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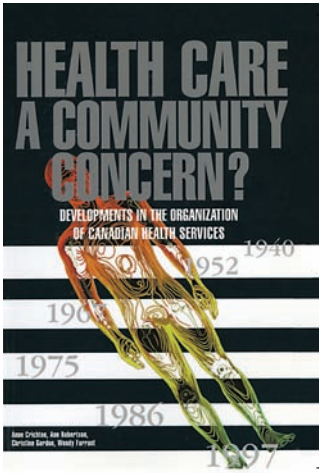


**HEALTH CARE: A COMMUNITY CONCERN?**
by Anne Crichton, Ann Robertson, Christine Gordon, and Wendy Farrant
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## CHAPTER 20

# Health Promotion: Development of a Demonstration Strategy

In the previous chapter on organization theory and its applications, the concepts of Bartunek and Reis (1988) about the modification of organizations through first and second order change were discussed. The application of theory to first order change was explored in looking at transorganizational development of subsectors of the health care system. However consideration of second order change was not dealt with there. It will be recalled that Bartunek and Reis said:

> The major difference between first and second order organizational change is in whether or not a particular framework for understanding is altered. In first order change the framework remains the same but in second order change it shifts in some way. The alterations of the framework in second order change have an effect on the assessment of change ... Because the primary shift in second order change is the framework itself, it is more difficult when this type of change occurs to determine whether the change results in better or worse outcomes than before. (pp. 100–101)

In discussing the development of Canada's health care system it was pointed out that Dr. Maurice Le Clair set up a task force to examine whether access to medical and hospital care was likely to result in better health status outcomes. This task force produced *A New Perspective on The Health of Canadians* (Canada 1974a) which argued that good health was more closely related to lifestyle, environment and biological risk than to medical and hospital care. However, Canadians wanted access to health services more than anything else at that time (and still do). The Canada Health Act, 1984, closed off the discussions on the issues of universality, comprehensiveness, portability, public administration and equity of access (at least for the 1980s). The federal gov-

ernment was ready to accept the challenge of the World Health Organization (WHO) to review its policy on *Achieving Health for All by the Year 2000*. In 1986 the federal Minister, Jake Epp, presented Canada's policy statement on this topic (Canada 1986c) to an international conference on health promotion (WHO 1986). This statement proposed a second order change in health service organization for Canada. Health promotion was to be built on top of guaranteed access with a view to improving health outcomes.

Wendy Farrant (now deceased) prepared in 1991 the following chapter on health promotion research which has greatly influenced this second order of change in organization of health services in Canada.

The idea of health promotion is a response to increasing recognition of the limitations of conventional approaches to health care. To quote from the introduction to the *Report of the International Conference on Health Promotion* (held in Ottawa in 1986):

> In the industrialized countries inequalities in health are increasing between social groups while health costs continue to rise. The gap between the potential for health of people in industrialized countries and their current health status has indicated a need for new strategies and programmes. While there is growing concern about lifestyle-related disease patterns, there is also growing awareness of the links between the overall conditions of everyday life and behaviour that influence health. Moreover, the public interest in health, self-care and mutual aid has led to the questioning of professional approaches and definitions in health problems. In some countries these changes in health problems and perspectives have stimulated a shift in the emphasis of health policies; they have encouraged innovative intersectoral health planning and the development of advocacy approaches and enabling strategies. Health promotion is an effort to crystallize a wide range of activities that have contributed towards a changing model of public health. (WHO 1986, 407)

Canada is widely recognized (e.g., Kickbusch 1989; Milio 1988) as having played a lead role in its formulation of a national strategic framework for health promotion. The federal *Framework for Health Promotion* (see Chart 8.1) both reflects and has stimulated the evolution and growing acceptance, since the 1974 Lalonde report, of a broader concept of health promotion that incorporates the principles of the "Health for All by the Year 2000" (HFA 2000) movement (Hancock 1986; Labonté 1988).

The World Health Assembly in 1977 launched HFA 2000 and since then WHO policy has shown a progressive shift towards identifying community involvement as the cornerstone of a broad-based strategy directed at intersectoral action on the determinants of social inequalities in health (WHO 1978,

1981a, 1985a, 1986, 1987, 1988, 1990). This trend culminated in the adoption, by the 1986 First International Conference on Health Promotion, of the Ottawa Charter on Health Promotion (WHO 1986). Health promotion is defined as *the process of enabling people to increase control over, and to improve, their health.* The Ottawa Charter emphasizes that health promotion focuses on achieving *equity* in health, and works through concrete and effective *community action* in setting priorities, making decisions, planning strategies and implementing them: "At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies" (World Health Organization 1986).

Whereas the initial impetus for HFA 2000 came from demands for new approaches to health development in the Third World (primary health care), the WHO health promotion initiative can be linked, as indicated by the above quotation, to the health care crisis and social movements in advanced industrialized societies. Central to both the primary health care and health promotion approach is an emphasis on: *redressing inequalities; intersectoral collaboration;* and *community participation.*

These key HFA 2000 principles present a profound challenge to conventional notions of organization of community health services. Reorienting community health services in a health promotion direction, in accordance with these principles, means much more than adding on to, and/or coordinating, existing service provision. As Siler-Wells (1989) observes: "Behind the euphemistic phases of 'community participation and empowerment' lay the realities of power, control and ownership. To implement health promotion in communities requires changes in each of these three areas, accompanied by an entirely different set of principles, values, actions and processes from those commonly used by the health sector" (p. 142).

Health promotion is integral to the concept of strengthening community health services[1] advanced in *Achieving Health for All: A Framework for Health Promotion* (Canada 1986c). The *Framework* stresses that community health services "should be expressly oriented toward promoting health and preventing disease." This assumes that community health services will:

> focus more on dealing with the major health challenges ... there will be greater emphasis on providing services to groups that are disadvantaged ... communities will become more involved in planning their own services ... links between communities and their services and institutions will be strengthened ... [and] community health services will become an agent of health promotion, assuming a key role in fostering self-care, mutual aid and the creation of healthy environments. (p. 10)

1 Also discussed in *Strengthening Community Health* (Canadian Public Health Association 1990).

The *Ottawa Charter on Health Promotion* similarly emphasizes that:

> The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components. (WHO 1986, 1)

The increasing support at the provincial level for the principles and strategic direction of the *Framework* is reflected in the *Proceedings of the National Symposium on Health Promotion and Disease Prevention* (British Columbia 1989d), sponsored by the provincial and territorial governments. Symposium participants agreed that five major challenges for health promotion in Canada are: placing health promotion on public, professional and political agendas; achieving equity in the determinants of health; enabling community participation; reallocating resources for health promotion; and increasing intersectoral collaboration.

## Rhetoric and Reality

While the need for a health promotion approach has been strongly endorsed at international, national and provincial levels, the constraints upon translating the vision into reality cannot be overestimated. This review of the evolution of community health services in Canada has documented the gap between the principles of a health promotion approach and the traditional medical model that has dominated the pattern of service development. It has also documented some of the professional, organizational and political barriers that have militated against a shift to a more social model.

Asked whether the *Framework* was intended to be a guide to topics for research, Irving Rootman[2] (now Professor of Health Promotion at the University of Toronto) said:

> It was rather intended as a tool for integrating some of the ideas that were current in health promotion at the time and as a way of mobilizing the field and getting health promotion onto the larger health agenda. In other words it was basically a political device. In our view, it succeeded rather well in achieving its purposes. However, it still leaves those of us who have an interest in building so-called 'theory of health promotion' scratching our heads and wondering what to do now. My feeling is that the Centres and Institutes that are developing now might usefully take this on as a collective challenge.

2 Irving Rootman, personal communication, 1991.

Draper (1988a), in an editorial in the Canadian Journal of Public Health on "The future of health promotion in Canada," underlines both the significance of the *Framework* as a mandate to "move health promotion from the periphery to the centre stage of health policy" and also the "severe obstacles to overcome" in moving from rhetoric to implementation. In addition to the challenge of resolving "the inevitable conflicts of interest associated with healthy public policy," he notes that: "It is difficult to innovate in an environment of shrinking resources and health authorities have yet to find rational and effective means for reallocating money and effort to fit new priorities." While acknowledging that "[h]ealth promotion practice in Canada is complex enough to make any generalizations dangerous," he observes, "It seems clear, however, that the field is dominated by disease prevention concerns using programs addressed to specific health behaviours — fitness, diet, smoking, drinking and drug use. Information, education and promotion designed to sell prevention ideas are the strategies of choice" (p.75).

A trend has similarly been observed in Europe for health authorities to respond selectively to those disease prevention and lifestyle aspects of health promotion that can be accommodated within a conventional medical paradigm, while ignoring those aspects (particularly concerning confronting inequities and involving communities in policy development) that challenge existing ways of working (Farrant 1987). Even within such a medically appropriated concept of health promotion, Spasoff (1990) concludes that: "there has not yet been any significant adjustment to the health care service, which continues to spend almost the entire health dollar in traditional ways. ... The health promotion movement now enjoys considerable support in Canada, especially in the public health sector and in the policies of several governments, but is almost completely detached from mainstream services" (p. 166).

## Strengthening Community Health Services: From Rhetoric to Action

The problems and possibilities for reorienting community health services in a health promotion direction was the subject of the series of provincial level consultative workshops entitled "Strengthening Community Health Services," conducted by the Canadian Public Health Association (CPHA), in collaboration with Health and Welfare Canada (Siler-Wells 1987, 1988a.b), following the release of the *Framework* and a discussion paper (Canada 1986c). Approximately 400 health professionals and community representatives met across Canada to identify issues, needs and gaps in community health services and strategies to strengthen them. The consultation highlighted the idea

that "one couldn't talk about community health services without defining what community health is. Furthermore, as we examined the interaction between community and health we realized that in order to strengthen community health we were talking about strengthening the community" (Siler-Wells 1987, 3).

Major barriers to implementation of a health promotion approach to community health identified by workshop participants were:

1. Lack of adequate planning at all levels
2. Little or no political will
3. Lack of or ineffective inter-agency or community linkages
4. Minimally effective community participation
5. Resistance of health care professionals to changing roles

Reorienting community health services in a health promotion direction was seen to require:

> changes in orientation and focus, changes in roles, ways of operating and in the locus of power and control. ... Five conditions were identified as being fundamental to effecting such change:
>
> 1. Create a supportive policy focus and orientation. This requires a fundamental reorientation of services, based on community-determined needs and community-based planning and implementation and focussing on the determinants of health.
> 2. Mobilize political and community will. Both federal and provincial governments must be involved in a clear specification of policies and resources and identified actions that support and strengthen community health.
> 3. Support new partnerships. Strengthening community involvement and control requires new partnerships between citizens, professionals and governments.
> 4. Adopt a co-active approach. Co-action encompasses the activities of cooperation, collaboration and coordination among key players in community health.
> 5. Nurture our strengths. Strengthening community health services should build on the numerous examples of innovative community-based initiatives that were identified by the consultation workshops. (Siler-Wells 1987, p. 4)

## Strengthening Community Health Action: A Way Forward

As indicated by the CPHA "Strengthening Community Health Services" consultation, the gap between a health promotion approach and mainstream community health services, contrasts with the wealth of community-based health action across the country that exemplifies health promotion principles. In Canada as elsewhere, community-based projects and initiatives are tak-

ing the lead in redefining health needs and developing action strategies in accordance with the principles of redressing inequalities, intersectoral collaboration and community participation. This burgeoning international community health movement has, in part, been stimulated by recent developments in health promotion, particularly the WHO healthy cities/communities initiative (Tsouros 1990, 1990 [ed.]). It can also be seen as having provided an impetus for international and national health promotion policy developments (Farrant 1991; McKillop Farlow 1987).

The *Report of the International Conference on Health Promotion* (WHO 1986) notes: "Though this has been an international conference of local, national and international delegates, the deliberations were primarily a response to the rising and changing expectations of populations around the world, who are demanding assistance in achieving their self-set goals. ... People are seeking a broader social response to improving their personal, social and health environments" (p. 450).

The pioneering role of community-based health projects is referred to throughout the *Framework* — "People everywhere are demonstrating a willingness to act on matters of health. Each year, for example, federal funding programs receive thousands of applications for resources to be used in community health projects. Low-income women, seniors, native people, the disabled, immigrant groups and many others are expressing their own ideas on the health needs of their communities, as well as their eagerness to find ways of meeting those needs" (p. 12).

The potential and principles of strengthening community action as a key strategy for health promotion have been well documented (e.g., Brown 1989; Labonté 1988; McKnight 1984, 1987, 1990; Minkler 1985, 1989). Attention has recently focussed on possibilities for enhancing this potential through the creation of infrastructures for supporting and networking, community health initiatives and facilitating links with the policy making process (e.g., Blennerhassett, Farrant and Jones 1989; Smithies et al. 1990; Trojan 1990; Vienna Dialogue III 1989).

The importance of policy support for community health action has been noted in all major international policy documents on health promotion. The WHO (1987) publication on health promotion, *Concepts and Principles in Action: A Policy Framework* states that, "to increase control over their own health, the public requires a greater sharing of resources by professionals and government." This point is underlined in the Ottawa Charter (WHO 1986), which emphasizes that strengthening community action "requires full and continuous access to information, learning opportunities for health, as well as funding support." The Adelaide conference recommendations on healthy public policy (WHO 1988) noted that:

> Women's networks and organizations are models for the process of health promotion organization, planning, and implementation. Women's networks should receive more recognition and support from policy makers and established institutions. Otherwise, this investment of women's labour increases inequity. For their effective participation in health promotion women require access to information, networks and funds. All women, especially those from ethnic, indigenous, and minority groups, have the right to self-determination of their health, and should be full partners in the formulation of healthy public policy. (p.28)

Support structures for community health projects was the subject of the *Vienna Dialogue III on Health and Social Policy*, organized by the WHO Regional Office for Europe, the European Centre for Social Welfare Training and Research, and the Federal Chancellery of Austria (Evers 1989). The consultation noted that, in addition to making a direct contribution to the health of those involved in such initiatives, community health projects and initiatives are key "allies, partners and pioneers in reforming and restructuring public health, and have skills, knowledge and organizational structures that are essential in meeting the health challenges of modern societies. ... The new public health movement needs such partners to find and explore more efficient, effective and humane ways to deal with health problems, and to change the circumstances leading to such problems" (Vienna Dialogue III 1989, 261–62). Participants called upon governments at all levels to take note of WHO guidelines on community participation, and develop systematic policies to support and link community health projects and initiatives and strengthen their contribution to policy making. While funding and other support might originate from many sources, government funding was seen as the key that can open up other sources. The importance of community involvement in the formulation of appropriate funding policies was emphasized. Specific support needs identified by the consultation included:

1. The creation or reinforcement of intermediate structures to help community initiatives interact and develop a strong contribution to policy making at the local, regional and national levels
2. The establishment of clearing houses for the collection and distribution of resources and information
3. Local mechanisms to provide funding and other support to community health initiatives
4. Training, research and information dissemination aimed at helping participants in community projects increase their effectiveness, and helping health professionals and policy makers appreciate the vital role of such initiatives and develop the skills required to interact fruitfully with them

It is now important to look at progress made within Canada towards the development of such an infrastructure, in the five years following the publication of the *Framework* and the *Ottawa Charter*.

## Building the Infrastructure

The need to create an infrastructure of support for community health action, along the lines suggested by *Vienna Dialogue III*, was endorsed by the recommendations of the CPHA "Strengthening Community Health Services" consultation summarized above. This has been reinforced by subsequent consultations with people involved in community health projects across Canada (British Columbia Healthy Communities Network 1989, 1990b; Sherwood 1988; Siler-Wells 1989; Canadian Public Health Association 1990).

Canada has been recognized as having taken a lead in instigating a policy of supporting community health action through the federal Health Promotion Fund (Milio 1987). The Health Promotion Fund (Canada 1988d) was first established in 1980 and is administered by the Regional Services Division of the Health Promotion Directorate. The objectives of the fund are:

1. To increase the effectiveness and impact of health promotion programs undertaken by the voluntary sector
2. To strengthen this sector in ways that will increase the opportunity for people to become actively involved in dealing with the health issues that most concern them

Some of the achievements and limitations of the Health Promotion Contribution Fund (the original core program) are summed up by Stern (1990):

> Throughout the years, the program has legitimized new issues such as independent living for the disabled, has worked with the women's health movement in re-defining health issues and has encouraged the beginning of a seniors' movement across Canada. Due to limited financial resources for community action, this program has and continues to be one of the most important mechanisms for innovation in the field. Sadly, the program has not provided a mechanism to influence public policies nor is it perceived as more than a simple funding program within its own institutional walls. (p. 228)

Support from the Health Promotion Fund has mainly taken the form of short-term individual project funding. The potential of the fund as a mechanism for coordinating community health action and facilitating links with the policy making process has not been realized. The more strategic approach to health promotion stimulated by the *Framework*, however, has opened up debate within the Regional Services Division about the potential of viewing

the funding "in strategic terms, not as a project-by-project enterprise" (Canada 1988d, 17) and "developing, through and from the funding, a systematic mechanism for influencing public policies" (p. 23).

An important step in the direction of a more strategic approach to funding support for community health action has been Health and Welfare Canada's support, through the Health Promotion Fund, for the *Strengthening Community Health Program*, sponsored by the Canadian Public Health Association (Bhatti 1989; Canadian Public Health Association 1990; Harvey 1991) and the *Canadian Healthy Communities Project*, co-sponsored by the Canadian Institute of Planners, the Canadian Public Health Association and the Federation of Canadian Municipalities (Canadian Healthy Communities Project 1989; Berlin 1991).

The reports, publications and newsletters of these national healthy communities projects, and of the provincial and local healthy community initiatives that they have stimulated, together with the recent of the Strengthening Community Health Program (Harvey 1991), testify to their success in seeding the beginnings of a national and provincial infrastructure for coordinating, supporting and promoting local healthy community action in accordance with HFA 2000 principles.

The national evaluation of the Strengthening Community Health Program (Harvey 1991) strongly endorsed the potential of intermediate structures, in the form of provincial healthy community steering committees, as a catalyst and vehicle for coordinating and supporting community initiatives through such strategies as: community forums for health professionals and community members, workshops on community development, creation of a citizens' health forum, producing materials to document case studies of community action, a survey of needs of provincial agencies involved in community health activities, creation of computer-based networks and presentations to provincial commissions/task forces. While emphasizing the importance of decentralization of resources and control, respondents to the evaluation survey recognized a national role in resourcing and networking provincial infrastructures and providing support, through such functions as advocacy, and provision of a clearing house (for gathering and sharing such information as case studies of successful projects, resources and/or packages developed in other provinces, lists of funding sources and lists of resource people). The evaluation also showed that federal funding of the Strengthening Community Health Program had provided an important lever in legitimizing provincial healthy community initiatives and attracting resources from other sources including provincial governments, municipal governments, the Health Promotion Directorate, the private sector and foundations.

The evolving partnership between the British Columbia Healthy Communities Network Steering Committee and British Columbia Ministry of Health, Office of Health Promotion, provides one example of the potential of such collaboration for supporting new ways of working in accordance with health promotion principles, and facilitating links between community initiatives and the policy making process (British Columbia Healthy Communities Network 1989, 1990a,b; Gruno 1991).

The national healthy communities projects have also provided an important entry point for *reorienting professionals*. The HFA 2000 principles of redressing inequalities, community participation and intersectoral collaboration have far-reaching implications for the role, education and training of health professionals, as well as a the wide range of other people with a role in promoting community health (Bhatti and Hoffman 1990; Doucette 1989; Kickbusch 1989; Labonté 1989; O'Neill 1989-90; Rootman 1988; Swanson 1989). The report of the first evaluation of *Strategies for Health for All in Europe* (WHO 1985a) cautioned that unless measures are taken to reorient the work of health personnel with their consent and full support, the basic principles of the *Framework* are put at risk.

Martin (1991), discussing her personal evolution of a community development approach to community nursing within the Vancouver Health Department, describes the significance of the publication of the *Ottawa Charter* and *Framework* in legitimizing this approach:

> With the legitimization of health promotion, all my ideas and interests had found a home. My visions of working with the strengths of communities, rather than focussing on the problems of individuals was in, so were collective action and social justice. A social movement focussed on health promotion — and modelled on the effectiveness of the feminist, environmental and peace movements — *could* happen. Citizens, politicians and the new general public wanted to debate the new ideas around health. If the general public comes to understand the difference between health and illness, perhaps the medical model will (at last!) take its proper place in health care; hospitals and professionals will understand the limitations of their services; and the allocations of public funds will change. (p. 8)

She goes on to describe the importance of the emergent British Columbia Healthy Communities Network as a vehicle for developing intersectoral partnerships and alliances to support community health action.

*An Evaluation of the Strengthening Community Health Program* (Harvey 1991) concluded that: "Despite its non 'medical model' approach, the survey results indicate that the SCHP was reasonably successful in engaging at least some health professionals in new patterns of co-action. It is also evi-

dent that the program enhanced the presence of regional Health Promotion Directorates, provincial Public Health Associations, and universities and colleges in issues and activities related to community health" (p. 41).

The Registered Nurses Association of British Columbia (1990), for example, states that it is:

> an active participant in the healthy communities movement because of its belief in the value of public participation as a way to make health care more responsive to the needs of the community. The community forums and subsequent follow-up action initiated by several RNABC chapters ... have convinced the Association that local health advisory councils and community forums are effective ways of stimulating the public participation that is necessary to encourage the health care sector to identify and address the social determinants of health. Community members have demonstrated through the healthy communities process that they have insights into the factors affecting health in their communities; an understanding of ways to address these factors; and knowledge of the local resources that are available to do so. Community members have also demonstrated that they have a broad view of health and thus concern themselves with such factors as the environment and social and economic conditions. (p. 37)

The healthy communities movement has also played a significant role in developing *new organizational structures and mechanisms* for enabling communities to define their common health needs, articulate these needs to relevant policy makers, and participate in the planning, development and implementation of action strategies. While different organizational models have evolved in response to different local circumstances, these initiatives have typically involved the creation of some type of community forum for canvassing a wide cross-section of opinion, and the establishment of an intersectoral health council/committee/advisory group with a visible mandate to carry forward recommendations from the community forum into the policy decision making process (British Columbia Healthy Communities Network 1990a). Governments at local, provincial and national levels could usefully draw upon the experience, skills, networks and organizational structures of the healthy communities movement, for developing structures and mechanisms to facilitate effective public participation and intersectoral collaboration in community health policy development. Other examples of creating new organizational structures for multisectoral health planning in accordance with health promotion principles include the transformation of the city of Toronto Department of Public Health over the past decade (Hancock 1990) and the creation of the Ontario Premier's Council on Health Strategy in 1990.

Reorienting community health services in a health promotion direction requires *new strategies for research and evaluation.* National and international consultations on health promotion research have highlighted the need for a style of participatory action-research that incorporates within the research process the principles of redressing inequalities, community participation and intersectoral collaboration (Canada 1989b; Canada 1990a; Hancock and Draper 1989). This implies funding, supporting and promoting participatory research "that deliberately sets out to activate, mobilize and empower people. ... Participatory research agendas are set by the community, who use the research experts as a resource. Participatory research must transfer skills and resources to the community" (Hancock and Draper 1989, 87).

The Health and Welfare Canada Health Promotion Knowledge Development Project (Canada Health and Welfare 1989b, 1990a) has played an important role in legitimizing a more participatory, collaborative and empowering approach to health promotion research. Further legitimization and support for participatory action research has come from the CPHA *Strengthening Community Health Program* (1990) and provincial innovations such as the British Columbia Health Research Foundation Special Research Demonstration Program (aimed at encouraging collaboration between researchers and community groups) and the Ontario Prevention Clearinghouse. The recent growth of interest in participatory action research, among people who are active in community health promotion, has been reflected in an upsurge of inquiries to such bodies as the Participatory Research Network based in Toronto and the Vancouver Women's Research Centre.[3]

## Constraints, Dilemmas and Contradictions

These steps toward development of an infrastructure for support of community health action demonstrate the potential of health promotion principles as a framework for reorienting community health services toward a social model. At the same time, however, in Canada as elsewhere:

> most of what has happened so far falls in the category of preliminary action and little has taken place that makes an immediate difference in the lives of people. We still run the risk of 'dynamics without change' on a massive scale. This is because [health promotion] runs counter to ... day-to-day practice. The social model of health on which it is based is different from the medical model of prevention and treatment. Community empowerment challenges the concept of expertise and professionalism that are now dominant. Public bureaucracies are based upon vertical divisions

3 J. Barnsley, personal communication, 1991.

> of labour that run counter to ecological concepts of policy. Hierarchical decision-making is still the dominant form of bureaucratic practice and in many institutions it seems to become more extreme as pressure on the institutions grows. (Draper 1989, 194)

Many of those involved with the international and national healthy communities movement have documented the constraints, dilemmas and contradictions of attempting to bridge the gap between the rhetoric and reality of community participation for health for all (e.g., Baum 1990; B.C. Healthy Communities Network 1989; Farrant 1991; Farrant and Taft 1989; Hunt 1990; Lord and McKillop Farlow 1990; O'Neill 1989a, 1989b; Rose 1990; Siler-Wells 1989; Stacey 1988; Stern 1990; Sturtevant 1990; Tester 1990; Tsouros 1990; Tsouros (ed.) 1990). Fear of co-option, professional dominance, turf protection, conflicting ideologies of participation and dangers of state-sponsored participation as a device for shelving government responsibility are recurrent themes. Concerns have centred on issues of power and control that have been integral to the historical relationship between the state and community action, both in Canada and in other countries (Barnsley and Lewis 1985; Ng, Walker and Muller 1990; Beattie 1986; Coburn 1988; Mayo 1975). Many of these issues have been extensively debated in relation to earlier experiments in reorienting community health services discussed elsewhere in this review, such as Quebec's Centres locaux des services communautaires (CLSC) and Département de santé communautaire (DSC), and the British Columbia community resource boards and community human resources and health centre (Clague et al. 1984; Lomas 1985; O'Neill 1989a,b, 1989–90, 1992; Randle 1985). A recent article in the newsletter of the Social Planning and Research Council of British Columbia noted that: "British Columbia has come full circle, returning to debate the appropriate framework for community based social services within the changing 'social contract' between senior governments, local communities, and citizens" (Murphy and Kilcup 1991, 11).

Participants at the Quebec workshop for the CPHA Strengthening Community Health Services consultation (Siler-Wells 1987) underlined the need for the health promotion movement to acknowledge and learn from the successes and pitfalls of the Quebec CLSC and DSC twenty-year experiment in community participation and empowerment. This point has been highlighted by O'Neill's (1989a,b) illuminating analysis of the relevance of the Quebec experience to current developments in health promotion.

An analysis of the relationship between health promotion and community health action in Great Britain cautioned about the need to see the current state of interest in community participation for health in the context of broader debates around such issues as retreat from the welfare state, community care and volunteerism, and to take note of the now well documented

lessons from the implementation of primary health care in the Third World (Farrant 1991).

These observations reinforce the point made by Pederson et al. (1988), in their review of the literature on healthy public policy, regarding the importance of analysing current health promotion policy developments from a historical perspective, and locating them within a social, economic and political context.

Analyses of Canadian experiments in state-sponsored participation have demonstrated the usefulness of recognizing the multiple contradictions within state-sponsored community participation, including both their controlling and conservatizing tendencies and their progressive potential.

The contradictions of the *Framework* being launched in the absence of national policies to address the major challenge of reducing inequities did not pass unnoticed (McKillop Farlow 1987; O'Neill 1989b; Wharf 1989). At the same time, our review indicates that the *Framework* has provided a useful focus for legitimizing approaches that are rooted in community health action, and facilitating the development of progressive alliances for social change. While the absence of a significant reallocation of resources to back up the rhetoric about moving in a health promotion direction remains a major contradiction (Terris 1989), Milio (1987) has suggested that evidence of widespread public interest and support for the policy thrust "may in time make the Ministry's request for new funds to fully implement the strategy a politically feasible proposal" (p. 10).

McKillop Farlow's (1987) review of the *Framework* for the feminist periodical *Healthsharing* concluded that, despite the contradictions, the *Framework*

> indicates at least some movement on the part of government to incorporate health promotion into overall health strategies. It may provide a stepping stone to increasing budgets for health promotion activities. Certainly, it provides us, the public concerned about health issues, with a tool to pressure the government to continue in the direction implied by the release of the report. Within the document we find a clearly stated support for the goals and activities of Canada's women's health movement and we should use the Epp report to substantiate our position at the leading edge of health promotion. (p. 10)

## Summary

This chapter reviews developments of health promotion ideas and activities since 1977. The burgeoning national and international healthy communities movement demonstrates a widely felt need for a more socially oriented approach to strengthening community health. The policy direction of the *Framework For Health Promotion* (Canada 1986c), and the federally supported

Strengthening Community Health Program and Canadian Healthy Communities Project, have provided useful stepping stones toward the development of an infrastructure for supporting increased local action. The recent evaluation of the Strengthening Healthy Communities Program clearly demonstrated an impressive return on investment and a strongly felt need for continuation and expansion of such support. The readiness of governments at all levels to develop systematic policies to support healthy community action *and* respond to the community health needs identified by such action provides a measure of the political will to reorient community health services in a health promotion direction.