COMMENTARIES

Community-based health care: a different approach to health outcomes

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ABSTRACT

Health sector organisations are undergoing a period of fundamental change. One set of changes is about increasing the capacity of the system to provide integrated client care. This paper discusses the practices that community health care workers have used to approach some basic issues of service integration. Although the discussion is about practices in community health, the issues are important for health care providers, managers and policy-makers throughout the health care system.

Introduction

This paper is about the skills used by community health care workers to develop integrated systems of care. Although it discusses the practice of community health work, the issues are important for managers, policy-makers and acute care providers who are also concerned with providing integrated or coordinated care to users of the health care system.

It is now commonplace for health sector personnel to acknowledge rapid change in the way health organisations go about their work. They

are expected to 'do more with less', for example, to re-examine work processes and eliminate waste. The rate of change is probably greatest in the acute care agencies; however, few organisations are escaping change. Community health centres, psychiatric services, intellectual disability services, and home care services are all being swept into the reform process. The organisational models underlying change are usually derived from the market, and frequently from the literature on corporate reform (for example, Osborne & Gaebler 1992). Valuable lessons can be learned from industry, but they cannot be imported uncritically and expected to deliver the anticipated outcomes. The discussion below will illuminate this point.

For health care workers the reforms have created some powerful contradictions between, for example, efficiency and ethics, instrumentalism and caring, care as a set of discrete tasks and care of a whole person. Clarity requires that a position in regard to some of these forces is taken. At the core of our argument in this paper is a set of values that are about the provision of a caring service that is relevant and effective in addressing client physical, social and emotional needs; that is, a set of values that are about *health outcomes* for clients and valued by clients.

An important objective in many of the changes under way in the health system is transforming the way work is done. In this paper we wish to explore the theme of linkages that is so important in contemporary organisations (Limerick & Cunnington 1993; Kanter 1989). In particular, we wish to address the way health care workers in a community setting can increase the integration and continuity of care. We argue that the practices that lead to successful linking and service integration are not well developed in the acute care services which are, coincidentally, where most health care professionals gain their practical education. It follows that when these health care professionals move into community settings, a whole new set of skills and practices are required.

Work practices are embedded in an organisational framework that sanctions only certain kinds of employee behaviour. Organisations can either facilitate or inhibit the kinds of practices that lead to the provision of integrated care. Although the discussion in this paper is about health care worker practices, it contains clear lessons for managers and policy-makers. A failure to acknowledge this point, we argue, will create forces that prevent the achievement of the policy goals regarding integrated and 'customer-focused' community health care services.

Hammer and Champy (1994) write about the importance of whole work processes which can be interpreted in a health care setting as the

integration of the care process within organisations. Limerick and Cunnington (1993) discuss the importance of linkages, not only within an organisation, but outside as well. Both aspects are essential, in their view, to the capacity of an organisation to meet the needs of their clients (customers) and survive in a rapidly changing and competitive world. Central to all of these changes is the relationship of the provider to their client.

The context of community health services

> [T]he successful implementation of a major community health program could be jeopardized without the development of appropriate education (Sax Report of 1973 cited in Health Department of Victoria 1985).

In this quotation the authors of the document known as the Sax Report, the report upon which the Australian community health program was based, were referring to the demands a new kind of health service makes upon a staff trained in more orthodox settings. Over the years the novelty of community health services has diminished as they have become a significant part of the health system. However, there remain a number of contentious issues in practice, for example, the implementation of community development strategies, the changing relationship between service user and health professional, and the issue of service integration.

When it was established in 1973, the community health program was very different from the existing programs and services. The idea represented a break with the tradition of equating health care with centralised acute illness care. The community health program was to provide services characterised by an emphasis on the prevention of ill-health, the provision of local level illness-care services, and rehabilitation and support for those with long-term disabilities. It was intended that there be 'strong and reliable' links between community health projects or agencies and other elements in the health and welfare systems. Services were to be integrated 'so that individuals and families can look forward to a convenient local point of reference when they require help' (Sax 1980 cited in Sax 1989).

In the 1990s, over 20 years later, some of the old community health program issues are being revisited. Once again the issue of primary health care integration is troubling policy-makers. The problem of how to provide community-based services that actually deal with the reality of peoples' lives is bothering community health care workers when reform is being driven by change in acute care services.

Who works in community health?

In retrospect, it is apparent that the initial community health program was asking an enormous amount of the service providers, many of whom were health professionals trained in the system of acute illness care. If we take the case of community health centres, almost half of all staff are clinically trained health professionals. The other half are trained in social or welfare work, or administration, or are untrained (Health Department of Victoria 1990).

A minority of community health centre staff, for example, hold formal qualifications that are additional to their basic professional qualification. Short courses, professional seminars and conferences are the most frequently identified extra-organisational means of acquiring new skills (Walker, Grain & Mitchell 1995).

Linkage issues for community health care workers

The linkages likely to be effective in helping a community health service achieve its goals can be analysed at four levels: professional–client, professional–professional, professional–organisation and organisation–organisation.

Professional–client

If community health goals of self-help and individual independence are to be achieved, health care workers need to foster their clients' capacities to achieve health outcomes without the intervention of health services. McWilliam et al. (1994) argue that client independence needs to be assessed within the context of a client's daily life, a part of which is the client's mind-set. A client's own mind-set is significant in shaping the capacity to act autonomously. Mind-set consists of three things: the client's perspective on life, or their degree of optimism or pessimism; the client's attitude towards themselves, particularly their involvement in their own care; and the client's attitude towards dependence on others, especially carers. Relationships with health care professionals have a substantial influence on a client's mind-set, and consequently their independence (McWilliam et al. 1994). McWilliam et al. argue that client–professional relationships that are strongly rooted in the paternalistic biomedical perspective and practices are likely to undermine self-esteem and self-

confidence, and consequently support a cycle of disempowerment and decreasing capacity for self-care. Client–professional relationships are an important variable influencing a client's capacity to utilise social and physical resources that are essential for self-care in the community.

In the context of mutual aid or self-help group relationships with health professionals, the professional–client relationship has been redefined. This redefinition of relationships can go some way towards transforming professional–client relationships in a community health centre setting; it has the potential to go further and support clients in demanding different kinds of relationships in other appropriate settings. Lenrow and Burch (1981) explore the sources of some of the many difficulties experienced by the participants in mutual aid or professional relationships and explore some of the ways these relationships can be reconstructed. They argue that equalisation of power is one effect of professionals (health or welfare) recognising their *interdependence* with clients. Where power is equalised, the satisfaction of both parties to the relationship improves. Where power is eroded, the reverse is the case (McWilliam et al. 1994). From the professional's point of view, clients are better informed, professionals receive better cooperation and the relationship between professional and the members of mutual aid groups is more effective in achieving shared goals. An interdependent relationship in which power is equal is not characteristic of client–professional relationships in the acute illness care system, although some practitioners choose to operate in that way. Lenrow and Burch (1981) argue that professionals who take interdependence seriously work from a particular attitudinal base and with a particular set of interpersonal skills. They rely heavily on clients' perceptions in the formulation of problems and options, and assume it is essential for clients to develop decision-making skills and to negotiate the ground rules for the client–provider relationship. Working with a client on a particular issue, the professional seeks to model good decision-making and to develop the client's decision-making skills.

> This coaching includes encouragement and information about how clients can approach other professionals and service agencies in ways that enhance client's self-respect rather than leaving them feeling defeated and degraded. It includes adding to their information about how to find resources that will be useful in making good decisions and

> resources that will be useful in implementing them. And
> it includes providing them with information about what
> contributes to healthy bodily and psychological
> functioning (Lenrow & Burch 1981).

Through collaborative relationships that enhance the capacity of clients to formulate and solve their own problems, a community health care worker can influence the demands made upon other service providers and can support the development of self-help strategies on behalf of individuals and groups. This type of relationship is described as a developmental casework role in the influential conceptual framework of community health, 'The Community Development Continuum' (Jackson, Mitchell & Wright 1989).

Professional–professional

Professional–professional networks are often the machinery that provides integrated care to a client. In the acute care system they support referral systems, the coordination of complex episodes of care and the coordination of services to clients with multiple needs. In the community, professional– professional relationships extend well beyond traditional health professional boundaries. For example, relationships with the local police may well be crucial to the work of community mental health teams. An earlier study by the authors, of the networks developed by workers in community health centres, illustrates just how extensive and intersectoral these relationships can become (Walker, Mitchell & Wright 1993). It was apparent in that study that the techniques of identifying, forming, sustaining and breaking network relationships are problematic for health care workers entering the community sector.

The skills involved in developing and sustaining professional– professional links are substantial. Whittington (1983) argues, in regard to social workers' efforts in case coordination, that the relationships involved are characterised by instability and informality. When social workers and other personnel achieve concerted action, they have succeeded in an active process of construction. The key skill involved in this is negotiation.

> The combination of differing interests, ideologies and
> aims and the recognition of varying degrees of
> dependence on others for their realisation, in a situation

> involving large areas of unruled action has the following result: the *negotiation* of agreements on courses of action (Whittington 1983, p 272).

In Whittington's view, the sources of influence available to social workers involved in these negotiations are of three kinds: rhetoric or the use of language to persuade; interpersonal skills in the development and sustenance of relationships with other actors; and access to and control over useful resources. Where members of other professions in community health care engage in the process of coordination, they are sharing this aspect of social work experience. They also are engaging in complex social processes of negotiation.

The use of those skills and strategies usually assigned to the field of social work is not as inappropriate as some health care professionals may assume. After all, the social worker has traditionally been the link between the acute clinical services and the support available in the community for discharged hospital patients. The skills used to do this are similar to those required in developing networks in the community setting. The creation of links between acute and community services, and between different community-based agencies, is an increasingly important task for all health care workers at a time when acute care services are being encouraged to discharge patients early, systems of home-based acute care are being developed, and coordinated community care is being emphasised.

Professional–organisation

Good working relationships between agencies are essential for the provision of integrated or coordinated care. The relationships with other organisations in a community, whether they be mutual aid groups, advocacy groups or other service delivery agencies, require community health care workers to have skills that are not characteristic of health care practice in most acute care agencies. When community health care workers link to another service-providing organisation, they are linking with other people. Where the two individuals are able to act with a high degree of autonomy in regard to the client, we consider that to be a professional–professional relationship. Where that autonomy is reduced by organisational policies, practices, rivalries, power structures, for example, we regard that as a professional–organisational link.

Brager (1978), again in regard to social work, argues that professionals providing services that require the participation of people other than

themselves need to think clearly about the differences between their relationships with clients and with other providers working within the structures and processes of formal organisations. If an organisation, and consequently its constituent providers, is to respond appropriately, a professional may need to invest effort in processes involving that organisational entity. Brager argues that the transition from a relationship focused on a client to one focused on a formal organisation requires a transition from a helping relationship to an influencing relationship. These two kinds of relationships differ in regard to '(1) the uses of power, (2) commitment to goals and (3) worker–client' relationship (Brager 1978, p 558). Bar-on (1990, p 148) summarises the differences in the following way. The first difference in the helping versus influencing relationship:

> involves the use of power. When helping clients, workers are likely to be in a commanding and authoritative position, but will typically strive to down-play the inequality to increase the probability that their clients will accept their services. In attempting to influence, on the other hand, the case is reversed: the workers' task is to increase their power so as to get their targets to comply with their requests. The second distinction involves different goal commitments. In a helping relationship this is a joint problem-solving process, where the client is presumed to be the final arbitrator of the goals that are sought. Conversely, an influence relationship entails being committed to a specific objective which is determined by the worker prior to the very establishment of the relationship. And lastly, the nature of the relationship is different. In helping it is supposed to be unilateral. The worker gives something to the client with no manifest reciprocity expected by either side. Influence, in contrast, is predicated on bilateral trading: each party is a priori expected to give something in exchange for what he or she desires.

It is very difficult for a person trained to work in helping relationships to develop the capacity to also work with influencing relationships. It requires self-consciousness and skill in identifying and interacting with the intangible elements of social relationships. The best community health care workers are able to move between the two kinds of relationships with ease.

Although one may argue about some details implicit in the definition of the helping role, the kinds of differences between helping and influencing relationships that Brager describes are useful for understanding some of the role conflicts community health care workers experience. A health care worker who is 'naive' about the complexities of community-based work will often view a professional–organisational relationship as a professional–professional one. To make matters worse, they may not distinguish it from a professional–client relationship.

Organisation–organisation

In community health there are many problems that are complex, long-term and for which no one agency has the capacity to provide satisfactory solutions. One example is provided by people with degenerative physical and mental conditions, another by people suffering the complex and debilitating consequences of poverty. There are a variety of devices used to formalise the relationships between organisations delivering community-based care, for example, co-location, contracts, shared protocols, and the development of relationships in which one organisation provides services under the auspice of another. Issues in the development and maintenance of inter-organisational relationships are likely to gain a much higher profile as systems for the provision of coordinated care are developed.

The issue for community health care organisations is to understand a process of inter-organisational development that will allow progress to be made on meeting complex client and organisational needs. Gray (1985) has developed a process model of organisational level domain development that is applicable. She is concerned with inter-organisational systems which are under-organised and exist in problem areas within which no single organisation can satisfactorily manage by itself, but in which success is possible if collaborative action is undertaken. Although Gray is writing about the problems of industry, her analysis is useful for understanding the processes of developing coordinated service provision in health and welfare and the establishment of community structures (Smith 1988). The phases in her model are problem-setting or the identification of stakeholders and issues; direction-setting, in which a shared perspective and common purpose are built; and finally, structuring, in which stakeholder interactions are managed and structures are established to support and sustain collaboration in the longer term. Gray argues that implicit in her model 'is the idea that domain level dynamics can be managed to improve the

likelihood that collaborative relationships are achieved and sustained' (1985, p 916). In other words, she is saying that there are identifiable skills in analysing, understanding and acting which affect the outcome, and that these can be learned. The skills in strategic action that Gray is referring to are not prominent in the repertoire of skills learned by health care professionals unless they have worked in certain kinds of health care agencies or community organisations. The body of literature on coalition formation (for example, Dluhy 1990; Hinckley 1979; Weisner 1983) is also pertinent to aspects of strategic action.

As the market and competitive pressures in health care develop, notions of strategic alliances between networks of community health care agencies and acute care facilities are likely to gain currency. Community health care organisations almost certainly need to develop local clusters of public and private primary health and acute care providers, the composition of which will vary from area to area depending on client needs and the availability of services. Many devices can be used to create these links. They include the designation of preferred provider status, the provision of services on contract, sharing of resources such as information systems, and the development of protocols for joint or compatible action.

It cannot be assumed that the health care market will automatically increase integration of the community health system. If some agencies are in a strategic alliance, others will necessarily be out. The dynamics that govern getting in, staying in, getting out or staying out are complex and demanding to manage. The discussion above describes some of the reasons this is so. 'While the modern industrial world is alive with examples of strategic alliances, it is also littered with dead ones' (Limerick & Cunnington 1993, p 86).

Pitfalls for reformers

There is evidence to suggest that non-clinical skills are required to be exercised in a substantial proportion of a community health care worker's job. Bar-on (1990), in a study of social workers involved in assessing client needs and coordinating services, found that only one-third of practitioners' time was spent interacting with the client. Most of their time was spent interacting with managers and administrators, other professionals and members of informal client networks. A similar pattern emerged from a South Australian study of community health work. The Southern

Community Health Services Research Unit found that community health workers spent almost 29 per cent of their time on the direct provision of services, the remainder being spent on planning, interaction with other actors, evaluation, supervision of students and volunteers, staff development, record maintenance and administration (Southern Community Health Services Research Unit 1987).

As the community health care sector is reformed and the organisations change, there are pitfalls the size of chasms into which they could fall. Organisations could become competitors and institutionalise adversarial practices in relation to other actors and organisations of the kind Kanter (1989) describes as characteristic of traditional American business. Alternatively, they could become skilled allies and collaborators, practitioners of the network style of organisation described by Limerick and Cunnington (1993). Which way will they be forced to go?

Policies and administrative arrangements that fail to support appropriate health care worker practices in the community health sector will not achieve the stated policy goals of integrated and 'customer-focused' services. We argue that community health practice and acute illness care practice are different. The technical practices that underlie acute care have a diminished role in community care. Social practices, such as negotiation, have a larger one. The lessons that can be learned from social workers and others involved in inter-organisational relations are pertinent to the facilitation of service coordination or system integration and community development aspects of community health practice. The differences between community-based and institutional practice suggest that new staff entering the community health field are probably confronted with a kind of professional culture shock as they seek to reorient their professional work in this new environment. Their orientation to community health care, and sources of professional support in the field, are of considerable importance for their performance in, and satisfaction with, the job. If governments are to 'steer rather than row' in regard to the provision of community-based health care, they must learn the intricacies of navigation. They must learn the kinds of practices that result in good community-based services and establish frameworks that achieve those practices, not their reverse.

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