Promoting Health at the Local Level: A Management and Planning Model for Primary Health Care Services

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Introduction

As a member nation of the World Health Organisation, Australia seeks to implement the concepts of Primary Health Care and Health Promotion and to re-orient the existing curative focus of health resources. Several Federal Government policy statements and programs provide evidence of this direction.[1] The Government of South Australia, in particular, has developed a Primary Health Care Policy (South Australian Health Commission, 1989) and Draft Implementation Plan (South Australian Health Commission, 1992) in order to focus its health promotion efforts.

This thesis will demonstrate that implementation of these concepts will be facilitated by a clear understanding of the ideological and political issues to be faced in bringing about such change. It will also demonstrate that clarity about the ideological underpinnings of the World Health Organisation's concepts of primary health care, as advocated in the declaration of Alma Ata (World Health Organisation and UNICEF 1978) and health promotion, as outlined in the Ottawa

[1] See for example Better Health Commission (1986) Health For All Committee (1988) National Health Strategy, Commonwealth Department of Community Services and Health (1990).

Charter for Health Promotion (World Health Organisation 1986), will assist in the development of supportive planning and management processes. This, in turn, can support a reorientation in health service delivery and provide direction for the range of strategies and activities which can be undertaken, within a Primary Health Care Service, to improve the health of a community.

Debates in Health promotion, since the Ottawa Charter of 1986, have focussed on means of implementation of the Charter's principles.[1] They have exposed and made explicit the difficulties inherent in establishing two fundamental planks of primary health care and health promotion, community participation and inter-sectoral collaboration, in the development of healthy public policy at the local, regional, national and international levels. It is broadly acknowledged in the literature that the way to decrease the gap between the rhetoric and practice in relation to the development of healthy public policy is to develop an understanding of the strategies to increase community participation and inter-sectoral collaboration. A methodology advocated by prominent writers is the analysis and

[1] See, for example, the Proceedings of the Australian Community Health Association Conference of 1989: Health Promotion: the Community Health Approach, the Proceedings of the second World Health Organisation Health Promotion Conference, Adelaide 1988; Strategies For Action, Allison et al (1988) Canadian Health Services and Promotion Branch Working Paper; Co-ordinating Healthy Public Policy, The report of the Australian Health Targets and Implementation Committee (1988).

promulgation of case studies which demonstrate the issues contributing to the success or failure of such strategies (Ashton 1988, Allison et al 1988, Rifkin 1986, Hexel and Wintersberger 1986, Wadsworth 1988). In 1986, Both the Australian Federal Minister of Health and the South Australian Minister for Health outlined the important potential role of community health services in Australia in developing an understanding of, and a community constituency for, health promotion and a reorientation to a more primary level of care (Blewitt 1986, Cornwall 1986). The community health sector is faced with the challenge of spearheading the broader public health movement. Case studies of the activities of community health agencies will assist in the development of a knowledge base which can support this kind of action.

The Parks Community Health Service, a primary health care service in Adelaide, South Australia, has a long history of commitment to community participation and health promotion. This, together with its multidisciplinary staffing arrangements and the associated professional stakes in health decision making, make it an appropriate case study to contribute to this knowledge base. The narrative elements of this thesis depend in part on the author's experience as Director of the Parks Community Health Service from 1988 to the

present day and in part on other historical sources.[1]

Service policy and planning processes at Parks Community Health Service have reflected different perspectives on social policy over the years, from its establishment in 1976, to the present day in 1992. George and Wilding's description of the various ideological positions on social welfare provides a useful framework for analysing the underpinning ideological approaches to management and planning taken at Parks Community Health Service and for understanding the nature of organisational politics at important points in the organisation's development (George and Wilding 1976). They describe the individualistic social policy perspectives of anti-collectivists and reluctant collectivists who believe that social policy should aim to equalise where the market system fails; and the collectivist position of Fabian Socialists and Marxists who believe that social policy should be aimed at justice and equity through redistribution.

The ideological commitment of management and health workers is a major determinant of how social policy will be interpreted and implemented in a health service. The story of service planning and

[1] See Sources section for details of the method used to gather historical material.

management at Parks Community Health Service highlights the importance of this fact. Values and ideology will also determine the approach to health policy development which will be taken, more broadly, by governments and health professionals to address the community's health issues. After describing the relevant societal ideological positions and their consequent health policy characteristics, chapter one argues that the underpinning value base of the Australian Community Health Program of 1973 and the similar World Health Organisation's concept of Primary Health Care, is collectivist. As such, it acknowledges the inherent inequities in society's pluralist political system and supports the role of public intervention and community participation in redistributing the political and economic power so important in influencing health experiences of groups within a community.

Referring to the Parks Community Health Service from 1976 to 1984, chapter two describes how, despite a collectivist ideological framework, the implementation of the Australian Community Health Program of 1973 was based on the prevailing individualistic ideology of the professional planners and health workers who interpreted the Program's principles. The dominant societal value of individualism, which the planners reflected but did not clearly articulate, rested on a

belief in functionalism within the existing economic and political systems and in traditional elitist approaches to planning. This resulted in narrow definitions of the Program's principles. Community participation was taken to mean involving the community in already planned activities. Health promotion was defined as health education. Equity meant equality. Coordination was taken to mean cooperation between services in the health and welfare sector. These strategies could not possibly have achieved the scale of transformation necessary to bring about redistribution as originally conceived by the 1973 Community Health Program. That kind of redistribution depends on political participation by those less powerful groups in society and the development of partnerships between these groups and health workers in a struggle for social justice.

A Community Health Service, seeking to implement the collectivist principles of the Community Health Program or primary health care, must clearly articulate its underpinning value base and develop management and planning processes which support them. Its mission then becomes redistribution or social justice. Management and planning are means to that end. Its strategies and activities will be self-consciously political. Chapter three describes the orientation of management and leadership issues faced in Parks Community Health

Service from its establishment in 1976 under the management of a medical director, through to its first attempt at organisational planning in 1984. Using Handy's theory of cultural propriety as a tool for analysis, it is clear that a developing organisation requires different management emphases at different stages (Handy 1985). Organisational establishment, the development of administrative procedures, the development of clear organisational goals and structures are progressively developed and are heavily influenced by organisational politics. Nevertheless it is also clear from this analysis that organisation development management techniques, which are derived from social learning theory, combined with a supportive ideology in the leadership positions, can play a strong role in the development of organisational values and structural arrangements to support exploration of collectivist approaches to health practice. This exploration continued at Parks Community Health Service from 1984 to 1988. The goals of the organisation were, essentially, the principles of the Community Health Program and of primary health care. They related to the activity and processes of the organisation rather than to outcomes for the community.

The term "managerialism" describes an ideology in which the techniques of management have become ends in themselves.

Managerialism is possibly useful in the private sector where, clearly, the underlying reason for organisational improvement is the improvement of the profit margin. However, it is problematic in public sector health and welfare services. Whilst organisational or management goals are useful to improve efficiency, to fine tune processes and improve technology, to improve staff relationships and decision-making processes, they must clearly support the attainment of social goals. The economic rationalist environment of the Australian public sector in the 1980's and 1990's has emphasised the economic aspects of all social policy and has made social goals subservient to economic development. This has resulted in a concern with the implementation of services rather than with their impact. (Pusey 1991)

Social goals relate to outcomes for the community and establishing them requires different planning approaches to those used in organisational planning. Social justice is a social goal. The methods used in its attainment will vary according to the population subgroups who seek it. It requires a mobilisation of community resources as well as government agencies. Chapter four, using a framework for analysis developed by John Friedmann(1987) describes the various traditions in social planning and reflects them against health promotion planning

at Parks Community Health Service and, more broadly, in South Australia and Australia. It concludes that radical planning, originating in the tradition of social mobilisation, has the potential to mobilise groups in the community to take action in their own health and welfare and to develop the political constituency required to challenge the predominant economic rationalist approaches to social 9planning. Radical planning has an ideological basis compatible with the primary health care approach.

The political issues inherent in the implementation of radical planning processes by a professional organisation are, essentially, associated with professionalism. Chapter five describes the application of organisation development management techniques to mobilise staff commitment to the concept of a more participatory and community based approach to planning and strategy development at Parks Community Health Service.

Accountability mechanisms are important, both as a means of informing the community and the funding bodies of the worth and the effectiveness of the strategies chosen, and as a means of consolidating organisational commitment to the values, goals and strategies deemed important by the local community in promoting their own health.

Chapter six describes the issues related to accountability both to the community based plan developed by the Health Service and to the economic rationalist context of the bureaucracy funding the organisation. It is argued that accountability structures and processes in social service agencies must be able to demonstrate progress towards social goals, as well as the cost effectiveness of the strategies chosen.

The substantial outcomes of three health promotion projects, which were based in radical planning and practice, are described in chapter seven. The chapter demonstrates the importance of a community health service making the links between between personal care, radical practice and the needs of the local residents.

If organisation development management techniques, combined with a clear ideological direction, can be influential in the development of staff commitment to a collectivist interpretation of the principles of primary health care or community health, and the implementation of radical planning and practice within one organisation, such techniques and practices would also be useful in the development of a more broadly based collectivist interpretation by primary health care workers and community members. Chapter eight proposes such a

process and argues that it should be based on a recognition of the need for political mobilisation which is not exclusive to professionals, but includes the broader community. It is only with a strong commitment to social justice from a broadly based community constituency that today's economic rationalist obsessions can be challenged to make way for the promotion of health.

Chapter one

Ideology: the basis of health policy

This chapter outlines the various ideological positions in social policy. It also establishes that Primary Health Care policy and principles are located within collectivist ideology but that they have been interpreted and implemented within existing individualistic societal values.

Since the Alma Ata Conference of 1978, sponsored by the World Health Organisation (WHO) and UNICEF, member nations have accepted Primary Health Care as the basis for their health care system and have emphasised community participation as its fundamental principle. Primary Health Care was defined as;

> ".....essential health care made universally accessible to individuals and their families in the community by means acceptable to them, through their full participation and at a cost that the community and the country can afford(WHO/UNICEF 1978, p34).

This emphasis on community participation aimed to shift the focus in health care planning from traditional 'expertise' and methods of health care delivery. In Australia there is clearly a search, at the

national, state and local levels of health planning and management, for a way forward in the implementation of these fundamental principles. This is evidenced by recent Australian health policy reports such as the September 1991 Interim Report on the Role of Primary Health Care in Health Promotion, a project sponsored by the National Centre for Epidemiology and Population Health and the Better Health Program of Australia, the report of the Health Targets and Implementation Committee (1988) and the South Australian Health Commission's Primary Health Care Policy (1989) and Draft Implementation Strategy (1992). All these reports emphasise primary health care as a means to the promotion of health.

Acknowledgement of the importance of primary health care in the promotion of health has increased the need for health program planners to understand the way in which community participation develops (Rifkin 1986). The search for understanding has not always been fruitful and frustrated planners have sometimes taken the rhetoric of community participation but failed to implement the concept. As a result,

> "many planners and agencies are supporting programs which merely have the cloak of a new community based approach under which the traditional health care delivery system remains."(Rifkin 1986, p240)

In this statement, Rifkin captures the essence of the problem where the principles have been espoused but are seldom evident in the processes of implementation.

Policy is made and implemented within a social, economic and political system. In Australia, the economic system in society has dominated the political and social systems. Dickey (1981) describes the strong relationship between the development of social policy and economic requirements in Australia from the early days of convict settlement to the mid 1970s. He points out that between 1788 and 1870, the insane and Aboriginal people, two dependent groups for whom some form of social policy had to be evolved, were not catered for. The Aboriginal people were regarded, in practice, as a barrier to rural capitalism and a threat to the development of respectable white society. Death was the most convenient if not the most public solution to the aboriginal "problem." Throughout the 1980s, the ideals of economists have come to dominate social policy considerations in Australian Labor governments (Pusey 1991).

To develop health policy, without reference to this broader societal context, accepting existing social and economic relationships and

their underpinning ideology unquestioningly, is conservative[1]. Prior to developing a planning and management framework capable of supporting health promotion in a primary health care organisation such as Parks Community Health Service, therefore, it is necessary to consider the ideological positions on health and social welfare in our society and their implications in relation to norms and action. Ideological assumptions largely determine the direction of policy and planning. Therefore, a clear and explicit implementation of primary health care firstly requires an analysis of contending policy options and an exposition of their varying ideological bases.

Many analyses of social policy are confined within one particular ideological framework, be it essentially collectivist, individualist or administrative.[2] They fail to provide a comparative and comprehensive analysis across the full range of ideological positions in social policy. George and Wilding (1976), on the other hand, provide comparisons of the implications for social policy between order and pluralist positions in social and political theory as well as conflict and elitist positions. Their approach provides a useful framework for analysing both the ideological underpinnings of

[1] See Theophanous (1980), chapter five, for a description of the ideology of conservatism.

[2] See, for example, Forder (1974) and Abels and Murphy (1981) who provide an analysis in terms of social administration, Walker (1984) who provides a socialist analysis and Merton and Nisbet (1966), who provide a functionalist anaysis which is apparently based in liberal individualism.

Primary Health Care and various interpretations used in its implementation.

George and Wilding point out that the view a social scientist holds of societal organisation and the distribution of political and economic power will affect the explanation he or she gives of the nature of social problems and of the government's response in the form of social policy measures. This inter-relationship has been obscured by the compartmentalisation of social science into separate disciplines, concerned with what is perceived as separate domains. Indeed, Walker (1984) suggests that the separation between economics and social welfare administration has led to a false boundary between these two areas of policy, resulting in society failing to set social goals in favour of economic goals, thereby compounding social welfare problems. This false demarcation has a long history which Blume (1982) has described with particular reference to inequalities in health. He suggests that the social administration approach, on discovering a relationship between class and social conditions, has called for an improvement in conditions for the poorer classes without a theoretical examination of the economic causes of their inadequate social conditions.

Social Administration is particularly isolated from other realms of knowledge, partly because of its late arrival as a discipline and partly because of its heavy concentration on pragmatic, empirical studies of social problems and social policies with little emphasis on social theory (Walker 1984). Yet all social problems are the product of a process of definition. An understanding of who does the defining, of what is defined as a social problem and how it is defined, as well as of who shapes policy and, therefore, legislation and in what ways, is clearly crucial to any understanding of social policy[1].

Order and Pluralist Theories of Society

George and Wilding (1976) concede that the division between sociological theories of society into order and conflict theories and of political theories of power into pluralist and elitist theories is a simplification of a complex picture. However, they argue that such a division exposes the relationship between sociological theories of society and political theories of power and how they lead to different perspectives on social problems and social policy. They suggest that

[1] The descriptions of order and pluralist theories, of anti- collectivist and collectivist theories and of conflict and elitist theories which are contained in this chapter, are derived from George and Wilding (1976). However, other literature is used to provide more concrete examples of the George and Wilding descriptions.

sociological order theories of society stress consensus amongst society's membership, stability, integration and functional relations. All parts of society have a function and are integrated in such a way as to ensure the smooth operation of the system. If one part of society is out of line, pressure for re-integration or re-alignment of the surrounding parts results in a re-establishment of stability.

Using the functionalist approach to explain social problems, Merton and Nisbet (1966) distinguish between manifest, or outwardly visible functions of the problem and latent, or covert, functions. They suggest that even the worst social problem often has a functional relationship to the institutions and values by which we live. Lowrie (1974) describes the 1937 analysis of the "problem" of prostitution by Davis as the most enlightening example of functionalist analysis. Davis pointed out that one of the allegedly manifest functions of prostitution was economic reward for females who could not find alternative employment because of inequities in the social system. Yet, in reality, the most important latent function of prostitution was support for the monogamous family system, which institutionalised sex for familial purposes. By extension of this argument, it can be seen that if prostitution becomes too acceptable, too open, less outcast, it is equally likely to threaten the familial

values which its existence is purported to support. Pressure is therefore periodically created to contain the "problem." This pressure is a product of societal consensus as well as functional consensus.

According to functionalist theory, individuals share the same basic social values and thus agree on norms about what is a good society and how people should behave. These theories make little allowance for change which is generally seen as an aberration resulting from dysfunctions within society. It is therefore necessary to build in mechanisms to absorb change and channel it into harmless processes. Conflict is considered harmful to society and any dissension with consensus values is considered deviant.

The influence of functionalist or order theories of society on political views can be seen in the political theory of pluralism which holds that political power is shared between the state and the various pressure groups in society as well as private individuals. Government is, in essence, an umpire, free from domination by any one group or individual. If one part of the society, a pressure group for example, exercises undue influence, then the system produces another pressure group to counter the influence and restore balance and integration.

This would be the explanation, proffered by functionalists, for the increase in consumer power in health policy. It provides a counter balance to the historical domination of professionals in health issues. The individual maintains control over the "umpire" by voting during elections. Fundamental to the functional view of society is the belief that there is a common interest in society. Since there are obvious inequalities which exist in society, this is a major point of criticism.

The functional/pluralist view of society and power will tend to see social problems either as problems of deviance, where the individual's behaviour is non-conformist or aberrant, or as problems of social disorganisation, where the system itself is faulty and therefore produces defects in the process of socialisation or breakdowns in channels of effective communication. The theory acknowledges that disorganisation and deviance are related and, under some circumstances, can induce each other (Lowrie 1974). Merton and Nisbet (1966), for example, describe how the New York City Mobilisation For Youth Project acknowledged the relationship between poverty, a product of social disorganisation and delinquency, or deviant behaviour, by opening up the opportunity structure through the establishment of a Job Centre, youth services, a homework helper program, reading clinics and legal services as well

as developing programs to assist poor people to participate in community decision making.

The functionalist view of social problems has dominated social welfare literature where its concentration on deviance and disorganisation obscures the relationship between social problems and economic or political inequality. Functionalism, therefore, obscures the need for a change of the social structure if social problems are to be resolved: it emphasises collective, gradual, piecemeal amelioration of problems without disturbing the existing social and economic systems. It views social policy (and legislation) in mechanistic terms as a functional accompaniment of industrialisation, a way of restoring balance and ensuring that the needs of society as a whole are met. The Mobilisation For Youth Project, for example, attempted to re-socialise the victims of poverty rather than to seriously question the economic and political aspects of that poverty (Marris and Rein 1972). George and Wilding are pointed in their critique;

> "The two main weaknesses of functionalist explanations of social policy are to be found in their two claims that social policy is "inevitable" or "functionally necessary" in its causation and that it is "neutral" or "generally beneficial" in its consequences.....Both the causation and consequences of social policy are affected by both social class and pressure group conflict and, so far, the pattern and development of social policy

> have been subordinated to the economic interests of dominant social groups or the ruling class in society." (George and Wilding 1976, p8)

Conflict and Elitist Theories of Society

It is possible for functionalist theories to incorporate conflict, by regarding the conflict as beneficial to the social system, not altering the system itself, but assisting it to make changes which render it more effective. Functionalist theories which do incorporate conflict are very similar to pluralist theories, viewing the groups in society as holding more or less equal power. Where, on the other hand, a social theory sees conflict in society as taking place between groups possessing unequal power and it maintains that resolution of some of the more fundamental conflicts is not possible within the existing social and economic system, then it tends toward the conflict model of society.

Marxist theorists view the economic system as the foundation on which the social, political, and ideological systems are based. Conflict is, therefore, centred around these economic relations and is the means to fundamental change in society. The social system is not viewed as a stable, integrated structure but as conflict ridden and always changing. Power is not shared equally between societal

groups. Weaker social groups, though forming the majority in society, are economically dependent on the powerful groups and, therefore, easily coerced into subordination, whether that be openly or in a more concealed fashion. The improvement (absolutely, if not relatively) of material standards of the weaker classes under capitalist economic regimes, and the provision of social services, have resulted in a subordination of class conflict.

A more subtle form of control of the weaker classes is the societal acceptance of a set of values that serves the interests of the more powerful groups. These values become part of the national cultural heritage and are accepted by the weaker group resulting in their self control. It is argued, then, that rather, than a natural convergence on societal values, this normative consensus is better understood as the socialisation of one class by another. Societal values are enshrined in legislation and social policy which is very rarely the subject of equitable debate. The outlawing of homosexual activity is perhaps the most glaring example of legislation based on moral rather than factual considerations.

Conflict theorists believe that through coercion, economic dependence, the legitimation of dominant social values, rising

economic affluence and welfare state provisions, overt class conflict in society is reduced. They oppose the claim by consensus theorists that the absence of fundamental conflict is evidence for functionalist theories. They argue that this is simply evidence that the structure of the conflict has altered.

Conflict theories stress that political power is concentrated in the hands of a small minority which influences the affairs of the state disproportionately, perpetuating its own privileged position. This ruling elite is made up of subgroups who have economic interests in common.

Elitist theories of power in society do not view government as being an unbiased umpire on an equal playing field, but as manifestly serving the interests of the ruling elite. In Australia, for example, this is evidenced by the conservative ideology of senior bureaucrats who are committed to economic rationalism (Pusey 1991). The entrenchment of the interests of capital in the corridors of power and the reigning ideology means that non conservative governments are impotent to make "anti-capitalist" policy. Even where radical governments succeed in developing reform policy, it is often not implemented in ways which will affect the status quo. There is a

distinction between the first stage of policy formulation, in which conflict decides whether there will be legislative change, and the second stage, in which the actual form and shape of the legislation is decided. In this latter stage, the various groups whose economic interests and value systems are affected join in the conflict in an attempt to shape the legislation or social policy in accordance with their own views or to their advantage. This conflict is won by the most powerful groups. Once again, there is no level playing field. Sax (1984) describes this second stage of struggle between the policy makers and the implementers in relation to the attempt to develop a National Health Insurance system in Australia. The medical profession were successful in their struggle to retain the right to charge whichever fee they saw fit, despite attempts by the policy makers to constrain those "rights."

Conflict/elitist theorists view the main social problems of contemporary industrial society as being the product of the conflict of economic interests between the social classes in society. Solving social problems resulting from poverty for example, must affect the economic position of the rich and the non poor in society. These groups, seeking to maintain their elite and powerful positions, label issues such as poverty, as "social problems." Responsibility for their

existence is then defused and the search for solutions does not entail any analysis of the existing distribution of wealth, income and power. Emphasis can quite legitimately be placed upon a search for technical and administrative means of solving the social problem.

Even more sinister than defining economic and political conflict as social problems, according to the elitist theorists, is the problem of who defines what will officially constitute a social problem. Since power is concentrated in the hands of the ruling class, the definition of social problems is also in its hands. Too much deviance from the norms accepted and perpetuated by them will be considered dangerous to societal stability. Conflict theories accept greater cultural diversity in society.

A conflict theory of social problems proposes that unequal power structures in existing social relations are the cause of disharmony and that solutions should move away from the technical and administrative approaches which dominate existing social policy and towards an approach which recognises and abolishes these differences in power. Activities which strengthen the self determination of less powerful groups, such as the political participation strategies of trade unions or conservation coalitions are,

therefore, favoured. Marxists claim that existing social policy is a result and evidence of power negotiations between those who hold the power and those who have less. Social policy is begrudgingly developed to ensure that dissension does not threaten the status quo.

As a means of exemplifying the implications of the consensus and the conflict theoretical positions on social welfare policy in more detail, George and Wilding provide descriptions of the ideology and characteristics of four different groups of thinkers: anti-collectivists, reluctant collectivists, Fabian socialists and Marxists. The first two groups are, essentially, individualist in their ideology and the latter two are collectivist. An explication of the implications of each opens up important scope for analysis of the various interpretations of community health and health promotion in Australia and in Parks Community Health Service, in particular, which will be explored throughout the thesis.

Individualism: anti-collectivists and reluctant collectivists.

Liberty, individualism and inequality are the fundamental social values of anti-collectivists. These social values were best expressed by John Stuart Mill in his books "On Liberty" and "Representative Government."[1] Theophanous (1980), referring particularly to Australia, argues that the political expression of these values, conservatism and liberalism, are used to legitimate most aspects of the distribution of power and wealth. George's and Wilding's following description of anti-collectivist views conforms with Theophanous' description of conservatism. This philosophy seeks active preservation of the status quo and change back to traditional structures which have broken down.

Anti-collectivists believe that the coercion of some by others in society should be reduced as much as possible. The role of the state is as protector of the interests of all, ensuring that individuals can pursue their freedom unmolested by others. Any government activity which affects people's natural right to liberty is deprecated. It is argued that if the individual is free from all coercion by other

[1] First published in 1859 and 1861 respectively. They are combined in Mill (1962).

individuals and from unwarranted coercion by the state, then he will respond by exerting himself to the limit of his ability to the advantage of himself and his country. Individualism, the belief that promoting the freedom of the individual to pursue his interests and the consequences of his actions is the means to promoting the good of the whole society, is the underpinning ideology. Anti-collectivists argue that it was this type of individualism which created Western European civilisation and that led to the economic prosperity of the nineteenth and early twentieth centuries through capitalism.

Anti-collectivists argue that liberty has nothing to do with equality, except in relation to general rules of law and conduct. Equality of income is not supported since its creation would mean that liberty would have to be sacrificed. Furthermore, the extent of inequality is justified and conducive to economic growth, since people require incentive to produce and to accumulate capital and will do so differentially.

Anti-collectivists argue that the welfare state disrupts the social fabric by translating what is no more than a want or a need into a social right. By providing services free of charge, the state stimulates false demand and breeds a spirit of alienation. Free state services are

therefore considered to be wasteful of resources. Anti-collectivists would claim, for example, that universal health insurance is the cause of over use of the system by the alienation of the consumer from the price of the product. Furthermore, since they are not regulated by a price and profit mechanism state services are inefficient. State planning requires state intervention which has the potential to be a dictatorship. The safe role of the government is to act as "umpire", to intervene in situations where strictly voluntary exchange is either exceedingly costly or impractical, and to intervene for those whom society designates as not responsible. Anti-collectivists call for a reduction in the scope of social welfare services, the number of people whom the services attempt to help and the areas of people's lives to which they minister. Their's is, then, a residual, means-tested and locally administered conception of the welfare state.

The Australian Social Welfare approach from 1835 to 1870, was based in British notions of individual self improvement and laissez-faire capitalism which is still reflected in today's Australian Liberal Party policies[1] in particular. The many formative years of Liberal Government in Australia have produced a community acceptance of this individualistic approach to social welfare (Dickey 1981).

[1] Despite its name, the Australian Liberal Party has been categorised as conservative by Steed (1987) and as pragmatically conservative by Theophanous (1980).

Dickey's description of the welfare characteristics of the early era helps to illustrate the extreme consequences of the anti-collectivist, or conservative, position. The degree of urgency with which the various social welfare problems were dealt with varied. Restoring the health of the functionally valuable workers who had been injured at work, or of children who could provide labour in the future, was considered more important than providing shelter for aged and destitute ex-convicts. Hospitals for the sick and deserving poor were, therefore, the first forms of social welfare service in almost all Australian States. These hospitals were usually formed by private and voluntary charity organisations and were eventually subsidised by government. Patients were admitted on the recommendation of a subscriber, who vouched both for the patient's respectability and for his need. They aimed to help respectable working class people of the labouring sort.

In relation to destitution, Benevolent Societies distributed welfare selectively. Indeed, so concerned was the 1855 Government of New South Wales about the possibility of the unworthy poor imposing on the charities of the Societies and of "pauperisation," the process whereby individual self respect is destroyed when aid is given without a requirement that a return be rendered, that it appointed a

Board of Inquiry of the State's charitable institutions. It condemned the Benevolent Society, in particular, for discouraging industrious habits among the recipients of its aid.

In South Australia, self sustaining private wealth was never sufficient to support a network of voluntary agencies as was the case in New South Wales. Direct Government action was therefore far more likely. Dickey suggests that possibly the community tolerated such government intervention since it was recognised that all its members began their careers in the South Australian Colony respectably. Possibly, the policy makers in South Australia were reluctant collectivists.

George and Wilding describe the reluctant collectivists value base as similar to anti-collectivists, although their values tend to be qualified by an intellectual pragmatism not present in anti-collectivism. Their description of the reluctant collectivist position conforms to the political philosophy of classical liberalism (Theophanous 1980) Although reluctant collectivists believe that capitalism is the best economic system, they believe that it requires regulation and control to function effectively and fairly. This belief is underpinned by a strong humanism. They emphasise the value of individualism, private

enterprise and self help. Although they do not believe in absolute equality, they believe that inequality could and should be reduced.

In relation to social welfare policy, the reluctant collectivist view is pragmatic individualism. The role of the welfare state is to abolish avoidable ills. This role should be reactive and focussed on problems rather than promotional. The welfare state should supply what is not being adequately supplied by private enterprise and should abolish want. The position is based on humanitarianism and on utilitarianism. It is considered good in itself and good for economic growth, for example, to have a healthy, well educated population. Poverty and lack of education amongst the working classes reduces the likelihood of future generations of strong, talented workers. The provision of large scale public child health programs, such as the free milk program conducted during the years between 1950 and 1954 by the Federal Liberal and Country Party Government was, according to Dickey, easy to justify. Not only could it be made to appear as a contribution to child care for the masses, it was also a subsidy to the dairy farmers who were crucial to the Country Party's electoral survival. The program was cancelled support for dairy farmers was no longer required.

Reluctant collectivists' aim is to purge capitalism of its inefficiencies and injustices so that it may survive. They believe that capitalism and planning are compatible, that government intervention is necessary to make capitalism morally acceptable. George and Wilding conclude that their achievement has been to save capitalism and to preserve its essential elements while reducing or eliminating what has become unacceptable (George and Wilding 1976).

Collectivism: Fabian socialists and Marxists

There are various strands of Marxist and socialist thinking. However, within these strands, characteristically the most obvious differences between reluctant collectivists and socialists can be found in socialists' stress on equality and on their more positive attitude to the possibilities of government action.

The central socialist value of humanitarianism means that socialists believe that social growth rather than economic growth should be society's priority. The role of government is to modify what the socialist regards as the injustices of the market system of distribution. The individual and communal dis-welfares resulting from economic and social development are a charge that should be

assumed by the community as a whole. The power of government should be used to modify the market distribution of freedom and power accordingly. Socialists see the welfare state as concerning itself with the various types of redistribution necessary and desirable in a complex society. They argue that equality of opportunity, say, through universal services, does not in itself create an equal society. Equality of outcome, for example, the attainment of universally high standards of public health, education, housing, transport and so on, is more important. This may require affirmative action for those most in need.

Socialists are aware of the limitations and the dangers of the welfare state. There are four general concerns; that the welfare state is concerned with injustice rather than with justice, that it can be used by government as a substitute for necessary preventive action, that it can be limited to seeking equality of opportunity, and that it is concerned with poverty not with equality. In essence, these concerns are related to the welfare state's preoccupation with remedial or ameliorative aspects rather than with preventive social change.

Hardy (1981) outlines the inherent contradictions of the welfare state which is dependent on the institutions of capitalism to both define

need and provide resources to meet them. He suggests that need is so relative and potentially enormous that it may often be seen entirely in relation to the resources that any particular agency can provide. He points out that social workers may be missing the whole picture by tending to the parts of it, assisting the individual in "eligible" need, whilst assisting the maintenance of a pernicious system.

Despite these concerns, socialists regard the social services as offering the potential to change attitudes and aspirations, thereby mobilising a permanent force to modify social structures and to slowly but surely transform social relations. Participation in all forms of decision making, rather than occasional elections, is the lynch pin in this type of social democracy. The emphasis on participation is not only related to democratic rights, it is also regarded as essential for the smooth operation of the social order. Participation engenders trust in the system and increases the likelihood of responsible, and accountable decision making. George and Wilding conclude that socialists are optimistic about the influence of the welfare state. They see it not as dampening down the political forces for further social change, but rather as a powerful ally, raising aspirations, widening reference groups, illustrating and

exacerbating the value conflicts of welfare capitalism and providing a dynamic for further change.

Walker (1984) argues that the welfare state creates an environment which offers the potential for social planning. Through the Welfare state, social agenda can be debated. However, first it will be necessary for the welfare workers to move away from their preoccupation with administration of services. The community development welfare strategies of the 1960s and 1970s in the United States and in the United Kingdom, for example, although meeting major obstacles, did manage to politicise poverty and even to facilitate the creation of new leaders who were capable of continuing the political processes long after the programs finished (Marris and Rein 1972).

Marxists believe that without a substantial degree of economic security, freedom is a hollow concept. Unlike anti-collectivists, Marxists view liberty as unattainable without equality of economic circumstances. The economic structure is regarded as more important than the social or political structures. Changes in the mode of production, exchange and distribution of goods are the ultimate causes of all other change. This view means that Marxists are as

obsessed with economic issues as are capitalists whose values are more aligned to individualists.

Marxists account for the survival of capitalism, and the continued domination of the owners of capital over the majority of workers, by the interplay of three forces; the economic power of the ruling class, the domination of the state apparatus by the ruling class, and the legitimation of a national ideology that fundamentally reflects the interests of the ruling class.

Marxists do not advocate violence as a means to socialism. They believe that where the members of a state enjoy fundamental political rights, it is possible to transform dissent into orthodoxy.

Marxists believe that government should have a strong role in the social and, particularly, the economic aspects of society. They view economic equality as necessitating industrial democracy and the nationalisation of large industrial business and commercial enterprises. They argue that the private ownership of the means of production is not compatible with democratic institutions. Equality of political power is not viewed as compatible with the economic inequality inherent in private ownership. Government planning, with

the widest and most varied form of participation is, therefore, an essential feature of a socialist society.

The welfare state is viewed by Marxists as the ransom which the ruling class has had to pay for its survival. Its extent is determined by the unity and strength of the working class, the state of the economy and the nature of the demands made by the working class. The social reform movement has delayed and perhaps averted for good, the collapse of capitalism by humanising it and making it more acceptable to the working class. This de-radicalisation effect is compounded by the fact that even modest reforms are not implemented to the full with the result that they deliver less than they promise.

All of this is not to say that Marxists disapprove of social reform. Indeed, they see social reform as the only type of socialism that people are prepared to support. Further, they believe that social reform has served to raise people's expectations in life and that every step forward is a base from which further improvements and further demands for change can be made. When capitalism reaches the point where it can no longer satisfy people's rising expectations, it will reach a crisis point which may lead to its downfall.

Marxists believe that the welfare state cannot solve the problems of today without the abolition of the capitalist system.

George and Wilding set out their own interpretation of the welfare state and of its successes and failures which is outlined more fully below.

Social Justice and Social Policy

In the United Kingdom, one of the most striking aspects of social policy since the second world war has been the failure to achieve aims which were accepted as fundamental in the years between 1944 and 1948. In relation to health, the distribution of morbidity and mortality is still inversely related to the pattern of distribution of health services. The situation is similar in Australia (Glover and Woollocott 1992).

Common explanations for this failure are lack of resources or policy weakness, or lack of staff training. While these faults in the system might explain casual, occasional and limited failures, they lack credibility when used as explanations for the fundamental failure to achieve central objectives (George and Wilding 1976). A capitalist

economic system fosters the liberal values of self-help, freedom, individualism, competition and achievement. These values, although required for the successful operation of a capitalist economy, are in clear opposition to the values needed to underpin a successful public welfare system. Social welfare is the concern of socialist values of co-operation for the collective good.

The introduction of government social welfare programs is very often a departure from the individualistic liberal view which dominates in society. However, the framing and the implementation of policy are subordinated to liberal ideas about freedom, competitive incentives for work and the absence of restraint.These undermine the objectives of social welfare programs. The individual needs of welfare service staff for freedom, for example, is considered more important in capitalist economies than the community need for services. Doctors, social workers and other key workers, who have been trained at the expense of the state, may practice their skills in the private sector to their greater personal profit and to the loss of the community which has financed their training.

Liberal individualism remains a strong societal value, undermining

generalised intentions of social policy to achieve equality. It is reflected, for example, in Australian social policy relating to unemployment as an emphasis on self-help through training, and on residual and minimum unemployment benefits. Liberal individualism conceives a social problem as the product of the individual to be remedied by education or treatment. Too many benefits would reduce the incentive to be employed, however, so. solutions to the problem become piecemeal. personal and inadequate.

There are two fundamental problems with welfare policy driven by the ideology of liberal individualism. Firstly, the welfare recipient experiences shame and punishment as a result of the domination of social policy by liberal ideology. This, in turn, contributes to a reluctance to access welfare services and so to the perpetuation of hardship and inequality. Secondly, income is seen as a personal reward for the private efforts of the individual. Although this view accords well with the needs of a mass producing private consumption economy, it does not accord with the need to socialise a proportion of the national income for social purposes. In the capitalist expression of liberal individualism, taxation, the life blood of welfare, must inevitably be regarded as a burden. This is the fundamental reason why welfare services are under resourced in

these economies. It is simply not good politics, to increases social services, no matter what the extent of the need.

Individualism, which is generally associated with functionalist view of social problems, has consistently prevented the achievement of proposed social goals. Social welfare has been concerned with modifying inequality rather than with achieving equality. Whilst acknowledging that certain gross inequalities prove dysfunctional, inequality has been viewed as a motivating force in the capitalist society. Therefore, piecemeal attempts to modify them without a fundamental shift in the status quo makes sense. Indeed, governments buttress the continuance of inequality by subsidising private services. In Australia, Government subsidies to private schools, for example, reduce resources available for public education whilst supporting a service for which only those who are more wealthy in society can pay. Governments support private medical services to the extent that doctors, paid largely by the national health insurance scheme are among the wealthiest professions in Australia.[1]

Whilst welfare services in capitalist society has modified the excesses

[1] See, for example, Australian Bureau of Statistics survey of Occupational Wages and Hours, May 1992.

of laissez -faire capitalism, the past forty years has shown that it has no inherent tendency to produce a socially just society. This is essentially because of the conflict between the values of capitalism, which coincide with and are supported by a belief in individual self help and the role of competition in providing for self improvement, and the ethic of welfare which is based in values of collective co-operation and support. The latter ethic has been undermined by the incorporation of individualistic functional views of social problem amelioration. George and Wilding argue that social policy must, therefore, switch its concern from equality of opportunity to equality of result. They suggest that recent work on the nature of social justice will provide a new and vigorous basis for this new egalitarianism. By concerning itself with outcomes, activity directed to achieve social justice will necessarily concern itself with the broader political and social structures causing inequality. The satisfaction of needs would mean a socially just but unequal distribution of resources because people's needs can vary. The basic problem in achieving social justice, then, becomes how to define and measure needs.

The expert approach to defining need relies on the professionals in a particular field being honest and objective in their assessment.

However, professional groups are self interested as well as altruistic. It is likely, therefore, that their definitions of need will be such as to leave the existing structures unaltered because they are elite groups and part of the established social order which benefits by those structures. The medical profession in Australia, for example, has consistently resisted what it perceives as government interference in the free enterprise aspects of medical service in the community, despite obvious inequities in the way medical services are distributed and accessed. The expert approach also takes for granted a positivist epistemology, which Tesh (1988) has argued, sustains the need for experts.

The populist approach to defining needs also has difficulties. People may not always know what they need and it is possible that limited aspirations of some groups restrict their demands (Walker 1984). A comparative approach, which identifies and addresses major material and power inequities between groups in the community, offers the potential to engage in meaningful social justice oriented activities. Strategies could be developed by both professional and lay people. The development of policy and plans to achieve social welfare objectives must reflect the value base inherent in social welfare; collective social justice (George and Wilding 1976).

The health system and the Community Health Program: an overview

The themes of consensus and conflict in social structures and relations, pluralism and elitism in power structures, individualism and collectivism and freedom in public service ideology, participation and technical planning in social issues, social justice and equity in social program objectives will emerge throughout any thorough analysis of health policy and service. The key objectives and aspirations of health policy and service can be used to locate that policy ideologically and assist in an analysis of whether the policy can ever result in the achievement of social welfare goals.

Two fundamental characteristics of capitalist societies are relevant to the development of health policy. Firstly, the distribution of ill health broadly follows the distribution of income. Those with lower incomes tend to have higher rates of morbidity and mortality. This is not surprising given that income is a major determinant of people's standard of housing, the location of housing, of their diet and their ability to keep themselves warm and well clothed, all of which is

significant for their health. Secondly, all aspects of health and illness are viewed as belonging to the realm of scientific medicine, whose reductionist tendency limits its capacity to come to terms with social determinants or modifiers of disease such as inequality. This is not surprising since many historians of science and of medicine have demonstrated that the theory and practice of scientific medicine is inextricably linked with broader theories about the nature of the world. Individualism under-pins and supports the positivist epistemology of the "scientific method" (Tesh 1988; Jewson 1976; Doyle 1981).

As medicine adopted cell theory, the ultimate reduction of the human being to biological processes, the power and social standing of the medical profession began to rise. They became experts in all issues related to health and disease. It is the view of these experts which has formed the basis of the social definition of health and illness throughout the western world. Health is defined in capitalist societies in a functional way; as a person's fitness to carry out expected duties or as the absence of incapacitating or externally verifiable pathology. Hopes, fears, pain or suffering not externally verifiable are not the concern of medicine and are therefore marginalised in expert definitions of health.

The medical emphasis on the individual origin of disease is of considerable social significance, since it effectively obscures the social and economic causes of ill health (Widdershoven-Heerding 1990). This does not interfere with the processes of capital accumulation thought necessary for economic growth. The broader community has developed faith in the medical profession's ability to restore sick people to health. The government response is usually to focus its health policy on medical intervention and the treatment of illness. Australia has followed the rest of the western capitalist countries in this regard.

In Australia, the social policy and epidemiology literature of the 1960s and 1970s indicate a growing awareness of the inadequacies of existing health services. Auer and Powning (1982) suggest that three factors affected this realisation; firstly, an alarming increase in health costs coinciding with an emerging economic recession and fiscal crisis; secondly, a growing awareness that the system consisted of a plethora of largely uncoordinated public and private services dominated by a costly, institutionally based, high technology, curative model of care; and thirdly, a challenge to the existing biomedical model of care in the face of growing evidence that social factors

influenced illness and health status. The third challenge was strengthened as some sectional interests, such as the women's and the aboriginal health movements, developed alternative models of care.

Concern over these three issues was so great that even the conservative Liberal government of the late 1960s, sought to extend health insurance cover for high risk and chronically ill groups and to regulate fees for medical services via a common fee system.

A climate of reform prevailed under the Whitlam Labor Government which won the election of 1972 after 23 years of Liberal government. Evidence that poorer groups in the Australian community had poorer access to health care and suffered from poorer health[1] raised questions about the cost effectiveness of the curative approach to health care. Better organised, non-medical groups began to demand that governments extend the definition of health to encompass social, environmental and cultural determinants. Models were developing which used a social framework for the analysis of health problems within particular communities of interest (eg. Aboriginal, occupational and women's health services.) Furthermore, these models offered alternative approaches to

[1] See, for example, Henderson (1976).

organisational and decision making structures as well as a preventive orientation (Auer and Powning 1982).

The Labor Government of 1973 had a pre-election promise to improve access to services, quality of care and efficiency in the use of public funds (Hayden 1972). It proposed to integrate services on a regional basis, develop community based services, including health centres, and upgrade hospitals. It championed spending on public facilities and services to ensure their ready availability to satisfy people's needs on a universal basis. It was acknowledged that the rich would be among the potential beneficiaries. However, this would be offset by direct progressive taxes on income.This was at odds with the Liberal view that cash transfers should be made to groups unable to provide for themselves so that individuals could exercise choice about their services and, more importantly, so that the state budget would be protected whilst private enterprise is enhanced.

The institution responsible for implementing the Labor proposals was to be the National Hospitals and Health Service Commission (HHSC). The Commission, pending legislation, was established and its chair, Dr. Sydney Sax was appointed on 19th February 1973.

In announcing the creation of the Hospital and Health Service Commission, the Prime Minister stated that

> "Health is a community affair. Communities must look beyond the person who is sick in bed or who needs medical attention.....The Commission will be concerned with more than just hospital services. Its concern and financial support will extend to the development of community based health services and the sponsoring of preventive health programs."
> (Cited in Sax 1984 p103)

A national medical and hospital insurance scheme was also announced. Its objectives were, first to extend aid for basic medical and hospital care to the whole population and, second, to reallocate the costs involved more equally amongst the population. This reallocation was to be achieved by a levy on tax payers related to their taxable income. However, this levy was rejected in the Senate which was controlled by the opposition. These objectives of universal care and redistribution indicate that the ideology of the (then) Labor health policy can be located within a collectivist framework.

The HHSC promptly proposed a model set of arrangements for health services based on primary care as its key element. Primary care was defined as

> "those services which most people used most of the time for most of their health problems.It included a range of services for meeting the majority of daily personal care needs and, in an organisational sense, was the point of entry into the health care system which included private specialist care, hospitals, nursing homes, special purpose hostels, rehabilitation and

> domiciliary care and support for those with continuing disability" (Sax 1984, p103)

The HHSC submitted its report on a Community Health Program for Australia at the end of May 1973. The objectives of the Program were to encourage;

> "the provision of high quality readily accessible and reasonably comprehensive coordinated and efficient health and related welfare services at local, regional state and national levels. Such services should be developed in consultation with, and where appropriate, the involvement of the community to be served." (HHSC 1973, p4)

It could be argued that the Community Health Program was unstable from the beginning. Exactly what was to be achieved and how was never fully articulated, possibly because it would have been too radical as reform policy to stand up to public debate at that time. The dominant societal ideology is individualistic and, indeed, the medical profession, being largely a group of small business people, lined up ideologically with the Liberal Party on issues relating to health service policy.

Milio's history of community health policy in Australia alludes to the inherent tensions in the Community Health Program. She suggests that the Program was largely a political "surrogate" for a total public health system which was advocated by the Left Faction within the

Labor party. That Faction did not support the proposals for a national health insurance scheme and were more likely to be satisfied by a combination of the national scheme and the public primary care facilities (Milio 1988).

Hicks (1987) describes the Program as having three strands of competing goals. Indeed, these goals can be seen in the objectives set out above. Firstly, it was concerned with cost control, efficiency and effectiveness. Secondly, it was concerned with reform from a medical and curative orientation to a preventive and social approach to health care. Thirdly, it was concerned with redistribution to overcome the existing inequities in relation both to access to care and health status in the community. These goals broadly address what Alford (1975) describes as the power struggle between the competing interests of the health system. These interests are the professionals; those who actually control the system, the bureaucrats; those who seek control in order to effectively plan and reduce costs, and the consumers; those whose voice is generally unheard in the power struggle between the professionals and the bureaucrats. It could be argued that the Community Health Program was reform policy aimed at tipping the balance of power in the health system towards bureaucratic and consumer power.

The speed of implementation of the Community Health Program meant that very little of the rhetoric of the Program was put into practice. Applications for specific project grants came through the state instrumentalities which made recommendations to the Federal Government. There was little consultation with local communities (Milio, 1988; Commonwealth Department of Health, 1976; Australian Community Health Association, 1986). Indeed, in South Australia, some of the largest and most significant projects funded by the Commonwealth had a conventional medical service orientation and were submitted by existing private general medical practices in Tea Tree Gully, a newly developing private housing estate, Ingle Farm, a developing housing estate which comprised both public and private housing, and Clovelly Park, an older industrial area of Adelaide.

The Program aimed to provide curative, rehabilitative and preventive services. Although 136 community health centres and 194 community health resource centres were funded under the program by the end of 1975, the implications for health workers within the new Program had not been anticipated. Workers had no real experience in multi-disciplinary team work, had no training in

preventive approaches to their work and had no experience in community consultation or lay decision making (Najman et al 1981, Furler, 1982). Yet all of these approaches were to be cornerstones of the Program.

The training of most health professionals emphasised therapeutic intervention with individuals in need. It is, therefore, unlikely that staff of the new health centres were committed to the collectivist ideology underpinning the Program's development. Most preventive projects, where they existed at all, focused on early detection of illness and health education strategies rather than on primary prevention aimed at the underlying causes of illness in populations. These interventions were those most familiar to the professional staff at the time and most comfortable in terms of the dominant ideology in the communities they served (Milio 1988). The importance of these issues in interpreting and implementing the Community Health Program as social policy in the new centres will be discussed more fully in the next chapter.

The Community Health Program was not backed by legislation and has, therefore, been vulnerable to bureaucratic turbulence almost from its beginning (Auer 1988). This has resulted in differences

between the states in the extent of services and in organisational arrangements within them (Community Health Association of New South Wales 1981; Australian Community Health Association 1986). Although a body of public community health services exists in each state, the overall priorities of the health system have not changed. Primary health care is still largely controlled by private medical practitioners who are unable to maintain people in their communities, prevent illness or promote health largely on their own. In addition, expensive specialist curative services continue to dominate the system, largely due to the lack of public control of its primary health care "gateway." That "gateway" symbolises a dichotomy between private general practice and salaried primary health care personnel working in community health agencies (Australian Community Health Association 1986). Indeed, the processes whereby such gate keeping might be enhanced are fraught with ethical and practical difficulties from the medical practitioner's point of view. Pellegrino (1986) outlines some of these difficulties. He describes three types of gate keeping role, each raising moral issues for a doctor whose foremost concern should be the delivery of the best possible service and treatment to the consumer. He suggests that a more systemic shift is required to ration medical services than to depend on one group of providers within that system.

The manifestations in the workplace of these political, practice and definitional problems will be examined in detail throughout the following chapters.

The new public health movement

The development of the Community Health Program was divorced in policy and in practice from the traditional public health services of health departments in all states. This has come to be viewed as a strategic disadvantage in that it prevented the integration of primary and secondary approaches to prevention. Health centres have offered secondary preventive services aimed at reducing risk factors and containing the severity of illness. Their benefits are seen in the short and medium terms. Public health services aim mostly at primary prevention, addressing the underlying causes of illness. Their benefits are seen in the long term (Milio 1988).

Nineteenth century public health successes in the containment of diseases actually served to consolidate the individualistic preoccupation of medicine by increasing the community's faith in the reductionist scientific paradigm. Public health collectivist practice

has never enjoyed mainstream medical status (Lewis 1987). Since the second world war, there has been a resurgence in the public health approach. Epidemiology has broadened to include the study of patterns of health and illness, generally, in populations and not merely epidemics. This change has assisted in a medical recognition of the importance of social and cultural factors in determining health status (McMichael, 1988). It is possible, given this shift, for community health and public health activity to compliment each other, in so far as the prevention of ill health is the major orientation.

Milio (1988) argues that community health centres can be the bridge linking the individual perspectives of primary care with the collective perspectives of public health policy at the local level. A number of documents relating to health promotion in Australia show at least an awareness of this potential[1] . Primary Health Care and health promotion, as articulated by the World Health Organisation, can be used as a framework within which to attempt this new approach.

The 30th World Health Assembly in 1977 endorsed the aim of Health

[1] See, for example, National Centre for Epidemiology and Population Research and the National Better Health Program (1991), Jackson et al (1989), Victorian Health Department (1988).

For All by the Year 2000 (World Health Organisation 1979). In 1978 the International Conference on Primary Health Care at Alma Ata declared Primary Health Care as the major strategy for the achievement of Health For All (World Health Organisation 1978). Australia, as a signatory to the Health For All Charter has endorsed Primary Health Care and developed health promotion strategies[1] .

Health For All provides advocates of community and public health with the first opportunity since the introduction of the Community Health Program to re-orient the the public health system to prevention. Its strategies include intersectoral coordination at the highest policy levels and the development of primary health care as the basis of a country's health services.

Primary Health Care has five major characteristics;

> It is the first point of contact with the health system. It is a network of basic services within the community which are affordable and accessible to all;
>
> It is oriented towards the primary and secondary

[1] See the report of the Health Targets and Implementation Committee (1988)

prevention of illness;

It is oriented towards narrowing the gaps in the health status between groups in the community and provides opportunities for community participation in planning, managing and evaluating health services;

It is based on a social model of health and therefore uses strategies which attempt to address social, economic and cultural factors affecting health as well as biological ones;

It is based on a commitment to the participation of people in their own health care and by communities in health policy development and program management.

(South Australian Health Commission, 1988)

These characteristics are similar to those intended for the Community Health Program. However, Primary Health Care is a more powerful concept in that it provides a framework for the entire health system. It proposes the integration of primary, secondary and tertiary health services where-as, in many ways, the community

health services were left to attempt what other services did not do, or did badly. It could be argued that this residualism increased, rather than decreased, the differences in approach across the health system and marginalised community health.

As with the Community Health Program, key objectives relating to equity, participation and a social model of health which places emphasis on societal transformations rather than medical prevention, locate the Primary Health Care concept in collectivist ideology. Yet neither the concept of primary health care nor the Health For All strategy articulate clear directions to implement these collectivist policy principles.

The international collaboration which produced the World Health Organisation's regional strategy for Europe is significant in relation to the broader task of ameliorating social, economic and ultimately political relationships within and between the countries of Europe. However, the strategy is still technocratic, ahistorical, apolitical and unreflexive (Strong 1986). Although the complexities involved in achieving any kind of agreement across Europe on anything at all must be acknowledged, there is a need to elaborate on these issues and to view the Health For All strategy as the first in a series of

steps. The Australian Health Targets and Implementation Report demonstrates similar characteristics.

Hexel and Wintersberger (1986) acknowledge that primary health care has unclear goals but suggest that this is a characteristic problem with political charters. They point out that it cannot be denied that Primary Health Care contains elements which are useful for dealing with inequalities in health. As a philosophy, it refers explicitly to equality and social justice and as a strategy, it clearly indicates some key issues related to the equality/inequality dimension. For example, the provision of services to vulnerable and under-served groups, community participation, intersectoral collaboration, (another term for government planning frameworks to support health) and self reliance. It can in principle, therefore, be a useful instrument for coping with inequalities in health. Its limits will be the political and economic ones given by the societal situation, professional demarcation and training, and the organisational arrangements of existing health institutions. These were all limitations identified in the attempts to implement the Community Health Program. Hexel and Wintersberger, using the Italian worker's health movement as an example, point to the potential role of real community participation

in overcoming that resistance and in enhancing a political constituency for change.

Rifkin (1986), after reviewing two hundred case studies in community participation in primary health care, develops an analytical framework to assist in understanding the range of possibilities for community participation. She concludes that analytical tools and action, different from those traditionally used in health care delivery, are needed to develop health programs.

Australian attempts to gain Health For All have had an uncertain career, indicating a somewhat shaky ideological base. The Better Health Commission Report (1985), the first in Australia's discussion of Health For All strategies, was heavily oriented to health education and self help, indicating an individualistic value base and the associated deviance or disorganisation view of the social problem. The Health For All Australians Report (Health Targets and Implementation Committee 1988), which set out goals, targets and strategies to promote health, expressly addressed a population focus as did the following National Better Health Program. This concern with population differences and population based strategies is more consistent with a collectivist ideology. However, the more recent

revised Health goals and Targets (Nutbeam 1992) suggests a conservative return to those approaches which can be measured and evaluated in a more "objective" manner. This is not surprising in the economic rationalist environment of 1992. Throughout these apparent ideological shifts, health policy has invariably espoused the role of community participation in appropriate health planning but has rarely described programatically what is meant by this.

An analysis of service orientation and policy interpretation within a primary health care service such as Parks Community Health Service will provide some lessons for primary health care programs more generally in relation to their attempts to implement the primary health care principles of equity, participation, coordination and prevention. The following chapter provides an overview of these aspects of the Parks Community Health Service from its establishment in 1976 to 1988, when the author was appointed of Director.

Chapter two

Parks Community Health Service management and planning 1976 to 1988

This chapter provides a historical account of the changes in Parks Community Health Service services and organisational arrangements, as well as the ideological environment within which it functioned, between 1976 and 1988. To set the scene, there is a brief introductory discussion of the political, professional and administrative influences affecting the interpretation of community health practice in Australia at the time of the introduction of the Community Health Program in 1973.

The Community Health Program, with its goals to maximise community participation, and equity of access to services, co-ordinate health services and develop a preventive orientation in the health system, arose from Labor Party interests in a collectivist view of health planning and management. To that extent it was social policy aimed at redistribution in health from curative to preventive care, redistribution of access to care and the reduction of costs. Yet its

rationale and specific objectives reflect the same individual orientation that it was seeking to overcome (Hospital and Health Services Commission 1973, pp1 to 10). Its major emphasis was the development of primary care and the redistribution of power from the hospital doctors to the general medical practitioners (Milio, 1988).

The medical profession's interpretation of the community health principles, not unnaturally, reflected their prevailing individualistic ideology. The fact that, in South Australia, medical practitioners were instrumental in the development of submissions to the Community Health Program carried that ideology into the early community health centres. The Community Health Program itself, having no legislative backing, provided no strong policy guidelines for service development across the states (Milio,1988; Australian Community Health Association, 1986). Community health services in South Australia were, therefore, vulnerable to shifts in ideology and politics.

In politics, the Federal Government changed from Labor in 1975 to Liberal until 1983. South Australian State administration changed from Labor to Liberal in 1979 and back to Labor in 1982. In health care ideology, the World Health Organisation's 1978 declaration of Alma Ata stressed the key role of primary health care in achieving Health

For All By The Year 2000 (World Health Organisation 1978). Primary Health Care mirrored the Community Health Program. World Health Organisation Policy had little effect in Australia, however, until 1984 when several progressive South Australian bureaucrats began to make use of it for policy development. At another level, again, management ideology and practice were in flux in government agencies during the 1980s.

Generalist community health workers and services in South Australia have struggled to interpret the principles of primary health care and/or community health. Their strategies and their objectives have varied amongst health workers within health services and across health services. Women's health centres, on the other hand, have a long tradition in the successful implementation of primary health care principles. Their interpretation of those principles is consistent in its recognition of power differentials in society between men and women and of the need for active and political community participation (Milio1988, Auer 1988).

The primary health care orientation of the women's health centres may well have developed in the very struggle from which it arose. The women's movement was a force for change and power redistribution

across society generally. It created conflict in the health system. Touraine (1976) and other collectivist theorists argue that until conflict arises, redistribution of power and change is not possible. Tesoriero (1985), describing the professional activities of social workers, supports this view and argues that social work practice, in particular, must give up its struggle for professional status and replace it with a leadership role in the struggle for social justice. This argument is relevant to community health practice. As with the women's services, the struggle to gain a real power shift both within the health system and in society more generally, will be the learning ground for community health practitioners. It will be necessary for management in community health services to develop from a concern with the management of the means and techniques of professional care givers, to leadership in a social movement for power redistribution.

An analysis of the changes in planning and management processes, as well as service provision, over the years at Parks Community Health Service, provides an opportunity to identify those elements in the macro and micro administrative and organisational environments which influence the interpretation and implementation of primary health care principles at the local level. This analysis will assist in the development of suitable planning and decision making structures and

processes to support the development of primary health care more broadly.

The establishment of Parks Community Health Service

Parks Community Health Service is located within a large Community Centre comprising social welfare, recreational and educational services for people living in the area of Adelaide known as the Parks[1].

The Parks, situated in an industrial area north west of Adelaide, consists of the suburbs of Angle Park, Athol Park, Mansfield Park, Ferryden Park and Woodville Gardens. Most of these suburbs are South Australian Housing Trust estates which were constructed in the late 1940s and early 1950s to house workers and their families. Many of these residents were migrants who were enticed to become the labour force for an economic strategy of rapid industrial development. As with many large scale public housing estates, the Parks has suffered the difficulties associated with thin social mix; an over-abundance of young families with children and a large proportion of residents living

[1] Andrew Parkin, a social worker who was instrumental in the consultation phase of the establishment of the Parks Community Centre, has documented the experience (Parkin 1978). This account is the primary source for the following narrative.

in poverty. The hastily developed plans for the estate did not include adequate recreational or community facilities.

In 1973, the South Australian Education Department proposed to redevelop the physically and educationally poor Angle Park High School which had been constructed in 1960. This gave some progressive bureaucrats and politicians the opportunity to develop an approach to public school education based on two sets of beliefs. Firstly, that community participation in planning educational facilities and programs is valuable. Secondly, that education and the efficient use of resources could be enhanced if the school were to form the nucleus of a community centre, around which other human services were coordinated.

The Reports of the Committee of Enquiry into Education in South Australia (1971) and the Interim Australian Schools Commission (1973) are the primary documents referring specifically to these ideas and philosophies. In particular, it was thought that

> "joint planning and even conduct of schools by educational, health, welfare, cultural and sporting agencies could provide additional facilities for the school, allow the community access to its resources and thus, generally increase its fruitfulness. In this way, a link could be forged between school, family, peer group and the society at large."
>
> (Interim Committee for the Australian Schools' Commission, 1973)

Capitalising on the sentiments prevailing in both the State and Federal Labor Governments in 1973, the South Australian Minister of Education secured a grant to study the feasibility of setting up a community centre in Angle Park. A coordinating committee was established representing several State departments, local government bodies and the architects. It was hoped that the Community Centre would serve and be largely managed by the community.

The Department for Community Welfare was delegated the task of involving the community in developing proposals for the Community Centre. Reflecting on the inherent difficulties involved in the participation process and , in particular, on its unrepresentative nature, it would appear that the process was driven by bureaucrats wishing to involve the community in a notion already decided. The process might best have been described as "consultation" or "public discussion." Such processes are initiated by governments to legitimate decisions and, perhaps, to improve them. They have little to do with redistribution of power to the community being consulted and may actually be aimed at extending the control of the bureaucracy (Dwyer 1989, Bates 1983).

The initial stated goal of the project to invest public funds in a

deprived area is consistent with the collectivist ideology that redistribution of resources is a solution to the problems of the disadvantaged community. However, some assumptions involved in the decision to maximise community participation apparently evolved from a narrower, individualistic, and possibly even victim blaming, ideology. Parkin suggests that, although not publicly stated, this second ideology seemed to lurk in the shadows of more benign rhetoric and that it may have come to dominate the final plans. Bryson and Thompson (1972), describing the decision making processes in a newly developing urban Australian community, suggest that external community "care takers" are often the major actors in community decision making processes. These people are not residents in the community but are employed to "help" it. The planning of the Parks Community Centre was initiated by such "caretakers". Indeed, very few mechanisms for ongoing local community participation in the planning and management of services have been provided to date.[1]

The South Australian Government eventually financed the school section of the Centre and the Federal Government financed a health service, child care centre, public library, theatre and cinema, heated

[1] Up to 1992, there have been three reviews of the Parks Community Centre, each concluding that it has failed to develop any meaningful participation in local activities.

pool, sports hall, restaurant, coffee lounge and open plaza and lawned areas.

The South Australian Department for Community Welfare workers who consulted the Parks community during the planning phase of the Community Centre, reported a definite request for dental, medical and counselling services, as well as services for mothers and babies. Support for a health component in the new Centre was also provided by the South Australian Departments for Hospitals, Public Health, Community Welfare and Education, by the University of Adelaide's Faculty of Medicine, the Mothers and Babies Health Association, the local general practitioners and the Queen Elizabeth Hospital, the regional hospital associated with the University of Adelaide. With such strong professional "caretaker" support, it is conceivable that there would have been little difference in the plans had the local community not supported the proposal for a health service. In any case, it was decided that the health component would take the form of a community health centre, since funding was available at the time through the Australian Community Health Program.

The Federal Government contributed 75% of the initial capital costs and 90% of the operating costs. The Australian Universities

Commission provided a small fund (approximately $40,000) for teaching facilities for the University of Adelaide Community Medicine students. From the beginning, Parks Community Health Centre was developed as a teaching health centre, accommodating students of medicine, nursing, social work and other professions.

An Interim Committee of Management was formed in May 1975, chaired by Professor Tim Murrell from the University of Adelaide's Department of Community Medicine. It developed proposals for service policy and staffing. A Medical Director and a Clerical Officer were appointed in March 1976. The newly appointed staff were accommodated in "borrowed" premises and then in a temporary building erected prior to the completion of the Parks Community Centre.

The medical service was the first to be established and the first patients arrived on 1st November 1976. A community health service, including school health nurses, social work services and clinical psychological services was established within a few months.

The objectives of the Service on establishment were:

"To promote health by means of a primary health care service, health

> education, involvement in the community and other activities." (Section 6.1, Parks Community Health Centre Constitution)

The first management framework within which services were to be developed appears to be in the form of specific organisational "guidelines" for the implementation of the constitutional objective. They described the type of activity required for health promotion, specific protection, early diagnosis and early treatment, ongoing treatment and the limitation of disability, rehabilitation, training of health professionals, evaluation and research, the development of community participation and liaison with other health and welfare services. Activities such as, information giving-seminars, education groups, screening for specific at risk groups, crisis intervention, relaxation classes, clinical and curative services were specifically mentioned within these "guidelines."

The original medical service comprised two full time positions, one of which was made up of sessions provided by three local general practitioners and the University Professor. The Medical Director was a full time staff member, responsible for both the clinical and the administrative activities of the Centre.

Having contributed financially to the establishment of the health centre,

the University had a very specific teaching agenda in the planning of services. Indeed, the University's medical faculty had a powerful position in determining services. The professor of community medicine was Chair of the Interim Committee of Management and also a practising general practitioner in the centre. Consequently, a major focus of the medical service was teaching. As early as 1978, Parks Community Health Service doctors were supervising consulting sessions provided by interns of the Royal Adelaide Hospital and, as described above, two Family Medicine Program trainee positions were available by 1981. The fact that the greater number of doctors in the centre were trainees on placement increased the volume of medical services but not the average level of medical experience. Furthermore, users of the service have periodically identified the lack of continuity in their care, which results from this emphasis on training, as a problem. This was not seriously addressed until 1991.

From the beginning, the medical service was committed to a preventive and multi-disciplinary approach to health care, although, as described by the "guidelines" above, the interpretation of these terms was relatively narrow. Four community health nurses provided clinical services, supporting the general medical practice and in people's homes. Their role changed several times over a period of five years

from initially providing support to the general practitioners to later becoming independent nurse practitioners, providing most of the after hours "medical" care. Over the years, their desire to engage in more preventive work resulted in a division of labour between clinical and health promotion work roles amongst the nurses.

Two school health nurses operated out of Parks Community Health Service on a full time basis. They were employed initially by the Child Adolescent and Family Health Service, a statewide service, and were located in a different section of the Community Centre. Later, they moved into the Parks Community Health Service and were eventually transferred to its payroll. They provided screening, assessment, and referral services as well as health education in schools and with local parent groups. Follow up visits were also conducted.

Soon after the establishment of the nursing service, a social worker and clinical psychologist were employed. Podiatry and dietetic services followed in 1977, a speech pathologist in 1980 and a physiotherapist in 1982. These professionals, although referred to as the "multi-disciplinary group", were grouped together more because they were not doctors or nurses than because of any positive professional cohesion. Their specific services were quite separate. Most often, they

were the professionals delivering group health education services.

As early as 1978, staff were beginning to debate the need to increase accessibility of services to Vietnamese refugees living in and around the nearby Pennington Migrant Hostel. Two ethnic health workers were appointed to provide general counselling services to people needing information and support in the process of settling in to the Australian community. They also conducted a number of health education group programs.

A dental health service for pensioners was established in the 1979/80 financial year. This service was conducted within the policy parameters set by the South Australian Health Commission Dental Services Branch but was managed by the Parks Community Health Service. It was referred to as a "clinic" and had its own Director. Although this formal separation changed in 1985, these early separate management arrangements may be the reason for a continued separateness between the dental service and the rest of the services provided by Parks Community Health Service.

Although individual treatment and/or therapy was the major staff activity during these early years, preventive services were provided by

some nurses, the ethnic health workers and the multi-disciplinary group in the form of health education groups. Their objective was behaviour change. Some preventive medical intervention such as family planning services, immunisation and ante-natal care was also provided.

Decision making processes, the means by which plans are made and organisational structures, the staff arrangements which the organisation makes to implement its plans, changed over the years at Parks Community Health Service. The Interim Committee of Management, established in 1975, was responsible for the development of policy and service plans for the yet to be established Health Centre. It attempted to do so, keeping in mind the results of the community consultation conducted by the Department for Community Welfare in relation to the establishment of the Community Centre. Its membership included representatives from groups such as the Salvation Army and local schools, two residents of the local community, a South Australian Health Commission representative, the University Professor of Community Medicine and a local general practitioner who was also eventually employed by the Centre and a Visiting Medical Officer employed on a sessional basis by the Centre.

From the beginning, the major role of the Centre, as seen by this group, was to provide primary care within a teaching framework. Primary care was defined as personal medical and health education services. Aside from the fact that the local residents had indicated a need for these types of service in the early consultation, it was also the case that as few as two private general practice surgeries in the area served a population of approximately twenty thousand people. This was seen as unsatisfactory by health planners. The establishment of the medical service was to more than double the number of doctors in the Parks community. The other primary care positions, allied health positions, were to be developed as the need was indicated by the general practice. The deliberations of the Interim Committee of Management set the broad policy parameters within which services would be provided.

The Medical Director was responsible for the day to day management of the Centre. Prior to the development of an organisational chart in 1983, no formal organisational structure existed and until 1980, all staff reported directly to the Medical Director. Informal professional groupings were beginning to be formed by 1979. At this point, an organisational analysis, conducted by an external management consultant during a period of staff conflict, indicated the need for an

administrator position responsible to the Medical Director. It was argued that this would enable the Director to do more clinical work.

By 1980, a form of executive structure was in place. Co-ordinators were elected for the medical, nursing and dentistry professionals. They met with the Medical Director and the Administrator on a regular basis. The multi-disciplinary "group" were not represented in these early "coordinators'" meetings, although a process for choosing this coordinator was later developed.

The Medical Director maintained the power of veto over any decision discussed in the coordinators' meetings and all decisions were to fit the policy parameters set by the Interim Committee of Management. In turn, these policies were to support those of the South Australian Health Commission.

Between 1981 and 1982, there was a great deal of confusion amongst staff about the roles and decision making processes operating in the Centre. The Medical Director was criticised for playing too much of a role in administration and duplicating the work of the newly appointed administrator. Some clarification of the roles of the clerical coordinator, the Administrator and the Medical Director was attempted

and a document entitled "Delegations of Authority" relating to those three positions was circulated to staff. During the same period, there was significant staff disquiet about the Medical Director's right to veto decisions made by the coordinators' group.

By 1982, the Parks Health Centre was incorporated under the South Australian Health Commission Act of 1976. This gave it greater management flexibility. In July 1982, another organisational review was conducted by the same management consultant who conducted the review of 1979. This second review recommended that the Medical Director's position be abolished and that general management of the Centre be the responsibility of the Administrator. A new position of Chief Medical Officer was proposed to accommodate the Medical Director and a rudimentary organisational structure, which formally recognised the changes, was also proposed.

The Medical Director resigned soon after report of the organisational review was tabled at the Committee of Management. A sub-committee was formed to develop organisational arrangements now made possible by the review and the Medical Director's resignation. The first formal organisational structure was proposed by this group. It formalised the "Advisory Executive" of coordinators and strengthened its decision

making power. Decision making was to be by consensus. The Administrator's job description formally limited the decision-making capacity of the position and ensured a consultative decision-making approach. This was in keeping with developments in the British National Health Service which will be described more fully in chapter three. Delegations of authority were established, clearly indicating decision-making in relation to administration and program planning.

Until 1979, service planning remained in the domain of the Interim Committee of Management who, as described above, had established the earliest policies and service objectives. The Medical Director, of course, once appointed, was instrumental in informing the Committee's decisions. He took advice from staff meetings and, later, from the coordinators. The policy parameters defining the early services were set within a medical definition of primary care. No statistics were gathered on clients using the Centre or on the reasons for their attendance. This is surprising given the professed epidemiological focus of the University's Department of Community Medicine. Community Medicine was Adelaide's only public health orientation for medical students and epidemiology was an important component. The Service was, however, very busy and nurse practitioners recall being "on the go" every working day. Time was not allocated to recording

activities. Program planning and development was largely as a result of staff noticing patterns and having the time and interest to develop health education responses to them.

After 1979 and the report of the first organisational review, staff became involved in the planning process through the development of the coordinators' meetings and "in-service training days" which appear to have been, in fact, a broader staff planning forum. The review was called by the Medical Director who was aware that staff were unhappy with a range of issues relating to policy, planning and management in the Centre. In December 1980, the in-service training day debated the Service's apparent concentration on medical care and proposed objectives to increase access to the service and to review the role of the coordinators' meetings. A range of working parties were set up to address these issues over the following year.

Apparently there was no satisfactory process by which solution to these issues could be implemented. Staff complained that some groups' suggestions could be vetoed by other groups. Fundamental planning issues continued to be identified and consistently reappeared in in-service planning days, staff meetings and Committee of Management meetings throughout 1980 and 1981. A case in point is the lengthy

debate, in early 1981, about whether the Centre should employ a full time or part time medical officer on vacancy of the position. The Medical Director supported a full time doctor. However, the staff argued that the vacancy provided an opportunity to review the Centre's progress towards its objectives. Specifically, the multi-disciplinary staff identified the need to expand its role in preventive work and argued that the position should be used for health education and the more political aspects of health promotion. The nursing staff, who were engaged, essentially, as nurse practitioners, saw the need to maintain a full time medical position since they perceived that a reduction in medical time would mean an increased need for nurse practitioner time but with inadequate medical backup. This would consequently reduce the time available for nurses to engage in health promotion activities.

A series of special staff meetings were held on the subject of the medical officer position in which the staff decision was changed several times. The minutes of Committee of Management meetings reflected similar vacillation. The final decision was heavily influenced by the local general practitioner on the Committee of Management who was also a part time medical officer employed by the Centre. His argument developed a clear role for the Health Centre as an allied

health adjunct to local general practitioners, rather than as a competing general practice. He proposed that scarce allied health professionals should be employed and health promotion and health education should be developed. He further proposed that local general practitioners be employed as sessional medical officers in the Centre, thereby increasing the interaction between local general practitioners and the Centre. This, he suggested, would increase community access and usage of the allied health services. The argument won the day.

It is apparent that no systematic planning process was developed and, indeed, review of Health Centre goals and strategies was impeded by the organisational and decision-making processes. The Medical Director did acknowledge the need to define program objectives and the need for evaluation and review. However, he implemented no clear process for this other than providing staff with guidelines by which they could propose programs and service development. It was the Medical Director who finally approved programs and who reviewed them.

Health Service Planning and Development 1983 to 1988

The Health Centre's first official planning framework was developed soon after the reorganisation resulting from the management review. It was based on the guidelines for the implementation of health service objectives which had been developed by the Interim Committee of Management. All the work of the Centre was understood in terms of the type of service delivery or as support for service delivery. Professional teams reported on their specific areas of service provision in line with this framework.

The development of a Community Health Data Collection System began in late 1982 and a research officer was appointed soon after. By 1983, statistics collected in the Centre indicated that 80% of the service users were from local post code areas. A large proportion were less than thirty years old and females out-numbered males. Asian clients were the largest group from a non English speaking background and most people attending the Centre were recipients of pensions or benefits. Very little was recorded on main reasons for attendance, although the majority of attendances were with doctors or nurses.

After the implementation of the new decision making structure, the number of health promotion programs offered by the Centre increased slightly. This reflected the staff's new policy emphasis that the Health Centre services should not be adjuncts to the medical practice. By mid 1985, approximately one fifth of the staff were specifically dedicated to health promotion programs. Other staff not so dedicated also provided health education programs. Although the data collection system was not sophisticated enough to provide accurate details on all programs coded "community education and support," a monthly average of nearly 1,150 such contacts were made, in addition to the more traditional health education groups which yielded 2,968 contacts for the year. The fact that 16,520 contacts for the year were made with individuals seeking personal care indicates that the pattern of usage of the Centre had not changed rapidly. Nor had the nature of health promotion activities despite an increase in the number. A total of eleven health promotion campaigns and six other activity categories aimed broadly at public relations were described in the Annual Report of 1984, compared with three campaigns in 1983. Health education was the major orientation of these programs in both years.

The Administrator observed in the Annual Report for 1983 that,

although the Centre had provided excellent primary care services, it had been unable to achieve the goals of community participation, provision of preventive health services and multi-disciplinary team work. He suggested that these issues would be the challenge for the next phase of the organisation's development. At the end of 1983, with a decision-making structure and a range of upgraded administrative systems in place, the Administrator resigned to take up a promotional position in another organisation.

After a period of time during which the organisation consolidated its new decision-making arrangements, the newly appointed Administrator led a strategic planning process. Early in the process, the Committee of Management identified extension of the Health Service's role in community development and health promotion as a priority issue.

In the Annual Report of 1984, the Administrator foreshadowed that community participation in planning, decision making and service evaluation was to be enhanced by the implementation of the "Needs and Information Exchange Network" which had been proposed the year before. This structure was to improve communication between the Health Centre and the local community. Furthermore, she proposed to

reorganise the existing team structure from professional groups to teams based on function.

At least part of this new organisational arrangement was in place by the end of 1984. The "Community Education and Liaison Team" was formed specifically to develop the Health Centre's role in health education, health promotion and community development. It comprised the ethnic health workers, school health nurses, and some community health nurses, a recreation officer and a nutritionist, most of whom volunteered to be members of the team. The Team was established as a "pilot" and operated, for a time, within the existing structure of discipline specific teams which continued to provide personal care services. However, by the end of 1985, a multi-disciplinary Personal Services Team was established to engage in sickness prevention, health education and treatment activities.

The Personal Services Team included all doctors, clinical nurses, the speech pathologist, the physiotherapist, the podiatrist, and the psychologist. The Dental and Clerical Teams remained intact. However, by early 1987, on the resignation of the Dental Service Director, the South Australian Dental Service and the Parks Community Health Service negotiated a management arrangement in

which the Dental staff became employees of the Health Centre which contracted the South Australian Dental Service, a statewide service, to manage it.

Multi-disciplinary team functioning was taken very seriously at this point. Two team leader positions were created from existing service provision positions. They carried no service load, their purpose being to lead the Teams in their respective planning, implementation and review processes. They were also responsible for day to day service management, ensuring the full participation of their staff, personnel management and staff development for the organisation and their teams. They represented their Teams on the Health Management Coordinating Committee (HMCC) and were responsible, along with the Administrator and a staff representative, to the Committee of Management for the operational policies of the Centre and their implementation.

Health Service decision making was by consensus and the Administrator chaired the weekly HMCC meetings. Teams met fortnightly to consider program and service issues and were responsible for the development of strategies to implement HMCC operational policies. Specific project groups of staff met for detailed

planning of implementation and review strategies. Staff met as a whole group fortnightly at first and then monthly in 1985 to share information and to discuss major policy issues.

The Health Centre's constitution was changed to enable equal representation of community members and members with professional expertise on the Committee of Management. Nominations for membership became a more public affair with active advertising and recruitment through the newly formed community involvement network, now called "The Friends of the Parks." Skills development programs were developed to increase the confidence of community members as well as the quality of their input.

By the end of 1985, the Statement of Purpose and the Goals of the organisation, which were a product of the strategic planning process, reflected the principles of community health as they had been espoused by the Hospitals and Health Services Commission Report of 1973. Goals related to the provision of treatment services which encouraged self support, to health education and promotion, community participation, co-ordination of human services and to provision of undergraduate and graduate teaching services for health professionals.

The organisational arrangement reflected the functional separation of these goals. The Community Education and Liaison Team developed strategies to maximise community participation in the Centre and to develop health promotion programs. The Personal Services Team developed strategies to increase equity in access to services and to improve the preventive orientation of personal care. All Teams developed strategies to improve co-ordination and teaching. The Dental Team, however, continued to function comparatively independently due mainly to its very specific service focus and to its dual management system between the Health Centre and the South Australian Dental Service. This situation slowly improved as the communication between the two management bodies improved.

In effect, the Community Health Program policy principles became the new goals of the Centre. The planning process was supported by a comprehensive staff development program and the development and formalisation of the Management Coordinating Committee's role in review and evaluation of Health Centre programs towards stated organisational goals. The combination of these management activities and some significant changes in the South Australian Health Commission's policy environment, was instrumental in developing a staff commitment to a more social view of health and a primary health

care approach between 1985 and 1988.

The Influence of Ideology: a Preliminary Analysis

As discussed in chapter one, ideology can have a major influence on social health or welfare policy and on how it is implemented. George and Wilding (1976) distinguish between two stages of social policy formulation. The first stage decides whether there should be social policy while the second determines its shape. The first stage is the result of pressure exerted on government by those with the least power, and consists of concessions won by or granted to that group. In the second stage, the various groups whose interests are affected by the social policy develop a "pecking order" of power that then shapes the social policy. This acts as a check to the victories of the least powerful group. Given the lack of clear policy directions in the Community Health Program of 1973, the way in which it was to shape practice depended on which ideology was largely dominant within this "pecking order."

In relation to a community health service, the dominant ideological

position amongst staff will influence what meaning is given to community participation and to approaches to health promotion. A staff commitment to individualism would suggest minimal community participation in the actual decision making, whilst volunteerism and self help would be supported. Health promotion would probably be interpreted as health education. A belief in a collectivist social framework would suggest a commitment to active political participation by community members and promotion of health by addressing what would be believed to be structural causes of illness through social action in public policy.

The Ideological Environment

Management within a community health service can influence how policy is set and who participates in the process. However, the ideological environment of the workers is also important.

One objective of the Community Health Program of 1973 was to develop primary care services where access to such care was inadequate. General medical practice was described as pivotal in this development and an individualistic rationale for the program and service orientation was provided despite the collectivist character of

the policy objectives. This is not surprising since the modes of explanation of organisational behaviour are a function of prevailing social ideologies (Cherns 1981). Although the existing approach of the health system was identified as problematic by the 1973 Program, there were few alternative models available. Medical definitions of health and health promotion influenced even those few alternatives proposed.

The scenario described by the 1973 Program was attractive, particularly in South Australia, to a number of entrepreneurial general medical practitioners who were practising in areas relatively deprived of primary care services. St. Agnes was a new private housing estate described as a "mortgage belt" by social planners. Clovelly Park was an older industrial area and Ingle Farm was a combination of old public housing and new lower cost private housing. Private general practitioners in these three areas were successful in their submissions to the Federal Government to establish community health centres in their areas. In the Parks, the initiative was taken by teaching general practitioners. Since medical practitioners were in such a strong position to plan the services and to develop their policies, the traditional individualistic medical approaches to health promotion and personal care were continued within the new Program.

By 1979, the South Australian Government had changed to Liberal. Its policy and administrative context supported an individualistic orientation to health promotion programs. These programs were often no more than group processes for delivering therapeutic intervention. Auer (1988) has outlined the importance of this context in relation to women's community health service development in South Australia. Programs tended to fit the bureaucratic definition of a service as "client contacts", thereby individualising the types of service provided.

These traditional approaches were reinforced by a Commonwealth Department of Health Report on Health Promotion in 1978/1979, commissioned by what was by now a Liberal Government. It emphasised the central role of general medical practice. In keeping with the Commonwealth Government's health ideology, and the view of the Australian Medical Association (the two were in close accord), the Department suggested that health education services be located within group medical practices and other primary care settings such as hospitals. Health educators could then receive referrals from doctors "in cases involving smoking, exercise, weight reduction, sex education, interpersonal and family communication, effective parenting, and other time consuming behavioural problems" (p44). The report went

on to suggest using methods such as individual counselling and advice, as well as running groups for people with like needs. However, it also indicated that community health services were not engaging in enough health promotion and pointed to the need to appoint personnel for their expertise in health promotion in fixed ratio to the therapeutically oriented personnel. It suggested that such people might also occupy administrative positions and thereby re-orient health services (Commonwealth Department of Health 1979b).

The policy and administrative environment of the still relatively new community health services changed again by 1983 with Federal and State Labor Governments in place. It is significant that the Federal Minister of Health was a South Australian Member of Parliament with close links to the South Australian Minister of Health. In South Australia, the ideological direction taken by the Health Minister, or perhaps more particularly, his advisors, supported a marked extension of preventive activity and a social policy backing.

Sawer (1990) describes the increasing power of women in social policy making in Australia through the development of bureaucratic machinery at the State and Federal levels. The effect of the appointment of a Women's Advisor to the South Australian Health

portfolio and, more particularly, to the executive group of the South Australian Health Commission in late 1983, was to promote collectivist ideology within the policy division of the South Australian Health Commission. Lack of equity in health outcome and in access to health services were highlighted by the Women's Advisor as problematic, not only as issues for women generally, but for particular groups of women (South Australian Health Commission 1985). Social policy solutions were increasingly debated and, in South Australia, the development of women's community health centres was expedited.

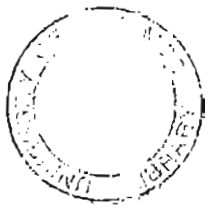
Information exchange between community health practitioners was another important environmental condition for change in South Australia. Prior to 1981, there were few forums for multi-disciplinary discussion and debate about health service and policy issues. The development of the South Australian Community Health Association in 1982 and its later role in the development of the Australian Community Health Association, enabled common concerns and issues to be identified and discussed by a range of community health workers.

The South Australian Community Health Association provided a mechanism for community health workers to participate in policy issues and a forum for education in community health practice. Many

of the women involved in the early women's health struggle were also involved in the formation of the Community Health Association. The ideals of the community taking power, not only in their interactions with health workers, but in the choosing of service priorities and the development of strategies to address them, began to be understood more broadly.

In 1984, the South Australian Community Health Association convened the first Community Health Conference in Australia. It was attended by over one hundred and fifty people, most of whom were community health practitioners. Of particular interest is the fact that over one hundred of the participants attended a workshop devoted specifically to the role of community development in health promotion. The ideology of extending community power was beginning to take hold.

The Australian Community Health Association convened its first conference, "Options For Action in Community Health", in Adelaide in 1986. Its second conference, "Health Promotion; The Community Health Way" went some way towards consolidating a more collectivist ideological position. The 1990 conference, titled "Healthy Environments in the 90s; The Community Health Approach" further confirmed the association's position. Clearly, the community health



workers were organising, on a multi-professional basis, around a common ideological position.

Accessible documentation of issues affecting community work and community health was also important in informing health practitioners of possible problems and solutions to issues of equity in health. Such documents as Hodgson and Potter (1982), Henderson and Thomas (1981), The World Health Organisation Working Papers, Proceedings of the various Community Health Association Conferences and the South Australian and Australian Community Health Association Newsletters, analysed the problems from a collectivist ideological framework and made clear that the struggle to implement community health principles in the health system was identical to the struggle by other weaker groups in society and that the same strategies had to be employed. As indicated in the Australian Community Health Association submission to the Federal Government's Better Health Commission in 1983, maximising community participation was seen as the key to achieving equity. Most significant amongst the literature was the establishment and increasing promulgation of "Community Health Studies," the journal of the Australian Public Health Association.

The Australian Community Health Association provided an auspice for

a project to develop community health accreditation standards for use throughout Australia in 1984. Parks Community Health Service had participated in the development of the standards by offering itself as one of the pilot sites in the early development phase of the project. The

standards were widely available as tools for improving community health services by 1985.

The understanding of community health practice amongst staff at Parks Community Health Service shaped and was shaped by this external environment. Health Service non-medical workers, supported by the managers, played a large role in the preparation for the first South Australian Community Health Association Conference in 1984. The Administrator, by now called the "Director" in recognition of the leadership role this position played, was a feminist with a social work background. She was familiar with a structural analysis of illness in society. She encouraged staff to attend community health forums and to engage in critical review of existing practice in the light of the social view of health now being espoused by the Policy Division of the South Australian Health Commission. The prevailing ideology within and amongst the staff of the Health Service began to be challenged, particularly by the Community Education and Liaison Team. By 1987,

the Team changed its name to "Community Education and Development Team" to more appropriately reflect its commitment to community development as a strategy for health promotion.

By 1988, this interplay between the ideology of management and the external policy and political environment had influenced the service approach taken at Parks Community Health Service. The medical staff had by now been incorporated within the Personal Services Team and had lost a great deal of power to provide an exclusively medical interpretation of the principles. The Committee of Management, which had by now become The "Board of Management" under new South Australian Health Commission guidelines, was no longer dominated by the medical professionals, having equal numbers of residents and professional members. Ways and means of implementing the principles of the old Community Health Program and the new World Health Organisation concept of primary health care were being explored by the various Teams within the Service, most particularly the Community Education and Development Team and the Personal Services Team. The following two chapters will analyse, in detail, the management and planning processes throughout the various stages of the organisation's development.

Significant Events in the Development of Parks Community Health Service

	National level	State level	Parks Community Health Service level	
1967		• Australian Labor Party elected to government		
1972	• Australian Labor Party (ALP) elected to government			
1973	• Australian Community Health Program established			
1975	• Australian Liberal Party elected to government		• Interim Committee of Management appointed	
1976			• Medical Director appointed	• Medical Service opened
1979		• Liberal Party elected to government	• Organisational review recommends executive structure	
1980			• Professional Executive structure in place	
1982		Labor Party elected to government	• Organisational review recommends abolition of Medical Director position	• Resignation of Medical Director
1983	• Australian Labor Party elected to government		• First administrator appointed	• First administrator resigned (late)
1984		• Women's Health Advisor appointed • Community Health Association Conference	• Second administrator appointed • Strategic planning process initiated	• Community Education and Liaison Team (CELT) established
1985			• Appointment of permanent CELT leader	• Personal Services Team established
1986	• First National Community Health Conference	• Social Health Branch of S.A. Health Commission established	• Appointment o Personal Services Team Leader	
1987		• Review of Health Promotion Branch of S.A Health Commission	• Aministrator (now called Director) resigned	
1988		• Social Health Strategy & Primary Health Care Policy Discussion Papers released	• Director (author) appointed (early)	• CELT Leader resigns (late)
1989			• Appointment of new CELT leader (early)	• Board decision on priority issues
1990				• Radical planning framework in place

Table 1

Chapter three

Parks Community Health Service management and planning: 1976-1988

Chapter two outlined the influence of the context within which the Parks Community Health Service was shaped prior to 1988. In essence, the development of a community health movement influenced the organisational and management arrangements at Parks Community Health Service by the development of a climate for a service approach which challenged the status quo. In that climate, the articulation of a model of community health service and management which differed from the traditional model was instrumental in bringing about a shift in the dominant values and interests in the organisation.

From its establishment when there were only a few staff operating within a medical model of service delivery, through to the present organisation of over 40 staff operating within a social health model, different skills and approaches to management and conflict resolution have been required at Parks Community Health Service. Each stage of management was instrumental in shaping the

service's present role in primary health care. Reviewing those roles, it is clear that the first years required management to attract the necessary resources and determine work practices that would carve a niche for the service, both within the South Australian Health Commission and the local community. Once this was achieved, participatory decision making and administrative procedures had to be established to ensure smooth functional relationships between workers within the organisation. It was only then that primary health care policy issues and goals could be fully debated, defined and operationalised in the form of an organisational structure representing the functional components of primary health care.

Chapter three focuses directly on the role that managers played in leading the organisation through these stages which, arguably, could be applied to any developing primary health care organisation. Through an analysis of the experience at Parks Community Health Service in terms of management and organisational literature, it identifies the important tasks to be undertaken by managers and the organisational arrangements to be developed at each stage of the emerging primary health care organisation.

The application of management theory to social service organisations — a dilemma

Hardy (1981) warns that an over-riding tendency of management is to convert moral issues into technical issues and problems of politics into problems of administration. Bureaucracy, the dominant form of organisation, also tends to "segment" the service into manageable parts rather than moral wholes. At the same time, it maintains control at the top, thereby limiting broad participation in organisational policy.

Professional agencies, Hardy argues, communicate a world view that defines lives and societies as a series of technical problems. The professional will often excuse him/herself from engaging in political or moral controversy on the claim that as a "professional" he is a neutral technical expert whose task is to get on with the job in hand. Therefore, although management and professionalism are often portrayed as contradictory forces in the organisation of human services, the social authority enjoyed by

professionals and, even more strongly, the management methods that control social services, can be seen as partners in a system which can belittle the recipients of services and maintain control in the hands of elite management and professional groups.

Management and organisational literature, which is developed outside of the inherent political context of state bureaucracies, is often used by those bureaucracies which manage, fund and control human services as a prescription for organisational development (Bryson 1987). As a consequence, management approaches are often ill-fitted to their purposes. However, an alternative approach is possible. Abels and Murphy (1981) have developed a normative approach to human service administration which incorporates management and organisational literature but attempts to maintain the values and goals historically framing the mission of human service organisations. Human service managers, they point out, are different from other managers in that their principal task is management for "just social consequences" (p8). The political context of the organisation is clearly acknowledged in this approach. This theme will be developed throughout this and the next chapter.

The South Australian Health Commission Act (1976) recognised

the inefficiencies and alienating tendencies of the bureaucratic form and legislated an administrative system which sought to transfer direct responsibility for services away from central bureaucracy to individual health units. It was intended that service delivery would be separated from the statewide funding and planning functions of the South Australian Health Commission (Committee of Enquiry Into Health Services In South Australia 1973). Hospitals and health centres were incorporated and management was delegated to ministerially approved Boards of Management whose responsibilities included ensuring that operation of the unit was in accord with South Australian Health Commission policy. Units were held accountable to the South Australian Health Commission through a range of mechanisms for finance and staffing issues.

Although Parks Community Health Service was not legally incorporated under the South Australian Health Commission Act until 1981, from the beginning of its operation in November 1976, it was managed as if it were incorporated. The Interim Committee of Management took on the roles and functions of an incorporated board and it related to a "Community Health" branch within the South Australian Health Commission.

Auer (1988), analysing the effects of the South Australian Health Commission Act on the Adelaide Women's Community Health Centre, which had been operating prior to the establishment of the administrative arrangements outlined under the Act, argues that the legislative and administrative arrangements of the South Australian Health Commission Act (1976) resulted in an improved "fit" between a primary health care service and the central administrative structures. In particular, incorporation provided a buffer between the service and the central bureaucracy. Global budgets allowed flexibility in the management of services. The Act allowed for community and worker participation in the planning and management of services. The Committee of Management had the power to support a treatment/prevention service mix, multidisciplinary models of service and different styles of service delivery. Auer concludes that, although the new arrangements did not foster and encourage these developments, they did not hinder them as did the previous bureaucratic administrative arrangements.

From the beginning, then, Parks Community Health Service had the freedom, within broad South Australian Health Commission policy guidelines, to develop its own service plans, organisational arrangements and styles of service delivery. It was required to

provide information to the South Australian Health Commission bureaucracy but not to be a creature of that bureaucracy. It is within this context of relative managerial freedom that the various stages of Parks Community Health Service development will be identified.

The role of management

Charles Handy (1976) defined the role of management as the blending of differences into one coherent whole. Applying this definition in his later work outlining the theory of cultural propriety, he suggested that the purpose of management is to develop cultures appropriate to the organisation's task and to so blend them that divergent interests are reconciled within an overall organisational culture supporting its mission or reason for being (Handy 1985). This definition provides a useful framework through which to view an organisation. It acknowledges that management is a creative and political process, owing much to the prevailing culture and tradition relevant to the particular place and time.

Handy argues that, although there are well studied technical aids to management, organisations, like families, have their own way

of doing things, their own culture, which must be understood for the manager to be effective. He proposes four broad categories of culture which will be described more fully in their particular application to Parks Community Health Service. Each of these cultures works on different assumptions about the basis of power and influence, about what motivates people, how they think and learn, how things can be changed. These assumptions can often be traced to the ideological framework of the organisational leaders. Organisations nearly always need a mix of cultures to carry out their different tasks but each culture must acknowledge the role played by others in the achievement of the organisation's goals. According to Handy, conflict or communication breakdown is often the result of one culture clashing with another.

Handy's framework is particularly useful when describing and understanding community health organisations which comprise different professionals with distinctly different values and expectations about the job to be done and the role of management in that job. The primary health care approach does provide the manager with the opportunity to reconcile a range of approaches, previously thought to be at odds with each other, within one policy context. Different cultures, relevant for varying approaches, can legitimately exist within the same organisation as

long as they all have a role in achieving the mission. Balancing the cultures can be difficult, particularly when there is no clearly agreed and articulated mission. A description of the various cultural clashes at Parks Community Health Service highlights this fact.

The establishment stage

The Community Health Program of 1973, emphasised the redistribution of power from hospital doctors to general medical practitioners and the equitable distribution of primary medical care. As described in chapter two, this provided an opportunity for some enthusiastic, creative and entrepreneurial doctors to extend their spheres of influence in community health services in South Australia. Successful applications for the new Federal Government funds resulted in the development of publicly funded community health services attached to, and managed by, a number of private general medical practices.

In the Parks, the concept of the Community Centre was already being debated by 1973. Community consultations had resulted in requests for medical and dental services and the Hospitals Department (later to become the South Australian Health

Commission) officer responsible for community health services began to connect them with the possibility of Federal money. This officer was instrumental in developing the interest of a number of influential people in the concept of a community health centre and an application for funds was submitted to the Federal Government Community Health Program in 1975. Major energy and commitment to the Community Health Centre, outside the Hospitals Department, came from The University of Adelaide, whose professor of Community Medicine chaired the inaugural committee of management in May 1975. It was this committee which created the vision for the Health Service. The Committee's task was to develop a set of policies that would guide the soon to be appointed Medical Director in the management of the new centre.

Using Handy's "Theory of Cultural Propriety," the management and organisational culture during the first years at Parks Community Health Service could be described as a "Zeus" or "Club" culture. Zeus was the king of the Greek gods. An irrational, charismatic but often benevolent power, he represented the patriarchal tradition. He is described by Handy as being feared, respected and occasionally loved. The symbol of a spider's web represents the way in which the rest of the

organisation relates to Zeus, the manager. The lines which radiate out from the centre are the various functions of the organisation. The encircling lines are those that represent power and influence, reducing in strength the further they are from the centre. The relationship with the manager matters more in this culture than any formal authority outlined in a job or position description.

The Zeus culture is common in the small entrepreneurial organisation. It is an excellent culture for speed of decisions but not necessarily for their quality. Procedures for operation are rarely defined since the culture thrives on affinity and trust. Selection and recruitment rest largely on how like-minded the candidate is. Individual efforts are valued and rewarded. The culture is most useful for responding quickly to creative ideas, for starting projects and for speed of action. Usually only one or two people are at the centre of these activities.

In Parks Community Health Service, the Service objectives (as prepared by the Interim Committee of Management for the proposed Standing Committee of Management) included community participation in the planning, management and delivery of services, the provision of a range of preventive, curative and rehabilitative services, the provision of training for

primary health care students and the conduct of research.

The ambiguities and conflicts centering on the main purposes and methods of community health since the inception of the program have already been discussed. The Parks Community Health Service Interim Committee of Management had its own interpretation of community health practice in 1976. To understand this interpretation, it is helpful to consider community health literature of the time. A collection of articles entitled "Community Health in Australia" which was edited by Walpole and published in 1979, reflects the thinking of the Interim Committee of Management in 1975 with its heavy medical and professional membership. Generally, the articles equate preventive services with preventive medicine and focus on primary prevention only as it relates to individual or community behaviour change[1]. They also equate primary health care with primary medical care[2]. As already discussed, this is not surprising, given the language of the Hospitals and Health Services Commission's report. They call for a new breed of doctor, able to work as a member of a team[3] , albeit the leader of the team[4]. They acknowledge the need for more appropriate training of primary health care workers, although the

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1 See article by Murrell in Walpole (1979)

2 See article by Manzie in Walpole (1979)

3 See articles by Gordon, Bridges-Webb and Ryan in Walpole (1979)

4 See articles by Anderson and Murrell in Walpole (1979)

training of general practitioners is the only profession specifically addressed[1]. Walpole's preface calls for "common sense and not nationalised medicine, evolution not revolution." It points out that community health has a strong component of preventive medicine, which involves health education and behaviour modification, most effectively achieved within general practice. It draws the conclusion that citizens must take more responsibility for their own health and lessen their dependence on the authoritative figures of medicine.

The text by Walpole, other literature of the era,[2] more recent publications of Professor Murrell, the Chairperson of the Interim Committee of Management[3] and interviews with another medical member of the standing Committee of Management which was appointed in 1977, support a conclusion that the vision of the Interim Committee of Management related to the development of a community medical practice. The practice was to be the centre of a dynamic, multidisciplinary group of health professionals. These people would be skilled in developing health education programs appropriate to the needs of the local community and able to support the individual behaviour change advocated by the

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1 See article by Webster in Walpole (1979)

2 Commonwealth Department of Health (1979b), Connor (1977)

3 Murrell (1985, 1989)

general practitioner to his patients. The vision entailed the development of a teaching community health practice, similar to a teaching hospital, where students could learn and practice first hand, community and preventive medicine in a multi-disciplinary team. It also included community health research which would be made possible through the collection of morbidity data by the general practice. All this would be achieved with the involvement of community people, although apparently there was no defined strategy to achieve this other than the 1977 proposals for community membership on the standing Committee of Management.

This was radical thinking within the traditional illness orientation of the health system and within the medical profession's political preference for private fee for service operation. It was represented, however, by a medical power base in the Committee of Management. Although it is true that medical practitioners did not dominate in number, their ideology relating to the nature of health did dominate. The membership was relatively well socialised in relation to its attitudes to the expertise of doctors on all matters pertaining to health. Furthermore, no alternative framework for health service policy was articulated at that time. Dynamic and single minded people were required to make the

Committee of Management vision a reality. In Handy's terms, a Zeus figure and the supporting "club" was required.

This original "club", then, was the Interim Committee of Management with its chairman at the centre of the web. To this group was added the medical director. He was to become the new Zeus. Three medical professionals, who included two local local general practitioners, formed the inner circle, conferring as necessary on service and policy issues outside the Committee of Management, within the "medical subcommittee". This was not viewed as irregular in any way by the larger group who sanctioned the activity. It was considered pragmatic, given the doctors' acknowledged expertise in health issues and the need to develop the service quickly. The outer circle included the community member who has been described by the then chairman as a "salt of the earth type" but not fully understanding her role (Murrell 1990).

The immediate tasks of the new Director included securing suitable facilities for the health centre, both in the short term and within the plans for the soon to be constructed Parks Community Centre, beginning the operation of the general practice and establishing an appropriate mix of professional staff to provide the

services deemed most appropriate to support the general practice. All this had to be achieved in a hostile professional environment, given the opposition of the Australian Medical Association to free public medical services. (Milio 1988) A further task, therefore, was the establishment of workable, or at least non-threatening, relationships with the medical profession both at the local and the state levels. Indeed, the medical director was appointed as much for his credibility amongst his private practice, fee for service colleagues as for his suitability to perform the tasks of establishment (Murrell 1990).

A few months after the Health Service opened, the Committee of Management decided to fill the medical position, additional to clinical time worked by the medical director, with sessions provided by local general practitioners. This was seen as strategic to securing good working relationships with general practitioners, many of whom viewed health centres as forms of unfair competition (Milio 1988). The general practitioners who provided sessions were members of the Committee of Management. In addition to the policy level, the inner circle was now strengthened in relation to the operational level of management. This is not a surprising situation in the culture of Zeus. The culture depends on networks of friendships, old boys and comrades and can therefore

appear to be nepotistic, closed shops. However, trust and friendships are good bases for getting things done (Handy 1985).

By 1979, nine professional services were provided in a new centre which was considered to be a model of its time and, even by today's standards, is very impressive. The medical staff were still the inner circle, or power elite in that they determined the parameters of policy debate, and the operational interpretation of primary health care, by their involvement on the Committee of Management. By May 1977, a medical staff committee had been formed to advise the Committee of Management and staff on all medical matters. The status of the medical professionals on the Committee of Management is indicated in the facts that all but one medical staff member were members of the Committee of Management and the doctors names always appeared first on the minutes of the Committee of Management. Indeed through their involvement, and particularly through the efforts and political acuity of the Medical Director, the service enjoyed a form of mainstream credibility and was the subject of great interest as a progressive experiment in health care (Murrell 1985).

In spite of a medico-political environment threatening enough to force the closure of some interstate community health services,

Parks Community Health Service maintained enough credibility and support from the medical profession to remain viable and, indeed, to develop. Several compromises on the original service policies were necessary in order to avoid outright antagonism from the Australian Medical Association. This included a limited right to private practice for all general practitioners employed by the centre as well as the introduction of fees for patients who were privately insured. The latter policy decision was a direct result of an article in the Australian Medical Association Bulletin of February 1977, expressing the view that fees should be charged at Parks Community Health Service. The decision to charge fees was later acknowledged by the Australian Medical Association as "fair competition." By October 1977, Parks Community Health Service was approved by the Medical Board as suitable for placement of medical interns.

The tasks of the establishment phase had been more than satisfactorily achieved. Yet by mid 1979, the first signs of organisational conflict were visible.

The need for skill in the management of differences accompanied the arrival of the "allied" health staff at Parks Community Health Service. The resolution of differences or potential differences

takes up the largest single chunk of managerial time and energy and it is not always well done at the end of it all. A manager needs to understand the nature of differences in his/her organisation, and to have an awareness of the possible sources of conflict and the strategies for handling such conflict. He or she must be a good "politician" (Handy 1976).

Organisational analysis has generally been concerned with organisational objectives, goals and structures of authority. The exercise of power and conflict has, therefore, been treated by the literature as aberrations of the proper functioning of the organisation, rather than as a normal characteristic of operation. More recently, though, organisational studies, attending to power and conflict as matters of primary interest, have developed a knowledge base which can assist managers to structure power and deal with conflict in a way that moves the organisation forward (Walsh et al 1981). There is no point in an organisation having a set of goals without the manager having a political strategy for reaching them.

The major political task at Parks Community Health Service during its early stage of development was to recognise and deal with the relationship between professionalism and industrial

democracy. Industrial democracy, first in vogue in South Australia at the time of the first Medical Director's management, sought to increase worker participation in decision making. Industrial democracy has a range of rationales from conservative managerial requirements for consensus amongst workers through to shifting control of the means of production from the owners of capital to labour (Hyman 1987). The rationale provided by the (then) Labor Government, which promoted the concept in South Australia, was that worker participation in decision-making was fundamental to real social democracy (Dunstan 1981). This broad worker movement was reinforced in community health organisations by an increasing tendency for community health workers to professionalise, thereby seeking more control over their own work content and territory. Professionals tend to build their own place in an organisation when they enter it. The dominance of medicine in most health settings means that it can delegate and define the work of other occupational groups. There is, therefore, an in-built tendency for conflict in health teams (Furler, 1982; Bucher and Stelling, 1969).

The influence of the medical profession on the interpretation of community health practice at Parks Community Health Service has been described more fully in chapter two. For the purposes of

this chapter, it is important to focus on the nature of the conflict which this caused, that being, essentially, dispute over the right of one professional group to be making important decisions which affected the work practices of the other professionals. The inner circle, the club, was being challenged. There was a need for a shift in culture to accommodate the increased number of staff who regarded themselves as professional and therefore sought their share of functional autonomy within the organisation.

Handy suggests that in the Zeus culture, power is seen to depend on the control of resources and personal charisma. "If you own the club you can tell people what to do."(p44) From this power base, the culture creates change by changing people. If there is a weak link, it may need to be replaced. There is an undeniable arrogance about Zeus. Planning and decision-making is opportunistic and unsystematic. Appropriate to most establishment phases, the organisational culture engenders experimentation and expansion. Credibility is the most important variable to Zeus. It is extremely difficult to change the direction of the organisation on the basis of logical argument. Most often who is arguing has more impact than what is being argued.

Staff employed at Parks Community Health Service in 1979

report a "consensus" model of decision making at the staff level. (Beaumont 1990, Bickley 1990, Jory 1990, Renney 1990) Things were, apparently, aired thoroughly in an informal way. This worked very well for the majority of decisions. However, when conflict occurred, there was no resolution process other than a decision by the Medical Director or the Committee of Management. Given that four members of the Committee of Management were doctors, and that they were also staff members, non-medical staff began to feel that the process by which organisational decisions were made favoured the values and the interests of the medical professionals. This was compounded by the fact that the medical director claimed the right of veto over any decision made at the staff level.

The first outward signs of discontent came from the nurses. They had been attempting to define a preventive service role for themselves in the face of increasing pressure for clinical work from the medical staff. When in July 1979, a nurse resigned in anger, staff called for a series of sessions to evaluate and propose alterations to the health team. Typical of the Zeus culture, the proposed sessions were called "staff development" and aimed to "improve communication" in the health team. This response is based on a view that flawed interpersonal relationships and

knowledge are the fundamental causes of discontent. Education, the preferred solution, rests on an individualistic interpretation of conflict as an aberration of consensus within the organisation. The response does not address the issue of power. This analytical approach is to be expected since there is a strong relationship between management's preferred organisational intervention methodology and the prevailing ideology of the particular organisation and of society at large (Cherns 1981). At this stage, although there was a requirement for industrial democracy in the decision making of the Health Service, there had been no articulation of an alternative to the prevailing individualistic model of health care by other professionals within the centre.

At the request of the Medical Director, a management services officer from a staff development group which was a support service for health units of the South Australian Health Commission, carried out a series of interviews with staff. The intention was to develop a staff development program for Parks Community Health Service to address the conflict problems. However, the report, based on interviews with staff, which he presented to the Committee of Management on 19th November 1979, went a great deal further. It recommended a management structure and decision making procedure consisting of a new

"health administrator" and professional "coordinators" who would participate in weekly decision making meetings with the medical director. The report argued that this would assist in the development of team-work and reduce the administrative load on the Medical Director, leaving him free to develop clinical services. It recommended that the whole staff take part in regular "staff development" sessions which could focus on the longer term issues for the centre and begin to move it away from what he termed a "crisis management" approach. The Committee of Management accepted the recommendations of the report which the Medical Director implemented immediately.

Professional coordinators were easily appointed or elected within the medical, nursing and administrative groups of staff. However there was a range of health professionals who were categorised as "multi-disciplinary" who had nothing in common other than the fact that they weren't doctors, nurses, dentists or administrative staff. They did not support the recommendations of the organisational review and continued to claim that they were denied access to real decision-making. Various members of the medical staff regarded their arguments as "irrational" and ultimately the Committee of Management accepted the recommendations of the report of the organisational review. The

multi-disciplinary staff duly, if begrudgingly, elected a coordinator. The administrative officer, classified at a comparatively senior level, was employed by August 1980.

The path had been laid for the development of a new culture. Apparently, however, the medical director did not acknowledge its need, or perhaps was incapable of making the appropriate behavioural changes. Staff report that the situation improved only slightly and that important decisions seemed to go around in circles in the main staff forums, the coordinators meetings and the Committee of Management. (Newton 1990, Beaumont 1990, Clisby 1990, Bickley 1990) These impressions are verified by minutes of planning forums, and Committee of Management meetings which indicate that items continually reappeared as a result of unsatisfactory resolution. Furthermore, staff were now confused as to the respective roles of the Medical Director and the Administrative Officer. (Birch,1991)

The distinction between operational decisions and Committee of Management decisions was by no means apparent. Minutes of Committee of Management meetings of the time indicate that the committee was heavily involved in the operational level of management. Still no long term plan for the health service had

been developed that could guide policy decisions. The Medical Director was in an untenable management situation. He reports that by 1981, Committee of Management were forming subcommittees to do things which should have been done by him, without including him or consulting him (Allen 1990). This report is supported by the Administrative Officer of the time (Birch 1990).

Handy's theory of cultural propriety holds that much of the trouble in organisations comes from an attempt to go on doing things as they have always been done. This arises from a reluctance to change the culture when it needs to be changed. Rotem (1984) has developed a complementary framework for analysing problems in multi-disciplinary health teams. He suggests a hierarchy of structural issues which the team must address to be functional. This includes clarity of decision-making procedures, roles of the team members and organisational goals. By 1982, the team at Parks Community Health Service was in need of clarification of procedures and of management roles. Procedural clarity is not a Zeus strong point (Handy 1985). Some staff felt that it was time for Zeus to go and they began to exercise their power to bring this about.

Walsh et al (1981) define power as the determination of outcomes by an individual or group in accordance with his/her or its values and/or interests in the face of opposition from other individuals or groups with opposing values and/or interests. They suggest that, when applying a political model of organisational analysis, the natural focus of management's interest is on the decision-making process where conflict of interest is manifested. However, the outcome of that conflict is only a limited expression of power within the organisation. Power exists, in a stronger and more structural sense, in the patterns of domination and control. This is articulated through a mode of rationality which consists in a set of "deep rules" or values governing the forms that thought and action can take in the organisation. Manifest conflict at Parks Community Health Service, for example, arose from, but did not challenge, the values inherent in professionalism. It was driven by values of efficiency and participation in decision-making and indeed, aimed to increase the functional autonomy of a range of professional groups.

Values held by groups and individuals are not free floating, idealistic positions but are connected to material interests. What is valued depends to a considerable extent on an assessment of the consistency of a group's interests with the likely organisational

implications of a particular set of values. Interests are expressed through a motivation to enhance or defend a particular distribution of organisational resources (Walsh et al 1981).

At Parks Community Health Service, the expression of professional interests was most evident in the debate over the need for a full time medical officer. This was the final test of the Medical Director's diminishing influence over staff and the Committee of Management. It was the subject of special staff meetings and appeared on the agenda of Committee of Management meetings over a period of almost a year. The Medical Director reports that he knew that "the writing was on the wall." He no longer had credibility with the Committee of Management and the situation with staff had, once again, become dysfunctional (Allen 1990).

The Medical Director advocated a strong general medical practice. He believed that through interaction with the general practitioner, the individual can be moved into health promoting schemes. He argued for an expansion of the general practice. In promoting this concept, he was confronted by the newly emerging professionalism of the non-medical staff, who questioned the dominance of medicine in health care and promoted the

development of preventive approaches. He was also confronted by the values and interests of some powerful medical staff who did not wish to see an expansion of a public medical practice that had the potential to attract their own private customers. A letter from one of the doctors to the chairman of the Committee of Management argued that the health service should support local general practitioners by the development of allied health services, not duplicate services already offered in the community. Other members of staff were concerned about the extent of organisational dysfunction and still others were concerned to bring about a climate of industrial democracy. The vacant medical officer position put all these issues on the agenda of an extremely confused decision-making process.

A partnership of four people, comprising two members of the multi-disciplinary staff, a medical officer who was also a member of the Committee of Management and the Administration Officer, developed a strategy of opposition to the Medical Director which involved developing a staff constituency for prevention and challenging the medical dominance of decision-making (Davis 1990). The Medical Director finally called for a second management consultancy. He was aware of the risks to his own position in the organisation but, by this time, significant events

had indicated a need for him to leave (Allen 1990). Several planning activities had developed without the direct involvement of the Medical Director. A research and development project was conducted by the Health Promotion Services of the South Australian Health Commission to ascertain community need. Staff began to relate directly to the Committee of Management in advocating for the need for policy and plans for preventive health programs and for a process by which this might happen. By the beginning of June 1982, the chairperson of the Committee of Management took the matter of planning into his own hands and appointed a subcommittee to develop Health Centre policies. The Medical Director was not a member of this group. A statement of organisational aims and objectives was approved by staff and the Committee of Management by August that year.

The Medical Director resigned after the management consultant's report of the organisational review was presented to the Committee of Management. This provided the organisation with an opportunity to develop some of the issues raised in the report and to modify its recommendations. A specially appointed sub-committee developed proposals for an organisational structure, delegations of authority and duty specifications where appropriate. The sub-committee recommended the legitimation of the

professional coordinators' meeting as the operational decision-making body, to be called the Health Management Coordinating Committee, and proposed delegations of authority. Under this arrangement, medical personnel would no longer have any right of supervision over other professionals. Duty specifications for the professional coordinators outlined responsibility for professional supervision as well as for the participation in multi-disciplinary decision-making and management as members of the Health Management Coordinating Committee. The administrator's duty specification outlined his responsibility, as chairman of the Health Management Coordinating Committee, for administering policies of the Committee of Management and for the development of information systems for the purposes of planning. He was required to facilitate a consultative approach to decision-making and forward planning.

The procedural stage

The technical task of the next era of management was to develop smooth administrative procedures. The political task was to facilitate the development of effective decision-making procedures, both at the policy level and at the operational level of management, such that various professional opinions could

influence service planning.

Handy describes the management culture preferred by professionals as "Dionysus". Dionysus was the Greek god of wine and song and represented the existential ideology that each person is in charge of his or her own destiny. The organisational implication of existential thinking is that the organisation exists to help the individual worker to achieve his/her purpose. It is a commune culture existing for its participants. It is an excellent organisational culture where talent or skill of the individual is the crucial asset of the organisation. It is preferred by professionals because they can preserve their own identity and freedom whilst retaining the support, flexibility and bargaining power that association brings.

Dionysus is a fulfilling culture for the professionals working in them but not for the manager. The participants in this culture recognise no "boss." No sanctions can be used on them. They accept co-ordination for their own long term convenience. Management is viewed by the professionals as a necessary task much akin to housekeeping. Decisions are made, as a rule, by groups of equals. Professionals do not willingly receive orders, or compromise their own plans. Dionysian cultures are organisations

of consent, where the manager governs with the consent of the governed.

Harrison's (1988) propositions regarding the management arrangements for the British National Health Service, after the re-organisation of 1974, provide a health organisation example of Handy's concept of an organisation of consent. The 'Grey Book' (Department of Health and Social Services,1972) set out the definitive philosophy for the National Health Service arrangements of 1974. Management was to be conducted by multi-disciplinary management teams. Individual team members were to have personal responsibility for their own spheres of work whilst issues or decisions which were multi-disciplinary or strategic were to be handled collectively. The mode of decision-making by such teams was to be consensus. This arrangement, he argues, adheres to the notion of clinical freedom. Brown (1979) suggests that consensus management teams were both a reflection and a cause of professional aspirations to managerial autonomy. Harrison proposes that during this period, local level doctors, not managers of the National Health Service were the most influential actors. Arguably, this was also the case at Parks Community Health Service.

Given the fear of medical professional dominance among the staff, arising from the management experience of the establishment years at Parks Community Health Service and the limitations placed on the decision-making capacity of the new Administrator, Parks Community Health Service, between 1982 and 1984, is best described by Handy's notion of the Dionysian culture, an organisation of consent.

Whilst the years between 1982 and 1984 were a productive and expansionary period at Parks Community Health Service, the actual resource allocation to the medical service did not change, nor did its work practices. In contrast, the other professionals became more cohesive, supported admirably by the administrator in their exploration of the various interpretations of community health principles. The medical service apparently favoured a change in priorities but only on the basis of their own priorities remaining intact. However, the new management arrangements were supported by all concerned because the new administrator was not to influence "professional" decisions. He was to be, as Harrison describes the role of the British National Health Service administrators, a diplomat.

The process of diplomacy is defined by Harrison and Hallas

(1979) as " a process concerned to conciliate, in as co-ordinated a fashion as possible, all the sub-groups within an organisation" (p1486) They argue that in the context of diplomacy, there is rarely a meaningful overall objective; more often there is a set of partially, or sometimes completely, contradictory objectives held by groups or individuals. It is true that a range of interests and values were instrumental in bringing about the new decision-making procedure at Parks Community Health Service. There is no doubt, therefore, that that same range of interests and values were represented in the decisions made within that process.

The new administrator had a head start in tidying up the administrative systems of the service. He had begun developing a range of improvements in his previous position as Administrative Officer in preparation for the incorporation of the Health Centre. This was finally confered in December 1981.

By March 1982, a management data collection system had been implemented. In place of the previous simplistic head count, client and service profiles were now possible. A marketing strategy was being developed and a process for monitoring and reviewing office accommodation was in place. The clerical team was restructured in January 1983 to support the computerisation of

health service functions and a staff development program was in place. Procedures for the selection of staff representatives on the Committee of Management were established and promulgated. By March 1983 procedures for the accounting and finance functions had been developed and approved. For the first time, service agreement contracts were developed with other agencies providing sessions within Parks Community Health Service.

This new sense of order, along with the new spirit of consultation and co-operation which was supported by a consensus approach to decision making, helped to create a climate conducive to planning and review. A number of submissions by staff, relating to processes for planning and implementation of preventive health programs, had been prepared during the debate leading up to the resignation of the Medical Director. It was now possible to more fully debate these issues at the staff level. The approved statement of aims and objectives incorporated protection and health promotion services in a very comprehensive list of objectives.

During 1983 several research projects were initiated. One, initiated under the auspice of the South Australian Health Commission, was designed to ascertain need for health services in

the western region of Adelaide. Another was initiated by the Centre's own recently appointed research officer. In conjunction with the Health Promotion Branch of the South Australian Health Commission, the research officer had instigated a "research and development" project to support the Parks Community Health Service in establishing its health promotion priorities. The part time research officer position had replaced the extension of medical services as proposed by the Medical Director during the debate leading up to his resignation. It was a major coup for the multi-disciplinary group who had articulated the need for systematic planning and evaluation within the health service. The research officer had proved invaluable in establishing an information base relating to services provided and service needs. She also developed a procedure for proposing and reviewing programs which included some rudimentary assessment of need and indicators of program success.

Specific local health issues were identified and a proliferation of new programs aimed at health promotion were initiated in this period. However, although this kind of exploration relating to the range of possible methods to address the issues was fundamental to the centre's development as a primary health care service, it also frustrated those staff who saw a need to get on with the "real

work" of treating people's ill health. Staff attempting to engage in preventive activities were conscious of the possibility of criticism and were not particularly confident in their endeavours (Davis 1990).

An apparent lack of planning characterised health promotion in community health throughout Australia in the late seventies. Health promotion was often the result of ad hoc approaches from members of the community or the interest and enthusiasm of individual workers rather than a reasoned and well researched strategy development process (Commonwealth Department of Health 1979b). To a certain extent this was true of the Parks Community Health Service during 1983. Signs of inter-professional frustration began to show to the extent that by November 1983, staff called upon the Administrator to re-institute the planning days, previously called staff development days, that had not occurred for some eighteen months .

At Parks Community Health Service in 1983, the statement of aims and objectives was comprehensive enough to provide a policy context to any activity which one of the professional staff might choose to undertake. A range of professional values and interests could be accommodated without creating conflict. The central

issue, however, is that the professional staff had all the power in planning.

Perusal of Committee of Management minutes throughout 1983 indicates that the committee had a "rubber stamping" role in the Parks Community Health Service decision-making process. Recommendations came to the Committee of Management from the Health Management Coordinating Committee already well worked out by the Health Management Coordinating Committee. Committee of Management members were well informed by the Administrator, both in writing and verbally, but very little debate is minuted and all recommendations throughout the entire year were carried. Words such as "ratified" and "endorsed" were used to describe the activity of the Committee of Management in decision making. All new initiatives came from the staff of the centre. By late 1983, the power of the Committee of Management had diminished to such an extent that the Administrator proposed a program by which the Committee of Management could become more involved with the centre. Ironically, at the same time, work was in progress on the development of a proposal for a "subscriber" scheme which was intended to address the issue of community participation in the service. It was anticipated that such a scheme would provide, on the one hand, a constituency of

support for the centre whilst, on the other, a much needed community input to planning.

On the whole, the Health Service staff team was functioning well. This was mainly due to the fact that the underlying individualistic concept of health care had still not been challenged. Procedures of operation had been defined, roles of staff had been negotiated in relation to prevention and goals, although not clearly defined, were based on a set of values which for the most part, were uncontested. The service was still experimenting with options for health promotion, for community participation, for improving accessibility and co-ordination. However, the options were determined by a professional view of what was appropriate. Indeed, to the extent that the professional staff controlled the policies and operation of their own sectors of work and to the extent that they influenced policy making for the whole institution, it fitted Bucher's and Stelling's description of a "professional organisation" (Bucher and Stelling 1969).

Professionalism in groups brings with it a quest for functional autonomy which is more conducive to conflict than co-operation (Furler 1982). In general, professional organisations consist of a number of professional groupings, each working in

their own directions, implementing their own professional values (Bucher and Stelling 1969).

The Administrator had performed the technical and political tasks of that stage of the organisation's development well. Smooth operating procedures were in place, a culture had been developed which enhanced participation of all professions in decision-making, professional boundaries had been protected and a level of exploration, relating to the interpretations of the community health principles, was underway. Paradoxically, this exploration resulted in the development of inter-professional rivalry over which "model" of community health service should be employed at Parks Community Health Service. The medical model was still dominant (Roe,1990) and, although wearing the hat of an Australian Medical Association representative, the medical coordinator on staff was still a member of the Committee of Management. He was influential amongst the other members of the Committee. The organisational structure of the Service provided a traditional power base, analogous to a hospital, in which services were judged by the medical staff. Diagnosis and treatment excellence were their criteria.

Bucher and Stelling (1969) point out that conflict within professional organisations has its roots in the divergence of professional values and influence. With a sizable collectivity of different kinds of professionals, each professional group has its own notions of what directions the organisation should take and where it needs changing. However conflict generally proceeds in a "gentlemanly" fashion. Aspersions are not cast, outside of small groups of close allies, on the motives or competence of the opposition. The tactics most favoured in professional organisations involve face to face negotiations among key political figures, some caucusing and development of more or less acceptable compromises. This was certainly true of the "Dionysian " culture at Parks Community Health Service during this stage.

The task of the next stage of the organisation's development was to develop an organisational plan, incorporating an ideological position on the principles of community health, which could provide a more singular direction for the future development of the service. For this to happen, the culture of the organisation had to change again. When the Administrator resigned in December 1983 to take up a position as an administrator in a large teaching hospital, the new Administrator, whose background was training and education within social administration, initiated this change.

The organisational planning stage

The new Administrator, appointed in December 1983, determined that her major task was to break down the professional boundaries. Establishing some common ground on the meaning and practice of prevention in community health would address the most significant area of conflict, plaguing not only Parks Community Health Service but community health generally since its inception in 1973. Ambiguities exist in Community Health in Australia relating to, firstly, whether prevention is to involve illness detection and early intervention or avoiding illness at the outset, and secondly, whether it is to use strategies aimed at individuals and small groups or the whole community (Milio 1988). The former ambiguity was the source of a great deal of the inter-professional conflict at Parks Community Health Service. A singular vision of the health centre's role in prevention which could inform health centre goals and strategies was, therefore, necessary (Roe 1990).

By April 1984, the Committee of Management had supported the new Administrator's proposal to undertake a strategic planning exercise, beginning with an exploration of a staff and Committee of Management vision of the way in which the Health Centre

would be practising if it was "doing prevention right by 1990". This exercise was useful in developing a framework for services which could incorporate the beliefs of all staff. It confirmed a range of different functions as appropriate for preventing ill health and the importance of different ways of working. Not surprisingly, it defined the distribution of resources between treatment services and health promotion, education and community development as the priority issues for planning. The eventual resolution of this issue involved developing a clear statement of the health centre's purpose and goals and a change in organisational structure to reflect the various agreed functions of the Community Health Service, rather than the professional groups within it.

The Administrator facilitated the change process by the use of Organisation Development techniques. This approach reflected the social learning and social work background of the Administrator and the collectivist philosophies of her close advisor, the social worker of the Health Service, in the early stages of this process.

Organisation development is a long range effort to improve an organisation's problem solving and renewal processes, particularly through a more effective and collaborative management of

organisation culture, with special emphasis on the culture of formal work teams with the assistance of a change agent or catalyst and the use of theory and technology of applied behavioural science, including action research (Gray and Stark 1981).

Sofer (1972) describes the evolution of management theories, from Taylor's mechanistic preoccupation with performance of the individual, to Lewin's social learning approach which emphasised group functioning. The social learning theories acknowledged the importance of formal and informal dynamics of the workplace as major determinants of individual effort. Organisation development is located within this social learning framework. It provides the organisation with the means of coping with its own problems. It emphasises team development in small work groups. Programs generally concentrate on improving both the human and task elements of the organisation. The most fundamental human goal is the changing of beliefs and attitudes of individuals. Before these changes can occur, however, it is considered important that people trust each other. Procedures such as open confrontation of conflict are used to achieve this trust. The most basic task goal is to improve processes of accountability (Gray and Stark 1981).

The new organisational structure of Parks Community Health Service, fully in place by June 1986, comprised four teams, one responsible for personal treatment and health education services, the Personal Services Team, one for community development, health promotion and community liaison, the Community Education and Liaison Team, one for administration and one for dental services. Team leaders were responsible for planning and review within their own functional area. Teams were responsible for defining ways of working that could best meet the organisational goals. The entire service was managed by a group comprising the Team Leaders, a staff representative and the Administrator, whose title was now changed to "Director" in recognition of the leadership role of the position. This group was responsible for operational management within policies determined by the Committee of Management and for overall health centre planning and review. New delegations of authority were developed to fit the new organisational arrangement.

The new organisational arrangement allowed for the creation of several different cultures within the organisation to adequately perform its different tasks. The dominant organisational culture could be described within Handy's theory of cultural propriety as "Apollonian," the role culture, in that it defined functional

divisions. However, the culture within most teams is best described as "Athenian," the task culture.

Handy describes the task culture as ideal when the product of the organisation is the solution to a problem. It tends to flourish in times of expansion when the products, technologies or services are new. Individuals are viewed as resourceful humans rather than human resources. The leaders recruit teams or individuals apply to join groups to solve problems. Assignment is usually subject to agreement between both individual and leader. Command can be exercised through the socially acceptable form of "persuasion". The culture works best when a heterogeneous group of talents becomes homogeneous through a common cause (Handy 1985).

Operation within the teams at Parks Community Health Service was characteristic of this task culture. The task of each of the teams was to develop strategies (technologies) for working in a way which would implement the principles of community health and which would achieve each team's particular organisational goal. Within a short period of time, using the organisation development methodology, staff were not only well versed in community health rhetoric but had developed their particular goals and strategies to achieve them. By 1988, there was an

unprecedented cohesiveness apparent in all the teams and a range of creative programs were in place. However, getting to this point was not a completely smooth transition.

There are a number of specific problems in relating the characteristics of good group functioning to a health team. Firstly, health teams face considerable uncertainties concerning their goals or missions. They cannot ignore social problems and retreat into the relative security and certainty of medical work. Secondly, the nature of the task demands a highly diverse set of skills, knowledge and backgrounds resulting in a mix of many cultures having to work together. Thirdly, decisions can seldom be made in a routine, programmable or unilateral manner and the decision-making process can be influenced, as already discussed, by the interests and values of the various power groups in the teams. Behavioural norms of flexibility, support and openness in communication are essential for the team to develop the ability to critique its own functioning in an ongoing way for its own self renewal (Rubin and Beckhard 1971).

Each of the newly formed teams at Parks Community Health Service experienced these problems to a greater or lesser extent, depending on factors such as when the team was formed; the

Community Education and Liaison Team was the first to be established in what was essentially an incremental change process, which professions were in the team; the Community Education and Liaison Team did not include medical professionals, the nature of the team's function; the Personal Services' Teams function was to provide the more traditional interventions with patients or clients.

The Community Education and Liaison Team was the first established. Its mandate was the development of processes to increase community participation in the Health Service's activities and the development of health education programs. The task was necessarily vague. The team, consisting of community and ethnic health workers and nurses and lead by a social worker in an acting capacity, grappled with the task. Other professionals within the organisation who were concerned with treatment issues, regarded their efforts as an interesting but costly luxury (Davis 1990). The permanent team leader, appointed almost a year later, determined that although the group had developed some passion for their area of work, there was no congruity in the way individual team members defined the subject of their work and, generally, the group felt unimportant within the organisation (Lane 1990).

The Service's Statement of Purpose was, by this time, able to serve as a framework for team planning. The Community Education and Liaison Team Leader initiated a two day planning process during which a team mission relating to community participation, prevention and co-ordination and liaison was established. This was followed by a three month process during which goals, objectives and strategies were developed. Staff worked in task groups on particular issues and brought their recommendations to the larger team. The results of this process constituted a strategic plan for the team. Team members had defined their roles in relation to each other, in relation to the community and in relation to the rest of the organisation. They had also defined the norms by which the team would operate. Their tasks were to develop training packages for community members and for staff as a means of maximising community participation in health issues, to further develop the "Friends of the Parks" subscriber scheme and to develop a community consultation process to identify, direct from the local community, what health issues should be the focus of preventive work. This planning process assisted the team to develop a cohesive view about what it was supposed to be doing.

The Team Leader's background as a clinical psychologist and staff

developer was a major determinant of the approach used. She identified the need to develop staff skills to achieve the goals they had chosen. A comprehensive training program was developed to increase staff's skills and confidence in consulting with the community, in planning and evaluating their own activities, and in group problem solving. At the same time, the Team Leader was encouraging debate at an ideological level in connection with the team goals. This was influenced by the increasing availability of World Health Organisation literature on health promotion which recognised a broad range of activities and incorporated community participation within a framework for promoting health. Staff were supported with individual supervision as well as regular team meetings and planning days.

Team cohesion increased as a clearer and more shared interpretation of what was meant by terms such as "community participation," "community development" and "health promotion" began to emerge. By the second major planning round, the team was ready to focus less on process and more on outcomes. It chose a number of specific population groups, and assigned task groups to recommend goals, and strategies using the processes developed in the previous planning phase. After three months of consultation with the local community, of data exploration, and professional

input, a second plan was developed and endorsed by the Health Management Coordinating Committee. By 1988, the team was engaged in implementing the plan.

The successful development of the Community Education and Liaison Team's cohesiveness can be attributed to a range of factors, not the least of which was the group leadership skill of the Team Leader. She was able to establish the clear goals, roles and procedures indicated by Rotem (1984) as being so essential to good team functioning. However, it should also be acknowledged that some very important barriers to team functioning were absent from the beginning. The team had limited status differential between its members. Explicit status differential in a group tends to reduce interaction and social support among members and confuse lines of authority and power (Hunt 1983). The Team Leader not only had the authority that comes with position, but also was able to quickly establish her unambiguous power as the group's leader. From this vantage point she was able to systematically implement the strategies involved in organisation development. Furthermore the team was relatively new. Staff had voluntecred to be members based on their interest and commitment to health promotion. Rubin and Beckhard (1971) argue that in "older teams" a considerable amount of The

"unfreezing," which may have to take place in older teams before new approaches can be tried, was not necessary in this new team (Rubin and Beckhard 1971).

The development of the Personal Services Team, on the other hand, was not quite as straight forward. While the Community Education and Liaison Team had been established as a "trial", the rest of the organisation had been allowed to continue to operate as it had before the re-organisation. This was not a particular problem for the dental and administrative areas since their functions were relatively straight forward and narrowly defined and necessitated a certain degree of group cohesion as a matter of course. However, for the remainder of the personal service providers, the group had become fragmented into smaller groups based, essentially, on professional division. This continued for over a year before the Personal Services Team Leader was appointed in June 1986.

There had been a great deal of debate, prior to the arrival of the Personal Services Team Leader, about the nature of his role. The medical group, continuing to call itself a medical "unit" modelled on the medical teaching function within teaching hospitals, viewed the Team Leader's role as clerical and administrative support for

the team. Apparently there had been a gentleman's agreement concerning the position of "head of unit" under the previous administration. The senior visiting medical officer assumed the title unofficially. Teaching within the Family Medicine Program, a training program for general medical practitioners, funded through a Federal Government grant to the Royal Australian College of General Practitioners, had become the medical "unit's" major priority. The perception amongst the medical staff was that the rest of the personal service providers were not operating as a team, that the medical training program was functioning well, and that this should not be compromised in any attempt to foster team functioning (Broderick,1990).

The new Team Leader's background was in social work. He recognised immediately the need to develop a structure for multi-disciplinary functioning. Using the organisation's Statement of Purpose as the framework for goal setting within the team, he defined the goals of the team as the development of processes for inter-disciplinary communication and for operationalising the principles of community health, or primary health care, within treatment services. The team began to devise ways of increasing equity of access to the service and to explore the possibilities for alternative approaches to service provision that incorporated

community participation and a preventive orientation. Organisation development techniques were used to identify strategies and assign task groups in a similar manner to the Community Education and Liaison Team's planning process. As in the earlier stage of Community Education and Liaison Team planning, the Personal Services Team goals were, essentially, process goals, related to improving and developing methods of working rather than to health outcomes.

There were a number of barriers to the smooth functioning of the Personal Services Team which are acknowledged as problematic in health teams generally. As well the issues surrounding professionalism, there were quite marked differences in the status of the various team members; the doctors had historically enjoyed the highest status in the group. Huntington (1977) suggests that, as well as a range of fundamental value differences between medical professionals and social workers, status differences can be a major obstacle to multi-disciplinary team work. For some considerable time, this status differential made it extremely difficult for the team leader of the Personal Services Team to assert any other than a positional authority.

Ultimately, as other team members became more cohesive, the

medical staff sought to separate themselves from the team rather than to dominate it. This dynamic may be explained by the tendency for general practitioners to see themselves and, to be seen by others, as the leader of the health team (Dopson 1971). When their status is diluted to being just one of the people giving care, there is a reluctance on their part to admit that any formal operating leadership is necessary for their particular service. The doctor, then, develops alternative structures to avoid losing status in a health team which is formally led by non-medical professionals (Hunt 1974).

The other major variable effecting team development for the Personal Services Team was its age. It was made up of all the staff that remained after the other teams had been formed. These staff had developed group norms consistent with professionalism over the years. Generally the team members had not had the opportunity to explore the various interpretations of the community health principles and were, relative to the Community Education and Liaison Team members, more traditional in their individualistic orientation to health care.

Although the culture of the Personal Services Team was originally that of "Dionysus", by 1988 it was moving towards an "Athenian"

culture. A range of specific task groups, with a brief to develop outreach and access projects as well as projects related to quality assurance, were in place. These task groups eventually included the general practitioners.

The task culture had proved useful to explore different approaches to prevention and multi-disciplinary team functioning within the particular functional areas. The employment of skilled team leaders was a major determinant of the success of the new organisational arrangement. They were responsible, within manageable sized groups, for ensuring that the processes of teamwork were developed and socialised in the team. This required the articulation of a clear direction for primary health care service provision.

A number of significant external events were influential in the developing commitment to this direction amongst staff. These were; the first South Australian Community Health Association conference in 1984, the first Australian Community Health Association Conference in 1986, the development in 1988 of the South Australian Health Commission discussion paper on primary health care and the development of the Community Health Accreditation Standards Project in South Australia. All of these

activities raised the level of debate and discussion about the concept of community work and created strong networks within which the World Health Organisation concepts of primary health care were compared to the community health principles. This debate and discussion confirmed the Parks Community Health Service exploration of community development and community participation.

The South Australian Primary Health Care Policy, in particular, provided the Health Service with a major confirmation of its direction. The organisation had, in many respects, broken new ground in its attempts to develop a model for community health service provision which was based on the old community health principles. The Policy re-stated those principles and called for creativity in attempts to ensure their implementation. The Administrator of the Service was able to use the debate inherent in the release of the policy to strengthen her staff's understanding of the issues and their tolerance to new ideas relating to their implementation.

A major component of the Primary Health Care Policy was health promotion. The conceptual framework was the World Health Organisation's Ottawa Charter for Health Promotion (World

Health Organisation 1986) which calls for a multi-strategy approach to address the underlying social causes of ill health. The proposed strategies incorporate social action and the development of healthy public policy. They require maximum community participation.

The Community Health Accreditation Standards provided the Service with a tool for evaluating its new ways of working. The Standards are concerned with processes of the organisation in relation to community health principles and enable the staff to develop a concrete understanding of the characteristics of primary health care services.

Between 1987 and 1988, all team leaders were actively involved in the South Australian Community Health Association and many of the staff had served on various of its policy development groups from time to time. As described in chapter two, the Association was by now establishing itself as a forum for debate and discussion on health issues and was increasingly recognised by the South Australian Health Commission as a source of primary health care policy expertise. The Parks Community Health Service, having been dominated by leaders who were skilled in group development

and who shared a common collectivist ideology, consciously espoused a social view of health. Over a period of three years, even position descriptions required that candidates demonstrate their belief in the social view and staff were encouraged to attend conferences and seminars aimed at the development of skills in community health service provision rather than "professional" conferences. Most of the problems of the Personal Services Team functioning had by now faded as a common interpretation, within the team, of primary health care was developing.

The issue for debate by 1988 was whether the organisation was being radical and pervasive enough in its interpretation of community participation and community development. The functioning of the teams had reached what Handy describes as "steady state". They had developed their own particular ways of working, their own planning processes and, although the separate teams appeared to function well, their activities were not well co-ordinated. The culture of Athena, the warrior goddess, the arch problem solver, had served its purpose. As the functions of the team became more predictable and more separate, the organisational culture tended toward "Apollo", the role culture.

Handy describes the "role" culture as excellent when it can be

assumed that tomorrow will be like yesterday. Stability and predictability are assumed and encouraged. The role, the set of duties are fixed and segmented into divisions to improve their efficiency. Unfortunately, it can suffer from this very attempt at efficiency as the divisions between the organisational components become more pronounced. It becomes necessary to develop a range of coordinating mechanisms to bring unity back into the organisation. Co-ordination is usually met with resistance from within the comfortable divisions of the organisations.

Whilst it had been necessary for the Parks Community Health Service teams to develop their separate functions and to explore their particular approaches in the early years of their existence, their separateness was now becoming dysfunctional. Organisation development techniques had been successful in developing a new organisational commitment to a social view of health and to define and explore new approaches to service provision. It is clear that leadership skill and a clear management direction relating to the way in which primary health care is to be interpreted is important in assisting an organisation through the stage of organisational planning. There was now a need for these approaches to be applied in a co-ordinated fashion to achieve significant change in the community's health. It was time to stop looking inwards to

organisational, or functional, planning and to start looking outwards to community and social planning.

Chapter four

Planning for community health outcomes

Chapter three described how Parks Community Health Service developed through a number of stages of management; through the establishment phase, when the management structure was in keeping with the medical interpretation of community health and planning was no more than the opportunistic establishment of more professional services; through the procedural stage, when management and planning processes became more democratic in their style but were professionally determined and still largely individualistic in their orientation; through the organisational planning stage, when the organisation reached agreement on its purpose and functions and planning and management structures were developed to reflect them. This stage also saw the development of a strong ideological position amongst staff at the service and a commitment to the principles of primary health care in the planning of services. Once this organisational plan was achieved, it became necessary for the service to consider a planning process that was oriented to health outcomes rather than to professional, organisational or process issues.

This chapter argues that a radical planning approach is imperative in a primary health care context. John Friedmann's framework for analysing planning in the public domain is helpful in developing an understanding of planning as it relates to primary health care (Friedmann 1987). The framework is used below to analyse the way in which services have been planned at Parks Community Health Service and to articulate differences in planning models over the various stages of management.

Primary health care, planning traditions and ideology

No matter what the theory used in planning, all planners must address the question of how to make technical knowledge effective in informing public actions. Friedmann argues that solving this meta-theoretical problem is the major object of planning theory. He suggests that, if it is not solved, planners will end up talking only to themselves and, eventually, will become irrelevant. The planning question in the primary health care context becomes; How best does the organisation use its resources to effect an improvement in the health of the community?

Planning has been defined as the art of making social decisions

rationally (Robinson 1972). The classic decision making theories are rationalist. They propose that an effective decision-making process moves through the following stages;

1. Faced with a given problem, a rational person;
2. first clarifies goals, values and objectives, and then ranks or otherwise organises them in mind;
3. lists all important possible ways of achieving the goals;
4. investigates all the important consequences that would follow from each of the alternative policies;
5. compares consequences of each policy with the goals;
6. and so chooses the policy with consequences most closely matching the goals.

It is problematic that social life is not particularly linear or rational and the results of the application of a "rational" approach to social decision making have not yielded very promising or, indeed, predictable results (Hardy 1981).

Hardy (1981) presents the limitations of the rational approach. He points out that when "faced with a given problem" different people may have quite different perceptions of what "the problem" is. "We each take our own world around with us and, when asked to think about a

certain problem, have only this world to bring. When "clarifying goals" the decision maker may need to consider goals that are not specifically related to the issue at hand but are more related to various organisational power plays. When "listing all the important ways of achieving the goals" decision makers may be extremely limited by the exigencies of their time or politics and values which are deemed acceptable by society or their organisations. When "investigating all the possible consequences", there will be many hidden agendas, vested interests, already worked out codes that will influence the course of most decisions.Hardy concludes that the rationality model does not accord with the actual activity in the welfare state where people work in systems, carry preconceptions and assumptions around with them, are swayed by often contradictory considerations, work often in conflict rather than consensus situations and often even speak a different conceptual language. From that perspective, rational models are reduced to "ideal types" of problem solving which do not account for the political realities which influence decision making in planning.

The literature abounds with various critiques of this rational approach and efforts to improve on it. Braybrooke and Lindblom (1963), for example, propose a theory of evolutionary change. They believe decisions are made on the basis of precedent. Each new decision is only marginally modified because of issues pertinent to the current situation.

Principles spring from action, rather than the other way around. Walsh et al (1981) are concerned with the relative power of individuals and groups involved in making a decision, rather than with the rationality of a decision. Their theory puts forward a scheme of negotiation which can be quite implicit. Instead of assuming value consensus among the participants in the decision making process, they assume that conflict is basic.

Etzioni (1968) attempted to develop a theory which is not as unrealistic as the rationalist approach in that it can take account of power and societal influences and which is more innovative than the incremental approach in that actions do not have to depend on precedent. He believes that a planner can constantly be considering the wider issues and their values whilst paying particular attention to the more detailed problems at the same time. He proposes a theory of "mixed scanning" where the decision maker reflects from the general to the particular and from the particular to the general in an attempt to define principles for action. This analysis at least has the potential to realistically relate theory to action.

Friedmann (1987) agrees that at, its most basic level, planning relates scientific and technical knowledge to actions in the public domain. However, he proposes that public actions are concerned essentially with

societal guidance from a central level, or with social transformation through the encouragement of the political community. A useful theory of planning, he argues, is one which can be applied more precisely to the whole system of social relations and which therefore includes all possible states of the political system; maintenance, evolutionary change and transformation of existing social relations. He argues that the planning theories previously examined do not address the potential to plan for social transformation. They are, essentially, concerned with societal guidance within an existing set of social relations. They fall short, therefore, of any requirement to plan for a transformation of those relations even if they assist us to analyse the structures which are in place. Friedmann's analysis of rational methods implies that they not only fail to account for political realities, but they make the assumption that the existing structures ought to remain. Planning activities are seen as occurring within these given structural and political parameters. This view is supported by Lowry's critique of functionalist approaches to defining social problems. He suggests that, whilst a functionalist approach to defining social problems is humane and understanding of the victim and looks to social causes and remedies, it is based in a belief that society is basically sound and that social policy is a fine tuning process to improve its few problems of functioning (Lowry 1974).

Whilst Friedmann would widen the events which planning theory must

accommodate, others would seek to widen the range of actors. For example, Thorpe and Petruchenia (1985) argue that, in identifying ways in which community work might contribute to larger social change, the potential for developing a vision of the sorts of relationships we might like to see in a transformed social order, should be fully recognised. They suggest that a clear theoretical distinction can be made between those initiatives which have planned for alternative societal relationships, and those which are designed to gloss over conflicts of interest and generate cohesion. The latter initiatives have been described by Skenridge and Lennie (1978) as starting with a problem of poverty, converting it to one of decision making, and offering participation as a solution instead of substantially increased resources. Thorpe and Petruchenia (1985), like Walker (1984), believe that transition to a socialist system is the logical object of social change. They would agree with Friedmann, therefore, that a planning theory must be able to assist the actors to get closer to their aspirations for values and relationships which may well be outside of existing social relationships. Rather than assuming existing structures as given, they should be questioned, thus allowing the planning process to accommodate options of radically alternative structures.

Friedmann's framework locates the various forms of planning on a dimension of change within a particular system of social relations. He

suggests three principal forms of planning roughly corresponding to the three possible states of the political system. They are; Allocative planning, concerned essentially with the central disposition of scarce resources among competing uses; Innovative planning, which is concerned with changing the guiding institutions in society; Radical planning, which promotes social transformation. These forms of planning may overlap along the change dimension, although radical planning and allocative planning would rarely come together (Friedmann 1987).

As argued in chapter one, the ideological base of primary health care can be located within the collectivist view of social change. It aims specifically to redistribute control and power over the determinants of health to the collective community in which health occurs. It is concerned with both evolutionary change and structural transformation to improve health outcomes in the community. It follows, logically, that the approach it must take in planning to achieve its purpose of structural change, is one that directly addresses these structural issues.

Since primary health care acknowledges the importance of the political aspects of a system of social relations in determining health, Friedmann's framework is more helpful when developing a planning model for primary health care than those theories which assume a static

view of the influence of politics and which do not address the possibility of social transformation. Furthermore, Friedmann develops his framework in such a way as to locate the ideological underpinnings of the various types of planning. This analysis assists the prospective planner to match the ideological objectives of primary health care with the planning methodology necessary to achieve them.

Friedmann (1987) categorises four major traditions of planning thought: Social reform, policy analysis, social learning and social mobilisation. The oldest of these, social reform and social mobilisation, represent the continuing dialectical tension in social practice based in oppositional ideologies of social life. Social reform is the dominant tradition in planning thought and it views planning as a form of societal guidance. It began through the works of macro-sociologists and political economists who believed that a social science would guide the way to social progress[1]. They developed models of social rationality and explored devices for institutionalising planning. Their work, primarily, addressed the authorities of the state and the business elites. Modern day reform planners believe that through appropriate reform, capitalism as the economic order can be perfected to become a complete social order, promoting representative democracy, human

[1] Friedmann (1987) describes the evolution of the tradition, identifying major themes, models and personalities from Thorstein Veblen and Harlow Person in the 1930s and their notion of scientific planning and management, through to Max Weber and Karl Manheim and theories of rationality, to Rexford Tugwell's notion of "collective mind" and Charles Lindblom's concept of a decentralised and incremental approach to planning in the 1950s and 1960s.

rights and social justice. They view planning as an expert professional responsibility which is best kept outside the influences of politics and ordinary people.

The counter to this dominant tradition, social mobilisation, arose from social criticism of what was then the new order of industrial capitalism. Since its object is emancipation, it directly addresses working people, women and oppressed races. Its strategies have their underpinnings in utopian, anarchist and Marxist thought[1]. Planning is viewed as a form of politics, its object being social transformation, either through disengaging from the mainstream of society and developing alternative communities or through challenging the existing structure in a political struggle.

The more recent approaches to planning are policy analysis and social learning. Policy analysis grew out of the field of management science, public administration and classical economics. Its practitioners believe that correct solutions to social problems can be derived from the rational or "scientific" analysis of data. The *locus classicus* of the tradition appears to have been Herbert Simon's work on decision

[1] Friedmann (1987) traces the three areas of thought. The utopian movement has its beginnings in the works of Robert Owen and Charles Fourier concerning perfect communities. Joseph Proudon, urging structural reform to an order based on self governing communities rather than state rule, is generally acknowledged as the founder of social anarchism. Karl Marx and Frederick Engels advocated a revolutionary movement of social change from capitalism to socialism. The movement was viewed as being bound to the struggle between the classes.

theory (Simon 1957). Policy analysts see themselves as technicians: therefore, in theory, they have no particular ideological or philosophical position on social life. Friedmann argues that, since policy analysis relies on the tools of economics, values of that discipline such as individualism, market supremacy in the allocation of resources and the conservatism of the supply demand paradigm, are built into their work. Since the practical application of this model has not yielded the results that were expected by its proponents, for all the reasons previously discussed, some policy analysts have begun to shift toward a social learning model of planning.

The social learning tradition is not unified: there are conservative and revolutionary interpretations in its application. More narrow than a theory of planning, it is essentially a theory of knowledge. Social learning theorists propose that knowledge is a part of action. It is practical in that it emerges from our experience. Action, knowledge and change is, therefore, seen as a continual and integrated process. The tradition has its intellectual origins in John Dewey's theory that we learn by doing (Dewey 1980, original 1929). Theorists in organisation development have applied the theory to problems of corporate control. A more revolutionary application can be seen in Mao Tse-tung's writings relating to China where the social learning perspective was incorporated in the broader tradition of social mobilisation.

The four traditions of planning described by Friedmann, span the social change dimension from maintenance of the status quo, through evolutionary change of the system to a total transformation of the system. He proposes a tentative classification of the political value bases of the various traditions of planning. Social mobilisation and social reform are seen as the more radical approaches to social change. Social reform approaches that change through the actions of a few elites whose role it is to guide society. Social mobilisation approaches the change process through mass participation in the transformation of society. Policy analysis and social learning traditions are viewed as the more conservative approaches to change, but, once again, there are differences in the role which participation plays in the planning process. Social learning can include mass participation while policy analysis advocates the role of the experts in guiding the change process. Friedmann sees revolutionary practice as outside the system of political order but, nevertheless, acknowledges it as action aimed at system transformation.

Participation as the key to planning analysis

By analysing the level of participation used in the four major traditions of planning, it is possible to draw conclusions concerning the

appropriateness of each of the planning approaches as a means of achieving the objectives of primary health care and health promotion.

Given the commitment of primary health care to reducing inequities, planning processes aimed at social transformation are essential. Social transformation is only possible when the planning processes move beyond the gamut of the elite to include those currently alienated from decision making processes. This requires an active political community or, as Bates (1983) defines it, "public action." Therefore, if planning processes for primary health care are to implement its fundamental collectivist principles, they must ensure an active political community. Participative models of health planning spring from an explicit theory of social change as a political process or social movement. These models are change generating rather than change inhibitive. Elite or rational approaches to planning fail to acknowledge the political context of health decision making by assuming that consensus exists (Broadhead et al 1989).

Bates (1983) distinguished public action, as initiated and controlled by the public for the purposes they determine, from public involvement, which is initiated and controlled by agencies to gain support for decisions already made, or to develop discussion and consultation on issues still to be decided. Arnstein (1969) illustrated the distinction with

an eight rung "ladder" of participation. Each rung of the ladder represents more power to the citizens participating. From the lowest level of citizen control to the highest are the strategies of manipulation, therapy, informing, consultation, placation, partnership, delegated power, citizen control. Arnstein's ladder can be used as a framework for analysing the ideological underpinnings of the planning approaches outlined by Friedmann.

The approaches to participation of the policy analysis and social reform traditions are inspired by a consensus ideology which interprets society as essentially sound, with widespread agreement about desirable social objectives. Problems arise from shortcomings in people and their communities. Planning, in these approaches, is seen as non-political and carried out by neutral and objective administrators. It is assumed that professional planners make decisions a-politically and that the general community consensus for the decision making framework is developed through the process of representative democracy. The general community can influence particular decisions, if they so desire, through access to local "power brokers". These people possess some kind of power or control over others. They are often used by the planners to provide information on the perceived needs of a community (Thorpe and Petruchenia 1985).

Perloff (1980), writing in the social reform tradition, saw the need for technical planning to get people involved in a co-operative dialogue in order that the relevance of plans is increased.This dialogue was to be outside the normal channels of politics but did not include what Friedmann (1987) describes as the "rough and tumble of city politics." Its concern was essentially with consensus formation at the broader level. In a similar vein, Etzioni (1968) saw societal guidance as a combination of downward control and upward consensus formation in order that the technical elites should be responsive to the needs of the non-elites below them and so that the community below should be made ready to understand and accept the decisions being made by the planners. Whatever the form of community "dialogue," the essence was that information from the general community was to be simply one more source of information to bring to the technical planning problem. This approach to participation has been described as "elitist". It uses "consultation" to contribute to the decision making process. This is a one way process by which the public feed information in to the decision makers (Thorpe and Petruchenia 1985). Methods available to the community to participate directly in the decision making process include; participation in public surveys, public meetings, developing submissions or formal letters of concern. Elitist planners, seeking to solve social problems, advocate the promotion of self help through giving information and educating people in the skills they require to

compete successfully for opportunities. They also call for improved co-ordination of services to meet the community's needs. This approach is apparently based on a belief that social problems are caused through deviance or social disorganisation. Lowry (1974) describes the approach as "victim blaming."

Writers in the policy analysis tradition were more concerned with the technology of decision making than with the decision or its content. The process was viewed as the domain of the professional who applied the principles of science and rationality to the identified problem. In this, it advocated no particular philosophical position. Both Friedmann and Lowry argue that, under the guise of objectivity, the approach plays a profoundly conservative role. It is sufficient for the present discussion to note that policy analysis does not address the questions of power or conflict. Like the social reform tradition, it uses community information as just one more cog in the decision making machine.

Dwyer(1989) has grounded Arnstein's categories of participation, ranging from non participation through tokenism to citizen control, by particular reference to government bureaucracy. She has developed three categories of rationale for public participation in decision making. The social reform and policy analysis rationales rest on the belief that better decisions or service improvements are possible. The type of

participation used in these traditions is public involvement rather than public action. As such, the social reform and policy analysis traditions of planning, if they were to use participation strategies at all, would tend to use those strategies at the bottom end of Arnstein's ladder. Informing, therapeutic and manipulative strategies are useful in the development of consensus formation around decisions, or as the solutions to the community's or the individual's problems. The strategy of consultation is useful for the "dialogue" necessary to bring information to the decision making process.

The social learning tradition of planning conforms to the characteristics of Thorpe and Petruchenia's description of the "Pluralist and social democratic" approach, which acknowledges that there are inequities in the distribution of power and resources in society and that representative democracy fails to represent all interests equally (Thorpe and Petruchenia 1985). The approach espouses participatory democracy as a better alternative. Conflict is recognised as necessary, even useful, in the decision making process. Decisions are made through representational processes and groups and individuals can exercise power and influence in the process by negotiating and bargaining. Strategies for community participation include giving people information to help them make choices and voice their opinions, developing forums and committees, advocating for those with limited

power in the process. Emphasis is placed on facilitating community involvement as an end in itself. The decision making process is as important as the decision itself. Social action groups are supported.

The social learning tradition of planning assumes that the actor and the learner are one and the same. It is the action, rather than the decisions, which are the focus of attention. Friedmann states that, in comparison to policy analysis, social learning represents a major step forward since it enables movement from anticipatory decision making to action. However, the approach does not acknowledge the inequities in access to the bases of social power. Existing power relations will be reproduced unless countervailing measures are devised. Those groups with more resources, education, skill will participate in decision making. For this reason, social learning theorists advocate training to equalise access to power and resources. Once again, as with the social reform and policy analysis traditions, the assumption is that the system is functional, but individuals who are having difficulty accessing what they need, require support. Furthermore, within the social learning tradition, planning for social change is orchestrated from above. Although the objectives of that change may evolve through the course of dialogue with the community, the change agents are separate from the community.

In relation to Arnstein's ladder of participation, the citizen participating

in the social learning planning exercise has possibly moved two rungs further up. Participatory processes of manipulation, therapy, informing, consultation, placation, and partnership are all used in the social learning approach. However, the citizens are still unable to control the decisions ultimately made and the parameters of the decision making in which they participate are still determined by the existing social relations. Bureaucratic planners using a social learning approach would believe that participation is useful both to improve services and to develop a sense of legitimation and, therefore, compliance with decisions (Dwyer 1989).

The social mobilisation tradition has much in common with the "structuralist or radical" approach described by Thorpe and Petruchenia (1985) which argues that the real power in decision making, even in the social democratic approach, rests with a few interests, notably, big business. Inequalities in society are believed to be caused and maintained by the economic, social and political structures in society which maintain this unequal balance of power in public decision making. Social problems are seen to arise from a fundamental conflict of interests between groups or classes in society. The institutions of the state are considered to reinforce the advantage of the powerful groups and therefore compounds the problems of the weak. It is claimed that for community work to be effective it must be aligned

with class politics aimed at restructuring the economic, social and political system.

Friedmann suggests that the planning tradition of social mobilisation was influenced by the three social movements of utopianism, social anarchism and historical materialism, each of which contributed to the rich history of revolt and revolution in the capitalist industrial world. All three movements are concerned with the emancipation of the powerless and the development of an equitable society. Whilst Friedmann acknowledges that these movements would normally regard planning as just one more bourgeois domination and, therefore, something to be resisted, he suggests that a definition of planning which encompasses the social transformation spectrum of the change dimension would enable one to consider the classical oppositional movements as a tradition in planning. Indeed, Friedmann argues that it is absolutely essential that social mobilisation be included in any discussion of planning theory since, for the popular classes, whose only possibility of gaining access to power is through social mobilisation, political struggle and self empowerment, planning "from below" is frequently necessary.

Friedmann describes planners in the social mobilisation tradition as "radical planners". Their objective being transformative action, they

necessarily walk a thin line between licit and subversive action. Radical planning is described as eclectic and there are different ideological positions, within the approach, on the question of strategies. However, the following characteristics of the approach demonstrate its similarity to the radical approach to participation as described by Thorpe and Petruchenia (1985).

1. It addresses the concerns of people who exert no significant influence on societal decisions and who therefore bear the brunt of exploitation or oppression.
2. It rejects the consensus model of society in favour of a model based on conflict within the dominant society.
3. It involves political practice by actors collectively committed to bringing about specific forms of structural change within society.
4. It is informed by a belief in the unity of knowledge and action. Groups engaged in political struggle learn from the practice of changing reality. (Friedmann 1987,pp 256-257)

The radical approach to community work encourages decision making by the people most affected by the decision. Decisions are aimed at equality of outcome, not just equality of opportunity. It uses methods such as advocacy, community action and consciousness raising to

increase the power and advantage of those disenfranchised by the current system. Participatory processes aim at community control. Therefore the final two rungs of Arnstein's ladder are relevant to the approach. The rationale for participation within this tradition would be redistribution and intrinsic benefit to the participants. This moves away from management oriented reasons for participation and draws more on the politics of progressive social change (Dwyer1989).

To summarise, the social reform and policy analysis traditions of planning are based in a belief in the functionalism of the current society. They are, essentially, conservative. They call for low levels of participation of the broader public and, where participation exists at all, it is generally for the purpose of improving the decision and increasing consensus formation. Social learning approaches to planning are generally aimed at evolutionary change. They call for increased levels of participation for the purposes of legitimation and for improved public compliance with decisions. The social mobilisation tradition of planning is aimed at social transformation, emancipation and equity. It supports mass participation.

The community health program as social planning

Gough Whitlam led a Labor Party win in the 1972 Australian Federal

election with a list of 140 reforms emphasising social, rather than economic, considerations (Whitlam 1985). The very character of the Australian Labor Party was based on a social learning approach to planning and a collectivist ideology. The party prided itself on its democratic approach to policy which, it was said, was not framed by directives from the leadership, but by resolutions from the members within branches and affiliated unions using a conference process. It maintained that political freedom could exist securely only in a society free of the social tensions which issue from poverty, economic injustice and gross economic inequality. It believed that government should use its powers to maintain full employment, maximum standards of health and physical efficiency to abolish poverty, to clear slums and unhealthy environments, to stabilise the economy and to ensure freedom from want (Australian Labor Party Platform, constitution and rules 1967).

The Australian Community Health Program, as proposed, shared the characteristics of Australian Labor Party policy. The principle of equity, both in terms of access to health services and in health outcomes for all groups in the community had its value base in societal redistribution. It proposed a decentralised management and planning process which would assist communities to identify and solve their own health problems. It acknowledged that different solutions were appropriate for different communities. The encouragement of full and

active participation of communities in health decision making, within the framework laid down by the program, was very much a social learning practice. The social learning view of the unity of theory and practice, knowledge and action, is evident in its advocacy for a strong evaluation component to enable ongoing learning about which strategies work and under what circumstances.

Individual community health services administered the policy once the policy development process was complete and the administrative and funding arrangements were decided. In effect, policy implementation rested in the hands of the individuals and groups who had been funded to develop services within the guidelines outlined by the Program. Theory, however, offers a corrective lens to this neat image of practice. Although Lindblom (1959) is often criticised for falling short of a comprehensive theory of planning, he provides a normative theory on how decisions are actually made. His central thesis is that policy implementation is not value free. He argues that no matter what seemingly rational approach the decision maker uses to decide on a course of action, in the final analysis he makes a choice which maximises his own values. Even where an explicit objective is prescribed for the administrator, there remains considerable room for disagreement. Furthermore, social objectives do not always have the same relative values. Lindblom argues that the value problem is always

a problem of adjustments at the margin. Change is therefore incremental.

Lindblom's reassessment of his original thesis restated his belief that neither drastic policy change nor even carefully planned big steps are ordinarily possible (Lindblom 1979). The implementation of the Community Health Program fits quite snugly with his prescriptions to decentralise decisions to many small actors who each control only a small part of the total action, give each actor substantial autonomy over decisions and develop a network of communication between all actors in the system. What results, he argues, are the best possible decisions.

Etzioni (1969) argues that this approach to decision making results in many small, incremental changes. Where the small actors with autonomy are members of the elite or traditional professionals within the dominant ideology, those changes are not merely incremental, but are also conservative. Apparently, The 1973 Australian government overlooked the importance of the development of a sympathetic ideology within the newly emerging community health system. It was unable to implement its new collectivist and social learning community health policy as it might have wished since it was being interpreted within the dominant ideology and tradition of social planning; social

reform[1].The key people in the implementation of the Program were those employed in the newly developed services, were professionals who had a predetermined set of training and experience which was informed by the dominant ideology of society.

Analysing the level of, and the attitude to, participation at Parks Community Health Service provides clues to the approaches taken over the years by the actors in one community health service.

Planning at Parks Community Health Service: 1976 to 1988

Allocative planning and its limits

Conservatism is evident when one analyses the way in which the Community Health Program's principle of participation was interpreted at Parks Community Health Service during the early years. In spite of proposals for participation, the original planning group for the service consisted of societal "caretakers" who were non-resident medical and administrative professionals, and a few very quiet and overpowered community members (Bryson and Thompson 1972). In fact, the

[1] This is not surprising in the light of Cherns (1980) who argues that the time for a theory may arrive when the time for it has past, simply because the organisation to which it has arrived is laggard.

community members had no constituency in that they were not elected by the local community and, as far as is evident, had no structured access to community people in any other capacity than as friends, family or neighbours. These people, according to the attendance record of the Committee of Management meetings, were also extremely inconsistent attenders.

Participation by the local community, in the form of a community survey, had been responsible for establishing the need for a health service within the, then, proposed community centre. However, as described in chapter two, the centre was proposed by "experts" or, rather, bureaucrats as one way to redistribute services more equitably to a deprived community. The community survey was a way of gaining information to improve the decisions and to gain broader consensus for the notion of a community centre.

In relation to the Health Service, the nature and extent of the services to be provided, were planned by the Interim Committee of Management comprising, essentially, local or academic doctors as well as bureaucrats. Whilst they believed, fundamentally, in the private market approach to planning health services, their main aim was to rectify the gaps by providing services that the private market could not or would not provide. The power this group had in maintaining this bias towards

the market system is obvious when one considers the conflict, described in chapter three, which arose over the medical director's proposal to employ a medical officer. The private general medical practitioners on the Committee of Management were adamant that resources should be spent chiefly on those services which could not be provided by private medical practice. The Community Health Service was to be a residualist compliment to private general medical practice.

There can be little doubt that the approach to social problems in these early years was informed by an ideology of consensus and functionalism. It was assumed that health problems existed because people in the community were deviant and did not know or understand how to look after themselves, or because services were inadequate and uncoordinated. The focus of preventive programs was the education of groups or individuals in relation to health, food, exercise, parenting etc. A slightly different dimension of services stemmed from a belief in "self help" and social organisation as a solution to social problems and was aimed at increasing the informal networks amongst community members. The professionals established "social support" groups to address the lack of social organisation in the community. People were said to "participate" in these programs. However, program content was the responsibility of the professionals, as was the decision relating to the nature of the programs to be delivered. Professionals also engaged in

planning to better co-ordinate services and to develop new services.

Volunteerism was apparently accepted as a form of community participation. When one of the community health nurses suggested that local volunteers could offer a service to people needing assistance of a practical nature, the Committee of Management acknowledged the idea as worthwhile but indicated its concern that it might be held responsible for any negative consequences of such a program. By June 1979 a policy which proposed that volunteers had the right to attend and vote at staff meetings was approved. After some discussion, the Committee of Management proposed that volunteers wear some identifiable smock. Since policy decisions of any importance were made at the Committee of Management level, it is hard to see what increase in power the local people had as a result of this decision. Even so, within the control of the Committee of Management, community people had some say in what it was they were doing in their voluntary capacity.

Dwyer (1989) points out that volunteerism is "mixed bag" in terms of its participation value. She suggests that at worst, it is an exploitation of unpaid labour (primarily of women) and at best, it is a powerful developmental process for individuals, communities and needed services. She suggests that health bureaucracies assist in the development of these groups not only for the positive impact of their

work but also for the decreased costs of largely volunteer labour.

There is some evidence to suggest that the Parks Community Health Service Committee of Management attitude to participation was tokenistic in this early stage of the organisation's development. In September 1979, the Committee of Management approved a proposal to call a public meeting to select community representatives. There is no record of this having occurred by October 1980, when it was again mentioned in the minutes as a possibility. By 1982, with the incorporation of the health service under the South Australian Health Commission Act, an annual public meeting became a constitutional necessity.

As far as can be ascertained, in the absence of a consumer rights policy of any description, community members had a right to complain about the service they received. The one complaint that could be found in the Committee of Management minutes was delivered verbally through one of the community members. She was asked to approach the complainant to request that she or he put the complaint in writing. There was no further record of discussion of the complaint.

The first Parks Community Health Service Annual Report, written in 1982, although containing a two line commitment to the notion of

community participation at all levels of planning and management, contains no evidence that any participation actually occurred outside the contribution of the three community members of the Committee of Management. Indeed, the last paragraph of the Medical Director's report describes the development of greater community "involvement' in the work of the Health Service as a "challenge" and whilst acknowledging the work of the community members on the Committee of Management, somewhat patronisingly describes it as having "great potential and (it) will hopefully increase in the future" (Parks Community Health Service Annual Report 1982).

From the perspective of Arnstein's ladder of participation (Arnstein 1969), the techniques used from 1976 to 1982 at Parks Community Health Service can be seen as, essentially, aimed at "involving" the community in programs and activities, of which the parameters had been determined by the professional staff and the Committee of Management of the Health Service. These techniques are represented by the bottom three rungs of the participation ladder; manipulation, therapy and informing. The approach shares many of the characteristics of Thorpe and Petruchenia's "bureaucratic or elitist" category of participation in decision making (Thorpe and Petruchenia 1985). In Dwyer's terms, it was managerially oriented rather than being concerned with redistribution of power (Dwyer 1989) and stemmed

from a consensus view of the world.

Given this ideological position, which also saw the individual rather than the collective community as the focus for health professionals' attention, it can be concluded that the early implementation of the Community Health Program at Parks Community Health Service was based in an individualistic and functionalist analysis of social problems. Social planning, or policy development was approached from the social reform tradition. It aimed to make the adjustments to the people who did not conform or to the services which did not provide adequate care, rather than transform social relations. Therefore the fundamental collectivist principles of primary health care were not implemented.

Although there had been a limited introduction of an alternative ideological approach to health service planning by the end of 1981 (as indicated in chapter three), the major critique of the individualistic functionalist approach came about more as a consequence of a staff belief in the need for an increase in industrial democracy in decision making rather than because of an ideological shift in the Health Service. However, as well as a clamour for more power to the staff, the staff representative on the Committee of Management articulated a desire for a broader approach to health planning that included decisions on preventive programs as early as June 1982. There had been

debate for some time about how to get more preventive work done and about which preventive issues were the most important.

Coinciding with the move for increased staff participation in Parks Community Health Service decision making and planning, there is evidence to suggest that the planning process became even more the preserve of professional expertise during the period between 1982 and 1984. By the time the new administrator of the service officially took up his position in early 1983, a new organisational arrangement was in place. The decision making arena was opened to include all professional coordinators and the planning and decision making power of the Committee of Management was diminished. The community members on the Committee of Management became even more distant from the decision-making as a result. Rather than having limited opportunity to participate in making decisions, they were now asked to inform the Committee of Management if they thought the health service was not acting in the best interests of the community. They had been cast in a reactionary and negative role as complainants.

From the beginning of 1983, the development of a long term plan for the health service became a high priority for the staff of the service. The administrator, supported by the research officer, who had by this time been able to gather statistics to develop a profile of the service's

clients as well as of the surrounding community, engaged the services of the South Australian Health Commission's Health Promotion Unit to assist with the planning process. Several planning days were conducted with staff during which the needs of the service to promote itself as well as needs of the local community were identified. A range of information was used to do this including community surveys, epidemiological data available on the local community, staff opinion, information on available resources and what was happening in other states and services.

The entire process displayed significant elements of a rational planning model and developed with a minimum of community participation. The participation that did occur was regarded as yet another piece of relevant information to be fed into the decision making process. The staff of the centre maintained the power and set the parameters for community participation and ultimately they made the decisions the Committee of Management approved.

At the same time, the social worker on staff, who had been enthused by the extent of community participation in some community health services in Melbourne, was developing a "subscriber" scheme for Parks Community Health Service. The scheme's terms of reference related to the need to publicise the Service, to give people a sense of

belonging to the Service, to involve more people in the activities of the Service, to create stronger networks in the community, to foster the notion of self help and to stimulate community action. Rather than developing as a part of the planning process and contributing to it, this scheme was one of the objectives of the plan. Although its intent represented a willingness on the part of the organisation to increase the involvement of the community in the Health Service, the parameters were still determined by the professionals and it was still managerially oriented. It was to have an executive decision making structure of its own, its organisational arrangements being laid down in a fairly bureaucratic fashion, despite the involvement of paid community people in its design, well before it even had any members.

Although there was still no evidence of a consumer rights policy, complaints to the Committee of Management were handled less cursorily than during the previous administration. In June 1983, when a community member of the Committee of Management reported that complaints had been received from residents relating to the lack of continuity of medical care, the issue was treated seriously and transformed into a research project. The chairman of the Committee of Management wanted to know specifics and the Committee of Management proposed research into patient expectations, mean waiting times and other related variables. This research was to be conducted by

the Administrator. Apparently, the complaint was the sum total of the community's input to the solution of a problem.

The methods of working and the approaches to community participation used during the years from early 1982 to early 1984 still conformed to the "bureaucratic or elitist" approach (Thorpe and Petruchenia 1985). However, the rational planning model used was characteristic of the policy analysis tradition rather than the earlier social reform tradition. By 1982, an organisational structure had been developed which, to an extent, institutionalised planning for the first time. It became customary for workers to develop a comprehensive needs analysis, which incorporated as much "scientific" evidence as possible, before proposing a program.

The participation techniques were still aimed at "involvement" of the local community and may have included the next two rungs of Arnstein's ladder; consultation and placation. The rationale for the subscriber scheme bordered on a desire to develop a partnership with the local community but, in relation to Dwyer's categories of rationales for community participation, it was largely managerial in its orientation (Dwyer 1989).

The central concern of planning to date had been how best to allocate

resources across the range of issues which had to be addressed. There was an apparent belief that providing the "right" services, through an appropriate allocation of Parks Community Health Service resources, could have an effect on the health of the community.

In the Annual Report of 1983, the Administrator wrote that the centre had been unable to achieve the ultimate goal of community participation and the provision of preventive health services, health education and health promotion, teamwork and teaching. He called for the development of a "corporate plan" which would provide a "blueprint" for direction over the next five years. He was beginning to use the language of organisational development, the conservative interpretation of the social learning tradition of planning. Staff and the Committee of Management were beginning to seriously question whether the approach to planning used to date had really addressed the principles of the original Community Health Program.

Walker's (1984) critique of social policy in capitalist society and the limitations he identifies may go some way towards explaining this sense of failure in the organisation. He argues that the scope of social policy and its potential for a positive role in producing social and economic change is severely limited by its narrow social construction. At best, social policy is regarded as a largely passive response to welfare

problems created by industrialisation or economic development. It is concerned, essentially, with social services to individuals and is held in rigid distinction from economic policy. This excessively narrow definition of social policy means that significant sources of social inequality and social welfare are overlooked because the attention of planners is focused on only one form of action; the provision of services. This one dimensional approach to social policy oversimplifies the nature and operation of power.

In the model which Walker criticises and in the practice of the Parks Community Health Service in the early eighties, social problem solving is carried on in the absence of a critique of the social structures which cause inequality. This usually results in an over-emphasis of the role of the individual in the cause of inequalities.In this context, social planning has been equated with public administration and particularly with the administration of social services. It is not comprehensively addressed to overall social development. Walker argues that it plays an important role in creating and enhancing inequalities by blaming the victim of social dis-welfare whilst reinforcing values and structures which are, indeed, the deep-rooted causes of the problem. George and Wilding (1976) conclude that social policy in relation to welfare is often an instrument of class domination, social reproduction and control over those who deviate from the values and structures of mainstream society.

There is general consensus about the values and structures seen as good and worthwhile in society. This construction of social welfare policy as service for deviants means that major social changes are not seen as necessary to eliminate poverty and inequality.

The policy analysis tradition does not declare a consensus ideology outright, but uses rational scientific decision making strategies. In ignoring the influence of power, ideology and values in the decision making arena and assuming value free decisions, it develops no critique of the dominant societal structures. Its consensus approach favours management and organisational efficiency. This was evident in the increased "settledness" of the staff at Parks Community Health Service during 1982 to 1983. Organisational efficiency, however, is not necessarily the same as efficiency in actually meeting need. Not all social problems are capable of resolution by bureaucratic or technical means (Walker 1984). Although consensus may be possible within small scale organisations such as Parks Community Health Service, it is not evident across society. There is, then, a mismatch between the organisation's assumptions about the production of health and the ways in which health is actually produced in the community.

Walker's analysis may go some way towards explaining the obvious feeling of failure or, at least, lack of success, described by the

Administrator of Parks Community Health Service in the Service's Annual Report of 1983. None of the programs offered by the service were aimed at changing social structures. Instead, programs aimed to change the behaviour of groups or individuals or to increase self help in the community. In a community as deprived as the Parks, the chances of seeing an improvement in health or welfare using such an approach are extremely remote. Furthermore, the chances of increasing the "involvement" of the recipients of welfare services in self help activities designed, in the main, by middle class health workers, were also extremely remote. According to the new Director, who arrived in February 1984, staff were seriously questioning ways to implement the principles of community health as espoused by the Community Health Program of 1973. In particular, they were concerned with the principles of community participation and with prevention; they wanted increases in both. As professionals, they were all "doing their own thing" but without much of a sense of direction or confidence (Roe 1990).

Innovative planning

The newly-appointed Director, using the principles of the Community Health Program as the starting point, and the social learning techniques of organisation development, began to develop an organisational plan

which would at once enable the increase of preventive services and community participation as well as provide the range of professional disciplines with organisational unity in direction. The new Director wanted to change the organisation to enable it to implement the principles of community health. In terms of Friedmann's change dimension, this was innovative planning (Friedmann 1987).

The principal focus of the social learning approach is the task oriented action group. This group, facilitated by a "change agent" who brings formal knowledge of some sort to the group's practice, learns from its own practice. The change process resulting from learning may involve a simple change in action or strategy or it may involve an adjustment of the values governing the action process. It is a useful approach to the development of a shared goal and commitment to achieving it.

Sofer (1972) describes the development of management approaches as an evolving realisation that human aspects are important determinants of worker performance. The stages of management theory development moved from Taylor, whose somewhat mechanistic focus was the "science" of getting the worker to undertake the "best" method of carrying out a task, to the humanists who were concerned with the motivation of the individual to perform, to Lewin who was concerned with the group dynamic aspects of the work place and its effect on

performance.

The study of group dynamics was a form of action research in that the way to study groups was to try to change their behaviour. This unity of theory and practice, of knowledge and action, provided a link with the social learning approach and soon the study of group dynamics came out of the laboratory and into corporations and therapeutic groups. In both cases it was an approach to helping people reach their full potential, whether for the advancement of some organisational goal or for individual self actualisation.

The use of organisational development techniques at Parks Community Health Service after 1984 resulted in agreement on a set of goals which reflected the principles of the Community Health Program. The organisational structure, in turn, reflected the goals which were essentially process oriented. They were concerned with developing the technology of community health; providing treatment services in a way which increased equity of access, increasing the level of community participation in the service, developing health education and health promotion as an integral part of the services offered.

Having gained the commitment of staff and the Committee of Management for these goals and structures, the organisation moved

forward. The teams were learning about the technology as they went. In developing team plans and choosing the issues on which to work, they developed an understanding of what they meant by health promotion, community development, increasing access etc.

Smithies (1990) has outlined the connections between organisation development and community development theory. She argues that organisation development techniques are almost identical to those used in community development work. This is certainly true of the definition of community development that was used at Parks Community Health Service during these years. Small group consultations were held to identify issues of concern to the local community. This information was then put back into the planning process and models of operation were developed in an attempt to address the issues. These were checked with local people again in a kind of two way consensus formation.

A concerted attempt was made at this stage to implement the membership scheme as a major participatory mechanism for community members. It was to have an elected executive, annual meetings, a regular newsletter and was seen as a means to increase the sense of local ownership in the service. In so far as pro-active forums (such as those used in the "healthwise" groups[1] and ongoing

[1] An adult educational technique devised by the Victorian Department of Health (1986) to increase understanding of the health system by community members.

committees were favoured as consultation strategies, the approach conformed to Thorpe's and Petruchenia's pluralist or social democratic approach (Thorpe and Petruchenia 1985). It acknowledged that some groups in the community do not have equal access to information and decision making and aimed to provide equality in opportunities to participate by facilitative and educational processes. The organisation's rationale for community participation was apparently still managerially oriented and initiated (Dwyer 1989). Although the organisation acknowledged that the playing field in a pluralist society is uneven, it addressed this by attempting to increase the skills of the less powerful. It accepted existing social institutions and structures rather than attempting to transform them.

Friedmann (1987) acknowledges social learning as a major step forward in comparison with policy analysis approaches to planning in that it enables movement from a preoccupation with planning prior to decision making to a concern with action and practice. He points out, however, that it abstracts from power relationships. Its ideology is focused on small group and intergroup relations. Power, which is essential to the understanding of how organisations and communities are constructed, is not directly addressed. The focus is on increasing the skill of those who are not part of the existing power structure, rather than on their struggle to be part of it. Friedmann suggests that this

focus may be a result of its primary concern with the elites in management or community work rather than on the non-elites. Its interest is the technology of change rather than the change itself. It is certainly the case that Parks Community Health Service managers directed a great deal of time and attention to staff development programs aimed at skilling staff in the techniques of change.

There are several fundamental problems with the social learning approach to planning. The first is its naive belief that people will change their ways once they become aware of an error. People have sacred cows. Secondly, social problems are never necessarily solved. Rather they are replaced by a different, bigger or more urgent problem. This means that knowledge about a social problem can never really be validated since test by replication is not an option. Thirdly, even if many people are to agree that the knowledge can be trusted, those who have the most persuasive argument, or who already have power, have a disproportionate influence on social planning. Unless strong countervailing measures are devised, the tendency with social learning techniques is for the existing power relations to be reproduced or for inequalities to be increased. Repo (1977) illustrates this last but important fact with a description of the actions of a working class residents' association who were struggling to maintain and improve low income housing in an inner city area of Toronto, Canada. The group's

struggle was undermined by influential and articulate middle class connections whose agenda included upgrading for the purposes of improved aesthetics. The middle class proposal related to a large section of public housing which catered to the needs of the so called "sub classes" rather than to the needs of the working class people. This aesthetic upgrading increased the value of rental properties in the area, rendering the existing housing out of the reach of the working class people who had originally set out to improve the conditions of the rental housing.

A tendency toward middle class domination in participatory mechanisms at Parks Community Health Service can be seen in the fact that, despite an increased dialogue with the local community, a broad mechanism for participation and a process of two way consensus formation, the policy development process was still largely in the hands of the staff and managers rather than the local community. Some community members of the Committee of Management at that time described their role as "rubber stamping" decisions already made by the staff. A health education project, devised to train Vietnamese women in issues pertaining to health, was later described by Vietnamese community members as reflecting western practice and culturally inappropriate despite an elaborate consultative planning process. Apparently, even talking about health problems in the Vietnamese

community, is believed to be bad luck. It would appear that the parameters of participation were still set by the elites at Parks Community Health Service.

These experiences reflect some of the problems in attempting to use the techniques of organisation development in public planning. The approach may be useful for the development of community self help and self reliance in that the skills of decision making are imparted to a larger group of people. However, it assumes no fundamental change in the existing power relations. It is an evolutionary process of change, essentially aimed at changing the institutions in society. It was successful at Parks Community Health Service, not so much for its ability to change structures in the community which created or maintained ill health, but in that it enabled the organisation to explore the issues of community participation and preventive work. It was a useful approach for organisational planning but limited for social planning. It develops a process not a social outcome.

The case for radical planning in primary health care

Structural change in society is only possible by bringing about fundamental changes in the relations of power (Friedmann 1987). This

can only be achieved through social mobilisation and conflict.
How, then, can planning for health promotion proceed in a way which maximises the participation of the people who are effected and in way which focuses on equity in health outcomes across society?

The dominant liberal individualistic ideology in society has nurtured the use of social planning traditions which reflect its fundamental values. Social reform methods of planning have been aimed at finding the best way for the state to fill the gaps that the market place has not been able to fill. Policy analysis methods have sought rational solutions to social problems by the application of the scientific method to the broader social context: Social learning methods have aimed to open the decision making arena to those who are affected by the problems to assist them to develop a solution for themselves. None of these traditions, except the social learning tradition which acknowledges the biased nature of representative democracy, have questioned the fundamental structures in society. Nor have they had a marked impact on the health and welfare trends in western capitalist societies where an increasing demand for services by people in lower socioeconomic groups and where the health status differences between these people and those from higher socioeconomic groups, are expanding (Commonwealth Department of Community Services and Health 1990).

The dominant theme shared by the great number of definitions of social policy, during period since World War Two, has been the idea of collective, or state intervention in the private market to promote individual welfare. This has meant that those people in society who, for one reason or another are unable to buy housing, health care or other goods and services necessary for their welfare, have had these services provided for them by the State. Social welfare, within this individualistic interpretation, has come to mean the administration of social services which are entirely delivered by the state or, sometimes, the voluntary sector. This has meant that the impact on the community's welfare of decisions made in the private sector has largely been excluded in social planning. This, in turn, has contributed to the rigid distinction made in our society between economic and social policy. Social policy has come to mean public service administration, a preoccupation which has at least four major limitations.

1. Significant sources of social inequality are overlooked.
2. The nature and operation of power in maintaining inequality is oversimplified. For example, the structure of inequality is accepted in the belief that inequality can be diminished by social reform.
3. Policies without explicit "social" objectives are ignored by policy analysts. Therefore economic policies which can have a

drastic impact on the welfare of large groups in the community, may be held in high esteem by the private and public sector alike.

4. As at Parks Community Health Service, planning has come to mean finding the best way of providing services rather than finding the best way to particular health or welfare outcomes (Walker 1984).

Legge (1989) has applied these limitations of social policy to sick care and health in particular. In developing a framework for thinking about sick care and health, he traces the politics of the interactions between service providers and recipients from the clinical or "sick care" system through to the politics of health. He points to the empathy gap in illness care, where the relationship between doctor and patient is affected by the degree of congruence in background, their ability to communicate, the patient's ability to trust and the doctor's ability to identify with the feelings of the patient. Both the patient and the health care provider can become institutionalised and develop values, expectations and needs which reflect their roles and their inherently (in this society) different social origins, contributing to a lack of fit between services provided and what is perceived to be needed by the patient. This points to the importance of attending to the sensitisation of professionals to these issues in planning services. Legge advocates community control and

accountability of health care as a solution to the problem.

In relation to the broader aspects of the sick care system, Legge points to the increasing costs of care and the questions relating to how resources are best used as the heart of the politics of health. Political support for one type of health care or another depends on the ideological positions of the interest groups involved in the debate. He suggests that the bureaucratisation of health and illness care has depersonalised care and alienated the patient from the health care worker, thus strengthening the argument for increased consumer advocacy and community accountability structures.

Moving onto the broader political context of the sick care system, Legge points out that, although we define the sick care system as including all those institutions which fulfil the function of caring for the sick, this does not occur in isolation from other parts of the social system. The development and interplay of social institutions can be accounted for in terms of various subgroups defined in different ways for different purposes. For example, subgroups can be defined in terms of race, sex, ethnicity depending on their relevance to planning needs (Legge 1989). Friedmann(1987), provides a similar framework when he suggests that the subgroups can be defined in terms of their access to the politics of decision making. This allows analysis of different issues

in different ways for different purposes as the planning need arises.

Social reform and policy analysis traditions of planning, valuing the role of the expert, do not acknowledge this interplay in planning services. This has resulted in large numbers of sub-groups having decisions made for them by only a few sub-groups by virtue of the latter's attachments to institutions rather than by virtue of their empathy with the life experiences of the recipients of care. Relating this characteristic to health planning, it can be seen that the interests and values of those with access to decision making, in particular, the medical profession and a few other providers and bureaucrats, tend to be reflected in the decisions made (Waitzkin 1978, Relman 1980). What results is a professionally of provider driven system with a focus on illness, cure and treatment, rather than health.

Focusing health planning attention on the sick care system and making decisions which reflect the ideology and experience of the personnel within the sick care institutions, produces an individualistic model of health care. The individual view of health corresponds to the daily experience of clinicians (Furler 1982, Legge 1990). The method of intervention in illness and the ideology are enmeshed in a conservative cycle of care where even health promotion is interpreted as the provision of health education to those less fortunate and more ignorant

members of society who do not adequately look after their health care. This approach to health promotion will be elaborated in chapter five.

Legge argues that, although the public health movement recognises collective responsibility for health as well as individual responsibility, the rational scientific approach taken towards planning for healthier communities has excluded an understanding of health within the context of its full social relations. The approach, recognising health as being simply the absence of disease, focuses on disease and how it occurs, not on the fact that health is determined by social processes and social relations. Wealthier people have greater access to safe living and working conditions and those with power can assert their right to continue to expose other, less powerful groups to health risks.

Both Legge (1989) and Walker (1984) make it clear that the politics of health and welfare is simply one dimension of the politics of society. Alienation and powerlessness are, therefore, key concepts for understanding the community's health or illness and for planning action to address health issues. The World Health Organisation's Health For All Strategy, (to which primary health care is considered to be the key) and its Health Promotion Charter reflect recognition of this fact. The object or goal of health workers may be couched in terms of health but the process of achieving those goals is part of a broader strategy to

achieve equity in society (Legge 1989). Health workers will need to adopt the political and cultural priorities of the people they are working with rather than imposing health goals. This means that the community health service becomes a resource for the community, controlled by the community to strive for social justice. The service may therefore encompass, and extend beyond, the conditions traditionally seen to be related to health.

Legge's "community development" proposals for health work are comparable with Friedmann's description of radical planning and with Thorpe and Petruchenia's "structuralist"or "radical" approach to community participation. The planning tradition on which these approaches are based is social mobilisation.

Friedmann argues that, approaching the end of the twentieth century, the social mobilisation tradition is becoming even more relevant to planning. There are signs that industrial capitalism is entrenched in a crisis with which the traditional forms of planning are incapable of dealing. The capitalist distinction between economic and social goals, for example, has enabled the development of economic policies which have devastating social and environmental consequences. Social planning, aimed essentially at the administration of social services, is unable to rectify the problems. The State, being so tightly linked to the

system in crisis, has become part of the problem. As a result, people around the world have begun to search for an alternative form of development less tied to capital development and more oriented to social goals. Emancipatory movements have emerged to demand social change from outside the system (Pusey 1987).

If the present crisis is to be overcome at the cause and not merely its symptoms, then this sense of an active political community must be encouraged. The separation of planning from the people who are being planned for is bound to have destructive consequences. If social planning is the tool of corporate capital it will always be directed to economic expansion, possibly at the expense of social development. It is through a renewal of politics, moving out from the local level, that a new State and economics can be fashioned. Radical planners, operating from the social mobilisation tradition, are committed to this alternative world of greater self reliance and a more active political life. The plans they make relate to how to facilitate the efforts of households, local communities and regions to assert power over their own lives (Friedmann 1987).

Once it is grasped that social welfare depends on a wide range of social policies, the task of the social planner becomes less concerned with an unequally shared welfare service than with the social production of

inequality. In this new context, social and economic policies will not be separated. Institutions, hitherto ignored by social policy analysts, such as private enterprise, trade unions, banks and insurance companies, must become part of their considerations. Social planning will address the development of structures in society which produce and maintain equity. Walker calls it "structural planning" and its objective is to reverse the dominant relationship between economic and social values and priorities (Walker 1984).

Walker concludes that, in order to counter the conservative dominant tendencies of traditional social planning and to ensure the implementation of structural social policy, it is necessary to reassess both the role and function of social services. This requires concentration on needs and objectives rather than on forms and techniques of resource management. It entails long term oppositional planning and consciousness raising with a wide range of community groups in order to change existing social relations which inhibit radical change. Most importantly, it means that the practice of planning as an expert pursuit must be transformed. It should be located locally, outside the main administrative machinery, and subject to local control and veto. Plans will be concerned with how to encourage people to liberate themselves politically in order that they may secure their own economic and social freedom. The role of the social planner is the facilitator of

this political freedom by supporting the struggles of the people already caught within the welfare state or reform pressure groups. Walker proposes "community development planners" at the local and regional levels.

The principles of primary health care acknowledge the necessity for redistribution of power and resources which determine equity in health in society. Traditional planning methods used in community health agencies and, in particular at Parks Community Health Service, have been limited in their approach to the delivery of services and, arguably, have compounded the inequities. Radical planning, which is oriented towards the social goals of equity and justice, and which is based on the experiences and desires of community members, therefore presents as a more suitable approach to planning for a community's health.

For Parks Community Health Service, this meant that the development of a social plan for health improvement, over and above the already developed organisational plan for service delivery, was required. Goals to increase community participation, to educate the community in health issues, to provide high quality accessible services are not adequate to address the deeper structural aspects of ill health as reflected in the statistics relating to who gets sick and who doesn't. If the principles of

participation and equity were to be implemented, these outcomes would be those determined by the local Parks people rather than the health workers or the bureaucratic planners. This means that the service would be a resource to be used in a local community movement for change. Its first task would be to hand over the decision making regarding health promotion planning and health services to the local community.

Chapter five

Developing a primary health care planning framework

Chapter four argued that the social reform, policy analysis and social learning traditions of social planning do not address the basic social relations of dominance and dependence which contribute to the unequal distribution of health and illness in society. It argued that health improvement is but one part of the struggle for social equity. Primary health care services, seeking to improve health, must therefore adopt a planning methodology which has the potential to transform the existing social relations which create and maintain inequity. They need to combine a concern with organisational planning and professional services with the development of a role in the political practice of human liberation.

Chapter four also discussed Friedmann's view that a useful social planning theory is one which can be applied to the whole system of social relations and which includes all possible states of the political system; maintenance, evolutionary change and transformation of existing social relations. If planning can be defined as an activity in which knowledge is joined to action

in the course of social transformation, then revolutionary movements can be incorporated in planning theory. Friedmann describes this transformative social planning as "radical planning."

This chapter brings together the previous analyses of the management and social planning literature. It describes the development of a radical planning framework, based in the social mobilisation tradition of planning, at Parks Community Health Service and analyses the tensions within the service which arose as a direct result of this development. It describes the application of organisation development management methods in resolving these tensions and concludes that such techniques can be useful in assisting organisations to develop a role in social change as was originally envisaged for community health services.

Radical planning

Friedmann (1987) provides a thorough analysis of the historical development of the social mobilisation tradition. For the purposes of an introduction to the tradition, it is sufficient to know that social mobilisation incorporates aspects of the various oppositional movements to social reform; utopianism, social anarchism, and historical materialism. Each of these movements was motivated by moral outrage over the conditions of

early industrial capitalism. They were guided in their quest for a better society by a belief in the possibilities of social emancipation through collective action. Each movement has contributed important elements to social mobilisation as a planning tradition.

Utopianism suggests the possibilities of life lived in small separate money-free communities where an emphasis on human character and development coincides with an emphasis on the social and physical environment. It emphasises a balance between work and play, industrial and agricultural pursuits and the passionate nature of human beings being given free reign.

Social anarchism is based in a view of a world of reciprocal exchange, of separate self-managing communities able to join as federations as and when required. It is suspicious of hierarchical relationships and views the State as a repressive force. It emphasises principles of cooperation as an alternative to competition in social organisation, the virtues of spontaneity over an administered life and the strategy of mass action in defiance of State and corporate authority. It is possible to distinguish two branches of social anarchism, one advocating co-operation as the road to achieving an anarchist social order and the other championing violence to destroy all authority relations.

Historical materialism offers an understanding of the class structure of social life through a view of history as a political process originating in class struggle. World history is analysed as a clash between contradictory social forces which underpin capitalism as the current mode of production. As discussed by Karl Marx and Frederick Engels, historical materialism is a science of social revolution. It concerns itself with questions of practice in the struggle of the working class and its allies to expedite the inevitable demise of capitalism. It is important for the working class to be conscious of itself as a revolutionary class. Lenin argued that guidance must be provided by professional revolutionaries whose task is to establish the connection between the politically diffuse economic struggles of the working class and the ultimate objective to seize state power. Theory must continually be adjusted to practice as it fits world realities.

Planners using strategies developed by the revolutionary movements are defined, by Friedmann, as radical planners. They are committed to equity in access to power and the emancipation from oppression of any social group. Rejecting the harmony model of society and acknowledging an inherent societal conflict between dominant and oppressed groups, they believe that the path to equity is through social mobilisation of the popular classes (Friedmann 1987).

Radical planners believe that to take up their democratic rights to co-determine their own destiny, oppressed people must engage in planning from below with the objective of transforming existing social relations, thereby learning from the practice of political struggle. This bottom-up perspective is a major difference between radical planning and the other planning traditions which are based in consensus or pluralist ideologies. Radical planners begin with a thorough social critique and acknowledge themselves as partisan in the struggle for equity. They regard themselves as leaders in a social movement for change. The implications of this form of identification are clear when one considers some of the characteristics of social movements.

Social movements have been defined by Piven and Cloward (1977) as "structured political activity" (p18). They consider that the emergence of protest movements, one form of social movement, involves the development of group consciousness created by a loss of legitimacy of the system as perceived by the movement members. Associated behaviour changes involve people in asserting their perceived rights, defying tradition, norms and even laws.

The literature is clear that the purpose of social movements is change. However social movements as deliberate collective endeavours may promote

change in any direction (Wilkinson 1971). The activities and values of a particular social movement may lead to either a just or an unjust demand for change (Gusfield 1970).

Radical planning and community work

The body of literature describing community development programs in Britain and the United States and, to a lesser extent, in Australia, during the 1960's and 70's provides a basis for an analysis of radical planning in community work. These programs were established as central government responses to the problems of urban decay and deprivation at the local level. Small teams of community action and research workers were based in selected neighbourhoods with a brief to find ways of improving the co-ordination of services and to stimulate self help projects.

Some proponents of these community development initiatives believed that social welfare policy at the time was not getting it right. They perceived that poor people were not finding their way out of the poverty trap because they were apathetic. On this view, poor people required motivation to help themselves. This would come about through participating in developing local initiatives for problem resolution. Program proponents also considered that, because poor families may need support from a number of

agencies at once, it was important that these agencies co-ordinate their services around needs rather than professional traditions or specialties. They believed that people receiving welfare services were in the best position to tell governments how to co-ordinate the services that were delivered. The lessons learned from attempts to improve co-ordination of services at the local level could then serve to bring about changes at the central level[1]. It was not long before community workers in these programs found it necessary to question beliefs about the causes of social problems and the assumptions behind strategies which were proposed to alleviate them. It is important to delineate some of the main features of the debate in order to develop an approach to community work which can address emancipatory or social justice goals.

Smith (1981), commenting on the development of community development as a profession in the UK during the late seventies, outlined four main ideologies operating within community work: a conservative theory, a liberal democratic one, a libertarian theory and Marxist ideology. These are similar to the four major ideologies identified by George and Wilding (1976) as underpinning social welfare policy. Smith argues that each theory and resulting approach to community work has weaknesses as well as strengths: Therefore community workers should

[1] See Maris and Rein (1972) for an analysis of the British and American initiatives and Thorpe and Petruchenia (1985) for an Australian perspective.

be prepared to use a combination of approaches depending on the requirements of particular situations.

According to Smith, conservative theory proposes that we live in an over-planned society in which a significant by-product of the welfare state has been loss of individuality and initiative and increased dependence on public institutions. The approach used by community workers with this set of values is to recreate a sense of "community" through self help schemes and community care programs. Liberal democratic theory concerns itself more with breakdowns in the political system than with the problems of social life. It is an organisational rather than a social or political analysis. It seeks to redress the inadequacies of large bureaucratic approaches to planning by the development of localised democratic structures which can potentially sensitise the bureaucracies. Libertarian theory places an emphasis on direct action, with associated values of self determination, dispersal of power and anti-institutionalism. This ideology forms the basis of radical community work. Experimentation and flexibility are highly valued. It starts with those issues considered important by the people but never really defines who the people are, outside the few who are the co-actors in the community work. Marxist ideology holds that the issues for community work stem directly from the part played by the government in creating the right climate for

industry. Community work itself is seen as a part of the State's social function. Community work, then, can never be a force for change because the community lacks sanctions and a power base. Its only validity lies in its potential as a vehicle for political education, and as a way of broadening the concerns of the labour movement through links with community groups.

Smith denies that the State is as monolithic as Marxist theory would have us believe and, indeed, that the interests of community groups and the trade unions are always co-incident. He suggests that this view of community work fails to appreciate the possibilities for community action outside of an economic context.

A further categorisation of community work is observed by Winwood (1977) who describes the "colonial" tradition in community work. This assumes that basically the structure of democratic capitalism is sound enough but that major institutions of the government and the public service have simply "gone astray." The rhetoric of community work for change in the colonial tradition makes five major assumptions according to Winwood;

> that governments mediate between competing interests in the allocation of scarce resources;
>
> that government decision making is the target for community workers and community groups since governments control the most resources;

> that pressure, information, analysis, co-ordination are significant rational innovations which will produce change to meet real needs of ordinary working people;
>
> that economic growth has produced sufficient resources to ensure that basic needs are met but that bureaucracy and the rapidity of change inhibit the most efficient and effective means of distributing those resources;
>
> that incremental changes in policy and practice on the part of public service bureaucracies will gradually eliminate any remaining inequities or injustices.

The colonial tradition of community work is typically concerned with the therapy of relations; with adaptations to change and where concerned at all with politics, with community politics. The development of self help or mutual aid is the preferred strategy and where politics enters the picture, the emphasis is on "partnerships" with authorities. Winwood argues that the "social movement" tradition in community work is the only tradition really capable of handling both the conceptual and practical difficulties inherent in mobilising for change.

Maris and Rein (1972) are also critical of this "colonial" tradition, describing its model of community organisation as a form of treatment for collective depression; its techniques of discussion, participation, devolution of responsibility, and self analysis of community problems, they argue, imitate the techniques of group therapy. They suggest that communities,

unlike an individual patient in a therapeutic situation, cannot initiate and ultimately control the relationship with their helpers; therefore this form of social therapy tends towards a paternalism which ultimately undermines the very qualities of self confidence and self respect it is seeking to promote. This dilemma arises, they argue, whenever the restoration of individual dignity is taken as a psychological problem, inherent in those who are demoralised, rather than as a moral problem, inherent in the society which humiliates them.

Lukes (1974) and Bachrach and Baratz (1970) demonstrated that control over the agenda of social policy is equally as important as the taking of decisions within the agenda. Similarly, Winwood (1977) and Saunders (1975) both stress the importance of being fully aware of the extent and nature of bias in the system of State organisations and institutions when developing strategies for change in community work. An understanding of the political economy of the community is crucial, not only in the development of strategies to mobilise for change but also in understanding what has to be changed and what the key resistances to change might be. Social movements seek to change not only the amounts of resources at the disposal of communities but also the control of those resources. Ameliorative attempts to make the system more responsive or to open up the decision making process are not good enough. Winwood concludes that a

serious response to the political and economic biases in society and the consequent powerlessness of the poor, requires that community work must begin the task of counter mobilisation. It must assist poor communities to take control of decisions which affect them.

The literature points to a conclusion that community work must change social relations rather than simply ameliorate social depression and bureaucratic inadequacy. Castells (1983) observes that social change movements are the sources of innovation and social transformation rather than of social bargaining as is the case when attempting change through the political system using the normal political games. He argues that the crucial phenomena in a variety of social change contexts throughout history have been self conscious, self organised social movements, successful in achieving their stated purpose because they have a solid social base, a communalising and coherent social issue around which to mobilise, and an articulate and well grounded social force; leadership.

Maris and Rein (1972) describe the dilemmas of community workers in reconciling the demands of their government employers with the demands of communities who were, quite justifiably, in conflict with government policy during the American Community Action Program. Repo (1977) and

O'Brien (1974) also gathered evidence that community development activities remain captured by the local ruling elite and are generally concerned with assisting people to cope more effectively with their less equitable situation. On the basis of evidence such as this, Dixon (1989) criticises those who suggest a role for community work in the development of social change movements. She argues that the role of community work in fundamental social change (here she refers to the ongoing class, race or gender struggles to transform the existing economic and power structures) is limited by the nature of its government sponsorship and by the parochial nature of its activities. In unravelling the confusion inherent in the meanings that the term "community development" has for different people and groups in the community, she points out that community development has been, generally, an intervention imposed from outside for the good of those inside and has therefore been a paternalistic intervention. Dixon concludes that, by placing the conservative, uninspiring aspirations of communities at centre stage and setting out to "make the best" of the often oppressive local power relations, the community development method may result in changes meaningful to participants - but these developments are never towards fundamental social change. She suggests that unless community development is redefined so that it approximates political action, or unless the projects establish themselves from the inside rather than the outside, the sponsorship arrangements and the necessary ingredients of parochialism and self interest

will repeatedly doom community development to fall short of fundamental social change.

The literature of radical planning attempts to overcome these shortcomings. For radical practice the question of strategy is both decisive and divisive. The kind of core questions debated in the radical practice literature relate to who should lead the movement (professional revolutionaries or the people themselves?); the social basis of the organisation for struggle (gender, class, ethnicity, religion or territory?); whether long term uncertain gains should be sacrificed for short term certain benefits; whether alliances should be made and if so with whom; whether violent means should be employed and if so in what circumstances; whether the movement should be centrally organised and directed or decentralised and informal in structure (Friedmann, 1987).

Friedmann describes the practice of a radical planner as being concerned with the linkage of knowledge to action by the broader community seeking change. The planner can help in providing a critical account of the situation to be changed, using information strategies which not only describe the problem but provide an analysis of it. The planner can help the community

and groups that are already mobilised to search for practical solutions to the problems perceived by them and help with the intelligence they need for devising a successful strategy of action. Planners can help to refine the technical aspects of transformative solutions and help the group to learn from its own experience and to disseminate the newly acquired information in ways appropriate to the project. The radical planner can mediate in oppositional encounters with regulatory and repressive agencies and enhance the group's relationships with other like minded groups in the community. Planners can assist the group with the development of an ideological framework capable of explaining their successes and failures.

Friedmann concludes that radical planning requires specialised skills in communication, group process, social analysis, problem synthesis, as well as familiarity with the social learning paradigm, its requirements and its applications, familiarity with planning theory, and experiential knowledge in social transformation. These skills, he argues, must be embedded in critical thinking and in a moral commitment to an ethics of emancipation.

Results of a Victorian Department of Health project, which attempted to make the skills and frameworks for successful community development activity in health promotion explicit, provide evidence that these skills are important in community work. The key is a critical mass of the

community participation in the change process and a community worker working as an enabler with that mass (Victorian Department of Health 1988). In this context, community work is radical practice.

Both British and Australian literature on community work provides information to support the development of successful radical practice. Thus Boaden et al (1981), reflecting on the results of surveys conducted under the auspices of the Royal Commissions into Local Government in England and in Scotland in 1969, observes that people show a much greater interest in matters directly affecting them in their immediate neighbourhood than they do in the wider affairs of a region. The survey results indicated that community feeling is specific, localised and many layered and that people constantly respond in different ways to the social needs expressed through their interaction with their neighbours. About half the people interviewed expressed an interest in events occurring in a "home" area and this was most often described in physical terms by reference to street patterns and local landmarks. For most people, "local" meant about four surrounding blocks. The results indicate a mismatch between the functional needs of most local authority services and the scale of area organisation which would encourage more people to participate in the discussion or control of such services. Flexibility in providing for participatory activity is therefore needed.

Recent Australian investigations into methods to increase community participation in local governments have yielded findings similar to those in Britain and Scotland. The development of local "precincts" for participation in decision-making has provided encouraging results in the development of effective and sustained participation in local government (Stevens 1987, North Sydney Council 1990).

There are a range of ideological positions and strategies used in community development work. Overseas programs of the 1960s and 1970s and recent practice in Australia indicate the need for community work to be grounded in a popular movement for change in which local issues mobilise action and community workers provide support from the inside rather than the outside. This is exactly what Friedmann describes as radical practice. Without community participation and control, community work can only provide therapy and amelioration in impoverished communities. The literature acknowledges the tensions experienced by community workers who are employed by government agencies when they are engaged in this form of political action with community groups, particularly when that action is directed at their own employer. The existence of tension does not, however, diminish the need for radical practice.

Priority setting for health promotion may be a means by which community members can mobilise for change. Communities of interest jointly identifying common needs and goals for health and strategies to achieve them might be reasonably expected to initiate movement for change. Yet efforts to generate broader community participation in health promotion priority setting have had varying levels of success because the processes which might enhance community participation may be hijacked by professional or professionalised lay caretakers with strong and well organised agendas. They may also have financial interests which outweigh their concern for health. Saunders (1981), making these points in a case study of power relations and patterns of influence in a London borough, outlines how a largely unconscious "routinization" of bias regularly favours some interests (such as business) while disadvantaging others in so-called participatory political systems. In many cases these interests are destructive to the health and welfare of residents.

O'Brien (1981) reports on a number of studies of independently sponsored neighbourhood organisation efforts in Britain which have shown a lack of interest by the poor and a disproportionate involvement of middle class people in the organisational processes. He argues that this "apathy" is not adequately explained by the "poverty culture" proposed by social critics such as Michael Harrington (1962) and Oscar Lewis (1966) and supports the

view that what is referred to as "cultural" is merely a situational adaptation that can be changed if the situational constraints are altered. Poor people cannot afford the luxury of getting involved in political activities which promise to yield results in the future when they are engaged in a daily struggle to provide the bare minimum for physical survival.

In Australia, similar disappointment awaited Broadhead et al (1989) who developed a participatory process of priority setting meetings to identify the range of issues affecting the health of the Western Metropolitan Region of Victoria. They found that;

> "inevitably, the participants at these meetings tended to be those who had the greatest interest, and the available time, including many health workers." (p252)

O'Brien suggests that the answer to the question as to why the poor don't get involved in relevant neighbourhood organisations can be found in Olsen's theory of public goods (Olsen 1965). This theory states that an individual in a large group cannot make a noticeable contribution to any group effort. Since no-one in the group will react if the individual makes no contribution, that individual has no incentive to contribute. Indeed, if contributing requires the individual to divert attention from her own struggle for survival, she would see that as a disincentive. In urban situations where professionals are interested in maximising participation in planning issues

affecting the lives of the poor, the situation approximates the "large latent group."

Bolman offers another explanation of the failure of the poor to get involved, by way of a useful distinction between intrinsic and extrinsic barriers to participation in health planning (Bolman, 1974). Intrinsic barriers generally stem from the people and programs operating within the organisation seeking to develop community participation. These barriers can be removed by the organisation. Extrinsic barriers are beyond the boundaries of the organisation and are largely beyond its control.

One intrinsic barrier is the tendency to emphasise the importance of professional expertise. This can be at odds with the value of community participation which often challenges that expertise. Professionals are likely not to have the expertise that comes from living with an issue or experiencing the life conditions of the people who they encourage to participate (Fauri 1973). Bracht and Tsouros (1990) point to the skepticism of professional organisations and possible attitudinal barriers. Professionals may unwittingly convey messages that particular individuals or groups may be less skilled and able to participate in health planning. This tends to reduce the confidence of the participants and

leads to progressive reduction in participation. Only those who become "professionalised" remain.

Organisations may develop bias (either intentionally or unintentionally) in participatory planning by designing processes which systematically exclude particular groups. Monolingual forums, for example, exclude non-English speaking groups. The times of the meetings can determine how many women, men, unemployed, employed can participate. Bracht and Tsouros (1990) suggest that some organisations lack the creative capacity to encourage effective participation. Many public health workers, for example, lack the training and creative skills to assist the process of community action.

Bolman suggested that some of the more extrinsic barriers to participation are the various social, economic, ideological and political milieu in which an organisation exists. Often real power to change anything lies elsewhere and may restrict the scope and benefits of participation. Social policy affecting public housing, for example, may be more a result of deals done between governments and developers than any form of participation by the prospective residents Other political difficulties of engaging lay people in planning relates to their need for knowledge and time.

Some conditions which are conducive to participation in health priority setting may be synthesised from the literature. Piette (1990) commenting on the Community Health Councils in Wales during the debate about fluoridation, pointed to the importance of considering the training of participants, the presence of a facilitator in meetings to assist in identifying the pros and cons of different values and to clearly define the points of agreement and disagreement, the training of chairpersons, adequate and appropriate time periods for participants to prepare for meetings and to react to decisions.

Bracht and Tsouros (1990) also point to the need for strong organisation of the community through networking of subgroups and organisations; two way communication flow between representatives and their accountable bodies or groups; multiple systems for representing the population; avoidance of professional dominance in the participatory processes; sufficient time for representatives to organise.

One participatory approach to determining priorities for health promotion action has been used by the World Health Organisation's "Healthy Cities" project (Ashton 1992). This starts with workers facilitating the development of a community's vision for health as opposed to a collection of data on health problems. Priorities begin and end in the familiar experiences of

community members and these are elicited through processes which are familiar and comfortable to them (art events, drama, picnics etc.). The vision is a starting point for dialogue rather than a blue-print or bureaucratic plan. In South Australia, the Noarlunga Healthy Cities Project supported community groups to mobilise to clean up the local river system after a community "vision exercise" identified clean waterways and parks as a priority for the residents. Baum (1990) argues that this approach minimises the tendency to develop strategies for health promotion which blame the victim of illness by focusing on strategic development to enhance health rather than to reduce disease or to address problems. Disease reduction would, of course, be an outcome of health promotion but designing programs to promote health would move the organisation beyond a preoccupation with disease and therefore beyond the status quo.

The Healthy Cities experience supports an argument to develop structures for participation at the neighbourhood level where there are not only incentives to join for those people most disadvantaged but where social and organisational sanctions support participation. Then, not only would participation cost the individual nothing that she is unprepared to give, it would contribute something to the individual's life. Participatory processes which take account of what is known of the conducive conditions and barriers to participation, would seek advice

from the potential participants themselves about what processes would be most acceptable to them.

Community health planning and radical planning

If, as Friedmann's framework suggests, the planning tradition appropriate for social transformation objectives is the social mobilisation tradition or radical planning, then community health services, as partisan agents in a social change movement, must develop a radical planning approach to priority setting and strategy development in health promotion.

The social justice values, underpinning the primary health care principles by which a community health service seeks to operate, imply a requirement that the nature of the relationship between a community and a community health service in developing priorities and strategies to promote health, is equitable. The relationship required between professionals and the community, given the collectivist principles of primary health care, will be a partnership. Furthermore, social justice values point to the significance of social and economic inequality in the production of unequal burdens of illness. A community health service which acknowledges the social and economic causes of illness, will shift its focus for planning from a

preoccupation with service provision to a concern with broader outcomes which, simultaneously, address inequities in health status and social relationships. The community health service will therefore offer itself as a resource to be used by local people in action to improve health and social equity in their community.

In practice, however, evidence from Australian community health services suggests that a power inequality between the services and their communities exists and is most obvious in the fact that expert professional service providers have been making decisions for many years about health service priorities for service recipients (Milio 1988, Australian Community Health Association 1986, Southern Community Health Research Unit 1987, Hicks 1982).

Southern Community Health Services Research Unit (1987), studying community health services in the southern region of Adelaide, observed differences between types of health professionals in their "community health ideology," as measured by a Community Health Ideology Scale. The scale measured workers' attitudes to;

A population focus:

> whether the community health worker should be responsible not only for individual clients with whom he/she has contracted for treatment but for the entire population of both identified and unidentified potentially ill members of the community.

Primary prevention:

> the concept of lowering the rate of new cases of illness in a population.

Comprehensive care:

> the concept that health care should be directed at physical, psychological and social health needs and the belief that this will sometimes involve attempts to modify lifestyle and environmental factors.

Integration:

> the view that there should be a continuity of professional responsibility as the client moves from one program to another in an integrated network of care-giving services.

Participation/teamwork:

> the belief that the community health worker is only one member of the group of community agents providing health care and that he/she can extend his/her effectiveness by working with and through other people, whether ordinary citizens or other health care providers.

The researchers concluded that the score for ideology was determined by the training which the health workers had experienced. For example:

> "Community health nurses have generally had substantial formal training in community health. Social workers, also with a relatively high score, have training that is generally community oriented, whereas the other professions have had considerably less, or none at all..... The inescapable

> conclusion is that the score for ideology is determined mostly by the nature of the professional training."(p74)

Training and professional socialisation also play a major role in this tension which is often experienced in community health services (Furler 1982, Milio 1988, Australian Community Health Association 1986). Furler points out that three fundamental values are common to the undergraduate training of almost all health and welfare occupations: the inherent worth and paramount value of the individual; the key contribution of the professional/patient relationship to effective therapy; the importance of confidentiality in that relationship. She suggests that the need to work with whole communities requires different skills and can precipitate difficult questions concerning individual versus community rights and privileges.

These professional values generate intrinsic organisational obstacles to participation and must be addressed in order to develop maximum community participation in priority setting and strategy development. Organisational planning processes are required to bring about an organisational "readiness" to engage in radical planning. Unless staff feel comfortable in sharing power, professional attitudinal and structural issues will continue to inhibit community action and control over health issues.

Organisation development techniques offer the means by which such organisational change can be achieved whilst also ensuring the staff commitment to new organisational goals. The change leadership required is described by Dunphy and Stace (1993) as "consultative." This approach involves consultation with employees, primarily about the means of organisational change, with their possible limited involvement in goal setting relevant to their area of expertise and responsibility. Dunphy and Stace argue that the leadership required is directive, articulating a clear vision of the organisations's future processes and achievements. A description and analysis of the process developed at Parks Community Health Service to change organisational goals, values and practices to support radical planning is outlined in the next section.

Social planning at Parks Community Health Service

Chapter four described the organisational goals and structure at Parks Community Health Service when the author took up the position of Director in April 1988. They were essentially concerned with developing the technology of primary health care. They were process oriented rather than outcome oriented and included the provision of treatment services and health education programs, maximising community "involvement," increasing co-ordination between services and providing training to primary

health care workers and students. Teams were, in effect, functionally separated in terms of which of the organisation's goals they addressed. The issues on which teams chose to work were determined by separate planning processes.

The Community Education and Development Team had the mandate of increasing community involvement in health promotion. The first Community Education and Development Team Leader was a trained psychologist whose specialty was staff development and training.[1] She describes herself as initially having no clear framework for community development, her training having been based on an individualistic analysis of social problems. The Southern Community Health Services Research Unit's study of 1987 found psychologists to be the lowest scoring professionals on the Community Health Ideology Scale and, as already mentioned, concluded that this was determined by the training they received. Although the Team Leader had unspecified experience with social action in the 1960's her training probably limited her understanding of social planning and community development in her early days at Parks Community Health Service.

[1] The history provided in this section is taken largely from interviews with the Community Education and Development Team Leader and her Personal Services Team counterpart who then held the positions. The analysis is the author's.

The re-organisation undertaken by the previous Director in 1984 had been the first attempt by any community health service in South Australia to specifically allocate positions to primary prevention. The Team Leader, therefore, had no local models from which to work. Communication between people doing similar work in other states was, as yet, undeveloped. Her task, as the first Community Education and Liaison Team Leader (later to be titled Community Education and Development Team Leader), was to develop the team's cohesion and its skill in community development and health education, areas in which she had specifically chosen to specialise.

The Team Leader first implemented intensive staff development programs for her team. She relied heavily on the work then being undertaken in Victoria on community development and the "popular education" techniques which the Victorian Community Development Project advanced through "Health Wise" courses. Her team became skilled in this methodology which was designed to assist community groups to define their problems and issues and develop a group understanding of the broader social context within which those problems arose (Victorian Department of Health 1986). The information gleaned from these groups then formed the basis of the Community Education and Development Team's planning process.

The Team defined the priorities to be addressed and the strategies to be employed. They were aimed at increasing people's self esteem, increasing co-ordination of services, increasing access to services of certain groups in the community, increasing social support amongst certain groups and increasing the knowledge and skill of people in their own health care[1]. It seemed that, despite a commitment to participation and a new technique for its development, there was a limit to how far that participation went, even in the Community Education and Development Team's planning process. The type of "participation" was akin to "consultation" (Arnstein 1968).

By 1987 the first Community Education and Development Team Leader had established a relationship with the Social Health Branch of the South Australian Health Commission. This may have influenced the Team's change to a population focus for planning since goals and strategies were defined at about this time for specific population groups within the local community.[2] Using the Health Wise methodology, team members got a picture from community groups about what health issues were important to them, and what aspirations they had for the future. On the basis of this information, small groups of staff, each of whom undertook the task of focusing on a particular population, designed goals and strategies. Self help programs,

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1 Community Education and Development Team planning papers (1986).

2 Community Education and Development Team planning papers (1987).

trainer training programs, social support programs, health education programs, liaison activities with other agencies were combined with a formal and somewhat bureaucratic scheme aimed at increasing the involvement of the local Parks residents in the affairs of the Health Service. A program aimed at fostering community participation in planning for primary health care services across the whole of the surrounding western region was also developed with leadership by the Team Leader. All of these programs appeared to have been developed from the conservative and the liberal democratic theories of community work as described by Smith (1978).

Planning for primary health care in the western region of Adelaide, where Parks Community Health Service was located was being pursued in partnership with the Social Health Branch of the South Australian Health Commission. This work eventually resulted in the formation of the North West Suburbs Health and Social Welfare Council, South Australia's corollary of the Victorian District Health Councils, the United Kingdom's Community Health Councils and, roughly, the American Health Systems Agencies. Its aim was to create a more participatory mechanism, for residents of the region, in health planning issues than was then available through existing structures. It was to be a two way communication process between the South Australian Health Commission and the people who were affected by the

decisions that it made. There was, at this stage, no attempt to develop social action or protest strategies aimed at bringing attention to the lack of equity in resources for the people of North West Adelaide, nor to address the lack of electoral power of a community which was situated in a traditionally safe Labor Party seat. Rather, employees paid by the South Australian Health Commission were to assist in the development of a council of people who, in turn, would assist the South Australian Health Commission to improve health planning by commenting on planning issues as they affected health.

The major gains of the team's development so far were a clear team commitment to community participation, at least in the information gathering stage of planning; the development of team members' skills in assisting groups to articulate their needs; a team commitment to a population focus for planning and the development of team cohesion. There was, however, no community control over the planning process and the strategies employed were still those which aimed to assist the community members to more adequately cope with their situation rather than to participate with them in changing their situation. Ongoing community participation was limited to the community members who were Committee of Management members or who were members of various social support programs.

This approach conforms to Milio's observation that, although Australian community health workers espouse a social view of health which acknowledges inequality in power and social relations as important influences on health differences, they devise strategies which help individuals cope with their limited personal choices. The choice of strategy, she suggests, is determined by the individualistic and illness oriented training which health workers receive. She reports how, in one locality in South Australia, the main problems identified by health centre staff were isolation, low income, unemployment and lack of transport. Nonetheless, the staff felt that people's problems lay in their attitudes and detrimental lifestyles, their lack of self help and mutual support, their low self esteem! To deal with such problems the centre program focused on either counselling to foster individual's development or forming support groups to improve socialising (Milio 1988). She could well have been describing Parks Community Health Service in 1988.

In addition to an initial knowledge and skill deficit in community development, the Community Education and Development Team suffered from a lack of credibility amongst the traditional service providers at Parks. They were especially vulnerable to the powerful medical group, who, also lacking a framework within which to understand these new concepts, were critical of what seemed to them to be time wasting activities. The medical

group believed that the Community Education and Development Team should be developing programs which directly addressed those diseases and problems which the personal care providers had to contend with every day. They did not understand why the team spent large amounts of time consulting the community and its various subgroups on issues which were important for them. They did not believe that a community health service such as the Parks could actually achieve any change in the more fundamental causes of those illnesses and that strategies which could have some effect on existing patterns of illness, should be employed.[1]

It is not uncommon, in Australia or internationally, for health promotion to be defined in terms of disease prevention. Despair among community health workers in the face of the seemingly impossible task of social change is a major obstacle to community health services engaging in primary prevention activities other than health education and self help programs (Milio (1988), Australian Community Health Association (1986), Southern Community Health Services Research Unit (1987)). This compounds the effect of the limitations of traditional health worker training in relation to community development. The result is that programs focus on the poor or disadvantaged in the community rather than the community relations and structures which maintain the inequity.

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[1] This description is supported by data from interviews with two of the Service's doctors and their Team Leader of the day.

To avoid the tendency to develop strategies which inadvertently blame the victim, it is important to develop theory and practice of community development that is consistent with the collectivist principles of primary health care.

In 1988, five years had elapsed since the strategic planning process undertaken by the previous Director had created the organisational goals outlined above and the team structure which allocated and separated significant resources for health promotion. Organisational development techniques had gone a long way towards developing a culture which supported multi-disciplinary practice, participatory decision making and a greater appreciation of a primary health care approach to health service provision in both teams. However, the process of planning by separate teams within the organisation had become dysfunctional. Separate cultures were beginning to develop across the teams, producing somewhat disparate value systems in relation to health. It was time to unify the service in a move beyond organisational planning towards taking up a role in social planning. A unifying framework which built on and consolidated the previous developments was required.

The Director's task by 1988 was to develop in Parks Community Health Service, an organisational culture which valued a holistic and Service-wide plan, as well as community control. The Director proposed to the Committee of Management that the Service undertake its second major planning process. This time the objective of the process would be to choose priority issues on which all teams could focus and which would ensure broader community participation than was currently in place. She warned that the staff would need to be involved in the design of the process by which priorities should be chosen in order that they become committed to the outcome. She also explained some of the principles of organisation development.

The Committee of Management agreed that the staff should prepare a process for choosing priorities that incorporated as much community participation as possible. However, the Committee was clear that it should retain the right to determine the final priorities since those would be, in effect, the broadest service policy.

Essentially, the planning process beginning in 1988 at Parks Community Health Service consisted of three main stages: developing the mandate to plan; defining the process by which to plan and implementing; and refining the process by research and consultation prior to decision-making and

implementation. Strategic planning is never a totally linear process. It is characterised by many processes of review and modification (Gray and Stark 1981). However, it is less confusing in presentation to follow the process across the major stages outlined above.

To begin, the Director posed the planning problem: how does the organisation develop a set of priorities which are relevant to the local community and maximise the participation of the local people in the planning and implementation of strategies to address those priorities? The staff's task was to design the solution to the problem. The Director led a debate amongst staff about the need to develop Service-wide goals that addressed changes in the social environment of the Parks community. She presented to all staff a discussion paper which described the nature of strategic planning and a possible application at Parks Community Health Service. She posed a series of questions that would yield information about the organisation's readiness to undertake strategic planning. These questions developed an analysis of strengths, weaknesses, opportunities and threats, thereby forming the basis of an organisation development approach to strategic planning (Steiner 1979). Staff participated in the analysis within small discussion groups.

This preliminary process enabled staff to debate the Director's proposals and to develop an understanding of what was meant by "outcome goals" and "process goals." Health workers at Parks Community Health Service had been accustomed to accounting for their work in terms of the number of services they provided and the strategies which they used, rather than in terms of the social change outcomes of those services. This accountability system was partly driven by the reporting methods imposed by the South Australian Health Commission and the Community Health Data Collection System which was in operation at the Service. It provided the only measures of the service's activities and, essentially, counted the numbers of people attending particular services and the reasons for attendance. Very few information requirements related to the changes made in the community as a result of health worker activity. Although a number of evaluations had been undertaken at Parks Community Health Service, they, also, had evaluated process rather than outcome.

The lack of familiarity among staff with an outcome approach to planning required some grappling with the concepts of goal setting and strategy development. A new language, oriented to outcomes, had to be acquired to replace the process-oriented language of the organisation's previous goals. Staff came to agree that the existing goals would be more accurately described as "strategies" than as "goals" if the service were to become

accountable in terms of the changes it made to the community's health status. Some initial staff support was developed for the notion of a structured program and service review process which addressed the need to assess outcomes as well as the process by which they came about.

The major achievement of this stage in the planning process was a general agreement amongst staff that a centre-wide plan would unite and consolidate the existing planning frameworks. It was considered important that this plan should build on the strengths inherent in the team structure. Staff perceived that even the existing team structure enabled the Service to engage in a broad range of primary health care activities and, indeed, the full range of health promotion activities, stated by the World Health Organisation Ottawa Charter for Health Promotion, as essential to a complete health promotion program. A more consolidated dedication of resources around fewer issues was required in order that the Service could make a greater impact in the community.

A second, equally important, outcome of this stage was a shift in staff's belief systems about why they engaged in their work. The notion of health workers being accountable for outcomes of their activities rather than for the number of activities had been introduced. This represented the beginning of staff's appreciation that the provision of services alone failed

to address the central concern of primary health care; that is, redressing the social and structural inequities concomitant with illness.

Thirdly, there was an abstract understanding amongst staff of a need to generate evaluation and review procedures which could demonstrate that the Health Service's activity, in a global sense, made changes to the community's health status. However, this linkage between the global activity and health status partially served to maintain some resistance to change. This was reflected in some staff's perception that the process, although useful, should not affect them. In particular, the doctors and counsellors in the Personal Services Team were concerned, at this stage, that the establishment of Service-wide goals should not undermine the importance of providing treatment services to the community. They argued that the high need for free treatment services among residents of the Parks impinged mostly on the Personal Services Team and the Dental Team. They believed that this demand made it necessary that they defend an extension of service provision, despite their stated commitment to social health outcomes. They saw themselves as unable to be as flexible with their strategies as, perhaps, the Community Education and Development Team could be.

The fact that these concerns were articulated most strongly by the Personal Services Team may be explained, partially, by their professional training

and experience. Membership of the Personal Services Team at Parks Community Health Service came about through self-selection. Whilst it included a large number of community health nurses, they were committed to personal care. Other staff comprised professional types which were found by the Southern Community Health Services Research Unit's study to be the lowest scoring on the Community Health Ideology Scale. Whilst the study did not measure the ideology of doctors, it would not be surprising, given the Parks Community Health Service's previous debates on health promotion (see chapter two), if these professionals were also found to be low scoring.

The effect of the self-selection to teams, which had occurred under the previous administration, was probably compounded by the separate training programs developed for each team after they were established. Not only did the Community Education and Liaison Team (which was now called the Community Education and Development Team) comprise mostly social workers and those community health nurses who had chosen to belong to a team which was specifically concerned with primary prevention, but the Team Leader had also invested a great deal of energy in staff development relating to the issues measured by the Community Health Ideology Scale. Although the Community Education and Development Team staff were still struggling with the problem of how to translate the ideology and rhetoric of

primary prevention and community participation into activity, the cultures and the resulting ideologies of the two main service teams, were quite different.

The appropriate role of the Personal Services Team in addressing the organisation's priority issues was a source for some debate and confusion amongst management and staff alike throughout the planning process. It was acknowledged that certain clinical services had to be provided no matter what the goals of the Service as a whole, simply by virtue of the fact that the service was a generalist community health centre. However, the Director argued that these services should still be developed and provided with particular outcomes in mind lest they become services for services' sake rather than a means to better health. Somehow the Personal Services Team had to address the still to be determined Service goals. They had to be accountable in terms of health outcomes for the community as well as the way they were provided.

The confusion in this debate stemmed from differences in assumptions between the Personal Services Team members and the Director. The Personal Services Team members assumed a hard dichotomy; either the team provided personal care services, or it focused on particular Service goals. The Director assumed that it was possible to maintain personal

services but to refocus them to contribute to the achievement of agreed social health outcomes. These differences in assumptions were not recognised at this stage, either by the Personal Services Team or the Director, and therefore remained unreconciled.

Staff did acknowledge that direct service provision, such as that undertaken by the Personal Services Team, was fundamental to the Service. The most important issue at this stage was to develop the Service-wide goals. This was acknowledged and supported by all staff. Agreement on this issue, then, became the starting point for the next stage of the process.

This initial stage of the process had served to identify those aspects of the Service's existing approaches to planning which staff strongly believed should be retained and enhanced. Whilst these beliefs were also, to some degree, an indication of resistance to change, the information served as a guide to what level of change was possible at this point in the organisation's development.

The Director summarised the outcomes of the first stage, and proposed a planning process which would address the need for participation by staff, management and the community, in a second discussion paper to all staff. This second part of the strategic planning process is described by Steiner

(1979) as the "goal formulation" stage. The proposed process at Parks Community Health Service called for the identification of the key community health issues by reference to staff and other expert information and included a community consultation process to gain community opinion on the issues, once defined. It was an inherently conservative proposal, still based on rational planning tenets and not far removed from the processes already used by all service provision teams. Its conservatism was not surprising, given the interpretation of the meaning of the term "community participation," which as described above, had been in vogue at Parks Community Health Service. It was modified over time as the Community Education and Development Team developed a more political definition of community development and community participation. The changes were heavily influenced by a change in the Team Leader position early in the planning process.

The move for radical planning

The new Team Leader of the Community Education and Development Team was trained in social work, specialising in the role of social work in social movements. He added new and radical aspects to the debate about how goals should be set and about health workers' roles in the attainment of goals. Like the relatively new Director, he had no historical investment in the

existing organisational goals or even in the organisational structure. His interpretation of the principle of community participation was political and firmly based on a value of social equity. He had an extensive community development background and provided strong leadership amongst a group of people who had been, and who had been perceived by the Personal Services Team members to be, struggling with the concept of community development.

The significance of the new Team Leader's sympathy with a political perspective on social change was its potential to move the planning process into a radical model. He began to articulate community development as a series of strategies specifically directed towards particular social health changes. Consequently, the focus of his team gradually shifted from a "therapeutic" approach to community development, to a social action approach by the creation of an infrastructure of key individuals. He achieved this by supporting the development of one of his ten team members as a potential leader in this new political approach and creating an extra half time position which was designated "community development worker." There was now a small but strong group of credible staff with strong leadership skills who were able and ready to place this approach on the agenda for planning within the organisation.

The Community Education and Development Team believed not only that the new goals should provide the unifying force and direction for the organisation, but also that the process of choosing them would be the organisation's opportunity to give meaning to the terms "community participation" and "community control." It viewed community power to develop and maintain its own health as vital if a vision of social justice was to be realised. This belief was, indeed, supported by the Federal Government's and the State Government's Social Justice Strategies. The Federal document states;

> "participation in decisions relating to their health (is a) basic human right of all Australians and an important element in social justice."(p29)

If the plan was going to assist the community to move towards social justice and equity in health experiences, the Community Education and Development Team members believed that it would also need to begin a mobilisation of local people to take action for their own health and to change the social relations producing and maintaining inequity.[1] The Community Education and Development Team saw a role for the Service in supporting and participating in a community mobilisation for change and

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[1] The Community Education and Development Team Leader had introduced the Team to the works of Touraine (1981) and Castells (1983) who believe that, for social change to occur, there must be a redefinition of power and a preeminence of human experience over State power and capitalist profits. Castells supports his hypothesis that only urban social movements can influence structural social change and transform urban meaning, by an analysis of social movements in Paris, San Francisco, Latin America and Madrid.

for engaging the community as an active and powerful player in its planning process.

The staff workshops convened by the Director to discuss the planning process proposed in the second discussion paper were organised in small groups of staff from a mixture of teams. Each small group contained one of the new core of Community Education and Development Team members. This was a strategy devised to take control of the agenda. It resulted in every group supporting the concept of a joint staff and community decision making process at the earliest stage of goal setting. This process would be informed by the findings of a research group whose membership would include community members.

The planning process, as agreed by all staff, differed from the Director's proposal contained in the second discussion paper. The collation of relevant information for planning and the determination of the goals was to be undertaken jointly by staff and community at the earliest stage of the process. The assumptions of a significant number of staff had shifted from a belief in the imperative of professional, expert knowledge to the desirability and validity of the expertise of community members' experience as valid data in planning. With the adoption of this new assumption, there

was an accompanying concern that the Director's proposal was inadequate as a mechanism for achieving community participation in planning.

The Community Education and Development Team had developed power in the organisation. It had been able to control the agenda to gain the commitment of most of the Service's staff members (including many from the Personal Services Team) to an interpretation of "community participation" as "community control" over the process. The newly emerging leaders from the Community Education and Development Team were able to exploit the staff's commitment to the principles of community participation and social justice by moving the concepts from a statement of *principle* to action. As discussed in chapter three, the strength of commitment to particular values, and the amount of clear disagreement between groups and individuals over the relevance of alternative values, influence the way in which outcomes are determined in an organisation. The specific sets of values held by particular groups and individuals are connected to material interests. What is valued depends to a considerable extent on interpretation of the consistency of a group's interests with the likely organisational implications of a particular set of values (Walsh et al 1981). At this stage of the Parks Community Health Service organisational development, staff were well versed in the concepts of social justice and were committed to the principles and values underpinning primary health

care, including community participation. They lacked, however, a clear model of action by which these principles could be applied. The clarity of the principles emerging in the Community Education and Development Team and their articulation into all staff discussion groups resulted in the establishment of a new model for choosing priorities. At this early stage in the planning process, staff saw no conflict between the model for planning, which was based on the value of community control, and their own professional interests.

Although on first analysis it seems unusual for the staff to have devised a planning process that diminished its own power in determining priorities, the decision may well have served their own professional interests at this particular point in time. No real priority setting process had ever before been implemented at Parks Community Health Service. Although planning methods had been used to identify priority issues, this had never necessitated the cessation of a particular program considered important by a member of staff. When programs did cease, it was usually because a worker with expertise had left or because the program had little community attendance or because the worker had become bored and was looking for a change.[1] By 1988, for the first time, the organisation was prepared to limit the number of issues which it addressed. The Committee of Management and

[1] This statement is supported by data from interviews with all informants in response to questions relating to methods for needs assessment.

management wanted to maximise the resources allocated to a fewer number of issues thereby increasing the likelihood of having an impact on the community's health.

Making a decision about what issues were to be addressed meant that the organisation was also making a decision about what not to address. Staff had, for many years, attempted to accommodate all community needs. Like most health planning issues, the decisions about resource allocation and their ethical implications had not been debated well. It is likely that, at this point in the planning process, staff would not feel comfortable in maintaining obvious elite control over the resources available to the community and would prefer to share the responsibility for the decision with a broader and more representative group of people. It was certainly the case that many staff preferred the community group to make the decisions which would effect the work practices of themselves and colleagues rather than to engage in debates with each other about which (and whose) programs were more important and therefore needed to be retained and which ones were the least important[1].

There was some discussion at this stage about work practices and team relations. Staff acknowledged that there had been little communication

[1] This was confirmed by personal communication with staff members at Parks Community Health Service.

between teams on priorities and coordinated strategy development. It was agreed by the discussion groups that strategies to achieve the new goals should be developed in work groups whose members were derived from a mixture of teams. This would ensure that the planning process acknowledged the range of strategies employed by all teams. The work groups were to be led by the Team Leaders. This was a major shift in the role of Team Leaders. They were no longer to be responsible solely for the management of a team and a limited set of strategies. They were to be held accountable for the coordinated development of a range of strategies to address a particular health issue. They were to manage people from other teams in achieving outcomes in these goal areas, whilst still retaining responsibility for the personnel and resource development aspects of their teams. They would provide a focus for, and ensure the quality of a particular type of strategy (such as personal care or community development strategies) but would also ensure the achievement of social health outcomes. It was, in effect, a re-introduction of the "Athena" style of management to an organisation which, as chapter three suggested, had settled into a "steady state" or "Apollo" style.

It was from this point that the research group, comprising two community members of the Committee of Management, a staff member from each of the four teams, the Director and a Research Officer began its task. The

research group acted as a steering committee to the project officer who gathered information from a number of sources including the newly developing *Social Health Atlas for South Australia* (South Australian Health Commission 1990), the Epidemiology Branch of the South Australian Health Commission, South Australian Health Commission Hospital Admission Data, Australian Bureau of Statistics[1], a survey of local and regional health and welfare agency opinions on priority issues in the community and the health service's own data on reasons for attendance at Parks Community Health Service. A review of existing services and their target groups or issues was also carried out. Twelve key health issues were identified: Environment; food and diet; smoking; pregnancy and babies; children's safety; problems with children's development; youth health and welfare; sexually transmitted diseases; difficulties being a parent; domestic violence; social isolation amongst elderly people; and disabling conditions in the elderly.

The style of information gathering was typical of the epidemiological approach to choosing health promotion priorities. Not surprisingly, the issues were more concerned with illness or its causes than they were with health or health promotion. Not only were they derived, essentially, from an investigation of ill-health problems within the community but they also incorporated the therapeutic agendas of most staff members within the

[1] These sources provided data on reasons for morbidity and mortality in the region.

organisation, which, in themselves, were based on a relatively traditional approach to health promotion priority setting.

During the process of identifying the major health issues for the Parks community, there was debate amongst the staff, led by the Community Education and Development Team Leader and supported by the Personal Services Team Leader, about the possibilities for effective participation by community members in the proposed joint professional and community decision-making forums. The Team Leaders argued that the people most likely to participate, aside from professional people, would be those most familiar with such a process. Groups who already lack access to information would tend not to come. The process would be dominated by professionals and other caretakers of the community. Little real control by the community most disadvantaged in relation to the twelve health issues would be developed in the process. They argued that, without community ownership of the strategies developed for health promotion, there would be little ongoing participation and no fundamental shift in the power relations that contribute to social inequity and, eventually, to the twelve health problems.

The Community Education and Development Team Leader often played the role of ideological conscience, reminding staff and management of the social justice principle which must guide the service if it were to contribute to any

fundamental improvements in health. He argued that the health service must develop processes for community participation that were accessible for the most disadvantaged groups in the community and for those people less familiar with the professional style of decision making. These processes must be the beginning of continuing participation in the movement for a shift in power and towards social justice as distinct from consultation on already decided priority issues.

The Community Education and Development Team Leader convinced his colleagues that the proposed forum should be replaced by a number of strategies specifically targeting disadvantaged groups and using techniques which demanded little from the participants. He argued that the strategies should be preceded by a public information campaign outlining, in popular terms, the results of the reference group's research. A concerted effort by the Service was required to elicit information from members of the broader community other than those people who were already familiar with the Service. The information had to be based in their own experience and assist in the development of their own vision for health. Furthermore, this early participatory process should begin a partnership between the health service and people in the community.

The Community Education and Development Team Leader believed, on the basis of his understanding of the power relations in society creating social injustice, that the relationship between the health service and the community members who participated in the planning process would, in some cases, require a political partnership. The service would need to develop a strong political constituency around the priorities since only concerted political action could address some of the fundamental issues affecting health. He argued convincingly that people participate actively in those issues which are dearest to their own hearts, no matter what the experts say. The Health Service should assist community groups to participate effectively in their own priorities. He therefore believed that the Committee of Management should choose the priorities on the basis of the potential for active community participation and be prepared to ensure the allocation of resources to those issues which engendered the most community passion. He argued that this choice must, however, be guided by the social justice principle which underpinned the primary health care role of the Service. In essence, he argued for a radical planning model for a community health agency.

Although the Community Education and Development Team members acknowledged this important aspect of participation in successful community work, at this stage in the debate about planning at Parks Community Health

Service, not all staff fully appreciated the implications of the political direction upon which the service was about to embark. There was, however, enough support within the organisation for maximising community participation. The whole idea of a broadly based community participation strategy was exciting to a group of community health workers who had been, for over a decade, dancing around the edges of problem of how to develop participation. The debate within the service had raised people's interest and developed a degree of critical appraisal of previous techniques.

Since it was clear that the priorities would form the broadest policy on service provision at Parks Community Health Service, the development of which was, constitutionally, the responsibility of the Committee of Management, staff also supported the proposal that the final decision making authority should rest with the Committee of Management. As yet, there was to be no resistance from the staff for a radical planning approach at Parks Community Health Service.

Following several weeks of media coverage in the local press concerning the identified issues seriously affecting the health of the locality, a large visual display was developed and located at the regional shopping complex. It was staffed full time by people from all teams for a two week period. Community Health Workers stopped shoppers and asked them to identify

three things which could make the community healthier. They were also asked whether they would like to work with the Health Service and other residents to develop strategies to address the issues they raised. In this context, the research, media coverage and display relating to the health problems of the community provoked and informed the input from the community but did not limit that input. The same questions were put to all users of the Health Service over a one month period and all community groups with which the Health Service had a relationship. All staff participated in the questioning after training by the Community Education and Development Team members.

Eliciting the active participation of community members whilst developing a plan inevitably moves the planning process from a rational approach to a more radical approach. The participation of citizens becomes another force in shaping both the process and its outcomes. This change in dynamics was revealed in the final decision-making forum. By the time the decisions about priorities were to be made, community members were already mobilising around most of the priority issues chosen. Staff had met with approximately 1000 people, individually, in local groups connected with the Service and with local agencies. Approximately 60 people had indicated an interest in working with the Service to develop strategies to address their particular issues of interest. A report outlining the results of the research phase of the

process was prepared for staff and the Committee of Management. It was agreed that the Committee of Management would consider the report along with submissions from the Teams and any individual staff members who wished to make a separate contribution. Although the fairness of this last form of staff input into decision-making can be debated, handing over power to non-staff Committee of Management members was uncomfortable for many staff. The freedom to make personal submissions eased the discomfort slightly.

A power play from the professionals

Prior to the Committee of Management's workshop to determine the final priority issues, the staff began to consider the content of their submissions. They were to propose to the Committee of Management their opinions as to the *criteria* which should be considered in reaching a decision on priorities as well as their opinion on what the priorities should be.

The renewed focus on professional opinion exposed the tensions inherent in developing a true partnership with the community.
Some of the professional staff began to see clearly for the first time that their own opinions on priorities would have to be balanced by the Committee of Management against the opinions of the broader lay

community. Some members of the Personal Services Team were concerned that the Committee of Management would not choose issues which the Personal Services Team considered important and which the service already addressed. An indication of the differences in culture and ideology between the two general health teams was the fact that the Community Education and Development Team welcomed the possibility of maximum community input, even if it meant that services might be changed, whilst The Personal Services Team did not.

The meeting at which the whole staff was to develop its submission to the Committee of Management became an extremely political event. Once again, the Community Education and Development Team used political tactics, ensuring that each small group of staff was led, either officially or unofficially, by a key community development worker. The task of this worker was to convince the group that they should suggest to the Committee of Management that the single most important criterion for consideration when choosing priority issues was the potential for active community participation in addressing that issue. In this instance, however, the Community Education and Development Team was unable to consolidate its position. The staff of the Personal Services Team had too much to lose. The Director and the Team Leaders were called back into the staff meeting to face a demand for five staff members to attend the Committee of

Management meeting. Staff, more particularly, the Personal Services Team members, did not feel satisfied, at this stage, to rely on the power of their representative on the Committee of Management.

To be fair, given the different perspectives across the two general services teams which would be most effected by the Committee of Management's decisions, the single staff representative, although being a member of the Personal Services Team did not feel comfortable about her ability to adequately represent staff views. It was agreed that the staff representative could be accompanied by another staff member (who was also a member of the Personal Services Team) and that teams should develop separate submissions in addition to the whole staff submission which could more adequately represent the different concerns arising from their different perspectives. Submissions, which were ultimately included in the information package to Committee of Management members in preparation for their planning workshop, reflected the positions of the Personal Services and the Dental Team, who attempted to influence the Management Committee's choice of priorities, and the Community Education and Development Team, who attempted to influence the Management Committee's choice of criteria by which to select the priorities. The package of information contained large amounts of written information although the Community Education and Development Team Leader had attempted to

develop simpler graphic representation of the issues for discussion.

The "Whole Staff Submission," generated from the staff meeting described above, more accurately reflected the explicit concerns of some members of the Personal Services Team than the whole staff. However, these concerns, primarily centering around an unwillingness to change work patterns, resource allocation and personal areas of expertise or interest, were powerful obstacles to progress. The submission was based on the assumption that the Committee of Management was accountable to the staff and was driven by some anxiety that the Committee of Management might not comply with staff expectations.

The information contained within the whole staff submission was useful in developing a more complete analysis of the management requirements of the next stage of the organisation's development. It was clear that attention had to be given to developing an understanding of how those people who were providing general treatment services could coordinate their activities with Health Service priorities which might be focused more on health than on health problems.

The obvious concern amongst the staff, and their assumptions about who was really in control, provided evidence of professional attitudinal barriers

to participation by the local people. They arose largely out of the fact that the fundamental concerns of the Personal Services Team had not been addressed. At this stage, most Personal Services Team members had a limited understanding of their role in any priorities chosen by this participatory process, preferring to believe that any real change would have to be initiated by the Community Education and Development Team. Their confusion was not helped by the lack of sensible senior management strategy proposals on the issue. It is not surprising that the Personal Services Team's response to its ill-understood position was to reduce the likelihood of unfamiliar priorities being chosen by attempting a "coup" of the planning process through the imposition of an extra five staff members at the all important Committee of Management meeting. Although the coup was avoided at this stage, the Personal Services Team's confusion about its role in the priority areas remained a problem until well after the priorities were chosen and continued to present a barrier to community participation.

The Committee of Management planning day was attended by all Committee of Management members, including the staff representative, the Team Leaders and one extra staff member. Out of seventeen participants, only five were local community members and seven were staff members. It is reasonable to presume that this composition presented barriers to participation by the community members. The fact that the Chairperson of

the Committee was a medical practitioner who lacked outstanding chairing skills threatened to compound the problem. Community members perceived him as an "expert" since he held positions as medical administrator at the regional teaching hospital and in the South Australian Health Commission. They often deferred to him and, at times, were embarrassed to disagree with him. After some discussion between a caucus of community members from the Committee of Management and the Director, it became clear that to develop conditions conducive to their participation in the important priority setting meeting, it would be appropriate for the Director to chair the meeting. This, it was suggested, would enable full and equal participation by all members of the Committee including the Chairperson. Some delicate negotiations took place between the caucus, the Chairperson and the Director to enable this. In this situation, the Director took the role of advocate for the community members. The Chairperson agreed with the proposal.

The planning day began with a session designed to establish group norms for the day, to familiarise all members with the various submissions and reports received and to decide on criteria to be used in choosing priorities. This opening session also gave participants a chance to identify and discuss any individual interests which they thought might impede an open decision-making process. This initial stage was useful in exposing the various agendas

around the table and allowed people to engage in open debate about the criteria for decision making.

The range of criteria which was mentioned represented the various perspectives on health planning. The Community Education and Development Team Leader argued that the most important criteria were that the issue should be perceived as relevant by the local community and that it should maximise the potential for community participation. The Personal Services Team Leader warned that many issues might not be identified by the local community as important but were nevertheless vitally important and should be addressed. His team ranked issues rather than offered opinions on the criteria to be used in choosing. He said that these issues were based on the experience of the workers daily interaction with the community.

The Community Education and Development Team Leader was, once again, influential. The Committee of Management was convinced by his argument that the Health Service could achieve more and broader change towards better health if it was able to call upon the resource of local community members rather than work alone. The already mobilised groups in the community, which were addressing several of the priority issues, provided

evidence for his arguments. The Committee of Management chose all but one of the criteria proposed by the Community Education and Development Team submission. It agreed with the Personal Services Team submission, however, that severity of the issue was more important than the prevalence of the problem.

After reaching agreement on the criteria to be used in choosing, it was a relatively simple task to reach agreement on the priorities: environmental improvement, improving access to better food for the people of the Parks, increasing safety, particularly for children and families, and reducing social isolation of the elderly in the area. These issues, not surprisingly, coincided with community opinion outlined in the report of the consultation phase of planning. Allowing the extra Personal Service Team representation at the planning day had proved useful. The staff representatives, having participated with community people in a process they regarded as fair, reported a satisfactory result to the staff. All that remained to complete a framework for planning was for the organisation to reach agreement on the range of strategies to be used in addressing these issues. The Committee of Management considered it appropriate for staff, as health promotion professionals, to provide advice in this regard although they were clear that the strategies should be conducive to maximum community participation.

Developing health promotion strategies

Health promotion literature and developments within the World Health Organisation provided the ideological spurs for discussions at Parks Community Health Service about strategies to address the newly established priority issues. Like any other form of social policy, health promotion policy and practice reflects a range of ideological positions and it is useful to review some of the positions which most affected practice in community health services during the period under analysis.

Kickbusch (1984) suggests that prevention implies conserving the health of individuals at risk of ill health. Most preventive methods reflect a medical or "scientific" model and maintain the status quo. She contrasts prevention with health promotion, defined as using a broad range of strategies, including environmental change, to move towards a more healthy state.

A number of writers have argued that individualistic approaches to disease prevention assume that ill health is caused by a defect in the victim of illness, whether that defect is in knowledge, skill or intelligent manipulation of the resources necessary for health. Making the individual the basic unit of social analysis carries an implication that health education is the best way to prevent disease. This approach appears as a politically neutral approach

to disease prevention by taking the structural conditions as given; in reality, it is conservative since it reinforces the dominant individualistic ideology of society (Tesh 1988, Owen 1980, Brown and Margo 1978, Crawford 1977). By way of example, Tesh (1988) offers the distinction between the question "Why do large numbers of people smoke cigarettes?" and "Why do these particular people smoke?" She suggests that the first question directs attention to the tobacco culture in which everyone lives: the growing of tobacco, the advertising of cigarettes, the meaning of smoking. The second question directs attention to the psychology and physiology of individual people. Prevention programs directed only at individuals, she concludes, tacitly endorse the structures supporting the tobacco culture.

As discussed in chapter one, individualism is the dominant ideology in our society. It has shaped, and continues to shape, popular culture supporting the capitalist mode of production in western society. Failure of governments to engage in any substantial way in non-individualistic action for promoting health or preventing disease can be partly explained, therefore, in economic terms. Until recently, attempts to limit the activities of the tobacco industry have been less popular than attempts to reduce smoking amongst the consumers of the products (Tesh 1988).Tesh points out that, in addition to influencing the kinds of research questions posed, individualistic ideology fuels the denigration of people who are seeking more structural responses to

social problems. People who think in holistic terms about toxins, for example, are labelled "environmental activists" or "extremists," whereas people who think from an individualist perspective, advocating protective devices on the job and substance by substance regulation, attract no labels.

The "scientific" approach to disease prevention, consonant with medical professional power, has served to support individualistic ideological barriers to a more systemic approach to promoting health. Tesh argues that the dualism of science, which places facts in one category and values in another, leads to a narrow analysis of disease causality and limited proposals for disease prevention policy. It takes for granted a reductionist unit of analysis and therefore reinforces the political assumptions which prevent a more structural analysis of causality. Research which analyses the relationships between disease and social structure is considered "soft." What results is a plethora of health professionals discussing ways of motivating people to attend immunisation clinics, to eat the right foods, to stop smoking, to wear protective clothing, to have their blood pressure checked, without ever seriously addressing why the professionals are always targeting low income groups for their motivational campaigns. The radical distinction between subjective and objective knowledge favours political judgments which protect the status quo. The authoritative voice of "science" stating that, as yet, there is no conclusive proof of causality for a particular type of disease,

more often quietens public distress than it articulates causes for real concern. Tesh argues that, in doing this, science becomes a shield against the effort to ensure public accountability.

This methodological individualism in science, and a focus on disease prevention, appear to have been characteristic of Australian health promotion during the 1970's and up to the late 1980's. Two Commonwealth Department of Health reports on health promotion written in 1979 (Commonwealth Department of Health, 1979a and 1979b) defined health promotion almost exclusively as health education and individual behaviour change. The first report was written by Dr. Trevor Beard "to give consumers and health care professions an introduction to the current world debate on health promotion and its possible future impact in Australia" (p1). The document argues that suspicions concerning the effectiveness of techniques for "changing lifestyle" can be laid aside by investment in a program of expenditure on educational projects specifically designed to demonstrate whether or not they are effective. The second report was written by Professor Lindsay Davidson to investigate and examine the potential of health promotion, primary prevention, health education and self care in Australia and elsewhere. Out of just over nine pages on promoting better nutrition approximately half of one page is devoted to the benefits of

legislation in improving nutrition. Nothing was written on the relationships between nutrition and poverty.

Both reports demonstrate the authors' beliefs in an unproblematically benevolent intervention of government to maximise a healthy social and physical environment. Each is silent on the political aspects of this intervention and neither devotes more than five percent of the total document to what may be called broader environmental strategies. Those strategies mentioned relate more to protection than to health promotion. Legislating to ensure that medicine bottles are childproof or that seat belts are fitted is possible where scientific proof of a relationship between the disease or death and the protective method exists. However, legislating against pollution was not even discussed, presumably because no scientific proof existed to relate it to a particular disease.

At an international level, the debate within the World Health Organisation's Regional Office for Europe had, for a number of years, recognised the important health determining influences of social and economic hardship. Since 1981, a number of meetings and workshops specifically addressing health promotion had been conducted by the European Regional Office of the World Health Organisation in an attempt to define the nature of a health promotion program. The definition was established in 1984 when a working

group produced a discussion document entitled "Concepts and Principles in Health Promotion" (World Health Organisation 1984). This document was significant in the development of a more social view of health promotion in Australia as well as Western Europe. Even more significant is some of the thinking which produced it. The document appears to have been informed by those emerging analyses of community development programs in the United Kingdom which were discussed earlier[1] . Participants of the workshop and some of the more prominent writers included Ilona Kickbusch, Robert Anderson and Lowell Levine.

Kickbusch defined health promotion as a departure towards an ideal state. Its activities should aim to advance health in a whole population rather than to merely reduce disease. Health, she argued, must flow out of everyday life. Unless a given society or culture provides for health, people have to *do* something to be healthy. People must have the resources and time, which only the middle and upper classes can afford, to be healthy. She argued that an individualistic approach maintains inequity in health and that political action is required to promote the health of the whole collective.

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[1] See, for example, Boaden, Goldsmith, Hampton and Stringer (1982), Smith and Jones (1981), Henderson and Thomas (1981), Thomas (1983) who articulate analyses of social welfare policy similar to the central debates within the World Health Organisation on health promotion.

Robert Anderson also argued for reference to social goals when developing a framework for health promotion. He suggested that it may be more useful to describe health promotion's general principles of approach, rather than to attempt to create definitions of it. He proposed that these principles might include;

> "working with people rather than on them; starts and ends in the local community; directed to underlying, not only immediate causes; balances concerns for the individual and environment; emphasises positive dimensions of health; multi-sectoral." (p16)

Lowell Levin, in a similar vein, argued that the first job of the health promotion professional is to find out what is the *minimum* that he/she can do to facilitate people getting what they want. The professional's task is to discover what stands between the public's interest in health and their achieving it and to ensure that they get there with the least amount of professional effort or control.

The principles of health promotion, derived from this workshop for the European Region of the World Health Organisation, defined health as a resource for everyday life rather than an objective of living. The underpinning ideology appeared to be collectivism and discussion about strategy reflected an acknowledgement of the role of conflict, of political action and of government in health promotion. In brief, the principles are;

A population focus rather than a focus on groups at risk for specific diseases.

Action on the total environmental causes or determinants of health.

Diverse but complimentary methods which can include spontaneous local activity against health hazards.

Effective and concrete public participation.

The role of health professionals in advocacy for health.

The Concepts and Principles document, which summarises the workshop, warned against inappropriately directing health promotion at individuals, at the expense of tackling economic and social problems. It pointed out that providing information without addressing the lack of control and prospects for change among subsets of the population is inadequate as a means of promoting health and is likely to increase inequity in health. It also argued that, to increase control over health, the public requires a greater sharing of resources by professionals and government. Professionals, it argued, should not be allowed to appropriate the field of health promotion.

The First International Conference on Health Promotion held in Ottawa, Canada in 1986, built on the increasing focus on health which had been developed through the Declaration on Primary Health Care at Alma Ata, the World Health Organisation's goal of Health For All by the Year 2000 and

the (then) recent World Health Assembly debate on inter-sectoral action for health (World Health Organisation 1986).

The Ottawa Charter on Health Promotion, resulting from the conference, was essentially a refinement and consolidation of ideas raised in the European Region's Principles and Concepts of Health Promotion document. The Ottawa Charter appears unashamedly collectivist in orientation, defining the role of health promotion professionals as advocating for health, as enabling groups in the community to take control of their own health and as mediating between different interests in society for the pursuit of health. The Charter describes the range of strategies characterising health promotion as; building healthy public policy, creating health-supportive environments, strengthening community action and, therefore, control in health issues, developing personal skills and knowledge about health and illness, and re-orienting health services increasingly to include a health promoting role.

Though the words of the document read like a lesson in socialist community work, they are silent on one obvious impediment to this kind of fundamental change to the way in which health is conceptualised by the individualistic and scientific approach to life in western capitalist countries. They ignore conflict between those who control resources and those who

don't. Strong (1986), whilst acknowledging this deficit, suggests that this silence is understandable given the political need to make participation in the Ottawa Charter acceptable to so many capitalist countries. The World Health Organisation's Health For All framework, incorporating primary health care and health promotion, must be recognised as a first and necessary step in the process to achieve re-orientation of the health system and of the social constructs which influence health. However, she points out that strategies will need to be defined which give meaning to the rhetoric.

It is true that, despite the lack of specificity on the nature of the strategies to be undertaken, the Ottawa Charter provided countries and communities with a framework for health promotion which addressed the broader social and political determinants of health and which was conducive to the collectivist principles underpinning the primary health care approach. The recent history of health promotion policy and practice in South Australia provides an example of the shift in thinking that the Ottawa Charter was able to produce.

The Development of Health promotion in South Australia

In the early 1980s the Health Promotion Branch which the South Australian Health Commission established to develop health promotion policy and practice in South Australia, resembled an advertising agency. It employed marketing specialists, editors, graphic designers and social psychology researchers. This reflected its relatively singular focus on attitude and behavioural change techniques to promote health.

In 1983, the Director of the Branch had resigned amidst criticism relating to the allegedly exorbitant sums of money that had been directed towards external marketing companies and advertising agents and of the limited efforts that had been made to incorporate the broader network of community services in health promotion. Dr. Simon Chapman, trained in medical sociology and a well known activist against the tobacco industry, was appointed as the new Director in late 1983. The Branch produced the South Australian Health Commission's blue print for health promotion in South Australia[1].The introduction, written by Dr. Chapman, acknowledges

[1] The document outlined priorities for health promotion in South Australia and was written by David Wilson and Melanie Wakefield who were research officers trained in behavioural psychology . They had worked under the previous Director of the Branch. It is not surprising that the document focussed on addressing risky behaviours or creating new healthy behaviours amongst the population.

the social, physical and personal factors that influence health and that problems as diverse as social injustice, housing, transport, resource allocation, the economy, law and social control, family politics, child rearing, and immigration policy all have implications for health. However, the report then opts out of accepting any responsibility for the Branch in addressing these areas, developing instead, an argument for a narrow choice of priorities.

The report states that, given that the Branch is a small project-oriented organisation,

> "The practical consequences of ever attempting to claim a mandate to solve the health promotion aspects of social policy in every field of human activity are plainly ludicrous. It means that unavoidably, the Branch must be selective in what it seeks to achieve, must set limits and be able to account for why the limits fall where they do." (pi)

The report's starting point for "health promotion" is disease. Chapman argues that this is not because the Branch has succumbed to the seduction of the "medical model" but that

> "promoting health (.....) is ultimately only meaningful through reference to the consequences of not keeping people healthy: to the avoidance of ill health."(pii)

The report proposes a rational planning process using criteria of disease prevalence, severity and preventability to develop statewide centrally

administered health promotion "campaigns." It acknowledges the need for the Branch to work with other organisations and groups in the community, but only those which identify with the priorities. It points to the need to guard against being all things to all people, as this would result in the Branch spreading its resources so thinly that its effectiveness would be questionable and its "accountability unmeasurable" (p1).

The report then develops an argument for behaviour change campaigns based on analysing the behavioural risk factors associated with major diseases in the community. It cites research relating to behaviour change programs which has demonstrated reductions in relevant risk behaviour or increases in risk reduction behaviour. It uses the term "community organisation" to describe the process of organising community agencies and professionals to comply with the Branch's objectives to address these risk factors.

The Health Promotion Branch's 1984 report is an example of the way in which "scientific" accountability measurement had begun, at this point, to be the methodological tail wagging the health promotion dog. Questions relating to the fundamental economic and social causes of inequity in health experienced by different groups in the community are not addressed in the report. It raises no objections to the system which maintains these inequities,

nor does it support any community based organisation for change since the only form of acceptable health promotion activity is deemed that which complies to the methodological requirements of the Branch.

The Health Promotion Branch was the focus for health promotion in South Australia in the mid 1980s. It can be argued that it set the scene for health promotion thinking throughout the state. Indeed, aside from a few individuals from generalist health services and several people from the women's community health services, community health practitioners in South Australia were heavily influenced by the report and the subsequent priority campaigns.

Despite the influence of the Branch, the proceedings of the first South Australian Community Health Conference, which was also the first community health conference convened in Australia, reflect the confusion which was beginning to emerge in the thinking amongst professionals interested in health promotion (South Australian Community Health Association 1984). Workshops addressed a range of subjects set untidily against each other with no solid framework or theme to tie them together. A workshop on "Prevention and Community Development" described neighbourhood work and its value in prevention. It did not address the broader issue of promoting health and reducing inequities. Workshops on

Occupational Health and Safety and Aboriginal Health expertly addressed the political context of health but these were marginalised workshops and informed the remainder of the conference to a very limited extent. Despite a keynote address from Jocelyn Auer, the Director of the Adelaide Women's Community Health Centre, which contained a well argued plea for community health's role in informing community debate and in stimulating community action for health, none of the workshops or papers addressed the issues around social action in promoting health.

By late 1987, a radical shift in thinking was beginning to emerge in relation to health promotion in South Australia. It related to the more global debate taking place within the World Health Organisation. Community health academics and policy people in South Australia read the World Health Organisation documents assiduously. In particular, the political framework for health promotion which the documents advocated was supported by the Office of the Women's Advisor on Health within the South Australian Health Commission. In fact, the Women's Advisor proposed to the Minister of Health that a Health Advancement Branch of the South Australian Health Commission would be able to continue with the directions developed by the Women's Office in a far more pervasive way, if it had a broader mandate to advance health.

The Women's Office, rather than being preoccupied with specific diseases, had always used a social and economic analysis of women's health and proposed system re-orientation as well as broader policy change to address women's health issues.[1] The Office had developed skill in political advocacy and maintained a powerful constituency in South Australia. Many members of this constituency were also community health practitioners, mostly from the women's community health services. The Office was also beginning to develop skill in communicating across sectors which potentially or actually influenced health. It had produced a number of unsolicited health impact statements on various public policy proposals and had participated in policy development forums which had not usually been considered to be relevant to health professionals or bureaucrats. Given the health promotion framework adopted by the Health Promotion Branch of the South Australian Health Commission described above, it is not surprising that the initiative to develop this social approach to health promotion came from outside the Health Promotion Branch.

After much debate among the constituents of the Women's Office, a Social Health Branch of the South Australian Health Commission was established in 1984. The new Branch had a mandate to develop a public policy approach to health promotion in South Australia and to develop mechanisms and

[1] See for example, the South Australian Women's Health Policy (South Australian Health Commission ,1985).

policy to support primary health care. Unlike the Health Promotion Branch, which concentrated on health education strategies to promote health, the Social Health Branch directed its attention to the South Australian Government and health service infrastructure for health promotion.

The focus of the Health Promotion Branch was disease. The focus of the Social Health Branch was inequity. Although the prevention of disease and the provision of information was seen by the Social Health Branch as an important strategy in its "Social Health Strategy for South Australia," its objectives went further: it aimed to re-orient an entire health system to become an infrastructure capable of advocating for health, rather than only treating disease, and of supporting broader public participation in health issues (South Australian Health Commission 1988a). In essence, it sought to place health on the political agenda in place of the prevailing political commitment to the medical treatment of disease. Its broader collectivist view of health promotion put it in ideological conflict with the individualistic approach taken by the Health Promotion Branch.

In 1987, the South Australian Health Commission's health promotion activities underwent a review as part of the re-organisation of the central office of the South Australian Health Commission. Those resources of the Health Promotion Branch more directly concerned with policy and

infrastructure issues, rather than with the specific campaigns, were transferred to the Social Health Branch.[1] This was testimony to the influence of the Director of the Social Health Branch in policy issues in the South Australian Health Commission. The Social Health Strategy had the full support of the Minister of Health as the health system's contribution to the South Australian Government's Social Justice Policy and as South Australia's strategy to achieve Health For All by the year 2000 (Cornwall 1989). A cornerstone of the Social Health Strategy was to be the development of primary health care. It was apparent that the rhetoric and methods of the World Health Organisation now had a formal place within the South Australian Health Commission.

This rhetoric, whilst not having a fundamental impact on bureaucratic practice in relation to health resource allocation, did encourage some Central Office experimentation to increase community participation in health decision making, and community development approaches to health promotion. It also raised the profile of the concept of a more social view of health amongst health professionals and, more importantly, in government circles. This was supported by the development of the *Social Health Atlas* which demonstrated, in graphic terms, the relationship between social issues

[1] The author, who on the resignation of Dr. Chapman became the Acting Director of the Health Promotion Branch, convened the review team for this task and wrote the report of the review. The underpinning principles by which the review was conducted were informed by the developments within the World Health Organisation.

such as housing, education and income, and illness (South Australian Health Commission 1990).

An informal expectation on the part of the South Australian Minister of Health, who was also the convener of the Human Services Subcommittee of Cabinet, that the Social Health Branch should comment on the health impact of proposals for State Government policy at large and, where possible, on Commonwealth Government policy, also helped to increase government understanding about the possible health impact of public policy.

By 1988, a discussion paper on a South Australian primary health care policy was developed (South Australian Health Commission, 1988b). This created debate about the current approach to resource allocation and consolidated and re-energised community health practitioners around the principles which underpinned the Community Health Program of 1973. This time, the principles were backed by World Health Organisation, Federal Government and State Government rhetoric. For the first time in South Australia, community health had a policy framework to support its approach and, indeed, interpretation of the principles of community participation, health promotion, co-ordination and social justice was less conservative than it had been in 1973 when the Community Health Program was instituted. Case studies, included in the Social Health Strategy document

to develop an understanding of how communities can participate in their own health promotion, reported the organisation, by health workers and residents, of social action to address environmental hazards created by the private industrial sector. They reflected the strategies, interpreted at a local level, of the Ottawa Charter for Health Promotion. This broad concept of health promotion had become a legitimate concept, endorsed by the World Health Organisation and supported by the Federal and State governments, which could be applied by primary health care services as part of their principles of operation in South Australia.

The Ottawa Charter strategies for health promotion offered an obvious framework within which a primary health care service could plan for health promotion. Contemporary Australian and South Australian literature was pointing to the need for community health to develop these types of strategies further.[1] National and international literature and research had, for some time, been quantifying inequities in health experienced by different social classes and pointing to the need for a broader approach to promoting health (McMichael 1985; Department of Health and Social Services 1980; Paul 1985).

[1] See, for example, Australian Community Health Association (1986), Victorian Review of Community Health Services (1985), Southern Community Health Services Research Unit (1987), Milio (1988).

Health promotion and radical planning

The development of health promotion in South Australia, as described above, was particularly significant for Parks Community Health Service. As described in chapter four, at the point in 1983 when Parks Community Health Service was, for the first time, seriously addressing the issue of planning to meet community need, it retained the Health Promotion Branch as consultants to assist staff with this process. The result was an analytic rational model of planning by the experts for the community.

By 1989 a strong relationship had developed between the Community Education and Development Team and the Social Health Branch. Staff at Parks Community Health Service were in agreement that every one of the strategies outlined in the Ottawa Charter and included in the South Australian Primary Health Care Policy was important in the promotion of health. Indeed, the various teams had developed a degree of expertise in one or more of the strategy areas for a number of years.

The Director consolidated staff commitment to the Ottawa Charter in a discussion paper which reframed the categories of activity currently employed at Parks Community Health Service within the categories contained in the Charter. It was agreed by both management and staff that

Parks Community Health Service Radical Planning Framework

Priority Issues Identified with Community Participation

Health Promoting Strategies Used by Health Workers

	Improve Access to Nutrition	Reduce Pollution	Decrease Social Isolation of Elderly People	Increase Community Safety	Other
Provide Personal Care	*				
Increase Skills and Knowledge					
Re-orient Services					
Support Community Action					
Create Supportive Environments					
Develop Healthy Public Policy					

* Principles of Equity, Community Participation, Service Coordination and Prevention inform the development of any activity (cell)

Table 2

the Ottawa Charter did not encompass the activities of the Personal Services Team in its delivery of personal care. This reflects the Charter's failure to acknowledge that, even in individual service provision, collectivist ideology can link personal care to health promotion. However, it was agreed that the Ottawa Charter health promotion strategies, with the addition of the provision of treatment services, represented the "how" aspect of the organisation's plan to promote health. Furthermore, staff proposed that each strategy should be reviewed in terms of the application of the primary health care principles. This would ensure that strategies focused on those groups in the community most disadvantaged, that they were coordinated with other services, that they were developed with the active participation of local people, and that they were preventive in their orientation.

It was now possible to conceive of the Parks Community Health Service's plan for the promotion of health as a matrix of issues against strategy categories (See table 2, opposite). The Health Service now knew what issues it was to allocate its resources around and which type of strategies it was to use in addressing those issues. The community had contributed to the matrix by helping to define the priority issues. The Health Service had contributed to the matrix the framework which defined the range of strategies suitably employed by a health promoting agency. That framework was a political statement about the nature of health promotion. It is dependent on people

from the community participating in planning and implementing their own strategies to address the issues they, themselves, had identified as essential to achieving a healthy community.

Although the newly established planning matrix tightly defined the parameters of health worker activity, the exact nature of the activities was loose and open to development in an opportunistic way. This "tight-loose" planning framework, which Peters and Waterman (1984) argue is necessary for dynamic and innovative management, is exactly what is required to support a radical planning approach to health promotion. Community development requires that workers are able to be opportunistic in the direction of their activities. It adopts a broad framework. However, the specific components within the framework emerge from communities of interest and in a partnership arrangement. Therefore, whilst the broad direction for change is tightly defined by the Health Service plan, particular activities to achieve the directions can only be formulated by the community, and can therefore only be loosely defined at any point in time. Hancock (1989) describes this planning approach as a kind of "goal directed muddling through." From a health worker's point of view, the notion of "tight-loose" directly reflects the inherent power sharing between the professional and the community that is a fundamental tenet of radical planning and community development.

Organisation development techniques of management had been useful at the Parks to develop a readiness amongst staff of the organisation to implement the values and principles of community participation and to share power. This, in turn, had resulted in the design of a planning process which could engender a degree of community passion and participation.

Once the issues were chosen, the Ottawa Charter had provided a framework for strategy development which was compatible with the principles and values of community participation. The next stage in the planning process would address resource reallocation and the development of a mechanism for evaluating the effectiveness of the strategies.

Chapter six

Evaluation and accountability for primary health care

This chapter outlines some general issues in evaluation and accountability in management, considers the application of these in the community health arena and describes the tensions created by a new fashion in centralist public service managerialism. It proposes a means by which community health services might evaluate their progress towards social change goals within this managerialist context.

Once the planning framework was established at Parks Community Health Service, two management tasks became important, both of them related to accountability. Firstly, it was necessary to ensure that the allocation of human and financial resources reflected the organisational priorities. The second task was to develop a process of evaluation which could ensure that the strategies to achieve the goals were effective and that the principles of primary health care were being implemented. It was important that the management approach to developing the process should facilitate staff motivation and support

for accountability. Therefore the accountability mechanisms had to be seen as relevant by the staff.

Accountability and the discourse of management

The 1980s, described by Baum (1992) as the era of the managerialist, saw increased calls for accountability in all health services. Historically, the discourse of management has been developed and shaped by the requirements of management in the private sector. How far the public sector can borrow and adapt this discourse, without having its public service mission distorted, is a matter for debate. Yeatman (1987) argues that the adoption of the discourse of management by the Australian public services in the 1980s can be seen as a cultural revolution in which results-oriented management, subordinated to economic considerations, has become the dominant approach. Her argument is supported by Pusey's study of the Canberra Senior Executive Service which has shown that this economic dominance is entrenched in the central steering mechanisms of the Australian State (Pusey 1991).

Yeatman describes how an emphasis on "results-oriented" management tends to reduce the purposes of public administration and public management to the effective, efficient and economic management of

human and financial resources. This is a technical approach to public administration. The fact that it is dominated by economic considerations is evidenced by the assumption that government activity should be measured in terms of its effective resource management.

Hillier (1987) shows the inadequacy of this technical approach in health care planning by analysing the implications of the application of Max Weber's concept of rationality to the health care system. Weber distinguishes between *wertrational* action, which is undertaken as a result of a belief in the intrinsic value of acting in a certain way, and *zweckrational* action, which is calculation of the appropriate action to be taken to achieve a desired objective. In relation to the health system, the *wertrationalitat* position suggests that health services should exist because aiding the vulnerable or promoting health is good in itself. The *zweckrationalitat* argument is that a good health service ensures a healthy and, therefore, productive population.

Hillier points out that it is Weber's contention that, in modern society, *zweckrational* action becomes the preeminent form because it is calculable, predictive and capable of being assessed. The danger in this is that questions of value, a *wertrational* consideration, become defined as technical questions, which are *zweckrational* considerations.

Hillier argues that the application of science in medicine has increasingly produced knowledge about disease processes and the means of controlling them. Although modern medicine acknowledges the importance of economic, social and even psychological experiences to health and disease, this is essentially as an extension of zweckrationalism. Incorporating these broader considerations into the calculations about health improves predictability. Hillier points out, though, that lay concepts about health and illness can serve as important defences against the zweckrational medicalisation of everyday life.

In Weber's theory, bureaucracy, the dominant form of public health service organisation, is a type of legal rational determination. The rationality of its structure, based upon formal law, is the basis of its power. The management processes of the bureaucracy, because it is a formally rational system, will tend to favour zweckrational action because it does not concern itself with awkward questions of value. The bureaucracy, Hillier argues, has a wertrational goal to improve health and health care for all but its zweckrational means, bureaucratic management, fails to acknowledge the politics and power plays which influence decision making. This produces an irrational outcome, indicated by inequities in allocation of resources between groups, between types of care and between regions. The bureaucracy's

response to this has been to emphasise financial control, efficiency, effectiveness, cost-benefit analyses, all of which are zweckrational instruments and unable to measure wertrational purposes. They have therefore been seemingly unconcerned with measurements of outcome in terms of health, welfare, education or other social goals and even less concerned with how fair the process of decision making is.

This view is supported by Wilenski (1986) who points out that goals of efficiency and cost containment often undermine social justice goals of the public service. Public administrators, he argues are constantly deciding between the conflicting values of social justice, which is a social change outcome, and efficiency, the technical means of achieving the more measurable objectives common in the private for profit sector.

This technical obsession is described by Yeatman as "scientific management." She suggests that genuine creators, entrepreneurs and visionaries will not accept being confined by its strictures since it tends to reduce their substantive activities to technical types of activities.

Yeatman's suggestion is in line with the argument of Peters and Waterman (1984). They describe "eight basics" of excellent management practice, one of which is evidence of a "loose-tight"

planning framework. Although their chief interest is in management for profit, this concept of simultaneous loose and tight properties is relevant to the application of a radical planning model in social planning. It has the potential to support the mobilisation of both staff and the broader community to achieve social goals.

According to Peters and Waterman, organisations that apply the loose-tight principle are, on the one hand, rigidly controlled but, on the other, allow autonomy, innovation and entrepreneurship from the rank and file. They do this through value systems. A value system forms the goal of excellent service which is the key to increasing customer satisfaction and profit. This value system tightly controls activity but the activities, themselves, are not predetermined. There is room for workers to be responsive to particular situations and customers' needs. Peters and Waterman argue that this external, problem-solving focus, which is tailored to the consumers of services, results in cost efficiency over time. The provision of freedom to the employees of the organisation to be innovative in terms of how they develop strategies and solve problems, given their expertise and the values of the organisation, assists with the development of staff commitment and skill. This, as described in chapter three, is a characteristic of organisation development approaches to management and planning.

Peters and Waterman have discovered that organisations which they regard as "excellent" do not engage in long term thinking. Their formal plans are often marked by little detail or don't exist at all. However, there is a value set and evaluation of performance is in terms of whether those values have been implemented.

Whether one sets out to increase profits in the private sector, or to improve public services, this loose-tight framework has a place. Hugh Stretton, one of Australia's best known exponents of management and planning in the public sector, describes the "enterprise" model of management which is similar to Peter's and Waterman's "loose-tight" management approach (Stretton 1987). In relation to government business enterprises, he describes the difference between an "authority model" and an "enterprise model" as that of control versus accountability. He argues that the tendency to apply an authority model of control stems from the fact that public enterprises tend to attract attention when they perform badly. Steps are then taken to control the enterprise and to ensure that mistakes don't happen in the future. What results is a tendency in the public sector to control errors and to ensure compliance with procedures, rather than to encourage good practice. He suggests that the best control strategy is one which shifts the emphasis away from negative constraints toward positive stimulation and flexibility. The major elements of such a strategy are a

requirement for forward planning which embodies major policy requirements, few detailed external controls by other arms of government (for example, works, contracts, appointments), exacting audit and review processes, a response to unsatisfactory performance which relies on re-education or replacement of the people responsible rather than adding external controls.

Acknowledging that "radical planning" can be facilitated by "loose-tight management" can assist in legitimising activities to funders who are concerned about cost effectiveness. It also assists managers to resist the lure of rational planning, or "mapping," by a technical elite who do not even have to live in the community about which service decisions are to be made. Improving accountability can also assist with this process.

Evaluation, accountability and primary health care

Research practices designed to evaluate the new style of health promotion and health care activity proposed by the "new public health" (incorporating primary health care and health promotion) have not been well developed and community health workers have traditionally spent minimal effort in research activities. Research and

evaluation techniques, traditionally used in the so called "social sciences," have been viewed by community health workers as irrelevant to their requirements (Southern Community Health Research Unit 1987, Blacker and McLelland 1987). They have also been irrelevant to policy makers (Weiss 1977). The main dilemma faced by a community health researcher is how findings can be produced that are reliable and valid, yet also conform to the main tenets of the new public health movement; that is, promoting participation and equity and focusing on preventive health services.

Australian literature on community health research methodology is extensive and outlines the characteristics of an alternative to traditional positivist approaches. Furler (1979), for example, outlines two schools of thought in Australia regarding evaluation; one focuses on outcome measures and uses research methods based on a positivist or empiricist paradigm; the other stresses the utilitarian purpose of evaluation studies, in their intention to yield information on program effectiveness which is useful for decision makers. The second school focuses on program process in addition to outcome, and draws on so called "less rigorous" techniques of enquiry.

Empiricists and positivists base the production of knowledge on observation. They believe that science should be value free and that the

application of the scientific method prevents contamination by values and ideologies. If one compares the "capacity" of traditional methods of evaluation with the complexity of social reforms, innovations or programs, it is possible to see why evaluation studies within a positivist/empiricist orthodoxy often fail to have a significant impact on program change. Furler argues that positivist empiricism is not able to subject to "scientific" enquiry three important components of a social program: the ideals; the theory of intervention; and the social process of translating the theory into practical programs, all of which can vitally effect the program's outcome. Evaluation studies must subject the internal coherency of the program to critical analysis and focus on the *process* of implementing the program's development and evolution at least as much as they focus on outcome (Furler 1979). Decision makers have often answered these substantive questions through recourse to opinion about what seems pragmatic, rather than to formal research and evaluation techniques (Weiss 1977).

Epstein, Tripodi and Fellin (1973) point out that the use of the "scientific" method is particularly ill-fitted to evaluating community development activities.

> "The use of experimental design for evaluation implies that the program is already operative, that the flow of organisational resources is secure, that "contaminating" variables are controlled and that the objectives and the programmatic means to accomplish the objectives are relatively static. In fact few community development projects

> satisfy these criteria. Program resources aregenerally in short supply and their flow is highly variable. Ethical and circumstantial factors lead to problems in controlling the control groups. Program goals change. And, during this period of search for a community development technology, the means to achieving program goals are often varied." (p 30)

This analysis was supported by the Victorian Community Development in Health Project which showed that it is not meaningful to evaluate community development work purely in terms of outcome indicators. Indeed, a demand to do so may reflect a lack of understanding about community development work and/or an attempt to curb and constrain that work. Questions relating to the process of community work (for example, are people developing more power? Are there more social links made after community development intervention?) are of interest and are just as much "outcomes" of community development (Victorian Department of Health 1988).

The argument that the application of positivist methodologies in the evaluation of community health and human services is not only inappropriate but politically sinister has been elucidated by a number of authors (Furler 1979, Wadsworth 1982, Owen and Mohr 1986, Tesh 1988). They all agree that positivist methodology is not value free in that it both informs and is informed by the ideological superstructure of society. They therefore argue that traditional methods of evaluation conducted within the prevailing orthodoxy, and their emphasis on immediately measurable outcomes, serve to protect

vested interests and to preserve the status quo in an area such as health. This actively undermines the social justice objectives of community health.

Wadsworth (1982), for example, analyses the assumptions and beliefs which underlie the empirical, or positivist, mode of research in this fashion. Firstly, she says, positivism assumes that there is a "truth" to be discovered in the "facts". It does not deal with the many sides to "the facts". Secondly, it attempts to count and measure but what is measured, what it will mean and how it will be measured is determined by the researcher, not by the measured thing itself. Wadsworth argues that this leaves those people who are to be researched as the objects of the research, powerless in relation both to the means of evaluation and the ends of the evaluation. Most importantly, perhaps, in the process of undermining social justice, is the fact that the results of the research accrue to the researcher, or to the organisation employing the researcher, to interpret as they see fit or as they are ideologically predisposed. This means that responses, attitudes, viewpoints and opinions resulting from the techniques come to be treated as having a life of their own, potentially alien to the experience of the people from whom they have been derived.

Baum (1988) argues that if research is to serve the movement for social change towards equity and a fuller and more democratic participation of the community, it must incorporate these values in its methods. Research questions must reflect the crucial dimensions of equity rather than the capacity of the scientific method to answer them.

Applying this view specifically to evaluation in community health services, it can be seen that community health services must be reviewed according to the real goals and values of the program, not according to factors that are measurable, but quite extraneous, such as costs of services, efficiency, numbers of services provided (Owen and Mohr 1986). The program must be ready for evaluation (Hawe 1984) and the evaluation must provide useful and relevant information to the managers, workers and consumers of the community health service. Interdisciplinary collaboration may be necessary since it can enable a reform to be viewed from different perspectives and the results to be interpreted in the light of values and assumptions held by different disciplines (Furler 1979).

Wadsworth (1982) proposes that community health research should build into its methodology a desire for users and providers to want to learn new situational aspects of which they were previously unaware. She suggests that such research would seek first to identify, explicitly,

whose interests it is trying to serve. It would try to find out how those actors see their world, then try to find out what other things also affect their interests and influence how they see their world. It would use a continuous communication process so that actors participating in the research would perceive the interests and influences and would gain insight into possibilities for change. This "self managed action research" would be more akin to the requirements of the community health movement. It would be eclectic in its application of methodologies, matching method to the type of question needing to be answered.

Baum (1988), supporting this view, argues that research to support the new public health should incorporate community participation. Researchers should give up the sole power to decide what questions are asked and data collected, how they are collected, what meanings are derived from them. They must also be prepared to hand the process over to community groups or service providers interested in doing research. Researchers may then advise on, but not control, the overall direction of the investigation. They would be "on tap not on top." She also argues that to avoid "data raid," described by Wadsworth (1982) as the process by which researchers take data from the researched and retreat to their ivory towers, community health researchers have an obligation to ensure that the findings of their research are reported to

the community. Community health services are required to develop skill in the manipulation of various forms of media in order to make research results accessible and meaningful to community members.

There are methods of evaluation and review that can be appropriately applied to community practice based on a social and collective view of health and which aim to assist in social change. The elements of these methods include; evaluating the real goals and values of a program, ensuring the evaluability of the program, ensuring multi-disciplinary collaboration, providing the opportunity for people to learn new approaches to a problem, continuous communication between the actors in the evaluation, full participatory processes, an eclectic application of methodologies, transferring control in the research to the community and consideration of ethics relevant to social justice issues. Indeed these elements, together, form a paradigm for evaluation which seriously challenges the empiricists and is consistent with primary health care principles and radical planning (Baum 1988).

The Community Health Accreditation Standards Project is an example of this approach to evaluation. It attempts to ask relevant questions about the process and the outcomes of community health practice. It clarifies broad goals which are expressed as principles and operational objectives which are expressed as standards. These are then translated

into a series of questions, seeking quite specific answers, which are applied to a community health service. An evaluation of a community health service is based on peer review. The Community Health Accreditation Standards Project provides a model for whole service evaluation which could be adopted for program evaluation. It has the potential to assist community health programmers/workers in being accountable for and improving their process, it supports and is determined by values of equity, community participation, maximum co-ordination and a preventive orientation (Australian Community Health Association 1991).

The Community Health Accreditation Standards and review process can be applied in a number of different ways at different levels to improve the quality of community health practice. The standards can be used by practitioners, managers and consumers to assist in problem identification and solution and to guide service development. The set of standards and the review process can be used to evaluate community health activities comprehensively, systematically and accurately and information gathered from reviews can be aggregated to assist with the development of sound and practical policy at regional, state and Federal levels (Fry and King 1986). The Community Health Accreditation Standards can provide a basis for review and evaluation

in a community health service such as the Parks Community Health Service.

An "accountability" strategy, within the radical planning framework, was required at Parks Community Health Service once the 1988 planning framework was in place. An appropriate strategy would ensure that staff had room to be innovative in their decisions about how best to contribute to the goals and that the values of the organisation shaped staff's activities. Staff needed to be accountable in two ways: to the organisation in terms of the value base on which they operated; to the community and the South Australian Health Commission in terms of their objectives and their effectiveness. A pertinent accountability process had to be able to increase staff commitment and skill in facilitating social change. It should not be threatening, as is so much evaluation of health promotion activity, in its narrow and restricting focus. Most importantly, it should contribute formatively to ongoing radical planning by increasing knowledge about strategies and outcomes and should incorporate community participation in the process.

Evaluation and accountability at Parks Community Health Service

Yeatman's (1987) descriptions of the technical preoccupations of the new culture in the upper echelons of the public sector can be fairly applied to the South Australian Public Service environment surrounding the Parks Community Health Service in the late 1980s and early 1990s. Throughout 1990, for example, the activities of the South Australian Government Agency Review Group (GARG), were aimed at finding ways of "doing more with less" and improving cost effectiveness of services. There was little debate about what is "costly" and, indeed, what is "effective," let alone the question of who should be doing the debating. There was certainly no mechanism by which the broader community could participate in the decision making.

At the same time that GARG was slashing the budgets of services which it considered were not cost effective, a relatively well funded unit was established, within the South Australian Department of Premier and Cabinet, to encourage government departments to pursue "excellence" in customer service. This was to be achieved through "responsive management" which rested on "systematically listening" to the customer's needs as advocated by Peters and Waterman (1984). The fact that most consumers of the public human services do not pay,

do not have options to use private services and are often the dis-empowered groups in society, less likely to complain or to know and use their rights, is not addressed within this management context.

The GARG process put pressure on the central planners in the South Australian Health Commission to increase "cost-effectiveness," which meant identifying savings, increasing co-ordination and integrating services or identifying service changes which had the potential for shifting costs from the State to the Federal Government. There was little evidence of interest in the developmental aspects of planning for social change or long term health promotion. Management was reduced to the technical means of achieving measurable objectives. The community health sector was required to put forward plans deemed cost-effective by the Health Commission. In the case of Parks Community Health Service, it was important to develop methods of accountability which did not reduce the flexibility and creativity of the organisation but which had the capacity to demonstrate that the Service was achieving its goals in a cost-effective manner.

In the initial attempts to respond to the GARG rhetoric, Parks Community Health Service inadvertently reverted to a rational planning model. Newly formed "goal" teams comprising both Personal Service Team and Community Education and Development Team

members developed a "map" of activities, in which they believed the service should engage to achieve its goals. The goal teams included very few community members. The "experts" planned for the community in the areas which local people had indicated as important to them but did it in categories set by the GARG rhetoric.

This response was an example of the "Athena"[1] or "task Force" approach to management and was useful in further breaking down organisational divisions between the teams and mobilising staff around the new goals. However, in its desire to develop the commitment of the professional staff, management temporarily forgot what it had learned about radical planning and its potential for mobilising community participation in and a constituency for achieving the goals. The management technique had become more important than the social health outcome.

Although the activity did increase staff's familiarity with the range of possibilities for action to achieve goals, it raised other problems within the Parks Community Health Service as a whole. Most obviously, it appeared to restrict the understanding, which Personal Service Team members held, of their possible roles in the achievement of the goals. The pressures of providing personal care to people in pain had still not

[1] See chapter three for a description of Handy's (1985) concept of the Athena approach to management.

been addressed. Personal Service Team members reported feeling they now had more work to do than ever before, as indicated on the newly formed "maps". They perceived little organisational recognition of the importance of their primary function. Furthermore, the "map" comprised a large number of community development strategies. Personal Service Team members therefore felt threatened by what they perceived as an emerging organisational requirement to change their roles to community development workers; roles with which they were unfamiliar and in which they were untrained, and at the same time to increase the numbers of people seen in individual case work as required by GARG.

The Personal Services Team advocated that the service should have a fifth goal relating to the provision of general services as a means of asserting the importance of their tasks in the organisation as personal care providers. The team members perceived that this would legitimate their role in the plan. Whilst this seemed a logical way to include the team in the strategic plan, it actually did no more than change the goals to fit current practice. It would also have ensured that only those resources contained in the Community Education and Development Team would be allocated to achieving the new goals. These resources were inadequate, given the importance which was placed upon the achievement of the new goals by the community

groups and individuals who participated in the planning process. By far the largest proportion of Health Service resources were spent through the Personal Services Team.

At the same point that Personal Service Team members were feeling threatened by the new plans for achieving the goals, the Community Education and Development Team members became critical of what they perceived as a departure from the process of maximising community participation in the planning. The Community Education and Development Team also protested about the possibility of being solely responsible for addressing the goals.

The domestic response of the Parks Community Health Service to the external context of GARG revealed that the rational approach to planning, whilst yielding a complete document entitled "Strategic Plan," had failed to acknowledge the internal politics and psychology of the staff. The management task of developing a plan had become an end in itself. Rather than being a means by which social goals could be articulated over time by community groups, the plan had no credibility as anything but a set of futuristic possibilities.[1] Within a radical planning framework, the process of bringing about change through partnerships between professionals and communities was regarded as

[1] Minzberg (19) describes the change in approaches to corporate strategic planning over the 1980s as a response to a gradual recognition that planning should be a whole of enterprise activity as opposed to an activity undertaken by a small group of experts.

equally as important as the achievement of improved health outcomes. The partnerships themselves had the potential to increase the community's control over its own health and environment. In an environment that included GARG as well as staff who felt threatened by a new community development approach, it became necessary to accommodate the techniques of radical planning with more traditional organisational planning and management techniques.

The Parks Community Health Service planning framework, as described in chapter five, provided firm central direction. It was based on the values underpinning the principles of primary health care and defined the broad directions of the organisation, both in terms of what was to be achieved and the range of strategies which could be used to achieve it. If staff were to apply the principles of primary health care, especially relating to maximum participation by the community, room for opportunism and for innovation was required. It was necessary for staff and management to abandon the rational "map" developed in the "goal teams" and engage in problem solving with the community.

Accountability provided the clue and the tool by which the Personal Service Team's problem in relation to the organisational plan could be resolved. The Director argued that Personal Services Team staff should propose to the organisation how they, given their particular

expertise and their particular function within the organisation, would contribute to the organisation's goals. In doing so, they were to be accountable for the implementation of the primary health care principles, thereby ensuring the outcomes of their services were equitable; that their services were coordinated, not only with external service providers but also with other strategies within Parks Community Health Service; that they were preventive; and that they incorporated ongoing community participation in the planning, evaluation and delivery of services.

Such an accountability process had the potential to consolidate all staff activities within the framework of the organisation without undue supervision and control, to contribute to an ongoing radical planning process and to evaluate the effectiveness of community development and other community health strategies for broader publication to funders and the field of community health workers.

The principles of organisation development require staff participation in the development and implementation of any program review or evaluation process. At Parks Community Health Service, it was the staff who were required to be accountable for the programs they developed and implemented. It was, therefore, necessary that the

evaluation process be perceived by them to be relevant to their needs and the needs of the various communities with which they work.

The organisation development technique of managing organisational change was employed to define a process for proposing and reviewing programs in relation to organisational goals. A whole staff meeting, facilitated by the Director, resulted in agreement on the principles of an organisational review mechanism as well as a proposal outlining how to proceed towards developing a process to review and evaluate programs.

Staff agreed that review and evaluation was essential for service accountability to the community and to the funders. They believed that any evaluative process should be multidisciplinary, instructive and supportive to workers in the development of skill in evaluation. Most importantly, they believed that it should support the existing decision making processes rather than replace them. That is, it should not become a decision making mechanism itself but rather should facilitate decision making by providing evaluative information. Staff proposed that a Program Review Planning Group, comprising staff from all teams within the service and community members from the Committee of Management, should develop and recommend a process that would assist staff to plan their work in relation to the organisational goals.

They proposed that the process should also encourage review and evaluation of programs in relation to plans or objectives. The group was to be chaired by an expert in community research and included the Director and a representative from the Team Leaders.

After developing a broad understanding of community health research and evaluation methodologies, the Program Review Planning Group suggested a program proposal and review process based on the Community Health Accreditation Standards. It consulted staff (in another whole of staff meeting) on their perception of the applicability of the process. Staff accepted the proposal with minor modifications. Essentially, the process involved a Program Proposal stage, in which staff would develop a proposal for all new initiatives, an Evaluation or review stage (or series of stages) and a multi-disciplinary review process, in which staff would discuss proposals and reviews of their own activity with a Program Review Group. The membership of the Program Review Group was to be similar to the Program Review Planning Group which developed the proposal but would rotate so as to provide an opportunity for all staff to participate in the review process.

The Program Proposal process aimed to assist staff to clarify their program objectives in relation to the organisational goals, the

strategies to be used and why they were chosen, how they would know when the objectives had been met and how they intended to evaluate the program. It also assisted staff to clarify how they incorporated the principles underpinning a radical planning approach in their own planning. The evaluation component of the process aimed to assist staff to critique their own work but was designed in such a way as to ensure community participation in the evaluation of the program. Educational benefits for community health professionals and community members result from their participation, as evaluators, in the Parks Community Health Service Program Review Group. The process has the potential to demystify research and evaluation as it provides an opportunity for questioning and debating the objectives, indicators and methods of assessment at the earliest stage of program development (Abbott 1991).

As described earlier, the Personal Service Team members had been consistently confused, concerned and even fearful about the role which they might be able or might be expected to play in achieving the organisational goals. This was essentially because they viewed their work and the work of the staff who were trained in community development as mutually exclusive. Their job was to engage in personal and individual care, an activity seemingly antithetical to community development activity aimed at social change.

Jackson et al (1989) argue that there has been an artificial boundary drawn between case work, the so called "bad old way" of keeping people dis-empowered, and community development. They describe how health services have structured themselves across this boundary in one of three ways. Most commonly, they have ignored community development altogether and got on with the "real" work of one to one treatment with a little one to one health education squeezed in and called prevention. This describes Parks Community Health Service in the early stages of its development. A second approach has been to hire special workers to "do" community development. These people were often marginalised as their colleagues got on with the therapeutic work. This was, indeed, the experience of the first Community Education and Development Team Leader at Parks Community Health Service, despite the fact that her staff were able to make some inroads into developing the technology of community development. A third approach has been to allocate some part of every worker's time to community development. Jackson et al point out that, whilst this may seem to under-value the special expertise required to "do" community development, it does make al workers accountable for their role in social change action. Conceptualising case work and community development as distinct and incompatible has led to conflict and confusion amongst community health practitioners. However, this

tension and confusion will disappear if it can be recognised that community development is broader than a technique, but is a philosophy on which all the work in a community health centre is based. Community development can then be ranged along a continuum describing a person's development towards gaining control over larger realms of life. The goal towards which activities anywhere on the continuum are aimed is the development of links between individuals and groups with common interests in order to achieve a more equitable distribution of social and economic power.

The "community development continuum" encompasses developmental case work, mutual support, issue identification and campaigns, participation and control of services, social movements. These points along the continuum define modes of development work appropriate to particular communities, sub communities and individuals at particular times. Participation by a particular individual will shift back and forth across the continuum over time (Jackson et al 1989). Whilst it is debatable that these strategies are, in fact, a continuum, it is useful to recognise that links are possible between strategies if an underpinning framework of values is established.

By 1990, staff and management at Parks Community Health Service shared a commitment to this "developmental" philosophy and to

assisting members of the community to take more control over their lives. Despite the fact that there was still a division of strategies between the teams rather than a recognition of the links between them, staff now had a tool by which to measure the relevance of existing activity to the organisational goals. As staff began to review the objectives and strategies of existing programs, it was necessary to change their objectives to meet organisational goals.

The problem of adequate resourcing of activities to achieve the new goals was slowly addressed as staff, even those proposing programs which were essentially providing individual treatment, re-oriented their services to address the goals. The medical staff, for example, proposed the development of a practice protocol which assessed the nutrition knowledge and status of people receiving medical care and referred people, who wished to participate, to some of the community development activities being supported by the Community Education and Development Team. In the first instance, this may have been to "mutual support groups" although progressively the mutual support became social action projects aimed at increasing access to fresh and nutritious food. A link between community development practice and other types of service, similar to that described by Jackson et al, began to emerge.

The Personal Service Team members discovered that they had just as much power to make the developmental links as the Community Education and Development Team members had. As staff from both teams became more familiar with the possible contributions of their respective types of activity to the mobilisation of community members to achieve social change, the potential for more powerful strategy development was enhanced. Informal working groups began to develop around particular issues incorporating members of staff from all teams as well as community members. The program proposal process assisted Personal Service Team staff to understand their role in the "community development continuum" and to see that it is possible to be accountable for how provision of personal care can contribute to a social change objective and a more equal partnership between the service provider and the person receiving the service.

The planning framework was now firmly in place. It addressed the outcome goals, which were indicated as important by community people, and process goals, which were the strategies and principles of operation which would support social change in power structures. A means was also in place to account for staff activities in terms of their contribution to achieving these organisational goals.

Although the Program evaluation process was gradually used and supported by staff, it was not really accessible to community members. Aside from various attempts to tap the opinions and perceptions of community participants, it soon became clear that there was an inconsistency between the Service's values relating to true partnerships with community members who were actively participating in the planning and implementation of community development activities and the fact that it was essentially the Health Service which was evaluating their activities. Any recommendations for improvement or change which may have resulted from the evaluation process, whilst possibly being of interest to community participants, were not owned or developed by them. It became necessary to ensure that the evaluation process should be a tool for community development workers to assess whether their techniques and approaches had reached their own *process* objectives. The process could then be used by the community action groups, if they so desired, as a means of formative or summative evaluation of their own goals and objectives. This approach conformed to Wadsworth's and Baum's recommendations concerning community ownership of the evaluation process.

Other methods of ensuring that the Health Service's activities were accountable to the broader community had to be developed. A commitment to community accountability required that the Service

make the plan and the successes and failures of the health service more publicly accessible. The Community Education and Development Team had become skilled in assisting people to use the local media to raise their issues on the agenda of local and State authorities. Indeed several of the issues raised by local resident action groups have also attracted the attention of the State's television and newspaper networks. Although this helped the Service to develop its profile amongst community members, it provided piecemeal information relevant to only a few issues at a time. A comprehensive accountability endeavour relating to what the goals of the organisation were, what strategies had been developed, whether they worked and what was to be done next would never be of interest to the mass media. Yet the Service accounted to the South Australian Health Commission for all these things (despite the fact that the only question ever asked by the bureaucracy related to why the service had apparently increased spending in clerical salaries and wages.) The chances of social action being successful could be increased if more people were participating in the activities. It was therefore important for the service to establish ways of providing information and of being more directly accountable to the broader community.

To address this issue, the Service decided to create its own media. To replace the traditional Annual Report to the South Australian Health

Commission, the Team Leaders and the Director designed a newspaper entitled "Parks Health Observer" which popularised information about the health issues in the Parks community and invited the participation of the broader community. It included a centre page which outlined the planning framework and gave many examples of successful partnerships between the community health service and local community members in achieving outcomes. It featured community and staff members in photographs illustrating partnerships at work.

Previous annual reports had been distributed to other health welfare and educational services and to the South Australian Health Commission so, ironically, the only community members who ever saw it were those who were members of the Committee of Management. The old reports did not make very easy reading, either. The 1990/91 Annual Report, produced as a newspaper, was distributed to the 9,000 Parks households as well as to the original mailing list. Significantly, the officers of the South Australian Health Commission also found the Report easier to read. Subsequent feedback confirmed to the Director that it had the effect in the South Australian Health Commission of making community health practice understandable.

The planning framework was explained graphically on wall posters throughout the Health Service and was the subject of a sizable display

contained in the foyer of the service with accompanying descriptions of the strategies being used to achieve the goals. This not only had the effect of increasing the knowledge of the users of the Service in relation to what it was that the Service was trying to achieve, but actually attracted further community participation in several of the activities described. It also consolidated staff commitment to the plan and to the new goals. They became, increasingly, a part of the "scenery," the chatter and the reason for being in the Health Service.

A major effort was also invested in informing community members of their rights in relation to the Service. A large graphic display was mounted in the waiting area of the Service which outlined all the rights of consumers as set out by the Australian Consumer's Health Forum as well as information about how to make complaints and suggestions. Suggestion boxes, with pens and paper available, were clearly visible in and around the Service and every member of staff was issued with suggestion sheets and encouraged to assist people to make suggestions or complaints in writing or in person.

Despite attempts to increase the power of community members to evaluate the services of professional health workers, it must be acknowledged that the success or failure of these efforts rests to a large extent on the support provided by the professionals. Checkoway

et al (1984) point out that active community participation in these sorts of processes in the American Health Systems Agencies were correlated to the values and ideology of the Chief Executive Officer and Agency staff. At Parks Community Health Service it was important to continue to develop in staff a culture of non defensiveness and support in relation to evaluation by the community and to establish training and support in evaluation for community members.

Parks Community Health Service had, by this time, developed a framework for planning and methods of evaluation which staff and Committee of Management considered more consistent with primary health care principles than had previously been the case. The management process had developed a staff constituency for a more collectivist interpretation of these principles. Chapter seven provides several examples of the radical practice made possible within this framework.

Chapter seven

Radical practice
at Parks Community Health Service

It is important, at this point, to demonstrate that radical social planning and practice in a community health service has the potential to promote health and contribute to social justice. Community health workers and communities can mobilise, politically, to achieve policy changes that have the potential to promote health. The mobilisation process, itself, can contribute to a redistribution of power in the decision making processes of a community, from the economic interests of a few, to the social interests of a community. What results is a more healthy balance between economic and social goals in a local community. This chapter describes several examples of radical practice or community development activity, in which Parks Community Health Service was involved, which provide evidence of this form of power redistribution at the household, neighbourhood and community level.

Friedmann (1987) and Walker (1984) agree that, in the industrialised world, the work that needs doing to re-make everyday life from a preoccupation with economics and production to a concern for social and civil existence in harmony with the planet must begin in small ways in local communities and neighbourhoods. Friedmann goes further in suggesting that the household itself will be the key to achieving that aim. Both authors agree that the recovery of the political community, that is civil society which is organised for a life in common, will be the central guiding force to shift power from the corporate economy to civil life. A re-activated political life will draw the relatively powerless and alienated groups back into the process of civil decision making.

Friedmann argues that different levels of spatial integration can be identified, ranging from the household economy, the smallest political conception, to the world economy, the largest. However, within any one level of spatial politics, there are internally differentiated power structures which depend on the access of different groups and individuals to decision making processes and their ability, within them, to influence the contested outcomes. Women, for example, are devalued despite their labour contribution at the household level, primarily due to the

separation of the household and consumption from work and production in a capitalist society (Friedmann 1987).

At the broader level of neighbourhood and community, planning decisions are also influenced by differential power between various communities. Adelaide offers an example of this influence. Adelaide's north western region is highly industrialised and contains large public housing estates. The affluent western beach suburbs are separated from the city by a few, poorer, inner city suburbs. The south-east of Adelaide is also very affluent, accommodating a large proportion of professional people[1]. The western metropolitan population is, as indicated by voter turnout, comparatively unpolitical (Jaensch and Narmon 1990) and, until its recent movement towards gentrification, the planning decisions made in the inner western area by the local Council of Thebarton have been dominated by business interests who have gained by the past decisions. Enfield Council, where Parks Community Health Service is located, is still dominated by business interests. The Mayor, for example, owned a local dump and several other Council members are business owners. The politicisation of households and neighbourhoods holds the potential to alter the power balance.

[1] See maps at the end of this chapter for socioeconomic index and various health statistics by local government are in Adelaide.

One of the major strategy planks of health promotion, according to the Ottawa Charter for Health Promotion, is participation in the process of developing healthy public policy (World Health Organisation 1986). Allison et al (1988) conclude from a literature review of the Canadian and European experience, that, to strengthen citizen participation, a distinctive power base must be developed, perhaps from an identifiable local constituency or from representation of relevant grass roots community organisations. They suggest that strategies should be developed which increase citizens' confidence in their own abilities and with decision making responsibilities. This conforms with the proposal by Checkoway et al (1984), based on a consideration of Health Systems Agencies in the United States, that citizens should develop personal skill, organisational capacities and lobbying strategies to build effective citizen groups and to institutionalise themselves into the policy-making process. In developing recommendations for government action, they conclude that general support should be provided for citizen-initiated organisations which are capable of generating further citizen support for their programs.

Friedmann (1987) supports these views. He argues that recovering the political community will begin in the household. It

must be freed from the system that keeps it servile through conscious programs of self reliance and made democratic and free from gender or age based division of labour. The development of its power will depend on the provision of adequate space, time, knowledge and skills and through organising efforts which assist it to reach out to successively wider networks of people engaged in a common struggle to resume control over their lives and their environment. This argument is, indeed, the basis of community work. A description of the implementation and outcomes of three community action efforts with which the Parks Community Health Service has been associated as a means of achieving its social goals, demonstrates this connection between the household and community power base.

Environmental action

The area known as The Parks is situated on the Adelaide plains between the port and the city. It was described in the original Parks Community Centre planning report as

> ".....consisting mainly of stereotyped rows of Housing Trust dwellings constructed en masse just after World War II. Backyards tend to be bare areas surrounded by corrugated iron fences, while the front yards are divided by cyclone (wire mesh) fences. The soil is such that most types of trees will not grow or will be stunted in their growth. This creates the appearance of a treeless suburb and has led the residents to place high value on landscaping and grassy shaded areas" (South AustralianEducation Department 1978).

There has been little environmental change since that report was written in 1978 (Verity and Goodes 1991).

The Parks area also includes a high concentration of manufacturing and construction industry. In particular, the zoning of Wingfield, less than two kilometres away, allowing for light commercial through to special industry, allows for the co-existence of residents and noxious and dangerous industry. The Australian Social Health Atlas (South Australian Health Commission 1990) indicates that The Parks area has higher than the Australian urban average rates of illnesses such as ischemic heart disease, cancer, tuberculosis and other respiratory diseases[1] . Although there is no conclusive causal link between these disease rates and industrial pollution, there is a perception by the local people that their environment affects their health (Delfante 1989).

In 1988 the Parks Community Health Service and the North West Suburbs Health and Social Welfare Council, a community participation mechanism established by the South Australian Health Commission, jointly conducted a series of public meetings about the local environment and industrial pollution. The residents attending these meetings had indicated a desire for action

[1] See maps at the end of this chapter for socioeconomic index and various health statistics by local government are in Adelaide.

to address the unsatisfactory living conditions produced by the industry in the area. Some local residents subsequently came together, with assistance from the Health Service, to discuss strategies to reduce pollution. A survey of 164 patients attending at Parks Community Health Service, (conducted in 1989 by a Parks Community Health Service Family Medicine Program trainee general practitioner working with the group of residents), indicated that one third believed that the industrial smells and gases were negatively affecting their health (Delfante 1989). Furthermore, as described in chapter five, the planning process conducted by Parks Community Health Service during 1989-1990 revealed strong concern, focussed on the unpleasant smells from industry and the possible health implications of pollution, by the local people who were questioned. The Health Service subsequently chose the improvement of the local environment as a health goal for the next five years.

Some of the the local residents, who had attended the public meetings, or who had indicated an interest in environmental issues through the Parks Community Health Service planning process, organised themselves as the Parks Residents Environmental Action Group (PREAG) at the suggestion of a health worker who had convened the public meeting.

Membership of the group, described in terms of Bryson's and Thompson's categories of community actors[1], included some "locals" who lived opposite polluting industries, none of whom had previously participated in any form of community group activity. Two of the members had previously participated in local planning issues, and were associated with political parties. One was a member of the Labor Party and the other was a member of the Liberal Party. These people might be classified as "internal caretakers." They were identified as key people in the community by the "external caretakers," who, in this instance, were community health workers. Still another member was a local woman who was also a member of Greenpeace. This person linked the local action to "cosmopolitans" through her association with this broader social action organisation. PREAG made an early decision to put a priority on the smells and emissions emanating from the nearby industry.

Verity and Goodes (1991), the two community development workers supporting the group's activities, describe the process by which the group became focussed and passionate about planning

[1] Bryson and Thomson (1972) categorise community actors as; locals, who live in the community; caretakers, who engage in some form of care taking role. These people can be external to the community or local residents; cosmopolitans, whose span of interest is broader than the local community but who may wish to influence action in the local community.

and development issues in their community.

It was opportune in terms of the group's development, that an invitation to residents to attend a special meeting to discuss a proposal to establish a tannery in Wingfield appeared in the local newspaper soon after the group had determined its priority concerns. The proposed tannery was to process up to 2000 hides a day using an acknowledged hazardous substance in the tanning process. There were, already, four tanneries in the area which were known by the residents to be the source of smells which caused nausea and even vomiting, especially on hot summer evenings when windows and doors could not be kept closed. It was through the discussions about the proposed new tannery that residents observed for the first time that their personal symptoms of nausea on hot summer nights were shared by other people. PREAG members decided to attend the discussion meeting convened by the Enfield Council.

Initially the residents were undecided about the tannery development proposal, acknowledging its potential to increase employment in the area. This was vitally important for the community's young people, some of whom were the members' own sons and daughters. At the same time, they were not

convinced that the tannery would be any different from other polluting industries despite claims by the State Government Department of Environment and Planning and the Korean developers, that the technology was new and improved. They called for an environmental impact study and, over the next few months, became progressively concerned by their inability to gain access to any reliable information about the development. It appeared that major barriers were being placed in their way by State bureaucracies and the local Council, possibly so that the development proposal could be "fast tracked" through the planning process.

"Fast tracking" is a system designed by the planners to accommodate business developers, who, for economic reasons, do not want to have their proposal stalled by lengthy community debate or research studies on the potential impacts of the business. Whilst fast tracking makes good sense economically, its costs may include major social consequences of inappropriate or badly planned communities. Social issues are more likely to be raised in the planning context by those people who live in the community. Minimising their input through fast tracking results in an almost exclusive concern with economic development.

PREAG was eventually informed by the Department of Environment and Planning that there was no need for an environmental impact study. It was increasing uncertainty concerning the development and its consequences for the local environment and residents' health which catalysed the transformation of anger into political activity (Verity and Goodes 1991). Residents began to develop strategies to influence the planning and development in a process which seemed bent on excluding them. For a group of ordinary people, the already complex planning system was made even more inaccessible by the fact that their own landlord, the Housing Trust of South Australia, owned the land and were to construct the building to be leased by the Korean company. The State Planning Commission deals with planning decisions relating to government owned land. This planning authority was even more remote than the Enfield Council, the local government authority which deals with most local planning decisions.

The group began to develop its knowledge of the planning process and at what points it could be influenced. The community workers, or "external caretakers" were able to call on resources such as legal advisors, media specialists and trainers, to provide training in group meeting procedures, minute taking, filing and

the use of computers and desk top publishing facilities. The Health Service provided facilities such as desks and office space, child care and transport. The "internal caretakers" were active in soliciting community support and increasing membership. The "cosmopolitan" members were able to make connections with "cosmopolitan" organisations which operated at a broader level. Greenpeace, for example, provided strategic information and promoted the group's activities at a broader political level.

PREAG lobbied the Council and distributed information to residents of the Wingfield area about the tannery proposal and about how residents could influence the planning process. PREAG formally opposed the development at the Planning Commission hearing and made effective, almost weekly use of the local media as a means of developing the debate more broadly in the Parks and adjacent communities. It also conducted a public meeting which was attended by fifty local people and two members of the local Council. Verity and Goodes suggest that the anger expressed at the meeting was enough to influence the Enfield Council's decision to withdraw its support for the tannery and to join PREAG in formally opposing the development which, by this time, had been given approval by the Planning Commission.

The Planning Commission's approval meant that PREAG's opposition now moved into the Supreme Court in an appeal against the decision. The group developed a loose coalition with the Enfield Council and a group of industrialists from the area who were also opposing the Planning Commission's decision. The industrialists included one of the existing local tanneries and some other industries who had recently upgraded their facilities to comply with healthier environmental standards than were being imposed by the State government in the case of the tannery development. Together, they developed a joint strategy of opposition and appeal to the Planning Commission's decision. PREAG also, by this time, developed strong alliances with other environmental groups such as Greenpeace and an environmental health academic who was conducting research on the health impact of pollution. These outsiders provided information which assisted the group to develop their court case. The Supreme Court ultimately overturned the Planning Commission's decision.

The planning framework and the principles of operation, or value base, of the Parks Community Health Service provided the community development workers with a mandate to actively engage in a partnership with the residents throughout this

process. Resource and training support for local people, as described above, was also available. Particularly important was the advice, which the workers provided, on how to put forward a case to large Government bureaucracies.

Verity and Goodes (1991) describe an even more subtle form of support as being the encouragement the Health Service gave residents to recognise and claim their rights and to believe in the inherent value of their own experience of the locality. They suggest that this was particularly important when the crux of the residents' case was smell and quality of life issues, rather than the scientifically measured argument of a rational planner. Tesh (1988) argues that such "scientific" measurement devalues this kind of unmeasurable experience and helps maintain a conservative position in relation to change. Furthermore, all the way through the process, the group was faced with anxious "firsts" such as court appearances and interaction with Council and Government officials whose secrecy seemed to actually be supported by the rules of planning. The health workers helped the group to identify achievements and gains, even when strategies had failed. This was a major means of maintaining motivation amongst a group of people who had never won against such structures before and whose lives were controlled, in many ways,

by the very government departments against whom they were fighting.

Verity and Goodes (1991) report that the outcomes of PREAG's action included a strong local profile for the Group itself. Local community members now contact it with concerns and complaints about local environmental issues. It has a clear understanding of the planning process and the points of potential influence. A strong core membership has developed lobbying and social action skills, to the extent that the group's spokesperson felt confident to represent the Group in the Supreme Court case and decided to stand for election to local Council. It has a formal agreement with the Enfield Council to establish an Environmental Advisory mechanism to ensure the community has a voice in other developments and is proactive rather than reactive in relation to social issues.

PREAG members are now being consulted by other environmental action groups in South Australia and interstate on strategic issues. They pass on their increasing knowledge and skills in environmental and planning issues gladly and have been instrumental in the establishment of the Western Region Coalition of Environmental Groups. They have become a legally

incorporated body in recognition of the type of legal and political action they may be forced to take in future attempts to improve the environment. They have developed a range of strategies to increase participation in action to improve the local environment. This includes a twenty four hour "Smell Hot Line" which people can call to record any unpleasant smells, their location, the direction of the wind and other data which might assist in locating possibly polluting emissions. They are assisted in this by other Parks Community Health Service workers, particularly those providing personal care to individuals who complain about their environment. This is an example of the way in which, as Mills (1960) suggests, people can be assisted to make the connection between their individual troubles and broader public issues. The provision of information on the potential for action and referring individuals to the community development workers is one example of the use of an effective link between community development activities and other personal care services. The group is maintaining its involvement in the Metropolitan Adelaide Planning Review and the planning for the contentious Multi-Function Polis proposed for the Gillman site adjacent to the Parks area, thus ensuring that social issues remain on the agenda of State and local government planning bodies.

Arguably, the most important outcome of this activity is the strong awareness amongst PREAG members and the broader local community, which observed the process through the media campaign, that collectively, ordinary people do have power. What they need is support to access the resources and decision making processes that are so easily purchased by other, more economically independent groups and individuals in the community. Health Service and health worker commitment and belief in people's right to have this kind of support is fundamental to community work (Verity and Goodes 1991). Knowledge of the support provided to the group by the Parks Community Health Service has resulted in approaches to the Service by local people who previously had no connection with the Service, to provide support on other issues affecting the community's health. The issues pertaining to safety for families living around the Wilson Street Reserve are an example of this kind of development.

The Wilson Street reserve project

Tesoriero (1991) describes the aims of the Wilson Street Reserve Project as strengthening community action around a single issue, identified by local residents, using health promotion and

community development as public health tools for change as suggested by Labonte (1986).

The Wilson Street Reserve is a 3.32 hectare reserve in Mansfield Park, in the heart of the Parks region. It was developed by the Enfield Council as a Community Employment Project, thus capturing funds from State and Federal Government programs to initiate and stimulate employment in areas of high unemployment. Local authorities, with access to this "new" money, often showed little commitment to ongoing employment, using the money, instead, to develop once-off projects incapable of sustaining permanent employment in the community.

The original Council plan for the Wilson Street Reserve, developed with assistance from the State Government Department of Parks and Gardens but without broad community input, included informal woodland garden, raised garden, barbecue, sunken garden with walkway to be used for weddings, arboretum with native and ornamental trees and shrubs, concrete paths and grass mounds. Few of the intended features are present today, although a playground, which was not included in the original plans, is present. The sunken garden is merely a pit with steps leading down into it. There are a number of sitting benches along

the pathways. Observations by health workers indicated that it was not well used by residents.

The potential for health problems associated with the Reserve came to the attention of the Health Service from a volunteer in the local church-run coffee shop who was discussing the issue with other local residents. Apparently, the volunteer was concerned about finding syringes in the play ground area and was fearful of the gangs of youths who used the park at night. The conversation was literally overheard by a health worker who was subsequently invited to join the conversation. The health worker suggested that there was a high probability that many of the volunteer's neighbours might share her concerns and that they may be prepared to develop some action to address them. It was decided to door-knock the houses adjacent to the Reserve and interview the occupants to establish whether this was the case.

The circumstances by which the Wilson Street Reserve issue came to the attention of the Health Service was no accident. It is important for community workers to be seen and known in common community meeting places. Visibility of the Health Service in the community has direct implications for accessibility.

It also sets the context of community work with residents. It is in their territory and with them as a collective (Tesoriero 1991).

The door-knocking exercise revealed significant community concern relating to the safety of the play equipment and lack of equipment, the lack of barriers which might prevent a fall into the pit at night, the smashed bottles, syringes and condoms found in the pit and the people loitering in the pit at night who had a history of threatening and abusive behaviour, particularly to women, the lack of lights in the park and the consequent obscuring from view of what happens in the pit at night, the lack of suitable shelter around the barbecue, the dogs' faeces around the park, the vandalism and graffiti, the lack of places to sit. Some indignation was also expressed at the lack of consultation that had occurred in the Council's development of the plans.

The health workers, having confirmed that the coffee shop volunteer's concerns were shared, decided to conduct a public meeting to provide an opportunity for residents to share and discuss concerns and to identify them as a public issue rather than as individual and household anxieties. It was hoped that a group of people willing to take action would be identified at the meeting

which was held at the local coffee shop, a natural community meeting place for adults.

The residents decided that not all the concerns could be tackled at once and that they should be dealt with in stages. The safety issues surrounding the sunken pit were the major concerns. It was agreed that lights would create immediate improvement and that possibly, the pit should be filled in and re-scaped. The meeting also agreed with the suggestion of one resident, who had connections with PREAG, that a group should make a presentation to the recently instituted bimonthly public forums at Enfield Council which, although not particularly "friendly" in style, had been used effectively by PREAG.

A petition, developed by local residents with support from the Health Service worker, raised seventy signatures and was presented at the Enfield Council forum by a representative of the group who was nominated at the coffee shop meeting. It received a mixed response from the Councillors, ranging from anger and rudeness to support from one Councillor who promised to personally follow up the issue. At a further meeting, the Group decided that pressure needed to be applied to ensure that the Council investigated and acted on their concerns. A media

strategy for the local newspaper was initiated. Lights were installed throughout the park at the end of 1990, six months after the first public meeting on the issue.

The residents were successful in achieving a change to their local environment which has the potential to increase safety for the users of the Park. However, an important outcome was the sense of power experienced by those in the project in dealing with the Council (Tesoriero 1991). They, like PREAG, have been consulted by other residents, specifically in relation to improving the safety of other reserves in the area. They have been able to assist other groups to make connections with public health experts who can assist them to mount an effective campaign for playground safety. The distinction between internal caretakers, external caretakers and cosmopolitans in the process of community action has blurred as community members became more skillful and powerful participants in the community planning process.

The opportunistic beginnings of the Wilson Street Reserve Project are set in the context of a radical planning framework. Although clearly stating a goal for the organisation of improving safety for families in the community, the framework did not prescribe, in

any rational planning sense, which particular strategies should be pursued other than the broad strategy categories outlined by the Ottawa Charter for Health Promotion (World Health Organisation 1986). The organisation is guided by the principle of community participation. This means that particular strategies will depend on the direct participation of community members.

Data, which the clinical work of the Health Service generates, allows it to take an active role in the development of broad community debate and the provision of information relating to health issues in the community, thereby increasing the possibility of direct community participation in a health issue. To support this role, workers providing personal care services have engaged in data collection relating to injury of the people who use their services. "Hot spots" can be identified and information campaigns can be developed by the community development workers. However, as Tesoriero argues, seeking and responding to local issues which are those belonging to the local people, not the health workers, is an extremely significant indicator of the philosophy of participation to which the Health Service adheres. There is no expectation that the local residents must participate in the Service. Rather the onus is always on the health worker to accept any forms of invitation to participate in the lives and issues of local

people which are in keeping with the primary health care principles (Tesoriero 1991).

The improved potential for health promotion, made possible by the local residents involved in both the Wilson Street Reserve Project and PREAG, was achieved cheaply. PREAG depended on the support of a full time equivalent community development worker for approximately six months, after which the support was gradually reduced to approximately four hours per week by one worker after twelve months. This person remained a member of the group. The group working on the Reserve Project required no more than support for a few hours by a community development worker each week. The project reached successful outcomes within a matter of months. The unpaid labour of the community members was the preponderant but, otherwise, inestimable resource.

Vote for health campaign

The literature of the new public health suggests that the most influential collective mechanism affecting health is public policy. Influencing public policy and making policy accountable for its existing and potential health impacts is an imperative strategy for

promoting health. (Allison et al, 1988; Milio 1988) Implicit in this assumption is an acknowledgement that health promotion is political.

The emerging sense of power and success by pockets of the Parks community in dealing with previously inaccessible decision making authorities was instrumental in the development of the Vote For Health Campaign. The health workers, who were partners with the local residents in various discrete activities, capitalised on the opportunities to make connections with residents and between the issues. The context, development and outcomes of the Vote For Health Campaign have been described by Millington, Tesoriero and Verity (1991), who were directly involved in the strategy development.

Local government elections are held every two years in South Australia. The candidates are not overtly organised along party political lines and voter participation is usually less than 20% (Jaensch and Narmon 1990). Prior to the local government elections of May 1991, the Parks Community Health Service had approached the Community Centre, its landlord and the Enfield Council to discuss ways to improve voter turnout in the elections.

Both the Council and the Health Service dedicated worker time to developing strategies. The Health Service saw the opportunity offered by the elections to place health on the political agenda and to develop a community policy-making structure that would support health. Jaensch and Narmon (1990) have suggested that local government should be targeting people who might be convinced to vote if there is good reason. Parks Community Health Service attempted to convince people that their health was a good reason to vote in the Council elections. For the 1991 election, then, there were more actors than usual with an investment in the election outcomes.

The Health Service joined with the nearby Gilles Plains Community Health Service in the development of a campaign which covered the majority of wards in the Enfield Council area. The campaign's message was simply "Vote For Health." Using information about the role of Council distributed by the Enfield Council, the Health Service added the question "Will the person you vote for on May 4 spend your rate money in a way that will improve the health of your community?" This message was reinforced by a series of cartoons illustrating health in terms of access to good, cheap food, safety, having strong community networks, jobs, clean air. Information strategies were developed

to inform people of their voting rights, how to vote, and where to vote. A display was mounted in the Health Service and two thousand flyers were distributed, one thousand of which were specifically targeted to the Wingfield and Dry Creek areas which have particular environmental and health problems. Both the display and the flyers were also developed in relevant Indo-Chinese languages and the Health Service's Indo-Chinese staff ensured that the campaign reached the appropriate community networks. "Vote For Health" advertisements were placed in the local newspaper at strategic times and a questionnaire was distributed to all eighteen election candidates seeking information on their health platforms. Personal care providers distributed campaign information to people seeking individual care at the Health Service.

The Health Service "packaged" the campaign and sent it to all other community health services in an attempt to place health on the broader agenda across the Adelaide metropolitan area. Although the campaign was unconnected to any political party or particular candidate, the pressure and increasing uncertainty of the political process worried a number of candidates who had previously been elected unopposed in Council elections. The strong connection between the Health Service and PREAG caused

the role of the Health Service to be called into question. Complaints reached the Minister of Health, senior Health Commission officials and the President of the South Australian Community Health Association. To that extent, at least, the campaign politicised health in the community! Comments from many local people who had never previously been concerned with local politics indicated that the Health Service had raised the stakes for all the players. Kickbusch (1986) recounts similar experiences in European cities as a result of the World Health Organisation Healthy Cities program.

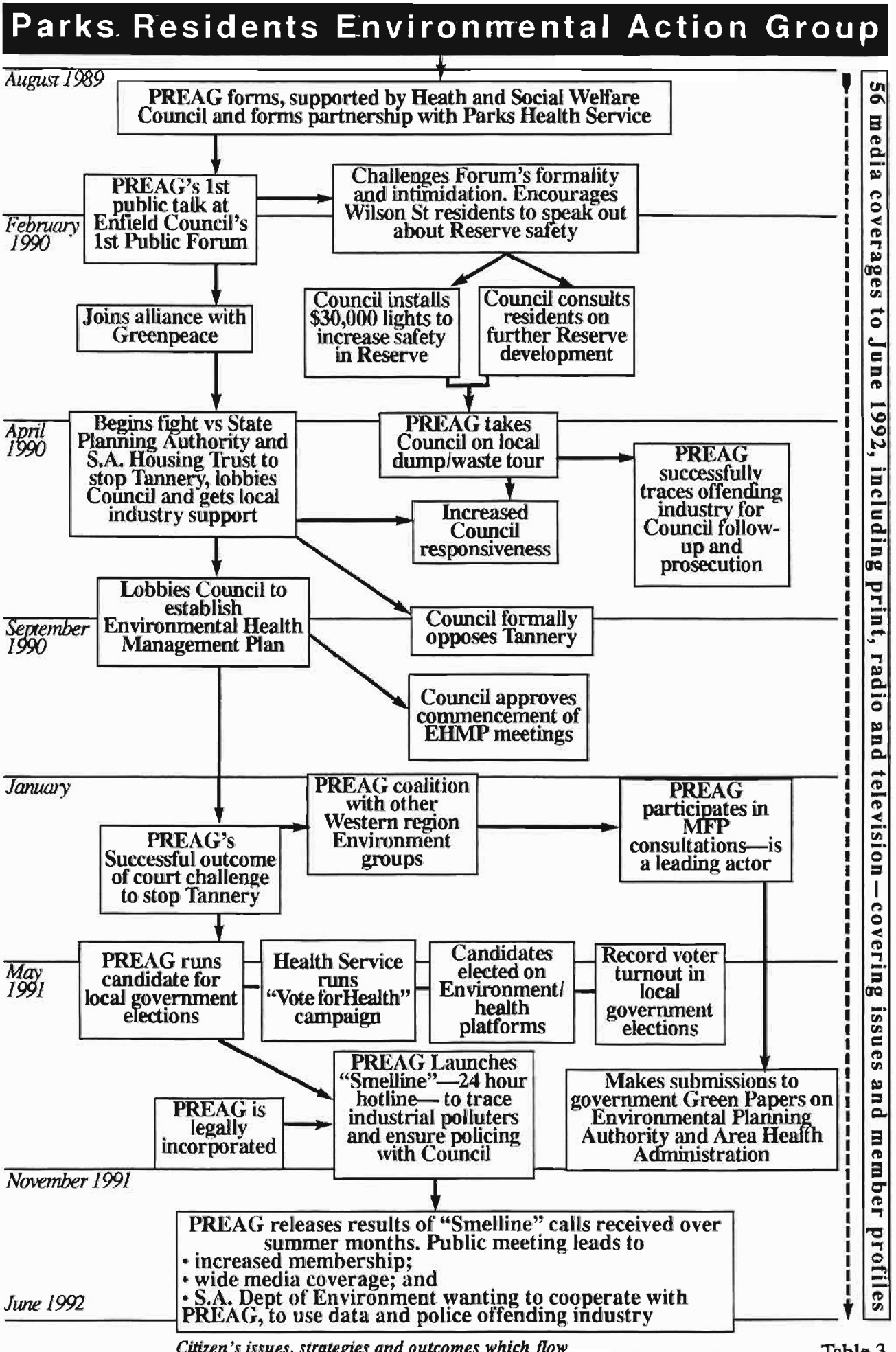
The effects of the Vote For Health campaign have been broad ranging. The 1991 election was the first Enfield election since 1985 in which some wards were contested. An increase in voter turnout of 2.1% was recorded in the ward which was contested by the PREAG member. The higher than usual turnout of Indo-Chinese people, combined with a higher than usual "incorrect" vote is probably a reflection of the campaign's influence. The PREAG candidate had distributed translated information on where and when to vote but had omitted to include a translation of the "How to Vote" card on voting day, a rather fundamental mistake.

The Parks Community Health Service survey of the eighteen candidates yielded twelve replies which were published in the local newspaper. This not only continued the visibility of the campaign but has given the Health Service and other local groups a record of election promises of the newly elected Enfield Council members. PREAG, in particular, has strengthened its resolve to continue to monitor the policies and practices of the Council and to maintain the pressure to clean up the local environment.

The campaign highlighted some of the dangers and tensions for a community health service openly engaging in politics. Although primary health care and health promotion principles recognise that improving health is a political process, this is generally not recognised by the broader community which is socialised to believe that health is about medical treatment. It is important for a health service to be completely open, ensuring that all affected parties are fully informed about intended actions and to continue to publicly make the links between health and politics. Slowly, the process will build a constituency for primary health care that is broadly based and able to recognise the need for a community health service to overtly attempt to influence the political agenda. An increased number of community health services participating

in a non-partisan, but pro-health way in future Council elections might decrease the concerns of the authorities and increase the understanding in the community about the relationship between health and politics.

The PREAG, Wilson Street and Council election examples of radical practice demonstrate the importance of primary health care workers forging links between the individual, households, neighbourhoods and communities to increase the power of ordinary community members to control the planning agenda in a way that balances health interests with economic interests. Individuals who seek health care from personal care providers, or external caretakers, can be encouraged to discuss their issues with other people experiencing similar concerns. Household members can be encouraged to develop strategies to address neighbourhood concerns with other households. Community action groups can be encouraged to form links with cosmopolitan groups in broader community, regional, statewide and national issues. This has the potential to develop movements for change that can successfully challenge existing interests in the planning and policy setting arenas and can propose alternative healthy public policy. Millington et al (1991) illustrate the type of linkage which is possible between action groups, planning and political forums in



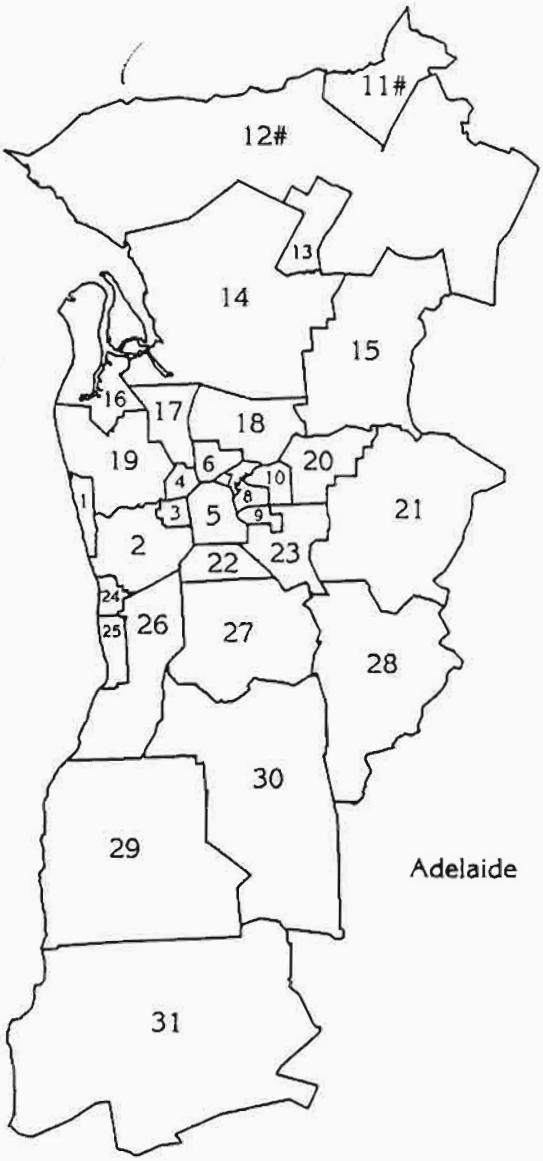
Citizen's issues, strategies and outcomes which flow from radical practice at Parks Community Health Service (Source — Tesoriero and Verity 1992)

Table 3

table 3 (opposite) which refers specifically to the radical practice described in this chapter.

It is clear that a radical planning framework, informed by the principles of primary health care, can be used by community health services to assist communities in their endeavours to promote health. This approach has major implications for the way forward for primary health care and its managers. The development of a movement of primary health care workers who are capable of participating in a broader community mobilisation for social change is essential for the new public health, based in health promotion and primary health care, to be implemented. This will be discussed more fully in the following chapter.

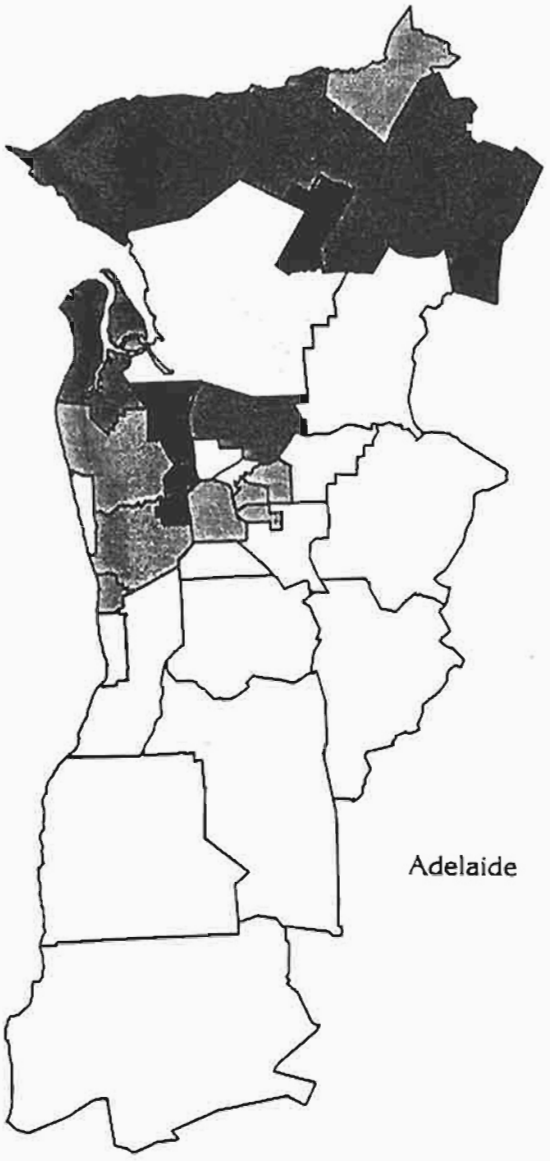
Key to Metropolitan local government Areas mapped for Adelaide, South Australia



Major urban centre & statistical local area	Area number
Adelaide	
Adelaide [C][1]	5
Brighton [C]	25
Burnside [C]	23
Campbelltown [C]	20
East Torrens [DC]	21
Elizabeth [C]	13
Enfield [C] - Pt A	18
Enfield [C] - Pt B	17
Gawler [M]	11
Glenelg [C]	24
Happy Valley [C]	30
Henley & Grange [C]	1
Hindmarsh [M]	4
Kensington & Norwood [C]	9
Marion [C]	26
Mitcham [C]	27
Munno Para [C]	12
Noarlunga [C]	29
Payneham [C]	10
Port Adelaide [C][3]	16
Prospect [C]	6
Salisbury [C]	14
St Peters [M]	8
Stirling [DC]	28
Tea Tree Gully [C]	15
Thebarton [M]	3
Unley [C]	22
Walkerville [M]	7
West Torrens [C]	2
Willunga [DC]	31
Woodville [C]	19

Source: Glover and Woollocott (1990) A Social Health Atlas of Australia, South Australian Health Commission

Australian Bureau of Statistics Index of Relative Socio-economic Disadvantage in Local Government Areas of Metropolitan Adelaide

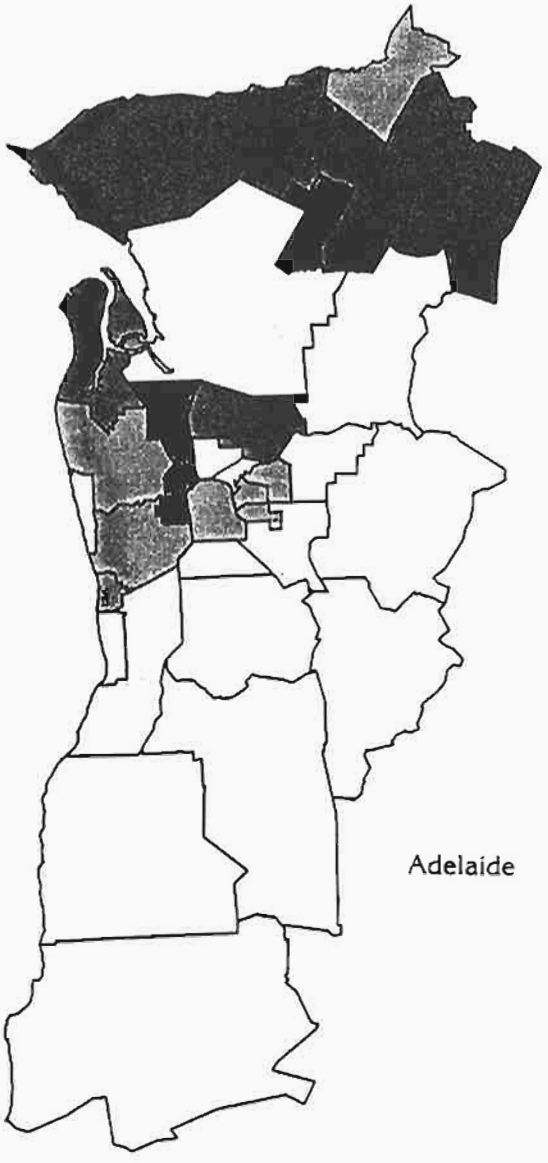


Index number of relative disadvantage:

- fewer than 900 (most disadvantaged)
- 900 to fewer than 950
- 950 to fewer than 1000
- 1000 to fewer than 1050
- 1050 or more (least disadvantaged)
- fewer than 100 persons

Source: Glover and Woollocott (1990) **A Social Health Atlas of Australia**, South Australian Health Commission

Australian Bureau of Statistics
Index of Relative Socio-economic Disadvantage in Local Government Areas of Metropolitan Adelaide



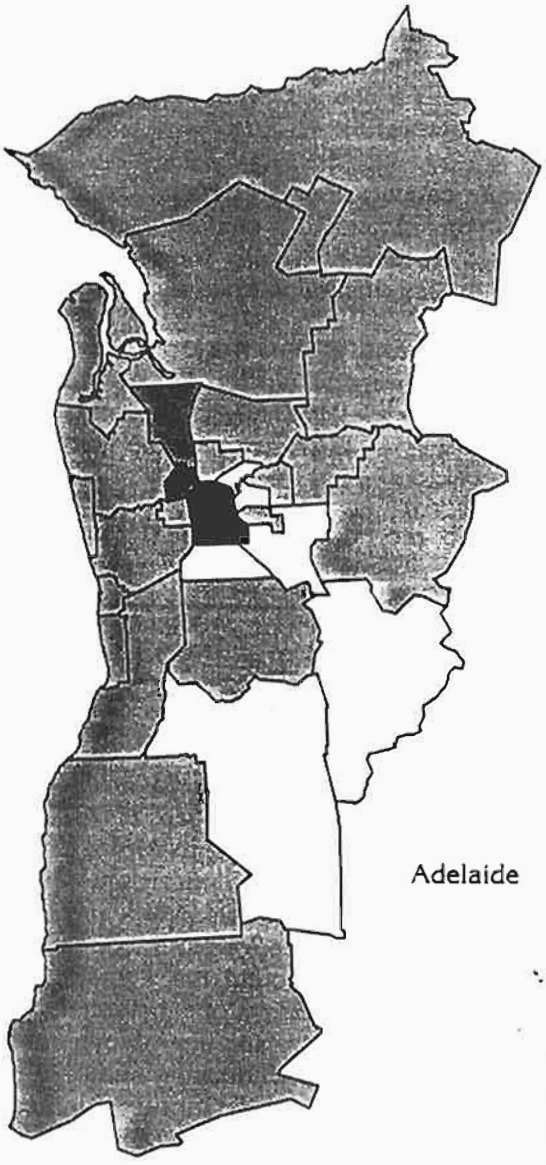
Index number of relative disadvantage:

- fewer than 900 (most disadvantaged)
- 900 to fewer than 950
- 950 to fewer than 1000
- 1000 to fewer than 1050
- 1050 or more (least disadvantaged)
- fewer than 100 persons

Source: Glover and Woollocott (1990) **A Social Health Atlas of Australia**, South Australian Health Commission

Deaths of People aged 15 to 64 years from all cancers in local government areas of Metropolitan Adelaide

actual deaths (by area of residence of deceased) compared with the no. expected (based on Australian totals)



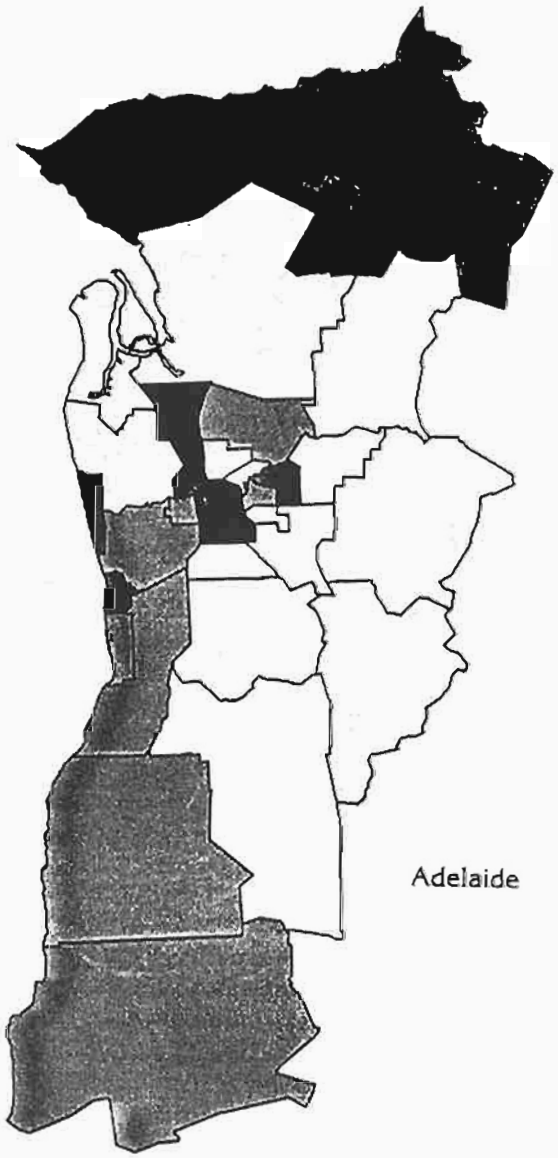
actual deaths compared with the number expected#

- 30.0% or more higher
- 15.0% to 29.9% higher
- 14.9% lower to 14.9% higher
- 15.0% to 29.9% lower
- 30.0% or more lower
- fewer than 5 deaths

Source: Glover and Woollocott (1990) A **Social Health Atlas of Australia**, South Australian Health Commission

Deaths of People aged 15 to 64 years from accidents, poisonings and violence in local government areas of Metropolitan Adelaide

actual deaths (by area of residence of deceased) compared with the no. expected (based on Australian totals)



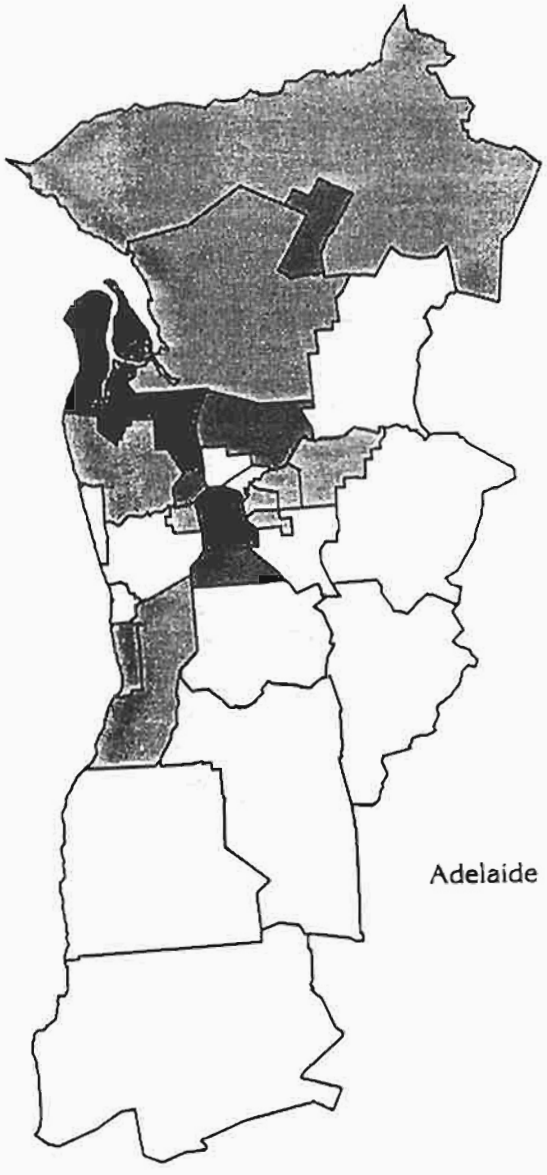
actual deaths compared with the number expected#

- 30.0% or more higher
- 15.0% to 29.9% higher
- 14.9% lower to 14.9% higher
- 15.0% to 29.9% lower
- 30.0% or more lower
- fewer than 5 deaths

Source: Glover and Woollocott (1990) A Social Health Atlas of Australia, South Australian Health Commission

Deaths of People aged 15 to 64 years from circulatory system diseases in local government areas of Metropolitan Adelaide

actual deaths (by area of residence of deceased) compared with the no. expected (based on Australian totals)



actual deaths compared with the number expected#

- 30.0% or more higher
- 15.0% to 29.9% higher
- 14.9% lower to 14.9% higher
- 15.0% to 29.9% lower
- 30.0% or more lower
- fewer than 5 deaths

Source: Glover and Woollocott (1990) **A Social Health Atlas of Australia,** South Australian Health Commission

Chapter eight

Developing the movement for primary health care

A community health service implementing participatory planning and practice faces inherent tensions. The resolution of these tensions increases the likelihood of a community constituency for health generally and for the service in particular. Chapter seven described three examples of radical practice which Parks Community Health Service implemented in partnership with local people. Collectively, they demonstrated the importance of linking individuals and groups in the community who are directly participating in local issues, with each other and with broader social movements for change. This mobilisation of people to claim a place in planning processes can influence public policy to support health and related social goals. Healthy public policy is a cornerstone in the promotion of health according to the Ottawa Charter for Health Promotion. The process itself can contribute to a redistribution of power, thereby promoting equity in decision making arenas.

This chapter draws on the analysis of practice at Parks Community Health Service developed in the preceding chapters and concludes that an approach to community health management and planning practice which is based on collectivist values is essential to meet the redistributive objectives of the Community Health Program and of primary health care. It also proposes a way forward in the development of a strong movement for primary health care within the health system and for social justice more generally.This kind of movement will be essential for the potential of primary health care to become a reality.

The Community Health Program in Australia, despite a boost by the World Health Organisation's commitment to the concept of primary health care over the last ten years, has failed to achieve its objectives of redistribution of health resources. Resources are still largely oriented to curative services rather than to prevention and health promotion and major inequities still exist between societal groups in both health status and in access to the goods and services which influence health. Yet it is acknowledged at a policy level, both nationally and internationally, that the concepts and principles of Primary Health Care, which are identical to those of the Community Health Program, have the potential to

support major reform in the health system and in society more generally.

Legge (1989) holds that policy makers seeking reform of the health system must develop strategies to foster broader social reform. The underlying value base guiding the activity of the workers should, therefore, incorporate a commitment to social justice. On this view, the struggle for reform to strengthen primary health care is a component of the struggle for more basic changes in the social order. A primary health care movement, combined with other compatible movements for social change, can have an important role in developing the political constituency for including health and other social goals on the various planning agendas. Practice at Parks Community Health Service has demonstrated this potential.

Some important organisational issues in South Australia have enhanced the capacity of Parks Community Health Service to engage in radical practice. The South Australian Health Commission Act 1976 made possible the separate incorporation of health units which have the freedom to determine policy on service provision within broad policy parameters set by the South Australian Health Commission. The Act also allows for global

budgets to be administered by Boards of Management. These arrangements, although not overtly facilitating the implementation of primary health care principles, they do not overtly impede them either (Auer 1988). The maintenance of these kinds of organisational arrangements in South Australia under-pins the potential of primary health care services to engage in the development of a broader movement for radical practice as exemplified by Parks Community Health Service practice. Yet recent moves by the South Australian Health Commission to reduce the number of local health service incorporations in favour of area health boards indicates a lack of understanding of the organisational requirements of primary health care (South Australian Health Commission 1991).

Internal management arrangements at Parks Community Health Service have been established to ensure a continuation of an organisational culture which supports a partnership between professionals and the community they serve. In addition to the program review process, which was described in chapter six, personnel procedures include position descriptions which incorporate a requirement for commitment and skill in developing community participation in all activities. Staff selection processes ensure a community perspective on interview

panels. Questions at interview solicit information relating to candidates' commitment to primary health care principles and evidence of previous attempts to encourage community control or participation at relevant levels in their activities.

In relation to broader health reform in Australia, it is the provider groups and the professional consumer advocates with an interest in health promotion who have been able to place primary health care on the policy agenda contained in the Health For All Australians Report, the National Better Health Program, the South Australian Primary Health Care Policy and Draft Implementation Plan and various other policy documents. The broader community has not yet participated in the implementation phase of that policy. Aside from the fact that this process has not addressed the inherent elitism in centralised planning, it has meant that, in reality, the policy will not be implemented. Dominant provider interests, as discussed previously, are too entrenched to allow easy implementation of real change. Without a citizen movement and broader political participation in health policy and implementation, health promotion will remain marginalised and tokenistic.This is particularly true in an economic rationalist environment. Alternatively, as described in chapter five, the concepts of health promotion may be redefined by the dominant

interests to maintain a disease focus, thus ensuring themselves a place in the "new" field.

It could be argued that the original "movement" for primary health care or community health in Australia lost its way after a few successes. After the first wave of funding for the Community Health Program of 1973, funds for the Program were significantly reduced by the Federal Liberal Government which came into power in 1975. Although the 1983 Labor Government increased Federal support to the Program, the Federal financial commitment has never reached the 1973 level. The tactics and strategies of the community health workers in the early to mid eighties were aimed at getting community health back on the political agenda. They did this through professional organising. They were successful to the extent that the Australian Community Health Association, made up of delegates from the state associations of Victoria, New South Wales, South Australia and the Australian Capital Territory, was funded by the (then) new Labor Government in 1983 to provide policy advice. This was the first of a series of participatory forums supported by the Minister of Health at that time. Financial support was also provided, for example, for the development of the Consumer Health Forum which was initiated by the Australian Community

Health Association and ten other peak consumer and community groups.

At the State level,the South Australian Community Health Association enjoyed a particularly close relationship to the State Labor Government and, indeed, Association members were instrumental in the development of the Labor Party's health platforms over a number of elections. The Association continues to meet regularly with the Minister of Health in South Australia and continues to be invited to provide a nominee to almost every health policy making group controlled by the South Australian Health Commission.

The Australian and the South Australian Community Health Associations used organisational and political activity to increase the power in health policy making of a group of relatively marginalised health professionals. Nevertheless, as described in chapter one with reference to the early Community Health Program, reform policy continues to fail at the implementation stage. An analysis of financial allocation in health services in South Australia, in particular, leaves no doubt that little fundamental increase in the proportion of resources spent on the primary level of care has occurred (South Australian Health

Commission Annual Report 1991). Real power remains with the interests of the medical and administration professionals who implement the policy by making the day to day decisions in health care.

The organised community health workers are not supported by a broadly based political constituency voting for health system reform because they have not implemented their own rhetoric of community participation. The broader community is still relatively uninformed about the relationship between health and public policy. A cursory analysis of media coverage in South Australia relating to health issues demonstrates an individualistic preoccupation with cure and hospital services. Indeed, the South Australian Community Health Association agenda has been re-active rather than pro-active in health policy. Its method of operation has been to develop, almost exclusively, professional responses to policy statements from the bureaucracy rather than to generate broad community participation in the policy making, planning and implementation processes. Non-professional groups have rarely attended its conferences and other forums

The community health workers' strategies have stopped short of real community participation in health policy, reflecting a

preference for worker participation. They have apparently been co-opted by the bureaucracy. This co-option is partially caused by the dynamics of bureaucratic processes which make it difficult for community health workers to consult with their communities. The nature of the questions posed in planning are often complex and irrelevant to the community. Information is provided in jargonistic terms. Periods between planning meetings are short. The community health workers have, therefore, participated on behalf of their communities, although without their knowledge or consent. Organised community health workers have inadvertently maintained elitism in health planning, which remains out of the reach of the ordinary person. Community health organisations have become just another interest group in the pluralist political system in which decision making takes place.

Restarting the movement

The community development literature and the case studies described in this thesis demonstrate that a primary health care service and community members, mobilising to participate in social planning, can influence policy to better support health and social justice. Furthermore, the process develops the skill and

knowledge of communities to assist in the implementation of the policy once made.

As it was for the staff of the Parks Community Health Service, it will be important for community health workers to develop a value base which supports this approach. A re-orientation of the health workers from professionalism to a commitment to social justice and a willingness to work in partnerships with the community will be the first step. This view is supported by the Interim Report on the Role of Primary Health Care in Health Promotion which suggests that the primary health care sector must develop a consciousness of itself as having a shared purpose (National Centre for Epidemiology and Population Health 1991). The role of managers in providing strong primary health care leadership and skill in organisation planning and change is paramount in achieving this consciousness. The outcome of a consultancy, currently being undertaken by the National Better Health Program to develop support programs to assist managers to bring about this organisational change, is crucial to the development of individual primary health care agencies.

Organisation development and radical planning techniques have the potential to develop a value base, amongst workers across a

range of agencies, to support primary health care in the broader system. The principles of primary health care and the Ottawa Charter for Health Promotion provide a framework within which this can take place. A recognition of the existence and meaning of the ideological underpinnings of this rhetoric, which the majority of primary health care workers espouse, and a willingness to debate, in broad popular terms, the inherent tensions and potential strategies to address them, would be the first step in such a broadly based organisation development process. This would assist in the development of the "technology" of primary health care as well as the ideological commitment of workers to engage in radical planning within their own communities.

Pusey (1991) has demonstrated that, in Australia, economic rationalism has taken hold of the Federal Government policy development processes. The situation is similar in the South Australian Government. Traditional Labor policies and politics are disappearing to the extent that the Federal and State Labor Parties are now advocating privatisation of government enterprises, "fast tracking" of development and residual approaches to public health services. A broadly based community movement for change will be required to shift the entrenched position of the economic rationalists.

Primary health care activists within the bureaucracies, who are currently engaged in policy development and planning for primary health care, might also spend time organising the forums and processes which can facilitate workers and community groups coming together to determine and implement strategies in their common struggle for reform. The current activity of the Australian Capital Territory Health Authority is an example of this approach. Its Health Advancement Division is supporting the mobilisation of community health managers and workers towards health promotion by creating forums for discussion and strategy development to re-orient existing individualistic approaches to health care. An outcome of this process has been the establishment of organised groups capable of independent political action to expose, by use of various forms of popular media, the implications for health services of the economic rationalist policy environment. The Division is using the same "task force," or organisation development approach based in social learning theory, that was used at Parks Community Health Service to identify obstacles to participation in health promotion and strategies to overcome them. Direct participation of the workers in the development of these strategies increases the likelihood that the workers will implement them (Peters and Waterman 1984).

This approach acknowledges the lack of consensus in relation to what primary health care practice is and attempts to encourage a political community amongst the primary health care workers themselves.

Activists within the bureaucracies and other emerging leaders might develop as the fifth column in this struggle for reform in the health system and for transformation of existing social relations (Friedmann 1987). They will be instrumental in assisting the development of networks and political coalitions for radical practice in primary health care and linking these to networks with common goals outside the immediate health arena. The issues around which these networks will be developed will be determined opportunistically and will be those which maximise the potential for broader participation.

As the number of radical planners in primary health care increases, leaders might emerge who will be less wary about "coming out," particularly as the number of successful social action projects increases and as their community constituency becomes stronger and more vocal. An example of the potential for this community defence against economic rationalism relates to the South Australian Health Commission's moves to remove the

incorporated status of its health units (South Australian Health Commission 1991). Parks Community Health Service and other western region community health centres convened a meeting between bureaucrats and community residents. The residents made their point of the benefits of local control very clearly and have earned the Health Services the right to develop their own locally relevant processes for "better co-ordination" and planning. The possibility of this form of action is dependent on the ability of workers to inform communities of the implications of economic rationalist plans and policies. If media attention cannot be attracted, it may be necessary to develop other forms of media for the dissemination of information.

As both professional and non professional leaders in radical practice begin to emerge, the potential exists for alliances to be developed between primary health care and broader social movements that reach across individual communities to affect State and National policy and even global policy in relation to health and social justice. The guiding vision and purpose for unity will be social justice. The women's movement is an example of the influence of a broad range of local and specific issues groups, united at a global level in their struggle for equity. The environmental movement is a broad coalition of community based

organisations united in a common struggle for a cleaner environment but dedicated to specific local change. The rhetoric of thinking globally and acting locally has meaning in these contexts.

The role of primary health care managers

A community Health Service, like any other organisation, requires skilled management. This thesis has argued that organisations develop through different stages but that the ultimate goal of a primary health care organisation is social justice. This requires that managers be capable of ideological leadership within a collectivist framework, giving staff a clear understanding of the value base of primary health care. It also requires that managers be able to use organisation development techniques of management to enable the organisation to participate in the struggle for social justice.

Injustice is a broad social issue. Managers who are isolated within community health services can not be sufficiently influential to achieve real change in the structural relationships of society which contribute to injustice. Collective participation, however, has the potential to address the issue. It is important, therefore, for

primary health care managers to assume a role in broader mobilisation for change whilst remaining firmly grounded in community issues.

Primary health care managers, who engage in radical practice within the forums of the systems of which they are a part, might assist their colleagues and peers to identify the potential power of collective action to influence broad policies and decisions which support social justice outcomes. They will also create new forums, forge new alliances and coalitions and infiltrate and challenge existing power blocks. In extending radical practice, primary health care managers become yet another identifiable part of existing movements which challenge unjust social relations. Their contribution is made all the more important by the fact that they have access to decision making within the central State institutions and can inform local movements as to where to direct their strategies so that decision makers are faced with broad based and multi-faceted challenges. In this way, managers can develop their role in supporting a shift in society towards greater mutuality and play a major role in challenging economic rationalism.

Pusey (1991) points out that in the economic rationalist environment of the 1990s, societies are threatened by their own

coordinative structures and by an economic steering mechanism which violates the adaptive capacities of ordinary life and threatens the social reproduction of culture and individual identity. He argues that the co-ordination of the State used to be set in a moral and ethical context but that coordination is now equated with rationalisation. Culture and identity no longer have any practical relevance in the logic of the market. They are arbitrary individual choices and, as such, are simply a consequence, rather than a driving force in the market analysis of life. It might be argued, then, that there is no place for social goals and values in this world. Yet, pointing to the success of the small and middle sized nations of Western Europe in developing compatible social and economic policy and to the women's and the green movements' demonstration that life does not reduce to economic development, Pusey sees the potential for a change in the social relations of society from repression of the majority by the few, to mutuality.

This thesis has argued that primary health care practice can play an important role in this challenge to economic rationalism. Primary health care workers must first recognise that consensus does not exist within the primary health care field about approaches to practice; that consensus does not exist within the

health arena for change towards a more preventive and participatory approach to health; that consensus does not exist within the various planning authorities for social justice. They must turn the greater part of their attention away from the policy and planning processes that are a construct of consensus ideology and towards the people in the community who are, by various measurements, comparatively disadvantaged; not to provide *for* them, but to struggle ***with*** them for equity and social justice.

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Historical sources

Historical information relating to the establishment and development of the Parks Community Health Service has been gathered mainly from minutes of Interim Committee of Management meetings and staff meetings, annual reports and other reports which are contained in the Service's archives, as well as through interviews conducted with people who worked at Parks Community Health Service throughout various stages of its development. Discussions were unstructured but specifically addressed staff's impressions of planning processes as they related to prevention, health promotion, co-ordination of services and community participation. These are the principles of the original Community Health Program. The interviewees (outlined below) are referred to in the text and appear under the alphabetical reference section as "personal communication."

Interviews

Directors

Dr. John Allen	Medical Director 1976-1982
Mr. James Birch	Administrative Officer 1980-1983 Administrator 1983
Ms. Miranda Roe	Administrator (later changed title to Director) 1984-1987

Team Leaders

Ms. Jill Davis	Social worker prior to 1984 Acting Community Education and Development Team Leader 1984-1985
Ms. Susan Lane	Community Education and Development Team Leader 1985-1989
Mr. Frank Tesoriero	Community Education and Development Team Leader 1989-present
Mr. Danny Broderick	Personal Services Team Leader 1986-1990

Other staff interviewed

Ms. Val Bickley	Nurse
Dr. Gavin Beaumont	Visiting medical officer
Ms. Julie Clisby	Receptionist
Ms. Elyse Jory	Nurse
Prof. Tim Murrell	Visiting medical officer and Chair of Interim Committee of Management
Ms. Loris Renney	Nurse
Ms. Alison Newton	Psychologist

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