HEALTH AND ILLNESS IN A SOCIAL CONTEXT

The theoretical framework in which people and their health are seen within the context of their social relationships rather than as carriers of particular risk factors

The community development worker is working with communities which are powerless and excluded

Isolation and alienation influence health in many ways including low self-esteem, depression and extreme risk-taking.

The causes of many illnesses, especially the so-called 'life-style' diseases, are deeply embedded within the way society works.

Wealthier people can buy a safe living environment. People in poverty can not.

Community Development in Health

Health and Illness in a Social Context and the Role of Community Development

This Paper was prepared by
the Community Development in Health Project during 1988
through a process which involved the circulation of several drafts
and continuing discussion with community workers in the health field.
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1. INTRODUCTION

Blue collar workers have higher mortality rates than business and professional people and their take-up of health promotion messages is generally slower. Women report particular frustrations in relation to the health care available to them. Aboriginal people have worse health outcomes than does the broader Australian community. The wide variations which persist between the health experience of different social, economic, racial and ethnic groups present some of the most difficult problems in public heath policy today.

Being poor and unable to buy a safe living and working environment or unable to purchase appropriate health care is only part of the story. More fundamental are the ways in which health and sickness are embedded within the cultural and social context of people's lives.

The concept of community development encompasses a cluster of theoretical understandings, field of practice with its own skills and strategies and a set of core values.

Community development in health is based in a theoretical framework in which people and their health are seen within the context of their social relationships rather than as carriers of particular risk factors (such as smoking or their uptake of Pap smears). In this framework, poorer health outcomes are recognised as being linked to alienation and powerlessness; having a sense of not belonging to the broader society, a sense of not having much control over one's destiny.

As a set of practical strategies, community development involves working in a way that facilitates people and communities developing their strength and confidence whilst concurrently addressing their more practical and immediate problems. For example, a community development project with a health education focus will also have regard to the developmental process which accompanies the project. Is it experienced as exhortations and pressures coming from outside; yet another example of the control exercised by 'them', 'out there'? Or is it associated with local people finding out things that they want to know about, taking control, building their community? In community development, the recognition of these developmental issues is as important as the more immediate practical outcomes (in this case, information transfer).

The core values, which we believe are intrinsic to community development work can be expressed in terms of working towards a society which is more sharing of its resources; in which opportunities for personal fulfillment are more evenly spread; in which personal fulfillment is seen more in terms of being contributory and creative rather than simply in terms of status and material possessions; in which individual and collective contributions are appreciated, in which as individuals and groups we have a maximum degree of control over the circumstances of our lives.

2. HISTORICAL OVERVIEW

2.1 The Third World

The community development concept was first articulated widely in the context of aid programs in third world countries. It was, in part, a response to the failures of top down development programs promoting, for example, birth control or new farming practices. Instead, advocates of the community development approach suggested working with identifiable communities, starting from where they were at, helping them to recognise the causes of their poverty, assisting them to struggle for their own development in accordance with their priorities.

This was quite a challenge for the western development experts. Instead of seeing the problem in technical terms, for example, contraceptive technology or new seeds and fertilisers, the community development approach focussed attention on the social relations of underdevelopment, for example, the role of the money lenders and landlords rather than the need for new miracle seeds.

Newell has expressed it in terms of the relationship between health problems and rural hopelessness:

"The relationship between rural hopelessness and health is a complex one. Ill health adds to hopelessness but its removal does not mean that there is hope..... The problem and the priority have to be the total rural hopelessness complex and not just ill health. We are only slowly beginning to understand that people themselves are aware that health may have a low ranking among the starting points for change."2

In recent years there has been an international push for greater use of 'health auxiliaries' in Third World countries as part of a move to more 'community oriented' health care. However, as David Werner has pointed out, the role that such auxiliaries actually play varies widely:

"While in some of the projecJs we visited, people were in fact regarded as a resource to control disease, in others we had the sickening impression that disease was being used as resource to control people. We began to look at different programs and junctions in terms of where they lay along a continuum between two poles: community supportive and community oppressive."

"Community supportive programs and junctions are those which favourably influence the long-range welfare of the community , that help it stand on its own feet, that genuinely encourage responsibility, initiative, decision making and self reliance at the community level, that build upon human dignity."

"Community oppressive programs and functions are those which, while invariably giving lip service to the above aspects of community input are fundamentally

authoritarian, paternalistic or are stmctured and carried out in such a way that they effectively encourage greater dependency, servility and unquestioning acceptance of outside regulations and decisions; those which in the long run are crippling to the dynamics of the community."3

2.2 Urban Problems In Industrial Society

Community development ideas came into prominence in the industrialised countries during the early 1960s, for example in the United States, as part of the Great Society Of the Kennedy/Johnson era.

"..... two common themes emerge as baving stimulated the post-war growth in community development as a planned method for meeting people's needs and solving social problems. These were the isolation and alienation of people from the societies in which they lived and the need for better personal social services." (Raysmith and Einfeld)4

In Australia, the outstanding landmark in the community development field was the Australian Assistance Plan, established under the Whitlam Government from 1973. The Australian Assistance Plan raised the profile of community development as a perspective and as a strategy. It contributed greatly to a wider understanding of the principles and some of the controversies in the field. 5

The growing appreciation, in Australia, of the possible contribution of community development in health commenced with the Community Health Program 6 although the 1973 Program Statement did not, in fact, identify community development among the objectives of the Program. Nevertheless, the provision of funding for salaried, multidisciplinary, community health services, with opportunities for consumer and community involvement and employing some staff, such as social workers, who had as undergraduates been introduced to the concept of community development, provided the conditions within which the relevance of this approach in the health field became more widely recognised.

During the 1970's there evolved an increasing consciousness within the community health field of community development as an approach to health issues; as a stream of community health work. By the early 1980's this stream had developed a degree of self-consciousness which perhaps could be recognised as a 'movement', rooted within the practice of community health.

During the mid 1980's community development became recognised at the level of government as an important program element in addressing priority health problems. Examples of this recognition in Victoria include the District He.alth Councils Program, the Self Help Funding Program and the community resource workers of the Victorian Drug and Alcohol Program. At the Commonwealth level the possible contribution of the community development approach has been recognised in the Better Health Commission Report and the Health For All Australians Report.7

2.3 The New Public Health

During this same period in which community development ideas have become more widely recognised within the health field, there have also been important developments within the public health tradition, symbolised by the growing movement towards a 'new public health'. The adjective 'new' serves to distinguish it from the 'old public health' which developed during the classic period of the 19th century and which has continued to provide the intellectual and ideological framework for most epidemiological research and public health programs up to the present time.

The World Health Organisation has played a leading role in articulating and promoting the 'new public health'. The International Conference on Primary Health Care, held in 1978 in Alma-Ata, ended with a Declaration 'that the health status of hundreds of millions of people in the world today is unacceptable' and it called for a new approach to health and health care, to achieve a more equitable distribution of health resources and to 'attain a level of health for all the citizens of the world that would permit them to lead a socially and economically productive life.' 8

The Declaration recognised that inequalities in health are rooted in the way the whole society works, economically, culturally and politically and called for collaboration across all sectors as part of a new vision of 'primary health care'.

Following the call of the Alma-Ata Conference the World Health Organisation launched its Global Strategy for **Health For All by the year 2000** in 1979.9 The Health For All slogan aims to focus attention on the inequalities in health and on the goal of 'bringing health within reach of everyone ... including the remotest parts of the country and the poorest members of society'.

The next major landmark was the 1986 Ottawa Conference on Health Promotion which produced a Charter which defined Health Promotion as including:

- building healthy public policy,
- creating supportive environments,
- strengthening community action,
- developing personal skills, and
- reorienting health services.

Some of the concepts of the 'new public health' are converging towards the community development approach but there are significant institutional constraints on the way in which these ideas have been formulated and implemented. We will return to discuss the significance of the new public health shortly.

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3. THE OLD PUBLIC HEALTH TRADITION

The introduction of community development into the health sector and the advent of the new public health has been accompanied by some tension between these ideas and the very different perspectives which we have inherited from medicine and traditional public health about how we should understand health and illness in society.

It is necessary perhaps to define two perspectives for the purposes of description: the individual responsibility perspective and the (old) public health perspective. Both viewpoints arc alive and well in Australia today.

3.1 Individual Responsibility

According to the individual responsibility perspective, the conditions for good health arc all widely available in our society: adequate food and shelter, a high standard of public health protection and sufficient knowledge about healthy behaviours. It is largely a matter of personal choice as to whether people look after their health properly. This view assumes as inevitable the economic and social inequalities which affect peoples' health chances.

In conventional clinical settings also, the main focus is usually on the illness, within the individual. As a corollary, clinical attitudes to health are also built around the role and the risk behaviours of the individual. This perspective dominates the culture of the hospital and clinic. It is not simply that doctors are conservative; the individual view of health corresponds to the daily experience of the clinician. The clinician sees illness as individual episodes with urgent pressures for immediate action. Whether or not she or he recognises the broader social determinants of health, they arc regarded as immutable within the context and timescales of the clinic.

3.2 The Public Health Perspective

The **public health perspective** contrasts sharply with this conventional 'clinical' model of health. Within the public health tradition social influences on health arc recognised and policies to address them arc advocated. Public health is generally associated with the triumphs of the 19th century 'sanitary revolution': sewerage and fresh water (amenities which have yet to reach the bulk of the world's population). However, the old public health tradition still provides the theoretical framework within which modern health policy approaches to contemporary heath problems arc still based.

In the rapidly growing cities of Australia during the 1880's there were recurring public health problems, particularly in relation to housing, water supply, sewerage and drainage. For families living in overcrowded and unsanitary conditions the health hazards of the physical environment were only too evident. They were evident too, to the public health reformers who generally lived in more salubrious circumstances themselves, but were concerned about the living circumstances of the poor, in particular, recent immigrants, the aged and families without bread winners.

The key to the public health perspective was scale. The reformers were able to recognise causative processes across longer time frames than one illness episode and ecological systems operating at a greater organisational scale than that defined by the human body.

The science of epidemiology developed hand in hand with the advance of public health (indeed, their practitioners were often the same people). The epidemiologists documented the spread of illness within populations (rather than within the individual) and developed new ways of thinking about illness as a product of populations interacting with their broader environment. The epidemiologists identified and measured causative factors in the individual and in the environment and the public health reformers sought to introduce corresponding reforms to control those factors.

3.3 The Conventional Strategies of Public Health

The public health tradition still provides the basic framework for public health policy today. There arc three main sets of strategies: education, the provision of additional services and legislation.

These three strategies still form the basis for responding to a wide range of contemporary health problems which are recognised within a broader social context.

3.3.1 Education

The educational approach has customarily provided the first line of defence. In the early years of the century it was education about hygiene. More recently it has been education regarding risk factors such as smoking, unhealthy diets, risk-taking behaviours etc.

Undoubtedly health education, aimed at changing people's behaviour has an important part to play in health promotion. Its effectiveness can be demonstrated with reference to a range of recent and current health education campaigns: Quit, breast self-examination, safe sex, wearing seat belts, etc.

The need for an increased emphasis on patient education is also becoming more widely recognised, particularly in relation to diseases such as diabetes and asthma and wherever complex treatment regimes arc necessary. The need for better patient education is argued within the health industry in terms of improving patient compliance and discouraging over-utilisation. From the patients' point of view, it is argued for in terms of the patient's right to know, the patient as an active participant in clinical decision making.

3.3.2 Services

In some situations the educational approach is inappropriate and the introduction of new services is called for.

In previous decades the main focus was on infectious disease and new service systems for screening and treatment or to deliver immunisation were introduced.

More recently tlle nuin focus has been on screening and early treatment of certain cancers (cervix and breast particularly).

3.3.3 Legislation.

The last fall back position in the old public health tradition has always been legislation. A large part of the history of public health reform during the last century is the story of the continuing fight for appropriate legislation (at the Stale level) to compel municipal councils to adequately police public health stand:mis and the struggles for similar legislation \Villi respect to occup::itional health lo require employers to provide their workers with safe working conditions.

The continuing relevance of the legislative strategy is evident in its many contemporary applications:

- compulsory scat belt wearing,
- compulsory blood alcohol testing,
- prohibition of tobacco advertising and of sale to minors,
- legislated complaints procedures,
- mancbtory food labelling.

4. UNDERSTANDING HEALTH AND ILLNESS IN A SOCIAL CONTEXT

This is the policy environment into which community development has been introduced during the 1970's and SOs. In seeking to fully understand the limits of the old paradigm and the contribution that community development concepts can make we will explore some representative problem areas to sec how they have been approached within the old public health tradition and lo explore the limits of that approach. We will also discuss briefly the relevance of the 'new' public health. In a subsequent section we will cnnsidc:r huw the concepts and the practice of community development can com plemcnt and extend the strengths and achievements of tile public health tradition.

4.1 The Prevention of Lite-Style Diseases

i'vlany illnesses arc preventable; many deaths arc deferrable. The causes of many illnesses, especially the so-called 'life-style' diseases, arc deeply embedded within the way society works. Any kind of preventive intervention will require an understanding of health and illness in its social context.

A basic theme within epidemiology is the discipline of tracing backwards the chain of causation, backwards in time and also within broader social processes; identifying causative factors which might suggest possible points of intervention.

Let us work through an example. A person with high blood pres.sure may be treated with tablets to decrease the likelihood of stroke. If we take a broader view however, we can identify other ways of responding to blood pressure and the risk of stroke: encouraging moderate exercise, perhaps working through some low salt recipes with that person's family. At a broader level we might aim to encourage the local council to build up recreation facilities and perhaps seek to encourage the local super-market to give prominence in its marketing strategics to low salt products. At a national level we might promote food industry policies designed to increase access lo lower salt foods on a society wide basis.

Each layer of the 'onion skin' involves understanding the problem and planning possible interventions on a larger organisational scale and within a longer time frame. The issue is not whether 10 use blood pressure tablets or to advise a low a s::ilt diet or to seek long term food industry changes. for the clinician, the issue is lo address this patient's present needs whilst recognising that helping that family to adopt a lower salt diet would help the patient (and perhaps the family) and recognising that changing the family's eating habits would be easier if healthier food industry policies were adopted. for the hospital or community health centre the issue is to deliberately allocate some resources towards longer term prevention as well as meeting the needs of current sick care. For guvernmcnt, the issues is lo find a balance between meeting current sick care needs and promoting a healthier society in future.

The blood pressure example is a good one because in many respects this package of mcasu res is gradually being introduced. As well as individual treatment and advice being provided in the clinic and public education and media publicity, governments arc introducing clearer food labelling requirements and food producers arc introducing low salt lines. [n the fourteen years, 1976-198·1 the stroke death rate (in Victoria) fell from 123 to 55 per 100,000 for men and from J!i8 to 79 for women.IO

In relation Lo ischaemic heart disease, another 'lifestyle' disease, a similar program of measures lu.s also been associated with a dramatic downturn in the death rates, in this case from 326 to 198 per 100,000 for males and from 216 to 139 for females.II

Unfortunately there is also good evidence that this sort of apprnach docs not touch all parts of our society with equal efficacy. In fact, the improvements in health tend to be focussed mainly among the more affluent parts of our community, those whose:: health was already better than average. The net effect, paradoxically, may be to increase Lhc inequalities in health outcome in our community. We will return Lo Llis question shortly.

4.2 Environmental and Occupational Hazards

It is self-evident that environmental and occupational hazards arise in a social context and that their control requires an understanding of that context.

Occupational injury and disease has always been a major concern within the old public health tradition. The public health reformers of the nineteenth century were vocal about the conditions in the mills and the mines, the long hours and the exploitation of children. Out of these struggles came the early legislative framework for the control of occupational hazards, the factory inspectorate and the development of minimum standards with legislative backing.

The health hazards of environmental pollution have also been a major theme of reform within the old public health tradition. From well before the triumph of germ theory it was evident to the public health reformers that environmental pollution (sewage, offal, etc) was a major source of human injury and disease.

During the twentieth century there have been significant developments in occupational health legislation (in particular, a partnership role for worker representatives) and in environmental protection legislation (for example, the environmental impact statement). In both areas the development of international law has influenced the control strategies somewhat. Both areas continue as major sources of health hazards.

There is no doubt that the production and controi of occupational and environmental hazards have to be understood in their social context. This has been recognised very clearly within traditional public health thinking.

However, there are some aspects of environmental and occupational health which are not handled comfortable within this traditional model. Most obvious amongst these is the reality of political and industrial power and buying power as key determinants of exposure to such hazards. We will return to these aspects shortly.

4.3 Social Isolation

Another perspective on the social context of health is provided by the concept of social networks. The influence of social networks on health and on sick care has been *more* widely recognised in recent times and has been the subject of considerable research.12 There is growing evidence that a supportive social network helps to prevent illness and facilitates recovery from illness or injury.

The most immediate social support for many people is from their spouse or partner. The health benefits of such support come in many ways: shared material resources, encouragement to look after each other's health, shared rituals such as prepared meals. Behind these practical helps is the added purpose and security in one's life associated with mutually supportive relationships. There is evidence of increased morbidity and death following widowhood and bereavement. Rates of illness and death are generally higher among separated, divorced and widowed persons than for people of the same age and sex.13

A familiar example of the value of social supports is in the recovery and rehabilitation phase of injury or illness. Whether or not previous 'preventive' interventions might have reduced the likelihood of a broken leg or a stroke, the person's recovery and rehabilitation will involve a great deal more than the professional services provided by the doctors and hospitals. For most episodes of 'patient care', the most active carer is 'the patient' themself, supported variably by family and friend'> and in some situations, by other local community services.

Stroke rehabilitation can be an example of active self-care, with family and community support, in partnership with the professionals. The quality of social networks may determine how quickly the stricken person is found and brought to hospital. (There may be a need for some vigorous advocacy to ensure admission to hospital.) Once the acute phase is over, successful recovery and rehabilitation will depend on having access to rehabilitative opportunities and having a supportive and encouraging network of family and friends. One of the most important factors will be the person's own determination to undertake the heavy personal workload involved in relearning the damaged abilities or learning how to compensate for their loss. One's social network is an important source of motivation in facing this challenge. Having something to live for, beyond the stroke, is closely related to the quality of one's personal networks, quite apart from their importance in providing practical help.

Improved understanding of the significance of social networks and social supports has accompanied the development of a wide range of home and community care services (such as home help, delivered meals, domiciliary nursing, community transport, etc) and special income support provisions which arc designed to complement and reinforce existing 'natural' supports.

However, why arc the existing 'natural' supports inadequate? Why do we need to complement and reinforce them? Some of the underlying trends and pressures which weaken the social networks within our communities are actually rooted in the way our economy operates and in the dominant cultural values of our society.

The requirements of industry for a mobile, high turnover labour force has led to the creation of suburban neighborhoods which have no shared history; communities in geographic terms but with few other links. The retail market continues to penetrate further into our lives; the more we depend upon the commercial marketplace for all kinds of goods and services, the less we are relating directly on a mutually supportive community basis. The dominant cultural values of our society (in particular, competitive achievement with respect to status and material possessions) also have the effect of alienating people from each other.

Addressing health problems in their social context should mean understanding social isolation and lack of

support within this broader economic and cultural framework and being able to address the underlying structural issues as well as compensating for lack of social supports. We will return to this theme.

4.4 Partnership in Sick Care

The experience of being 'a patient'; the nature of the personal relationships with various professionals is another important area which needs to be understood in its social context. There are different issues identified from several different perspectives.

From the point of view of many people who have played the role of 'patient' there are issues of respect and dignity which need to be addressed. More basic are questions about the role of the patient and their family (and other supports) in clinical decision making. Clearly, there are some situations (eg. anaesthesia) where the patient is totally dependent and immediate decision making lies with the professionals. There are other situations where patients can participate more fully in decisions about their care.

The situation tends to be viewed somewhat differently from the medicai point of view. Failures in the doctor-patient relationship are recognised as requiring attention. It is recognised, for example, that underlying many patient complaints are instances of misunderstanding; failures of communication which arc common enough to justify some sort of general response. The most common response is to advocate for more training in 'interpersonal skills' to be included in the medical curriculum.

Another set of problems are those which are defined (from the providers' point of view) as issues of non-compliance and inappropriate utilisation. Non-compliance refers to patients not carrying out the advice of their professional advisors: not taking medications, not following diets, not attending for preventive services, not returning for check-ups as advised. Inappropriate utilisation refers to behaviours such as coming to see one's doctor more often than need be or going to the casualty depanment for (what are viewed medically as) trivial complaints. A common formulation of this problem in the medical culture is that it reflects a need for better 'patient education' and improved communications skills on the part of the doctor (or other professionals).

Undoubtedly there is a need for improved patient education and perhaps improved training in communications skills for clinicians. However, there are also broader structural causes for failures in patient care and communication. To rely solely on initiatives which are focussed on the two central participants, without recognition of the broader social context, would reflect a narrow frame of reference.

5. CRITIQUE OF THE OLD PUBLIC HEALTH

It appears from these cases that the most basic limitation of the old public health model may be that it is does not facilitate an understanding of health issues in terms of social relations. This is evident in all the areas discussed above but we will analyse it in more detail in relation to the prevention of 'life-slyle diseases' or health promotion.

As a starting point we will examine the problem posed by the continuing existence of marked inequalities in health between different social and economic groups in society (and globally). This is a problem which the old public health has not addressed successfully.

5.1 Inequalities in Health

The existence of inequalities in health outcomes has been recognised for a long time. Some groups in society get sick more often than others. Some groups in society have higher death rates.

It is a paradox that the effectiveness of public health campaigns over the last two or three decades may have actually exacerbated existing inequalities in health, *due* to their having had a more marked effect in particular sections of *the* community.

Over the last thirty years there has been continuing public education about diet and heart disease. A gratifying downturn in total death rates from heart disease has been observed. However, it appears that this improvement has been most marked among the higher socio-economic groups.

The gap between the health status of higher social class males and lower social class males may have actually increased. During 1975 to 1977 heart deaths among Australian born working age men in labouring, production and process work occupations were 22% higher than the Australian average; for men in professional and administrative occupations they were 14% lower than *the* average.14

Similar findings apply in relation to a range of illnesses and risk factors.15 There has been a constant and vigorous public education campaign about the dangers of tobacco use. There has been *some* containment of the growth in lung cancer deaths. However, the improvements are not evenly spread. For one thing, decreased overall smoking rates have been achieved in men only. The situation in relation to women is more complex. While lung cancer death rates for men are static, and for some groups, falling, they arc still increasing for women of certain age groups. Between 1970 and 1984 the death rate (from lung cancer) among women increased from 8 deaths per year per 100,000 women to 14 deaths. In the same period the death rates among men increased marginally from 44 to 48 deaths per year per 100,000 men (age-standardisect).16

There are increasing inequalities among men as well. The decreased smoking rates are concentrated particularly in the upper socio-economic groups (increased give-up as well as decreased take-up). These trends are reflected in the death rates of different occupational groups. In

1975/77 lung cancer mortality among men working in labouring, production and process work was twice as high as for men in professional and technical jobs_17

The general pattern of continuing inequalities in health applies in relation to occupational and environmental disease as well as to 'life-style' disease. Whilst many of the 'old public health' hazards are now under control (for white Australia), there are a range of continuing environmental risks, some of which are universally shared (such as increased ultra violet radiation due to the depletion of the ozone layer). Others, however, are far from universally shared (lead exposure to inner suburban children, occupational hazards to blue collar workers, opportunities for environmental hygiene for homeless people, access to a healthy diet for people in poverty).

Generally speaking, wealthier people can buy a safe Jiving environment. People in poverty can not. Groups with high occupational status can demand a safe working environment. Workers in low paid, low skilled jobs are often forced to accept more hazardous environments. Groups with political power can achieve public sector controls over hazards of concern to them which can't be avoided privately or which wou Id be more expensive to avoid privately. Groups without power arc often unable to achieve adequate public sector control over hazards that arc peculiar to them. Groups with political power can succcssfull y defend their right to con tinuc to expose others to environmental health risks.

The old public health model docs not help us to understand the causes of inequalities in health, nor docs it provide strategics for addressing these problems.

5.2 Epidemiology As A Barrier To Understanding The Social Context of Health

It is a paradox that the most basic weakness of the old public health model is rooted in iL5 greatest strength, iLs base in science and epidemiology, tracing back and intcrru pting scientifically proven causal chains. This orientation prcscnLs a major conceptual barrier to understanding the social relations of health.

Epidemiology and the old public health rest heavily on the concepts of health hazards and risk factors. For the purpose of understanding causation and for designing preventive programs, health is seen as being determined by factors in the individual (such as genetic defects and lack of immunity) and factors in the environment (such as germs, poisons and radiation).

This practice of positing 'health hazards' and 'risk factors' is basic to the epidemiological method. Factors are proposed; research tools are designed to measure those factors; correlations are demonstrated. Where ever possible the factors are defined in the most objective terms so they can be measured reproducibly. Possible interventions arc evaluated in terms of their effectiveness in reducing the measured levels of the risk factors. This approach has proved to be immensely powerful in many respects. However, it is **incompatible** with understanding the social relations of health because, while it focuses attention on measurable, 'objective' correlates of human interactions, it steers attention away from personal and social relationships and from the subjective experiences which help us to make sense of those relationships.

In the mining industry the inhalation of dust is a very material health hazard which can be seen to be part of the mining process. The control of the hazard is a question of ventilation and engineering. Contrast this with stress as a 'hazard' of teaching. Stress is much more difficult to disassociate from the social relations of the class room. It is not a 'hazard' which can be isolated and controlled through an engineering approach without reference to its social context. Clearly, teacher stress is a product of the social relations in which the teacher is working. Is mining so different? It is clearly equally legitimate to define the industrial circumstances of the miners' employment as being the primary health hazard and the dust exposure as being secondary. In these terms we recognise the miners' health as being a function of the social relations of coal mining rather than the size of the dust particlcs_18

It is clear that *we* need to understand health in terms of social relationships and peoples' subjective experiences. The task, however, is not to throw overboard all the information and insights of epidemiology and public health but to map what is known within the epidemiology-public health paradigm into a framework which recognises social relationships and which allows for the insights of subjective experience. How could the hundreds of 'risk factors' of the public health paradigm be understood within such a model?

What is needed is a set of constructs which makes sense within both domains so that the information and experience of the old public health can be considered in terms of social relations and so that the insighL5 derived from personal experience (as well as from statistical tests) can contribute to improved public health.

5.3 Alienation and Powerlessness: Understanding Inequalities in Health

The concepts of powerlessness and alienation provide such constructs. Insofar as peoples' health experience is socially determined, the major influences can be recognised in terms of these two dimensions: powerlessness (versus being in control over one's life), and alienation (versus the experience of willingly contributing and being appreciated for the usefulness of one's contribution).

5.3.1 Being in Control of One's Own Life

The message of much health education is along the lines of: 'act now and you will be healthy later'. Many people's personal experience, however, is that no matter how much effort they put into acting for their future benefit they are swept along by greater forces (such as their

teachers or their employers or the economy). If one's personal experience is of having not much control over one's life, then 'act now, on the expectation of being healthy later' does not apply. On the other hand, if your experience is of making plans, acting accordingly and then in due course, enjoying the fruit of those plans, then 'act now, be healthy later' fits in well with one's usual expectations.

5.3.2 Competing Priorities

Another way of looking at this is in terms of the balance in a person's life between what you have to do on ·1e one hand, and your resources and capacities on the other. If one's current life pressures include unemployment and the threat of eviction, for example, then the distant future benefits of struggling to give up smoking would not justify a high personal priority for most people. On the other hand, if one has sufficient resources to be assured of personal and financial security and sufficient self esteem to *be* secure in oneself, then the next highest priority may well be twice weekly squash or a morning jog or avoiding low levels of electro-magnetic radiation.

5.3.3 Individual Experiences and Subcultural Expectations

The experiences of individuals of trying to control their life (and health) or of balancing health prioriti.es against other pressures and needs, feed into the expectations that prevail within the different subcultures of our community (eg. the various subcultures of youth, of the business world, of farming communities, of the inner or outer suburbs, of various groups of blue collar workers). The cultural expectations which prevail within these subcultures reflect the accumulated experiences of the individual members of each subculture.

In social networks in which the common experience is of not having much control over one's life directions, that experience becomes the common expectation within that subculture. The converse holds true within social networks in which the cumulative experience is of making plans and in due course enjoying the fruition of those plans.

In a subculture in which the general experience is that people's coping resources are outweighed by a range of immediate and pressing demands health will be assigned a relatively low priority. This low priority will echo within and be passed on through that subculture. Conversely, in subcultures in which most of life's pressures appear to be under control, investing in ones personal heath futures may well be seen as the next priority.

There are marked variations in smoking behaviours across class, gender, ethnicity and age. The influence of peer group attitudes in determining the take-up and give-up decisions is well recognised. However, it is more complex than the common formulation of 'peer group pressures'. The attitudes and expectations that prevail in different sub-cultures arc not manufactured in isolation. The way in which they reflect the cumulative experiences of those sub-cultures is mirrored in the way that tobacco advertisements are targeted. The emphasis on the symbolism of reassurance, maturity and defiance in tobacco advertisemenL<; aimed at young people testifies to the significance of insecurity and low self-esteem in leading many young people to experiment with smoking. Understanding where that insecurity and low self-esteem comes from *is* part of understanding health and illness in its social context.

5.3.4 Willing Appreciated Neededness

Among the factors which influence our motivation to look after our health, one of the most important is the quality and meaning of our relationships with others in our community; the significance of our work and other life activities in terms of our relationships with others. It is widely understood that many instances of ill health stem from social isolation, lack of purpose, lack of belonging.

Human beings have evolved as social animals. Their basic needs include (as well as food and shelter): contributing willingly to the welfare of their group and being appreciated for their contribution. These needs, to belong usefully are denied to many people in our community. The message of uselessness is given clearly in the experience of school failure and youth unemployment and in the idleness of mandatory retirement. Personal isolation is for many the dominant feature of the migration experience. The need to contribute usefully to an appreciative community is denied in the isolation of suburban living. It *is* denied when the structure and context of people's work is so alienating that it is an experience of exploitation rather than contribution.

In this light the values of competitive materialism, epitomised in much television advertising, can be seen as dividing people from each other as well as wasting, in conspicuous consumption, resources which could have been directed to meeting more basic human needs. These values permeate our culture far more deeply than just television advertising. They are expressed in mainstream culture and sport and are clearly implied in much of the public debate about economic policy.

Isolation and alienation influence health in many ways including low self-esteem (contributing, for example, to drug use), depression and extreme risk-taking.

We are not advocating a wholesale rejection of the old public health model but it must be recognised that the experience of health in society is determined by social processes and social relations; not just disembodied risk factors. Health and illness matter to people because of the impact they have on the way we experience our lives. In this sense, experiential and subjective insights into the causes of health are every bit as valid as the objective statistics of the epidemiologists.

Alienation and powerlessness are key concepts for interpreting epidemiology without excising health from its social relations. They are key concepts for undertaking a community development approach to health issues.

5.4 The New Public Health

The new public health (as promoted by WHO) represents a significant paradigm shift vis a vis the old public health. It remains, however, essentially health centred, justifying initi'J.tives such as those in the Ottawa Charter on the grounds of the health outcomes that they are expected to produce. In this respect, the public healths, old and new, may be contrasted with more generally oriented community development and social change movements which would locate health advancement within a more general set of human goals.

The recognition that alienation and powerlessness are health hazards presents professionals in the health sector with something of an ideological challenge. Should I be working towards a fair, equitable and mutually supportive society, simply in order to achieve better health outcomes? Or should improved health be recognised as a means for achieving such a society, to be pursued as part of a broader strategy towards that goal?

Community development provides a theoretical framework and a set of values and strategies that address this contradiction explicitly by recognising the sovereignty of the people with whom the health professional is working; respecting their political and cultural priorities rather than imposing health goals. The objects of one's work may still be cast in terms of health outcomes but the process of achieving those outcomes is part of a set of broader strategics towards community development and empowerment.

6. COMMUNITY DEVELOPMENT AND SOCIAL CHANGE

Critical to understanding community development is to recognise the ambiguity between community development and social change.

In the term 'community development' (as used in this paper) the word 'community' refers to a local or identifiable community of interest or a looser network; in particular, one which is disadvantaged by social inequalities and exclusion from the mainstream. Community development means the development of that community or network; internally, in terms of its coherence and consciousness of iL5clf and externally, in terms of that group's power in relation to structures of the broader society.

Jt has to be recognised however, that in terms of the face value of the English language, 'community' could be taken to mean society generally and 'development' could be taken to simply mean change. Community development is often taken to refer to a set of strategics for achieving (or keeping up with) social change with no implications as to the direction of change to be achieved.

In fact, from a government point of view, community development does tend to be interpreted as being a useful 'adapting-to-change' strategy, a way of coping with the onrushing future. It is commonly argued that messages about changing people's health behaviours (more exercise, better diets, safer sex, etc) are more effective when they are delivered from 'within the community' rather than through mass media messages. However, 'community development' programs which are conceived primarily as strategies for coping with new social problems may in fact do so without any change in the undcrlying social relationships.

This is quite consistent with the traditional public health approach; simply a new way of reducing risk factors, complementary to the more conventional bureaucratic and legislative strategies. Such programs continue to ignore the existence of wide inequalities in health and the significance of social relations, in particular, alienation and powerlessness in understanding those inequalities.

It is clear that there is a contradiction between community development aimed at improving health through a more equitable and more sharing society versus community development as a set of strategies for achieving certain public health goals. On the other hand, there may be scope for government planners to negotiate some kind of a partnership with local (or other) communities; provided that there is space for give and take with respect to priorities.

In this paper community development is interpreted as the development in strength of identifiable communities within society. The processes of community development can be recognised within many different contexts, for example, a small organisation, a looser network of groups and individuals, a small town or an ethnic or racial group. The essential characters of the process are not tied to a particular level or criterion by which community is defined.

We have argued that the special application of community development in health is to address health problems which are also problems of powerlessness and alienation. In addressing such problems, the community development worker is working with communities which are powerless and excluded. While part of the task is to change the broader society, out there, part of that task involves working with our people, groups and networks, helping us to plan for the growth of our community, in strength and cohesion, in short its development. Through changing ourselves and changing our relations with the outside world we arc changing the outside world.

7. THE PRACTICE OF COMMUNITY DEVELOPMENT

We can think about the development of a group (or a looser network of individuals and groups) in terms of its

internal development and in terms of its relations with the outside world. Group building, considered in relation to the outside world, can be thought about in terms of empowerment, becoming stronger in relation to the outside world. Group building, from an internal perspective, can be thought of in terms of consensus-building.

(Consensus in this context should not be taken to imply 'negotiated compromise' or 'imposed agreement'. It means people working together because they have a shared consciousness of who they are and of the problems that they face.)

It is worth noting that empowerment and consensus building are in many respects two sides of the same coin. A group which is more together within itself is also more powerful in relation to the outside world.

We have earlier defined community development as encompassing, firstly, certain theoretical understandings; secondly, a field of practice with its own skills and strategies and, thirdly, a set of core values. We have explored some of key theoretical insights in the preceding sections. The values which underlay the practice of community development have been highlighted throughout this paper. We have argued that the special relevance of community development in health is that it provides a practical approach to health problems which are also problems of powerlessness and alienation. Clearly we are assuming a set of values in which a more equal and mutually supportive society is regarded as a high priority.

What of the practice of community development? We can describe community development practice in terms of three basic elements: **activities, projects** and **strategies.**

7.1 Activities and Projects

There is no controversy about the basic **activities** that make up the day to day work schedule of the community development worker: talking to people, giving support, arranging meetings, facilitating discussions, getting the newsletter out, arranging for an article in the local paper, arranging a deputation, writing up the minutes...

There is nothing specific to community development about these activities. Clearly, they only make sense in terms of particular projects to which the activities contribute; projects which are planned in relation to fairly practical objectives such as the establishment of a new community health centre or perhaps running a women's health day.

There is nothing specific to community development about undertaking such **projects,** either. What is specifically community development arises in the process as much as in the objectives of those projects. Clearly, the objectives of the projects will be in some way health promoting and worth achieving; but are the projects conducted in a way that will also address the underlying issues of powerlessness and alienation? Will they, in this sense, promote community development?

7.2 The Strategies of Community Development

And here we come to the strategies of community development; the strategies through which the community development practitioner aims to ensure that the way in which the project is carried out leaves the people, the networks, the community that much stronger, that much more together, as well as achieving worthwhile project objectives.

Consensus-building and empowerment are the basic strategies which underpin community development work.

7.2.1 Consensus-Building Strategies

Consensus, in this context means that we are able to work together because I can see myself in your shoes and I'm confident that you know and support what I'm on about also. It requires a degree of shared experiences; shared in the sense that people have actually been through the same or similar situations or that they have shared the recollections, the feelings and the understandings associated with those experiences.

To share one's experiences with others requires opportunities for fairly relaxed communication. It also involves making oneself vulnerable. To do so requires a basic level of trust.

Understanding consensus in these terms suggests a range of consensus-building strategies which are part of community development: creating opportunities for **relaxed communication,** for the **sharing of experiences** and for **developing trust.**

There are features of health (as an arena for community development work) which have a particular bearing on the relevance of this consensus approach. One of these is the uniqueness of individual sick care experiences. Different people often have very different experience of illness and of sick care and these experiences are quite personal and private.

There are health issues which affect subgroups in the population but which call for the understanding of the broader community if they are to be properly addressed. Examples include:

- the drug problem and the alienation of some groups of young people,
- myths and fears about particular immigrant communities,
- women's health issues,
- the significance of AIDS for gay men.

In so far as meanings and associations stem from our own experience, if we have different experiences we are likely to use words and sets of ideas as having different meanings. This can be a barrier to collective action where, because of differing and privatised experiences people do not see clearly the shared base for collective action or do not communicate clearly. This underlines the importance of experience sharing.

7.2.2 Empowerment Strategies

How should we understand **empowerment?** Connie Benn suggests four perspectives on power; four ways of thinking about power in society.19 These are power over: information, relationships, decision-making and resources.

Paolo Friere has also emphasised consciousness as a correlate of power.20 People who are confident of their rights and capacities are more likely to see their rights observed than people whose self-esteem is low and who don't have such expectations.

Thinking about power in these terms suggests corresponding **empowerment strategies** which are part of community development.

Information is a valuable resource particularly in the health field; the control of information and communication is an expression of power. Professional groups generally seek to retain their power through controlling access to information and through their monopoly over certain techniques.

Research projects and self-learning projects may be part of empowerment through gaining control over such information and newsletters in disseminating that information. Sometimes, more direct challenges are necessary, for example, women confronting obstetricians and hospitals in seeking different options for birthing. The act of doing so involves empowerment, partly through gaining control over information.

Relationships reflect power. A person who has lots of friends able to provide different kinds of support and advice is in a stronger position that one who is isolared.

Understanding relationships in terms of power points to the broader institutional structures of society and the degree to which they determine our relationships. The development of new organisational links is part of empowerment and changing patterns of control.

It is self evident that building networks and alliances is part of empowerment, but not in isolation. We are talking about changing patterns of control over people's lives; patterns of control that are perpetuated because of the way the structures are organised and people are kept separate. It is in the context of particular campaigns and struggles that new alliances are forged, new relationships and new organisations are established and real power is shifted.

Control over decision-making is another perspective on power; the power an individual may have over everyday decisions in one's own life. In the health sector the most obvious example is the lack of control that less powerful people have over their own medical care, particularly when they are are sick and vulnerable.

Perhaps the most obvious expression of power is access to various resources (including material resources, information, opportumtl'es, etc). In relation to social resources (such as hospitals and community health centres) control is determined by factors such as membership of the management committee, source of funds, staff, etc.

The Womens Movement has also emphasised consciousness as a correlate of power.21 Consciousness is more than confidence; it extends to how we understand the world around us.

Elements of what we call consciousness at the personal level correspond to aspects of ideology and culture at the broader societal level. Recognising consciousness as a perspective on power underlines the importance of consciousness-raising strategies at the personal and local level. Recognising ideology and culture as determinants (and manifestations) of consciousness underlines the significance, in terms of empowerment, of confronting the institutions and systems which determine ideology and culture.

Changing the way things are done usually involves confronting the established power structures and, quite are apart from the specific battles that are won or lost, the experience of conflict itself may be empowering in that it demystifies the opposition and opens our eyes to our own strengths.

Clearly, these different perspectives on power overlap considerably in practice. Likewise, the usefulness of making a distinction between consensus-building and empowerment is simply to provide a framework for thinking about the practice of community development. In reality the activities which carry these various processes are all going on at the same time.

As an example, consider the issue of illicit drug use by young people. Let us assume that among the underlying problems are powerlessness and alienation from the mainstream culture on the part of many young people and insecurity and antagonism among some older people; really about values and life-style, albeit expressed in terms of a 'drug epidemic'. Insofar as the 'problem' is actually the powerlessness of some young people, strategies focussed on empowerment would be appropriate. These might involve gaining access to resources, developing their own organisations, affirming the validity of their experience. However, insofar as the 'problem' is the alienation of some young people from the mainstream then there may also be scope for consensus-building strategies, the development of communication, the building of trust, an increased sharing of problems between young and old.