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Shaping the Shift to Community Health

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BACKGROUND

The Ontario Public Health Association (OPHA) is a voluntary, non-profit charitable association. Its individual members and constituent societies are drawn primarily from the public and community health field. The mission of OPHA is "to strengthen the impact of people who are active in community and public health in Ontario." Over the past two years the Board of Directors of OPHA has identified the shift to community health as a primary issue for the Association. The purpose of this policy paper is to help OPHA members to discuss health care reform and to define the shape of the shift to community health that OPHA supports.

Various panels and commissions over the past twenty years have made two primary recommendations: the health care system should be re-oriented away from an emphasis on curative interventions to an emphasis on health promotion and disease prevention; and health care and services should be moved from the institutions to the community. OPHA has supported these reform directions. The Ministry of Health Working Document on Goals and Strategic Priorities, released in January 1992, identified as priority areas the implementation of community-based reforms in long-term care and in mental health and the development and implementation of a community health strategy. At its January 1992 meeting, the OPHA Board identified "supporting the shift to community health" as a key strategic issue for the Association.

The Ministry of Health has pursued certain initiatives over the past year, and funding restrictions and cutbacks have seriously affected many areas of health care. In the absence of a community health strategy, these initiatives appear to be not health system reform but outright system downsizing. In January 1993, the OPHA Board re-confirmed that health reform was the top priority issue, but in light of concerns with the initiatives to date, resolved that the Association must "shape (rather than just support) the shift to community health."

This policy paper identifies the principles that OPHA believes should shape the shift to community health. It is a product of a discussion paper circulated among OPHA members, and it incorporates member responses to that original paper, detailed discussion by the Board, material from reform initiatives across Canada, and literature from the field. The Board of OPHA proposes that this policy paper form the basis on which to deliver an OPHA advocacy strategy to shape the shift to community health.

OPHA holds certain values it believes should shape the shift to community health.

Summary of values by which OPHA will shape the shift of health reform in Ontario.

The shift to community health is about the kind of society we want.

The shift to community health is an opportunity to re-affirm and re-define important public policies.

To support community health we need to create healthy communities.

To support health equity through health reform we need to promote the democratization of health policy-making and funding.

To make our communities health promoting, we need to support healthy community services and healthy service providers.

OPHA values inclusiveness, collaboration and shared decision making.

To make our communities health promoting, we need to create health in the context of using the determinants of health.

To service community health, we need to acknowledge our own power and be prepared to share it through information and research.

The shift to community health is about the kind of society we want.

Questions of health policy are not narrow questions of how to reform the health system; they are among the most profound questions we can ask about the society in which we live. [1]

OPHA believes that the goal of health reform is to improve the health of the citizens of Ontario. The definition of health incorporated in the Ministry of Health Working Document on Goals and Strategic Priorities is that proposed by the World Health Organization:

> Health is the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs; and, on the other hand, to change or cope with the environment. Health is therefore seen as a resource for everyday life, not the objective of living; it is a positive concept emphasizing social and personal resources, as well as physical capacity.

Given this definition of health, it is apparent that the determinants of health are significantly social and environmental. Social circumstances such as level of income, employment status, and social support, environmental conditions such as work environment, urban or rural settings, and more familiar physical environmental conditions of air and water quality are important factors in health and disease.[2] This perspective is consistent with the public health legacy of concern for the social and environmental contexts of health, a legacy due much credit for historical improvements in health and reduction of mortality.[3] This perspective also provides the rationale for the type of health promotion and disease prevention that emphasizes social and environmental intervention to influence the conditions that determine health, rather than concentrating on individual lifestyles. Although personal

behaviours may contribute to health and disease, most of these are themselves socially structured and influenced. [4] Event to understand lifestyle behaviours therefore requires that the behaviours be placed in their social context. Health issues are social issues, and health policy questions are questions about the kind of social circumstances, the kind of society, we want to nurture.

The positive definition of health, the emphasis on determinants of health, and the legacy of the public health movement provide the background for OPHA's position on the shift to a community-based health structure.

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Drawing attention to the social context of the shift to community health, the first general point to be made is to recognize that the shift is not just about delivery of services, although there are good, practical reasons for community-based service delivery. The context of the shift is a period in which values of the public sector in general and social programs in particular are being questioned, such that the question of how to deliver services is a political issue. What services should be available, to whom and under what conditions, if any? Should they even be public services?

Crisis?

Health reform could result in the dismantling of basic insured services and the abandonment of principles of universality and accessibility. The legacy of public health entails that a strong public presence should remain in the health system, that the collective provision of a public good such as health care is the best guarantee of equity in health services. To this end, OPHA defends the principles of the health insurance program embodied in the Canada Health Act. [5] Defending the principles, however, should not be construed as defending the system as it exists. For example, while universality is an important principle primarily debated among providers and policy makers, OPHA believes that communities must be actively engaged in this debate.

or opportunity?

The public health legacy also is one of progressive reform. [6] From this perspective and the perspective of the broad definition of health, the crisis in public services occasioned by public debt is an important opportunity to renew our collective priorities to the end of reducing inequities in the determinants of health. In this context, the shift to community-based health identifies new priorities and potentially allows us to re-invent the nature of public service.

In these terms, there is much to support in government initiatives to date. There is the development of more community-based alternatives to institutional care, the enhancement of community and neighbourhood-based support programs and of support to family caregivers. There is the intent to provide services that are sensitive to gender, culture, and race, and to tailor services to meet individual needs. All these are consistent with the shape of community health that OPHA recommends.[7]

OPHA is concerned that the policy discussion of the shift to community accommodates one set of values while another set is being used when implementation takes place. In the context of a public

service crisis especially, the shift to community can result in an abandonment of communities and individuals to their own devices rather than a support of communities and individuals in their aspirations; services may be restricted to a narrow set of needs instead of recognizing diversity; and existing power relations may be entrenched rather than recast. Full health reform will require resource allocation decisions to parallel the devolution of planning and community consultation.

OPHA values a broad vision of health and the contributions of a wide variety of individuals and groups. OPHA promotes participation in decision-making processes and a multi-sectoral perspective. OPHA's vision of community is an equitable and inclusive one in which differences are honoured and supported and relationships are collaborative and participatory. OPHA believes that government services should support community diversity, and that community involvement in the design and implementation of services should be encouraged in order to tailer the services to the community as appropriate.

> To support community health we need to create healthy communities.

Conceptually, the shift to community entails that the health of individual be valued in the context of their everyday lives. Community as place of residence is relevant here in terms of the influences on health that come from the kind of housing, the kind of neighbourhood, the kinds of local relationships, the kind of physical environment in which a person lives. People also live in various "communities of interest", the work community being especially important, but also recreational and other "social" communities. (also see Appendix A) The range of influences on their health that people encounter in their everyday lives is too broad to be encompassed by the traditional health care system.

The determinants of health approach entails that improving community health requires creating healthy communities. OPHA believes that creating community contexts in which health can flourish is preferable to temporarily rescuing people from their unhealthy circumstances through the traditional health care system. To cover the range of influences on health encountered in people's lives therefore requires that the health consequences of any activity should be taken into consideration. OPHA thus endorses as a policy for health, "healthy public policy", i.e., that the health consequences of activity in any policy sector, be it transportation, environment, or industry, be taken into consideration when designing policy for that sector. The policy decisions taken in any sector will influence the creation of health-promoting conditions of society. Conversely, no amount of investment in the traditional care system will serve to remedy the consequent ills of unhealthy conditions.[8]

> To support health equity through health reforms we need to promote the democratization of health policy **making and fundin**g.

Health Policy

While there seems to be general appreciation that the "conditions of life" can foster health or illness, [9] the public still seems to equate illness care and the availability of doctors and hospitals with health care and is subject to scaremongering media campaigns that play upon fears of sickness and death. OPHA's position on the shift to community health entails that community concerns around illness care must be taken seriously. Especially under conditions of fiscal crisis, there is need for a legitimate process to allocate resources appropriately and equitably. This in turn entails a democratization of the processes of health policy-making and funding, in which communities participate in the decisions affecting them.

Within Ontario, this could be realized in a variety of ways, such as better utilizing existing Boards of Health and District Health Councils, in requiring that new health services have community boards and that existing services such as hospitals demonstrate community participation in their board and committee structures.[10] Community Health Centres already provide one example of increased community participation in decision-making. At the same time, it must be recognized that communities often have been excluded from decision-making, especially in an area such as health that has been the assumed purview of experts.

To enable community participation requires sensitivity to the information and process needs of community members and attention more generally to building the capacity to participate effectively. These things are part of a commitment to community development and empowerment with respect to health issues, a commitment which stems from the community values endorsed by OPHA of respecting individuals while supporting collaborative action.[11]

and Fiscal Policy

At the general policy level, however, it is OPHA's position to argue for a critical dialogue about the real determinants of health and illness such that informed decisions can be made on whether and what kind of illness care is appropriate. Currently there exists and imbalance between the funding of institutional care and community care. Public spending on health promotion and disease prevention is a small fraction of what is devoted to the treatment of sickness, and this consumption of health care uses up resources that could be used to address other factors.[12] The public may be unaware of or misunderstand the sources of this cost of illness care. Given evidence on the determinants of health and continuing counsel to shift the system emphasis to health promotion and disease prevention, OPHA believes that illness care should receive a lesser proportion of health funding. In keeping with community values of participation and collaboration, however, this decision should be taken on the basis of critical community dialogue about the kind of services that are appropriate.[13] Wider dissemination of the concept of and evidence relating to the determinants of health is necessary to inform the community dialogue, to make it critical.[14]

> To make our communities health promoting
> we need to support healthy community services
> and healthy services providers.

There is already a range of community health programs that community input could enhance,

tailoring the programs to the needs and resources of the community. This means that planning and program linkages may be appropriate across a number of pre-existing health and community services, but also that the "primary (informal) caregivers", the families who provide care for their members, also be linked into and supported in the planning as well as the provision of service. The present political and public finance climate can easily mean that services are "off-loaded" to families under the guise of community-based care and self help.[15]

The principle OPHA endorses is to recognize the strength of community resources as evidenced in voluntary activity and family care, but to support such activities publicly and professionally. The services appropriate to a particular family may extend beyond the boundaries of traditional health services, hence the emphasis also on linkages across a variety of health and community services in the planning and provision of care.

Therefore, from OPHA's perspective, the shift to community care is not only about providing hospital services or treatments in the home, although there may be circumstances under which these are wholly appropriate. Rather, it entails a philosophical shift, a commitment to certain values believed to be both humane and practical.

The public and professional support of community-based health requires that programmes and services are collaboratively linked to prevent gaps and reduce duplication: the objective is to provide "seamless", appropriate support for health and illness care activities. On the basis of its community values, OPHA endorses a shape of community health that is democratized and empowering. For example, this means that community health care needs to be accountable and responsive to community need, rather than rule-bound, standardized, and bureaucratic. This calls for linkages among sectors at the policy level as well as at the service and practice or clinical level.

Such linkages are facilitated by shared language and concepts across sectors and services, but also by shared commitments to a certain kind of professionalism and service delivery.

Currently, the crisis in funding seems to be exacerbating "turf wars" among and within varied health agencies. A recent document articulated the impact of this tension, particularly when employment is at risk. While it is not from Ontario, it could be:

> In some communities lay people are unaccustomed to taking control of health issues, and have allowed health care and health administration professionals to dominate the process rather than provide technical assistance to it. If given the opportunity, health workers will assume this role, out of self interest as well as a sense of their traditional responsibilities for health care planning. Unfortunately this further undermines the community development process, and hinders movement toward a new partnership between health workers and the communities to which they are accountable.[16]

OPHA values inclusiveness, collaboration and shared decision-making.

OPHA's community values of inclusiveness and support entail a kind of professionalism and service delivery that emphasizes collaboration and shared decision-making. Health care professionals require technical skills beyond reproach, but the best end to which those skills are put should be in service of the needs identified in collaboration with the community, family, or individual. This describes a kind

of community practice that involves viewing clients and the community as participants in the determination of important aspects of service provision, that addresses health issues on a community or collective rather than strictly individual basis, and that recognizes the value of community resources in the provision of services.[17] At every level, including the individual client, the values of inclusion, support, and collaboration should be evidenced in the ways a client is supported in his or her quest to maintain and enhance health rather than merely to comply with professional directives. In enabling the informed choice by the client of the options that best suit his or her ends in the context of a determinants of health framework, recognizes the variety of health influences on an individual.[18]

> To make our communities health promoting
> we need to create health in the context of
> supporting the determinants of health.

Health professionals will find it difficult to move from institutions to the community without retraining to develop the approach required for working in community-based settings. A determinants of health perspective is required to appreciate the social, economic, and environmental influences on individual and community health, a perspective that has been neglected in the education of many traditional health care professionals; nor has a community practice approach, with skills in community mobilization, social support, policy development, even media relations, been considered essential in their training. While a new philosophy of professionalism is necessary for community-based care, there are existing models that support this transition.[19] For example, if institutional health care nurses are to be re-located into community care, public and community health nursing may be a model on which they can be re-trained.[20]

Therefore, people who are active in community and public health throughout Ontario need recognition of their impact on community health and support (policies, structures, and training) to match their dedication and professionalism. Workers and communities need assurance that provincial and educational institutions, in partnership with the provincial government, are keeping pace with change and planning for the future. Reform must challenge health professions to re-educate and re-orient current and future members to community development, health promotion and primary prevention. The required changes are more profound than merely adopting the rhetoric of health promotion or relabelling programs that perpetuate “business as usual.”[21]

> To serve community health we need to acknowledge
> our own power and be prepared to share it
> through information and research.

The shift to community care also has consequences for research and information. There is much expected of community members under the shift, not the least of which is that they be sufficiently knowledgeable to engage in critical dialogue about values, effectiveness, priorities and planning. This requires that information be accessible and ‘user-friendly”, not another source of professional distancing.

There is much expected of health workers under the shift, not the least of which is that they too be sufficiently knowledgeable to engage in critical dialogue about values, effectiveness, priorities and planning. As knowledge workers, health professionals are more familiar with technical, theoretical, and research material than other community members may be. Nonetheless, there are research and information needs that are unfulfilled even among people who work with research and information on a regular basis. While the shift to community is based partly on evidence about service cost effectiveness, there is still a relative lack of research to demonstrate the efficacy of different procedures, technologies, and programmes, and strategies in both health promotion and illness care. Evaluation of institutional and community practices is necessary to inform the critical dialogue about what services and actions are most conducive to desired health ends.

Yet, more fundamentally, the shift to community entails different kinds and conduct of research. More attention is required to the relations between environments and health and illness, to the "ecology of health and illness" as suggested by a determinants of health framework. Social scientists studying health and illness are familiar with the intertwined social, environmental, and biological factors that contribute to health outcomes, but such a perspective has been resisted by medically-oriented investigators. If social factors are considered, it is often "lifestyle variables" such as smoking that receive attention to the neglect of social or community structures that are primary influencers of these same lifestyle "choices". There appears to be a strong tendency to look for lifestyle explanations for social differences in any context, in a way that transfers the responsibility for solving health problems from society to the individual.[22] At the same time, research regarding the effectiveness of interventions at the level of the individual may attend to some "objective" outcome measure to the neglect of the outcomes relevant or meaningful to the person in question. Thus, longevity rather than quality of life has been the preferred measure of traditional research, even though the extent to which an individual or community can satisfy needs and realize their unique aspirations is the health outcome of importance entailed by the positive definition of health.[23] A determinants of health approach also requires historical and longitudinal studies in order to reveal health effects that emerge over the course of life.[24]

Inherently, most research designs, whether in the social or biomedical sciences, start with the researcher in control of how the research should be conducted. The community values of inclusion and collaboration endorsed by OPHA, however, require that community-based research be conducted in a way that engages the community in a meaningful way. In addition to casting a wide data net to gather information about the social and environmental determinants of health and illness, community-based researchers should be willing to give up sole power to decide what questions are asked, what data are collected and how they are collected and interpreted, and be willing generally to be "on tap, rather than on top" in the research process.

Community participation may be encouraged by giving prominence to the views of service consumers in programme evaluation, in consulting communities about research agendas, in reporting findings to the community, and in encouraging communities to conduct their own research. Community-based research conducted in this manner can contribute to the desired shape of the shift while providing information of practical relevance to communities and community health workers.[25]

CONCLUSION

The shape of the shift to community health discussed here is based on community values of inclusion, support, and collaboration in the context of publicly funded system. The discussion has been informed by a broad definition of health and a determinants of health perspective that is consistent with, but extends, the activist tradition of public health. OPHA's policy on health reform is consistent with the most recent version of the public health tradition, sometimes called "the new public health", that emphasizes the health of people in their everyday lives, the is concerned with the effect of social and economic conditions and relationships on physical and mental health, that extends health promotion activities beyond formal health services, and that operates on principles of empowerment and community development.[26] This perspective is distinct from one that would off-load public services to individuals and communities, that is disease and acute intervention oriented, that retains service delivery and professional hierarchies. Different values and languages exist in the health field and challenge meaningful collaboration among health workers and agencies with these different philosophies.

For OPHA to be explicit about its vision of the shape of the shift, however, enables people who are active in community and public health throughout Ontario to anticipate and understand conflicts, to gauge the progress of health reform, and to inform their own practice. If community and public health workers in general, and OPHA in particular, are clear on their values and commitments, then the present crisis may well be the opportunity to re-invent its public service, to influence the shape of the shift to community health, and to contribute to the kind of society in which we want to live.

APPENDIX A

The notion of "community"

It must be recognized that the notion of "community" has two different dimensions, the descriptive and the evaluative. Communities have been described in different ways, as places or localities and a communities of interest, of shared beliefs or shared values. Generally it may be said that the value of community relates to the need or desire of people to live in more intimate relationships with each other, to be rooted, to feel a sense of belonging and security. Modern, urban society on this account is too isolating and bureaucratic. The shift to community care thus includes a value dimension that seeks to develop community where it presently exists only tenuously. Such a community may or may not overlap with any geographical locality.

But the value dimension of "community" also varies. Communities may be hierarchical in their status and power relations, with little physical or social mobility and entrenched, traditional values. Communities may also be based on co-operation and participation, they strive to be egalitarian while still accommodating individuality.[27] Communities can be related to the wider public sphere in different ways also: on one hand, the presence of government services is considered to be an intrusion of last resort to be minimized through community self-reliance; on the other hand, government services are considered to be essential to extend and support the ability of communities to care for themselves as they see fit. Given these variations within a theme, it is little wonder that "the shift to community" may be fraught with difficulty.

ENDNOTES

1. Ehrenreich, John (1982). "Toward a healing society", in Ellen Frankel Paul and Philip A. Russo, Jr. (eds.), Public Policy: Issues, Analysis, and Ideology. Chatham, New Jersey: Chatham House Publishers; p. 196.

2. An extensive literature exists on the social determinants of health, one of the most striking, consistent findings being the direct relationship between socio-economic status and virtually all health outcomes. Wilkins, R. And Adams, O. (1983) "Health expectancy in Canada, Late 70s", American Journal of Public Health 73(9): 1,073-1,080, is one example from Canadian data. Carol Buck, (1985) "Beyond Lalonde - Creating Health", Canadian Journal of Public Health 76 (May / June) Supplement one: 19-24, for example, identifies social and physical environments as essential determinants of health and disease. The Premier's Council on Health Strategy has published a convenient overview on the determinants of health, entitled Nurturing Health: A Framework on the Determinants of Health (March 1993).

3. To account for historical changes in mortality and life expectancy is more difficult to determine than the glib attribution to "improvements in medical care" would suggest. Thomas McKeown 1(1976) The Modern Rise in Population. New York: Academic Press], attributed 70 to 75 per cent of the gains in life expectancy from the early 1800s to the 1970s to factors associated with increased prosperity, identifying improved nutrition as especially important. Simon Szreter, however [(1988) "The importance of social intervention in Britain's mortality decline c. 1850-1914: a re-interpretation of the role of public health," The Society for the Social History of Medicine 1(1): 1-41] re-interpreted the same epidemiological evidence and found that the public health movement and its locally administered health measures made important contributions to the decline in mortality over the early modern period.

   While medical intervention is obviously life-saving in some acute instances, its effect on population health measures is more difficult to determine. John B. McKinlay et. al, [(1989) "A review of the evidence concerning the impact of medical measures on recent mortality and morbidity in the United States", International Journal of Health Services 19(2): 181-208] argue that medical measures and the presence of medical services were not primarily responsible for the modern decline in mortality in the United States and elsewhere; they emphasize instead public health measures. Johan P. Makenback et. al. [(1989). "The contribution of medical care to inequalities in health: Differences between socio-economic groups in decline of mortality from conditions amenable to medical intervention", Social Science and Medicine 29(3): 369-376], however, suggest that medical intervention has had an effect discernible at the population level on those conditions amenable to medical intervention. Determining which medical interventions are effective is itself a challenge, with an estimated 80% of medical therapies never having been rigorously evaluated (Michael Rachlis and Carol Kushner [(1989). Second Opinion. Toronto: Collins Publishers). The point to be made in this endnote, however, is to give public health measures their due credit.

4. Personal behaviours do not exist in isolation, but are related in complex ways to the social and economic structure and the constraints of daily life (Martin and McQueen, 1989: 6).

   Martin, Claudia, and McQueen, David (1989). "Framework for a new public health", in Claudia Martin and David McQueen (eds.). Readings for a New Public Health. Edinburgh: Edinburgh University Press, 1989: pp. 1-10.

See also, Marmot, M.G., Kogevinax, M., and Elston, M.A. (1987). "Social/economic status and disease." Annual Review of Public Health 8: 11-35; and Lindhelm, Rosaly, and Syme, Leonard (1983). "Environments, people, and health," Annual Review of Public Health 4: 335-59.

5. The principles can be summarized as follows:

   Universality: all Canadians are entitled to health insurance;

   Accessibility: all Canadians are entitled to health insurance without financial or other barriers.

   Portability: a Canadian can obtain health service in any province without charge;

   Comprehensiveness: all Canadians have health insurance which covers a comprehensive range of medically necessary health care services; and

   Public Administration: health insurance is administered by a public agency on a not-for-profit basis.

6. Public health in Ontario has long sought to combine service and advocacy. See Heather MacDougall (1990) [Activists and Advocates. Toronto: Dundurn Press] for an historical account of the City of Toronto's Department of Public Health.

7. These principles appear in the long-term care redirection and mental health reform as described in the January 1992 Ministry of Health Working Document on Goals and Strategic Priorities.

8. Perfectly healthy conditions are infeasible, as health ecologists such as Dubos pointed out years ago (Rene Dubos (1959). Mirage of Health. Garden City, N.Y.: Anchor Books). Nonetheless, the environments of helath significantly determine health experience, and continuing emphasis on traditional curative practices can produce a diminishing return on health investment, if not actually reducing resources that could be used to address other determinants of health. See Robert G. Evans and Gregory L. Stoddart (1990), "Producing Health, Consuming Health Care", Social Science and Medicine 31(12): 1347-63.

   A metaphor for the practice of medicine has become that of practising artificial respiration beside a river in which drowning people are continually flowing by. As one victim resumes breathing, or not, another is immediately brought for aid. The point is that rescuers are so busy dealing with the acute situation that no attention is paid to how the victims got into the river in the first place. As Michael Rachlis and Carol Kushner (1989) [Second Opinion. Toronto: Collins Publishers] write, the rescuers are completely exhausted by the side effects, the pushing into the river, of our society and culture, and it is time to refocus upstream to prevent people from falling or being pushed in the first place.

9. As evidenced by the results of series of consultative provincial workshops conducted across Canada under the title of Strengthening Community Health Services. See the 1987 Report from the Canadian Public Health Association entitled Strengthening Community Health Means Strengthening Communities.

10. This latter recommendation was included in "Into the 21st Century: Ontario Public Hospitals", the Report of the Steering Committee, Public Hospitals Act Review, released in February 1992. Douglas E. Angus and Fran Managa (1990), in Co-op/Consumer Sponsored Health Care Delivery Effectiveness, the report of research managed under the auspices of the Canadian Co-

operative Association, recommend community based and controlled organizations, especially Community Health Centres, as the service delivery agency of choice on the basis of a number of selection criteria, including cost effectiveness, range of services, quality of care, and community involvement. They write (p. 49):

> Community involvement is also critical in the planning of health services, especially regarding the need to include user perspectives in decisions that may affect them. As pressures on limited resources continue to increase, effective participation from the clients and community served is increasingly essential to the planning and provision of appropriate delivery of required services.

Community-based care in this case does not refer merely to the location of services, but to the kind of values incorporated. While co-op and consumer sponsored services compare favourably with Health Service Organizations (HSOs) and fee-for-service private practice, they are clearly superior with respect to the community values of inclusion and collaboration.

11. Community development is a process characterized by a partnership within a community of interest or locale, that mobilizes the resources and skills of the community to build strengths, self-sufficiency and well-being.

    Community development involves people associated with a community in a process to:
    - identify issues and problems affecting community;
    - develop plans, skills and capabilities to act on concerns;
    - determine what resources are available and required; and
    - implement plans for change, through commitment and action.

    From Alison Stirling and Stefa Katamany (1989). “Implications of Community Development for Public Health Practice.” Paper presented at the 80th Annual Conference of the Canadian Public Health Association, Winnipeg, Manitoba, June 21, 1989.

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    > The important thing is to help men [sic] (and nations) help themselves, to place them in consciously critical confrontation with their problems, to make them agents of their own recuperation.
    >
    > And this, I would argue, is the alternative to “delivery of service” in human development fields: making sure that whatever program of action is implemented on behalf of perceived human needs becomes a vehicle designed, constructed, and piloted by those being served. It is the alternative called “empowerment”.
    >
    > Simply stated, “empowerment” means helping people take charge of their lives, people who have been restrained, by social or political forces, from assuming such control heretofore.

    From Robby Fried (1980). “Empowerment vs. Delivery of Services” Published by New Hampshire State Department of Education, Office of Community Education, 410 State House Annex, Concord, NH 03301, October 1980.

12. Whether resources freed up illness care would be used to address the determinants of health would be determined partly by the values mentioned previously about the role of government in creating health-supporting social conditions. See Robert G. Evans and Gregory L. Stoddart (1990),

"Producing health, consuming health care", Social Science and Medicine 31(12): 1347-1363, for a discussion of the conceptual frameworks for conventional care and a determinants of health approach and the trade-offs between them.

13. The objective of the Oregon Basic Health Services Act is to make health care available equitably and according to need. To this end, Oregon developed a public decision-making process to determine a rank ordering of services on the basis of cost / benefit ratios and public values about the relative importance of services. This ordering was then used to determine governmental resource allocation decisions. There have been criticisms of the Oregon process, that its public involvement was not representative, for instance, and that it did not address the wider issue of public versus private health care delivery, but it is one example of an effort to set explicit public priorities by which resource allocation can be made publicly accountable.

    See Mark Gibson (1991), "Oregon Medicaid Demonstration Project". Paper presented at "Health Care and the Public: Roles, Expectations and Contributions", the 4th Annual Health Policy Conference, organized by the Centre for Health Economics and Policy Analysis, Hamilton, Ontario, May 23-24, 1991.

    See also Lisa Priest (1993), "Canada eyeing Oregon health plan"' The Toronto Star Saturday, September 18, 1993: pp. B1, B4.

14. Rachlis and Kushner (1989), Second Opinion, is one example of an accessible, critical discussion of health care drawing concepts of determinants of health and healthy public policy.

15. Martin Mowbray (1983), "Location and Austerity: The political economy of community welfare services", Community Development Journal 18(3): 238-246, discusses examples from Australia in which an emphasis on local service control and management is consistent with the perspective of the new Right and other governments committed to the containment of social expenditures. Frances Baum (1990), "The new public health: force for change or reaction?", Health Promotion International 5(2):145-150, also warns that the rhetoric of community involvement can obscure right wing political agendas.

16. This is an excerpt from a paper entitled "Critique of Health Reform" by the Saskatchewan Public Health Association, 1993.

17. Hugh Butcher (1986), "The 'Community Practice' Approach to Local Public Service Provision - An Analysis of Recent Developments", Community Development Journal 21(2):107-115, discusses the promises and pitfalls of community practice in the provision of welfare services in England and Wales.

18. One way in which the relationship between clinician and patient has been characterized is that of the relationship between problem solver and decision-maker. Problem solving requires expert knowledge to structure the problem, to know what the alternatives are, and to know how likely each outcome is under the given circumstances. Decision making requires problem solving as an important component, but also involves making trade-offs in selecting what an individual would like to do under a particular set of circumstances. While a health care professional can help to solve a problem, only the patient can make the decision about what value he or she will place on a particular outcome. The so-called facts are seldom if ever sufficient to decide a course of action for an individual; rather, the interpretation of and values that a person applies to "the facts" will decide the action correct for that person. See Raisa Deber (1991), "Information for the patient". Paper presented at "Health Care and the Public: Roles, Expectations, and Contributions", the 4th Annual Health Policy Conference, organized by the Centre for Health Economics and Policy Analysis, Hamilton, Ontario, May 23-24, 1991.

19. For example, see Halbert, Tracy L. et al. (1993). "Population-based health promotion: A new agenda for public health nurses", Canadian Journal of Public Health 84(4):243-245.

20. The interdisciplinary and collaborative requirements of community care have consequences for professional training. Traditional professional status, roles, and demands cannot be maintained under conditions requiring close cooperation. Reprofessionalization along lines that facilitate teamwork is more appropriate to community

care than are traditional hierarchies and should be encouraged at the basic level of education. (Peter C. Hexel and Helmut Wintersberger (1986). "inequalities in Health: Strategies". Social Science and Medicine 22(2): 151-160) the Canadian Health Coalition has suggested that all health providers take their first year of education together in an generic curriculum, a proposal that could contribute to health care reprofessionalization.

21. This is an excerpt from a paper entitled "Critique of Health Reform" by the Saskatchewan Public Health Association, 1993.

22. See Clyde Hertzman (1990), "What are the Differences which Make a Difference? Thinking about the determinants of health". Paper presented at "Producing Health: Implications for Social Policy", the 3rd Annual Health Policy Conference, organized by the Centre for Health Economics and Policy Analysis, Niagara-on-the-Lake, Ontario, May 23-25, 1990.

23. With respect to the evaluation of services, Butcher (see Endote 17) contends that questions of effectiveness can rarely be tested through straightforward comparisons between the outcomes of traditional and community-practice approaches to service delivery because the claims of community-practice effectiveness may relate to a different set of outcomes. Identifying and clarifying the aims and values that lie behind different service delivery approaches and their respective desired outcomes thus becomes a prerequisite to sound evaluation.

24. Clyde Hertzman and Michael Hayes (1992), "Putting up or shutting up: interpreting health status indicators from an inequities perspective", in Hayes, M., et al. (eds.) Community, Environment and Health. University of Victoria Geographical Series, vol. 7, propose an approach to the investigation of health status that emphasizes the deeper structures of society whose transformation, over the long-term, will likely have the most significant impact on health status.

25. Frances Baum (1988). "Community-based research for promoting the new public health", Health Promotion (now Health Promotion International) 3(3):259-268.

26. See Claudia Martin and David McQueen (eds.) (1989). Readings for a New Public Health. Edinburgh: Edinburgh University Press.

27. See Raymond Plant (1974). Community and Ideology: An Essay in Applied Social Philosophy. Routledge and Kegan Paul.