interest and group membership. But if a definition from *Roget's Thesaurus*, is selected, community is linked to party and participation (the former defined as being concerned with alliances and the latter defined as being concerned with sharing). Both definitions seem to be used. In the past community-based health services were mainly defined by geography, although they could be organized by exclusive interest groups (such as paraplegics), or by membership groups (such as fitness clubs). However, these definitions seem to be changing, and we give more credence to *Roget's* emphasis on alliances and participation.

Community-Based and Community Oriented Services

The issue of public participation today raises another definitional question, the distinction between community-based and community-oriented health services. Hilton (n.d.) describes community-oriented health care as "health care in which plans are made by outsiders and community members are asked to participate. The program is centred around medical staff who dispense their knowledge to people. On the other hand ... community-based health care means that people begin to think about ways to solve their problems instead of just complaining ... they listen carefully and put into practice what they learn" (pp. 1–3). But "community-based" is not always defined in that way.

A Toronto document *Healthy Toronto 2000: A Strategy for a Healthier City* (1988a) defined "community-based" activity (which is not unlike the community-oriented system of Hilton) as "involving public health, community health centres and other forms of 'community-based' primary care, home care, community support services, day care/day hospital programs and free standing centres such as birth centres, abortion clinics and hospices." This strategy document distinguished between a "community-based" and a "community managed" system. "The community should play a much greater role than it does in managing its health services system. Such an approach, which

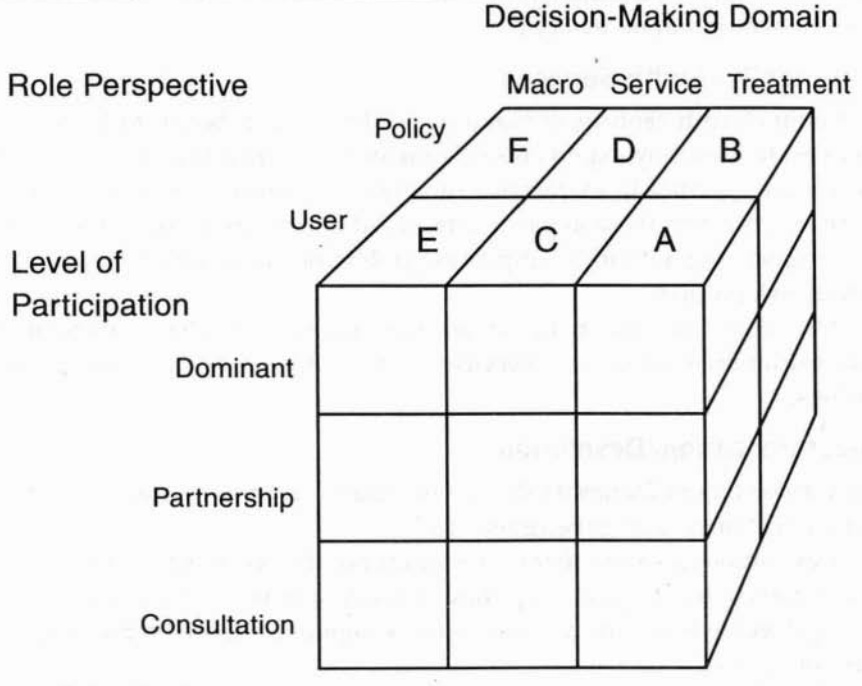
would integrate institutional and community services into a comprehensive community managed system, would be a more rational approach rather than the current fragmented approach to health care system management. ... [It] would require, over time, the development of community boards, democratically elected, to manage the entire health care resources of a given community" (p. 19). These discussions raise two issues: (1) that of increasing personal responsibility for one's own and others' health care in the community and (2) that of how participation in policy making can best be organized.

Charles and De Maio (1993) have developed a chart (A.1) analysing community participation.

Community Development

The evolving health promotion movement is concerned with improving both the physical and the social environment. It has been suggested that in order to achieve success *vis-à-vis* the latter, it will be necessary to undertake com-

Chart A.1
Dimensions of Lay Participation in Health Care Decision Making



Source: Cathy Charles and Suzanne De Maio. "Lay Participation in Health Care Decision Making: A Conceptual Framework." *Journal of Health Politics, Policy and Law* 18, no. 4 (1993): 891. Reprinted with permission.

munity development so that citizens may become aware of their rights and responsibilities. One of the implications of becoming involved in health promotion is that the public health departments' nursing staff will need to change their approach from being health educators to being community development experts. This shift from a one-to-one relationship with their clients to a broader way of working will not be easy for many established health professionals.

Community Health Centres/Community Clinics/Centres locaux des services communautaires (CLSCs)

A form of group practice which relies on teamwork among professionals (who may be doctors, nurses, pharmacists, physiotherapists, occupational therapists, social workers and possibly others); it focusses on the prevention of illness and the promotion of health, and is guided by an elected community board.

Where the doctors are paid by fee-for-service, they will then have to pool their fees and accept salaries in order to fund support staff. Thus they have to be ideologically committed to this concept of organization. (In some provinces other forms of remuneration have been worked out, but ideological commitment is still necessary.)

Community Health Services

In the nineteenth century, community health services began to be seen as services delivered by experts outside institutions. Then the term was often used more specifically to describe the public health departments' services (particularly when these departments added health education to their sanitary engineering activities, employing public health nurses to work with special risk groups).

However, "community health services" today have often come to mean non-institutional services — services given in the home or in out-patient settings.

Decentralization/Devolution

The *Concise Oxford Dictionary* defines decentralization as "undo the centralization of; confer local government on."

Devolution has a number of meanings but the one most relevant to the discussions in this book is "deputing delegation of work or power."

To devolve is to "throw work upon a deputy or one who must act for want of others."

The confusions in using the words decentralization/devolution, deconcentration, delegation are discussed (to some extent) in Chapter 29 on regionalization.

A chart developed by Mills and Vaughan (1987) attempted to sort out some of the terms used in WHO documents (see Chart A.2).

In Chapter 22 Pleiger is quoted on decentralization. She was discussing corporate partnerships and used the words decentralization, informalism and sectoralization. The point being made was that the remote formal authority of central governments (particularly Westminster Parliamentary governments) was being reconsidered. Other interest groups were being brought into the process of policy development in discussions outside Parliaments — discussions which were more informally structured. These discussions were not restricted to top level politicians, bureaucrats and business leaders but were being opened up to community inputs at a number of different levels.

Disease Prevention and Health Promotion

Statchenko and Jelinek (1990) have explained the difference between traditional public health activities (prevention) and the new public health activities (promotion) in Chart A.3.

Chart A.2
The Decentralization of Functions in Different Types of Decentralized Systems

Functions	Deconcentration to ministry field office	Devolution to local government	Delegation	Privatization
Legislative	–	**	–	–
Revenue-raising	*	**	**	***
Policy-making	–	**	**	**
Regulation	–	**	*	–
Planning and resource allocation	**	**	***	***
Management				
• personnel	*	**	***	***
• budgeting and expenditure control	**	**	***	***
• procurement of supplies	*	**	***	***
• maintenance	*	**	***	***
Intersectoral collaboration	*	***	***	***
Interagency coordination	*	**	***	***
Training	*	**	***	***

Key *** Extensive responsibilities
** Some responsibilities
* Limited responsibilities

Source: Anne Mills and Patrick Vaughan, eds. *Decentralization and Health for All Strategy* (Geneva: WHO, 1987), 15. Reprinted with permission.

Home Care, Long Term Care, Continuing Care

"Home care" was developed in order to hasten hospital discharges and to prevent hospital admissions — a matter of short-term assistance by public health nurses.

As the demand for "long-term care" in institutions increased (either from those blocking acute care hospital beds or those becoming frailer and unable to cope in their own homes), the provincial governments recognized that they might be able to cut down on the demand by establishing improved assessment processes and a case management policy.

"Continuing care" describes the bridging of community and institutional care by these methods.

Crises may be dealt with through respite care or other temporary solutions. In British Columbia, quick response teams may avert crises leading to hospital admission by providing help in the home on a temporary basis (Finnie and Layton 1990).

Chart A.3
Health Promotion Versus Disease Prevention Approach: Prevalent Differences in Concept

Health Promotion	Disease Prevention
• Health = positive and multi-dimensional	• Health = absence of disease
• Participatory model of health	• Medical model
• Aimed at the population in its total environment	• Aimed mainly at high-risk group in the population
• Concerns a network of healthi ssues	• Concerns a specific pathology
• Diverse and complementary strategies	• One-shot strategy
• Facilitating and enabling approaches	• Directive and persuasive strategies
• Incentive measures are offered to the population	• Directive measures are enforced in target groups
• Changes in man's status and in his environment are sought by the program	• Programs focussing mostly on individuals and groups of subjecjts
• Non-professional organizations, civic groups, local, municipal, regional and national governments are necessary for achieving the goal of health promotion	• Preventive programs are the affair of professional groups from health disciplines

Source: Sylvie Statchenko and Milos Jelinek. "Conceptual Differences Between Prevention and Health Promotion: Research Implications for Community Health Programs." *Canadian Journal of Public of Health* 81 (1990): 53–59. Reprinted with permission.

Lay Participation

Charles and de Maio (1993) developed a chart (A.1) to show how lay participation can be increased from individual consultation with professionals about treatment to dominant policy making roles in formal organizations. This Canadian study builds on Arnstein's ladder of participation (1969) but simplifies it and extends the dimensions.

Multicultural Integration

The YWCA of Toronto has been active in promoting multicultural integration through group action: "Multicultural organizational change is a process of dismantling visible and invisible barriers to the full social participation of non-dominant groups, establishing an organizational response and responsibility to that larger community" (YWCA 1987, 30).

The Y's Program for Action makes an analysis of four models of relationship between established and new members of communities who are seeking integration, that is, the melting pot, separate ethno-specific activities, limited integration and fully integrated multicultural organization. In the last of these models (deemed to be what Canada is aiming to achieve), the guidelines say that the multicultural organization must reflect its client community in all aspects of its organizational culture. Long-term, ongoing monitoring is necessary to make an agency truly responsive. Equality of access must actively address the barriers to such access, a major one being racism in all its forms. Agency activities must go beyond meeting individual needs to advocating on behalf of community needs. The program approaches and emphasis should be developed to respond to the needs of the constituency and not vice versa.

The main difficulty, identified by Doyle and Visano (1988), was that multicultural policies were not community-based. Because the federal government's immigration policy has changed Canada from a predominantly English-French society to an extremely diversified cultural community, there has been concern to establish clear policies about the meaning of the concept "multiculturalism" at the federal level (Canada 1987c). But as Doyle and Visano said: "The multicultural policy in Canada was introduced on a top-down basis by the Prime Minister of Canada in 1971; it was not the result of any groundswell of consensus from the grass roots. As a result, it seems to have remained at the level of abstraction and been largely confined to the mandate of one Minister and one government department, rather than being the responsibility of every Minister and department" (p. 13).

At the provincial level there are differences in implementation of this policy across Canada. Writing about Ontario, Doyle and Visano said: "a Multicultural Strategy has been introduced that encourages this widespread

responsibility, but it appears to be neither a 'policy' nor a 'strategy,' since it does not ensure a coordinated, coherent and interrelated set of activities" (p. 13).

They said that although they have consulted the public, politicians have not always listened to public views and top-down policies have not changed. The strategies need to be altered to take account of consumer inputs.

This was written some eight years ago. There seems to be more acceptance of multiculturalism today.

Multiservice Centres

Multiservice centres may provide all or some of the following services: medical care, pharmacy, physiotherapy, occupational therapy and social services. These are not quite the same as community health centres where the professionals work together under one managing authority. This term describes geographical continuity and an agreement to work on "team case management" between separate services agencies, not an ideological commitment to community identified needs.

Primary Care

Although primary care may be used to describe all kinds of care given outside institutions by health professionals and their support teams, it is often taken to be the first step on the ladder of medical care organization which may have three more levels of specialization above it.

Primary versus Community Care

While Hastings (1978a) distinguished between primary care and community care in Canada, attributing the latter to public health department activities, there now seems to be greater acceptance of the idea that all health professionals, whether in clinical or public health positions, should be concerned with promoting primary care in the community because good primary care focusses on the determinants of health (Evans, Barer and Marmor 1994). The Alma Ata Conference on Primary Health Care of WHO, 1978, stressed the importance of early interventions with respect to promoting health rather than the development of more and more specialist care for illness. This would seem to indicate that primary care should go far beyond any kind of biomedical care to give attention to such matters as nutrition, environment and so on.

Partnerships

Like many other terms used in discussing policy developments, "partnerships" has been used in a number of different ways.

When the idea was first adopted by the Mulroney government (1984–93) it was used to describe the promotion of improved linkages between the government and business and research leaders.

However, during the 1980s Gottlieb (1983) and Gottlieb and Selby (1989), working in the field of mental health, proposed a range of partnerships from improving relationships between those with mental health needs and other community members. Gottlieb's range is shown in Chart A.4.

Boudreau (1991), coming from the same stance, has also worked on defining this term. She proposed that partnership should be seen as a continuum, quoting Cawson (1982) who said: "This continuum has at one end 'the open competitive and fluid interplay of interests characteristic of pluralism' and at the other end 'the closed monopolistic and relatively stable structure of interests best captured by the concept of corporatism'" (p. 147).

She pointed out that partnership is still a theory waiting to be worked out in practice.

Guay (n.d.) has made out a case for partnerships to be developed among "survivors," consumers of mental health services who may know better how to give help to one another than other consumers or professionals.

To promote the development of partnerships there is need for community development to raise consciousness about social needs.

Resource Exchange Networks

Cummings (1984) said that *the interorganizational relations (IR) perspective*: "proposes that organizations enter into relations with other organizations in order to obtain needed resources. Moreover, because such resources are generally scarce, organizations tend to compete with one another, attempting to gain power and control over essential resources while trying to minimize dependencies threatening organizational autonomy" (pp. 370–71).

A Social Model of Health Care

Questions began to be raised about the effectiveness of the biomedical model of health care for a collectivist society in the early 1970s but, until the Canada Health Act was passed in 1984, access to medical and hospital care was a priority for Canadians. However, in 1986 an international conference on *Achieving Health for All* (Canada 1986c) drew attention to the social causes of ill health and the need for better health promotion activities. Following this conference some other nations (e.g., Australia) identified certain disease prevention activities which they could address. Canada recognized that while disease prevention was one aspect of health promotion there were, as well, other major social challenges which should be considered, for example, reduction of inequities and enhancement of coping. Since then there has been

a growing interest in identifying the social determinants of health and adopting a social rather than a biomedical approach to health policy development.

Chart A.4
A Typology of Support Interventions

Level of Intervention	Examples
Individual	
Support provider	Promoting a network orientation to coping
	Promoting ways of coping that invite support
Support recipient	Controlling distress during supportive exchanges
Dyadic	
Support from key network member	Consultation to informal community caregivers
	Spouse-coach in the Lamaze method of childbirth
	Enlisting close associate in health habit change
	Lowering levels of expressed emotion (EE)
Introduction of new tie	Home visitor programs,including companions and friendly visitors
	Therapeutic partnerships between 'fellow sufferers'
	Lay helping alliances such as buddies, coaches, mentors, and preceptorships
Group	
Support from set of network members	Cultivation of natural helping networks
	Network therapy and its variants
	Network/support assessment and development
Grafting on a set of new ties	Creation of support groups
	Family support programs such as Extend-a-Family and Family Clusters
	Psychosocial rehabilitation programs such as Fountain House and Lodge society
Social System	
Role redefinitions	Expanded role for the primary nurse and high school homeroom teacher
Organizational policy/ structural changes	Workplace day-care programs
	Network members room-in and assume care responsibilities in hospital
	Students in first year of high school stay together for core courses
Community	
	California 'Friends Can be Good Medicine' campaign
	Radio talk/phone-in shows featuring self-help groups

Source: B.H. Gottlieb and Peter M. Selby, "A Typology of Support Interventions." (Adapted from Table 1, Gottlieb [1988]). "Support interventions: A typology and agenda for research." In *Handbook of Personal Relationships: Theory, Research and Intervention,* edited by S. Duck (Chichester, G.B.: John Wiley, n.d.). 512–542. Reprinted with permission.