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THE UNIVERSITY OF ALBERTA

COMMUNITY DEVELOPMENT: A BASIS FOR THE SELF-CARE CONCEPT

by

© JEANETTE ADELINE BOMAN

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE

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Date. October 6, 1982.....

Abstract

This thesis has been developed around the relationship between health and the major social and technological changes that have occurred in society. To a certain extent, the health effects of these changes have been beneficial. However, as society has become increasingly orientated to the needs of extracommunity systems which evolved as a result of those changes (i.e., vertical pattern functioning), there has been a corresponding weakening of the ties among the units making up the traditional locality-based communities (i.e., horizontal pattern functioning). The dominance of impersonal bureaucratic systems over the more humanistic characteristics associated with locality-based community interactions has been perceived as having a negative impact on health.

The persistence of a vertical pattern orientation in society in general, and the health care system in particular, has encouraged individuals in families and communities to relinquish major portions of their responsibilities for various needs necessary for human existence to specialized social systems. The loss of control over decisions which affect life in general, and the manner in which illness and dependency needs are met in particular, has reached a point of diminishing health returns. It is suggested that further substantial gains in health are not likely to occur if the tendency towards vertical pattern domination continues.

The changing pattern of health problems and an approach to those problems which is expensive and largely based on the medical model ideology, not well suited to the etiology of current health problems, have been thought to be responsible for the increasing emphasis placed on the role that lay people can and are taking to overcome the inadequacies of current approaches to health. The involvement of lay people in personal and social health matters is equated with the concept of self-care in this thesis. It is suggested that the increasing evidence of personal and social level self-care activity is indicative of a general but random effort to regain some of the supportive characteristics historically associated with horizontal pattern functioning and to subsequently check excessive growth of vertical pattern functioning in society.

Although a great variety of activities have been identified as part of the self-care movement, a three-dimensional model based on the level of action, the type of health behaviour, and the source of activity origins and control is developed within this thesis and gives a sense of order to the concept. With this organizational approach in mind, a number of issues are discussed which stand as serious barriers to many of the changes in the approach to health care decision-making implied by the self-care concept. Several of these obstacles are linked to the tendency of units within the vertical pattern to manage and control the kind and amount of self-care activity performed by the lay sector. It is suggested that any self-care activity planned and controlled by those with vested interests in maintaining the power of vertical pattern

system functioning will ultimately undermine the aspirations of the self-care concept and fail to produce any further health gains which vertical pattern systems do not already allow.

The significant roles that both the individual and social structures play in the determination of personal and social opportunities for health is acknowledged by the concept of self-care. Nevertheless, the terms "self" and "care" are commonly interpreted as having only a personal focus. Because of this, as well as the tendency for units in the powerful vertical pattern systems (such as that of the health care system) to maintain control over the form and scope of lay involvement in health matters, the potential ability of the self-care concept to restore a balance between the vertical and horizontal pattern functioning in society, so that the health benefits of both can be enjoyed, appears to be limited. It is suggested that the philosophy and practice of community development might serve as an appropriate basis from which to further promote the concept of self-care because of the support it offers for the development of supportive social structures.

As the deliberate attempt to strengthen the weakened horizontal patterns of society, community development philosophically appears to be an approach by which to counter-balance excessively dominant vertical pattern functioning. However, there are problems associated with the implementation of community development concepts and these in combination with the particular obstacles to the concept of self-care in

the area of health seem to present some rather formidable barriers to the successful evolution of meaningful lay involvement in health care decision-making. On the other hand, there are some reasons to believe that the self-care concept is not only a relevant approach to helping solve current health problems but that community development can also be an appropriate change strategy by which to support and promote personal and social level self-care. The thesis concludes with a number of recommendations, which from the argument developed within, should be perceived as philosophical guidelines for the development of any strategies where meaningful lay involvement in the advancement of personal and social health is a major concern.

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TABLE OF CONTENTS

PAGE

CHAPTER

LIST OF TABLES

LIST OF FIGURES

INTRODUCTION

> By changing institutions and creating new programs we can make medical care more accessible and deliver it more efficiently, but the greatest potential for improving health lies in what we do and don't do for and to ourselves. The choice is ours (Fuchs, 1974:151).

It sounds so simple. However, from a realistic perspective, those choices which appear to be favourable or detrimental to health are the result of a complex set of circumstances. This thesis was originally begun with an interest in how people could be "helped" to make "better" health behaviour choices. The words, helped and better, are in quotation marks because of the different meanings they now have to the writer as compared to their initial interpretation.

Approaching the subject area with several years of experience in nursing practice and education, the terms were first defined from a health professional's perspective. Briefly, that perspective might be described as one which offers a certain amount of expertise from the study and practice of a particular body of knowledge. While the objective intervention by the health professional in the determination of health outcomes can certainly be of value, it is only part of a number of variables which are responsible for health. More often than not it is associated more with the restoration of health than its maintenance. Another set of variables which obviously contribute to health are attributes of the individuals themselves. Their biological

make-up, physiological functioning, attitudes, knowledge levels, values, and skills all play a part in determining health levels. These attributes in turn are related to and affected by the social and physical environment in which those individuals live.

While the scientific and technological advancements surrounding the practice of medicine accentuated the roles of objective intervention by health professionals, the significance of the individual whose health attributes were a combination of personal and social forces was minimized. Accompanying these developments was the tendency to value the health contributions offered by specialized professional expertise more than those personal subjective attributes of the individual, or social and physical effects of the environment. Hence, "better" health became a concept which was defined by professionals and "helping" to improve health was equated with what those professionals could do for others.

A changing pattern in the prevalence and causes of health problems has had a major effect on both how health is perceived and what is done to achieve it. Acute, infectious diseases which were the greatest hazard to health at the turn of the century have declined. Taking their place are health problems which are chronic in nature and of multiple etiology. Two categories of causes commonly associated with current health problems are the contributions made by individual behaviours and contributions made by the social and physical environment. Neither of these respond to the cure tactics of scientific medicine.

The increasing awareness that there are limits to the health restoration abilities of scientific medicine, as well as the major costs associated with such efforts, have lead many to believe that substantial gains in health can no longer be expected from the medical approach to health. As a response to the inadequacies and the diminishing returns in health gains, compared to the expenditures made, alternative approaches to health problems are being sought. One that is increasingly acknowledged is the role that lay people can take in finding solutions to health problems which affect them personally and collectively. Identified as the concept of self-care, lay involvement in personal and social health matters is not a new concept. People have always played some role in meeting their basic health needs, and to one extent or another, their illness and natural biological dependency needs. However, the amount of lay self-care activity and the emphasis placed on the need for personal and collective responsibility for health has noticeably increased within all sectors of society over the past decade.

Objectives of Thesis

The objectives of this thesis are based on the writer's original interest in how health, within the context of a developed society, might be further advanced. This interest, along with the changing patterns of health problems and the increasing emphasis placed on lay

involvement in personal and social health matters have provided the basis for the following objectives:

1. To explore the health producing potentials of the self-care concept.

2. To analyze the potential support and reinforcement that community development philosophy and practice can provide for the health potentials of the self-care concept.

Research Methodology

The concept of vertical and horizontal patterns in developed societies as outlined by Warren (1963) is the conceptual framework used in this thesis to analyze the development of current health problems, the increasing emphasis on and occurrence of lay involvement in personal and social health matters, and the potential support that community development might provide for the growth of self-care and related gains in personal and social health.

Although the conclusions reached in this thesis are based on some historical documentation and descriptive accounts of various events reported in the literature, the research methodology must ultimately be classified as philosophical in nature. An attempt is made to illustrate a particular relationship that exists among the concepts of health, self-care, and community development. The basic data and

information used to formulate this relationship has largely come from a review of the literature that exists on these subject areas. The examples of situations which serve to illustrate the relationship among health, self-care, and community development have also been taken from various cases reported in the literature with the exception of one where personal interviews and unpublished documents were used as supplemental sources of information.

According to Leedy (1974:68), "methodology is merely an operational framework within which the facts are placed so that their meaning may be seen more clearly." Acknowledging the complexity which surrounds the concepts of health, self-care, and community development, it would be relatively easy to further complicate, rather than clarify their meaning. As such, the clarity that Warren's conceptual model gives to the relationship between these concepts and the presence and effects of vertical and horizontal pattern functioning in developed societies is crucial to the methodology employed within this thesis. The following chapter summaries provide an overview of the conceptual framework upon which this thesis is developed. It is hoped that this overview will be the equivalent to a map which is consulted by an individual about to embark on a journey. The destination will more likely be reached if the places which must be travelled through are first determined.

Chapter One: The Meaning of Health

In Chapter One, the meaning of health is discussed. A case is made for its subjective, multi-dimensional nature and the important contributions that the concepts of participation and subsequent perception of control over life events make to health. The major changes that have occurred in society as a result of scientific and technological advancement are reviewed and related to the effect they have had on the individual's participation in and ability to control the manner in which various functions necessary to life are performed. These changes are perceived as having had both beneficial and negative effects on health. As suggested by Warren, the functional balance between the vertical and horizontal patterns in society is necessary for social and ultimately, personal health. However, the growth of technology and specialized systems has favoured the functioning of the systems within the vertical pattern while weakening the connections between the units of the horizontal pattern.

The excessive orientation to vertical pattern functioning by society in general is detrimental to social and personal health. Even though the systems within the vertical pattern were originally established to help meet human needs, an imbalance between vertical and horizontal pattern functioning, where vertical pattern demands exceed those of the horizontal pattern, results in system needs taking precedence over human needs. Whether it is in the way care for illness and natural biological dependencies becomes big business, or the manner

in which technology is allowed to pollute the environment, the point is made that an overly dominant vertical pattern is bound to have a negative impact on health. And, it is this dominance which is essentially responsible for the prevalent health problems which currently confront developed societies.

Chapter Two: The Rise of Lay Participation in Health Matters

The increasing emphasis on and occurrence of lay involvement in health matters is focused on in Chapter Two. After a discussion of the various forms and incidence of lay health activities, their apparent diversity is given some semblance of order through the development of a three dimensional model. This model classifies lay activity according to its level of action (i.e., personal or social focus), type of health behaviour or concern, and source of activity origins and control (i.e., lay or provider). At this point, the meanings implied by lay involvement in personal and social health and the concept of self-care are viewed to be synonymous.

The surge in the level of interest surrounding the concept of self-care is related back to the functional balance between vertical and horizontal patterns required for personal and social health. The suggestion is made that the random and general rise in people becoming involved in their own, as well as their community health concerns, constitutes an unorganized horizontal pattern-like response to an increasingly dominant vertical pattern in an effort to regain personal and social health.

Chapter Three: Potentials of the Self-Care Concept

The self-care concept is analyzed in this chapter for its potential contribution to personal and social health. The obstacles most commonly associated with lay activity in health matters are presented as they appear in the literature and as such, these obstacles come from the perspective of professionals whose education and experience are grounded in the ideology of the medical model and vertical pattern functioning. Health providers (i.e., professionals and health care system bureaucrats) may indeed be interested in the value of the self-care concept, but more often than not, the fear is that this interest comes from the needs of the vertical pattern functioning health care system rather than from those of the horizontal pattern. The point is made that any self-care activity planned and controlled by those with vested interests in maintaining the power of vertical pattern systems will not likely succeed in producing any further health gains which the vertical pattern does not already allow. Hence, the perceived failure of lay health activity to improve personal or social health is traced back to the continuing imbalance between vertical and horizontal pattern functioning in society.

Chapter Four: Community Development: Its Relevance to Lay Involvement in Health Matters

Although the philosophy and practice of community development is wrought with ambiguity, this chapter is an attempt to decipher what its

essential elements are. The traditional perception of community development is recognized here as a deliberate attempt to strengthen the weakened horizontal patterns of society. As such, it is proposed that community development is an approach which can be used to counter-balance the health damaging effects of the excessive vertical pattern orientation in developed societies. The similarities between the self-care concept and community development are pointed out. Essentially, community development is perceived to be an approach to the re-establishment of social health and ultimately, a basis by which the self-care concept might be further organized and promoted.

Chapter Five: Hypothetical and Practical Approaches to Strengthening Horizontal Patterns

Chapter Five is a review of the manner in which community development techniques have been connected to health promotion efforts where the involvement of lay people is perceived as a necessary requirement for any gains in personal or social health. A summary of its hypothetical application is presented first and followed by a number of illustrative examples where the association between the development of a strong community horizontal pattern and the related increases in opportunities for personal and social health have been made.

Chapter Six: In Search of a Healing Society

This chapter is an attempt to analyze the realities of the major assumption of the thesis which is the relationship between further gains in personal and social health and the development of stronger community horizontal patterns in society. Many of the obstacles which thwart the objectives of various lay health activities have been linked to a vertical pattern tendency to manage and control the kind and amount of lay involvement in health matters. As well, there are problems associated with the application of the concepts which are basic to community development efforts for the re-establishment of the healthy vertical-horizontal pattern balance.

In order to benefit from the process of strengthening horizontal patterns, it is essential to approach such efforts with a critical awareness of their inherent limitations. Thus, the shortcomings of community development are reviewed with particular attention to the dilemmas associated with the self-care concept approach to health. Doing so serves as a reminder about how the concepts of community development might hinder the growth of self-care. On the other hand, there are reasons to suggest that community development is an appropriate approach from which to consider the self-care concept. Chapter Six ends with the discussion about those conditions which appear to favour the application of community development and hence, support its potential relevance as an approach to advancing personal and social health.

The thesis concludes with a set of conceptual recommendations and related strategies which, from the preceding discussions, are perceived to be essential not only to future gains in personal and social health but to what is implied by the concept of "meaningful" lay involvement in health matters.

CHAPTER I

The Meaning of Health

Despite the vast amount of thought that has been given to the concept of health, no universally accepted definition exists. And, as Blum (1974:76) states:

> The inability of various health service practitioners to formulate any suitable or working definition of health attests to the difficulties our society has with this concept.

However, the concept of health (as ambiguous and difficult to describe as it might be) which prevails in society is important because it forms the basis for what people do individually and socially to advance health (Breslow, 1972). It is not the purpose of this thesis to argue the merits of various health perspectives. However, it is a useful and necessary exercise to review the current trends of thought given to the meaning of health in order to understand the reasons for and the potentials of lay involvement in personal and social health concerns.

Williamson and Danaher (1978) summarize two basic perspectives which emerge from the various definitions of health, health needs, and health demands. One perspective sees health as something tangible in itself while the other sees it as the absence of inhibitors. They describe the first as a positive concept of health and the second as a negative one. The latter is typical of the traditional medical

orientation where health is seen as the absence of disease or disability. Both of these have a distinctive approach to health management and are summarized in the following section.

Health as an Absence of Inhibitors

Although the evolution of modern medicine was a long and involved process, it is a popularly held belief that scientific medicine came of age in the late 19th Century. It was then that scientists were able to isolate the active micro-organisms of infectious diseases. With the isolation of the cause came the related discovery of specific treatment. Successful laboratory experiments based on the specific etiological model were offered as proof of the supremacy of that particular theory of disease causation (Crawford, 1980). As vaguer explanations of disease based on a variety of magical, superstitious, religious, logical, and social considerations were swept aside, the assumptions of a clean, uncomplex way of explaining and understanding disease captured the imagination of the medical and lay world alike. Those assumptions are described by Hayes-Bautista and Harveston (1977) as being:

1. An illness has an organic base.
2. The organic base is the result of discrete causal elements.
3. The illness is the involuntary result of an invasion of the host by an overwhelming quantity of the causal element.

4. The appropriate treatment for an illness is an agent which will directly counterattack the causal element and neutralize it.
5. Such an agent can be prescribed and administered only by a technically competent specialist.
6. The knowledge held by the specialist is inaccessible to the lay person, hence the patient must submit to the ministrations of the specialist without interference.

The medical model approach to health problems which the preceding six points characterize was "heralded by many scientists as the last word in disease causation" (Sorensen and Luckmann, 1979:106). The spectacular success with the use of vaccines and antibiotics, along with increasing biomedical technological advancements lead many to believe that by "simply identifying and killing dangerous microorganisms, disease could be eradicated forever" (Sorensen and Luckmann, 1979:106). However, although effective in the treatment of many infectious diseases, practise based on the medical model ideology has not proven to be applicable to current prevalent causes of health problems and deaths in modern civilization.

The Declining Relevance of the Medical Model Ideology

It is commonly acknowledged that the primary causes of death around 1900 were infectious diseases such as influenza, tuberculosis, gastroenteritis, and diptheria. This is quite contrary to the common

causes of death in the 1970's. The 1971 Canadian morbidity and mortality statistics illustrate that the major causes of deaths and days spent in hospital were due to conditions that were non-infectious and chronic in nature (Lalonde, 1974). Many were related to various behaviours and social conditions common to modern living situations. Those causes of death which headed the list were: ischaemic heart disease, cerebrovascular disease, and cancer. In younger age groups, motor vehicle accidents and suicides were the two most common causes of death. The 1976 Alberta death statistics (Table I) demonstrate a similar pattern.

The current causes of death and sickness make the assumptions of the medical model obsolete. The complex, multiple etiology of most health problems today, go far beyond an organic base and discrete causal elements. Although there is still evidence of some faith in the ability of knowledge based in the medical model ideology to eventually include a cure for such diseases as cancer, it is widely acknowledged that a microbiological search for causes and subsequent treatment for chronic ailments is only one small part of an overall solution to health problems. This was politically documented in 1974 by the Canadian government with their publication A New Perspective on the Health of Canadians. Its major contribution was a conceptual framework by which to analyze health affecting factors according to any one or a combination of four categories. Calling it the Health Field Concept, the four categories include: the environment (those matters related to health which are external to the human body and over which the

TABLE I

CAUSES OF DEATH - ALBERTA 1976*

Cause of Death in Rank Order	Number of Deaths Per 100,000 Population			Predominant Ages Affected
	Males and Females	Males	Females	
1. Ischaemic Heart Disease	162.7	213.1	110.8	40 and over
2. Malignant Neoplasms (Cancer)	122.9	139.2	106.1	40 and over
3. Cerebrovascular Disease (Stroke)	56.3	51.5	60.1	55 and over
4. Other[1] Respiratory Disease	38.4	47.7	28.8	under 1, over 55
5. Other[2] Circulatory Disease	35.8	37.1	34.6	45 and over
6. Other[3] Accidents/Poisoning/Violence	34.7	50.9	17.9	5 to 45
7. Motor Vehicle Accidents	29.2	41.9	16.1	5 to 45
8. Diseases of the Arteries	22.4	24.6	20.2	55 and over
9. Suicide	16.8	24.9	8.5	15 to 50
10. Bronchitis/Emphysema/Asthma	12.2	18.6	5.7	55 and over

[1]Other than Bronchitis/Emphysema/Asthma

[2]Other than Ischaemic Heart Disease, Cerebrovascular Disease, Diseases of Arteries

[3]Other than Motor Vehicle Accidents

*SOURCE: Report to Health Care and Social Services Planning Committee, Alberta Social Services and Community Health, 1980.

individual has little or no control); lifestyle (those decisions and behaviours of individuals which affect their health and over which they more or less have control); human biology (those aspects of health, both physical and mental which are developed within the human body as a consequence of the organic make-up of the individual); and health care organization (those people and resources responsible for the provision of medical and health care and the adequacy of such service).

Lalonde (1974) acknowledged that until the Health Field Concept was developed as a tool for analyzing health problems and their potential solutions, most of society's efforts to improve health, and the bulk of direct health expenditures had gone towards the health care organization category. It was believed that one of the consequences of the Health Field Concept would be to raise health problems related to human biology, environment, and lifestyle to a level of categorical importance equal to that of health care organization issues, most of which were grounded in the medical model ideology. The disease causing and subsequent treatment approaches to health problems related to lifestyle and environmental issues, on the other hand, are not well suited to the medical model assumptions.

Lifestyle as a Determinant of Health

The attention given in recent years to lifestyle has risen out of the observed relationship between various individual behaviours or personal habits and the risk of illness, disability, or death. The

behaviours identified by the Canadian government in 1974 which increased the risk of major health problems in Canada were inappropriate and/or excessive use of alcohol and psychotropic drugs, cigarette smoking, abuse of pharmaceuticals, over-eating, high-fat intake, high-carbohydrate intake, fad diets, inadequate nutrient intake, lack of exercise, inadequate stress management, careless driving, failure to wear seat belts, and, promiscuity. The 1980 Alberta Report to Health Care and Social Services Planning Committee presents a similar list of individual behaviours which are linked to Alberta's leading health problems (Appendix I).

Unlike the organic, discrete causal elements of infectious disease, the absolute connection between these various behaviours and certain health outcomes have not been made. Although some links between some behaviours and health outcomes are well documented (such as cigarette smoking and lung cancer) others remain only tentatively linked (such as physical activity and ischaemic heart disease) (Joint Working Group on Health Promotion, 1980). However, such links do imply a risk which in turn establishes a probability context (Milsum, 1980). Thus, in any given group, more of those who pursue a particular practice which has been labelled a risk to health, will be affected than those who do not. Even though there are no guarantees, basic to the risk factor concept is the fact that an individual can reduce or increase his or her chances of developing certain health problems by the behaviours and personal habits he or she chooses to practice.

Environment as a Determinant of Health

The renewed interest in the origins of illness from our social and physical environment is another development which demonstrates the inadequacy of the medical model approach to health. Many will point out there has always been some awareness and acknowledgement of relationships between illness and social conditions. However, Waitzkin (1981) suggests there is a tendency for each succeeding generation to forget and rediscover these social origins. Each rediscovery phase is likely to occur when the amount of illness, disability, and death due to social and physical forces within the environment is too great to easily ignore.

The environmental risks identified by the Canadian government in 1974 included: air, noise, and water pollution; urbanization; crowded high-rise living; the lack of recreational areas in cities; working conditions such as repetitive production line tasks; rapid social change due to technological innovation; and, poverty which is related to inadequate levels of food, clothing, and shelter. It is acknowledged that all of these environmental conditions create risks which are a far greater threat to health than a[illegible]dequacy of the health care system (Lalonde, 1974).

Health as a Tangible Concept

The preceding discussion about the causes of and changes in the morbidity and mortality experiences of Canadians in particular, but Western socities in general, serves to establish the basis for the premise that health, as Williamson and Danaher suggest, is more complex than merely being the absence of certain inhibitors as measured by morbidity and mortality statistics. They support their premise with reference to the 1946 World Health Organization's definition of health:

> Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity (Williamson and Danaher, 1978:42).

The criticisms directed toward this definition have centred about its utopian aspiration of "complete" and the inherent problems associated with evaluating such a health status. Blum (1974:92) is typical of this line of thought when he describes the World Health Organization's definition of health as an:

> ideal state of affairs that few of us approach even at birth. It is not of any practical use as a standard against which to measure health or as a goal to try to achieve.

Dubos (cited by Sebag, 1979:78) as well, agrees but sees merit in maintaining such a concept of health in mind:

> The concept of perfect and positive health is a utopian creation of the human mind. It cannot become reality because man will never be so perfectly adapted to his environment that his life will not involve struggles, failures, and sufferings. Nevertheless, the utopia of positive health constitutes a creative force because, like other ideals, it sets goals and helps medical science to chart its course toward them.

Regardless of its utopian aspirations, a host of ideas have developed around the meaning of complete physical, mental and social well-being. The multi-dimensional and subjective nature of the concept of complete well-being resists precise description. Levin, Katz, and Holst (1976:7) state: "no life practice can be absolutely ruled out as a health practice." Antonovsky (1980) and Williamson and Danaher warn of the inherent problems of an all-inclusive concept of health. Too broad an approach results in a vague, perhaps meaningless, complex concept from which no clear directions for action can develop.

The Health Field Concept, as already mentioned, was developed with that problem in mind. The conceptual order it gives to the variety of determinants associated with complete well-being, makes an otherwise complex concept of health conceptually manageable. However, as Lalonde points out, just because a health problem fits nicely into an organizational model, there is no guarantee that it will be easily solved.

One other dimension of the multi-dimensional nature of health not included in the Health Field Concept or the World Health Organization's

definition of health is the spiritual element of human beings. Milsum describes this dimension as the creative, intuitive nature of man which contributes to a sense of purposefulness in life and a will to live. The lack of consensus which surrounds the debate on this aspect of health is largely due to the inability of science as a knowledge form to deal with such a concept. However, in spite of the absence of scientific validation, the spiritual dimension of health has received enough attention to be considered as part of an overall concept.

In their discussion on the meaning of health, Dwore and Kreuter (1979) suggest that reaching consensus on its exact definition is likely impossible. Rather, it would seem more appropriate to come to some agreement on what the irreducible minimums of health are. A final analysis of the discussions surrounding the concept of health as something more than the absence of inhibitors, would suggest that one irreducible minimum of this health perspective is its subjective nature. Aside from the objective measurements of the physiological dimensions of health, much of what is perceived as health status is subjectively judged. Such words as "valued," "positive," "negative," and "well-being" or the significance of various social conditions or the concept of spirituality, to mention but a few themes of the various discussions on health, have different meanings for different people. Each person, the result of a unique genetic make-up and social experiences, likewise, has a unique view of what constitutes health. It is because of this subjectivity associated with health, that

Williamson and Danaher conclude that health cannot be described as anything more or less than a state of perceived well-being (whether or not disease or disability is present) provided that the person is able to live, what he or she and those they live with, consider to be a normal life.

Participation: The Basis to Health

The preceding discussion was meant to establish that the current trend is to view the determinants of health as multi-dimensional and health, beyond its measurable physiological dimensions, as a subjective concept. Taking the discussion about health as a subjective judgement one step further, Antonovsky suggests it may be possible to explain and subsequently measure the variations in perceived health states by an individual's sense of coherence. He describes this as:

> a global orientation that expresses the extent to which one has a pervasive, enduring, though dynamic feeling of confidence that one's internal and external environments are predictable and that there is a high probability that things will work out as well as can be reasonably expected (Antonovsky, 1980:123).

The stronger one's sense of coherence, the better would one's perception of health status be. Antonovsky suggests that particular socio-structural and cultural-historical situations are quite likely to

provide the developmental and reinforcing experiences that create a strong sense of coherence. However; the exact nature of those situations is not as significant to the development of one's sense of coherence as is the sense of personal involvement the individual has in shaping his or her life experiences. To sense this participation in determining one's destiny is what Antonovsky ultimately believes to be the basis of health.

The significance of individual participation and involvement in one's life activities is particularly supported by the humanistic philosophies. Basic to the humanistic view is the belief that there is an underlying flow of movement toward constructive fulfillment of inherent possibilities in all human beings (Rogers, 1977). However, this natural tendency towards complete development can only occur if people are involved in making their own decisions and choices. May (1975) relates participation in shaping life experiences to the "myth of creation" where order comes out of disorder and chaos as it did in the creation of the universe. With this sense of participation, no matter how slight, comes a sense of joy and pleasure.

Maslow (1962) implies the necessity of participation in his discussion about healthy people. From his observations, healthy people are those who have sufficiently gratified their basic needs for safety, belongingness, love, respect, and self-esteem and can consequently concentrate on actualizing their intrinsic potentials, capacities, and talents. Maslow states that healthy people are characterized by:

clearer, more efficient perception of reality; more openness to experience; increased integration, wholeness, and unity of the person; increased spontaneity, expressiveness; full functioning; aliveness; a real self; a firm identity; autonomy, uniqueness; increased objectivity, detachment, transcendence of self; recovery of creativeness; and ability to fuse concreteness and abstraction.

Just as the philosophical concept of a healthy individual requires participation on the part of the individual, so does the concept of a healthy society. Dwore and Kreuter (1979:112) simply state "the health-promoted society will show an abundance of healthy people." Keeping those characteristics of healthy people listed by Maslow in mind, it is interesting to note what Blum believes to be a healthy society. He suggests it would be characterized by: low rates of premature death; low rates of disease or deviation from physiological or functional norms appropriate to age and sex; low rates of discomfort; low rates of disability; high rates of internal satisfaction (joy of living, self-realization); high rates of external satisfaction with the environment; high rates of positive health (i.e., the extension of resistance to ill health and creation of reserve capacity); and high rates of participation in personal and community health matters.

The Changing Nature of Individual and Community Involvement in Health

From the preceding discussion, the philosophical perspective is one which suggests that participation is itself healthy and a health giving

activity. Few would dispute that individuals and groups of people have always been involved in meeting their health needs to some extent or another. Well before the advent of specialized social functions, health care, like other aspects of survival and social development, was the individual person's responsibility (Levin, 1976a). Weiss (cited by Sehnert, 1977), describes personal participation in health maintenance as part of a "dual system" of health care dating from ancient Greece and prehistoric times where care has always been offered on one level by the professional and on the other level by ordinary citizens. The extent to which either level was used depended upon a variety of factors such as the type of health concern, related costs, and abilities of either level of care to deal with the problem.

According to Adeniyi-Jones (1976:8) community involvement in health concerns, as well, has always been evident:

> From time immemorial communities have organized themselves with varying degrees of sophistication to provide for the promotion of health and the prevention and treatment of diseases and disability, to ensure the well-being of individuals as well as of the community as a whole.

Withorn (1980) describes the existence of mutual assistance and self-help groups as a basic means of survival prior to industrialization. This was the case, she says, because the basic economic and social needs of the people were not cared for by employers, the state, the church or the geographical community.

However, at best, early groups could only provide the most minimal assistance to their members. According to Withorn, such limitations were the basis for the campaigns of early unionists and socialists in Britian for greater public responsibility in meeting social needs.

Moving from a point of no public responsibility to what Gordon (cited by Levin, 1977b) calls a "serviced society" where a social institution like that of health care perpetuates itself, manages its clients, controls information about itself, and creates services more in response to the needs of the health care system than to the needs of those it serves, has been the result of numerous changes in society. Warren (1963) outlines seven major changes which are not necessarily exclusive but largely responsible for this shift of responsibility, as being: (1) division of labour; (2) differentiation of interests and association; (3) increasing systematic relationships to the larger society; (4) bureaucratization and impersonalization; (5) transfer of functions to profit enterprise and government; (6) urbanization and suburbanization; and (7) changing values. Each of these changes have had an impact on how individual and social functions, such as food production, housing, education, and health care, are carried out. As his conceptualization offers a framework by which to consider some reasons for the rise and fall of individual and community participation in the performance of those functions, each change will be briefly described.

Division of labour

The accumulation of scientific and technical knowledge has lead to increased specialization and a subsequently expanded division of labour. As people develop specific and narrow abilities, they become part of a highly complex system. The individual produces smaller and smaller portions of what he or she consume and as a result, becomes dependent on the system for production and distribution of goods and services his or her unit of specialization does not provide. Warren calls this symbiotic interdependence.

Differentiation of interests and associations

The differentiation of interests and associations related to the specialization phenomenon has been a major cause of the decline of social interaction patterns within geographical communities or a particular locality. Whereas the individual's interests and associations once centred about his or her immediate locale, outside interests and associations now tend to dictate the individual's patterns of social interaction. Rather than establishing primary relationships within the family and surrounding locality, the individual tries to find a replacement through the secondary groups associated with the specialized, differentiated aspects of the larger culture. Primary group relationships accommodate the participation of

the "whole" personality of the individual while secondary group relationships take in the segment of the individual which represents the shared interest. People having more secondary group relationships than primary ones are more likely to lead lives which are segmented by their various involvements. With fewer people knowing each other as total people, the capability and desire to see that the individual's total needs are met diminishes.

Increasing systemic relationships to the larger society

Specialization and differentiation of interests and association have encouraged the development of many connections to systems which exist outside of the local community. Thus, the trend away from the locally-oriented community based on the coordinated aggregation of functional units (i.e., horizontal linkages) to one with units that are tied to regional and national systems (i.e., vertical linkages), tends to orient the individual to the specialized, vertical extra-community needs rather than those of the local community. It is not unusual for the needs of the two to be different.

Bureaucratization and impersonalization

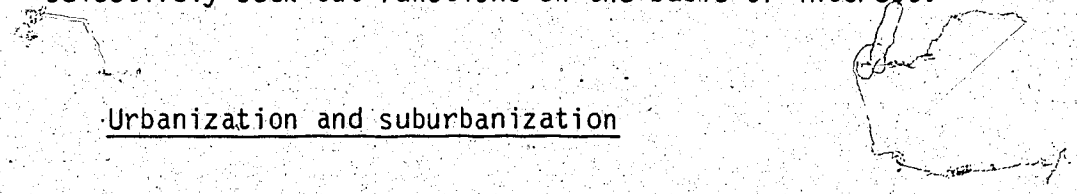
In an effort to coordinate the complex nature of systems based on specialization and vertical linkages, bureaucratic structures

developed. The efficient, impersonal nature of bureaucracies has an impact on the style of individual involvement and approach to local community needs versus those of the organization which are more significantly connected to an extra-community system. In that people do many things in the name of an institution or organizational authority that they would not do in their own primary group relationships, the benefits of bureaucracies can be undermined by abuse of the very characteristics which make them rational solutions to complex problems (Storch, 1977). As well, bureaucracies can and do demonstrate "goal displacement" which Warren describes as bureaucratic behaviour directed towards filling the needs of the organization rather than serving the functions for which it was originally established. These disadvantages aside, in an effort to assure just treatment for all, the structure and procedures of bureaucracies establish rules by which to make decisions. Thus, one of the ultimate effects of bureaucracies is the assurance that individuals do not have to take personal responsibility for the decisions that are made. In that most policy is set in headquarters outside of the community, community input into policy is often sacrificed.

Transfer of functions to profit enterprise and government

Another change which Warren sees as closely related to the process of specialization and division of labour is the transfer of many

functions which were formerly performed by the individual, the family, and their immediate neighbours to business and government. Such functions as education of children, care of the elderly, care of the sick, food preparation, and construction of homes are examples of this change. Warren states that such transference of activities gives individuals, families, and groups of people the opportunity to selectively seek out functions on the basis of interest.



Urbanization and suburbanization

As Warren states, the growth of cities has been one of the most striking aspects of recent history and occurred quite naturally as a social form of organization to accommodate the changes already mentioned. The anonymity, heterogeneity, impersonality, and formalized status of urban life does not necessarily encourage participation and involvement in local community affairs. Although it is difficult to generalize, Warren believes that for many, suburban living is an attempt, albeit artificial and superficial in some ways, to recapture those characteristics reminiscent of earlier small town living where primary group relationships and a sense of neighbourhood once ruled supreme.

Changing values

Warren reviews the values which have been particularly relevant to Americans although in varying degrees of importance. He includes: freedom; individualism; practicality; precuniary evaluation; success; education; science; progress; happiness; humanitarianism; and conformity. It is obvious that some values are contradictory in nature. For a variety of reasons, each value which may be in opposition with another has the potential of being upheld as more appropriate in certain given situations than in others.

These values have evolved through time. Although Warren does not address what role these values had in shaping the major changes in society, he does suggest that those changes have lead to some major value changes. He outlines those as the following: (1) gradual acceptance of governmental activity as a necessary and desirable function in a number of fields; (2) gradual change from a moral to a causal interpretation of human behaviour; (3) a change in community approach to social problems from that of moral reform to that of planning; and (4) a change of emphasis from work and production to enjoyment and consumption. Of these four major value changes, increased acceptance of government control over strategies designed to meet personal and social needs and a planning approach to the solution of social problems (which likewise, to Warren, implies an acceptance of expert or specialist problem-solvers) supported the already present

tendency for individuals, families, and their communities to relinquish many of their personal and social care responsibilities to systems which exist outside of the individual and community domain.

The Effect That Major Societal Changes Had on the Concept of Health

The major changes outlined by Warren can be linked to distinctive alterations in how health was perceived in general, and how specific illness and dependency needs were attended to in particular. As previously discussed, the ability to participate in and to perceive some sense of control over the character of one's life has been identified as an essential requisite for healthy individuals and communities. The major impact of the changes in society during industrialization was to remove the responsibility for various life functions from individual family and community members and allocate them to external systems. Thus, one might hypothetically expect a lowered sense of personal and community control over the manner in which those functions were carried out. Following the argument that participation is health-giving in itself, one might also expect that decreased levels of individual and community participation in the decision-making processes of external systems would lead to an ultimate loss in the levels of perceived personal and social health.

More specifically, the manner in which particular health problems and natural biological dependencies were managed also changed because of the major alterations in society. As already mentioned, the responsibility for life events such as birth, death, pain, and care of the sick, the young, the disabled, and the aged was historically assumed by family members and the community within which the individuals lived. Such dependencies cannot be avoided and virtually define human beings as social animals (Ehrenreich, 1978). As an elaborate health care system eventually assumed responsibility for the maintenance and restorative activities related to these life events, its own efficient functioning relied on a passive response, yet willing compliance on the part of the individuals who needed its services. As a result, the natural human tendency towards dependency during certain life occurrences was fostered by the health care system. Autonomy (i.e., participation) was generally discouraged as illness-care decision-making became the responsibility of specialized health care professionals (Ehrenreich, 1978).

Essentially the balance between the human need for autonomy and dependence was disrupted as health care, or rather illness and dependency care, was institutionalized. However, as long as the health care and other social systems were able to satisfy the general and specific health requirements of individuals, people were willing to relinquish their personal and community responsibilities to the professional expertise of external systems. The increasing dependency

on external community systems and the decreasing relevance of the locality-based community has been analyzed by Warren (1963) according to the concepts of vertical and horizontal patterns which make up a community. As this conceptual framework has been used in this thesis as a basis by which to understand the development of many current health problems, the increasing emphasis on lay involvement in health matters and the potential support that the philosophy and practice of community development might provide for the concept of self-care, the meanings of vertical and horizontal community patterns must be clarified. The following discussion is a summary of the ideas implied by the concepts of community vertical and horizontal patterns.

Community vertical and horizontal patterns

Building upon small group and social systems theory, Warren has developed the concept of community vertical and horizontal patterns as a way to analyze the manner in which goals are reached in communities. While the attainment of these goals might seem to be related to the performance of a particular set of actions (i.e., task functions), goal accomplishment is also dependent on the ability of the involved people to work together and to perform the necessary tasks (i.e., maintenance functions). And, whereas goal-oriented tasks arise from the group's perception of what needs to be done to survive in or improve the environment in which they live, the maintenance of group functioning

comes from the spontaneous relationships and expressions of sentiment towards one another which evolve as the group members work together. Warren (1963:139) states:

> In order to accomplish its purpose with respect to its environment a group must not only perform goal-oriented tasks, but it must also be able to keep its members so organized with respect to each other that they will continue to function as a group and perform the tasks.

Thus, effective group functioning and subsequent goal achievement by that group would be dependent on the development of positive feelings amongst group members and mutual agreement about the benefits of group interdependence.

To Warren, there are parallels, although imprecise, between the formal, external patterns of group activities and the concept of task functions. Conversely, similar parallels exist between the informal, internal patterns of groups and the idea of maintenance functions. Ideally, group integration and the ability of that group to survive within the environment would result from a balance between its formal/informal, external/internal or task/maintenance orientation. The constant, unavoidable changes within either side of these orientations means that the balance is a dynamic rather than a static conception (Warren, 1963). However, Warren explains that as groups become larger, their integration becomes more dependent on clearly defined rules and formal structures. Supposedly, communication of

sentiment and the development of spontaneous personal relationships provide less of an integrative function as groups move from small to large formations. As discussed earlier, the increases in bureaucratic structures and the differentiation of interests and associations lead to a reduction in the number of relationships an individual has in which he or she are perceived as a "whole" personality. Rather, formal, external or task orientations are geared more to the fragment or the part of the individual which performs the necessary function.

Relating all of this to the concepts of vertical and horizontal patterns within communities, Warren (1963:162) states:

> The community functions in relation to its environment as it performs tasks which relate it increasingly to the surrounding geographic environment ... The specific subsystems which perform these functions tend to have strong formal organizations dictated by the necessity of getting the job done.

The subsystems and their relation to formal organizations are what constitute a community's vertical pattern. It is defined as:

> the structural and functional relation of its various social units and subsystems to extracommunity systems ... such relationships often involve different hierarchial levels within the extracommunity system's structure of power and authority (Warren, 1963:161).

Just as small groups must concern themselves with individual member needs (i.e., maintenance functions) in order to achieve a group goal (i.e., task functions), the vertical pattern-oriented functioning of the subsystems within a community is also dependent on the relations that spring up amongst those subsystems "which are based on sentiment and not dictated by the environment" (Warren, 1963:163). This relationship is the community's horizontal pattern and is defined as:

> the structural and functional relation of its various social units and subsystems to each other ... a type of relationship into which all community units come in some of their aspects, a relationship which poses a different set of goals, organizational demands, norms, and so on, from that involved in the vertical pattern (Warren, 1963:162).

Although Warren states that both community patterns can and do assume task and maintenance functions, generally speaking, task performance most often relates to vertical pattern functioning while maintenance activities are more the concern of the community's horizontal pattern. With this conceptualization (although the exceptions to the generalization are acknowledged), the vertical and horizontal patterns provide a manageable framework from which to analyze the manner in which task and maintenance functions, both of which play a significant role in the attainment of goals essential to human existence, are carried out. As already mentioned, the survival of small groups is dependent upon a balance between their task and

maintenance functions. In a similar way, the ability of a community to optimally meet the needs of its members rests on the relationship that exists between its vertical and horizontal patterns. Warren suggests that a dynamic relationship exists between the two where at times one may take precedence over the other but at no time is either absent. This invisible balancing mechanism is described as:

> the tendency for the confining pressures of one set of relationships to grow rapidly as the contrary set begins to move beyond a certain point (Warren, 1963:269).

With the major changes in society, Warren states that the tendency for the vertical pattern to take precedence over the horizontal pattern of the community was responsible for the declining relevance of the local community to its individual members and a subsequent weakening of the horizontal pattern. As responsibility for education, food, housing, and illness/dependency needs were taken over by various units in vertical pattern systems, individuals in families and communities no longer perceived the need, let alone the ability in some areas, to take responsibility for essential life functions. In some cases, individuals were not allowed to perform certain activities. By law, they were required to submit to the services of people certified to practice specialized functions. Examples of this can be found in many areas but of particular relevance are those found in the practice of medicine.

Problems associated with excessive growth of the vertical pattern

The growth of the vertical pattern was so strongly favoured by the changes that occurred in society that, an overbalance of vertical pattern activity as compared to the human value of horizontal pattern activity, created increasing numbers of problems. Warren outlines the negative impact of the major changes observed by himself and other sociologists as being: a decline in community cohesion; a sense of anomie or normlessness where there is no longer general agreement among individuals as to what norms should guide their behaviour; a decrease in the numbers of people who know the "whole" person and an increase in those who know only "segments" of that person; excessive centralization, red tape, inflexibility, impersonality, and reluctance to take responsibility; faulty communication through the hierarchial nature of the vertical pattern units; greater loyalities to bureaucracies than to the people they serve; and finally, for the sake of efficiency, the concentration of decision-making power at the top of organizational hierarchies which inherently contradicts the ideals of popular democracy. Katz and Bender (1976:3) summarize the conditions of modern life which emphasize the precedence that the characteristics of the vertical pattern, in the aftermath of the major changes in society, took over those of the community's horizontal pattern:

> Industrialization, a money economy, the growth of vast structures of business, industry, government - all these have led to familiar specters: the depersonalization and dehumanization of institutions and social life; feelings of alienation and powerlessness; the sense for many people, that they are unable to control the events that shape their lives; the loss of choices; the decline of the sense of community, of identity.

Referring back to Warren's hypothesis that the actions of the horizontal and vertical patterns within communities are in equilibrium with each other, one might presume that the negative effects of vertical pattern growth would eventually be counter-balanced by a natural horizontal pattern response. Having reached a point where the problems created by too much emphasis on vertical pattern functioning outweigh the benefits of such activity, to many, there does appear to be a horizontal pattern-like reaction where people are demanding more participation in and control over the decisions being made about their lives (Levin, 1978; Henig, 1979; Katz and Levin, 1980; Toffler, 1980). This has been manifested in the United States by the civil rights, consumer's, and women's liberation movements of the mid-1960's. Toffler cites the increasing dissatisfaction with welfare, postal, education, social services, political, and financial systems as further evidence of a generalized reaction against the undesirable characteristics of industrialization. The general trend towards self-help and consumer movements are perhaps, in turn, symptoms of a society trying to right itself in an effort to re-establish a

satisfactory balance between the value of vertical and horizontal pattern activities within communities. In a sense, such activities might be described as an effort to also re-establish healthier individuals and communities in general as the health-related concept of participation is basic to the self-help and consumer movements.

In that individual and community health is also related to the manner in which their illness and dependency needs are cared for, the specific system which took responsibility for these components of health deserves particular attention with regards to the problems associated with excessive reliance on vertical pattern activity. As a representative part of the vertical pattern, the health care system has not been immune to the problems already related to vertical pattern functioning in general. It is commonly acknowledged that modern medical care has reached a point of diminishing returns where additional inputs of medical care fail to have much impact on the overall levels of sickness and death in Western society. This is not to say that the medical model ideology does not and has not proven to work in preventing death and reducing pain and suffering. It has (Ehrenreich, 1978). However, it is no longer making substantial gains to health levels in general.

The reasons for this are varied. One has already been discussed in that the medical model ideology was developed for health problems which are no longer prevalent today. Current illnesses of a chronic, behavioural, and/or environmental etiology do not lend themselves to

easy solution through the direct cause and related treatment approach of the medical model ideology. The other reasons are summarized by Ehrenreich as being either the political-economic critique or the cultural critique of modern medicine. Both can be related to the problems associated with excessive growth and reliance on vertical patterns of activities, specifically those of the health care system.

The political-economic critique of the health care system's inability to substantially improve health levels in society would have us believe the problems lie in the inadequate access to and distribution of medical care services. The tendency for hospitals and health professionals to situate in central, urban areas partly in response to the major changes in society have been the cause for the following complaints about the health care system which Crichton (1973) states are common to United States and Canada: problems with accessibility such as crowded waiting rooms, long waiting periods, and long distances to travel; depersonalized interactions which lack warmth and understanding; lack of continuity; and, inadequate communication of instructions. To Crichton, these complaints are generated by a health care organization structure geared to the needs and preferences of the health care providers rather than to those for which it was originally established. Even though this might be the case, Ehrenreich states the political-economic critique of modern medicine's failure to produce more health rests on the issues of scarcity.

The cultural critique of modern medicine (i.e., McKeown, 1976; Illich, 1976) on the other hand, blames health losses on the incompetence of medical practice, clinical iatrogenesis (i.e., illness induced by medical intervention), and the personal relinquishment of responsibility for health to the dominant medical elite. The cultural critique denounces the medical model approach to health as one which produces unnecessary dependence, reduces the opportunities for individual autonomy, and depoliticizes the impact that social issues such as class, race, and gender have on health. From this perspective, modern medicine as experienced in the health care system, serves as another example of "bourgeois domination," (Ehrenreich, 1978) where vertical pattern priorities have taken precedence over those in the horizontal pattern.

Summary

The tendency for the major changes in society to strengthen the vertical patterns of communities and weaken their horizontal ties has been identified as health producing to a point (e.g., as demonstrated by the successes of a medical model approach to illness). However, as the pendulum swung too far in favour of the vertical pattern needs of society in general and the health care system in particular, the health producing effects of horizontal pattern involvement were minimized. At the same time, the medical model approach has lost some of its

relevance as the health problems it was designed for have disappeared and new problems which do not respond to it, have become more prevalent.

The major point to be made is that, for whatever reason, the inadequacies of both the medical model ideology and the health care system through which it is delivered are commonly acknowledged. Just as in other areas of society where external systems are failing to meet the needs of the people they serve, there is a trend away from total reliance on the health care system to solve the current, prevalent health problems. Where medical model ideology is proving to be inadequate, different approaches are being considered. One major observation is the increasing emphasis being placed on the role that individuals and communities can and are taking to advance personal and social health. Evidence of these increases in lay involvement in health matters are presented in Chapter Two. If Warren is correct, the emphasis on increased individual and community involvement in the decisions made about their lives in general and health needs in particular, is perhaps a natural horizontal pattern reaction to the negative ramifications of an excessive vertical pattern orientation in society.

However, the documentation of the increasing emphasis placed on individual and community involvement in health matters in Chapter Two will illustrate the multitude of reasons behind this so-called trend. Not all of these reasons are indicative of the pendulum swinging back towards a restored balance with an increase in the strength of

community horizontal patterns and a decrease in the powers of the vertical pattern. In some instances, the reasons for encouraging and making allowances for lay involvement in health matters may actually be a way for vertical pattern systems to maintain their power and control. An already excessive reliance on the vertical patterns in society in general, and the health care system in particular, has been identified as detrimental to personal and social health. Once the forms of lay involvement in health matters and the reasons behind the interest in these activities have been explored, their potential for making any substantial gains to health will be discussed. In the instances which only serve to fortify the vertical pattern, it is suggested that further health gains are unlikely to occur. Support is ultimately given to the situation where attention is paid to the development of stronger horizontal patterns in communities. It is in these cases where the most potential for improving personal and social health possibly lies.

CHAPTER II

The Rise of Lay Participation in Health Matters

There is ample evidence in current health literature that lay participation in health matters is not an unusual event. It occurs in varying forms and for a variety of reasons. The intent of this chapter is to present an overview of lay activities in health matters, to develop a logical, organized framework from which to view those activities, and to explore the reasons why there seems to be an apparent increasing interest in this area over the past decade or so.

Selected Overview of Lay Participation in Health Matters

In her review of consumer rights in health care, Storch (1977) outlines the development of the Patient's Bill of Rights concept in the United States and Canada. Through a series of formalized statements, a number of organizations asserted, among other things, the individual patient's right to participate in health care decision-making. This focus on the right to participate in one's own health care occurred simultaneously with the emphasis on the need for individuals to take responsibility for their own health.

As previously mentioned, people taking care of their own health care needs is not a new concept. Several studies suggest that anywhere from 63 to 75 percent of health care is undertaken without professional

intervention (Williansom and Danaher, 1978; Fry, 1973). However, aside from it being a rather common and age-old phenomenon, individual responsibility for health has recently taken on expanded dimensions. One is a new name. Activities where individuals are involved in health matters that affect them are now frequently referred to as self-care. The "explosion of interest" (Tom Ferguson, 1980a:87) in the concept of self-care since the early 1970's is evidenced by a wide variety of activities.

One of the first modern forms of self-care activities to receive recognition in the United States was a comprehensive consumer health program called the Course for Activated Patients (CAP). Sehnert (1977), a medical doctor, initiated CAP in 1970 in order to provide individuals with skills that would enable them to take a more active role in their own health care and that of their family. This was done by teaching patients how to use health care resources more efficiently, providing a better understanding of self-help, emphasizing the importance of individual responsibility and training patients in various health care skills traditionally performed by health care providers. Sehnert and Levin (1978) both agree that self-care education differs significantly from traditional patient care and health education. Whereas traditional approaches are based on what the health care provider values as right in terms of the individual's health, self-care education derives its goals from the learner's perceived needs and preferences, regardless of whether or not they conform to those of the health professional.

Out of the original CAP program, Sehnert organized a health activation network throughout many parts of the United States. This was only the beginning of a phenomenon which would attract the interest of lay people, health care professionals, health care agencies, and government officials alike. Schwartz (1976) provides a comprehensive review of the directions that self-care activities took from the early to mid-1970's. Among those are courses geared towards the individual to enhance their abilities to prevent illness, evaluate their health, and treat their health problem. He cites the Canadian government's "Operation Lifestyle" as an extensive and innovative program designed to encourage individuals to be more responsible for their health. Other self-care trends identified by Schwartz included holistic health care approaches, humanistic medicine, bio-feedback, meditation, and personal lifestyle habit management courses. Books on how to manage and prevent illness appeared.

According to Tom Ferguson (1980a) over six hundred self-care books have been published in the past few years. Ardell (1977) provides a comprehensive annotated bibliography and analysis of such books. Categorized according to dimensions of self-responsibility, nutritional awareness, stress management, physical fitness, and environmental sensitivity, the books represent the broad concerns upon which self-care activity is based. In addition to these publications, a number of periodicals and organizational resources exist to enhance self-responsibility for health care. Several detailed listings of self-help health resources have been developed to enhance the

likelihood of self-responsibility for health care. Good examples of these resource lists are the ones developed by Simpson (1980) for the American Citizens Energy Project and Milio (1977b) for the National Self-Help Clearinghouse in New York.

Self-care has also become the focus of many self-help groups which have been said to number up to 500,000 in the United States (Riessman, 1979-1980). Whereas self-help and mutual aid refer to a group dimension of self-care, Katz and Bender (1976:9) define self-help groups as "voluntary, small group structures for mutual aid and the accomplishment of a special purpose." Such groups are usually formed by people who have a common need or problem. Through sharing their experiences, they mutually assist each other to more effectively cope with the problem. In many cases, this involves change of some sort at the personal level. However, in some cases it involves bringing about social change to remove the cause of the problem. Tracy and Gussow (cited by Gartner and Riessman, 1976) suggest that self-help groups geared to personal level strategies (such as emotional support, education, and specific skill training) are Type I self-help approaches. Type II self-help approaches are those with a broader social focus and include such activities as fund-raising for research, public and professional education campaigns, and legislative and lobbying activities as a means to alter health damaging conditions. Although each has a different focus, neither approach is mutually exclusive. Thus, where self-help groups may be either a Type I or Type II, some are a combination of the two.

Gartner and Riessman propose dividing the Type I groups into four categories: (1) rehabilitative work; (2) behaviour modification; (3) primary care; and (4) prevention and detection of health problems. Those groups engaged in rehabilitative work provide individuals with support after they have already received professional care in the acute stage of their illness. Groups which form around conditions like mastectomies, strokes, coronary attacks, and ostomies would be included here. The second type of self-help health group is concerned with behaviour modification of those engaged in activities which are harmful to health. Among the examples in this category are Alcoholics Anonymous, Weight Watchers, and smoking cessation groups. Those groups engaged in the area of primary care are largely concerned with chronic conditions for which there is no cure but care is necessary. For example, emphysema, arthritis, and diabetes are conditions around which several groups have organized. The fourth type of self-help health activity is in the area of prevention and case finding. Examples of these groups are those concerned with such issues as hypertension and fitness.

The Self-Help Reporter, a bi-monthly publication of the American National Self-Help Clearinghouse, provides extensive reviews of self-help efforts in the United States, Canada, and other parts of the world. In the May/June 1981 issue it is reported that self-help mutual aid activities have grown enormously in the past several years particularly in the areas of health. Three areas in which major

increases in numbers of self-help groups have occurred are those of chronic diseases (such as cancer, diabetes, emphysema, asthma, hypertension, coronary disease), life crises (such as divorce, death, aging, infertility), and caretaking responsibilities for others (such as children with handicaps, previously institutionalized people, sick or older parents, spouses with disabling conditions). Kickbusch, a consultant in health education for the World Health Organization states:

> There is a mutual aid group for nearly every disease category listed by the World Health Organization, as well as groups concerned with a wide variety of psycho-social problems (Kickbusch, 1981/82:7).

In order to inform people of their existence, many directories outlining the various self-help health groups in a particular area have been developed. Although more numerous in the United States, certain cities in Canada have their own self-help group directories. A recent one was developed for Edmonton in 1981 called Help Yourself to Health.

The women's health movement (Marieskind, 1975) is an example of self-help in health which has attempted to address both personal and social level health concerns. In their description of the Vancouver Women's Health Collective, Kleiber and Light (1978:47) identify the dual focus of many women's self-help health activities:

> Women cannot change the fact that they are women, but they can change the way in which they relate to the health care system and to society as a whole .... (however) Many of the changes sought by women's self-help groups are changes within society, rather than adaptations of the individual to society.

According to Marieskind, women's health activities which evolved from the women's liberation movement of the late 1960's, have spread to every major city in the United States, to Canada (see Health Action: A Conference on Health and Women, 1980), Australia, New Zealand, Europe, and South America. The diverse activities of the women's health movement include participatory health clinics, conscious-raising discussions, national and regional conferences, a vast array of literature, periodicals, newsletters, and self-help courses. Marieskind (as does Freudenberg, 1978; Levin, 1978; Gartner and Riessman, 1976; and others) states such activities serve to meet both a personal and a political or social need. The personal development of knowledge, skills, self-concept, and levels of confidence is an important aspect of the activities. However, the collective nature of women's health activities is also political in that the women's health movement challenges treatment methods and the manner in which those methods are delivered in the traditional health care system. As Marieskind and Ehrenreich (1975:39) indicate, the point of women's self-help health activities is not to replace the doctor with more socially compatible, sympathetic providers but rather:

> an attempt is being made to completely redefine the patient and provider roles ... the woman is not the object of care but an active participant; not the recipient of a commodity but a co-producer of health care.

In their account of the 1975 International Symposium on the Role of the Individual in Primary Health Care, held in Copenhagen, Denmark, Levin, Katz, and Holst (1976) describe how a population perceives a variety of self-care competencies is reflected in the level of public interest and lay involvement in decision-making and political action in health affairs. As well as the increase in personal and special interest forms of self-care just described, they suggest a similar trend has occurred in the levels of lay or public influence and action in health:

> Consumerism has recently emerged as a substantial factor in health policy and practice, pointing to both the actual and potential lay impact on the functioning of professional health resources (Levin, Katz, and Holst, 1976:12).

Warner (1981) states that since the mid-1960's, community participation in the health sector (particularly with primary health care) has become more prominent than ever before in Canada. He notes the historical lay representation in certain parts of the health system (particularly hospital and public health boards) but suggests their function has basically been of a "rubber stamp" nature. However,

attempts to move beyond this type of functioning can now be seen in a variety of arrangements that exist in Canada and the United States.

Warner outlines four phases in Canada which relate to the emergence of community participation in health related concerns. While each phase has its distinctive characteristics, they are also seen to overlap and co-exist in certain areas. He describes these phases as: (1) state intervention; (2) collectivist; (3) centralism to regionalism; and (4) individual action and collective responsibility.

The state intervention phase from 1910 and 1950 was characterized by ad hoc provincial government responses to the health needs of the population. These responses were not adequate, leaving what Warner calls a large number of medically indigent people. Only in Saskatchewan was a general concern for these people voiced by the Commonwealth Cooperative Federation (CCF). As the ideological principles of this political party were based on collectivism and equality, examples of community participation and cooperation in the development of general medical services preceded any other collectivist-type activities in the other provinces. The social and fiscal crises of the 1930's and the inability of provincial governments in general to provide adequate health care services set the stage for increased involvement by the federal government.

The collectivist phase essentially started, with an agreement between the provincial and federal governments to share in the provision of hospital and diagnostic services. A move towards

government funding of physician services began as well. In 1962, a disagreement over the mechanism for third party payment occurred between the government and doctors in Saskatchewan. The result was a strike by the doctors and community action to support those doctors who wished to practice under The Medical Care Insurance Act. Fourteen community-sponsored clinics were established and symbolized a desire to ensure access to health services through community involvement. By 1970 only six clinics remained in Saskatchewan and although many of the original clinics failed to survive, the community health centre concept had spread to other provinces. The Hastings Report, released in 1972, supported the development of community-run health centres and Quebec, Manitoba, and British Columbia in particular committed themselves to implementing a regionalized network of community health centres. Aside from the emergence of community health centres as one level of community participation in health matters, Warner states by this point, another form of public participation had developed with the vast majority of Canadians now enrolled in provincially administered medical plans.

The next phase of centralism to regionalism was one which only continued to emphasize the idea of community participation. In Quebec, the 1970 Castonguay-Nepveu Commission called for health reform through the practice of social medicine, decentralization of services, and decision-making, increased and more open participation in decision-making, and equalization in the rights and privileges of

health workers (Renaud, 1981). The resulting reorganization of the health and social services institutions lead to such developments as the local community service centres (centres locaux de services communautaires or CLSC). These centres were to be autonomously controlled by a board of directors basically composed of residents from the surrounding community.

Although not to the same extent as Quebec, Ontario and British Columbia implemented forms of regional health management which called for community participation in 1974. Community input was a mandate of the District Health Councils (DHC) in Ontario and was supposedly assurred by the appointment of community members to DHC boards. Meanwhile, four Community Human Resources and Health Centres in British Columbia were also established to encourage the idea of "locally planned, controlled, and operated health and social service programs" (The Development Group, 1974:6). The mechanism for this was through a governing board, the majority of whom were elected community residents and the remaining membership made up of representatives of the staff groups at the centre. The mandate of these boards was to set and carry out programs and services in response to the needs of the community. For reasons to be discussed at a later point, Young (1981) points out, despite the plethora of official documents and experimentation with the concept of community health centres, they have yet to appear on a large scale in Canada.

It is interesting to note that at the same time the various departments in community participation in health centres were occurring

the Consumer's Association of Canada published the Consumer Rights in Health Care resolution. In 1974, this charter, remaining true to the increasing attentions paid to lay involvement in health matters, resolved that consumers have a right to: (1) be informed about their health status, the health care alternatives available to them, and the cost of those alternatives; (2) be respected as individuals with the major responsibility for their own health care; (3) participate in decision-making which affects health at both a social and individual level; and (4) equal access to health care resources (health education, disease prevention, treatment, and rehabilitation) regardless of economic status, gender, age, ethnic origin, and location (Canadian Consumer's Association, 1974).

According to Warner, the last phase of the rise in community participation, individual action, and collective responsibility, was set by the Lalonde Report in 1974. Basic to its Health Field Concept, as previously described, is the premise that better health can only be achieved with greater individual and collective (or mass community) responsibility for health behaviours. Such thinking by government officials and health care providers in Canada and the United States has lead to the development of a number of strategies geared towards helping the individual to make decisions and behave in a manner which would reduce the likelihood of health problems. Through such strategies as health risk assessments, skill development clinics, and mass media campaigns, it is hoped that individuals will become aware of

the health effects of their lifestyle, change their attitudes about high risk behaviours, and begin to practice healthy lifestyles (Holtzman, 1979). Numerous examples of these lifestyle-oriented strategies in Canada are summarized in Appendix II.

The past two decades have seen a similar rise in the emphasis placed on lay involvement in health matters in other areas as well. From an internatinal perspective, the UNICEFF-WHO Joint Committee (1977:3) acknowledged the significance of community involvement in the general development process - "a process of which better health can and should be both an ingredient and derivative." In a document about the ways to promote health in the human environment, the World Health Organization (Meyer and Sainsbury, 1975) clearly indicated the need for citizen participation as a major component to the whole system of health care. In 1978, Symposium World Health presented a similar view:

> In order to make primary health care universally accessible in the community as quickly as possible, maximum community and individual self-reliance for health development are essential. To attain such self-reliance requires full participation in the planning, organization, and management of primary health care (Symposium World Health, 1978:34).

Community participation in health has received attention in the United States as well. MacDonald (1978) outlines the rise and fall of the Neighbourhood Health Centre (NHC) movement which began around 1910 in response to the rapid growth of urban slums due to massive

immigration of people to large American cities. Based on the concept of community involvement, NHC's peaked in 1930 and declined in the late 1930's as they were superceded by newer forms of health and social service delivery systems. However, thirty years later, NHC's reappeared once again with the United States' "war on poverty" which started in 1964. Initially sponsored by the Office of Economic Opportunity and then the Model Cities programs, the requirement of "maximum feasible participation" was basic to the NHC. MacDonald states the American NHC's were essentially a part of a larger set of programs geared to local neighbourhood improvement which were usually established in slums, ghettos, and other poor areas. Although such programs were initiated to reduce poverty and its related negative effects on life, they did not last and "withered away some ten years later" (MacDonald, 1978:147). A similar outcome occurred with the 1966 Partnership for Health Act which called for increased consumer involvement in health care decision-making. Reddick, Cordes, and Crawford (1978) state the anticipated effect of the significant increase in grassroots input never really materialized under the 1966 Act.

According to Ardell, another attempt to correct recognized deficiencies of a medically oriented and health industry controlled health care system was made in the United States with the creation of the 1974 National Health Planning and Resources Development Act. This law established a National Council on Health Planning and Development

of which not less than a third of the fifteen voting memebers were to be consumers of health care rather than providers. As well, a country-wide network of regional Health Systems Agencies (HSA's) were developed where consumer majorities, representing a broad cross-section of the local health service area were required on each HSA governing board. In policy, consumers were to be given the opportunity to help determine the direction of local health care planning. In reality, Ardell reports that the hoped for focus on population-based health priorities, disease prevention, and health care education strategies has not materialized:

> As was true of the agencies which they supplanted, the HSA's remain dominated by medical service and insurance interests, and the agendas are still almost entirely focused on utilization of hospital and long-term care and treatment facilities, review of medical equipment and program proposals, (and) illness data collection and dissemination (Ardell, 1977:209).

This sentiment is shared by others. Where consumer involvement in planning and operation of health services exists in bureaucratic theory, its actual impact in reality is questionable. Possible reasons for this outcome are discussed in Chapter Three.

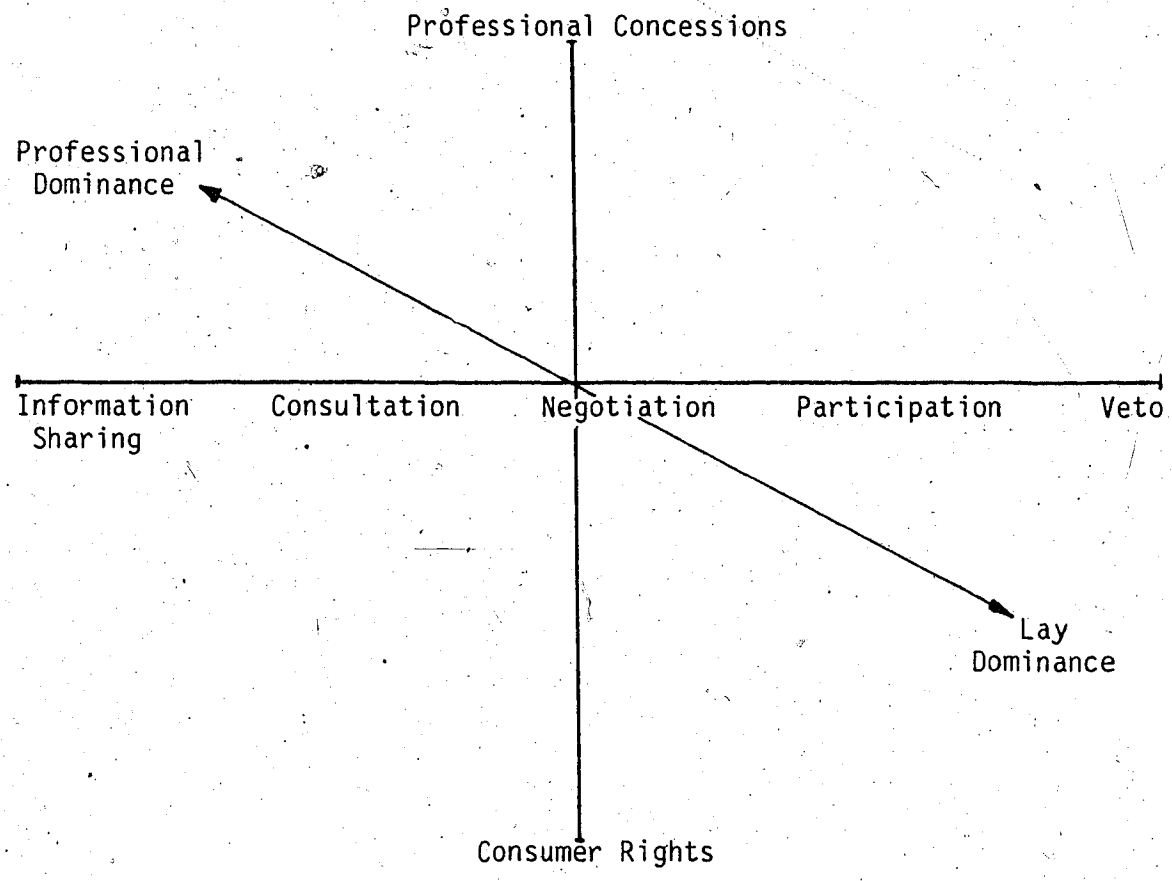
Dimensions of Lay Involvement in Health Matters

As well as to describe the rise of lay participation in health matters, the previous section also serves to illustrate the vast dimensions of such activities. Crichton (1973) summarizes the variations in these dimensions by identifying the various meanings that the words "lay" and "involvement" can take. For instance, the word "lay" may refer to an individual or group of people who lack the specialized training and education of another person or group, in this case, health care providers. Thus lay may be used to describe a community, consumers, users, citizens, public, residents, patient, and client. More recently, lay activity has also been labelled as self-help in general and as self-care in reference to more specific health actions (Levin, 1976a).

Involvement is also used as an all inclusive term for a great variety of activities. Klein (1972) describes how it can be regarded as a continuum where professional dominance at one end gradually gives way to lay dominance at the other as each takes on different roles (see Figure I Variations of Involvement). Thus, lay involvement is seen to take the forms of: information sharing; consultation; negotiation; participation; and veto. Information sharing is the weakest form of lay involvement where the individual or group is merely given some information by the professional sector. Consultation implies a more active form of lay involvement as the individual or group is at least asked for an opinion but not necessarily viewed as a significant force in the decision that is made. The negotiation form of lay involvement

FIGURE I

VARIATIONS IN INVOLVEMENT
(adapted from Crichton, 1973:3-8)



suggests there is a greater degree of equality between the lay and professional sectors where bargaining occurs about decisions that have already been made. Participation, on the other hand, means that there is lay involvement in the actual decision-making process itself. The distribution of power among the lay and professional sector at this stage may result in a weak or strong lay influence on the decision that is made. When the lay sector is able to veto a decision, lay involvement is in its strongest form.

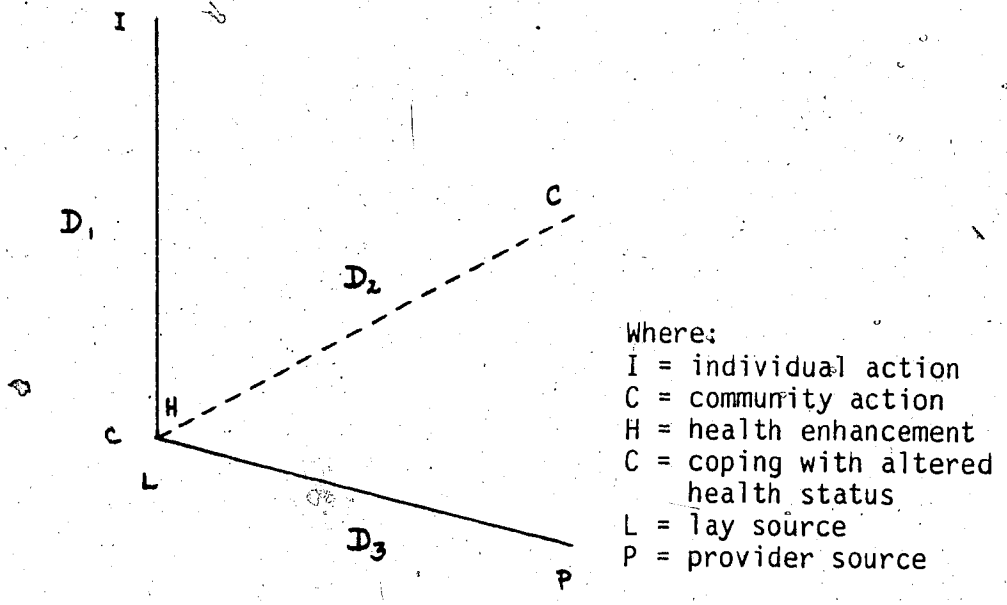
Traditionally, lay involvement in health matters has tended to lean towards professional dominance. Those who failed or refused to follow the health professional's directions were not necessarily perceived as having the "expertise" to veto decisions but rather were labelled as non-compliant or "difficult" patients. There are many obstacles which serve to actively obstruct the occurrence of the negotiation, participation, and veto forms of lay involvement in personal and social health care decision-making. Those obstacles will be discussed in Chapter Three.

In order to approach the topic of lay involvement in health in a logical manner, it is useful to consider its dimensions within an organizational model. Those models devised by Crawshaw and Wong (1980) and Barry, Pezzullo, Beery, DeFriese, and Allen (1979) have been used as the basis of a three-dimensional model from which the potential forms of lay involvement in health matters are perceived in this thesis.

Lay involvement in health matters has come to include an array of activities that to many may appear rather bewildering (Brown, 1976). As already mentioned, the term "self-care" has recently emerged as a means of describing health care measures that lay people take for themselves. As such it has been included as one aspect of lay involvement in health matters. Contrary to popular belief the concept of self-care has taken a much broader meaning than what the words "self" and "care" imply (see Figure II Three-Dimensional Nature of the Self-Care Concept). The variations in the definitions and descriptions of self-care in the literature range from what an individual does for him or herself to enhance his or her health status to what groups of people do collectively to eliminate health hazards in their communities.

FIGURE II

THREE-DIMENSIONAL NATURE OF THE SELF-CARE CONCEPT



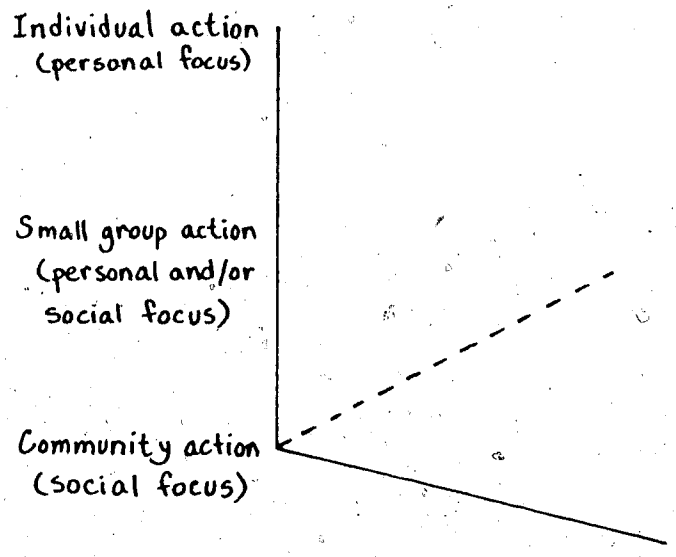
(For a summary of these variations, see Appendix III.) Whatever the focus or form of activity, the meanings implied by "lay involvement in health matters" and the "concept of self-care" virtually fall within the same organizational framework. For this reason, the terms will be used interchangeably.

Level of Action Dimension

The first dimension (D_1) of the self-care concept represents the level of action or activity (see Figure III Level of Action Dimension). At one end of the continuum is the individual who might be interested in learning personal skills which will enhance his or her health status. Families and small groups who meet regularly to help each other manage a common health condition would fall in the middle. Crawshaw and Wong identify this as an interpersonal level of self-care activity most commonly manifested through self-help and mutual aid groups. At the other end are large groups of people (i.e., communities, organizations) whose activities are directed towards organizational and societal health concerns.

FIGURE III

LEVEL OF ACTION DIMENSION



The small group organizations between the two extremes of this dimension may have either an individual or social focus or some of both. Such thinking relates back to Gussow and Tracy's Type I and Type II self-care groups described earlier. Whereas Type I self-care groups are concerned about their immediate personal needs, Type II self-care groups work towards goals which have broader social implications. In the self-help support groups of their analysis, Katz and Bender (1976:6) describe combined personal-social outcomes of small groups:

> Participants in self-help groups achieve not only subjective gains and private satisfactions, they are also helping to develop alternative structures and strategies ... they are contributing to a revolution ... that enhances individual social competence and relationships while simultaneously affecting society's attitudes and institutions.

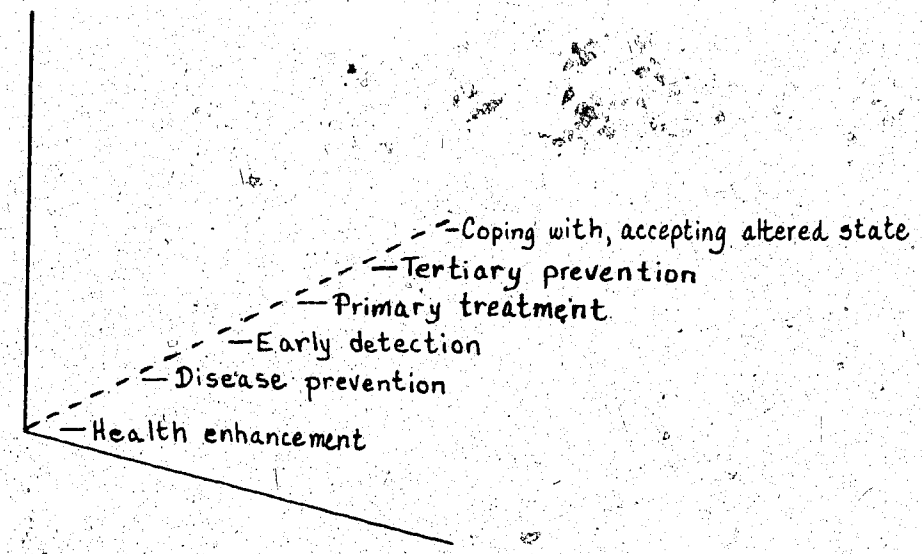
Levin (1976a) states that the self-care concept recognizes both the role of the individual and the society at large play in determining personal health status. Therefore, self-care must be approached from a concern for improving personal health behaviour skills and the development of socio-political skills. Only by recognizing the necessity of social action within a community domain can health problems with social origins hoped to be solved.

Health Behaviours Dimension

The second dimension of the self-care concept (D_2), represents the type of health seeking behaviours that individuals, small groups, and communities become involved in (see Figure IV Health Behaviours Dimension). The focus of these health seeking behaviours ranges from enhancing an already healthy personal or social state in general (i.e., health enhancement) to taking actions which will hopefully reduce further deterioration once a problem has occurred (i.e., tertiary prevention). In the case of some progressive, chronic, disabling personal conditions or social situations, preventing further deterioration might be impossible. In these cases, the continuum could extend to activities which focus on learning how to cope with and accept an altered health state.

FIGURE IV

HEALTH BEHAVIOURS DIMENSION



Between these ends of the continuum lie a number of possible activities which could be applied to either the personal or social levels of action. Their order along the continuum in Figure IV is not necessarily set or standardized. For the purposes of this thesis, the intention is to illustrate the scope of health behaviours compatible with the self-care concept. They are presented in what seems to be a logical pattern. Thus, where health promotion implies activities which enhance health in general, the idea of disease prevention is generally accepted to mean taking specific actions which are known to likely

prevent the occurrence of a particular disease or problem state. Given the fact that health problems do occur, the next point on this continuum includes activities which focus on early detection of the problem. Once a problem has been diagnosed, the next step involves treatment or restorative measures which will re-establish the previous personal or social health state.

Those health restoration measures performed by individuals are, to many, what the term self-care basically implies (see Appendix III). However, as already suggested by the three dimensional nature of the self-care concept, it has been interpreted to mean much more than what individuals do for themselves when experiencing a health problem.

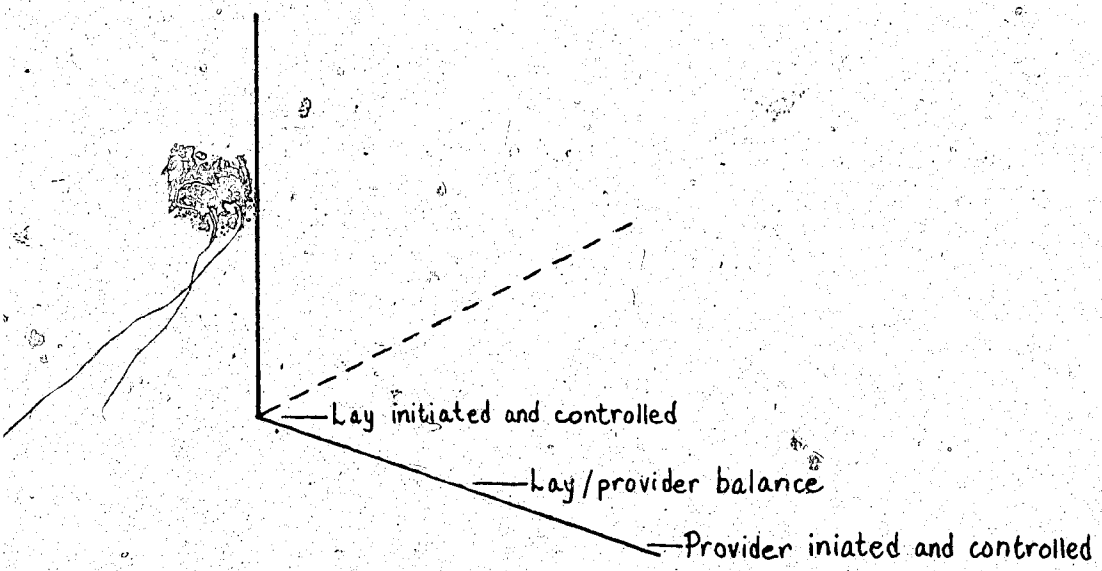
Origination and Control of Actions Dimension

The third dimension of the self-care concept (D_3), as described in the literature refers to who initiates the activities (see Figure V Origination and Control of Actions Dimension). This continuum ranges from one end, where self-care activities are totally lay initiated to the other end where health care providers (i.e., professionals or health care system bureaucrats) prescribe and determine what activities lay people should be doing for themselves. In between these two extremes are many combinations of cooperation between professional/bureaucratic and lay people. At mid-point one would expect an equal relationship between the two extremes. This dimension

is consistent with the earlier discussion about the variety of forms that lay involvement can take.

FIGURE V

ORIGINATION AND CONTROL OF ACTIONS DIMENSION



Values Implied by the Concept of Self-Care

The various descriptions and definitions ascribed to self-care (see Appendix III) are indicative of the different values implied by the self-care approach to health as compared to a more traditional medical model perspective. Those values commonly attributed to the self-care concept are related to certain beliefs about the capabilities and

rights of people to have more control over their life events. Included are the beliefs that human beings: deserve to be treated with dignity and respect; are capable of assuming responsibility for the decisions and subsequent actions taken to enhance health, and to detect, prevent, and treat disease at the primary health level; have the right to proper nuturance, support, information, and opportunities to learn skills in order to make competent, informed choices; and, subjectively determine their own meaning of health and as such, have the right to assume as much autonomy as possible in actively negotiating for what they believe is appropriate care for their own needs. (It is acknowledged that the degree of active negotiation will vary with developmental stages and seriousness of illness. In those cases, the balance of autonomy not assumed by the individual would become the responsibility of family or other such designated persons.) The concept of self-care is based on the concern for the whole person and decisions that are subsequently made are determined by how they will affect that person's entire life, rather than one particular segment. The professional health care provider is considered to be a therapeutic partner in the decision-making process but ultimately leaves the individual to make the final decision. The emphasis is on human values rather than those of the system.

In essence, the self-care concept is an attempt to overcome the inadequacies of the medical model oriented approach to health. Not only is it concerned with the recovery of personal autonomy in the

areas of illness care and dependency need decision-making, it relates personal health status to forces in the environment which are detrimental to health. Hence, it is also concerned with the development of social and political skills in order to bring about social change. Any substantial lay influence in advancing health is ultimately seen to involve both personal and social level involvement. Thus, the concept of self-care incorporates strategies in which people gain greater control over health-influencing life experiences in general, and illness care and dependency needs in particular.

Self-Care Concept: A "New" Way to Approach Health?

Referring to the critiques about the limitations and problems associated with modern medicine (Chapter One), Ehrenreich states that the political-economic critique places too much emphasis on the idea that "more is better." If "more" means medical practice which produces dependency, reduces individual autonomy, and depoliticizes the impact that social issues such as class, race, and gender have on health, he questions whether an increase in "bourgeois domination" would help solve the basic causes of health problems. Yet, the cultural critique alone does not offer adequate solutions either. With its concern about modern medicine creating more problems than it solves, it would have people believe that only occasional and minimal medical care is essential for optimal health. Ehrenreich believes its obvious lack of

concern for the scarcity situation and its overstated case against the usefulness of medicine has lead many to dismiss the cultural critique as naive and irrelevant.

Ehrenreich contends that a healthy society cannot evolve without the services of a health care delivery system. However, the changing nature of what constitutes health will not respond to those services if they are based on the medical model ideology. In other words, while medicine has gained technical mastery over people's bodily processes, it has lost its ties to people's daily mode of life, and to individual and social feelings about natural human events as birth, death, suffering, pain, and dependency (Ehrenreich, 1978). As such, it risks losing touch with the multi-dimensional and subjective nature of health. Individuals and the society within which they live will not become any healthier with increases or decreases in the present health care system alone. Rather, in order to move towards a healing society:

> we need to create a dialectical understanding of the crisis in medical care which draws from and integrates both the political-economic and cultural concerns (Ehrenreich, 1978:19).

In coming to an understanding that the two approaches to medical care are not contradictory, Ehrenreich suggests it is hard to imagine any healthy society which would not have ample health care services. He finds it equally hard to imagine any significant improvements in

health occurring without a different approach to health altogether. Such an approach would reconcile the human need to be both dependent and autonomous, two states which appear to be in opposition yet are both essential to health. Either one can be taken advantage of and carried too far so that the health of individuals and eventually the society they live in suffers. Thus, to reject all forms of medical technology would be a self-destructive form of autonomy while being too dependent on that same technology ignores the role that certain dimensions play in building a healthy state.

Essentially, Ehrenreich is calling for a new paradigm, a new ideology with which to understand how health can be better advanced. Ideally, he believes health would be viewed as both an autonomous and dependent state where people in general would reclaim the responsibility for both personal and social health and the health care system would be altered to incorporate, but not exploit, those times when people are in a natural state of dependency.

> What we have to develop is a medical system which acknowledges our need for autonomous control over our bodies and which accepts our need for dependency. Such a system should enhance autonomy but, when we feel the necessity to be dependent, should deal with that need in a dignified and nuturing way (Ehrenreich, 1978:20).

With these alterations as only one aspect of the new approach to health, another major characteristic would be the efforts directed towards eliminating or at least reducing the social causes of health problems. The new health paradigm would:

> be compelled to deal with the social and environmental causes of bad health, eliminating poverty and its ill-effects on housing, nutrition, and schools; eliminating or sharply reducing air and water pollution; as well an combatting unhealthy lifestyles (Ehrenreich, 1978:20).

To Ehrenreich, a healing society is ultimately a caring society. As such, the self-care concept, based on humanistic values and the belief that people have the right and the capability to determine their own health outcomes, might be a stepping-stone toward such a health ideology. In a sense, the emphasis on lay involvement in health matters and the concept of self-care over the past decade may indeed be a sign that a response, similar to a horizontal pattern reaction, is occurring within certain sectors of society as an attempt to counter-balance the negative effects of a vertical pattern oriented society in general and a health care system in particular.

Although in many respects lay involvement in health matters may be a way in which individuals, groups, and communities are attempting to re-establish some of the benefits of horizontal pattern functioning, it is still a very unorganized response to a society and health care

system oriented to an overly dominant vertical pattern. All the activities included under the rubric of self-care do paint a rather disorderly picture. To some extent, the three dimensional model presented earlier helps to relate what appears to be a widely disparate group of activities (Barry, et al., 1979). By analyzing each activity according to its three dimensional nature, one can begin to appreciate how the activity relates to the horizontal/vertical pattern interaction that the self-care concept is related to in this thesis.

A common assumption in most of the current literature addressing the manner in which to improve health levels of individuals and society is based on the belief that individual and community involvement are essential for any changes to occur. This emphasis, and in some cases, the plea for lay involvement in the decision-making over health matters which have both personal and social implications risks being rhetorical without an underlying critical awareness of the obstacles that confront an effective self-care effort. When the potentials of a self-care approach to health are considered, the chances of its success are dependent upon a number of factors. An important one to consider arises from the "origination and control of actions" dimension. As indicated earlier, this dimension represents a continuum of variations in lay and provider forms of initiation and control of self-care activities. Because each comes from varying perspectives and have different needs, it hardly needs to be said that each will have different reasons for their interest in the self-care concept. Where

lay people might pursue self-care activities to offset excessive professionalization and bureaucratization in the health care system or as a way to overcome the inability of medical model oriented treatment methods to help them with progressive, chronic ailments, politician/bureaucrats might promote self-care activity as an alternative to the financing of an expensive health care system. Professional interest in self-care activities on the other hand might arise from a concern to remain in control of what people do or do not do to themselves.

In some instances, self-care activities or lay involvement in health matters is an attempt to counter-balance the negative impact of a too powerful, vertical pattern orientation. However, in other instances, lay involvement in health matters is perceived by some, to be promoted by units in the vertical pattern with the interests of that pattern still at heart. In these cases, self-care activity is thought to only be tolerated to the point where such activities draw away from the system's inadequacies without altering the internal functioning of the system. As it is, the concept of self-care is largely addressed, discussed, and analyzed by health professionals and bureaucrats whose education and experience is soundly grounded in the medical model ideology and the efficient functioning of bureaucracies. As a result, the literature which serves as the basis for the discussion about the potential that the self-care concept has in making any substantial health gains is frequently analyzed according to how well it fits into

a medical model approach to health. As such, the obstacles to the self-care concept ever becoming a new approach seem great. In order to continue the discussion about the health potentials that lie within a self-care approach to health with some sense of reality, it is essential to review what the obstacles, as identified in the literature, are.

CHAPTER III

Potentials of a Self-Care Concept

Crawford (1980:365) states, "the social effort to gain control over that part of the human experience captured by the concept of health remains elusive." Likewise, whether or not the self-care concept will ever become a major force towards the overall improvement of health, is difficult to assess. Self-care enthusiasts believe it is the only way in which the lay public can take control of an otherwise oppressive situation. However, a number of critiques on the concept of lay involvement in health matters call for a certain amount of caution before expecting such hopes to materialize:

> In our enthusiasm for changes oriented toward creating new individual and social capacities freed from domination, we fail to identify aspects which may contradict those objectives, we risk repetitive disablement (Crawford, 1980:367).

While the goals of improved health via increased levels of self-sufficiency and lay involvement in health matters are admirable, it is essential to assess the known and potential barriers to personal and social level self-care issues. A number of these have been identified in the literature. An awareness of these barriers will serve to temper an otherwise naive and idealistic view of the potentials of a self-care concept, both in its ability to advance health and to prevail as a viable concept.

Barriers to Individual Level Self-Care

Professional dominance

> If self-care is to succeed as a real phenomenon, one assumption is essential: that people's integrity in making health decisions and their ability to perform successfully on their own behalf take precedent over any and all existing professional values of risk reduction and disease cure (Meyer, 1977:82).

The above assumption is an extreme one for many and causes some concern for those who do not subscribe to the concept of individual level self-care. The powerful forces that are the causes of the traditional lay-professional relationship are deeply ingrained from both a cultural tradition as well as the personal sense of vulnerability one experiences when ill. Gartner (1982) suggests the professional's role in health related self-help efforts is more significant than in other more generalized self-help activities because of the essential nature of medical information. Levin (1977a) on the other hand, fears the threat of professional cooptation and the temptation to create and regulate the self-care activities of the lay person. He questions how health professionals can contribute their expertise and transfer skills in a manner which conforms to their own professional ethics and at the same time be sensitive to the lay prerogative for self-determination.

The either-or situation of professional dominence versus lay person control is tempered by Riessman's observation:

> Both the professional and the aprofessional have valuable attributes, and in an integrated human service practice, each is needed. The self-help orientation provides the needed aprofessional dimension as a dialectic balance to much of human service practice which has become overly professionalized (1976:64).

Where the aprofessional dimension stresses the concrete, subjective, experimental, and intuitive empathy, the professional places more stress on distance, perspective, and systematic knowledge. To Riessman, neither perspective is enough on its own.

As reasonable as this seems, questions do arise as to whether lay people, let alone professionals will want or be able to change their traditional orientations of practitioner as active healer and client as passive recipient (Levin, Katz, and Holst, 1976). Of considerable significance here, is the complex impact that the institutionalization of health care (i.e., greater specialization of medical services, complex equipment, greater delineation of hospital employee roles, government intervention in payment of health services, and so on) has had on patient and professional roles.

Attempts to change the social perception of the roles played by health professionals (especially physicians) and lay people would necessitate an alteration of the existing social order. Jencks (1976)

focuses on power and status relationships and believes participatory care (i.e., a general acceptance of the client/patient having at least equal, if not greater decision-making power than the professional) will only occur if it is accompanied by a revolution in the social structure of medicine. Ehrenreich (1978) too, believes that in order to alter the traditional lay-professional relationship so that it is experienced by more than a minority, the practice of medicine will have to be radically deprofessionalized. The obstacles to this occurring appear to be great but Jencks feels that those who gloomily predict that medicine will never change, are ignoring some of the major forces behind the revival of interest in lay involvement in health matters. Of these, the demystification of medicine may be a significant factor, but to many, the term "radical" may constitute an unacceptable course of action.

Freire (1970) suggests that the fear of unknown consequences and the freedom of a developing critical consciousness actually inhibit and demotivate many. A keen desire to keep things the way they are for the sake of familiarity will be a difficult barrier to overcome. To some, this resistance to change is considered to be an inherent attribute of social systems. In the form of cultural patterns and traditions, resisting changes is a way to prevent complete disintegration of the system.

Brown and Margo (1978) suggest that some of the professional focus on self-care practices is motivated by a true desire to free people

from the dependency on doctors but fear that in some cases, professional interest in guiding the development of self-care practices is a way to retain general control and dominance in health care decision-making. However, Levin (1977b) suggests that services rendered by non-medical institutions such as schools, churches, service clubs, womens' groups, and so on, not traditionally defined as health resources may be a lucky blind spot in current health planning efforts to coopt self-care and alternative health resources into the health industry. Such cooptation, Levin fears, would destroy the potential break from professional dominance that the self-care philosophy offers. But, on the other hand, Levin, Katz, and Holst (1976:27) admit the formidable barrier imposed by the medical profession:

> Medicine is still profoundly self-controlling; there are few indications that it will capitulate before compelling arguments for democratization. Medical education remains essentially conservative and protective of professional values, roles, and social prerogatives despite various efforts to introduce consumer perspectives in medical education and practice.

The variables involved in the ideological shift from professional dominance to one where the lay person is in control are numerous and varied. As such, the complex nature of the lay-professional relationship cannot be passed off lightly by self-care enthusiasts.

Self-care as a means for professional avoidance

Jencks warns of another inherent danger that exists with professional interest in promoting participatory care and hence be viewed as a lay concern regarding the potential problems that redistribution of power might lead too. Where participation in health care decision-making might improve patient compliance to a co-determined treatment regime, it could also be used as a reason for health professionals to withdraw from unpleasant problems which are not easily treated. Under a self-care philosophy, the health professional could put minimal energy into the solution of a problem and rationalize the end result as the patient's decision or send frustrating cases away to do their own self-care. Ideally, as discussed earlier, it would lead to a partnership between the professional, who offers objective expertise and the individual, who offers subjective expertise. The traditional imbalance in decision-making power between the two could set a strong precedent for a similar imbalance if the self-care concept is abused and simply used as an excuse to dismiss or avoid giving "difficult" clients the benefit of professional counsel.

It is hardly necessary to say at this point that the reasons behind the health professional interest in self-care are complex and varied. As such, the general effect that such health professional involvement will have on the growth of the self-care concept cannot be simply predicted, but must at all times be seriously considered.

The question of safety

Concerns about safety are frequently cited as a barrier to individual level self-care activity directed towards health restoration. The fears that accompany such therapeutic self-care activities are usually those of the health professionals and vary to the extent it is imagined what those practices involve. The more technical skill and knowledge deemed necessary, the greater the concerns become. Levin, et al. (1976a) state no universally accepted classification of what constitutes safe therapeutic self-care practices exist. It is doubtful that one which is able to meet with the approval of the medical profession as well as allow for the subjective, unique nature of self-determination in the concept of self-care will ever exist.

In essence, those who state the question of safety is a barrier to the evolution of self-care are still operating from a "professional knows best" perspective. It is not that safety is not a concern for the individual who practices self-care. Rather, those who have truly made the ideological shift from professional care to self-care believe in the ability of the individual to make decisions which are in his or her own self-interests. Safety would be inherently part of these self-interests.

Actions which are done in response to chronic conditions, symptomatic relief, or treatment of minor non-disabling illness seem to

be less subject to question than self-intervention in disabling illness or life-threatening episodes. Jencks (1976:91) states that chronic diseases are much more suited to participatory care than are acute disorders for three reasons:

> First, patients who currently have a chronic disease are more motivated than consumers who only fear that they may acquire an unspecified illness sometime in the future. Second, creating an educational curriculum about the nature and treatment of a chronic disease is far easier than designing a broad course in basic health for a consumer who is not yet ill. Finally, chronic illness, more than acute, requires that the patient do things for him or herself such as adhering to diet, recognizing early signs of crisis, and changing life habits.

An implied assumption in the above description is that at the basis of chronic self-care is an initial guideline set up by the health professional. Self-care in this sense essentially becomes an issue of compliance to the medical regime.

Williamson and Danaher discuss the problem regarding what constitutes minor non-disabling illness. Opinions vary and no clear cut definitions exist which could serve as a guideline for lay diagnosis and treatment. The dangers associated with lack of competence and skills to accurately diagnose and treat take on added significance with acute minor symptoms. Most of these are self-limiting and rarely life-threatening (Fry, 1973). But what about those symptoms which indicate a serious problem that only a physician

may detect? To complicate the situation even more, Levin, Katz, and Holst suggest that the concept of what constitutes danger is a relative state and thus difficult to generalize about. For instance, competence to deal with various situations or conditions varies within the lay sector (and likely the professional as well) according to background knowledge, previous experiences, skills, and attitudes. Whereas lack of adequate knowledge and skills may be feared to be the typical characteristics of the lay sector and hence, the basis for potential error in self-care practices, Levin states there is no firm data to conclude that indigenous self-care practices are inappropriate or any less effective than professional care for the same ailments;

> ... recent research by Elliott-Binns in Britian and Paul Pedersen in Denmark found that 90 percent of the self-care procedures undertaken prior to professional contact were relevant and appropriate (Levin, 1977a:116).

Other studies as reported by Marieskind (1976) suggest that the lay person's ability to understand and transmit medical knowledge to others is underestimated by health care professionals.

Ethical and legal issues

Miles (1978:24) in a bid to support lay efforts in health restoration skills says:

> We have endeavoured for centuires to control incompetent practitioners and to maintain a level of "safety" for the public in health ... We should shift our emphasis away from "licensing and control" ... we must allow the constituent to make some mistakes since that is the only way we humans learn anything.

With health and medical affairs legally sanctioned as part of the health professional mandate, another barrier to the practice of therapeutic self-care is the legal implications of self-care "mal-practice." Self-care practices, according to Andrews and Levin (1979) are by and large unacknowledged in the legal literature. Professional health care, on the other hand is governed by laws which limit its practice to licensed individuals. The subsequent conditioning of such legal investiture leads to certain ethical issues as well. For instance, a health professional whose expertise is recognized by law may feel a moral obligation to do what is clinically correct for a patient. From a tradition of prescribed care, such objective norms would be imposed on the patient as the appropriate standard of care. Gadow (1980:2) explains the philosophy of self-care towards patient decision-making:

> ... a decision is valid because it is based upon self-determination and represents the individual's own definition of self and self-care, even if that definition conflicts with objectively established standards.

From a traditional-objective perspective, people who refused treatment were frequently labelled as uncooperative or difficult patients. Given the training and extensive conditioning most health professionals experience, their inability to implement what "they know is best" could become an ethical issue for them. But, as Gadow (1980:1) suggests, from a self-care philosophy, it is the patient not the professional who decides what his or her best interests are:

> Definition of a patient's self-interest made by anyone other than that patient is not only unethical in this view, but in fact is impossible.

The potential conflict between professional and self-care ethics as defined by Gadow is obvious. Where the compromise (if there is one) lies is a topic of considerable debate not within the scope of this thesis. At this point, the intent is to acknowledge the considerable legal and ethical issues which act as potential barriers to the widespread acceptance of therapeutic self-care activities.

Emphasis on personal behaviour change

Warren (1971) describes the problems of developed countries as being either structural or personal in nature. Solving a structural problem requires alteration of the society in general, whereas, problems of a personal nature involve the alteration of individual behaviour. Although the concept of self-care recognizes that illness and hazards to health are of either or both structural and personal etiology, those who are critical of the self-care concept believe more emphasis is placed on the need for personal behaviour change rather than social structural change. Crawford (1980:336), presents a typical view:

> ... the current preoccupation with personal health ... is particularly true of two new popular health movements which have attained considerable attention and popular participation: holistic health and self-care ... They seek to reduce the reliance of individuals on medical practitioners and substitute individual and group activities aimed at improving health, coping with chronic disease, acquiring diagnostic and therapeutic skills, and adopting disease prevention practices.

Brown and Margo, critical of the same individial focus in health education strategies, suggest it is the result of the pervasive effect that the medical model ideology has had on western thinking:

> The medical model became the paradigm and perspective through which all social and health workers were trained to see disease and social problems. The

> clinical medical model centred on professional intervention in individuals' lives to relieve or correct physical, emotional, or social "maladaptations." Even in public health, most practitioners simply saw community-wide problems as maladaptation of groups to society, correctable through professional intervention in the community (Brown and Margo, 1978:4-5).

They go on to suggest that, only when touched by growing political movements during the Progressive Era, the Great Depression, and the more recent American civil rights movements, has the public health movement even viewed advocates of major social change as more than a fringe to be tolerated.

Brown and Margo, with a good deal of support from others, fear that by focusing on behaviour itself, the social relations and structures that contribute to the illness-inducing behaviour patterns will not be dealt with. Thus, the alienation of people from their bodies, stressful working conditions, and inadequate nutrition due to insufficient income or inadequate food supply are ignored and the problem becomes that of the individual. Ryan (1972) and Crawford (1978) describe this as victim-blaming ideology where:

> Prescriptions for cure, as written by the Savage Discovery set, are invariably conceived to revamp and revise the victim, never to change the surrounding circumstances. They want to change his attitudes, alter his values, fill up his cultural deficits, energize his apathetic soul, cure his character defects, train him and polish him, and woo him from his savage ways (Ryan, 1972:35).

Ryan goes on to say that by analyzing social problems in terms of deficiencies in the individual, making structural changes in a social system which causes illness are painlessly avoided. Crawford (1978) believes the "long, healthy life as a do-it-yourself" proposition functions to resolve social tensions in favour of the dominant economic and political interests. He suggests in a political climate of fiscal, energy, and cost crises, self-sacrifice and self-discipline emerge as dominant themes. Tozer (1981) refers to this tendency as well. While self-help activities are a means to alternative, more effective solutions via personal and collective resources without dependence on formal agencies, the principles of personal responsibility and mutual aide are conveniently emphasized during periods of fiscal strain and cutbacks. In other words, the call to self-help becomes an inexpensive way for the government to do its work as it reduces unproductive expenditures and welfare burdens. The essence of self-help under these circumstances is captured by Woolley (cited by Tozer, 1981:75):

> It doesn't mean helping yourself to what an exploitive society owes you. It means the opposite, making do with what little society spares you ... Self-help tries to direct people away from protesting against injustice to make do with what little they have.

According to Labonte and Penfold (1980), the health promotion philosophy of the Canadian government has only served to deflect

attention away from the urgent political and economic contradictions and power struggles in society. The emphasis placed on what risks the individual should avoid in order to reduce the likelihood of illness, disabling conditions, or death, is criticized for its hypocricy:

> ... as one branch of government would have us moderate use of one drug and cease altogether with the other, several other branches are busy collecting the tax revenue (a token percent of which finances the health promotion directives to stop consuming)... (Labonte and Penfold, 1981:9).
>
> ... promoting the individual to quit "self-pollution without questioning the very existence of a tobacco industry and its tax revenue and without seriously addressing the whole morass of environmental pollution is hypocritical" (Labonte and Penfold, 1981:12).

By focusing on the individual, victim-blaming ideology implores people to be more responsible when they are actually becoming less capable as individuals of controlling the health effects of their environment. And thus, faced with an "everything causes cancer helplessness" (Crawford, 1980:377), the emphasis on indiyidual responsibility in making "wise" health decisions could potentially result in an overall sense of powerlessness. Such a feeling of powerlessness might lead the individual to opt for a personal protection plan and an attitude of "I can't change the world, but at least I can change myself" or perhaps a complete opting out with an "It doesn't matter what I do because everything is bad for me anyway" attitude.

In summary, the obstacles to the occurrence and the success of personal self-care activities in having any substantial impact on health result from the traditional professional dominance (which in turn is related to the issues of safety, legal/ethical matters, and avoidance of "difficult" patients) in health care activity and the fear that the self-care concept focuses too much on the personal rather than on the social causes of health problems. Health care professionals are part of a vertical pattern oriented system which essentially grew to monopolize the way health needs were met in society. As health needs turned into problems the health care system was not necessarily designed to solve, inadequacies in the system became apparent.

The obstacles which confront people who want to take more responsibility for the way their health, illness, and dependency needs are met, frequently come from those who are well-conditioned to a vertical pattern way of life and who also have vested interests in the system remaining unaltered. This is likewise related to the fear that too much of the self-care focus falls on what the individual should and should not do. By placing excess responsibility on the individual to seek his or her own solutions to health problems, the system within which they are generated (whether it be an impersonalized health care system or a stress-inducing social system) receives little pressure to change.

Milio (1977a) is adamant when she asserts that the development of personal level self-care practices will only be effective as a

community-based concept. In other words, isolated individual attempts to overcome the health problems of an illness-generating society or inadequate health care system will not likely succeed. Just as a strong community support system is seen to be essential to personal level self-care, it will also be identified as an essential prerequisite for the success of social level self-care. Before this issue can be realistically explored, it is important to have some awareness of the barriers that may be associated with social level self-care.

Barriers to Self-Care Potential at Social Level

Uncertain relationship between personal and social change

One underlying assumption of self-care philosophy is that increased individual responsibility in health promotion and disease prevention matters will eventually lead to an increased sense of social responsibility in those same areas. Thus, the proponents of the self-care concept argue that social reform is the eventual outcome of initial personal responsibility: "Heightened individual consciousness is a precondition for, not an antagonist of social action" (Katz and Levin, 1980:333). They argue that people who are alert to personal hazards are those who are more likely to be concerned with the underlying social, political, or economic etiology. The debate about whether to emphasize the role of the individual or that of society in

order to achieve social goals, such as overall improved health status, is extensive. Crawford, in his fear that sole emphasis on the individual is a form of victim-blaming, states:

> ... if individual responsibility is understood as actions taken on the individual level to enhance or alleviate a particular condition, there is no evidence that a more political conception or behaviour will follow (Crawford, 1980:377).

In a selected review of various ideas and theories about consciousness and human development with regard to eventual social change, Malloy (1976) develops a "Consciousness Model" for social changes where critically conscious individuals are the instigators of social restructuring. She builds on Maslow's study of self-actualizing people who are in a position to challenge and overcome the societal limitations that hinder his or her further growth and Hampden-Turner's extension of Maslow's proposition which suggests that for every level of self-actualizing person's personal development, there is a corresponding relationship to society where individuals ultimately recognize their duty in terms of its social dimensions. Malloy concludes that social change will eventually occur with the development of a critical consciousness which in turn leads to personal growth beyond mere adjustment to the existing social system. Marieskind (1976:66) presents a similar perspective in her discussion on the women's health movement activities:

> the women's health movement ... is indeed a political movement struggling to change power relationships. The self-help clinic and the women's health movement are not just personal solutions for an individual woman's health problem - though that is obviously a valid reason for their existence; they are tools for inducing collective thought and action from which radical social change can grow.

Crucial to the development of a critical consciousness is the awareness that there is a world of nature which humans did not make and a world of culture which they did. Freire (1970) suggests there are two major forces for social change, both of which are based on awareness. The first is the awareness that the present social reality is created by humans and therefore can be transformed by humans. The second is the awareness of the contradictions which exist in the present social, political, and economic order. According to Freire, through the development of critical consciousness, people can respond to and overcome these contradictions in their world.

The Freire method can be briefly described as action based on critical reflection which stresses total participation of the people themselves in a process where they dialogue as equals. As Shaull (1970:12) states in the Forward of Pedagogy of the Oppressed, Freire's basic assumption is:

> that man's ontological vocation ... is to be a subject who acts upon and transforms his world, and in so doing moves towards ever new possibilities of fuller and richer life individually and collectively.

Conscientization (Freire's term for education for critical consciousness) of a group of people is based upon a dialogical method which involves:

> (a) reflecting upon aspects of their reality (e.g., problems of poor health, housing, etc.), (b) looking behind these immediate problems to their root causes, (c) examining the implications and consequences of these issues, and finally (d) developing a plan of action to deal with the problems collectively identified (Minkler and Cox, 1980:312).

A role that a leader takes in facilitating conscientization is a key factor to whether or not true reflection and subsequent action results from the dialogue. Freire dismisses the traditional paternalistic aspects of the leader's role as a mechanism which perpetuates an oppressive regime. Rather, as paraphrased by Minkler and Cox (1980:313), a leader, concerned with education for critical consciousness, assumes the role which is:

> one of asking questions of the group which will help its members see the world not as a static reality, but as a limiting situation which challenges them to transform it.

Thus, critical perception cannot be imposed on the group by the leader or facilitator. According to Freire, the development of critical consciousness will not occur because of the ideas of one person

deposited into the mind of another. It will only occur under the auspices of problem-posing or liberating education where the dichotomy between the teacher (i.e., leader) and student (i.e., group) is eliminated and learning occurs as "acts of cognition," not transferrals.

> The teacher is no longer merely the-one-who-teaches, but one who is himself taught in dialogue with the students, who in turn while being taught also teach (Freire, 1970:67).

This perception of the teaching-learning process is essential in order for the leader (or "teacher-learner") to facilitate the development of critical consciousness. Minkler and Cox (1980:313) summarize the series of steps that such a leader would follow as:

1. Tuning into the "vocabular universe" of the people through a process of participant observation and, where possible, living with the people over an extended time period.
2. Working with small groups initially in searching for "generative themes" - key words suggestive of the hopes and concerns of the people.
3. Synthesizing the ideas of the people and codifying them in visual images, e.g., pictures and symbols.
4. Giving these symbols and images back to the people for decoding through "cultural circles" - groups of people who, with a coordinator-questioner, look at the causes, consequences, and possible solutions of the problems and generative themes they have identified.

Minkler and Cox cite several instances in developing countries where this series of steps was used to reduce oppressive situations through the development of critical consciousness and subsequent broad social change.

Bay (1980) refers to C. Wright Mills emphasis on helping people translate their personal troubles into social issues as the first challenge which faces the "sociological imagination." Whereas Bay argues a vested regime has an interest in having people define their anxieties in terms of personal inadequacies and misfortunes rather than blaming them on the system, Mills and Freire's concepts of relating private troubles to flaws in the social order are attempts to allow people to recognize their common oppression and the need for collective action. Anderson (cited by Malloy, 1976:73) believes that becoming aware of being dominated is a step towards ending that domination:

> Any process that develops the awareness of individuals - puts them in greater touch with their own feelings and experiences, gives them a clearer sense of what they do and how they are done to - is a force for both personal and political change.

In that sense, both Withorn (1980) and Tozer suggest that self-help activity has the potential to become a base from which people can criticize and affect the nature of a social service system.

However, before self-help activity can lead to broader criticism of problem-causing social structural issues and subsequent social change,

Withorn states that certain tendencies of self-help efforts must be recognised and dealt with. She believes the self-help model emphasizes personal dimensions of peoples' problems and in turn, offers a social support system with an emphasis on "reciprocity." The pressure to be part of the group may make it harder for people to move on to other activities which address the problem beyond the personal level. Withorn warns that the major thrust of this approach to problems is to help people adapt to them rather than alter their underlying social causes.

Marilyn Ferguson (1980) refers to the tendency to think of social change in either individual or social terms. According to her, the debate about which is the best way to achieve social change has "raged on for centuries." After tracing the history of the debate back to Plato, she concludes that the two are inseparable and not amenable to linear either-or conceptualizations.

> Arguing which is more important is like debating whether oxygen or hydrogen is the more essential property of water (Ferguson, 1980:190).

From this perspective she asserts that any transformation of the individual (i.e., personal empowerment), whether it be related to health concerns or other facets of life, ultimately leads to social action. Although this might be the case in some instances, there are

those who remain skeptical about the transition from personal self-care to social self-care concerns.

Health planning at the social level: lay-provider conflicts

Community and citizen representation on various health service agency boards has already been identified as one form of lay involvement in health matters. The failure of the community health centre concept to survive, let alone appear on a large scale in Canada, is thought to be the result of a number of reasons. A major one appears to be the inherent conflicts between lay and provider interests. It might be noted that provider interests could be further subdivided as professional and bureaucratic interests.

Checkoway (1979) in an extensive review of the literature about community representation on health care facility boards states that the attempts to bring together a healthy mixture of health professionals and lay consumers have no way of assuring effective lay participation in decision-making. Citing several studies and references, he comes to the conclusion that in many cases, consumers have had little "real" participation in planning. Although there has been minimal effort to appraise the obstacles facing consumer board members in carrying out their responsibilities, a generally accepted obstacle revolves around power and the power relationship that exist between those groups that have a stake in the production of health services - governments,

professional associations, health facility bureaucracies, and the public at large. The debate and tension which surround the lay-professional-bureaucratic-political mix, all having various needs and perspectives, is usually due to inequal power bases. In theory, lay control is democratically desirable; in practice, it only serves to interfere with provider interests.

From his analysis of several case studies, Checkoway suggests that health professionals (i.e., physicians) are trained to believe that they should control health care decisions, not only on the individual level but the health service planning level as well. He states that they generally believe consumers cannot well understand complex health systems. As well, professional autonomy has traditionally been accepted by the lay public. Medical professionals are generally reluctant to relinquish their subsequent freedom to pursue their professional interests in both their clinical judgements and the setting under which they practice. Checkoway cites two studies which found only a fraction of the general public perceiving health care planning as an activity in which they should participate.

New (1973) describes the potential conflicts within community health centres where both concerned citizens and health professionals have different degrees of involvement and different perceptions of "ideal" amounts of involvement in the political and health delivery aspects of the centre. New's observations of the different perceptions of what involvement means to lay and professional persons are presented in Table II.

TABLE II

LAY VERSUS PROFESSIONAL PERCEPTIONS OF WHO SHOULD CONTROL COMMUNITY HEALTH CENTRE

	Citizen Perceptions	Professional Perceptions
Political Roles	Citizen control Professional involvement	Citizen participation Professional non-involvement
Clinical Roles	Citizen participation Professional as advocate	Citizen non-involvement Professional control
Organizational Roles	Citizen control Minimal professional control	Minimal citizen participation Professional participation

Thus, according to New, citizens and professionals have conflicting perceptions of each other's roles in all three areas of activity necessary to the functioning of community health centres. He hastens to reiterate that the citizen perceptions included in this comparison are those of "concerned citizens" who have a political interest in the concept. (In his experience, these were far fewer in number than most of the community residents who were essentially apathetic about the fate of the health centre.) However, by identifying the differences in perceptions between interested, involved citizens and the professionals of a health centre, New believes the conflicts and problems which occur in community health centres could be better understood.

As well as the lay-professional conflicts of interest, Checkoway states there are strong administrative obstacles to lay participation

having any real impact in health services planning and evaluation. Consumer participation is often seen as the antithesis to administrative values. Warner (1981:364) identifies the contrasting characteristics between the two (Table III):

TABLE III

THE CONTRASTING CHARACTERISTICS OF BUREAUCRACIES AND COMMUNITY PARTICIPATION GROUPS

Bureaucracies	Community Participation Groups
Central technical purity	Local vested interest representation
Bureaucratic authority	Community authority
Concentration of the means of administration	Community (Democratic [?]) decision-making
The use of technical expertise	The use of local knowledge
Social responsibility (universalistic)	Social responsibility (particularistic)
Slow change	Fast change

The difference between bureaucratic and lay orientations in the way decisions are made, as well as what sorts of decisions are made, are potential sources of tension and conflict in the functioning of community-based health centres. Furthermore, Warner claims that the expertise and autonomy of the bureaucratic sector of health agencies is viewed quite differently by the public than is the medical professional domain:

> The bureaucracy is viewed simply as representing organizational or state power and as being concerned with restrictions of activities and daily life rather than problem-solving (Warner, 1981:363).

The effects of political-bureaucratic endorsement

Government interest in lay health activity involvement has been generally assumed to be related to reducing health care expenditures by encouraging people to make more appropriate use of health care services and to practice personal preventive behaviours. But does such interest extend to the point of major social reform as demanded by self-care ideology in its social dimensions?

Checkoway states that health planning agencies frequently use participation as an instrument to achieve administrative ends by promoting strategies which appear to favour lay participation but in effect are minimally successful in obtaining the "desired" participation. According to Spiers and Tropeal (1981) one reason for this may be due to the fact that much of community-based control organizational structures for health care planning have been placed in operation by an "alien" system:

> There have been few attempts to derive pure community-based systems, i.e., where the impetus for development of the system itself has come from the lay community (Spiers and Tropeal, 1981:55).

Renaud (1981) reaches a similar conclusion. He suggests the failure of the massive social and health reforms in Quebec which were implemented as a result of the Castonguay-Nepveu Commission is, in part, related to the forced legislative change. Rather than undermining the undesirable characteristics of the health institutions and professions, the reform seems to have reinforced them. This has been evidenced by:

> the introduction into the system of technocrats or "bureaucratic rationalizers," the growing centralization of decision-making in the hands of bureaucrats and health professionals, the increased demand for curative care and increased public dependence on the expensive medical-hospital complex, the acceleration and proliferation of professional autonomy, and the greater dominance of the medical profession (Renaud, 1981:379).

Renaud postulates that if the community is ever to really take charge of its health institutions and professionals, it will not do so as the result of interventions by a bureaucratic elite because, as what seems to have been the case in Quebec, the existing order is just extended. According to Spiers and Tropeal, this is partly due to the organized system of delivered services being so indelibly impressed upon the average community member's consciousness, that any deviation from the norm is difficult to conceptualize.

The power base that political-bureaucratic organizations derive from this orientation towards norms and the status quo is further developed through legislated decentralization and delegation of

decision-making powers. Warner perceives the creation of the District Health Council system in Ontario as an effective way to ensure continued government involvement and ultimate power, given the conflicts that exist amongst lay, professional, and bureaucratic interests.

> If local decision-makers in the District Health Council system in Ontario fail to agree, it is ultimately the political body, the government of the day, who makes the decision ... because day-to-day decision-making has been pushed to a lower level and because disagreement is likely to be frequent, thus necessitating continual governmental arbitration (Warner, 1981:366).

In light of this tendency for governments to control those projects or structures it has initiated and subsequently funded, Withorn (1980:27) explains the imperative nature of the women's health movement's opposition to "federal attempts to professionalize and control such services (i.e., women's health clinics) as a condition of funding" if it is to have any impact on social and political reform.

Bay (1980:241) suggests the political-bureaucratic propensity towards preservation of the status quo and hence a continuation of social structural causes of health problems results from the vested interests the political regime has in the system. He identifies two major categories of political preoccupations as being a concern with "advance" and a concern with "defence." Where there is a difference

between what is and what ought to be, concerns with "advance" would ideally posit goals and push for their implementation. Concerns with "defence," on the other hand, stress the precariousness of the past and the achievements of the present, subsequently pushing for protecting the system as it is. To Bay, every non-revolutionary regime has a strong vested interest in having its citizens preoccupied with thoughts about "defence" rather than those about "advance." With this understanding, it would appear that the social change aspirations of self-care ideology or broad based citizen participation in health planning are unlikely to occur under the auspices of political-bureaucratic endorsement and support.

Lay characteristics which inhibit the development of social level self-care

The potential success of lay-initiated self-care activities in altering disease-causing social conditions is also an issue for debate. Williamson and Danaher state the most basic premise of self-care is that people will act responsibly. An ideal in itself, they go on to clarify that acting responsibly includes not only what is good for oneself, but also that which benefits the whole community. Lorenz, Devra, and Manderscheid (1978) suggest that social level self-care activities in health promotion and disease prevention will be possible only if the public and private sectors are both willing to

make major intermediate and long-range investments in the restructuring of economic and social incentives that will encourage change in both consumer and provider behaviours. Williamson and Danaher allude to the phenomenal task involved. For example:

> We have to ask ourselves whether or not a government (and a public) which is heavily dependent on the income from the sale of cigarettes can be expected to take a dispassionate stance on the issue of smoking and health ... if a major attitude shift in the general population is to be attempted, leadership must be clear and uncontaminated by mercenary considerations (Williamson and Danaher, 1978:135).

Labonte and Penfold (1980) state the inability to mobilize around the existence of such a clearly pathogenic industry as cigarette manufacturing is a good example of how hollow the call to exercise our "collective will" is. Whereas dismantling the industry would obviously create economic distress for the workers, government and, industrial owners, they lament that little attention has been given to such ideas as crop substitution.

Sidel and Sidel (1976) suggest there is characteristic tendency of most self-help groups to help individuals cope with problems as individuals rather than to collectively work towards the elimination of the causes. They fear that such endeavours only serve to further fragment communities where too much emphasis is placed on insulated special interest efforts. Without an overall framework of a shared set

of goals, self-help groups could actually undermine each other's efforts and energies. Rather than focusing on special interest groups for support, they feel people should be working towards strengthening existing connections in the community. And, in order to move beyond coping activities to those which actually lead to broader social change, Sidel and Sidel believe lay-initiated self-help must organize itself within the context of an appropriate set of broader social goals:

> Perhaps the time has come to place the self-help movement into a clearer relationship to a set of social purposes. If this were done, the movement could help us move toward the achievement of these goals, and working for the goals can strengthen the self-help movement itself (Sidel and Sidel, 1976:69).

They go on to suggest the pattern of rise and fall of small groups (Toffler, 1980:409) quotes one Canadian government official as saying the assumed life-span of the new voluntary organizations is six to eight months) is evidence that without an ideological base and common purpose, such groups cannot be sustained by isolated special interests.

The likelihood of Sidel's and Sidel's plea for large-scale organization under a common ideology is tempered by Warren's statement:

> No way has yet been devised for engaging large numbers of people at any significant level of participation along the whole gamut of community concerns (Warren, 1971:85).

People have and always will make choices and take health risks according to their own priorities and within a context of competing needs. To ever anticipate that all individuals would have the same needs and priorities at the same time is indeed utopian. Bay (1980:248) alludes to such an ideal at least in the form of a majority rules in his attempt to synthesize Maslovian and Marxist psychology:

> As civilization evolves, there must be a primary focus on the basic physical needs of human beings and, secondly, on the community and solidarity needs. Thirdly, there must be a continuing dialectics between evolving subjectivity need priorities ... and the evolving patterns of human wants ... ascertainable by popular elections.

He suggests the contest between those who stand up for subjectivity needs and those who represent broadly based, popular demands would be decided on their respective humanist merits. Only in the kind of communist society visualized by Marx does he see this happening. Short of revolution, the likelihood of his bid for radical restructuring of Western societies seems to be remote. But, even if this did occur, what effects on overall health status could be expected?

Limitations to social restructuring approach

It is probable that even if the social structural etiology of current health problems was eliminated, new problems would surface.

Bay states that even Marx was humble in his ability to predict what a true communist society would be like composed of men and women leading unalienated lives. It could not be problem-free, for in Marx's dialectial view of history, new levels of achievement will create new contradictions at higher levels of productivity, consciousness, and human need diversification. Another point is that where many aspects of industrialization are responsible for the so-called social origins of illnesses and early death, many health benefits have resulted as well:

> In health terms, the older industrialized nations have certainly seen a reduction in the massive toll of suffering, disease, and death ... it cannot be denied that the life expectancy improved around the turn of the 19th century ... (but) the description of "modern epidemics" (coronary heart disease and the cancers) and their origins lie at least in part in the very process of development that has brought so many blessings (Popay, Griffiths, Draper, and Dennis, 1981:361).

Social restructuring in the name of health becomes a complex issue when a decision about which conveniences and benefits of industrialization should be given up. By eliminating certain precursors to illness and early death, we create new problems. To whose definition of health do we adhere? If the concept of health is viewed as being both subjective and philosophical in nature as well as a measurable concept via morbidity and mortality statistics, Blum

(1974:85) suggests a list of questions which must be answered before any decision can be made at a social level:

> How far do we want to alter the environment? If we alter it for some persons, such as infants or the aged, will it be suitable for others? In what ways do we want to alter environments? Should we remove psycho-social distresses? ... Can man achieve a sense of self-realization if others moderate the challenges posed by his environment? Can environments be modified suitably overall, given the variations between the needs and capacities of individuals for overcoming obstacles? ... at what point do we trade self-realization for security, at one extreme, or pleasure-seeking, at another?

These questions are dilemmas for most health promotion efforts where both personal behaviour and social conditions are perceived as important determinants of health status. It has been suggested that the priority of health strategies for the 1980's should be one of unifying these two poles so that individual and social responsibility become synonymous. The problem is how.

In summary, the obstacles to the occurrence and the success of social self-care efforts leading to any substantial gains in health are associated with the uncertain relationship between personal and social change, conflicts between lay and provider interests in health planning, and lay characteristics which inhibit the development of social level self-care efforts to improve the opportunities for health.

The criticism directed against the self-care concept connection between personal and social change is based on the skepticism about the

power of individuals to transform society. This skepticism, in turn, might possibly be related to an awareness of the weakened horizontal pattern in society in general and the subsequent diminished degree of community-based social support systems available to the individual.

Strong vertical pattern functioning, whose needs are quite different than those of the horizontal pattern in a community, is also a cause for the conflicts between lay and provider interests in social level health planning. Although it may appear to favour a self-care oriented approach to health planning, political and bureaucratic endorsement of lay involvement in health matters too often functions to ultimately serve the interests of the system. By encouraging and monitoring the form that lay involvement takes in health, vertical pattern functioning assures its continued control. As well, a weakened community horizontal pattern does not provide the necessary support that individual efforts need, in order to overcome the negative impact of vertical pattern functioning that has become too powerful. The failure of lay efforts to succeed in affecting any change when "given the opportunity" to do so has been used as evidence to suggest that certain lay characteristics inhibit the development of social level self-care efforts. The ultimate argument against call for restructuring the parts of the social environment ible for current health problems rests with the attitude not make much difference what is done because new health problems will only surface anyway. Such an attitude again serves to maintain the present

system's functioning and is suggestive of a basic fear that there may actually be another order or means of existence which is superior to the present state of affairs.

Linking the Self-Care Concept and Community Development

The following chapter is an overview of community development philosophy and how it has been used as an approach to change. The compatible natures of the concepts of self-care and community development will be illustrated by their common values. Based on the case that has been made about the detrimental health effects of a dominant vertical pattern orientation in society in general, and the health care delivery system in particular, the point will be made about how a self-care approach to health can be fostered through the application of community development philosophy to health promotion efforts. Although Warren (1963) states the vertical and horizontal patterns exist as a dynamic equilibrium where one eventually counterbalances the attempts of the other's excessive precedence, community development has been used as a strategy to intentionally facilitate the revitalization of community horizontal patterns in the aftermath of social changes which have favoured the development of strong vertical patterns.

Some references state the likelihood of personal level self-care succeeding as a viable means to improved personal health levels will

depend on how such practices can be promoted from a community base and how much existing connections in the community can be strengthened in order to built that basis of support. In essence, they are referring to the development of the community's horizontal pattern. However, the self-care concept has not been clearly associated with this as a potential source of strength. Rather, the rise of some personal and social level self-care activities appears to be a broad random reaction against too much vertical pattern activity in society which no longer effectively meets personal needs. Such activities aspire to counteract the negative impact of vertical system functioning and are most often initiated by the lay sector and in some cases, as Withorn describes, by "sympathetic" people in government and professional positions whose ideological orientation is towards less control by the dominant elite and more control by people themselves.

The obstacles to the health potentials within the self-care concept, on the most part, are due to the vertical pattern system's struggle to maintain its power. Professionals and bureaucrats, with their vested interests in the system as it is, look to the self-care concept as a way to get the system out of trouble but not to necessarily alter it. By initiating and maintaining control over any lay involvement in health matters, their positions remain relatively safe. Essentially any activity which fails to analyze the health-damaging effects of vertical pattern functioning and operates under the premise that health problems require only personal adaptation

and action, will ultimately act as a barrier to the overall health potential of the self-care concept. In order for personal needs to be better met, the social conditions which limit or enhance personal decision-making eventually must be dealt with. It is from this perspective that community development is looked to as a means of providing the social support base essential to the evolution of the self-care concept.

CHAPTER IV

Community Development: Its Relevance to Lay Involvement in Health Matters

In review, self-care as a concept, includes both personal and social-political skills. While each contributes to individual and family well-being, socio-political skills recognize that certain health problems result from the environmental and social structures surrounding the individual (Levin, 1976a). According to Barry, et al. the objectives of self-care at any dimension are to reduce the sense of powerlessness and to establish the ability of individuals and communities of people to self-determine the character of their lives, and hence health status. Dewar (1976) states this will only happen if one has control over the appropriate resources and the subsequent legal authority to act.

The "motherhood and apple pie" appeal of such concepts as self-determination and control can easily lead to their espousal without clear consideration of the realities of their implementation. In this chapter, the philosophy of community development will be described. The similarities between community development and self-care will be drawn out with the underlying intention to eventually demonstrate how certain elements of community development might serve as a model from which health promoting strategies based on lay involvement could grow.

Why Look to Community Development?

Bregha (1971) connects the relevance of community development strategy to the irreversible change process that has occurred with the shift to industrial and post-industrial societies. With this change, Bregha observes what many others have: increases in social turbulence; alienation; social disintegration; and, reliance on social welfare. What he feels has not occurred is a corresponding transformation of related cultural values, organizational philosophies, and ecological strategies. Subsequently, effective adaptive responses to the various changes have not necessarily evolved. Rather, the impact of tradition "is bent on institutionalizing accepted patterns of collective action with the risk of becoming blind to new needs and new strategies" (Bregha, 1971:32). As a result of all these changes and events, Bregha concurs with other sentiments already expressed in this thesis, that the number of relative masters of their own fate is shrinking while the number of dependents is increasing. As well, he believes that those who are dependent cannot improve their situation by self-help and mutual aid alone because their lack of power is related to social factors:

> It has now been widely recognized that the liberation of man - from whatever type of dependency - springs not alone from an act of his free will but also from a joint act of a community encouraging him (Bregha, 1971:33).

Moreover, such liberation requires the individual's conviction that she or he can influence the conditions that have promoted dependency in such areas as education, health, housing, and welfare services, as well as the negative results of those conditions. In other words, not only should individuals become involved in both the planning and bargaining processes of how they are serviced but also in doing something about the situation that created the need for those services in the first place.

Community Development: An Overview

In a selective review of the literature on community development it soon becomes apparent that a variety of connotations and hence, ambiguities exist in the area. An attempt will be made to describe the major themes attributed to community and development as separate concepts and then as the combined concept of community development. Once these have been delineated, the limitations of community development will be reviewed as well as the aspects which have potential for success and subsequent application to an approach to health based on the self-care concept.

Community

The concept of community has traditionally been viewed in some manner which includes a geographical dimension. Connor (1969) states the ingredients of community are: people; geographical place; a sense of identity or "we feeling"; common culture where knowledge, beliefs, habits, customs, values, and laws are shared; and, a social system in which all parts of the system exist in an interdependent relationship. A similar view is held by others (Christenson and Robinson, 1980). The United Nations (1971) describe community as an organic, physical concept where a group exists in face-to-face contact bound by common values and objectives. This particular reference goes on to explain that the concept of community most often associated with community development in North America is nearly always that of small communities or neighbourhoods such as deprived village communities, new planned communities, deprived urban neighbourhoods (i.e., slums and aging areas), and average, comfortable, small communities.

The limitations of perceiving locality or geography as a basic ingredient in the concept of community for community development as a change strategy have been acknowledged by a number of sources. Carey (1970) observes a shift in social participation from a locality base where one's immediate neighbourhood is the key organizational factor to an interest base where different clusters of people from many different neighbourhoods organize around issues. He states:

> The size and complexity of many of our communities today make it difficult to identify the community, or to identify where and how one can participate in decisions affecting the community (Carey, 1970:12).

In essence, Cary concludes that whenever a cluster of people come together because of a shared interest and interact over time, a community exists. The fact that this shared interest grouping may in some cases coincide with an actual geographical community is incidental.

Warren (1971) agrees that because fewer problems can be adequately confronted at a community based or locality level, participation must include alternatives to that organized by locality alone. This would include participation according to the principles of functionalism such as in labour unions, political partities, interest groups, and religious organizations. Although such locality-relevant needs such as schools, streets, police, and fire protection will likely always create reasons for some locality-based activity, many concerns are in some way related to the larger society. Because of this Warren states that no locality-based community can function as an island. Rather, local efforts must be coordinated with those at the regional and national levels as well in order to ensure that local communities can benefit from resources available from those levels. Such coordination of those efforts results in varying geographical boundaries for different functions. Although functional regions do not correspond with geographic regions, many functional boundaries overlap and include a common geographical area.

Roberts (1979) suggests there are disadvantages to viewing the community as a geographical entity. To him, grouping people according to where they live tends to provide only vague clues about their concerns. On the other hand, looking at how people group together around common interests and problems, gives a clearer indication of their concerns:

> The geographical identity of the group is secondary and largely consequent on other factors which form the basis of a common set of objectives of that group ... the community exists when a group of people perceives common needs and problems, acquires a sense of identity, and has a common set of objectives (Roberts, 1979:27).

It is not that geography or the location where a particular group of people find themselves living no longer inspires a sense of identity. In many instances it still may. However, as a specific cause for action because of particular problems and needs, geography is no longer the only factor which has the capacity to create a feeling of community. Roberts identifies communication as an essential requisite for the development of community. It is because of our contempory communication systems which are capable of drawing people from great distances together that Roberts believes the concept of community has extended from relatively tightly connected local groupings to those which can be dispersed over wide areas, where contact is a mere

conference call or a plane's flight away. Because of such changes, he concludes that the concept of community has to be seen as a:

> collection of people who become aware of some problem or some broad goal, who have gone through a process of learning about themselves and about their environment, and have formulated a group objective (Roberts, 1979:45).

And so, where this approach may support the development of community along the vertical lines of the extracommunity systems described by Warren (1963), it does not mean the concept of a locality-based community should be ignored. There is value in perceiving the concept of community in both ways because it increases the possibilities of where community development philosophy and practice can be applied. For instance, it might be used as a strategy to focus on the horizontal patterns of a locality-based neighbourhood, to confront problems specific to that area. It could also be used by a special interest group whose membership extend beyond the local area, as a way to confront the larger social structure from which some of their problems arise.

Bell (1971) concludes that the concept of community has multiple dimensions. He considers the territorial, administrative, social psychological, social structrual, and communication characteristics as important determinants of community. His conclusions are salient to the manner in which community will be perceived in this thesis:

1. Community is a multi-dimensional concept where there are no good and sufficient reasons for designating one dimension as the central one.

2. Beginning with a single dimension introduces a lack of fit with other dimensions and leads to compromises as conflicts in organizations.

3. Therefore a preferred strategy might be to remain flexible in regard to what the community is in order to recognize that different communities exist for different purposes and focus on common organizational problems rather than be locked into a rigid notion of the community (Bell, 1971:5).

Development

In the Webster's New Twentieth Century Dictionary (1976), development is defined as coming into being or activity, becoming larger, fuller or better, growing, advancing and evolving. Such terms as "fuller," "better," and "advancing" invite subjective interpretations. Christenson and Robinson (1980) address this issue stating that while development implies growth and improvement, it is usually one particular ideological orientation which is put into action. However, not everyone shares the same ideology and thus benefits to one means deprivation to another. Operating from a systems perspective they conclude:

> No restructuring of benefits in a social order occurs without some cost to a segment of that social order (Christenson and Robinson, 1980:8).

With this in mind, it is enough to say that numerous theories of development exist (MacDonald, 1978) based on the various interpretations of what development means.

Development from a community development frame of reference is a "process of making rational social choices and improving the ability of groups of people to make such choices, to implement them, to judge their outcomes, and to revise them so that the condition of life improves" (Roberts, 1979:41). Again, words like "rational" and "improve" carry subjective meanings. Before any choices are made, the community must first determine what rational and improvement mean. To Nix (1977), this process is not one with complete harmony and consensus, but one whose specialized leaders and group representatives realize that their interdependency requires an organized approach to compromise. This prior process in which initial problems and tensions are worked through and common objectives are established is also included by Roberts as a phase of development. Without a common understanding of the problems and tensions experienced by members of the community, Roberts suggests that any actions taken under such circumstances will likely have unsatisfactory outcomes. Referring to the concept of precipitate action described by Mannheim, he believes that inadequate levels of understanding and subsequent determination of objectives is often the case with certain groups who become more interested in destruction for destruction's sake and subsequently lose the ability to correctly diagnose the problem and potential solutions.

The relationship between the development of the individual and the community which he or she is a part of is pertinent to community development philosophy and practice. According to Roberts, development of the community will not occur without individual development.

> The development of the community involves the development of the individuals, of their personal insights, and of their understanding of who they are ... what starts off as a concern to influence the social and political circumstances "out there," sooner or later takes on the other dimension to get to know and develop oneself ... (Roberts, 1979:37).

A focus on the development of individual critical consciousness and personal adaptation is regarded by many to be an incomplete approach to social change. Katz and Kahn (cited by Roberts, 1979) believe there is a psychological fallacy in concentrating on changing individuals without regard for the role relationships within the social system of which they are a part. They suggest there is equally a sociological fallacy in assuming that alteration of organizational structures alone is enough to bring about changes in individual behaviour.

The development process invisioned by Roberts is based on a logical approach to solving problems. It includes: diagnosing the tension created by problems and needs by learning about oneself, the group, and the environment; developing communication skills and acquiring certain attitudes about oneself and others; developing commonly held

objectives; performing the actions appropriate for attainment of objectives; and, evaluating the impact of the actions in relation to changes in tension levels.

The manner in which development will be regarded in this thesis acknowledges the significance of both its personal and social dimension. Development, as it relates to the advancement of health, will subsequently occur only in the situations where the characteristics of individuals and their social context are considered. In essence, it implies moving towards a social state which is perceived to be "better" by the individuals involved. This in turn would occur by a process such as the one described by Roberts.

Community development: common themes

As already mentioned, a number of ambiguities surround the meaning of community development as a change strategy. Many provide a narrow, strict account of what it involves, while others present a much broader, lenient view of its possibilities. However, there are a number of common descriptions which seem to appear so often that it might be safe to conclude there is general agreement about some aspects of community development. These will be presented first. Those issues which inspire debate and controversy will be discussed last.

One cannot help but sense the optimistic and humanistic orientation that is basic to the community development view of human potential

(Blakely, 1979). Roberts (1979:167) captures this when he asserts one community development assumption to be:

> that people have the capacity to perceive and judge the conditions of their lives, and to adopt behaviours to improve that condition ... they can look critically at the reigning paradigms of society in which they live.

Dunham (1970) and Cary (1970) also refer to this confidence in the worth and dignity of individuals (values, which Dunham points out, are basic to a democratic society) and their subsequent potential to participate, contribute, learn, and grow under the auspices of self-direction and self-determination. With these values at its base, community development would appear to be the ideal development strategy which provides the opportunity for the worth of individuals to be revealed.

Another commonly held value in much of the community development literature is the significance of a holistic approach to diagnosing and finding solutions to community problems. Blakely, Warren, Dunham, and Cary all refer to the community development approach as one which is concerned with all the people and the total community life and needs rather than one particular segment. Although one aspect of community life may be the focus for improvement at one particular time, it is done with respect for the community's long-term needs as a whole

(Christenson and Robinson, 1980). The holistic perspective implies an integrated, interdisciplinary approach to community problems.

The concept of participation is a third important theme of community development efforts. In general, the desire is to have as many people participate as possible given the beliefs in the potential of all individuals and the recognized importance of a holistic approach. Christenson and Robinson provide further philosophical reasons for the ideological emphasis on participation when they describe community development as: community people working together to guide the future of their community; community control; local decision-making; program development by the users of the program; and, a process which makes it possible for people to identify and find solutions to their own problems. Without participation such involvement could not occur.

Community development is a change strategy which Warren points out can be a way to bring about change as well as cope with the effects of change. However, building on what has already been said, community development is a strategy which is philosophically concerned with particular approaches to managing change. It upholds the concept of felt needs. Blakely describes this as being value centred and normative where change in community development terms is concerned with what the community wants and sees as an improvement in community life. In order for people to perceive their own needs and subsequently manage the necessary changes, community development facilitates the

development of necessary skills through education. Relating back to Roberts' comments on development, this involves learning at the individual as well as the collective level. Thus, there is a focus on developing interpersonal and collective abilities which "seeks collective goals through the marshalling of the energies and resources of the community" (Roberts, 1979:167). To many, the process where the community members improve their problem-solving abilities is seen to be more important than achieving the actual task they set for themselves.

The assumption that people have the will and capacity to plan and work together is the basis of consensus, another theme commonly associated with community development. Through thorough investigation and total community involvement it is believed that community change can be approached with conscious and cooperative thought, planning, and action.

Warren (1971) summarizes the common themes of community development activities as those which would seek the broadest participation possible, consider the needs of the entire community, emphasize process and the development of problem-solving skills, act on felt needs, and ultimately seek consensus among community members before proceeding with any action. Describing these themes as "puristic" or traditional community development, he suggests they can be essentially described as deliberate attempts to strengthen the community's horizontal patterns.

As already discussed in Chapter One, the interrelationships of the various functional units within a locality-based community comprises

the horizontal pattern of that community. Even when the locality concept of the community is weak, these interrelationships do exist where "the operation of one type of local unit presupposes the presence and operation of others" (Warren, 1963:268). Although each of these functioning units have strong ties with extracommunity systems (i.e., the community's vertical pattern), Warren states that none can totally ignore the impact it has on its surrounding area and expect to survive. The vertical and horizontal patterns both play significant roles in how communities and society function.

The horizontal patterns of communities have generally been weakened by the major changes in society while vertical pattern functioning has been favoured. As a result,

> The widespread belief that all problems are best left to experts, particularly when "expertise" implies narrow technocratic specialization, has led to social systems marked by imbalance, inequity, rigidity, and inflexibility (Botkin, Elmandjra, and Malitza, 1979:61).

The basic goal of community development efforts is to re-establish a supportive environment for human needs through the development of strong horizontal patterns (Warren, 1963). In doing so, it is presumed that the community will be better able to offset the negative effects of a too dominant vertical pattern oriented society.

Challenges to traditional community development

As Warren and others indicate, all of these aspects of community development have been challenged and in some instances, present certain incongruencies. Most of the themes of traditional community development are based on a locality concept of community. Given the shift in social participation patterns away from locality-based concerns, the changing concepts of what constitutes a community has lead to some confusion, debate, and controversy about both the philosophy and practice of traditional community development.

To begin with, Warren questions the appropriateness of a comprehensive community approach and total citizen participation in a post-industrial society. He believes it is mathematically impossible and unreasonable to expect people to be interested in such an approach. Some of the reasons why there are limitations to the locality-based community approach to problems are related to the complex problems confronting society which no one particular community can control and the increasing number of functional interests that people are becoming involved with instead of those strictly related to their locality.

As well, focusing on the time-consuming concept of process and reaching consensus in situations where specific issues and conflict of interests are more often the case than not, is likely more in the

interests of the community development practitioner who wants to re-create a romanticized, traditional community atmosphere:

> The focus has been one of seeking to restore the sense of fellowship and participation which people enjoyed in the small agricultural community but which has been largely destroyed by the great change. As a result, much effort has been wasted in trying to restore old-fashioned town meeting models of social participation under circumstances where they are increasingly irrelevant (Warren, 1971:100).

Further limitations of a consensus approach lie in the assumption that locality-based communities are basically homogenous. Warren questions the related goal of striving for consensus. He believes that consensus strategies avoid conflict by attracting like-minded membership (which he suggests largely represents the middle class) and hence, avoid controversial issues. As a result, system changes which are likely necessary for true community development, do not occur. In essence, clinging to consensus strategies has basically served to support the status quo.

Traditional community development has also been affected by the interest that bureaucratic governments have taken in the community development values of popular participation, self-help, technical assistance when required, and the building of indigenous cooperative institutions. The United Nations in its 1971 document, Popular Participation in Development states the ultimate concern of community

development is the development of human potentialities and man's ability to control his environment. Although economic and material progress are important, it is implied that real development involves the development of human capacities and social institutions. In an effort to incorporate this dual nature of development, the United Nations defined community development as:

> the process by which the efforts of the people themselves are united with those of the government authorities to improve the economic, social, and cultural conditions of communities, to integrate these communities into the life of the nation, and to enable them to contribute to national progress (Dunham, 1972:13).

Its goals were to: induce social change for balanced human and material betterment; strengthen institutional structure which would support this process of growth; and, ensure the greatest amount of popular participation in the development process as possible, thus permitting the involvement of less privileged groups.

Inasmuch as this seemed like an admirable effort on the part of organized government, political interests of this type have been accused of impeding the process implied by traditional community development. Where working in cooperation with local government institutions earned the support of local leaders, community development of this sort has often been limited by the:

> rigidity of local institutions, paternalistic traditions, and the law and order approach to administration ... Acceptance of existing institutional arrangements foreclosed, moreover, any adoption of social reform in areas where structural and institutional change were long overdue (United Nations, 1971:3).

As well, it is feared that projects undertaken in response to the felt needs of a community by a particular agency, were more a reflection of the needs of that agency and the more articulate or powerful interests of that community than the community as a whole. Lotz (1969:265) expresses his opinion:

> Many people involved in community development have carried with them a characteristic white middle class culture - a desire to help others, an ethnocentric bias, a belief in the perfectibility of man, and in progress, a rational bent, a mechanistic inclination, reductionist beliefs, materialistic orientation, and a firm belief that they are right.

He goes on to criticize community development for an excess of idealization and theory, a lack of practical knowledge and its subsequent failure to substantially alter many of the human problems it set out to solve.

The Changing Nature of Community Development

The traditional concept of community development exists most likely as a utopian vision and there is no doubt that many attempts have been

made to achieve it (Blakely, 1979). Both Warren (1971) and Dunham (1972) acknowledge the pluralistic nature of community development. Its many variations are based on the people involved, the location of the community development effort, the type of problem and how extensive it is. Warren (1971:94) concludes, "because of the importance of such variations as these, there can be no simple recipe or formula for community development."

From their review of the publications which appeared in the Journal of the Community Development Society between 1969 and 1979, Christenson and Robinson (1980:42) discovered that the majority of articles focus on the "betterment of people." As well, most articles described community as people within a community who act upon their own plans in an effort to improve their situation. However, the manner in which this is actually done brought forth a variety of ideas. In general, the themes of cooperation, confrontation, and technical intervention came through. The community development practitioner functions, in turn, have been perceived as being wide and diverse in nature. A good deal of debate exists around the question of what is and is not community development. What is community development to some is another change strategy to others.

Although various strategies can be described as pure states on paper, in practice the lines of distinction are blurred. Rothman (1977) acknowledges this in his trichotomous model of change. The three approaches he identifies are: locality development (which is

basically the traditional community development approach where community change is pursued optimally through broad based participation at a local community level); social planning (which is problem-solving by technical experts with or without community participation); and, social action (which presupposes a disadvantaged segment of population and through conflict strategies aims to redistribute power and resource distribution). Rothman states that rather than being discrete, separate entities, most change strategies in actual practice are a combination of the three basic approaches. He does admit, however, that many organizations have a tendency towards one approach or another.

It is not the intention of this thesis to argue the merits of purity in approach. Rather, it is the writer's desire to decipher the successful aspects of what has been described as community development strategy in the literature. Although a great deal of effort has been put into the debate about what makes the various change strategies unique, it seems inevitable that in a complex society, a synthesis of strategies rather than an either-or situation is bound to develop:

> Like all other social phenomena, community development and other approaches to community action are constantly changing. It is possible that community development and some of these other approaches may tend to flow together and to effect some new synthesis, either under the name of community development or some new designation (Dunham, 1972:40).

According to the review of articles by Christenson and Robinson, it seems that the name, community development, persists, even though some of the associated activities stray from its original values. The three basic strategies identified by Christenson and Robinson do incorporate these original values to varying degrees. Such a tendency perhaps demonstrates what the United Nations (1971:2) described as the "resilience of community development as a change strategy (which) lay in its ability to accommodate itself to changing trends in development."

Cooperation themes in community development

The cooperation themes identified by Christenson and Robinson were most often labelled self-help strategies. The self-help process assumes people can come together, examine their situations, design strategies to deal with various segments of their surroundings, and implement plans for improvement (Littrell, 1980). It is suggested a set of companion notions exist which affect the practice of self-help: communities have basic autonomy from the larger society; the self-help approach is a self-contained process where people really can do it themselves; communities tend to be stable and homogenous; people know how to participate in the local setting; the local setting is open for those who wish to participate; and, decision-making is easier when people participate. Given these assumptions, the themes of self-help, locality-based groups, and cooperative effort are clearly connected to traditional community development concepts.

Just as traditional community development has been challenged, Littrell states each of these assumptions are subject to debate. It is questionable how autonomous communities can be from the larger society before discovering the limitations that conflicting needs impose upon their autonomy. Unfortunately, "an absolute common good concerning a proposed change seldom exists" (Littrell, 1980:68). The value of self-help as a self-contained process in a complex, specialized society provokes further analysis. Is it wrong to capitalize on existing resources outside the self-help unit? How is it possible to reduce the number of times the "wheel is rediscovered" and yet remain free of the "strings attached" to external resources? The remaining assumptions are also subject to query: communities are not necessarily stable and homogenous; people do not always know how to participate in a local setting; many people involved in decision-making involves time and energy; and, not all people believe that people have the right to participate in decisions which are significant to their life experiences.

> Citizens making plans for others may sincerely feel that they know what is best, even while excluding others from the planning process on the basis of sex, race, creed, age, class, level of income, or other equally invalid criteria (Littrell, 1980:70).

And, as Koneya (1978) suggests, even if allowances are made for citizen participation, it does not necessarily guarantee a community

development approach. Citizen participation as a government initiated activity is quite different than that initiated by citizens themselves. Whereas Koneya believes that classic community development ideology associates citizen participation with independence and the power to make decisions, government supported citizen participation creates and sustains a dependency relationship between the citizens and the bureaucratic government structure because the focus of power never really shifts from the government to the citizens.

Confrontation themes in community development

The second theme which came out of Christenson and Robinson's review of community development articles was that of conflict or confrontation. This is quite contrary to the traditional community development orientation towards consensus. However, in this case, it is a matter of one value taking priority over another. The philosophy behind the confrontation theme is based on the greater concern for more equal distribution of resources and power. It might be viewed as an admission that system changes cannot occur by a change process on which everyone must agree. Christenson and Robinson note that the organizational procedure associated with confrontation is the same as the cooperative strategies of self-help up to the manner in which their goals are to be achieved. Where self-help rests on a collaborative effort by the total group, confrontation emphasizes the polarization of

interests and ways to alter decision-making powers in favour of the needs identified by the group.

Thus, the conflict or confrontation approach is one way in which to cope with the limitations of some of the assumptions basic to the self-help approach. It is acknowledged that consensus and cooperation within the entire group are not always possible. Tactics used by one segment of a community whose needs and interests differ from another include strikes, marches, sit-ins, boycotts, and rallies (Nix, 1977). Christenson and Robinson indicate that within the scope of the community development literature, confrontation is more an account of philosophizing about it than its actual practice. They state little systematic analysis exists about when and how it should be implemented noting that it has most frequently been advocated as a change strategy for those outside the power system such as the poor, blacks, and ethnic minorities. They question how appropriate the strategy would be for the middle-class segments of the community. It might be noteworthy that the same criticism is directed towards self-help (Milio, 1975) where the outcasts in society are told to solve their own problems using their own resources. Self-help in these circumstances has been described as being one way for the larger community to avoid analyzing the real causes of certain social problems, while confrontation could be described as a way in which to force at least an awareness of the problems.

Technical assistance themes in community development

The last theme, technical assistance, came through in one-fourth of the community development articles reviewed by Christenson and Robinson. This theme is based on the philosophy that structure is a major determinant of behaviour but the nature of that structure does not necessarily have to be determined by community input. In fact, most "advocates of this theme end up working for people rather than with them" (Christenson and Robinson, 1980:45). Some community development descriptions incorporate the role of technical assistance which is significant in informing the community about their technical options. "Puristic" community development would refer to this as a consultation function only, with the final decisions ultimately being made by the community who is most affected by them. However, according to Christenson and Robinson, the tendency for technical assistants and planners to take over in such situations is high.

Approaching Social Change with the Appropriate Strategy

Warren (1971:98) asserts that most social change is nonpurposive in that it takes the form of an "unplanned aggregate of individual decisions by persons, families, and organizations of one type or another, as they pursue their interests and objectives." On the other hand, without an overall social development plan, any purposive or

planned change usually occurs as largely isolated, adaptative responses to the problems which arise from the larger uncontrollable changes taking place in society. The challenge to anyone interested in purposive change is knowing which adaptive response will be most effective with the problem at hand.

Most would agree that no one change strategy is perfect for all purposes and needs. As already mentioned, most attempts at purposive change are a combination of several ideas. Rothman, referring to the three discrete change strategies he described, states it is important to know which approach one is more inclined to support. This awareness, along with knowing that each approach is appropriate for different reasons, facilitates a situation where "the practitioner takes an analytical, problem-solving stand and does not become the captive of a particular ideological or methodological approach to practice" (Rothman, 1977:489).

Thus, one might resort to locality development or self-help strategies when populations are homogenous and there is consensus about the overall needs of the community. Or, given the realities of the conflicting needs and interests within a complex society, the decreasing emphasis on geography and the difficulties in achieving effective involvement within the concept of broad participation, social action, or confrontation strategies may be most useful in effecting change in a system which has otherwise favoured a problem-generating status quo. And finally, social planning might be recognized as the

most appropriate strategy when problems are fairly routine and can be solved largely through the application of factual information (Rothman, 1977).

The Compatible Natures of Community Development and the Self-Care Concept

There are a number of similarities between the concepts of community development and self-care. They can be summarized as their common beliefs in the: (1) worth and dignity of human beings; (2) capability of human beings to take responsibility for the decisions and related behaviours that contribute to the character of their lives; (3) ability of people to learn about the conditions of their lives and adopt behaviours which improve those conditions; (4) rights that people have to information (i.e., professional consultation) and supportive environments which provide the opportunities for learning about the conditions that affect their lives; (5) capability of people, once having obtained the necessary information and skills, to weigh the objective with the subjective dimensions of every situation and make the decision that is best for their own perceived needs (i.e., felt needs); (6) professional role as one which is used for consultation and not for making the decision about what is best for the clients; (7) need to approach the diagnosis and solution to problems in a holistic fashion rather than a fragmented, segment by segment approach; and

finally, (8) necessity of approaching change from both its personal and social dimensions.

The self-care concept acknowledges the personal and social dimensions of current health problems. The obstacles to its potential impact on health have already been discussed in Chapter Three. One major obstacle identified was a common tendency to interpret self-care from its personal dimension where individuals and groups of people focus on solutions to health problems which only involve personal change and adaptation. In order to have an eventual effect on the elimination or reduction of the social origins of health problems, it has been acknowledged that the self-care concept also needs the support of collective efforts whose focus is on changing the health-damaging structural conditions in society.

Self-care at a personal level implies those activities which produce "healthier" individuals with the assumption that personal transformation eventually leads to social change which in turn, supports the practices of those individuals. As indicated in Chapter Three, this assumption is subject to debate. Social level self-care, on the other hand, focuses on the need for a supportive environment which increases the opportunities for health as perceived by the individuals who live in it. However, as already indicated, the implementation of self-care activity with either a personal or social focus is not necessarily occurring in an organized fashion. Rather, the lay response to a society in general and a health care system in

particular, whose excessive orientation to vertical pattern functioning is no longer effective in meeting current health needs, has taken many forms. It has been suggested that the self-care concept is perhaps a random yet general attempt by individuals and groups to restore some of the benefits that were characteristic of horizontal pattern functioning.

Community development has been identified as an approach to change which deliberately tries to strengthen the horizontal patterns of communities as a way of reducing the negative impact of a society exceedingly oriented to vertical pattern functioning. A number of common values have been identified between the concepts of self-care and community development. Thus, from a philosophical perspective, they appear to be similar. From a practical perspective it would seem that community development is essentially a form of social level self-care. As such, it is the premise of this thesis that those who are proponents of the self-care concept might look to community development for the special strength that the dimension of community provides for personal and social gains in health. By incorporating the premise that the horizontal pattern of communities can be strengthened, the aspirations of the self-care concept could be related to concrete actions instead of abstract beliefs and values.

The following chapter is a review of how community development philosophy has been connected to health-related endeavours. The first part will be an account of its hypothetical application. The remainder of the chapter will be summaries of actual situations where the

strengthening of the horizontal pattern of communities has been specifically associated with the occurrence of health opportunities for the individuals in those communities.

CHAPTER V.

Hypothetical and Practical Approaches to Strengthening Horizontal Patterns

The connection between community development and health status is certainly not new. It has been used as a strategy in Third World countries to improve such things as sanitation practices, food production levels, and access to medical care resources (UNICEF-WHO, 1977). It has also been applied in efforts to improve the health status of those in the "Third World areas" of developed countries such as the deprived urban neighbourhoods (e.g., the slums and ghettos of deteriorating inner city areas) and non-urban areas (e.g., isolated rural communities with no health care facilities or, in Canada, various Indian, Metis, and Inuit communities). Community development has been described as an underlying theme in the development of community-based health centres in such areas (Plock, 1976). In the 1960's the Canadian Medical Services Directorate made a deliberate attempt to apply community development strategies to their Indian, Metis, and Inuit Community Health Worker program. Most of these examples have been acknowledged for their specific contribution or lack of contribution to particular health developments within the particular situation.

There is some evidence that community development principles once applied to achieve specific health goals mentioned above, are now incorporated into an approach which aims to advance health in general. A major example of this is the model developed by Nix (1977) for the

United States Department of Health, Education, and Welfare entitled The Community and Its Involvement in the Study Planning Action Process. In this document, Nix suggests how community development concepts can be hypothetically applied to obtain the lay involvement currently perceived to be necessary for achieving any major improvements in health today.

Overview: Hypothetical Application of Community Development

Reasons for the failure of traditional health promoting efforts to have any substantial impact on improving health are identified in the D.H.H.S. publication as being: (1) fragmentation of effort; (2) overemphasis on initial motivation and not enough to the maintenance of the behaviour change over an extended period; (3) appeal to individual behaviour change or adaptation, rather than building supportive environments; (4) overemphasis on knowledge and information and not enough attention to whether it can be applied; and (5) a "we will do it for you" approach rather than a "together we can do it for ourselves." Nix, on a similar note, relates people's resistance to change to: having no part in bringing the change about; not clearly understanding the change; having a vested interest and sense of security in the old way; perceiving no connection between the change and the cultural values of the community; and, not liking or trusting the people who advocate the change.

In order to overcome the shortcomings of traditional approaches to health and the challenges presented by change in general, Nix suggests that the guidelines provided by Rothman's locality or community development approach to change must be followed. In his mind, health will only be advanced through efforts which have a concern for: the totality of community life and not just certain dimensions; developing the community's ability to problem-solve in general, as compared to finding a specific solution to one problem; and, involving as many people as possible in identifying and solving their own problems. As such, he relies quite heavily on community development concepts and he states it is first necessary to know something about:

> (1) the people's present attitudes relating to health, (2) their scale of values including health, (3) their felt needs or problems in general as well as in the area of health, (4) past efforts to improve health, (5) community and health leadership, (6) the ways decisions are made, and (7) the relationship between various groups and organizations (Nix, 1980:67).

In spite of his reference to felt needs of the people involved, Nix builds his health promotion model around an external concept of what constitutes health and how it is achieved. This is obvious in the following:

> There are some basic underlying assumptions regarding the process of community change, whether it involves attempting to change individuals'

> behaviour for their own welfare (stop smoking) or changing people in relation to collective behaviour and organization for collective solutions to community health or other problems (Nix, 1977:65).

The implication that someone, other than the people involved, has a predetermined concept of what health should be is further emphasized by Nix asserting that the change agent should know what he is trying to change. In this way, Nix deviates from a "puristic" community development philosophy in that his approach actually involves convincing a target group of the necessity to change in an already given direction. It is important to acknowledge this incongruency which exists between expressing a desire to work according to the felt needs of a particular group and approaching the change situation with an already established goal in mind.

Nix is not necessarily unique in suggesting such an approach to change under the rubrics of community development. At this point in the thesis, it serves as a reminder of the dilemmas associated with planned change according to the value that community development places on the concept of felt needs. When the change involves a combination of the concepts of health, self-care, and community development, perhaps the dilemmas are even greater. These thoughts will be elaborated upon in Chapter Six. At this time the intention is to draw the reader's attention to the fact that Nix's model has been developed to help those who have a particular change in mind achieve that change through practices commonly associated with community development.

Given the etiology of major current health problems, Nix assumes that any health change (regardless of the source from which it originates) involves technological answers to a point, but ultimately depends on social change in order for the underlying causes of major health problems to be eliminated:

> all proposed health changes for a community population, whether they are environmental or medical, preventive or curative, involve changing the social structure in terms of the people's attitudes, values, beliefs, behavioural patterns, and relationships among persons and groups (Nix, 1977:66).

Hence, a polluted river might be cleaned up through technical (and possibly expensive) procedures but the river was originally polluted by people because of certain attitudes, values, and behaviours. In order to sustain an unpolluted river, the original cause of pollution must be altered which usually involves an alteration of those attitudes, values, and behaviours of the people using the river. At this point, Nix states any process of community change must acknowledge the different perspectives, interests, needs, and priorities which are bound to exist between different subgroupings in a community. Thus, if any change in the social structure of the community is required in order to advance health in some way, it is essential to first have a thorough understanding of the community's present social structure.

Once this has been achieved, the challenge lies in making a particular change program compatible with the different needs and priorities that have been identified in the community.

Nix makes a number of suggestions as to how a change is more likely to be adopted in a community where conflicting interests and priorities are evident. These are directed to those who are interested in facilitating the change process and include: communicating in terms that are understood by all community members; involving key (both formalized and reputational) community leaders and as broad as possible citizen input in the planning stage; learning the usual diffusion and adoption patterns of the community which includes the need to learn more about the social networks or sociometric groupings of the community; developing personal contacts; and, establishing a system-centred approach to education where the aim is to change the social structure of a community so as to create the conditions which facilitate rather than detract from the health of individuals in the community.

According to Nix, all of these efforts call for a community development approach which he summarizes in an eight-step study-planning-action process. The first step is the recognition and description of the need or problem in the community by some person(s) within or outside of the community. Nix acknowledges that if the need or problem is recognized by outsiders, insiders will have to be sold to the point where they see it as their need. The next step is to

determine organizations, leaders, and factions of the community who should be consulted on the problem or need because of their relevance to the success or failure of the potential health program. The following types of leaders and organizations are suggested: (1) top community influentials or legitimizers; (2) leaders in the health area; (3) voluntary organizations; (4) leaders of all those groups whose participation is desired; (5) specialists who can offer relevant knowledge; and, (6) representatives of the mass media. Once they have been identified, the third step is to win their support and subsequently legitimize the change process. This is accomplished in a number of ways. Included are such actions as seeking the opinions of leaders respected by all factions of the community and indicating how all groups can benefit from the change. Once the proposed change has been legitimized, the fourth step is to diffuse the idea to the general public. At this time the base of awareness and involvement is broadened though a variety of techniques such as use of mass media, social networks, personal contacts, community self-surveys, opinion leaders, and face-to-face interaction.

Once a general awareness level exists, an effort must be made to coordinate a community-wide set of activities necessary to study, plan, and carry out the program. This is the point where the breadth and depth of the change situation must be determined. For instance, a decision must be made whether the approach should be concerned with a subarea of health, comprehensive health needs or total community

development. All involve different strategies and considerations. A major factor that Nix continues to emphasize is the relationship between successful change implementation and the presence of "real" community involvement where the citizens have actual decision-making powers.

The sixth step is the studying and planning for the action to take place. This is divided into three parts where the citizens must collect facts about the subject to be studied, the community situation, and the available resources, develop skills in conducting an educational decision-making experience, as any solution(s) to the identified problem involve decisions, and finally, to come up with goals and a related plan of action for implementation. According to Nix, if the first six steps are patiently carried out and adhered to, a good basis (but not necessarily a guarantee) has been laid for step seven, where the plan of action is actually implemented. The final step is evaluation. Although evaluation should occur throughout the process, there comes a point after the implementation stage when the impact of the total program must be evaluated according to the original desired outcomes.

Brown and Margo, in recognizing that individuals act within a social context that limits their options for health behaviour choices as well as the impact of their individual actions on their personal health outcomes, suggest that any health promoting or health education efforts must not only provide the necessary information for informed

decision-making but must also work towards creating an environment which allows access to related health options. Their view of health education goes well beyond the role of disseminating health information to one of providing the means for people to examine the social context of their work and lives for health-damaging conditions and helping them develop skills and learn about strategies which will change those conditions. It is one thing to inform people about what constitutes a well-balanced diet; it is quite another to ensure that those people have the personal and social resources to act on that information.

Brown and Margo perceive the role of the health educator to be one of helping to change social conditions that make people sick rather than focusing on the medical model-oriented individual adjustment and behaviour change strategies. As facilitators for social change, Brown and Margo see health educators as people who:

> would help individuals and groups identify health problems in their communities and, if desired by the community people ... teach them organizational and political skills necessary to change and alleviate those problems (Brown and Margo, 1978:15).

They present a hypothetical situation, outlining the potential steps involved in a process which strongly ressembles the concepts of a community development approach to change. They state the focus of any health program would depend on the particular health problems as perceived by a particular community. Thus, the health educator must

first develop a sense of what the local problems are. Brown and Margo suggest that since the health educator does not have a ready-made organization to work with, he or she must begin by entering the community and talking with community organizations and individuals of all kinds. Although no specifics are given regarding when and how one would know a representative sampling of the community has been spoken with, they state that a meeting with collected representatives of community organizations and concerned individuals must eventually occur where problems discovered in the initial community interviews are discussed. At this point, the health educator would begin the process of helping the community members: understand the social as well as the personal dimensions of their perceived problems; articulate their subsequent health needs; develop programs and strategies for individual and social changes which would meet those needs; and, learn from their successes and failures in bringing those changes about. The time required for this process would vary according to the characteristics of the problem(s) and the people involved.

Although at best their conceptualization of efforts to advance health is quite general, Brown and Margo do develop a philosophical approach to the advancement of health which emphasizes the need for progressive social change rather than the traditional health education strategies which seem to perpetuate the inadequacies of the medical model ideology. As such, they challenge health advancing efforts in general to integrate their methods into the broader struggles to alter

the health-damaging structures of the social and physical environment. Their challenge has relevance to this thesis in that they are essentially calling for an approach to health which is compatible with community development philosophy.

The preceding section has been a general overview of ways in which community development has been hyopthetically linked to promoting health where lay involvement is deemed to be essential. It will be recalled that the self-care concept incorporates numerous possibilities of health related activities based on the various combinations of action levels, health behaviours, and origins of activity. From the following review of cases cited in the literature, it appears that elements of community development have been used in a way to promote various dimensions of the self-care concept. Examples which illustrate the application of community development concepts will now be examined. The underlying objective is to determine what has been perceived to be valuable and hence, what might be applied in future health efforts dependent upon lay involvement.

Application of Freire's Philosophy and Methods

Minkler and Cox (1980:311) refer to several case studies which illustrate the ability of a group of people to develop a "critical awareness of the root causes of their problems and a concomitant readiness to take action based on this awareness" within the context of

health. Their premise, compatible with that of community development, originates from the philosophy of Freire (1970) whose methods are based on a commitment to starting with the concerns of the people. Minkler and Cox see this approach to change as an important supplement to current efforts in the health field such as the self-care concept.

In order to explore how Freire's philosophy and method might be applied in health problem areas of Western society, they refer to a case study which takes place in the inner city of a large American urban centre. The impoverished, isolated elderly residents of San Francisco's "Tenderloin" area were observed to share many of the characteristics of an oppressed group. The majority of the elderly in the area existed on below poverty line incomes, and made their home in rented single rooms of the cheap hotels in the area. Their fear of violent crime in the area kept many in their rooms, even when in need of food or medical care. The result of all these factors was to essentially create a number of isolated, alienated people, most of whom felt helpless in changing anything about the situation. As a result of the work of two health educators, familiar with the Freire method, funds were sought and obtained from a local philanthropic foundation with hopes of reducing the isolation of these elderly and to facilitate their working together to improve their situation.

The initial phase involved having a health fair every month in a different hotel where screening for various chronic diseases such as hypertension and glaucoma took place, as well as providing any

requested health education and social service information. These health fairs served a number of functions in that they met some immediate health needs of the elderly and provided an opportunity for social interaction. In this way it was hoped the health fairs would be an important vehicle by which the elderly could confront the broader social problems which were, in part, responsible for their present state of alienation.

In order to carry out the steps of Freire's dialogical approach, "interaction support groups" as a follow-up to the health fairs were conceived as a potential way in which the elderly could explore and discover their common realities. These groups were established in the hotels where a sufficient number of elderly expressed interest in attending the group discussions and where hotel managers were supportive of the venture. The health education facilitators, through dialogical questioning, heard group members express their feelings of powerlessness, isolation, loneliness, and uselessness. Visual representations of various themes were originally planned to provoke emotional and intellectual responses which would then lead to a discussion where the visualizations would be decoded. Through the process of decoding, factors responsible for their life situation would be examined. Hopefully, the process would move on to subsequent reflection and action. In this particular instance, it was reported that bringing empathetic resource persons from the community into the group discussions served to stimuate greater dialogue than the use of

visualizations. As the major issue of powerlessness came through, the various small groups began to look at the potential power they could have as a group through an organized approach to voting. In order to carry this out, it was essential that the various support groups in different hotels would have to unite in some form. Unfortunately, this never happened. Funding was not renewed and the project was terminated before the groups had a chance to develop a strong enough identity to continue on their own.

In analyzing the termination of this project, Minkler and Cox outline issues which prevented this approach to change from being successful and one precondition which they believe is necessary before critical consciousness can lead to action. First of all, it was believed that the health education project was viewed with suspicion by the existing power structure in the community. Minkler and Cox suggest that most of the agencies in this inner city area were characterized by what Freire calls the "false generosity" of oppressors. Thus, where it appeared that those in power were taking action to improve the situation of the poor, there was no real intention to alter the system in order to eliminate the root causes of the problems. The health education project was based on a philosophy not well understood nor accepted by those in power positions. For these reasons, and possibly others, the project's grant was not renewed.

The second reason why the project failed to continue on its own was related to the elderly residents feeling no sense of kinship or

community with each other. Minkler and Cox suggest that such a bond is likely a precondition for action to occur out of the development of critical consciousness. Referring to Rothman's "locality development" they state:

> It may well have been more effective to focus on creating a sense of community ... before embarking on a process whose effectiveness depends in part upon some measure of pre-existing group identification (Minkler and Cox, 1980:320).

In essence, Minkler and Cox are suggesting that the connections (i.e., the horizontal ties) between the elderly in this particular situation should have first been strengthened. Perhaps in this way the "elderly community" could have better withstood the obstacles presented by the community external to theirs.

Increasing Lay Involvement in Health Through Locality Development

A few situations have been referred to in the literature where lay involvement in health matters and the horizontal patterns within the community have been connected. The following example is a case where an initial focus on locality development (i.e., strengthening the community horizontal patterns) was reported to eventually have a positive effect on the involvement of the community in health matters.

A case where community horizontal patterns were strengthened

Hatch, Renfrow, and Snider (1978) suggest that the health strategies which aspire to lay involvement should be based on well integrated community systems. They state that the disintegrated community is characterized by a number of phenomena which act as barriers to the success of such health strategies. These include: a failure to demonstrate the self-determination necessary for the resolution of community problems; isolation from significant exchanges of services and information within the community; an absence of united leadership around activities which would benefit the whole community; difficulty in the enforcement of community norms, many which are conflicting; and, a general inability to give individual community members a sense of community support.

Although Hatch, et al., specifically address the issue of assimilation of health information (i.e., health information programs), they tie what otherwise could be called a concern for a traditional approach to health education, into an overall aim which is to look at how communities might more effectively find solutions to their health problems. Their reported experience is worth noting in terms of how strategies, whose mandate is to advance health through lay involvement, can benefit from the application of community development concepts.

The community situation described by Hatch, et al., is one where community disintegration was assessed to be high. It consisted of the

black residential and business section of a small American municipality. Although the town basically carried a solid, middle class appearance, the particular community of interest appeared to be less advantaged than other communities in the town. In part, this was evidenced by poorer quality housing and road maintenance in the area compared to the rest of the town. As well, the elderly, handicapped, and unemployed had particular difficulty in finding adequate housing. The community had little to do with the formal political structure of the town and minimal success in sponsoring and electing local community members to represent their needs on the municipal council. In general, Hatch, et al., perceived the absence of a well-organized, representative, community-planned approach to problem-solving.

Although theirs was a broad and apparently non-specific approach to health, a health education field team, motivated by the availability of a potential funding source, entered the community with the idea that community health will only improve by first improving the community's problem-solving capacities. This in turn would be achieved by assurring a high degree of community integration. It was noted that the likelihood of succeeding with this rested upon: the community's awareness of their problems in the first place; the ability of the health team to establish a dialogue with community members around those problems; and, the extent to which both community people and team members could identify appropriate resources.

The health team gained entry into the community in a manner which "stressed contact with people through their daily routines rather than formal contacts with agencies serving the community" (Hatch et al., 1978:360). In this way it was hoped to get a feel for community attitudes and concerns according to the informal channels of the community. Information gathered in this experiential manner, plus evidence of past failures at community-wide problem-solving, resulted in a diagnosis which called for improved community-wide cooperation. It was decided that Rothman's locality development model would be the best intervention strategy for the identified problem.

> To overcome community disintegration, the locality development model stressed the involvement of a variety of community people in goal determination and action. This involvement depended upon the development of indigenous leadership through the democratic process of education, voluntary cooperation, and self-help (Hatch et al., 1978:363).

The actions that grew from this philosophy and model thus included a continual effort to facilitate dialogue amongst community members which would bring out community felt needs and subsequent ways to deal with them. In order to make certain the community accepted the responsibility for planning and continuity of activities, the health team was careful not to impose their ideas of what were "appropriate" goals for the community. Rather, the health team "would limit their focus to those concerns first voiced by community people .:. (and

provide) information about ... concerns beyond the community's immediate resources" (Hatch et al., 1978:364).

The creation of a small volunteer steering committee from the community came about as a result of the initial activities of the health team. The formation of the committee was timely in relation to the previous dialogue that had occurred in the community regarding prevalent and relevant needs within the community. Through a series of meetings, the committee formed problem statements into plans for actions. The health team continued to play roles which facilitated the process dimension of these plans rather than the task or determination of content dimension. If and when field team input occurred, it was presented in terms familiar to community life and at a time when it could be screened by the committee for appropriateness.

The initial goal established by the committee was to organize a series of community symposiums on the issues facing Blacks in a period of rapid social change. Once this was decided, the field team continued to accept responsibilities as requested by the committee. As well, they were prepared to buoy up anticipated, intermittent, "sagging" spirits as they experienced the typical problems associated with such planning. However, they discovered the committee members were quite capable of supporting each other during times of stress.

As an activity, the field team assessed the experience to be one which was both planned and implemented by the people who it was for. Hatch et al., (1978:369) conclude:

> Community members had successfully executed a self-determined education process which provided all members with the common knowledge about problems and an integrated approach to utilizing a wide variety of solution formats.

They go on to describe subsequent activities which took place in the community. Some activities involved the organization of new services while others improved already existing municipal services. Included were programs for young people, increased contact with municipal officials, achievement of funds for a housing program, and local representation on a state public housing committee. As well, the health team was pleased to see the development and funding of two programs which focused on reducing environmental health risks and increasing health education opportunities in the community. Thus, in assuming responsibility for locality development first and with a subsequent reduction in the level of community disintegration, the health team's underlying concern for health in the community was eventually addressed as "health needs became priority concerns for subsequent community programs (Hatch et al., 1978:370).

A case where community horizontal patterns were ignored

Englebrecht (1978) reports on a self-care project titled "Health Improvement" which focused on personal prevention of health problems. Promoted within the context of a community health program, it is

relevant to this thesis in its failure to obtain the necessary community involvement that was sought. Englebrecht attributes this failure to excessive reliance on a vertical system funding source and marginal attention to the horizontal patterns of the target community.

Dunes-Parkside, the community in question, is a suburban area of over 100,000 residents on the periphery of a large American city. Its unique historical development apparently created a community which in some ways was reflective of a "gemeinschaft" concept of community:

> Although not a pure type of gemeinschaft, the Dunes-Parkside shares some of the inward focus and provincial attitude of a gemeinschaft community (Englebrecht, 1978:12).

The Health Improvement Program was initiated in 1976 by the Dunes-Parkside Education and Action Committee (S.P.E.A.K.). Described as a non-profit, consumer-controlled community agency, in cooperation with a school of nursing and district health centre, S.P.E.A.K., from its very start "looked to the large vertical institutions and foundations of the metropolitan area for grants and supports" (Engelbrecht, 1978:13). In doing so, it apparently paid minimal attention to the characteristics of the residents within its target geographical area. In general, they tried to make themselves useful to the community by publishing newsletters, pamphlets, and an occasional study. The small, hired staff did not seek community support and volunteers.

Upon requesting and receiving a grant for the Health Improvement Program from a metropolitan university, S.P.E.A.K. continued to operate in its usual manner. A health planning expert, who was familiar with neither the metropolitan nor the local area, was hired to act as director of the program. Based on the latest health research, "she began to put together an excellent program" (Englebrecht, 1978:14). Knowing about S.P.E.A.K.'s previous record of low community response, it was hoped a new and better program, based on appraising personal health risks, would appeal to residents' concern for their own health states. However, once again, little thought was given toward the impact and acceptance of the program by the entire community. In this case, various laboratory and medical measurements were required to determine health risk levels. No consultation occurred with neighbourhood physicians regarding their potential involvement in following up abnormal test results. Rather, medical advice was sought from the university. This created problems for local physicians and a subsequent complaint about the conduction of such tests as blood level cholesteral and electrocardiograms as well as the actions which would be taken after the appraisal.

The opportunity for appraising health hazards was offered on four consecutive dates. It was not successful in attracting large numbers of community members. Based on the complaints from local physicians and a concern about potential legal issues, the laboratory testing was also discontinued. Not only was the planning team left with a poor

community response, they also had a significantly altered program with potentially even less public appeal. Left with dwindling funds, minimal community interest, and a watered-down plan of action, the program folded.

Englebrecht states that one can only speculate on the possible success of a more "grass roots" effort towards building more community support. In this particular case, she feels the major mistakes were failing to assess what the community wanted in the first place (i.e., determination of felt needs) and failing to realize how significant the support of the community's horizontal pattern was. She suggests that community horizontal support could possibly have been both developed and strengthened through: the creation of a funding nexus in the community itself; enlisting the advice and support of local health professionals (particularly the physicians); and, working through already existing community agencies like churches and schools. With the needs of the community in mind and its subsequent support of the program, Englebrecht predicts that the response of community members to the health program would have been greater.

James Bay

The community of James Bay in Victoria, British Columbia is another example which illustrates the eventual health-related impact that comes from a community in which the horizontal pattern is strengthened.

Whereas Hatch et al. describe how outsiders entered a community and intentionally triggered a horizontal pattern strengthening process, James Bay is a case where a similar community response was unintentionally initiated by an external stimulus. The following account is a summary of those events and why the community of James Bay became, what Dill (1981) calls "a self-care health mechanism."

James Bay is an urban community of about 12,000 people in Victoria's older, downtown residential centre (Dill, 1981). Although there is great variation in age and socio-economic status amongst the area inhabitants, Dill states that nearly fifty percent of its population is over fifty years of age and that it has a higher than average number of senior citizens. While some buildings show signs of decay (the area dates back to 1915), others have been well-maintained and in some cases, renovated.

In 1971, a great deal of speculation centred about the potential this particular area offered for high-rise apartment and office space development. With the deteriorating buildings, it made sense to the City Council to re-zone the area for high-density development. Little did they realize how the community residents would react to such a move. At about the same time the community became aware of these plans, a local church, concerned about the needs of the community's elderly, poor, and lonely, obtained a grant from its Toronto headquarters to survey the community. The original intention of the survey was to determine how the church might best serve the "faith and

friendship" needs of the community residents. The basic outcome of the survey was to essentially illustrate the community's overwhelming negative reaction to the re-zoning issue. What began as a spiritual endeavour, became the catalyst for a major community effort, aimed at preventing the drastic alterations that City Hall had in mind for James Bay.

The first step taken by the community's residents was to formally organize as the James Bay Community Association (J.B.C.A.). Their declared mandate was to act as "the vehicle through which the residents could express concern about community issues" (The Planning Committee of the James Bay Community [redacted], 1974). In an effort to halt uncontrolled development in the area, the J.B.C.A. submitted a brief to City Council requesting that no further development be planned for the community without first consulting the area's residents. In order to support the residents' vested interest in the community as a suitable place for their present and future homes, they also made requests for an improved sewage system, more community recreation facilities, and a promise that the older detached dwellings in the area would be preserved.

The J.B.C.A. pursued a variety of strategies to further fortify their position and hence, make certain their requests were fulfilled. For instance, they submitted a brief to the federal government expressing interest in the proposed federal housing policy concerning rehabilitation and stabilization of older neighbourhoods. The

legislation was passed and James Bay successfully obtained Neighbourhood Improvement Program funding. In this case, using Warren's concept of vertical and horizontal community patterns, the James Bay community residents capitalized on the benefits offered by one connection to an extracommunity system in order to counter-balance the undesirable pressures being placed on the community by another part of its vertical pattern.

About the same time as the J.B.C.A. was organizing around the zoning and planning issues, another key development occurred which would have a major effect on the "save-the-community" process and serve to strengthen its horizontal pattern. A new principal who strongly believed in the concept of community education had been hired by a local school board. With his enthusiasm and awareness of education-related needs which had surfaced in the previously mentioned community survey, he rapidly gained community support for the community education concept. Initially the school began with an "open door" policy and offered a number of courses and activities to the entire community. It was quickly realized that the activities surrounding the issues of zoning, planning, and community education could be complementary in nature. At an early point in its development, the J.B.C.A. voted approval of school consolidation in James Bay in order to develop a community school. A Community School Planning Committee was struck to present a proposal to the City School Board and ultimately the City Council. Although these bodies approved the

concept in principle, they declined to provide James Bay with the necessary funds to implement it. This decision stimulated further bonding within the community horizontal pattern. In an effort to increase their power base, the Community School Planning Committee merged with another citizen's group originally established to address concerns for social problems in the area. The combined committees called themselves the Neighbourhood Services Council (N.S.C.).

Meanwhile, the J.B.C.A. was involved in several meetings with City Council regarding the brief that had been submitted to halt development plans for the area. Ultimately their efforts paid off as the City agreed to alter the major plans for re-zoning the area for high-density developments. According to De Girolamo (Note 1), the James Bay residents were successful because of the large community response to plans which threatened to destroy the nature of the community and their subsequent organized efforts to communicate the needs of the entire community to City Hall.

These events, although briefly described, are presented in order to illustrate how James Bay residents, once having established a strong community support system, eventually became involved in matters which specifically related to health in the community. The N.S.C. was the first point where health needs per se were addressed. Because the N.S.C. was made up of people with concerns related to community education and social needs in the community, the council declared their

responsibility to be one which would coordinate and give direction to the development of the education, social, recreation, and health needs in James Bay.

Since the Community School Planning Committee had already failed to convince City Council to provide funds for community school facilities, the N.S.C. prepared and presented a proposal to the provincial government which was lead by the New Democratic Party at the time. This proposal differed from the earlier one presented to City Council in that it now included health, social, and recreational services as well as those related to community education. Although the J.B.C.A. and the N.S.C. were separate entities at this time, the J.B.C.A. had endorsed the expansion of the community education concept in order to meet wider social needs. The community's request for the integration of these various needs within James Bay coincided with the New Democratic Party Government's interest in the concept of community-based health centres. Defining health in its broadest form, the provincial government approved of the proposal in principle and "the James Bay Community Project encompassing health, education, recreation, and social services was born" (The Planning Committee of the James Bay Community Project, 1974). Provincial legislation established the concept of Community Health and Human Resources Centres (C.H.H.R.C.) in four different areas of British Columbia. De Girolamo speculates James Bay was selected as a site because it had clearly made its needs known to the provincial government.

The Community Health and Human Resources Act made provisions for a community-elected fifteen-member board of directors. Between the approval in principle (1973) and the actual appearance of the first elected C.H.H.R.C. Board (1975), a final cementing of strong community forces occurred. The N.S.C., successful in its bid for integrated social, education, health, and recreation services, received provincial funding to hire a community development worker and a project secretary. By May 1974, it was agreed that the community needs would be best determined through the collaboration of the N.S.C. and the J.B.C.A. At that point, the N.S.C. became a committee of the J.B.C.A. and the J.B.C.A. in turn acted as an interium C.H.H.R.C. Board of Directors.

During this period, a number of other autonomous community activities continued to occur. The James Bay Community School Project, aside from its already described connection with the development of a proposal to establish community facilities which would encompass the community's health, education, recreation, and social needs, continued with its "open-door" philosophy for the people of James Bay. Working in conjunction with other organizations in the community and in larger Victoria (for instance, the University of Victoria), community school programming flourished.

Another organization, the James Bay New Horizons Society was initiated by a small group of senior citizens in an attempt to revitalize their lives and improve community life for retired residents

in the area. Within the first year of their existence, membership rose from fifteen to five hundred and thirty seniors. They planned and carried out a number of programs (made possible by a federal government grant) in an effort to increase socialization opportunities for seniors, many who lived alone. One major outcome was the development of a Drop-In Centre. As of the 1980 James Bay Community Project Annual Report, membership in the New Horizons numbered over one thousand.

There were other noteworthy autonomous community groups, organizations, and individuals whose work and connections with the overall aims of the J.B.C.A. were significant. For instance, those who dealt with the concerns of the youth in the area (i.e., Y.M.C.A./Y.W.C.A. Outreach Worker, the Probation Officer and the Teen Council) were included in the community planning. And although the account is not complete, one final activity which deserves mention is the community newspaper, The James Bay News. Working on a Local Initiative Project grant, a group of community residents were convinced that there was a need for a major vehicle by which the various community activities could be communicated to the residents in the area. With local merchants, as well as community organizations supporting it, the paper became a success and was still being published when the community was visited in May 1981.

One of the actions by the J.B.C.A. during its interim period as C.H.H.R.C. Board was to hire an architect-programmer who would translate expressed desires, needs, and programs into space, location,

and staff requirements. This person was eventually hired by the board to act as the coordinator of the entire James Bay Community Project which was to see that the required health, social, recreational, and educational needs of the community were met.

Although the original driving forces behind the concept of the James Bay Community Project, (i.e., J.B.C.A., James Bay Community School Society, James Bay News Society, and the James Bay New Horizons Society), are connected to the government funded and community elected C.H.H.R.C. Board because they use some of its services, they remain as autonomous organizations. Those core services which do come under the direct administration of the C.H.H.R.C. Board are community services such as: the Volunteer Bureau, family programs, and a community office; home-makers services; health services which include a medical clinic, public health centre, and home care; and, social services which include youth programs and educational support services.

Robert Dill, the coordinator of the James Bay Community Project reported on what he perceived to be its major successes at the 1981 Symposium on Self-Care sponsored by the Health Promotion Directorate, Department of National Health and Welfare, Canada. When he was first hired by the J.B.C.A. as an architect-programmer, he felt there was a strong sense of community identity. However, with the numerous and varied community organizations, he stated there was a fragmentation of effort and subsequent competition for "scarce dollars." In his opinion, this prevented the community from ever really coming together

in a combined effort to assess the needs of the community in totality. According to Dill, the development of an organizational structure in the community provided by the James Bay Community Project allowed the community to define its needs as a total unit and take subsequent action to meet those needs. As well, the Community Resources Board was perceived to be advantageous in that much of the government bureaucracy connected with previous community endeavours was by-passed.

Dill states the first task was to get all the groups in the community working together on collectively identified priorities. He identified the conflicting needs between the senior citizen's desire for a drop-in centre versus the young people's wish for a new recreation facility. By sitting down with both groups and collectively assessing the situations of each, a list of priorities was developed with the agreement that there was power in numbers. Thus, once a need of one community group was met, the whole community would lobby for the next identified need in line:

> We started to develop a community organizing system (where) we could pull together four thousand people over an issue and decision-makers knew that (Dill, 1981:88).

Health needs, in both general and specific terms, were part of the many community discussions. The entire concept of involvement was seen as "being part of the self-care system because it gave people ... an

organizational pattern to begin taking responsibility for their community" (Dill, 1981:88). Specific health needs in the community were to be addressed with the creation of a community run medical clinic.

Thus far, what has appeared to be of significance to the success of the James Bay Community Project, can be related to some of the previous points made in the examples already discussed. Two, which have been identified in the James Bay situation, are associated with determining the felt needs of the people in question and working towards an integrated effort by the community units which make up its horizontal pattern.

While Dill speaks in positive and optimistic terms about the concerted community effort that he perceived, some differences in opinion do exist. De Girolamo, a community resident who was involved with the initial re-zoning and high-rise development issues, feels that a mistake was made when the J.B.C.A. began to rely on professional expertise. The need for professional input was an acknowledged necessity. However, it was felt that by not living in the community, professional consultants do not necessarily take a personal interest in the "real" impact that their professional decisions have on the community. This concern was reiterated by others who noted, with some sense of satisfaction, the decision of one of the Medical Clinic's salaried physicians to move into the community.

Another observation, made by a community resident who was also a hired staff member of the James Bay Community Project, questioned the actual role played by the community-elected fifteen-member Resources Board. As is the case with many other community-represented boards (see Chapter Three), Arden (Note 2) felt the James Bay Community Resources Board had not used their powers in the manner that was initially anticipated by some community members. She felt they essentially served to "rubber stamp" the ideas presented by either the coordinator or other hired staff of the Project. De Girolamo states that the C.H.H.R.C. Board is always involved in the planning to a lesser or greater extent, but feels the power behind the decisions made, essentially lies with the hired staff.

It was also acknowledged that interests in the community had changed over time and that general community interest fades away between major issues such as those concerned with re-zoning the area for development. As that interest level falls, the maintenance of "community" efforts to identify and respond to problems and needs in the community is left to those who are paid to do so.

A similar phenomenon has been observed with the kind of lay involvement in determining the direction and affairs of the Medical Clinic. Prior to the James Bay Project, the community had no centralized health care facilities or services. As a result of the provincial government interest in the community health centre concept and the noted community activity directed towards improving their

health and social services, provisions were made for the development of a community-directed medical clinic. The clinic staff consists of two salaried family physicians and one nurse practitioner. It is described as a standard general practice with an emphasis on prevention and patient education. An integrated approach and continuity of care are other stated values of the clinic's approach to health care.

An attempt was made to set up a "patient council" which would be responsible for getting and giving community feedback to the clinic staff. According to the nurse practitioner, this did not materialize. One reason for the failure of this feedback system was thought to be related to the fear that the clinical staff would withhold services from people who were critical of the clinic (Boldt, Note 3). In general, the nurse practitioner felt that the health needs of the community were determined from informal conversations with people who used the clinic. Using this subjective data and the prevention/education philosophy that the James Bay Project is based on, Boldt states that the clinic staff come up with health strategies and "try them out to see if they go." In this manner, several programs (such as the volunteer Grandparent program) surfaced, only to meet a quiet, quick death. One exception, however, has been the concept of a health fair.

Initiated and organized by the staff, the first health fair in James Bay attracted two thousand people. Its objectives were to provide people with an opportunity to assess their present state of physical health and to help participants increase their potential to

lead healthier lives by providing information on as many available health care alternatives as possible. One measure of its appeal to community residents and to others throughout Victoria was evidenced by the six thousand people who came to their second two-day health fair in 1981. (James Bay Community Resources and Health Centre have subsequently published a handbook which describes the concept of a health fair and how to go about organizing one.) To date, no attempts have been made to determine the ultimate impact of the health fair on the health behaviours of the participants.

James Bay is an example where opportunities for health increased as the horizontal pattern of the community was strengthened. The strengthening process occurred in two distinct phases for different reasons.

The first phase began with a community-wide negative reaction to a City Hall development proposal which promised to change the nature of James Bay. The promise was perceived as a threat by community residents. As people banded together in an effort to preserve and improve their community's chances of survival, a strong community identity emerged. The actions taken were health-generating in general because community residents significantly influenced the kind of decisions that were eventually made about their community. Their success in halting the development plans for the area was clearly the result of a spontaneous, internal community response to a broadly perceived threat.

The next phase in which the horizontal pattern of the community was further strengthened was the period of an organized reaction to the accumulated outcomes of the original actions taken to perserve the community. This phase was facilitated and supported by major amounts of government funding and legislation as well as professional expertise. Although this was perceived by some to ultimately mean a loss of "real" community control, various factions of the community were brought together to work in a collective manner towards meeting the needs of the whole community, several of which were specifically related to health.

While the initial horizontal pattern was strengthened by a self-help theme of traditional community development concepts, the second phase seems to be more closely related to the form of community development based on technical assistance. In both phases, health opportunities within the community were enhanced. As such, Dill contends that the locality-based community can be a viable mechanism by which to promote both personal and social level self-care.

Summary

The preceding discussion has been presented with the intention of illustrating the hypothetical and actual links that have been made between community development concepts and increases in opportunities for personal and social health. In summary, the first and most important point that has been made is the assumption that groups of

people with a well-developed sense of their being a community (i.e., a strong horizontal pattern) is an essential counter-balance to the health-damaging effects of the excessive demands of vertical pattern functioning within the community. It has been suggested that those who are interested in advancing health through efforts which call for personal and social level lay involvement might best achieve "meaningful" involvement by putting aside their professional, objective opinion of what specific measures are necessary to improve individual and community health and concentrating more on the development of the group's sense of being a community and its problem-solving skills.

The reasons that have been attributed to the failure of many efforts to advance individual and community health include: working from a professional's perspective of what the problem is rather than that of the lay group; imposing change strategies on people who have not been part of the planning process; developing minimal or no connections between the suggested change(s) and the cultural values of the people involved; appealing to individual change efforts based on cognitive and personal skill development rather than paying equal attention to the development of social and physical environments which facilitate easier access to health improving options; and, approaching problems in a fragmented manner rather than as a part of the totality of the individual's and/or community life.

In theory, it would seem that each of the above mentioned shortcomings could be overcome through an approach which is contrary to one based on the pattern of professional expertise and vertical pattern functioning. As already indicated in the discussion about the barriers to the concept of personal and social level self-care, such a suggestion is much easier said than done. Nevertheless, if lay involvement in personal and social health matters is to have any more than token recognition, a deliberate effort must be made to ensure that all forms or variations of involvement can actually transpire. Only under the circumstances where lay involvement can move freely from the position of simply receiving information to one of having veto power in the decision-making processes that affect their lives and subsequently, their health, can it be assumed that lay involvement is meaningful.

In both the hypothetical and actual links between community development concepts and health outcomes, a basic rule for any efforts to advance health is to start with the concerns of the people involved. These in turn are determined through community study strategies which can be very formal (i.e., the development of surveys and interview schedules) or informal (i.e., entering a community with no other set plan but to talk to as many people as possible). In some instances the concerns of the involved community are brought forth by internal sources; in other cases, the concerns might be discovered and articulated by an external community source. Either way, it is essential to have a good understanding of the community's social

structure and whether the problems are of general or specific concern. As with the James Bay example, an issue which is perceived to have a broad-based impact on the community is more likely to attract greater community interest and involvement than one which appears to affect only a small portion of people.

An important step towards strengthening a community's horizontal pattern (i.e., community integration) is related to the development of an overall understanding about the common reality of a problem or set of problems for the people in a community. The development of such understanding can happen only if there is opportunity and the desire for people to learn about each others perceptions. Sometimes this can happen spontaneously but most times there is a deliberate attempt to bring people together in order to discuss their perceived problems and to become aware of their possible common reality. Community integration will be further supported if the various units are able to work together in identifying necessary and available resources which in turn are related to the manner in which they will go about solving their problem(s). From a community development perspective, the process can be facilitated by a combination of internal and external resources. However, as illustrated in the previously discussed examples, the community itself must essentially perceive that it does have the power to affect change and influence decisions that have significance to community life. The perception of this ability is

likewise related to a strengthened horizontal pattern (i.e., a sense of community) and ultimately, to general and specific improvements in health opportunities for community members.

CHAPTER VI

In Search of a Healing Society

The concepts of traditional community development philosophy which support the strengthening of the horizontal patterns in communities have been identified as a way to counter-balance overly dominant vertical pattern functioning and to subsequently reduce the negative effects which are detrimental to health. While there may be some ideological merit to this approach, community development efforts will not necessarily be the panacea to overcoming the obstacles which currently block the aspirations of the self-care concept. In order to benefit from the concepts which are basic to the process of strengthening horizontal patterns, yet avoid being labelled naive, the shortcomings of community development will be reviewed with particular attention to the dilemmas associated with the self-care concept approach to health. This will serve to remind how community development might hinder the growth of the self-care concept. However, there are reasons to suggest that a community development approach could also facilitate its development. Once these realities and favourable conditions have been discussed, the thesis will conclude with a set of recommendations perceived to be basic to meaningful lay involvement in personal and social health matters.

The Realities of Using Community Development to Further the Self-Care Concept

The problem of ambiguity

The continuing intellectual struggle to identify what community development is and how it should be done (Christenson and Robinson, 1980) is evidence, to the critics of community development, that it basically remains an ambiguous, vague concept. There are several limitations in using a change strategy which is subject to multiple interpretations to promote a new concept such as self-care, itself resting on a particular vision. With a self-care approach to health, the vision calls for two major changes. The first change relates to an alteration in the perceptions that individuals have about their role in making health decisions. Up to now, the observation has been one where health care professionals and the health care system have taken, or perhaps been given, the major responsibility for making decisions about health. The second change relates to changes in social structures where social priorities need to be altered in order to eliminate, or at least reduce, current health-damaging social, economic, political, and environmental conditions. The fact that community development appeals to and has been used to promote the motives of differing ideologies has in part been responsible for the ambiguity surrounding community development. This gives reason to pause and consider the realities of

its potential to give clear direction for the necessary decision-making required for any changes that will allow for substantial gains in health.

The illusion of felt needs

Community development has been identified as a framework by which to diagnose and find solutions to the felt needs of community residents. More often than not, the lament is that community development efforts are more successful in serving the vested interests of the status quo than effectively meeting the needs of those who do not benefit from the social structure. Warren (1971:287) states that too often community development efforts are based on the hopes that when people are given the opportunity to confront their own problems, their decisions will "somehow magically correspond to what some outside agency thinks the community should be doing."

Levin (1977a) describes how the myth of the "good health imperative" serves to legimize provider interests in health promotion and disease prevention efforts without much thought to how it pressures conformity to professional norms about what constitutes good health. These professional norms in turn, are conditioned and shaped by the vertical pattern system within which the professional works and was educated. Levin goes on to say how it is taken for granted that health is life's highest goal. However, he also notes that health, as a

dominant social value cannot be documented in the human experience. Rather, he states that people have always made choices and taken health risks according to their own priorities. There are limitations to this logic because of Levin's tendency to define health as a physical phenomenon. From the discussion about health in Chapter One, "priorities" could imply social, emotional, or psychological health needs which sometimes take precedence over what is thought to be physically beneficial. Levin's failure to address the multi-dimensional nature of health illustrates the inherent problems involved with a subjective interpretation of health.

Overcoming the powerful interests and orientation towards the vertical patterns of society in general, and the health care system in particular, will be a considerable challenge for an approach to health based on an attempt to alter those interests through strengthening the horizontal pattern of communities. Given the skepticism which surrounds the historical precedents set by other such community development efforts, it is worth considering whether the self-care concept would fare any differently.

Finding solutions to felt needs particular to health matters poses another problem. In that community development and the self-care concepts believe in the capacity of human beings to take responsibility for their own decision-making and subsequent action, there is a parallel presumption that the individuals must have access to and fully understand the information that is the basis to an "informed

decision." Such a decision is based on the subjective and objective dimensions of the situation and might actually be described as a state of critical consciousness. But, with regards to decisions about health, illness, and dependency needs, when can it be determined that a state of critical consciousness has been reached? How would one know when all the necessary information (given that it can be obtained) had been gathered? And, is a critically conscious state necessarily the same for all people involved in the same situation? These questions are subject to debate and as such, illustrate the complexity of a self-care approach to health to which the community development experience can offer no easy solutions.

The problems of locality-based efforts

The general ineffectiveness that community development has historically had with causing broad social change has been related to traditional emphasis on working with locality-based communities. Roberts suggests that the attainment of any major changes in economic and political environments (which may likewise contribute to the prevalence of current health problems) usually requires the efforts of more than one locality-based community. However, because community development as a process is essentially designed to be applied to one community at a time, severe limitations are placed on its ability to cause broad economic and political change (Roberts, 1979).

One other limitation with this concept of community is related to locality no longer having as much significance to people's social needs as it once did. Although the concept is appealing and attractive to community development practitioners, change efforts dependent on the support of a locality-based community frequently fail as it is often an "illusive state of being" (Roberts, 1979:32). As previously discussed, it is generally acknowledged that groups of people who come from various geographic locations, but interact regularly and provide mutual support because of common interests, can also be described as a community. However, because community development is designed for the purposes of strengthening the horizontal pattern of locality-based communities, other groupings of people which are more common and perhaps more relevant to a modern, complex society can be overlooked. In that health problems have been related to excessive vertical pattern growth in general, and that the social origins of illness are not necessarily related to geographic location alone, goals related to how much and how quickly locality-based efforts will alter illness-generating social structures, must be realistically set.

The complexities of broad participation, process, and consensus

Whereas community development stresses broad-based participation in a decision-making process which is ultimately concerned with consensus, the difficulties which surrounding its application to the advancement

of a multi-dimensional and subjective concept like health are obvious. The more homogenous a community is, the more likely some agreement might exist among the people as to the meaning of health. However, heterogenous communities whose orientation is more towards vertical pattern functioning are not easily involved in consensus seeking processes. Participation levels are likely to be directly related to the scope and depth of the impact of a problem. Thus, where an issue has widespread implications in the community, participation rates would hypothetically be higher than when only a particular segment is affected. In the first instance, consensus would be appropriate. When only a minority's interests are at stake, consensus is difficult to attain. In these cases, conflict strategies are frequently resorted to (Crichton, 1973).

The obstacles to reaching consensus are essentially due to the variations that occur in what is "perceived." The wider those variations, the more elusive consensus becomes (Dunham, 1971). The subjective, multi-dimensional concept of health inherently leads to numerous perceptions. And, as discussed in Chapter Three, the validity of any one perception of the meaning of health over another is a difficult decision to make. The complex and philosophical dilemmas which surround the concept of health do not easily lend themselves to an approach which ultimately seeks consensus. Warren (1963) states the process of reaching consensus is at the same time what serves to strengthen the community's horizontal pattern. In reality, however, he

suggests the issue or task goal over which there is more or less agreement, frequently takes precedence over the process of effectively reaching a common understanding:

> The predominance of the task goal implies that the horizontal structure will be strengthened only if this does not interfere with task accomplishment - which it often does (Warren, 1963:335).

As such, the multi-dimensional, subjective nature of health-related task goals could very well be antagonistic to the development of a stronger horizontal pattern in a heterogenous community.

Summary

Furthering personal and social level opportunities for health through the strengthening the horizontal pattern of communities has been discussed according to emphasis that community development places on felt needs, locale, broad participation, process, and consensus. All of these are related to the manner in which community development has traditionally attempted to offset the negative effects of excessive vertical pattern dominance. The gains in health that are hypothetically expected from the development of stronger horizontal patterns, have been considered according to the inherent limitations which arise from combining the concepts of community development and

health. With the realities of the hypothesis in mind, the following is a discussion about the reasons why community development concepts still warrent consideration as a valid approach to the advancement of health.

Conditions Which Favour the Relevance of Community Development

Many of the obstacles and hence, limitations to the development of stronger horizontal community patterns are related to a generalized reluctance within a vertical pattern dominated society to alter those systems so "expertly" designed to meet human needs no longer assumed by families and communities. However, in spite of what sometimes appear to be insurmountable barriers to the use of community development as a means to further the health aspirations of the self-care concept, there are some reasons to believe it still has relevance.

Warren (1963) gives the following conditions which perpetuate, in spite of the favoured growth of vertical pattern systems, and are subsequently supportive of deliberate efforts to strengthen horizontal patterns: (1) the extreme symbiotic interdependence of units in the community situation; (2) the tendency for people to need to be treated as whole people rather than as bureaucratic fragments; and, (3) the strong cultural values which give high lip service to cooperative, neighbourly concern. The quest and need for community is essentially an inherent aspect of the human condition. The excessive growth of vertical pattern functioning as industrialization, science and

technology consumed society, took precedence over the less demanding horizontal patterns which were more or less taken for granted. Just as a flower dies without attention to its needs for water and soil nutrients, the sense of community declined as less emphasis was placed on the significance of the horizontal patterns in society. Roberts (1979) cites references which call for the need to revive the missing community in order to restore the human qualities of life and indicates there are a number of writers who suggest there are already signs of change:

> Their perceptions are of a condition in which sharing and cooperation will be counter-values to exploitation and competition, in which organic forms and collaborative relations will be the dominant organizational philosophies, rather than mechanistic forms and competitive relations, and in which interdependence will predominate as a cultural value over independence and achievement (Roberts, 1979:43).

Roberts states these are the features of a post-industrial society. While they appear to be more congenial to the philosophy and practice implied by community development, he reminds us that others hold less optimistic perceptions as to whether technological society can be redeemed. As well, he states that few of the features of the post-industrial society are commonly experienced by the majority of people. However, according to Toffler (1980) the survival of the human race is dependent upon the transition from the features of an

industrial to those of a post-industrial state. His analysis, which centres around the concept that technological society is undergoing a process of de-massification supports the relevance of community development. The following summary explains why.

The Move Towards a De-Massified Society

Toffler makes no pretense about his social forecast being scientific in nature. Rather, he describes the synthesis of the multitude of observations within his analysis as an art which cannot be tested within the realms of scientific methodology. As such, his predictions rest on facts, events, and illustrations he has come to observe and subsequently interpreted as indicators of a revolutionary change that society is currently experiencing. With the limitations of his methodology in mind, Toffler nonetheless presents a convincing case.

The essence of Toffler's analysis is that the propulsion towards a mass society, induced by the principles of industrialization (i.e., standardization, specialization, synchronization, concentration, maximization, and centralization) is diminishing. The reasons for this, Toffler states, are complex and interrelated. Those that he identifies are related to "intractable and insuperable" problems of the energy base (i.e., coal, oil, gas, and nuclear power) upon which the industrial society has been built. These include: the increasing recovery costs of diminishing energy reserves and the ultimate

realization that they are non-renewable; the ecological destruction that results from the use of these energy sources; and, the serious risks attached to nuclear power generation and resulting wastes.

The other reasons that play a role in the demise of industrial civilization are in a sense, the products of industrialization itself. The successful implementation of the principles of industrialization has reached a point where continued, excessive emphasis on any one is perceived by many to be undesirable. The conformity inspired by standardization gives way to a need to express individuality; concentration of people, and synchronization of work schedules create undue demands for the same services at the same times; maximization is not always related to bigger profits; and, the results of professional and specialized efforts are not necessarily the most satisfying ones. Beyond the increasing costs in time, money, and energy of an industrial orientation, Toffler (1980:17) states there are also:

> .... growing millions who recognize that the most urgent problems of the world - food, energy, arms control, population, poverty, resources, ecology, climate, the problems of the aged, the breakdown of urban community, the need for productive, rewarding work - can no longer be resolved within the framework of the industrial order.

In response to the inadequacies of the current manner in which society is organized, Toffler describes a number of phenomena which are indicative of a new move towards a more humane civilization away from

one based on principles prone to inevitable disintegration. The characteristics of the change include what Toffler calls a "techno-rebellion." Here the argument is not for the complete removal of technology, but rather for the careful selection of technologies which will serve the long range social and ecological goals essential to human survival. In effect, it is an attempt to humanize technology through the fusion of high-technology of global dimensions with smaller human scale organizations. Such combinations will be possible in a de-massified society that Toffler already sees happening. He describes how society is beginning to break into smaller, more varied pieces. As examples he gives the trend towards decentralization in the work place and the tendency for people to move away from large urban centres.

Major forces which foster the de-massification process are the computer and other high-technology communication systems. As it eventually becomes more economical (i.e., in time, energy, and money) to use these innovations instead of those common to the industrial society (e.g., centralized work force, automobiles to get to work, time spent commuting to and from work), Toffler predicts a society where people will increasingly do more work from their homes. The impact of such a transition has ramifications for all aspects of living. With regards to the suggestions put forth in this thesis, one which is perceived to be very significant is the increase in face-to-face relationships in the home and neighbourhood. This return to community, and the increasing tendency for people to assert their ethnic,

religious, professional, sexual, subcultural, and individual differences as they move out from a mass society mentality, will foster the growth decentralism even more. At the same time, one could also expect an increase in neighbourhood power and a proliferation of neighbourhood groups who work out their own solutions to their own problems. In Toffler's mind, such small decentralized groups will reflect:

> the breakdown of machine politics and the inability of big government to cope with the wide diversity of local conditions and people (Toffler, 1980:258).

Others support Toffler's observations and predictions. Spiegel (1980) notes the "golden opportunity" that the trend towards more decentralization and neighbourhood-oriented programs in the United States creates for community development. From a similar perspective, Marilyn Ferguson (1980) suggests that any hope for a more humane future will not come from a dependence on bigger and better technology, but rather from the "community-builders." She too notes the related response occurring throughout technological societies:

> The emphasis on building community and on action in small groups represents the major shift in radical political thinking ... Meaningful change can only be implemented at the level of the person, the neighbourhood, the small group (Ferguson, 1980:208).

Toffler suggests the diversity of interests that arise from a de-massified society will ultimately make the concepts of centralized government, power, and authority obsolete. The concept of "majority rule" and the need for consensus too, will no longer be functional. Instead, Toffler (1980:299) sees:

> a new concentration on "community" and "neighbourhood" on local politics and local ties at the same time that large numbers of people - often the same ones who are most locally oriented - concern themselves with global issues and worry about famine or war 10,000 miles away.

At the same time, he acknowledges how a de-massified society which accentuates differences rather than similarities, can make human contact and hence, a sense of community more difficult. Nonetheless, Toffler, as do many others, asserts that the community is a basic requirement of any individual and that "any decent society must generate a feeling of community" (Toffler, 1980:367). From Toffler's perspective, the trends in society and the new technologies have all the potential to make it possible for more bonded families and a closer community life.

However, the shift away from an industrial society geared towards its vertical pattern, to one which is once again concerned with the horizontal pattern's functioning, will not necessarily happen on its own. There are choices that still have to be made. Those who fail to

see the limits of an industrialized oriented society without making some attempt to alter its negative aspects, will also be faced with the continual threat of war over scarce resources, economic collapse, and ecological destruction (Toffler, 1980). In the event that any of these occur, the changes and trends outlined by Toffler will not necessarily take place.

Human Potentials for Adapting to the New Realities

Botkin, Elmandjra, and Malitza (1979) state that by failing to understand the environment and social problems that accompany the benefits of technological progress, people increasingly come to be at odds with the real world. Describing this as the human gap, they are essentially referring to the same dilemmas identified by Toffler. Whereas Toffler suggests that the emergence of a new order rests with the willingness and ability of people to adapt to new realities, Botkin, et al., are convinced that before this will happen, people must first understand these realities. Whether or not humankind is capable of this understanding is, of course, debatable. Yet, Botkin, et al., state it seems perfectly valid to assume that humans possess a great deal of untapped potential:

> The average person, even when living in deprivation and obscurity, is endowed with an innate brain capacity, and hence a learning ability which can be

> stimulated and enhanced far beyond the current relatively modest levels (Botkin, et al., 1979:xiii).

Thus, while not denying the possibility that the gap can turn into a chasm, they believe through the development of human understanding, otherwise destructive events can eventually be brought under control.

Bringing about such understanding is dependent on an approach to learning which goes beyond the conventional concepts of education and learning. Differentiating between maintenance and innovative learning, Botkin, et al., emphasize how the present current of events makes the innovative approach to learning mandatory. Whereas maintenance learning stresses adaptation and adjustment to the functioning of an existing system, innovative learning is based on the anticipatory need for change and restructuring in times of turbulence and discontinuity. They state that most often, innovative learning is triggered by a crisis of one sort or another after a long period of adaptation to a worsening situation.

> Under the influence of maintenance learning, those who should be alarmed are often not moved by gradual deterioration. Then when shock occurs and events roll like thunder, people finally stand up only to look for the lightning that has already struck (Botkin, et al., 1979:26).

In spite of these general societal tendencies, Botkin, et al., do see evidence of anticipatory learning in all branches of human

activities. Many occur in the form of projections and forecasts in future studies, science fiction, management, and long-range planning activities. The "near-universal demand for increased participation at all levels," is also viewed as having the potential to influence the occurrence of innovative learning because of the necessary complementary relationship between anticipation and participation (Botkin, et al., 1979:29). Where compulsory participation is likely to be counter-productive, they suggest the only form of participation which will have any real effect will have to be of a voluntary nature. Although the current demand for participation in some cases is legislated and mandatory, it is noted that another large portion is a spontaneous reaction on the part of people wanting to have a greater say in the events that affect their lives. Other problems such as isolation and apathy are also acknowledged as obstacles to the cooperation, dialogue, communication, reciprocity, and empathy required for effective participation and anticipatory learning.

Where a society confronted by turbulence and uncertain times continues to rely on maintenance learning strategies to cope with increasing conflicts, the eventual occurrence of some crisis situations and subsequent "shock learning" is the inevitable outcome. Botkin, et al., admit this to be the historical pattern which has been demonstrated by world societies. However, they maintain that apparently stable systems are not necessarily static and lacking in counter-movements. Numerous examples of innovative learning were

brought to their attention in the preparation of their report, the number and importance of which are "growing with astonishing rapidity" (Botkin, et al., 1979:80). Similiar observations of such trends have been made by Marilyn Ferguson in her conception of the activities which constitute an "aquarian conspiracy" and Toffler with his interpretation of events which indicate civilization's entry into a "third wave" having already experienced an agricultural and an industrial phase.

Summary

The preceding discussion has been presented in an effort to explain the present and potential relevance of community development as an approach to advancing personal and social health. In spite of one perspective which identifies the obstacles to and the limitations of the concepts that community development is based upon, there is evidence of another perspective which suggests that present social trends are moving in a direction which is favourable to a community development approach. To some, the pattern created by various outbursts of seemingly unrelated activities is suggestive of a building counter-reaction to the negative effects of a society oriented to technological progress and the bureaucratic organization of human affairs. If Warren's assumption that a dynamic equilibrium exists between the vertical and horizontal patterns in society is correct,

this reaction might be perceived as a natural phenomenon and an instinctive human response for survival.

However, the power and complex nature of vertical pattern functioning with its negative, accumulative effects, as well as the historical tendency for major reform to occur only in the event of a crisis, leads many to doubt whether the horizontal-vertical balance, necessary for a healthy society will or can occur without the triggering effect of a major catastrophe. Yet, hope remains for the unknown potentials of human capacity to understand not only what their own personal needs for survival are, but how these in turn are related to the needs of the larger social setting as well. Without a healthy society it is difficult to expect the development of healthy individuals. It is also the responsibility of those individuals to ensure that the society they live in remains healthy. There are no concise, specific rules about how to ensure this. However, based on the preceding discussion that has taken place within this thesis, there are a number of considerations which must be taken into account by any effort concerned with the promotion of personal and social health matters. These considerations are conceptual and form the basis of the conclusions that have been reached in this thesis.

CONCLUSIONS AND RECOMMENDATIONS

The initial question posed in this thesis was how the health of individuals can be further advanced in Western society. Although the modern health care system and a medical model approach has been acknowledged for their positive impact on personal and social health, it is becoming increasingly evident that further substantial gains in health will not likely occur through these approaches alone. Current health problems whose etiology is related to behavioural, environmental, and social conditions do not necessarily respond to the treatment methodologies of the medical model ideology. As a result, the roles that individuals and communities can take to improve health and minimize disease are increasingly being emphasized.

A major concern within this thesis has centred about the form that lay involvement in health matters is taking, the reasons for the development of these activities and whether or not this involvement will indeed have any substantial effect on personal and social health. The current health problems which threaten personal and social health have been related to the progressive effects of a society increasingly oriented to technology, specialization, and bureaucratic organization. This in turn has fostered the growth of vertical pattern functioning while that of community horizontal patterns has been weakened. The functions of each pattern are unique and essential for personal and social health. As such, a balance between the two is desirable. However, the excessive dominance of societal vertical pattern functioning in general; and the health care system in particular has

disturbed this balance. In spite of the improvements in health made possible by technological progress, the imbalance created by the favoured growth of vertical pattern functioning is detrimental to personal and social health. While vertical pattern functioning has been perceived to encourage undue dependency on the services provided by specialized systems, the health attributes of individual autonomy and self-responsibility have been minimized.

The emergence of various lay health activities of either a personal or social focus, might be interpreted as a general response, not unlike a horizontal pattern reaction, to excessive vertical pattern functioning in Western developed societies. While the deliberate attempt to strengthen the horizontal pattern of communities may hypothetically reinforce the base from which the concept of self-care can develop more fully, a number of obstacles do exist which limit the potential growth of either the concept of self-care or the strengthening of community horizontal patterns. The problem of professional, bureaucratic or political management and control of potential "acceptable" activities is one obstacle to both concepts. Other problems lie in the characteristics of lay people themselves (i.e., apathy and the manner in which people learn) and the conditioning process that society has generally gone through about whose responsibility it is to do what. As the development of strong community base has been identified as one way to facilitate the development of personal and social level self-care activities, any

obstacles which limit the application of the concepts of community development will also restrict the effort to encourage the growth of the self-care concept.

Neither the concept of self-care nor that of community development advocates total independence from technology and professional expertise. Rather, both look for a way in which to re-establish a balance between horizontal and vertical pattern functioning so that the benefits of both can contribute to personal and social health. Thus, the "meaningful" involvement of lay people in personal and social health matters ultimately implies neither self-destructive autonomy nor debilitating dependency. The subjective, multi-dimensional nature of health requires the involvement of the concerned individuals, if only to define what health means to them and how they want to achieve it. How health is defined and whether it will be achieved depends on a number of variables, some of which include the resources (i.e., information, services, and skill development opportunities) those individuals have access to. It is suggested that through the development of a strong horizontal pattern, these resources could be more easily accessed and hence, opportunities for personal health increased.

Even though some have perceived various social phenomena which indicate a renewed significance attached to the sense of community, attempts to deliberately further the development of horizontal patterns are still seen to be necessary. However, if these efforts are to

enhance the capabilities of communities to counteract the powerful forces of vertical pattern functioning, a number of considerations are critical. For the purposes of this thesis, they are summarized as a set of recommendations and related strategies. It is suggested that by taking the following into account, any efforts to advance health will likely have a greater impact on overall health improvement than by total reliance on a more traditional (i.e., the medical model) approach to health problems. The obstacles to these recommendations and strategies will be obvious in light of what has already been discussed in this thesis. As such, their implementation will be difficult. Yet, for those who are truly interested in advancing health through the "meaningful" involvement of lay people, they will serve as reminders of the direction in which such efforts must move.

Overall Assumption

Through deliberate attempts to strengthen the horizontal pattern of a community, the assumption is that a strong horizontal support system will offset the aspects of vertical pattern functioning which are detrimental to health and make use of those which are beneficial. The establishment of a strong horizontal base is analagous to social level self-care which in turn is linked with increased opportunities for personal level self-care. In this light, it is suggested that the process of strengthening horizontal patterns in communities (i.e.,

community development) could play an important role in facilitating the growth of the self-care concept. Furthermore, if the self-care concept is to reach its full potential in this manner, the concept of community will have to be expanded to include a variety of social grouping forms which are not necessarily determined by geographic boundaries alone.

Related Recommendations to Overall Assumptions

Regarding the significance of felt needs

Efforts to advance personal and social health through the strengthening of the community's horizontal pattern must avoid the tendency to begin the process with a professionally oriented pre-determined concept of what health means and hence, what the felt needs should be. Doing so would undermine the meaning of health as a subjective, multi-dimensional concept as well as the ideals held by the concepts of self-care and community development. The target group must be met on their own terms and priorities. Although the initial priorities of the community may or may not have a health focus, the efforts spent facilitating the development of the community horizontal pattern can be perceived as developing the community's social health state. As illustrated in Chapter Five, once the integrity of the community has been established, the progression towards health

opportunities which are relevant to community members, occurs quite naturally.

Thus, efforts to strengthen the community's horizontal pattern are more likely to be effective if they are based on what the people in the community want rather than what expert opinion deems necessary (Barry, et al., 1979).

Regarding the need for vertical pattern input and support

Whether the concern is for personal or social health, informed decisions and subsequent responsible action cannot occur without access to the necessary information and opportunities or support for informed decision-making and skill development. While social health implies the mutual benefits of a balance between vertical and horizontal pattern functioning, personal health is related to a balance between the human needs for autonomy and dependency. The horizontal pattern of the community and the autonomous individual must have access to the resources for health offered by the government, the professionals, or other units of the vertical pattern. Where the needs of the vertical pattern in society in general, or the health care system in particular, have taken precedence over the needs of the community's horizontal pattern, social and personal health suffers. In spite of the ideological aspirations of the self-care concept and community

development, both have also been used to further the growth of a vertical pattern orientation by those who have a vested interest in its functioning. As such, the intentions of any efforts to promote self-care activity or to apply the concepts of community development must be carefully analyzed for their relationship to vertical pattern interests. If they serve to strengthen vertical pattern functioning, no major personal or social gains in health are likely to result.

Yet, health gains will not occur without the benefits of vertical pattern functioning. Both personal and social health are dependent upon it. What is needed, however, is a less imposing vertical pattern. Stokes (1981) calls for a "creative partnership" where solutions should not be imposed from above nor can solutions from the bottom survive without support from above. According to Ehrenreich, this will only occur if both roles in the partnership are totally reconditioned. In the case of professionals, he believes radical deprofessionalization will be necessary. While waiting for this to occur, Withorn (1980:27) states that efforts can be made to form alliances with "service workers who do not see themselves as elitist professionals but rather as workers with a natural alliance to clients."

Regarding the required changes in roles taken by lay people

Just as alterations in the way vertical pattern units function are needed, a parallel change must occur in the roles traditionally assumed

by lay people in health matters. Ehrenreich states there is a need for major changes in how people perceive themselves, their bodies, and their relationships to others. Sentimental faith in the potential capacities of human beings for becoming autonomous and assuming renewed responsibility for their personal and social health is not enough to ensure that such changes will occur. After years of being conditioned to behave in a particular manner, a concerted effort will have to be made to change those behaviours and perceptions. To some, these changes can be encouraged through education:

> Systematic and imaginative educational efforts .... are needed to spur community development and to provide citizens with the skills and knowledge that they need in their roles and responsibilities as community health decision-makers (Reddick, Cordes, and Crawford, 1978:474).

The form these educational efforts take are crucial to their ultimate impact on human behaviour. From the perspective of Botkin, et al., education efforts geared towards maintenance of present system functioning would obviously be inadequate. Rather, the challenge would have to be met through the process of innovative learning which is based on human initiative and the acquisition of new skills, attitudes, and values. Efforts to foster innovative learning emphasize values, human relations, and images as particularly significant elements which are necessary for the occurrence of new behaviours. Values play a

crucial role in assessing preferences and examining the future consequences of present decisions, the pattern of human interactions can either enhance or obstruct innovative learning and the use of images fosters integration and generates insight. Freire offers similar suggestions in his concept of education for critical consciousness. If initiative for decision-making and subsequent action for personal and social health is to come from the lay sector, they most certainly will have to experience the type of learning described by Botkin, et al., or Freire. Thus, any genuine interest in the meaningful involvement of lay people in advancing personal and social health must have an equal interest in the educational approaches which facilitate innovative learning or the development of critical consciousness.

Regarding the emphasis on locale

Neither prevalent health problems of current concern nor many forms of human association are restricted to locality-based communities. If a community development approach is to have any significant impact on personal and collective health decision-making, it should be applied to all forms of communities.

In her discussion on the views of "community" and "the community," Bernard (1973) addresses the dilemmas of trying to understand the functioning of communities from either a locale-based conception or one

without the locale component. She contends that classic community paradigms are no longer appropriate guidelines from which to approach the communities that modern life generates. As circumstances change, so must the conceptualization by which they are interpreted. What Bernard points out, however, is that those circumstances do not change in total. Thus, there are areas where a locale-based community concept is still important and, "as long as locale means anything for many people, the concept of local community still has validity" (Bernard, 1973:185). However, she acknowledges the validity of those who perceive:

> a great impersonal world where groups, classes, coalitions, and alliances form and re-form, but remain always in flux, unanchored to any settled locale (Bernard, 1973:185).

In that neither perspective is adequate alone, Bernard states that by taking the "if ... then" format of the physical sciences, all community paradigms can be valid in the circumstances for which they were designed. By analyzing the "if's" or the parameters of a particular situation, Bernard believes the determination of the "then's" becomes more manageable.

Regarding the significance of consensus

The inherent difficulties of a heterogenous society coming to a common understanding about the meaning of health and a collective agreement about what needs to be done to increase the opportunities for personal and social health appear to be unsurmountable from the perspective which requires consensus. Instead of the essentially self-defeating "either-or" situation implied by consensus (as well as confrontation) strategies, Warren suggests the need to approach change situations with a sense of dynamic pluralism. He describes this as creative confrontation which emphasizes differences but channels opposition "within the bounds of acceptable and tolerable confrontation, rather than letting it engulf all other values" (Warren, 1971:291). In other words, a mechanism is required which both allows the expression of conflicting needs and truths and permits the pursuit of agreement:

> We need mechanisms that will fall short of satisfying every party to every controversy, but which will assure the right of the dissatisfied to be heard and to continue their efforts to persuade the rest of us (Warren, 1971:291).

Warren outlines a number of pre-conditions for dynamic pluralism. He includes: overcoming our tendency towards simplistic dichotomization by eliminating the use of such words as either/or,

right/wrong, and good/bad from our language; devising ways for the formal systems to accommodate new power relationships; and, developing a willingness to exist in situations without feeling the need to be in control at all times. He admits his vision is not necessarily a solution but rather "an uneasy resolution in which different truths may competé for acceptance, and resolutions short of full agreement may become implemented" (Warren, 1971:298). In essence, Warren is speaking of the need to consider the spectrum of possibilities which exist between two extremes, of which neither is desirable. To him, it is important that we stay clear of both being manipulated and being the manipulator:

> ... because you and I cannot both have our way, we are forced into compromise. We need to find ways of channelling change which will assure that you and I will reach the optimum agreement possible, but that our remaining disagreement will neither immobilize us nor result in our destroying each other and those around us (Warren, 1971:298).

Concluding Comment

Because of the inherent limitations within the human condition, individuals nor societies can ever hope to achieve perfect personal or social health. Attaining, restoring, and maintaining health is a continual process to which there are no easy answers. As solutions to one set of health problems allow for attention to be given to new health

problems that develop, it is essential that the nature of the solutions alter with the nature of the problems. From both the personal and a social need for the survival of human kind, we will continue the search for solutions to the prevalent health problems and causes of death in developed societies. It is both our personal and social choice as to whether these solutions will come about as a reaction to crisis situations or in an ultimately less traumatic manner where decisions are made as a result of anticipatory awareness ... one in which we perceive that potential for personal and social control over the events that add to or detract from our health.

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APPENDIX I

Association Between Selected Leading Health Problems and Individual Behaviours*

	Cigarette Smoking	Excessive/Inappropriate Alcohol Use	Nutrition Habits	Physical Inactivity	Safety Practices	Sexual, Birth Planning Practices	Excessive/Inappropriate Drug Use	Inadequate Stress Management
Chronic Diseases								
Lung cancer	++							
Other cancers	++	++	+					+
Cardiovascular/ Cerebrovascular	++	++	+	+				+
Respiratory	++		+					
Liver cirrhosis		++	++					
Diabetes		++	++					
Digestive		++	++					++
Other Health Problems								
Low birth weight	++	+	++			++	+	+
Foetal alcohol syndrome		++					+	
Obesity			++	++				+
Malnutrition		++	++					
Sexually transmitted disease						++		
Other communicable diseases			++					
Accidents		++		+	++		+	+
Mental disorders		++	+	+		+	+	++
Divorce/family breakdown		++				+	+	+
Suicide		++					+	+
Drug abuse				+				

\+ Well-documented link ++ Tentative link

*ADAPTED FROM: Report to health care and social services planning committee, Appendix B, Alberta Social Services and Community Health, 1980.

APPENDIX II*

Overview of Health Promotion in Canada

The following is a summary of programs and activities which have been developed in response to an identified need for programs to promote and encourage healthful personal lifestyles by the federal government, some other provincial governments and private organizations in Canada, and some organizations in other countries.

A. Federal Government

The role of the federal government, achieved principally through Health and Welfare Canada, Health Promotion Directorate, has been and will likely continue to be one of researching issues and gathering data on which to base health promotion programs; preparing planning and policy documents; funding or delivering small scale pilot and demonstration health promotion projects; and facilitating federal-provincial and inter-provincial information sharing. All programs are developmental and limited in scope. None are delivered to the public on a widespread, continuing or consistent basis.

*ADAPTED FROM: Report to health care and social services planning committee, Appendix D, Alberta Social Services and Community Health, 1980.

1. Operation Lifestyle was introduced in 1976 a a promotional vehicle for all federal programs aimed at improving lifestyle. Unfortunately, its programs have had little impact to date. The computerized Lifestyle Profile has been popular with the public, but is prohibitiverly expensive and has demonstrated little effectiveness in changing health behaviour. The current program focus is on the private industrial sector. A pilot project to assist young adults entering the work force to establish healthy lifestyles from the beginning of their working years has been funded. Other pilot projects which will attempt to encourage employers to implement company lifestyle programs for their employees, distribute health promotion materials through their marketing outlets, and cost-share production of health promotion materials with the federal government are being planned. Operation Lifestyle also sponsors the Lifestyle Awards, which honour Canadians who voluntarily work to improve community lifestyles, and is developing the Corporate Cup, which will encourage companies to participate in friendly team competition in physical activity events. All of these pilot projects are in the planning or early implementation stages, and evaluations of the effectiveness of those which have been implemented are not available.

2. EvaluLife (Health Hazard Appraisal). This program uses a computerized analysis which relates an individual's lifestyle and health habits to their risk of illness, disability, and disease by comparing the individual to an average Canadian of the same age and sex. EvaluLife offers the risk analysis free of charge to health professionals working is physician's offices, public health units, and employee health units in business, industry, and government. These professionals can use the assessment to inform their clients of personal health risks, and to identify behaviour changes which could reduce risk. An evaluation (Lauzon, 1977) of the method has indicated that the risk assessment tool on its own does not bring about changes in health behaviour. However, when combined with personal counselling, the method did result in improvements in physical activity but not in smoking, eating habits, or alcohol use. Health professional who use the method also tend to feel that it is most effective in increasing physical activity (Thornton, et al., 1978).

3. Fitness Canada assists organizations and professionals working in the area of physical activity by developing norms for physical fitness, funding small research projects on fitness, producing some promotional materials (brochures, posters, films, T.V. advertisements, etc.), developing tools and manuals for fitness leaders, and offering workshops in

leadership training. The program also funds one demonstration project per year (starting in 1980) to develop and illustrate models for integrating fitness with other community lifestyle promotion activities. Funds are provided to national associations for demonstration projects, meetings, and workshops. No evaluation of the effectiveness of these program activities has been undertaken.

4. Nutrition. The federal nutrition program is currently focusing on development of public awareness materials (print and electronic media). A media campaign of 19 television advertisements targeted at children was completed in 1979, and a similar campaign for adults will be developed in 1980. Evaluation of these awareness materials is currently underway.

5. Regional Office Projects. The Directorate's Regional Offices (Vancouver, Winnipeg, Toronto, Montreal, Halifax) fund a small number of demonstration projects on a variety of lifestyle related topics. Current or recently completed projects include smoking cessation for senior high school students, stress management methods in the health care network, and a resource kit for professionals on Women and Addictions. No lifestyle demonstration projects have been funded in Alberta. An evaluation of the high school smoking cessation program indicated that it had no demonstrable success.

6. Canada Health Survey. The Lalonde Report illustrated the need for information on risks and positive health not provided by existing health statistics. The Canada Health Survey was introduced in 1975 to gather information about alcohol use, tobacco use, activity and fitness, transportation and accidents, emotional health, blood pressure, and a variety of other health issues. This type of information is critical in assessing need and designing health promotion programs. The results of the first survey will be available in fall 1980. Unfortunately, the Survey has been discontinued, so that essential information about trends in health practices and health status will not be available in the future.

7. Mass Mediated Smoking Cessation Self-Help Project, a joint project of the Health Promotion Directorate and the Canadian Council on Smoking and Health, is in the very early planning stages. The program's goal is to increase rates of sustained smoking cessation, and will have four major components: (1) a three-part television series designed to create community interest and support, thereby increasing individual intentions to cessate; (2) a printed self-management guide, which will provide step-by-step guidance to cessate and will be available to the public on request; (3) a community support component involving voluntary agencies and health professionals working through local Interagency Councils; and (4) background research and formative and outcome evaluation studies.

8. Dialogue on Drinking was initiated in 1976 to provide relevant information about alcohol use to people at national, provincial, and community levels, and to encourage community-based action on alcohol-related issues. In its four years of operation, the program has worked with provincial alcohol and drug agencies primarily in the area of mass advertising (newspaper, radio, magazine, T.V., billboards, bus cards). Some community projects in Nova Scotia and Ontario have been initiated. Cuts in funding and problems in working effectively with the provinces have limited the progress and success of the program. Evaluations of the awareness campaign indicate that messages reached about one-half of the target population and encouraged very limited action among only about 10 percent of those who heard them. Plans for 1980-1982 are to spend $1.2 million on a national media campaigning and on stimulation of community action through local projects in cooperation with provincial programs.

B. British Columbia

The B.C. Ministry of Health, Health Promotion and Information Directorate provides consulting services to 18 health districts and develops province-wide information resources in the areas of health education and nutrition.

Action B.C. is a private non-profit organization 100 percent funded by the Ministry of Health. The program focuses on four lifestyle components: physical activity, nutrition, smoking, and stress management. Major program elements are (a) inservice training in fitness appraisal for teachers; (b) touring field teams (4 teams with fully equipped vans) offering fitness testing and counselling, nutrition analysis and counselling, and smoking cessation and tension (stress awareness) workshops; and (c) the B.C. Corporate Cup which organizes friendly competition in physical activity events among companies. The field teams offer services to communities throughout the province free of charge and to business and industry at a charge of $12.00 per employee. These mobile services are delivered on a "one-shot" basis, with no attempt to establish ongoing programs in communities or businesses. The goal is to increase awareness and motivation, which hopefully will then result in initiation of community-based efforts to improve lifestyle. No facilitation or funding of such continuing efforts is provided, however. No evaluations of the effectiveness of Action B.C. have been conducted or are planned.

C. Saskatchewan

The Saskatchewan Department of Health has a province-wide lifestyle program which uses mass media (T.V., radio, and print) to promote awareness and knowledge. From 1974-1977, the program, which was called

Aware, focused on alcohol. Evaluations show that knowledge and some attitudes changed, but behaviour did not. These results are to be expected from a program which includes media only and which does not utilize environmental, social, and interpersonal influences on behaviour. In 1977, the theme of the media campaign was changed to promote good nutrition and physical fitness, and the title "Feelin Good" was adopted. In 1979, the program was further broadened to include mental health and breastfeeding, and will add dental health in 1980. A 1979 evaluation found a good level of awareness of the lifestyle issues covered by the program, but indicated that the media campaign will have to be supplemented with a community-based behaviour change component if significant lifestyle change is expected.

D. Ontario

The newly formed Health Education/Promotion Unit of the Ministry of Health has been provided with significant resources to establish health promotion policies and programs in the province. No major programs have been undertaken to date. Small projects on hypertension screening in the workplace, youth and smoking, and smoking restrictions in the workplace have been initiated.

The Communications Branch of the Ministry of Health has a program of "health skills" advertising. Two media campaigns, one focusing on adult modelling of positive health behaviours for children, and one

promoting moderation and personal responsibility in alcohol use were conducted in 1979. A third campaign with the theme of personal responsibility for nutrition, stress management, alcohol use, and smoking will be completed in 1980.

Fitness Ontario, which is funded from proceeds of the Wintario Lottery, has an extensive program of fitness promotion. Included are provide-wide public awareness campaigns (radio, posters, pamphlets, newspaper articles, and advertisements - no T.V.); grants to community projects; mobile fitness testing and counselling (7 teams with fully equipped vans); employee fitness programs; and a fitness awards program.

E. Quebec

The Ministere des Affaires Sociales has developed three comprehensive health promotion policies on nutrition, alcohol, and smoking. These policies serve as a basis for development of programs to be delivered through Local Community Service Centres and Local Community Health Departments by the Ministry.

The Communications Branch of this Ministry produces extensive public awareness materials and campaigns (electronic and print media) to support the health promotion policies. All media and campaigns are funded through a tax on media advertising.

F. Other Provinces

None of the other provinces have major or innovative health promotion programs in place. Health promotion and education budgets are small in these provinces, and program activities generally consist of counsulting and provision of inservice training to community health professionals, as well as production of some printed information materials.

G. Non-Government Canadian Programs

1. ParticipAction is a private non-profit organization which receives an annual operating grant from Canada Fitness and Amateur Sport, as well as contributions from some provincial governments and the private sector. Its purpose is promotion of physical activity and fitness, primarily through mass advertising. Major activities are of four types:

   (a) Public service advertising, where federal government funds are used to develop promotinal materials (e.g., radio and T.V. spots), which are then carried by various media outlets free-of-charge;

(b) Public sector supported promotions, where materials developed by ParticipAction are paid for and distributed by provincial governments and other non-profit groups;

(c) Corporate supported programs, where promotions are sponsored by private sector companies; and

(d) Sale of promotional merchandise developed by ParticipAction and retailed on a break-even basis.

The goal of the program to date has been to create public awareness that Canadians are not as fit as they should be and that the solution may not be too difficult or unpleasant. A further goal has been to create awareness of ParticipAction itself. A 1978 market survey indicated that these awareness goals have been attained with over 70 percent of Canadian adults. The focus of the campaign has now started to shift from awareness to creating motivation for action. Mass media advertising to maintain awareness will continue, but new strategies will include direct consumer involvement through schools, sports clubs, recreation departments, public health units, and employee fitness programs.

2. Barrie Heart Health Project is a community-based project jointly funded by the Ontario and Canadian Heart Foundation,

Ontario Ministry of Health, Fitness Ontario, and Health and Welfare Canada. The purpose is to develop and test a skill oriented group approach to changing risk behaviours associated with heart disease. The approach uses trained volunteers who work with grous of 20 people on a weekly basis for 10 weeks. Participants are recruited through a community promotional campaign using radio, T.V., newspapers, shopping centre displays, and direct promotion by health professionals. The program is strongly research oriented, using a wide range of pre- and post-participation measures, as well as studying the ongoing process of motivation for change and actual behaviour change. Preliminary research results will be available in fall 1980.

3. Thunder Bay Community Fitness Campaign was developed by the Thunder Bay Distr[illegible] Council, and commenced in April 1979. It was implemented by a volunteer committee representing local agencies involved in fitness and recreation and a full-time paid project coordiniator. The project is funded by contributions from local and national business concerns, with matching funds from Wintario Lottery.

The goal of the initial portion of the campaign is to increase awareness regarding the benefits and availability of fitness and recreational opportunities and to increase the fitness of community residents.

Fitness, being a highly visible aspect of health-related lifestyle, as well as being a key to lifestyle change in other areas, was chosen to introduce this community health promotion project. In the future the project will address other aspects of lifestyle such as nutrition and smoking. The program will be evaluated by a private consulting firm.

4. Bodycheck is a research demonstration project sponsored by Dalhousie University Division of Family Medicine and Health and Welfare Canada. The goals are to assess the feasibility and effectiveness of using a health hazard appraisal followed by health education counselling in the physician's office, and to measure change in identified lifestyle risk factors with patients receiving the assessment and counselling. Preliminary findings indicated that improvements in risk behaviour occurred only for physical activity. Major problems encountered included failure by nurse and physician to encourage patient participation due to the extra demands placed on their time, reluctance of patients to participate

because of time required, and unwillingness of patients to return for follow-up. Funding for a more extensive research phase has not been granted, and the project terminated in June 1980.

5. Preventive Medicine Centres: A small number of medical practices focusing exclusively on early identification of health risks and provision of counselling and treatment services aimed at health promotion and disease prevention have recently appeared. These centres generally include one or two physicians supported by health educators or other with training in the behavioural sciences (e.g., social work, psychology). Services offered usually include an assessment of health status (biological, emotional, nutritional, behavioural), followed by appropriate counselling, preventive treatment or behavioural change programs. A small portion of the cost of these services may be recovered from provincial medical care insurance plans, but a fee is also charged to the patient.

APPENDIX III

Definitions of Self-Care

1. Self-care, the concomitant of self-responsibility, including actions taken by the individual to enhance his own health and well-being and to heal himself is a concept with the following objectives: to promote health through collective responsibility, mutual support, and specific self-help actions; to provide consumer pressure for more equal access to health care; to provide resources that respond more appropriately to health needs; to promote programs in the area of lifestyle change; and, to encourage self-help techniques which provide group support and pressure to make the necessary changes needed for health promotion (Brown, 1976).

2. Self-care is a process that permits people and families to function effectively in achieving their own health potential by developing skills in the following areas: monitoring, assessing, diagnosing; supporting life processes; following therapeutic and corrective strategies; preventing disease; specifying personal health needs; auditing and controlling prescribed treatment programs; and initiating support groups which centre around health care concerns (Norris, 1979).

3. Individual involvement in health care activities associated with the concept of functional ability and disability can be classified as those which: maintain functional ability (e.g., sleep, diet, activity); prevent functional disability (e.g., no smoking, moderate use of alcohol); validate functional ability (e.g., breast exam, blood pressure check); validate functional disability (e.g., seeking diagnosis for perceived dysfunctions); prevent impairment of functional ability (e.g., complying with therapeutic prescriptions) (Marshall, 1977).

4. The essence of self-care is to be in command of and to manage one's health by: selecting, coordinating, and supervising professional care; determining the forms and conditions of medical intervention; evaluating the outcome of these interventions; maintaining health records on family; and planning a healthy lifestyle including the choice of community, residence, employment, leisure activity, diet, and other health maintenance practices (Pratt, 1977).

5. Self-care is a bimodal phenomenon comprised of health maintenance activities (which includes disease prevention practices) and care of self in illness, however loosely the latter is defined (Williamson and Danaher, 1978).

6. Self-care can be defined as a consumer performance of activities traditionally performed by providers from medicine, education, behavioural and clinical psychology, public health, social work, and community development (Green, Werlin, Schauffler, and Avery, 1977).

7. Self-care occupies the first level of health care activities and is basically what people do for themselves once symptoms occur. However, self-care is part of a wider field that includes health education and communication about four basic areas: health maintenance; disease prevention, self-diagnosis, self-medication, and self-treatment; and, participation in professional care (Fry, 1973).

8. Self-care is a consumer-centred health care model which implies that the individual be able to read signs that portend a crisis, respond to the crisis of the moment, and establish and maintain an appropriate regime (Gartner and Riessman, 1976).

9. Self-care is the examining, monitoring, and treating that lay people do at the primary health care level in order to control their sickness and wellness states (Henig, 1977).

10. Self-care is a mode for personal health care which sonsists of: an information base for preventing, alleviating, containing, and

repairing illness states; methods for disseminating information; support structures for maintaining self-care, and a means for evaluating self-care efforts (Milio, 1977).

11. Self-care is a process whereby a lay person functions on his or her own behalf in health promotion and disease prevention, detection, and treatment at the level of the primary health resource in the health care system. As well as focusing on how to avoid or reduce iatrogenic illness and the transfer of certain medical concepts, strategies, and skills to lay use, the concept of self-care also relates personal health status to forces in the environment and hence, encourages the development of skills to bring about social change (e.g., community organization strategies, lobbying, and social advocacy skills). Self-care is concerned with strengthening the lay influence in health as both a social and a personal resource (Levin, 1976 and 1978b).

12. Self-care is a lifestyle attitude which subscribes to a respect for and belief in the dignity and worth of each and every individual; it upholds the individual's right to proper nuturance and growth, to information and knowledge, to opportunities to learn and acquire skills in order to make competent and responsible choices in pursuit of health and health care (Crawshaw and Wong, 1980). This source describes the self-care perspective as one which places responsibility upon the individual as a primary care-giver of the

self and as an informed participant in negotiating for appropriate health care. An attitude of self-care implies that the services and systems which society establishes to restore and maintain personal and public health must be responsive to and supportive of that exercise of personal responsibility and choice. In light of these beliefs, Crawshaw and Wong present the following operational definition: self-care refers to restorative and maintenance processes through which a person assumes primary responsibility on personal, interpersonal, and social levels of interaction for his or her own health.

13. Orem (1971) defines self-care as the practice of activities that individuals personally initiate and perform on their own behalf in maintaining life, health, and well-being. According to her, adults choose and follow courses of action which they judge to be beneficial for themselves or for those who are dependent upon them such as infants, children, the aged, and the ill.