THE NATURE OF PRIMARY CARE - A SETTING FOR SOCIAL WORK PRACTISE

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By

Beverley Ann Lowry

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A dissertation submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

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Masters of Social Work

Beverley Ann Lowry

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SETTING FOR SOCIAL WORK PRACTICE

Abstract

This thesis initially explores the philosophical and organizational features of the traditional health system. Within the context of that system, the historical development of medical social work is discussed. Subsequently, a general discussion is conducted of contemporary recommendations for reform of the health care delivery system.

The nature of primary care is explored conceptually, followed by an examination of the health reform experience in the United States, Great Britain, Sweden, and Canada where the primary level of care is receiving particular emphasis. An ideal primary care centre is developed from a synthesis of the general reform recommendations and the known experience in organizing primary care services in these four countries.

Proposals for the practice of social work in a primary care setting are made. Finally, the importance of the issues examined in the study is discussed from the point of view of the social work profession, the primary care centre, and the public at large.

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PREFACE

To achieve an understanding of the potentialities offered by a primary health care centre for social work practice requires a detailed examination of many issues related to health care planning and delivery, organizational systems, and social work theory and practice.

This examination will be structured in a way that takes the reader through four increasingly focused stages.

The first stage involves an examination of the theoretical constructs of health and disease for the purpose of establishing their influence on traditional and contemporary trends in health system planning and organization. Within the context of the traditional and largely treatment oriented health system, the historical evolution of medical social work is discussed. Finally, an indication is given of the expanded possibilities which exist for social work in a refocused, health system oriented towards prevention and primary care.

Having established a perspective on the traditional and contemporary trends in health system development, the next stage attempts to focus on that level of service referred to as PRIMARY CARE.

The concept of primary care is analyzed, followed by a limited review of the experience in the United States, Great Britain, Sweden and Canada which examines the organization of their health delivery systems with special emphasis upon the primary care level.

The third stage initially provides a synopsis of the common principles of health planning and organization illustrated in the four countries. Against the backdrop of these general principles, a model or "ideal type" primary care centre is developed which incorporates a full

discussion of such issues as mandate, goals, objectives, structure, program, tasks, manpower.

The final stage is focused upon the role of social work practice within this model of primary care delivery. The fundamental nature of social work is examined for its compatability with the formulation of a PRIMARY CARE CENTRE, herein presented. Summary recommendations are made regarding a role model for social work practice in such a setting.

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CHAPTER I

ISSUES AND TRENDS IN HEALTH CARE PLANNING AND DELIVERY

The health care industry is one of the most costly and labour intensive enterprises of our time. In 1975, 7.1% of the Canadian gross National Product was spent on health care. 1971 statistics indicate that 5.2% of the labour force or 449,220 Canadians were employed in health related occupations. (Canada: Department of National Health and Welfare, 1976: 41,45). These figures illustrate the critical economic importance of health care in this country.

However, when examined in terms of health outcomes and organizational efficiency, the Canadian system does not fare well. Many reviews of the health system have been conducted in recent years and their conclusions have shown the system to be clearly out of step and ill prepared to deal with current health care needs. Many progressive and far reaching reforms have been recommended, some of which have begun to be implemented.

For the purpose of establishing a broad perspective on the philosophical and organizational development of the health system in this country, an examination of the two theoretical constructs of health and disease will be conducted. The fundamental premise upon which this examination is based is that the traditional health system reflects a _disease_ or _treatment_ orientation while the contemporary recommendations for reform reflect a _health_ orientation.

A. Health and Disease

Each of these concepts has been defined in many different ways. Some definitions are very limited while others are broad and comprehensive.

The definitions of health and disease which come to be accepted by key decision makers have a significant influence on the philosophical orientation of a health care system. This influence is reflected in all aspects of the systems' operation: planning, delivery, management and evaluation.

Wilson (1970:3) suggests that health has been traditionally defined by physicians as, "the absence of symptoms" a definition, which he claims, effectively eliminates examination of the well functioning individual. Wilson (1970:4) also offered another formulation. "Health is compensated illness." This definition implies a weak and somewhat negative perception of the human condition. People are viewed as fundamentally ill and when they achieve health, this represents a conquering of the incursions of disease.

Illich (1975:167) offers a definition of health which focuses on adaptation ,

> Health designates a process of adaptation. It is not the result of instinct but of autonomous yet culturally shaped reaction to socially created reality.

Illich introduces the notion of personal responsibility for the state of one's fundamental existence. His definition shows an understanding of the cultural and social variables that impinge upon ones' ability to be and to stay healthy.

The 1958 World Health Organization definition of health provides the broadest parameters of any of the previous definitions.

> Health is a state of complete physical, mental and social well being, and not merely, the absence of disease or infirmity. (United Nations, 1958: preamble)

R.H. Davis (1975:1) claims the W.H.O. definition is not readily operational and suggests that any definition of health is of limited value

unless it clearly suggests ways that health can be measured or evaluated. Davis defines health as,

> the maintenance of a dynamic equilibrium between man and his environment.

He contends that this definition not only incorporates the essence of the W.H.O. definition but also makes possible:

> i the assessment of the ability of an individual to rally in response to insults (physical, chemical, psychological, social): and
>
> ii the measurement of health by observation or experimentation in the same ways as classical studies of specific physical functions have occurred.

Wilson (1970:5) suggests that health can be viewed as "a state of normalcy", when normalcy is defined in one of the following ways:

> i the most frequently occurring state of health
>
> ii a specific model of wellness
>
> iii a condition of moderately effective functioning that shows no serious disabling features.

Harriet Bartlett (1961:33), a prominent writer in medical social work agrees with the latter view of normalcy and suggests a link between health and overall effective functioning.

> Health can be defined in terms of ability to function to full capacity in all roles and relationships whereas illness characteristically produces diminished capacity for social functioning.

This incapacity to fully perform social roles is the feature which distinguishes the concept of illness from the concept of disease according to Berkanovic, Reeder, Marcus and Schwartz. (1974:2)

> Disease is the province of the science of medicine. It is diagnosed and treated by technical experts applying scientific criteria. Disease is what physicians are technically trained to treat. Illness on the other hand is a social phenomena. People are defined as ill

> by their friends or family when their behavior conforms to socially determined and recognized expectations of how ill people behave.

Davis (1975:5) developed a classification system for ill health which distinguished three, instead of two categories, as suggested above.

His system classified ill health according to:

i aetiology - the cause of the disturbance;
ii pathology - the structural changes in the individual; or
iii illness - the way in which the individual finds he/she is affected (signs & symptoms).

The health systems of most Western world countries have developed as though the classification category, pathology, was the most relevant.

B. Orientation of the Traditional Health Delivery System

The orientation towards pathology, just discussed, has resulted in a significant overemphasis on the physical manifestations of ill health and a serious underemphasis on the epidemiological basis and the collective (physical, social and emotional) human response to health and disease factors. Thus, health personnel (physicians, nurses, planners, administrators, et cetera) have adopted work attitudes and habits which reflect a preoccupation with pathology and treatment.

Berkanovic et al (1974:2) provide an interesting comparison between two health care philosophies and their respective priorities for action;

> The disease control model implies that the primary function of the health care delivery system is to provide technically high quality facilities and personnel to which patients may come for disease management. The patient care model, on the other hand, implies that health care delivery systems should also reach out to the community of potential patients and provide them with a range of services beyond those required for disease management.

The data in Table 1 helps to substantiate the assertion that the disease control model predominates in this country. Almost ninety per cent

of total national health expenditures in 1971 were devoted to curative or disease management aspects of the health system. If one cautiously considers the expenditures made to government public health activities, voluntary health organizations and the category, other health expenditures, as representing the commitment to health promotion, outreach, and other aspects of the patient care model, the total is a meagre 14.6%.[1]

From this analysis of expenditures, the disease control orientation of the Canadian health system is abundantly clear.

There is reason to suggest that the continuation of the disease control orientation is due, in large part, to the value orientations and vested interests of those with authority and influence in the health system. (Geiger, 1975)

Initially, the control of health care institutions in North America belonged almost exclusively to benevolent societies or wealthy philanthropists. Subsequently much of the control fell to members of the medical profession. Physicians have made significant personal and financial investments in the development and maintenance of the current health delivery structure. Furthermore, they stand to earn substantially more income in a system designed around disease control objectives than in one oriented towards health promotion. Therefore, they can be expected to challenge and have opposed reforms which suggest a fundamental reorientation of the system.

Any discussion of the need for change in the health system must recognize the total context into which that change must be introduced. In most cases where a shift towards positive health and primary care is the espoused purpose of reform, major organizational changes and inter-organizational linkages are advocated to bring this about.

Estimated National Health Expenditures, Canada: Distribution by Category of Expenditure (Percentage of Total

Categories	1965	1966	1967	1968	1969	1970	1971
Hospital Care[a]	45.3	45.9	46.9	47.9	48.6	48.8	47.7
Nursing-home Care	2.5	2.5	2.6	2.6	2.7	2.8	2.8
Total Institutional Care	47.9	48.4	49.6	59.5	51.3	51.7	50.5
Physicians' Services	16.9	16.6	16.8	17.0	17.5	17.8	18.7
Dentists' Services	5.0	4.8	4.6	4.6	4.7	4.5	4.5
Other Professional Services[b]	2.3	2.0	2.0	2.0	2.0	2.0	1.8
Total Professional Services[c]	24.1	23.5	23.4	23.6	24.2	24.3	25.0
Drugs and Appliances[d]	14.2	13.8	13.7	13.4	12.9	13.0	13.2
Total Personal Health Care	86.2	85.7	86.7	87.5	88.4	89.0	88.8
Cost of Prepayment & Administration	2.2	2.0	1.5	1.7	1.3	1.5	1.8
Government Public Health Activities	3.6	3.9	3.6	3.1	3.3	3.2	3.1
Voluntary Health Organizations	0.4	0.3	0.3	0.3	0.3	0.3	0.3
Research	0.8	0.9	1.0	1.0	1.1	1.0	1.0
Medical Facility Construction	6.8	7.2	6.9	6.4	5.5	5.0	5.1
Total Other Health Expenditures	13.8	14.3	13.3	12.5	11.6	11.0	11.2
Total National Health Expenditures[e]	100.0	100.0	100.0	100.0	100.0	100.0	100.0

a: includes general and allied special hospitals, mental hospitals, tuberculoses sanatoria, and federal hospitals
b: includes chiropractors, naturopaths, osteopaths, podiatrists, physiotherapists, and private duty and Victorian Order nurses
c: Expenditures relating to professionals employed in various institutions are included in institutional care
d: Includes prescribed and non-prescribed drugs, eyeglasses from optometrists, hearing aids and parts, and other prostheses.
e: The dollar values of total expenditures are shown in Table II.1.
Source: Health and Welfare Canada, Health Programs Branch, Health Economics and Statistics Division, "National Health Expenditures in Canada 1960 - 1970".

The early charitable health facilities were administered according to the regulations determined by their benefactors. There was no centralized authority for overall planning, standardization, or monitoring of health services rendered by these facilities.

> The retention of self government by thousands of health care facilities has impeded the co-ordination and integration of services by central authorities. (Science Council of Canada, 1974:19)

A change in the philosophical orientation of the health system is not enough. Improved mechanisms for co-ordination and accountability are also necessary if overall system reform is to occur.

Research and manpower development are other areas which require attention in connection with the reform thrust.

H. Rocke Robertson (1973) defined health care research as the area of study directed towards,

> the quality of health care; the prevention of illness and the promotion of health including studies of the environment; the people engaged in health care; the organization of management and facilities; the demands for service, and finally the part of socio-economic research that is closely related to health matters.

Although this definition of health care research is reasonably comprehensive, the apportioning of research funds is not. Marc Lalonde, the Minister of National Health and Welfare noted the inordinate skewing of health care research. (1973:304)

> It cannot be denied that if one examines the spectrum of health research beginning at molecular biology and going through to research on the organization of health care delivery systems, the bulk of the research effort to date has been concentrated in that half of the spectrum beginning with basic biomedical research.

This emphasis in health care research has resulted in a steady and continuing demand from treatment facilities for the most sophisticated technology and the most highly specialized personnel. This is reflected in the obvious preeminence of physicians in the health system.

Change in the organization or policy of a health institution most often occur in response to physicians' needs. Increasingly, lay administrators are assuming responsibility for the management of health care facilities. However, most administrators are more than casually influenced by physicians' opinions in making management decisions.

Physicians essentially control the entrance and exit of patients to and from health facilities (i.e., hospitals, personal care homes, mental health centres). They develop the overall care or treatment plan for each patient and assign responsibilities related to that plan for other health workers to fulfill.

An example of physicians' strong influence on the definition of health manpower roles is provided by medical social work.

C. Medical Social Work

The first officially recognized example of social work in a health setting occurred in 1905, when Dr. Richard Cabot introduced a social worker into the Massachusetts General Hospital in Boston. The first social service department in a Canadian hospital (i.e. the Montreal General Hospital, 1910) was also developed due to the initiative of physicians. The historical record indicates that these physicians were not motivated by an understanding of the purposes and skills of social workers, but, rather, based their actions on a perception of certain gaps in medical care which they felt could be dealt with by some allied health worker.

> The overburdened physicians needed a helper to visit the patient's home, and to look into his economic situation, to enter into his state of mind and to comprehend or to influence the many sided psychic, domestic, and industrial environment which is often a large part of what ails the patient and moreover, a necessary avenue to his cure. (Goldstine, 1954:7)

The influence of physicians in the development of medical social work is in evidence in the journal writings from the early 1900's to 1930. Few social workers made any journal contributions during this period. Interestingly, the physicians who wrote about the role of medical social work consistently emphasized the community and public health functions a social worker should undertake, an idea not unlike the contemporary concern for the patient/client in his total social environment.

As social workers themselves began to write about their practice experiences in health settings, (1930-1955) there was an obvious shift towards,

> the interpretation of social components of disease and the activities of medical social work in relation to them. (Goldstine, 1954:11)

Harriet Bartlett (1940:25) suggests that this preoccupation among medical social workers occurred because,

> There is a certain brilliancy and fascination about the medical program which may lure the social worker away from his/her own sphere.

At this time, social workers in general, appeared content to accept having their role conditionally defined in terms of the requirements of the dominant profession in their particular setting.

> Social casework thus accepts a specific definition of its function as related to that of other professions with which it is working and also the limitations of time and circumstance which are unavoidably associated with such joint endeavours. (Bartlett, 1940:27)

From 1940 to 1950, medical social workers were clearly oriented towards a crisis casework approach to practice. Most social work was for the purpose of assisting people to "adjust" to their health circumstances.

Several papers written on medical social work with ill or handicapped patients (Elledge, 1963; Grant, 1944: Abrams, 1951; Miller, 1951; Maginnis, 1951: Wilson, 1950) showed a common theme of patient or family stress due to a debilitating health condition and a common social work response of "adjustment" counselling through the casework relationship.

Zofia Butrym (1967:40) claims that these examples of medical social work illustrate how the field developed in line with the larger health system's orientation towards disease control and treatment. By viewing sickness as a crisis, the key issues requiring intervention by medical social workers then became:

i the loss or threat of loss of various kinds, or
ii the acceptance of the medical reality.

The Oslen and Oslen study of Role Expectations of Social Workers in Medical Settings (1967), illustrated that, although social workers and physicians were in agreement on only four of fifteen items which described the possible scope of medical social work[2], those four were clearly residual, "hand maiden" functions.

Social workers have been less than aggressive about establishing a distinctive role for themselves in the health field. William Rushing's study on the psychiatric professions, (1964) illustrated how weakly institutionalized or established is the social work role in health care settings. Social workers were found to be heavily dependent upon psychiatrists for the determination of their role and for the provision of rewards and praise. At the same time, most social workers appeared tremendously dissatisfied with the limited role definition they perceived psychi-

atrists to be conferring on them.

Traditionally, social workers have remained painfully silent in resolving such role dilemmas. They have obligingly accepted a continued state of role dissonance. Such passivity within the social work profession is typical but unjustifiable.

In the field of medical social work, there is an urgent need to clarify and establish an appropriate role description. Undoubtedly, medical social work will continue to be delivered in institutional health settings to a significant extent. To assist in the delivery of more effective and relevant services, medical social workers must achieve a more firmly established and autonomous role in the setting and must also expand their practice methods.

Furthermore, the social work profession now has an opportunity to become a part of the community and primary health care network. Major reforms in terms of health care priorities and organization are being recommended. Given the obvious relationship between behavioural/lifestyle issues and health status, the social science professions should be expected and required to make a significant contribution to the design and delivery of new and effective "health" services within a reorganized delivery system.

D. Current Health Care Trends

Many studies and recommendations have been conducted in the 1970's regarding needed change in the Canadian health care delivery system.

The chief motivating factor for many of these studies was economic. Mounting concern was being expressed at both the federal and provincial levels of government over the spiralling costs of health care and the seeming inability of the current organizational arrangements to contain

those costs. Several commissions and task forces conducted extensive examination of these issues and made many far reaching recommendations.[3]

Regardless of the indicators considered (e.g., aggregate amount spent on health care, the rate of increase in that amount, the amount spent per capita, or percent of the gross national product spent on health care), the reports essentially arrived at the same conclusion: Canadian health costs rank among the highest in the world.

The reports share other fundamental concerns, (in addition to that of cost) about the state of the health care industry in Canada. Three broad problem areas were discussed to some extent in each of them.

The first is the technology of health care. Tremendous expansion and sophistication of medical technology has occurred in recent decades. Knowledge regarding the nature and course of specific diseases has increased and improvements in the technical efficiency of treatment procedures are constantly being made. In spite of these technological advancements,

> the life expectancy for an average 20 year old male has increased by only 2.2 years since 1941. (Lalonde, 1974:19)

As yet, medical technology has not mastered the cure for many chronic and acute diseases. Furthermore, it has barely touched upon the field of positive health maintenance and the promotion of health. A shift in the priorities of medical technology is required to more effectively address the problems of the day.

There has been a notable shift in the major causes of ill health and death in recent decades. Diseases of choice or lifestype (e.g., lung cancer, traffic accidents, cardio vascular disease) account for the largest amount of the morbidity and mortality in this country. (See Appendix A)

By in large, these conditions are preventable. However, the health care system shows little evidence that it is prepared to deal with them in any way but its established pattern of crisis intervention and treatment.

The reports, previously cited, conclude that the health delivery system could benefit significantly from improvements in primary and ambulatory care services.

> 80 - 90% of health care demand involves only the primary care level for which no complex facilities are necessary. (Quebec, Report of the Commission of Inquiry, 1970)

They also suggest the need for aggressive action in the areas of health education and environmental health protection. These issues represent critical starting points for reform in the health system.

A second major problem in the system is the organization and management of health care delivery. The realities of fragmentation, duplication, discontinuity, inaccessibility, inefficiency, and ineffectiveness of service bear witness to the general disorganization of the system. The health reports of the 1970's unanimously propose the strategies of service integration and decentralization to address these system maladies.

> On the organizational side, these proposed (district health system) reforms should reduce fragmentation, for the main route to lowered costs, and the expanded services lowered costs make possible, is via the reintegration of a scattered service. (Manitoba, White Paper, 1972:51)

In the document, Health Security for British Columbians, Richard Foulkes, the principal author, makes the following assertion,

> The proposed new system will provide for the decentralization of services wherever appropriate so as to improve accessibility, the personalized nature of the service, and therefore, the overall quality. (Foulkes, 1973: III-4-1 to III-4-2)

The reports suggest that improving the coherence in the health system can be anticipated, if these strategies are implemented. Nevertheless, all of the reports emphasize the need to evaluate and monitor the effect of these strategies in order to ensure that the change which occurs, does in fact represent improvement.[4]

In the event that more internal integration and efficiency is achieved in the health delivery system, experimentation with varied management techniques can be expected. For example, several health care facilities may choose to employ and share the services of common administrative staff. Several human service agencies may decide to develop a comprehensive information system for the purposes of monitoring service duplication and fragmentation and of establishing a data base for long range planning.

Consumer participation is a third issue which is discussed in all of the reports. As the health system has become increasingly professionalized, consumers have not had sufficient opportunity to influence the type or manner of delivery of services they receive. Patients often find the system dehumanizing and unresponsive to their needs and yet see themselves as powerless to affect change. The recommendations for increased consumer involvement in the health delivery system are made in order to change this situation.

Bill 65, An Act respecting Health and Social Services, enacted by the Quebec Government in 1971, devotes numerous clauses to ensuring citizen participation both formally, through membership on regional council and local health facility boards, and informally, through public information meetings.[5]

Several arguments can be offered in defence of consumer participation. By virtue of their roles as citizens and service recipients, local

residents/consumers can make an essential contribution to the planning process in terms of identifying community needs and priorities.

A second benefit from consumer involvement is the improvement of patient-provider relationships. When consumers are aware of their rights and their responsibility to ask questions and to participate in their own care plan, the possibility for more effective health outcomes is greatly enhanced.

Finally, the experience of participation itself can be highly educational for consumers. By involving themselves in the processes of the health care system, they can expand their knowledge of the workings of their government, their health facility, and their own bodies.

> Equal in importance to the contribution that consumers can make to the health planning enterprise is the valuable educational effects that these activities have on the consumer himself ,...Health planning is an enterprise in which each individual and each group can certainly learn from the other. (Wells, 1970: 2135)

Undoubtedly, the strategies proposed to reform the identified system deficiencies will be difficult to implement given the entrenched realities of the current delivery system.

It should come as no surprise that many professional associations representing physicians, nurses, and other health care providers have officially responded to the recommendations for system change with reserve and caution.[6] These recommendations challenge the status quo and thus, pose a threat to professionals who have made significant investments in the development and maintenance of the system which is under criticism. However, for social work, these recommendations suggest a whole new field of practice which is virtually unexplored. The potentialities which these proposed alternations in the health system offer to the development of

social work practice are both progressive and challenging.

Summary

This chapter has examined the concepts of health and disease for their influence on the philosphical basis of the health delivery system. A brief review of the evolution of the health system was conducted which clearly established the predominance of the disease control orientation in the system. The influence of this orientation was duly noted in a discussion of the development of medical social work. Finally, an indication was given of the current interest in health system re-orientation and re-organization.

The next chapter will focus on the primary level of care within the health system. The nature of primary care will be discussed conceptually, followed by a review of the recent health system reform experiences in the United States, Great Britain, Sweden and Canada.

CHAPTER I

FOOTNOTES

1. The breakdown of health care expenditures for the Province of Manitoba provides even stronger evidence of the predominant curative orientation of the health system.

Health Care Percentage Expenditures for the Year 1975 for the Province of Manitoba

Hospitals	63.2%
Medical	19.1%
Personal Care Homes	12.9%
Administration	2.1%
Pharmacare	1.2%
Ambulance	.3%
Other	1.2%
Total	100.0%

Source: Manitoba Health Service Commission Annual Report (1975:37)

2. The four items on which physicians and social workers were in agreement were:

   i co-ordinating services for the patient,

   ii deciding on post hospital care for patients,

   iii arranging for post hospital care of patients in some other community institution, and

   iv arranging for post hospital care for patients in their own homes. (Oslen and Oslen, 1967)

3. The analysis of health cost issues formed a major component of the following reports: White Paper on Health Policy, Province of Manitoba, July, 1972: Patterns of Growth, 7th Annual Review of the Economic Council of Canada, 1970; "Health Care in Canada", a supplementary paper by H.R. Robertson to the Science Council of Canada Background Study Number 29,

1974. Cost issues were also addressed, but less extensively, in the _Report of the Commission of Inquiry on Health and Social Services_, Government of Quebec, 1970; _Health Security for British Columbians_, Province of British Columbia, 1973; _Report of the Health Planning Task Force_, Toronto, Ontario, 1974; and the _Report of the National Committee on the Community Health Centre in Canada_, Ottawa, Canada, 1972.

4. One third of the recommendations of the _Science Council of Canada Report Number 22_, referred to the need of improving our capacity to research and evaluate service delivery approaches.

5. See clauses 20, 50-55, and 89 in Bill 65, _An Act respecting Health and Social Services_, Province of Quebec (Queen's Printer, 1971).

6. See "Health Care in Manitoba as of today and tomorrow", a paper by the Manitoba Medical Association, Winnipeg, February, 1973.

CHAPTER II

A REVIEW OF PRIMARY CARE

A. The Concept of Primary Care

Primary care is a term which first began to appear in the health care literature in the mid 1960's when the deficiencies of the health system were finally coming under serious examination. Health care reformers were generally concerned about the inappropriateness of the disease control orientation in the face of its having to deal with a large number of preventable conditions. Proposals for the reorganization and reemphasis of the system consistently suggested that the primary level of care be the area in which to concentrate the efforts for reform.

Primary care does not refer to any specific category of disease or any particular treatment response. Instead it describes a level of service which is oriented towards,

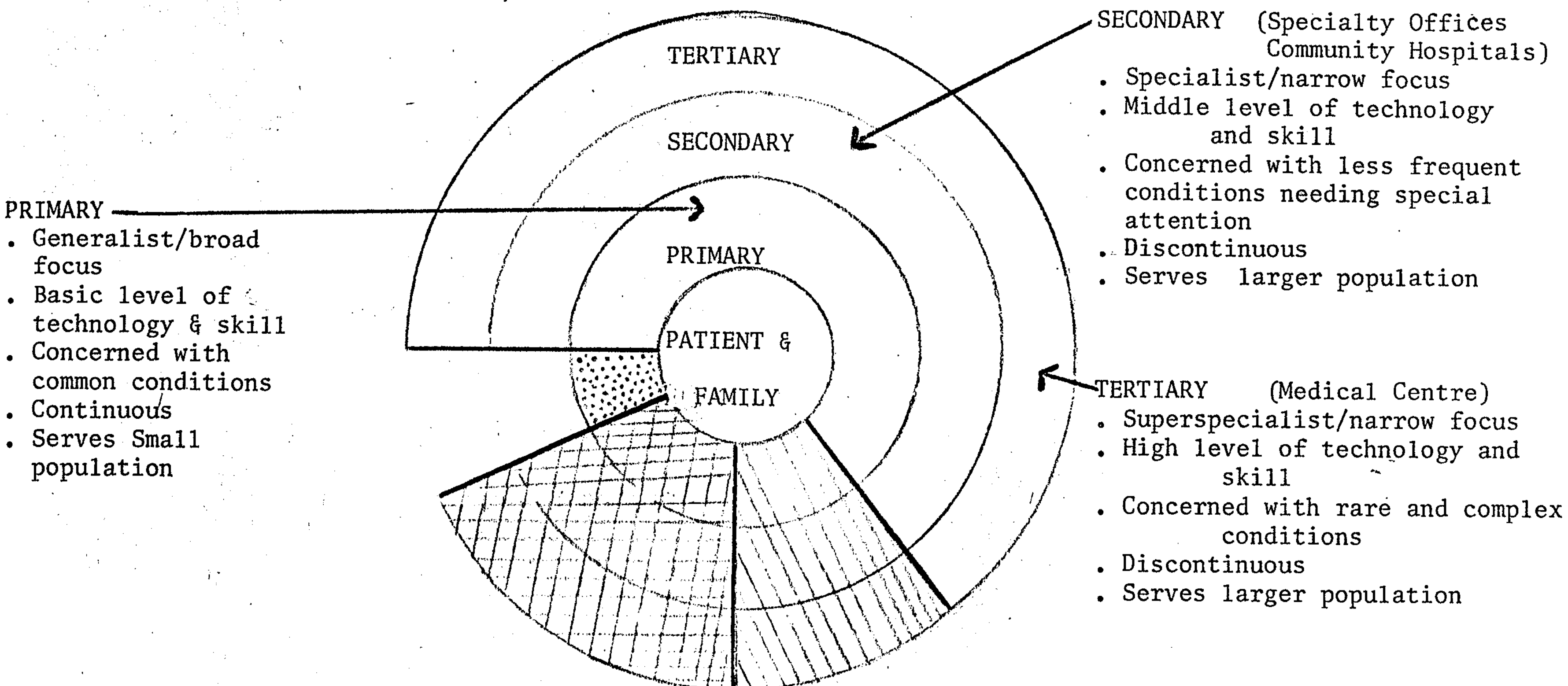
> caring for and caring about patients when they first approach the health services system or formally participate in the process of medical care. (White, 1967: 848)

A diagramatic model developed by Dr. A. Parker provides a context in which to visualize the personal health service system from which the patient may potentially require service. (See figure 1). Parker (1973:6) describes the personal health care system as that set of services which,

> help an individual in the context of his family and community keep healthy, get well or learn to live with a disability (Parker, 1973:6)

The Parker model assists in clarifying the three levels of care within the

PERSONAL HEALTH CARE SYSTEM - LEVELS OF CARE



PRESENT SUBSYSTEMS

Medical Care

Mental Health Care

Dental Care

Optometry

Source: Parker, A., The Dimensions of Primary Care - Blueprints for Change. (Sun Valley Forum on National Health, 1973) p. 8

personal health care system by providing a brief comparative description of each level.

Primary care services constitute the majority of health services rendered to patients and are normally provided in response to common, relatively uncomplicated conditions. However, the problems presented at the primary care level are highly varied and the services required to deal with them may be preventive, diagnostic, therapeutic, or rehabilitative. Thus, the health manpower who deliver primary care services will require generalist skills in all of these basic areas. A primary care delivery unit will normally serve a reasonably small population and will regard continuity of patient care and individual case management as critically important aspects of its operation.

The secondary level of care is normally regarded as either ambulatory care of a specialized nature or inpatient care in community hospital or related facility. A secondary care unit will serve a larger population base and will usually receive referrals from several primary care units.

The tertiary level of care is one in which highly sophisticated services are provided to patients with complex and serious conditions. Parker (1973:10) suggests that a facility such as a university hospital can handle the tertiary health care needs of one million people.

Dr. Leo A. Kaprio, W.H.O. Regional Director for Europe (W.H.O. Chronicle, 1971:567) stresses the need to assign the function of continuing case management to the primary care level. He points out that some patients may sometimes require more specialized levels of care and, when needed, these services must be accessible and of high quality. However, under most circumstances, patients will return to their homes and families and will continue to require periodic health monitoring and basic services

which should be rendered by primary care practitioners.

In addition to the management and coordination function, Dr. Parker (1973:14-15) suggests three additional task categories which belong to the primary care level: entry, screening, and routing; provision of basic services; and provision of human support.

This study will define primary care as comprehensive first level health care which incorporates the four features just mentioned and which recognizes health as a complete state of physical, emotional, and social well-being. The implications of viewing primary care in this way are significant. In Chapter III, a model of a primary service centre will be developed in a way which acknowledges the total scope of primary care and establishes organizational and manpower patterns which appropriately reflect that scope.

The phrase primary care, is often used incorrectly but interchangeably with other terms. The differences between these terms require clarification. Ambulatory care describes care which is provided to persons who are ambulant or capable of walking in for service.[1] General practice is a category of physician practice, traditionally delivered by a generalist doctor in a solo or small group arrangement. Services rendered by general practitioners form a significant proportion of total primary care but they still represent only one part. There is a lack of statistical data regarding comprehensive primary care as herein defined. Therefore, in order to provide some indication of trends in primary care, occasional reference will be made to general practice statistics.[2] in the limited reviews of the American, British, Swedish and Canadian health systems which follow.

In recent years, these countries have conducted major reviews of

their health systems. As a result, reforms which place new and special emphasis on the primary level of care are now in the process of being implemented. The health delivery system in each country will be briefly discussed and summarily assessed in terms of the conception of comprehensive primary care.

1. Health Care Delivery in the United States

The political and economic history of the United States has had a significant impact on the way the health system has evolved in that country. The liberal democratic philosophy of the United States encouraged the development of a vast voluntary hospital system. Many of these hospitals were built by means of endowments from wealthy philanthropists. These same people lavished support on highly specialized medical schools and sophisticated research facilities which were usually located in hospital institutions. Therefore, it is not surprising that the hospital and specialist sectors represent the largest components of the American health system.[3]

Although the American health system appears technologically sophisticated, it suffers from a lack of systematic organization. Currently, there is a vast array of public and private agencies involved in health care delivery which are essentially separate and independent. However, there is a growing interest in the United States in expanding the primary level of health service and in developing more coordination within the system at large. This interest may well represent the "thin edge of the wedge" in terms of reorienting the American health care industry.

Americans made some 567,000,000 visits to primary physicians in 1969 (Parker, 1973:23-24). This represents a sizeable investment in

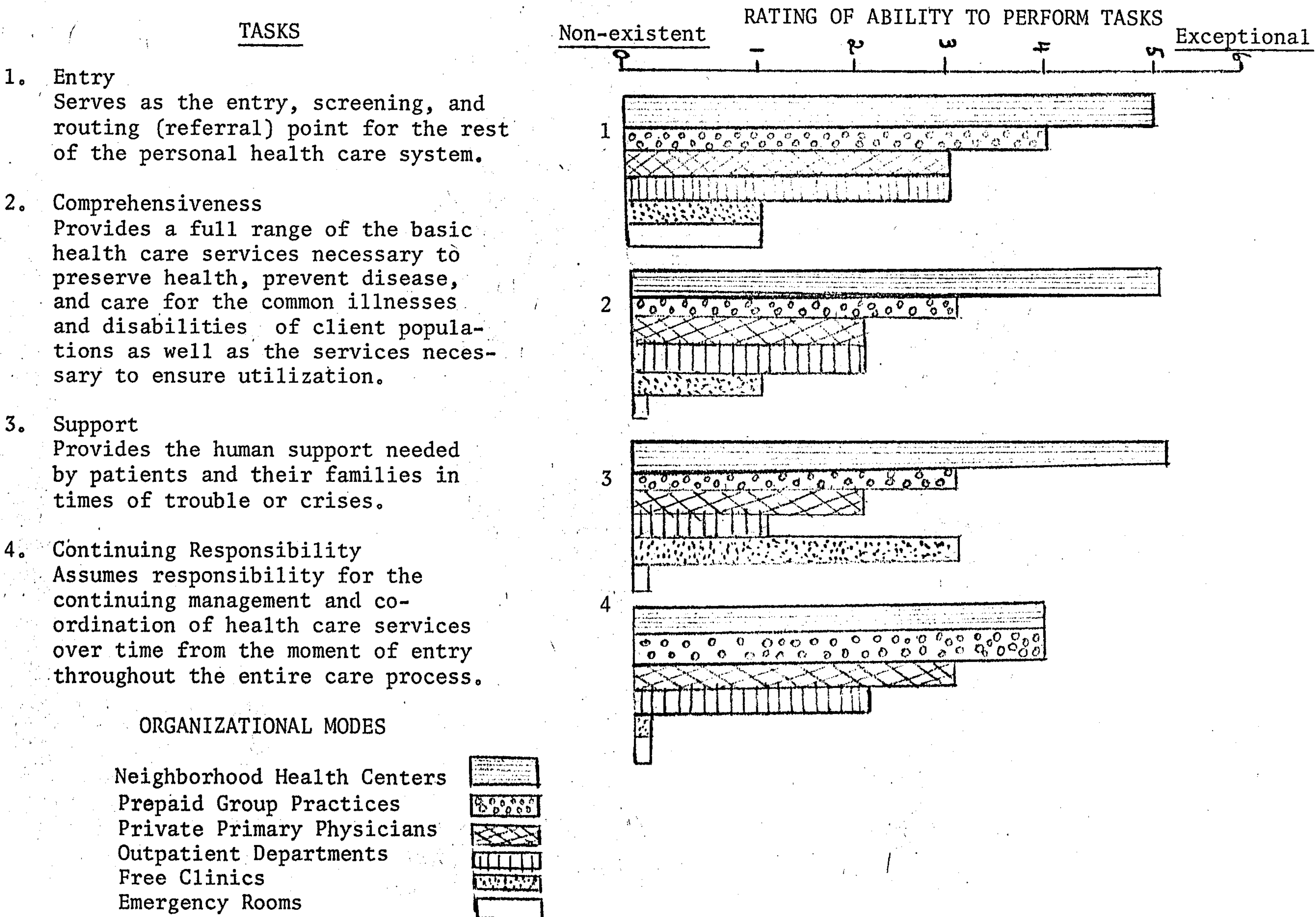
primary care, an investment worthy of more detailed analysis. Eighty percent of those visits were made to private practising physicians while only slightly less than five percent were made to physicians practising in neighborhood health centres and prepaid group practises. A survey of health care providers, particularly knowledgeable in the area of primary care, was conducted in 1973. When the participants were asked to rank various organizational structures according to their perceived capability to deliver each aspect of preimary care, the results indicated that neighborhood health centres and prepaid group practises possess features which are essential to primary care. (Table 2) . One must acknowledge potential reliability problems in a survey which has relied upon the experience and recall of a very small sample. Therefore, the information in Table 2 should be viewed as attitude data which simply represents the opinions of a few persons considered knowledgeable in primary care. However, certain organizational features of these modes of practice are believed, by this author, to make them more capable of delivering primary care and they will constitute the focus of the subsequent discussion.

As early as 1932, when the Report of the Commission on the Cost of Medical Care in the United States, (Medical Care Costs for the American People, 1932) was issued, recommendations were made for comprehensive health centres providing preventive and therapeutic services, under prepayment arrangements. There was no movement in this regard until the Office of Economic Opportunity (O.E.O.), a bureau set up to coordinate the American War on Poverty, began to fund neighborhood health centres in the mid 1960's.

Workers in the Community Action Programs established by O.E.O.,

TABLE 2

RESULTS OF PROVIDER SURVEY RANKING THE ABILITY OF SELECTED ORGANIZATIONAL MODES IN THEIR PERFORMANCE OF PRIMARY CARE TASKS



TASKS

1. Entry
   Serves as the entry, screening, and routing (referral) point for the rest of the personal health care system.

2. Comprehensiveness
   Provides a full range of the basic health care services necessary to preserve health, prevent disease, and care for the common illnesses and disabilities of client populations as well as the services necessary to ensure utilization.

3. Support
   Provides the human support needed by patients and their families in times of trouble or crises.

4. Continuing Responsibility
   Assumes responsibility for the continuing management and co-ordination of health care services over time from the moment of entry throughout the entire care process.

Medians of the ratings by 17 health service professionals, 9 of whom are physicians.

Source: Parker, A., The Dimensions of Primary Care-Blueprints for Change, (Sun Valley Forum on National Health) 1973, P. 27

were the first to stimulate interest in organizing primary health centres. In their education and employment projects, they found that participants were underachieving, largely due to personal or family problems or deficiencies. They were able to persuade the Office of Economic Opportunity that an improvement in the health status of persons living in poverty circumstances would contribute positively to the more general "War on Poverty".

The Office of Economic Opportunity agreed to fund the centres as demonstration projects on the condition that they be evaluated for their impact on the health status of the poor. The official mandate of the neighborhood health centres was outlined in November, 1966. The mandate was,

> to assure (health) services are made readily accessible to residents of such areas (of concentrated poverty), are furnished in a manner most responsive to their needs and with their participation and whenever possible are combined with ...arrangements for providing employment, education, social or other assistance needed by families and individuals being served. (United States, Office of Economic Opportunity, 1966)

The mandate was very broad and flexible. It attempted to give general direction and to accommodate a wide variety of organizational arrangements which might emerge as a result of community participation in the definition of needs. Many project staff saw the health centres as a means by which major reforms in the delivery of health services could be implemented. Accordingly, they proceeded to broaden the objectives of the centres considerably. These objectives ranged from,

> the elimination of poverty, to improving health status, changing the medical care delivery system, to providing jobs and access to services for low income persons. (Elinson and Herr, 1974: 97)

As a result the centres developed markedly different features in terms of structure, scope of service, size, styles of medical practice and governance. Each of the centres tried to employ service strategies that would be particularly relevant in their community.

An excellent example of this is provided by one of the earliest neighborhood health centres, the Tufts Comprehensive Health Action Program in Mount Bayou, Mississippi.

> Instead of personalized prevention services, energies were being expended testing and closing contaminated water wells and drilling new ones in significant numbers. Instead of family oriented social casework, energies were directed to building houses. Instead of diagnostic and curative services, energies were channelled into the organization of a farm co-operative and a food processing plant. (Elinson and Herr, 1970:102)

Most health centres did attempt to deliver the categories of service recommended in the Department of Health, Education, and Welfare publication, "A Conceptual Model for Organized Primary Care and Comprehensive Health Services". (1970)

i	primary medical care	- (family practice physicians, internists, pediatricians[4], physician "surrogates")
ii	nursing care	- (registered, public health or visiting nurse, licensed practical or vocational nurses, nurse's aide, home help/aide)
iii	health outreach and social advocacy	- (some of the above plus a social worker, patient advocate)

Virtually all neighborhood health centres employed and trained local community residents to undertake various primary care activities related to nursing care, outreach, and social advocacy. The family health worker

model developed at the Martin Luther King Junior Health Centre in New York has become the prototype for community worker roles in many other centres (See Appendix B for the job description of a Family Health Worker).

While staffing guidelines have been developed for neighborhood health centres, no such guidelines exist for the organizational design of the centres. Nevertheless, an overwhelming majority of the centres chose to organize their staff in teams. Recent research on the organization of family health care concluded that the interdisciplinary team approach was the most feasible method for delivering this type of care. (Beloff and Weinerman, 1967:383-389). Krohn (1972:69) suggests in his analysis of the community health centre experience in the United States that most teams in the health centres are organized on lateral and functional lines. He comments that,

> increasing emphasis on team work in the provision of health care indicates a movement away from traditional notions of line and staff relations.

The prepaid group practices in the United States provide a contrast to neighborhood health centres in terms of the delivery of primary care services. There are many types of prepaid group practices but the one chosen for examination here is the Health Maintenance Organization, (hereafter referred to as the H.M.O.). H.M.O.'s are a relatively recent innovation in the American health scene and have received support from certain American politicians, (notably Richard Nixon and Edward Kennedy) as a desirable mechanism for the delivery of health services. Although they vary in many respects, H.M.O.'s do share one common feature - the

delivery of primary medical care to a defined population by means of some prepayment mechanism. H.M.O.'s are normally of two main types, the prepaid closed panel group practise or the fee-for-service foundation practise. Under the first arrangement, the enrolled population must seek care only from the group practise to which prepayment has been made. Under the second, the enrolled population is free to choose any physician they wish and then submit their bill to the foundation for reimbursement according to the foundation's fee schedule. The latter type of H.M.O. is the preferred option of many physicians who see it as insuring payment for services while retaining complete freedom of choice for the consumer.

It has been suggested that <u>prepayment</u> is the most critical factor to be addressed in the process of reorienting the health system towards preventive and health promotion objectives. However, a recent study (Berkanovic, Reeder, Marcus and Schwartz, 1974:83) conducted in two counties with similar samples of Medicaid recipients, strongly suggests that prepayment alone does not increase the amount of preventive service provided by physicians. One sample received services from private fee-for-service physicians while the other received services from an H.M.O. foundation. The study suggested that the two samples of patients experienced little difference in seeking and receiving preventive medical services. For instance, the maternity services (pre and post natal) and the mental health services were the same under both of the delivery arrangements.

The foundation H.M.O. provides a financial guarantee for coverage of primary medical services. However, it offers no real advantages over the private fee-for-service arrangement, in terms of expanding or integrating comprehensive primary care,

Perhaps one of the reasons why prepayment had so little

> impact on the experience of medical care lies in the fact that prepayment merely rearranges certain economic factors within the present private business system of medical practice...the ultimate question is; Can social needs ever be fully met in a situation where the technical means for meeting those needs are under private control. (Berkanovic, Reeder, Marcus and Schwartz, 1974:87)

The prepaid group practice H.M.O. has potential advantages over the foundation H.M.O. in being able to deliver a more comprehensive package of primary care services. Because most prepaid group practises provide a full range of medical services, from home care to specialist services through a single delivery source, the opportunity for coordinated and continuous health care is increased.

Two of the more widely known prepaid group practice H.M.O.'s are the Group Health Cooperative of Puget Sound in Seattle and the Kaiser-Permanente programs in California, Colorado, Ohio, Hawaii and Oregon. These programs illustrate the advantages for continuity of care offered by a group practice. They attempt to provide comprehensive health care to their members through the use of their own facilities and staff. All primary care and many secondary care services are provided by the group practice to ambulant patients. If a needed medical service cannot be provided from within the group, it is purchased from outside without additional charge to the patient. Both of these group practice programs are closely affiliated with a hospital which is either run by the same board of directors, as the H.M.O. in Seattle or by a sister corporation, as in the Kaiser Foundation Hospitals. Thus, H.M.O. arrangements are able to provide continuous and coordinated physical health services.

One may occasionally find a public health nurse, a social worker, or a community based paraprofessional working in an H.M.O. However, there is significantly less emphasis placed on the importance of these workers'

services, (i.e., preventive health education, social advocacy, outreach, family counselling) in this type of organization than was witnessed in the neighborhood health centres. The major reason for this difference is that H.M.O.'s represent a repayment plan for medical services and are run as corporations or business.

> Stripped of its Nixonian public relations cover, the H.M.O. is a vehicle for corporate managers to move into control of health care. (Neighborhood Health Centres-Health Bulletin)

This approach to organizing health services poses no real threat to the philosophical basis of the current health system. Most H.M.O.'s indirectly encourage the utilization of services and facilities which treat physical problems because it is only these which are insured. While the H.M.O. has shown itself to be an effective organization for the delivery of physical treatment services, it has contributed only marginally to broadening the concept of primary health care, to integrating primary care services, to encouraging consumer involvement in health service design or delivery, or to the creation of a more preventive orientation in the system.

The American health care industry is extremely complex but lacks a sense of uniformity or organization. Primary health care services are delivered through numerous mechanisms. The Neighborhood Health Centres and H.M.O.'s now deliver only a small portion of these services. However, these modes of organization appear to possess certain characteristics which render them more capable of operationalizing primary care in a truly comprehensive way. Clearly neighborhood health centres possess the most potential in this regard.

There is little evidence of interest in massive health system

reorganization among American decision makers. The imminent possibility of a national health insurance scheme will likely influence certain structual features of the system. However, it is likely that innovation in the area of primary care will continue to occur on an intermittent and demonstration project basis in the future as it has in the past.

2. Health Care Delivery in Great Britain

A historical context is required in order to understand the current primary health care situation in Great Britain.

The National Health Service (hereafter abbreviated to N.H.S.) has been referred to as one of the few truly socialist measures implemented by the post World War II Labour government in Great Britain. There were two fundamental objectives underlying the 1946 N.H.S. legislation. The first was a commitment to the provision of medical care without cost in the form of a fee-for-service. The second was a commitment to the nationalization of all hospitals, then owned by local authorities and/or charitable organizations.

The N.H.S. did accomplish these two objectives but several problems ensued. These were related to the highly separate and autonomous organizational structure of the N.H.S. Hospitals and specialist services were provided and financed by the Minister of Health through specially appointed hospital authorities. Thirty-five boards of governors for the main teaching hospitals and fourteen regular hospital boards for the other facilities were appointed. General medical and dental practitioners, pharmacists, and opticians practised independent of the hospitals. Their services were made available through the administrative and financing machinery of one hundred and thirty-four Executive Councils. These Councils

were appointed on an *ad hoc* basis and were totally financed by the Ministry of Health. One hundred and seventy-three local health and welfare authorities had responsibility for a range of public health and social services (e.g., home nursing, health education, social allowance services, welfare homes for handicapped and elderly citizens, et cetera). These authorities were part of the local government structure and were largely financed by local taxes. (Paige and Jones, 1966:14). This autonomous tripartite structure resulted in poor coordination and communication among the branches and generally a low quality of service.

These difficulties were reviewed as early as 1956 by the Guilleband Committee. (Report of the Commission of Inquiry into the Cost of the N.H.S., 1956). However, none of the recommended changes were implemented because the N.H.S. was still felt to be in its "teething period".

Reform in the structure of the N.H.S. did not come about until 1974. Some people viewed the "reorganization" as the beginning of truly comprehensive, integrated health service.

> One of the main benefits of reorganization will be the opportunities offered to sustain and develop the technical advances in medicine and in other fields, allied to a system of multi-disciplinary teams with shared objectives so that interests can become self regulating and coordination simplified. (Palmer, 1975:51)

Others were less optimistic that the new N.H.S. could be truly comprehensive when most of the social services and related welfare resources were retained by the local authorities.

> The separation of health from personal social services...is unfortunate...since it may inhibit rational consideration of all of the alternative means of meeting the socio-medical needs of the frail and the mentally handicapped. (Brown, 1973:82)

However, the designation of coterminous boundaries between local authorities and the comprehensive health care districts did facilitate some degree of coordination.

Several other concerns also contributed to the decision to reorganize the N.H.S. The clinical independence of senior medical staff in hospitals weakened the formal management structure of the hospitals. In addition, there was a general lack of concern for evaluation throughout the system. Finally, there was a need to place a greater emphasis on primary care services at the local level. The reorganization was designed to rectify these problems.

Figure 2 illustrates the reorganized structure of the N.H.S. as of April, 1974. (Hallas, 1975:29) A brief outline of the regional and area levels of responsibility in the N.H.S. will be provided but the remaining discussion will focus on the district level, where the majority of primary care is delivered.

At the regional level, fourteen regional health authorities have replaced the former hospital boards. The new authorities carry most of the responsibilities of the former hospital boards with four additional areas of emphasis. There is significantly more interaction between the regions and the central department. The regional authorities have greater freedom in the distribution of resources once they have been allocated from the department. They have assumed responsibility for overall strategic planning of all health services (community and institutional) in their region. Finally, they carry responsibility for the teaching and research aspects of health care, a function formerly carried out by the boards of governors of teaching hospitals which were, for the most part, dismantled in the reorganization. The regional authorities also coordinate the deployment

of all medical manpower, except general practitioners, throughout the region.

The area tier, like that of the region, is primarily concerned with resource allocation. The ninety area health authorities represent the integration of area hospital management committees and health departments. These area authorities have a significant collaborative role to play with the local authorities which still retain responsibility for personal social services.

The local authorities and the area health authorities share similar boundaries and representatives of the two agencies participate on Joint Consultative Committees which attempt to coordinate their respective plans for new community or institutional services.

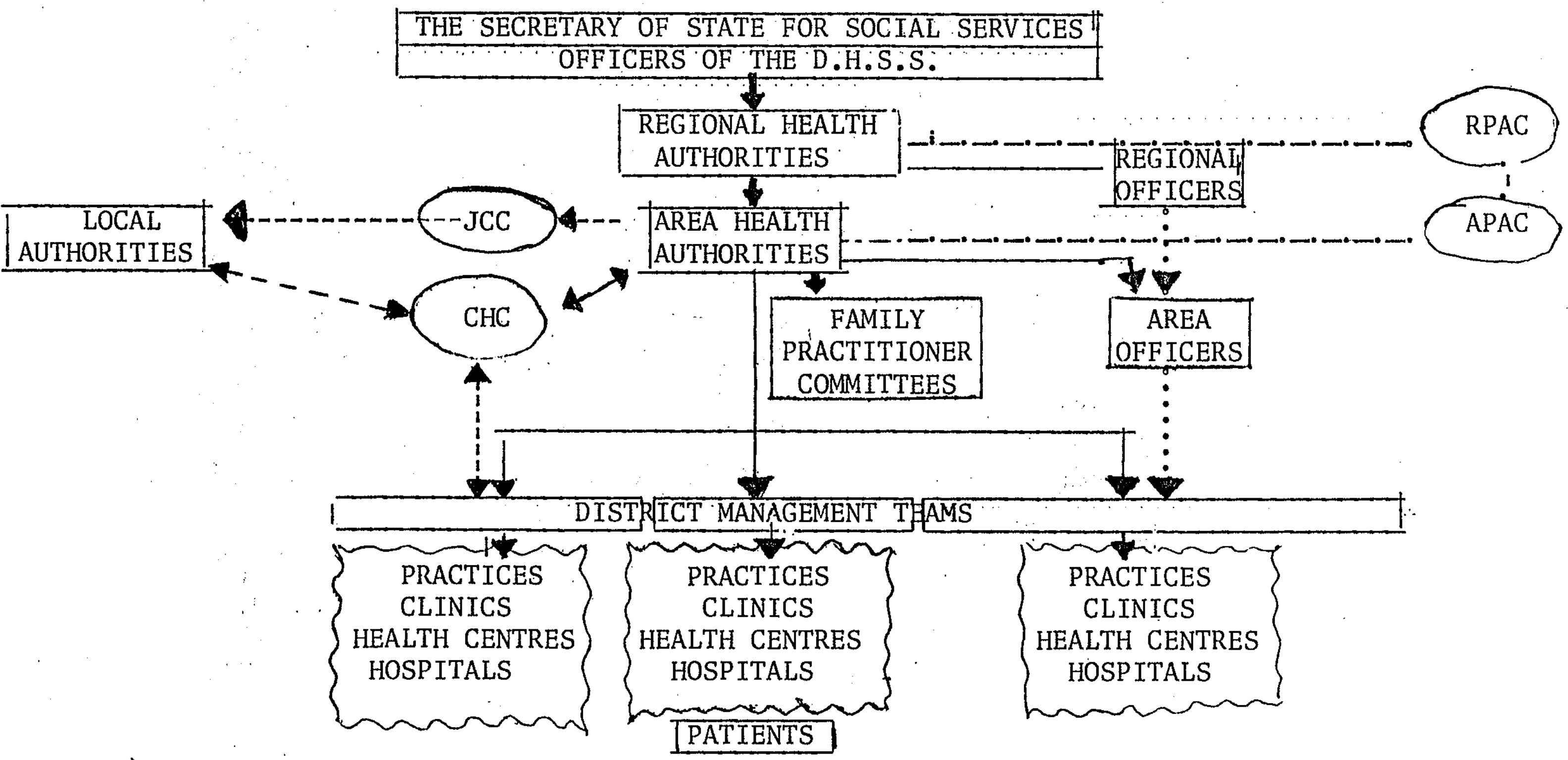
The areas are subdivided into two hundred Comprehensive Health Care Districts, approximately two per area. (Hallas, 1975:37) The intent of the reorganization was to establish districts comprised of 250,000 people. On the basis of this population estimate, each district was estimated to have approximately twenty general practice units and ten comprehensive health centres. The original hope was that the health centres would become the chief source of primary health care for local residents where,

> patients could come to consult their general practitioner in his surgery to have dressings and minor cuts seen to in the treatment room, to have advice and reassurance from the health visitor in the maternity or child welfare clinic. Ideally, social workers would also be based in the clinic. (Hallas, 1975:40)

However, because many primary care clinics and group practises already existed in Great Britain, it was necessary to develop a system which encouraged cooperative working relationships among the many primary care delivery sites. In time, it is expected that a system of comprehensive

FIGURE 2

Reorganized National Health Service (1974)



Corporate accountability as on White Paper
Individual officer accountability and joint team responsibility
Monitoring and coordinaging between teams and individual counterpart officers
Representative systems
External relationships

Key to abbreviated terms:
JCC - Joint Consultative Committees
CHC - Community Health Councils

primary care delivery through local health centres will be the foundation of the N.H.S. Table 3 illustrates the growth in health centre development since 1948.

Table 3

Health Centres (U.K.)

1948 - 1973

Number of Centres:	England	Wales	Scotland	Northern Ireland
Opened before July, 1948	5	5		
Opened July, 1948 - December, 1968	76	8		
Opened July, 1969	50	5		
Opened in 1970	61	8		
Opened in 1971	83	9		
Opened in 1972	94	10		
Total opened as of December 30, 1973	524		51	39
Being built	165		20	11
Approved for Building	56		15	21
Totals	745		86	71
Overall Total			902	

Source: General Practice for Students of Medicine, (R.H. Davis, Academic Press, London, 1975: 47)

The district general hospital is another aspect of the reorganization at the district level. Here a full range of medical specialities and

secondary level institutional care is provided.

The district plan did not develop along uniform lines. As might be expected, population distribution and density play an important role in the designation of district boundaries. Districts in Britain range from a population of 50,000 to 450,000. Understandably, there are also variations in the number of group practises and health centres in each district.

There is a district management team in each of the districts. The team, which is comprised of senior nursing, medical, (both general practise and specialist), finance, and administrative personnel, has the responsibility to set annual health priorities for the district and to consider innovations for the improvement of overall health service delivery. The full extent of the Management Team's responsibilities is described in Appendix C.

As illustrated in Figure 2, a body called the Community Health Council (C.H.C.) provides linkage between the Authorities (local and area) and the District Management Teams. These councils are a new addition to the National Health Service structure. For some, they represent an opportunity to promote real citizen involvement in the highly professionalized N.H.S. Others view them as insignificant tokenism, meant to appease the proponents of "community control".

Draper and Smart (1974) attach the reorganized N.H.S. for its highly centralized decision-making and power retaining structure. They claim that citizens and members of the social science professions have insufficient opportunities to participate in N.H.S. planning.

Malcolm Johnson (1975:85) suggests that Community Health Councils should adopt the following objectives which incorporate the essence of

all the community participation references in the N.H.S. legislation.

(a) To be wholly identified with the consumer of health care across the whole range of human conditions and types and to seek to promote an understanding of their needs and aspirations amongst those who serve them.

(b) To be intolerant of arrangements and uses of resources which serve particular categories of consumers or particular interests of staff to the detriment of other consumer groups.

(c) To actively propogate knowledge about consumer rights in the Health Service.

(d) To be a source of constructive criticism in an informed and creative way.

(e) To be seen as collaborators with the Area Health Authorities and District Management Teams in improving the quality, equity, and sensitivity of care.

(f) To be a countervailing force to the weight of power which is invested in non-elected members and professional staff.

As yet, Community Health Councils have not shown they have truly adopted, let alone fulfilled, these objectives. Additional time and experience is required to establish whether the councils can assist in deprofessionalizing the N.H.S. at the primary care level and in humanizing the service delivery process by means of more aggressive community involvement.

The current system of health service delivery in Great Britain reflects a sincere attempt to emphasize the primary level of care within a reasonably well integrated personal health care system. Although some mechanisms do exist for the coordination of primary medical care and primary public health, mental health, and social services, there are still serious barriers to the true integration of these services. These barriers

include administrative responsibility to different authorities and separate office facilities.

The local health centres traditionally delivered only public health services. However, the new centres illustrate somewhat of a preventive orientation. There is still a general reliance upon medical treatment services throughout the system. However, in summary, the British health system does reflect a sense of movement, however gradual, towards the fulfillment of comprehensive primary care objectives.

3. Health Care Delivery in Sweden

The political history of Sweden has strongly influenced the development of the comprehensive health service system which now exists in that country. The Social Democratic Party has been in power in Sweden for over forty years and one of their political pledges was,

> to enact public measures that would protect all citizens against threats of insecurity and illness. (Andrews, 1973:1370)

The Swedish infant mortality rate of eleven deaths per thousand live births, the lowest rate in the world, is often quoted, as proof of the government's success in this regard. In comparison, the United States' infant mortality rate is eighteen per thousand while Great Britain's is twenty per thousand. (Health Care in Scandanavia, 1975:5) Additional evidence of Sweden's success in terms of mortality rates can be found in Table 4 which provides the lowest age-specific death rates recorded in Western countries. The fact that twenty eight percent of total government expenses are spent on social welfare programs, which include health costs, (Andrews, 1973:137) undoubtedly helps to account for Sweden's positive health profile.

TABLE 4

THE LOWEST AGE-SPECIFIC DEATH RATES
RECORDED IN WESTERN COUNTRIES, LATE 1960s

Age	Country with Lowest Rate	Rate[a]
Under 1	Sweden	12.7
1-4	Sweden	0.7
5-9	Belgium, Denmark, France, Hungary, Sweden, England and Wales, Scotland, Australia, New Zealand, United States	0.4
10-14	Denmark, France, Hungary, Sweden, England and Wales	0.3
15-19	Ireland	0.5
20-24	Denmark, Netherlands, Norway, England and Wales	0.7
25-29	Netherlands, Sweden	0.7
30-34	Norway, Sweden, England and Wales	1.0
35-39	Greece, Netherlands	1.3
40-44	Greece	2.1
45-49	Greece, Sweden	3.3
50-54	Greece	5.1
55-59	Greece, Sweden	8.2
60-64	Greece	13.4
65-69	Norway	23.2
70-74	Greece	36.4
75-79	Albania	59.1
80-84	Albania	75.8
85 & Over	Albania	107.0

Source: Anderson, O. HEALTH CARE: CAN THERE BE EQUITY?, (John Wiley & Sons, New York, 1972 p. 245 Table A40

[a]Excludes countries with less than one million population because of the small number of deaths in some age categories. If it were not for this exclusion Iceland would have the lowest death rate in six categories and the Island of Malta in an additional four categories.

The Swedish health care delivery system has traditionally been focused around the provision of high quality and easily accessible hospital services. A great deal of primary medical care was delivered by hospital based physicians.

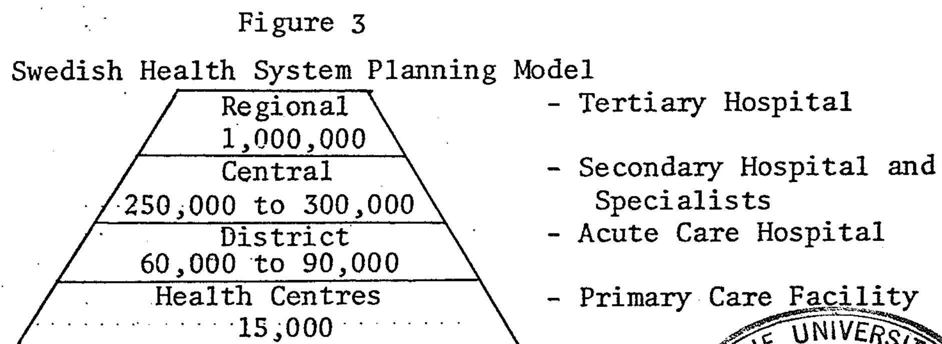
Private general practise developed as a cottage industry in which physicians rendered services from their own homes. However, this form of practise has been steadily declining and most physicians interested in primary care, now work for the government as District Medical Officers. In most rural and isolated areas, the District Medical Officer is usually the only physician available and his/her responsibilities include both primary care and public health.

At the core of the Swedish health system is the regional hospital service. There are six to seven general hospital beds per thousand population in Sweden, almost twice the ratio of the United States. (Berfenstam and Elling, 1975:44)

A common criticism levelled at the Swedish health system is its overdependency on hospital care. (Andrews, 1973: Berfenstan and Elling, 1975). The Swedish government has apparently recognized this problem. Since 1972, it has been attempting to reorient the system towards primary care objectives. An attempt is being made to introduce a more rationally planned health system based on the following pyramidal structure.

Figure 3

Swedish Health System Planning Model



Source: A. Engel, Perspectives in Health Planning, (London, Athelone Press, 1968:19)

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Health centres for the delivery of comprehensive primary care are beginning to develop throughout Sweden. However, there continues to be a reliance upon the sophisticated and specialized levels of care. As a result there are significantly fewer general practise physicians in Sweden[7] than there are specialists.

Swedish people have always had the right to seek services directly from any specialist they wished, without having to be referred by another physician. This is not the case in other countries such as Great Britain and Denmark where the family physician acts as a gatekeeper to other levels of care. Consistent with this reliance upon specialist care, the Swedish health centres have been developing with specialized medical manpower.

The health centre movements in both Great Britain and Sweden have attempted to integrate the various aspects of primary and preventive care. In Great Britain the process has normally seen,

> public health nurses, (family health visitors) and in some cases the public social worker, move into the family doctors office..(in an attempt) to incorporate preventive as well as curative services into the single source system. (Holst and Wagner, 1975:38)

In Sweden, the process has been reversed, with hospital based specialists being deployed into public health centres which provide preventive services.

One can therefore expect to find more highly professionalized primary care centres in Sweden as compared to the community focused centres of Great Britain.

In an effort to recognize the importance of family medicine or general practise, the Swedish government has undertaken several measures to encourage physicians to enter the field. For example, in 1970, the salaries of District Medical Officers (primary care physicians) were placed on a par with those of surgeons. This may reduce the economic

and status differential between generalist and specialist physicians, and induce more physicians to opt for general practise. This is important since one of the goals of the local health centres is the establishment of a family orientation and the improvement of overall continuity of care to individuals and families. This requires generalist primary care physicians through whom comprehensive care can be coordinated.

The Swedish health centres have done very little experimenting with the use of allied health professionals (e.g., family health workers, social workers, nurse practitioners). Social services and education are administratively separate from health services. However, there have been more efforts in recent years to intensify cooperation among the three jurisdictions. Health centre boundaries are similar to those of social welfare agencies and school districts. Various contractual arrangements for cooperative planning and service delivery have been made between authorities in the areas where they have a mutual interest.

The following services are normally delivered by a local health centre: general practise medicine, district nurse, midwifery, and maternity care, child welfare, school health service, tuberculosis clinics, public dental care and ambulance service. Many of these services naturally lend themselves to cooperative planning and delivery by health, social and educational authorities.

Berfenstam and Elling (1975:39) praise the various human service providers for their consistent efforts to cooperate and coordinate their efforts.

> Another characteristic of all primary health centre systems in Scandinavia is their high degree of integration of primary health care and primary social care...The primary health care physician works closely with social ser-

vices in planning for integrated care of
patients with special needs.

One final health reform issue which is just beginning to receive attention in Sweden is consumer participation. As previously discussed, the Swedish health system has developed with a highly professionalized aura. More recently, however, experiments have been undertaken which encourage and evaluate the results of different methods of consumer involvement, (e.g., a medical ombudsman who hears patient's complaints about service, and patient unions which act as pressure groups for health system reform). Nevertheless, these examples are few and, as yet, Swedish citizens do not have a large or effective voice in health affairs. The system continues to be structured so that most authority is retained by the central government level.

To summarize, from 1940 to 1972, the Swedish health system was centred around acute care hospitals. Since 1972, active attempts have been made to develop local health centres throughout the country. Although these health centres deliver some public health and statutory social services, there orientation is predominantly medical. Medical specialists in Sweden outnumber general practitioners and their presence in the health centres has lead to more of a clinical than a preventive emphasis in primary care.

Health, social service, and education authorities are experimenting with coordinated approaches to health planning and delivery. However, these experiments are limited in scope and geographically scattered. Although the process is gradual, there is some evidence that Sweden is moving towards a more comprehensive and integrated system of primary care at the local level.

4. Health Care Delivery in Canada

The Canadian, British, and Swedish health care systems share the common feature of universal hospital and medical insurance coverage. However, unlike the other two systems, the Canadian system does not have national government responsibility for health planning and delivery.

The British North American Act which has served as Canada's constitution for one hundred and ten years, clearly assigns the responsibility for health and social services to the provinces. However, the federal government has been playing an ever increasing role in health affairs since it first began distributing categorical health grants in the 1930's. Committees of the federal government began exploring many social security issues in the 1940's despite the fact that these issues were not officially part of the federal jurisdiction. For instance, the report of the federally appointed Marsh Commission recommended that a national system of insured health benefits be implemented in Canada under provincial administration.

It was not until 1956, after the Province of Saskatchewan had implemented a hospital insurance plan, that the Dominion government moved in this regard by passing the Hospital Insurance and Diagnostic Services Act. The Act provided for 50% cost sharing, (25% of actual and 25% of national per capita expenditures) of approved provincial hospital insurance plans.

The Province of Saskatchewan again led the way in 1962 with the introduction of a publicly insured medical services program. The federal government followed with the Medical Care Act in 1968, which provided for,

federal contributions to the provinces

> based on half of the per capita cost of the insured services of the national program furnished under the plans of all provinces excluding administration, multiplied by the number of insured persons in each province. (Canada, Department of National Health & Welfare, 1975:3)

In order to qualify for cost sharing, the provincial plans have to meet the following criteria: public administration, portability, comprehensive service and universality.

Although the provincial governments are exclusively mandated to design and deliver health and social services, they have become increasingly dependent on the federal government for a considerable proportion of the funding for these services. Therefore, the provinces have a certain obligation to consider the recommendations of federal authorities regarding needed change in the health and social service system. In addition, the fiscal arrangements provided by the federal government describe the boundaries within which provincial health services can be developed if eligibility for cost sharing is to be maintained. Only by not accepting federal contributions can a province design its health system without reference to federal goals and objectives.

Ruderman (1972:III-2) suggests that in economic terms, health services are indivisible.

> The share of national product devoted to the health care sector comes from a single source: (the public). Its allocation among the agencies or functions involved in the health care system ...can be viewed as a single transfer payment. The greater the freedom to allocate funds among the various functions that comprise the total health care system and the greater the emphasis on coordinated planning for the system as a whole, the greater is the probability of achieving the most rational use of resources.

Wolfe and Badgley (1973:168) comment that health services must be seen as indivisible, from a planning perspective as well.

> Governments in the United States and Canada, in particular, at the federal and state and provincial levels...have talked increasingly about the desirability of organizational change in medical practise. Yet, simultaneously they have failed to create the reorganization of their own archaic departmental structures that could lead to realistic integration and coordination of preventive and curative services for physical, social, and psychological disorders.

Since the early 1970's, there has been much discussion regarding needed change in the Canadian health system. Many jurisdictions have undertaken studies to identify deficiencies and propose avenues of reform.

During the last five years, the federal government has published two major health reform documents, the Report of the National Committee on the Community Health Centre in Canada, 1972, and A New Perspective on the Health of Canadians, 1974. The objects and purposes of the National Committee on Community Health Centres (Hastings Committee) is provided in Appendix D. This Report stimulated much of the subsequent examination of current health system priorities and the organization of health services. The Report explored the concept and reality of "Community Health Centres" in Canada, for the purpose of establishing their strengths in terms of cost reduction, efficiency, effectiveness, and community responsiveness.

The New Perspective on the Health of Canadians provided a broader analysis of the health system through the use of the "health field" concept. The four components of the health field: human biology,environment, life-style, and health care organization, were discussed and numerous recommendations were made concerning needed change in all four areas. The recommendations, especially in the area of health care organization,

reinforced much of what had been proposed by the Hastings Committee.

These two federal reports were by in large informational and hortatory. They were written for the purpose of initiating discussion in many sectors of the country with the hope that some of the "insights" offered would be incorporated into provincial health planning and policy. Extensive discussion has followed upon their publication and some provinces have implemented policies which reflect the influence of the federal recommendations.

Four provinces produced their own health systems reports during this same period. (Quebec, 1970; Manitoba, 1972; British Columbia, 1973; and Ontario, 1974). There was a remarkable degree of similarity among these reports in terms of their analysis of the current health system and their solutions for reform. However, the impact of each report in its respective jurisdiction has been distinctly varied. Four system issues consistently emerge in each of the reports: cost, unequal distribution, specialization/professionalization, and the preoccupation with treatment services.

Much concern is being expressed over the steadily increasing costs of health care services. Two areas where significant waste occurs are: (i) the excessive utilization of high cost treatment facilities, and (ii) the unnecessary duplication of services. In a speech delivered in 1972, the then Minister of Health and Welfare, John Munroe, made this telling observation:

> There is scandalous waste in Canada's health service. Dollars are being wasted on tests and operations that are not needed...Doctors spend much of their time treating minor ailments which could be handled by nurses. We may be underutilizing doctors' skills by 60-90% because of this. This is a scandalous waste. (cited in Shillington, 1972:191)

The Canadian public has developed excessively high expectations for services of the highest cost as a result of the historical evolution of national health insurance coverage. All of the reports make mention of this dilemma and acknowledge the need for more coordination and/or integration in the delivery system in order that appropriate and acceptable trade-offs can be made in program and manpower.

> The heart of the matter is that the system has largely lost touch with any method of a simple and effective kind, for providing incentives to use scarce resources efficiently. (Manitoba, White Paper, 1972:3)

To facilitate better utilization of available manpower and resources, numerous recommendations have been made concerning the need for interdisciplinary teamwork and the expansion of some of the roles of ancillary health professionals. Hastings et al (1972:2) suggest that community health centres may be the type of organizational structure wherein these recommendations can be best implemented.

A second major concern raised in the reports is the unequal distribution of health services. The distribution of resources in most provinces is grossly unequal. Urban areas normally have a disproportionate share of both health manpower and facilities, while rural and isolated areas are often impoverished of services. Although national health insurance did remove the financial barrier to hospital and medical services, it did not correct and may even have aggrevated problems of resource availability and accessibility.

H. Rocke Robertson (1973:51) commented on these isuses in his assessment of what the Canadian consumer should reasonably be able to expect from the health system.

> There must, for the well, be ready access to

> preventive services....and for those who are ill, there must be a coordinated consecutive process starting with comprehensive and efficient assessment of the social and medical needs and continuing where indicated through a course of diagnosis, treatment, and rehabilitation procedures.

Virtually all of the provincial and federal health reports of the 1970's suggest that some attempt at a trilevel delivery structure is required to ensure there is adequate access to services and to alleviate problems of inequality. The three levels in the delivery structure are generally referred to as the central/provincial level, the regional level, and the district/local level. The reports also give significant support to the extensive decentralization of services, with the district or local level representing a composite of primary services.

The Foulkes Report (Health Security for British Columbians, 1973:V-4-7) proposed a trilevel of care designation which is limited by its examination of only physical health components, but which conveniently corresponds with the three jurisdictions of the delivery system, local, regional, and central. (see Table 5). Foulkes suggested that integration within each of the three levels and coordination between them was critical to the success of the system.

A third issue which received attention in each of the reports was the increasing specialization and professionalization of health care. Many people may not regard specialization as a negative feature of the delivery system. Undoubtedly, medical sciences have become increasingly complex, requiring highly sophisticated technology and personnel. Those who support specialized practise claim it is the only way to guarantee the highest quality of care. However, others see many real and potential problems associated with excessive specialization. For instance, when

TABLE 5 - LEVELS OF HEALTH CARE

PRIMARY - General Care - Mental, Physical, Emotional

- Health Promotion and Prevention

  -Counselling
  -Education
  -Family Planning
  -Specific Protection Measure

- Diagnosis and Treatment

  -Reception and Direction
  -History Taking
  -Initial Diagnosis
  -Decision on Specific Therapy
  -Follow up
  -Continuing Supervision of Care

- Rehabilitation

  -Local Medical and/or Social Restorative Measures
  and/or
  -Referral to more Specialized Services

SECONDARY - More Specialized Treatment

- Includes the Following Medical and Surgical Specialties:

  -Family Medicine
  -Internal Medicine
  -General Surgery
  -Pediatrics
  -Obstetrics and Gynecology
  -Otohinolaryngology
  -Ophthalmology
  -Psychiatry
  -Geriatrics

- Also Includes:

  -Radiology
  -Pathology
  -Anesthesia
  -Microbiology
  -Hematology
  -Specialized Dental Care
  -Pharmacy

TERTIARY - Highly Specialized Treatment and Consultative Services

  -Neurosurgery
  -Genetic Counselling
  -Nephrology
  -Pharmacology
  -Forensic Psychiatry

each aspect of an individual's chemistry and/or psyche is attended to by a separate practitioner, a general desensitization to the total human being may result. The loss of a holistic perspective on the patient's total health condition is a persistent and dangerous possibility.

Specialization can lead to an unduly professionalized health system.

> There is a tendency to optimize the performance of the system from the point of view of those delivering the care. This is not to be decried but it is not necessarily sufficient for those receiving the care. (Science Council of Canada Report, 1974:24)

In order to counter the trend towards an overly specialized and professionalized health system, the reports call for consumer participation in health affairs. The plans for local/district health boards or councils proposed in Manitoba, Ontario, Quebec and British Columbia each call for the involvement of citizens in the design and implementation of the policies of their local health facilities.

> Overall policy in these centres (community health centres) is to be directed by a governing board composed of a majority of people who use their services and including elected representatives from the health and social service personnel at the centre. (Manitoba, White Paper, 1972:54)

It is expected that the involvement of consumers will assist in assuring that new programs and services are developed in ways that are relevant to the community.

The final issue which the reports addressed was the curative focus of the health system. In making a case for the introduction of a "care" rather than "cure" orientation to the health system, the New Perspective on the Health of Canadians document (1974:59) noted that,

> Of the ten major causes of death in 1900, six were either infectious or related to infectious diseases. In 1970, none of the ten major causes of death were infectious except influenza-pneumonia and certain diseases of early infancy. Today the list is headed by chronic diseases and accidents.

The health system has not been changed in order to deal with these realities, as can be witnessed by the continued emphasis on treatment services and acute care facilities. The major causes of ill health and death today are related to environment and personal lifestyle choices, (see Appendix A) and yet little attention has been paid to improving the capability of the system to influence and alter the social, cultural, or psychological conditions which encourage faulty health habits. The technology of health education and promotion requires significant improvements and development. The recommendations in all of the reports suggest a need to concentrate on this area and to place special emphasis on the role of positive health promotion within an integrated health delivery system.

As suggested earlier, the impact of the various reports cited, has been distinctly varied. The Province of Quebec has achieved the most far reaching reforms in terms of reorganizing the total health system. Regional Councils responsible for overall health and social service planning in their respective regions are in place throughout the province. As of February, 1976, there were seventy-seven local health and social service centres operating, where integrated and comprehensive primary care is being provided. (Canadian Council on Social Development, 1976) The reorganization in Quebec is likely to continue along present lines because it is founded on a firm legislative base (Bill 65, An Act respecting Health and Social Services) and because it has strong central government support.

Until the change of government in early 1976, the Province of British Columbia had been attempting the evolutionary development of community human resource boards and health centres. Some of the centres were organized to deliver broadly defined social services including child welfare, income maintenance, recreation, and library services. Others were designed along the model of an integrated health centre where these social services were delivered in conjunction with preventive and primary health care services. All of the experimental centres were organized at the most local level placing strong emphasis on consumer involvement and community action. Certain local boards became very actively involved in planning strategies and programs that would effectively address neighborhood health and social problems. These boards often adopted the role of advocate on behalf of local citizens and, in so doing, found themselves involved in political confrontations with municipal and provincial government authorities. These controversies undoubtedly contributed to the demise of the human resources centres. Some of the integrated centres (health and human resources) continued to function but they account for an extremely small portion of total primary care services in that province.

The Province of Ontario has concentrated its reform effort around larger population groupings than those chosen by Quebec and British Columbia. District Health Councils representing an average of 100,000 people have been developed in several parts of the province. The Councils have some representation from consumers in each district. They have a mandate only to plan for the overall rational distribution of health resources in their districts. These Councils are not directly involved in the implementation of services. They have been responsible for closing

many acute hospital beds in the province in conjunction with the Ontario Ministry of Health. However, they have had little success in integrating services at the local level nor have they achieved effective linkage between the health system and the traditional social service system.

The Manitoba experience, like that of British Columbia, illustrates the evolutionary approach. Subsequent to the publication of the White Paper on Health Policy, several community health centres of the type III variety (see Appendix E) were developed throughout the province. The intent was to encourage district health system developments in areas where local residents expressed a specific interest. The district systems were to assume eventual control of a wide range of health and social services. Appropriate public health and social services administered by regional authorities were to be transferred to the district boards for integration into a comprehensive human service program which would include district hospital and personal care services as well as primary medical care. Since the original development of nine such centres in the province, additional progress has been slow. Manitoba's District Health and Social Services Act (Bill 49) was proclaimed in June, 1975. This Act provided the legislative framework for district health system/community health centres to evolve if communities had the interest and/or if the government provided the incentive to reorganize in this way. In Manitoba at present, there is no significant barrier to the development of comprehensive district systems but there appears to be little government enthusiasm for reorganization at this time and this is a necessary prerequisite for real system change to occur.

Eleven governments are involved in health care planning and delivery in Canada. Although the federal government has increased its

influence in the health sphere by means of cost sharing arrangements, the provinces still retain the authority to decide what services they will provide and how the delivery system will be structured.

In recent years the federal and provincial governments have been involved in extensive discussion regarding the need for more decentralization, integration, and emphasis on prevention in the health system. However, the actual implementation of reform recommendations has been slow and spasmodic. Except for the province of Quebec little substantive change has occurred in terms of health system organization. The concept of comprehensive primary care continues to be discussed and demonstration projects in the organization of primary health and social services are underway throughout the country. More extensive experimentation may be anticipated if the current projects prove successful in fulfilling their objectives.

Summary

The initial intent of this chapter was to develop a conceptual understanding of comprehensive primary care. Some of the organizational implications of conceptualizing health care in terms of primary, secondary and tertiary levels were also discussed. An attempt was made to examine the experience of the United States, Great Britain, Sweden, and Canada where efforts, of varying intensity are being made to expand and emphasize the primary level of care within the context of a coordinated health delivery system.

Chapter III will attempt to establish the common organizational and planning principles which have emerged from the health reform experiences of the four countries examined. These principles will form

the developmental basis for an ideal primary care centre. The model will illustrate the creative potentiality that can result if primary care is actualized in a truly comprehensive way.

CHAPTER II

FOOTNOTES

1. It is quite possible for an AMBULANT patient to be receiving SECONDARY level services, (e.h., renal dialysis) and for a bedridden, institutionalized patient to be receiving PRIMARY care management.

2. Recent research is suggesting that many specialist physicians are delivering a certain amount of primary care. Therefore, the general practise statistics should be regarded as providing only a rough indication of primary care trends.

3. Hospitals, physicians, and other professional services accounted for 64.7% of total health expenditures in the United States in 1965. (Anderson, 1972: Table A8, 218)

4. This publication describes both the categories of service and the manpower required for a neighborhood health centre.

5. There were two hundred and five neighborhood health centres in existence, receiving project grant assistance from the Office of Economic Opportunity of the Department of Health, Education, and Welfare in 1971. (Zwick, 1974:357)

6. A study done in 1964, suggested that 88% of the cases seen by pediatricians and 77% of those seen by internists were for primary (not referred) care. (White, 1964)

7. There is a rate of one general practitioner per 10,000 people in Sweden. (Holst and Wagner, 1975:35)

CHAPTER III

A MODEL OF AN IDEAL PRIMARY CARE CENTRE

From the review of recent health planning and organizing experience in the United States, Great Britain, Sweden, and Canada, it becomes apparent that certain common trends are emerging. These trends will be summarized with a view towards utilizing them as the basis upon which a general model of a primary care centre will be developed.

Each of the countries is interested in achieving a general rationalization in their health system. Each is facing problems of fragmentation, duplication, inaccessibility, et cetera and has chosen strategies of decentralization and integration to address these problems. Local primary care units are being developed throughout each country. These units normally incorporate a broad range of "health"[1] services and personnel and are closely linked with a variety of more specialized "health" care resources. A well coordinated system based on a firm foundation of local delivery units is expected to overcome many of the chronic organizational difficulties previously cited.

Another common trend in the countries examined is the encouragement of consumer participation in health affairs. This is especially evident at the local level where consumers are becoming involved in policy development as members of health facility boards, in service delivery as indigenous workers, and in personal health management as participants in health promotion activities.

There are numerous educational and social consequences associated with increased consumer participation. For example, informational and

and skill development sessions must be planned for inexperienced board members. Outreach mechanisms must be developed to insure the regular participation of community interest groups in the determination of gaps in service and unmet needs. New local staff must be integrated into health care teams and must be assigned appropriate tasks. Patients/clients need to be encouraged to assume more responsibility for their own health. They, as well as the staff members, need to be made aware of their respective responsibilities in the management of individual health conditions. Many categories of health manpower will be required to insure all of these requirements are fulfilled.

Another consistent trend in the four countries examined is the gradual shifting of priorities within the health care delivery system. Increasing importance is being placed on the preventive and primary care aspects of health care. The spiralling costs associated with institutional and specialized medical services have forced health planners and decision makers to consider reorganizing the health system so that many of the causes of current morbidity and mortality can be eliminated by preventive action or at least detected and dealt with early by primary care services. There is a general expectation that by placing more emphasis on the preventive and primary care aspects of health care, improved population health status will result.

These international trends will be used as broad guidelines in the development of a model primary care centre. The model is presented in the form of an "ideal type". An ideal type is a mental construct. Max Weber, who originated the concept, claimed that,

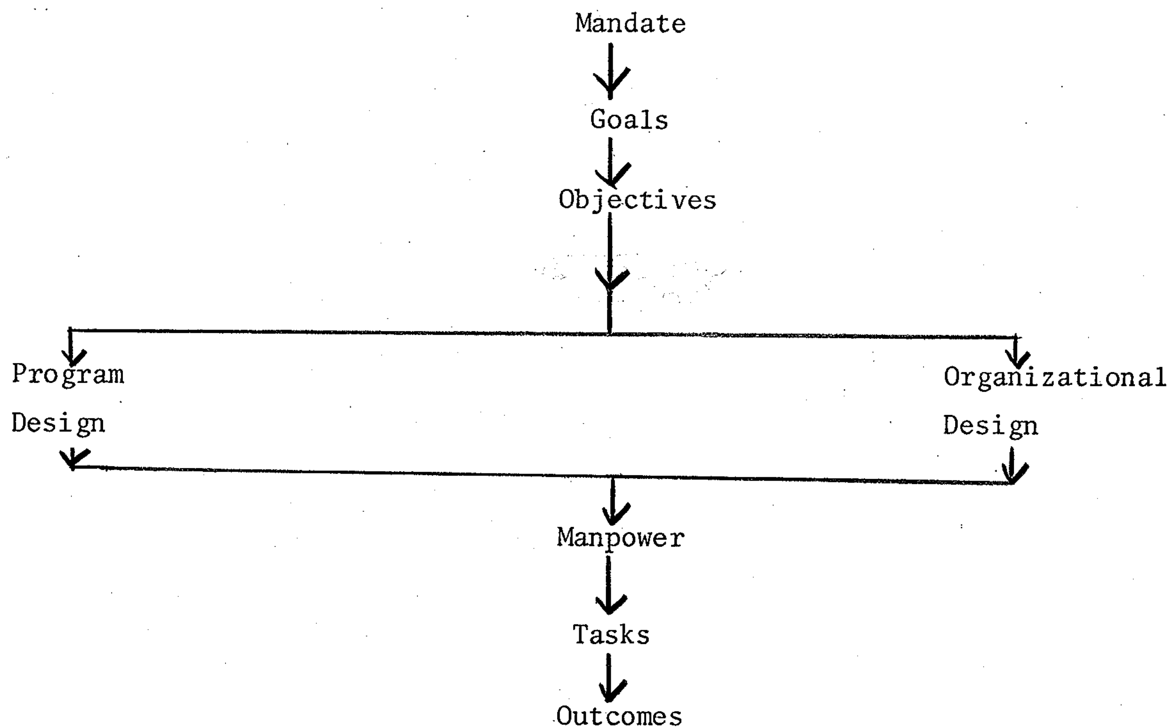
> Seldom, if ever, can there be found in life itself, phenomena which correspond exactly with a mentally constructed type. (cited in Timasheff,1955: 117).

Thus, it would be unrealistic to expect to find exact replications of the "ideal type" model. Situational variables inevitably influence all structural arrangements. Nevertheless, the model will provide a prototype against which actual health service centres can be compared and investigated.

The development of a specific organizational model requires an examination of several system components. These are depicted schematically as follows:

Figure 4

The Conceptual Components of the Model [2]



Every organization requires a sense of purpose. This is achieved when a consistent and logical flow exists between the various system components. When this flow is disrupted or appears inconsistent in some way, the organization is said to be experiencing "slippage".

While a risk in any organization charged,

> with the realization of goals, slippage (lack of fit between components) is a special risk in social service (and indeed, in all people processing organizations) for reasons inherent in their relationships to mandators, funders, and those whom they serve. (Scurfield and Ryant, 1975:105)

The model of a Primary Care Centre attempts to minimize the "slippage" between the various components. A limited discussion of each conceptual component in Figure 4 will now be presented for the purpose of establishing the context in which the model primary care centre will be developed.

A. Mandate

From the outset of its operation, an organization must be aware of the expectations that are being placed upon it. Having received its mandate, an organization knows:

i that a collective decision has been made to recognize a problem or a need as deserving of interventive action;

ii that authority has been granted to the organization to address the identified problem, and;

iii that resources have been provided whereby the problem can be addressed. (Ryant; 1976)

When a recognized social collectivity (e.g., government, community chest, or United Way) publically declares a social or health need to be deserving of intervention, a certain credibility accrues to the agency assigned the authority and the resources to intervene. The authority vested in the agency must be stated in terms that closely link it with specifically identified need. (Blau, 1956; Backley; 1967). A concise statement of authority and scope of responsibility provides a sense of organizational purpose and a clarification for what and to whom the

organization is accountable.

Without a statement of specific authority, organizations may temporarily enjoy a sense of autonomy to plan and deliver services as they wish. However, the current trend is for more frequent and more stringent evaluations of organizational efficiency and service outcomes. The consequences of such evaluations may prove fatal if there is a significant gap between the organization's performance and the implicit, if not stated, expectations of the mandating agency. Hollister, Kramer, and Bellin (1974:8) suggest that the demise of several Neighborhood Health Centres in the United States can be attributed to this exact sequence of events.

Finally, a mandate implies the allocation of resources to fulfill the stated responsibilities or authority. The adequacy of the resources will significantly influence the extent and the intensity of action that is taken. Ideally, resources will be realistically allocated in accordance with the scope of the organization's responsibility. However, in the area of health care the amount of resources allocated and the conditions under which they are allocated is, in reality, usually problematic.

B. Goals and Objectives

The first step in achieving cohesiveness within the system is to ensure appropriate linkage between the stated mandate and the goals and objectives of the organization. Goals and objectives usually reflect the value orientation of those most influential in the organization. Hasenfeld and English (1974:9) comment that,

> In human service organizations, the definitions of goals are primarily commitments to certain values, norms, and ideologies.

Therefore, goals, while primarily purposeful explications of the mandate, also reflect environmental and dominant value considerations.

Thompson and McEwan (1958:95) suggest that the goals of human service organizations must also establish the desired relationship between the organization and the environment. This relationship will cause periodic organizational stress because mandates are very slow to change and environmental circumstances change frequently.

Charles Perrow (1970:135) developed a classifiction system which identified five categories of goals. The categories are as follows:

System goals have as their referrent the manner of functioning of the organization, independent of the goods or services it produces or its derived goals.

Product goals have as a referrent the characteristics of the goods or services provided.

Output goals are basically concerned with the public in contact with the organization.

Societal goals are the concern of large classes of organization. They define the required contribution of that class of organizations to society.

Derived goals are those generated as a result of pursuing other goals. They are new organizational goals which have "spun off" from efforts to achieve previously established goals.

The first three categories of Perrow's classification system are particularly helpful in terms of clarifying the goals of a primary care centre and will be elaborated in the model.

Objectives must be closely related to mandate and goals. They must embody the general goals while specifying the particular desired

outcomes which the organization wishes to see accomplished.

> Objectives are statements of intent; they communicate the direction and shape of programs. (Deeds, 1975:4)

Objectives must be stated in terms which make them both realizable and measurable. The organization's objectives normally form the basis of all subsequent evaluations, and therefore, it is critical that they specifically state what the organization is attempting to achieve.

C. Organizational Design

The manner in which an organization is internally structured will critically affect its ability to realize its goals and objectives. Organizational theorists agree that the primary purpose of organizing work activities is to achieve maximum productivity. (Gouldner, 1954; Blau, 1956 and 1963; Parsons, 1956; Lewin, 1952; Mouzelis, 1968). To achieve this end, human relations theorists, (Lewin, 1952; Mouzelis, 1968; Whyte, 1969) suggest the need for organizations which,

> permit worker's autonomy, that provide for participatory democracy in decision making related to worker's tasks and, in general, take cognizance of related aspects of the informal dimensions of the organization. (Hasenfeld and English, 1974:28)

Many human service agencies subscribe to this perspective and their internal structure reflects provision for participatory management and teamwork.

Beckhard and Rubin (1972) suggest that the management style which is best for a comprehensive health service organization is one that encourages the participation of all staff members in making decisions about issues which directly affect them. In describing the role and functions of the executive director in a community clinic, Krohn (1966:117) commented that a particularly effective leader is one who sees his/her primary function

as "organizing services and staff" and whose approach to clinic management is one that relies upon contributions from numerous sources.

Planning is another organizational function which requires the participation of both staff and community members. Parker (1972:48) commented on one of the most important ingredients for effective implementation of a primary care organization,

> Working out and identifying with all participants, including community representatives, the objectives to be achieved by the team, its structure, and functions....its relationship to departments and the overall team coordinator and the extent of its autonomy.

Beckhard (1971) suggests this participatory approach to planning must be continued well after the centre's implementation stage.

At the level of service delivery, the "team approach" is often utilized in human service organizations. In Milton Roemer's international review of world developments in health (1969), he claims the concept of teamwork is the only one which is basic to all health centre models. Hastings (1972: 2-11 to 2-12) supported this perception by suggesting that,

> Health professionals working in teams is one of the nine characteristics of a <u>successful</u> health centre.

These reports, like most others analyzing new approaches to primary care delivery, recognize that the concept of teamwork is subject to much individual interpretation. It is virtually impossible to distinguish any universal features of a team approach outside of two or more staff members working in some cooperative arrangement.

John Noble (1976;266-267) described the evolution of three types of primary care teams. The first is the office practise team where physicians, nursing staff, and administrative personnel work in an integrated fashion,

maintaining cooperative relationships with community resources. The second model is the co-practise team where mid level practitioners (e.g., nurse practitioners) and physicians work together in the delivery of primary medical care. The final model is the multidisciplinary team which utilizes some form of integrated or coordinated practise among workers trained in any of the following disciplines: pharmacy, social work, mental health, community health, nursing, medicine.

The choice of team model in particular organizations will undoubtedly be influenced by the scope of the organization's mandate, goals, objectives, programs and personnel.

D. Programs and Services

The following conceptual distinction between programs and services may be helpful.

> Programs are defined as rights and entitlements which involved contact between a receiver and a giver but which do not necessarily imply that givers are helping professionals nor that receivers have a particular problem.
>
> Services are activities of helping persons often from the professions, which involve contact between the helper and the recipient, and which are usually, but not necessarily, required because of some problem. (Ryant, 1975:16)

The distinguishing feature about the above definition of program is that consumers do not necessarily have to have an identifiable problem. A program is essentially the operationalization of a socially accepted right. Having developed and accepted a relatively broad definition of primary care, the programs associated with it should reflect the right to achieve, to maintain, and/or to return to a state of physical, social and

and emotional well-being. Narrowly conceived programs which do not incorporate a recognition of the preventive, developmental, treatment, and rehabilitative aspects of a given health issue, would be inconsistent with primary care, as herein discussed. Furthermore, it is suggested that primary care programs be designed to encourage the use of many different strategies of intervention (e.g., counselling, treatment, procedures, education, organization). Finally, a comprehensive package of primary care programs should include provision for physical, social, and emotional health care services.

On this basis, a primary care service can be described as a helping function performed in the course of interaction between a patient/client and a primary care worker around some "health" concern. Primary care services will normally be directed towards individual problem solving, however, they should not be confined to the treatment sphere alone. Prevention, health promotion, and rehabilitation services all contribute to larger problem solving efforts and should be actively developed.

E. Tasks

For the purpose of this discussion, tasks are defined as all activities which are undertaken to fulfill the requirements of agency programs and administration.

Extensive use will be made of a primary care task inventory developed by A.S. Golden (1976), in the description of tasks of a primary care centre. The inventory is the refined product of a series of surveys which were conducted with primary care practitioners by a team of interdisciplinary researchers. The inventory provides a relatively complete account of the direct service tasks associated with primary care. The tasks are described

in the context of problem solving stages. (Golden, 1976:6) The stages are:

1. Data Gathering
2. Assessment and Evaluation
3. Diagnosis
4. Strategy Selection
5. Implementation of Strategy
6. Evaluation.

Samples of the task descriptions for each of the stages are provided in Appendix F, Parts 1-5.

Although some recognition is given to the primary care tasks which do not relate to one-to-one problem solving, this area is the least developed in the inventory. Educational and organizational tasks directed towards the prevention of health problems and the promotion of positive health are described only to a limited extent in the inventory. However, these tasks will receive more emphasis in the discussion of the model of a primary care centre because of their particular importance to the achievement of centre goals.

F. Manpower

The scope of health manpower required to deliver primary care should be determined from a detailed analysis of the centre's programs and the tasks associated with each program. The Primary Care Task Inventory provides assistance in this regard by proposing three dimensions on which level of skill or education required to perform each task can be rated. A full illustration of this rating procedure can be found in Appendix G. The three dimensions are:

i the affective - the level of human interaction related to each task;

ii the cognitive - the level of recall or recognition of knowledge and the development of such intellectual abilities and skills as reasoning and judgment;

iii the psycho motor - the level of motor or manipulative skill necessary to accomplish the task. (Golden, 1976:14-15)

This procedure assists in determining the range of manpower required by a primary care centre. Most of the tasks described in the inventory can be readily assigned to a major program area and to an appropriate staff person.

Example: <u>Performing a Physical Examination</u>
<u>(Task 2 - Data Gathering Stage)</u>

There are thirty-nine component activities involved in this task, all of which are related to physical health. The tasks do illustrate a need for differentially trained health manpower such as, a mid level practitioner (i.e., nurse practitioner), clinic nurse, health auxiliary, and lab and X-ray technician.

Certain other primary case tasks, such as the one described below, are relevent to virtually all members of the primary care team and could be conducted by any properly oriented generalist staff member.

Example: <u>Interviewing for a History</u>
<u>(Task 1 - Data Gathering Stage)</u>

This task includes thirty-six component activities such as receiving and screening patients, conducting a review of body systems, and obtaining an occupational history as part of a social history.

Decision making regarding task assignment in this case should be the

responsibility of the primary care team at large.

Every effort should be made to involve staff persons from every program area in tasks of this type. This would foster a sense of teamwork and service integration, two important components of a comprehensive primary care centre.

An analysis has been conducted of all the tasks associated with each problem solving stage, with particular emphasis being placed on tasks associated with prevention and health promotion. This analysis yielded the program designations and recommended staffing pattern presented in the model primary care centre.

Summary

The foregoing presentation of the conceptual components of an organizational model, has provided the framework upon which the ideal type primary care centre will be developed. Each component was generally discussed from a theoretical perspective followed by a discussion of its relationship to comprehensive primary care.

The model presentation which follows utilizes the conceptual components of an organization and attempts to describe the parameters of an ideal type primary care centre in a relatively detailed way. Nevertheless, the descriptions are sufficiently general to permit transferability of the model to settings with varying geographic and population characteristics.

A Primary Care Centre - An Ideal Type

Mandate

WHEREAS, there is a felt and known need for comprehensive primary care services in the district bounded by ______________________; or, by the population of ______________________;

BE IT RESOLVED, that a primary care centre be developed to provide services to said area/population on a voluntary basis.

WHEREAS, all people have a right to receive health care services appropriate to their needs;

BE IT RESOLVED, that a primary care centre serve as an entry point to the health and social care system, providing screening, assessment, direct service, referral, and follow up, as required.

WHEREAS, people have a right to receive primary medical and social services;

BE IT RESOLVED, that a primary care centre provide a comprehensive range of primary health and social services, (preventive, developmental, treatment, and rehabilitative)

WHEREAS, primary care includes many types of health and social services and yet, represents only one level of care in the personal health care system;

BE IT RESOLVED, that a primary care centre develop mechanisms to ensure regular health management and continuity of care for individuals and families,

within the primary care level and between it and other levels of care.

WHEREAS, the majority of primary care services involve human interaction:

BE IT RESOLVED, that a primary care centre develop mechanisms for the promotion of personalized and family oriented service as well as adequate human support during times of ill health or social crisis.

WHEREAS, the design and delivery of primary care services should reflect a sincere responsiveness to consumer needs;

BE IT RESOLVED, that a primary care centre facilitate consumer participation in all aspects of centre operation.

WHEREAS, the fulfillment of these responsibilities, requires adequate provision of resources, both capital and operational;

BE IT RESOLVED, that a global budget be granted to the board of the primary care centre to be revised annually in line with changing economic circumstances and changing needs in the service area/population.

Goals and Objectives

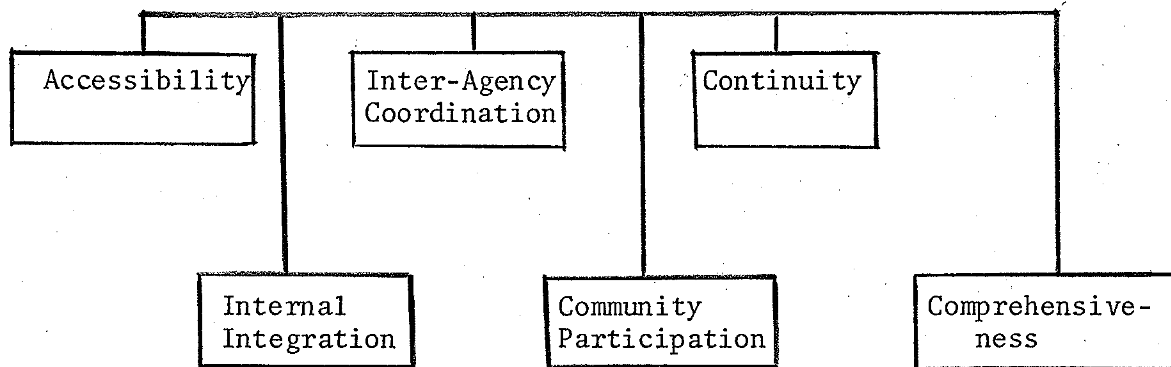
The goals and objectives of the primary care centre are stated in a way that establishes the former as general aims or purposes and the latter as specific statements of desired outcome.

1. System goals describe the manner in which the centre intends to

operate. There are six system goals in a primary care centre. They are illustrated diagramatically in Figure 5 and elaborated with their respective objectives in Figures 5a to 5f.

Figure 5

System Goals of a Primary Care Centre



Operational Objectives of System Goals

Figure 5a

Goal 1 - to develop a Primary Care Centre which is accessible to the designated district/target population.

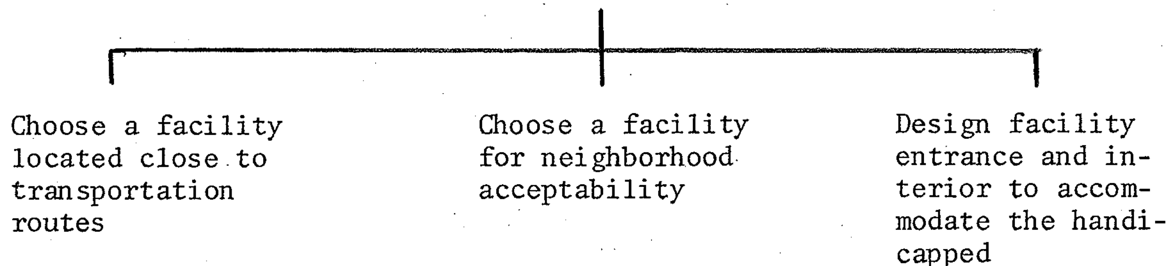


Figure 5b

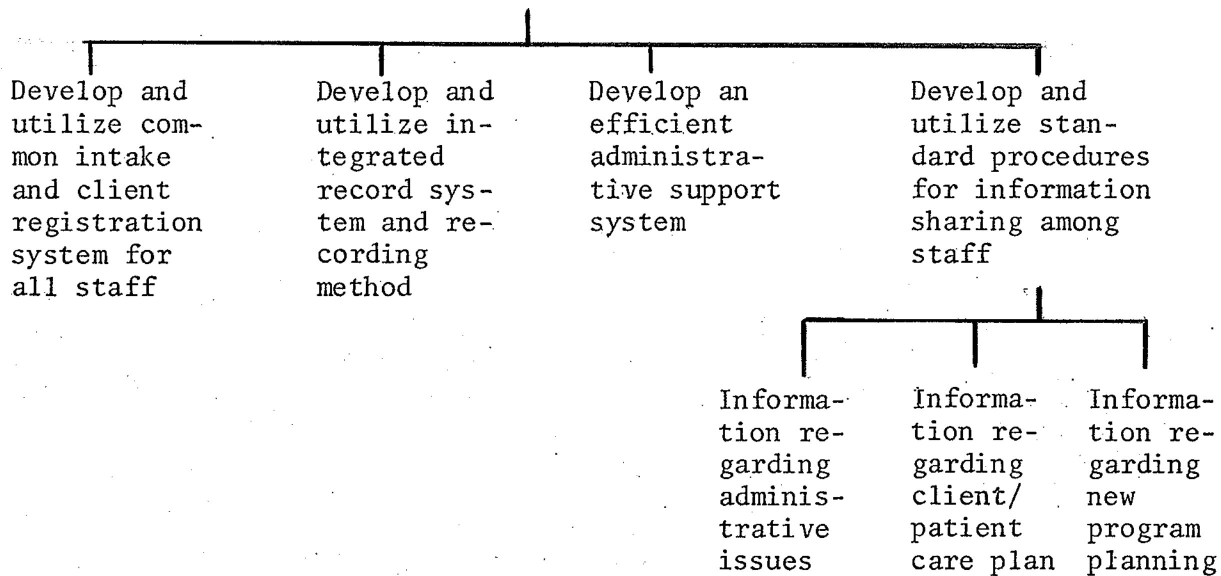


Figure 5c

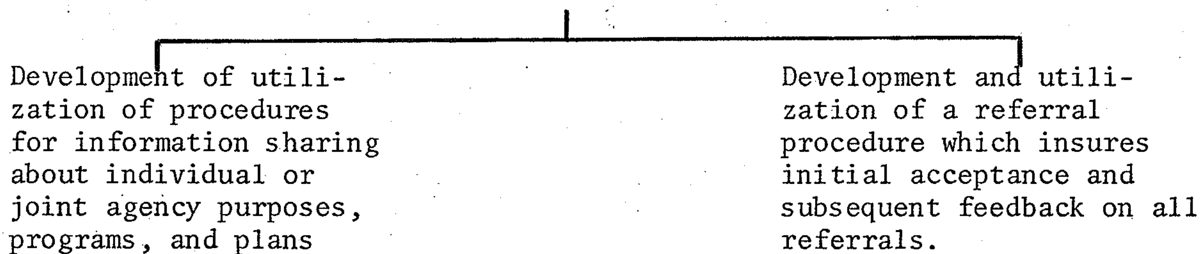


Figure 5d

Goal 4 - To ensure community participation in the planning, administration, and service delivery of the centre.

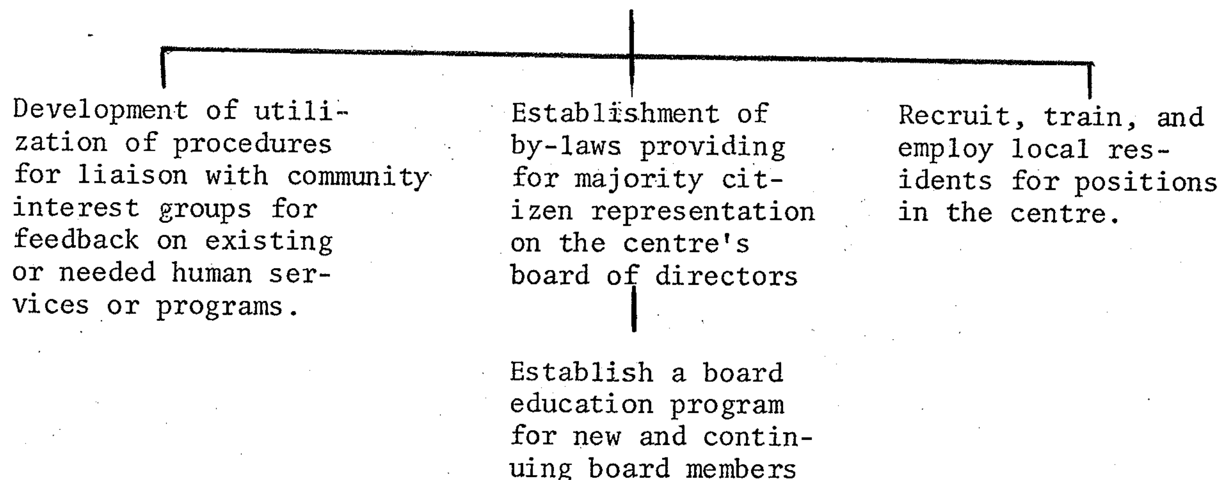


Figure 5e

Goal 5 - To ensure continuity of care for those receiving services through the centre.

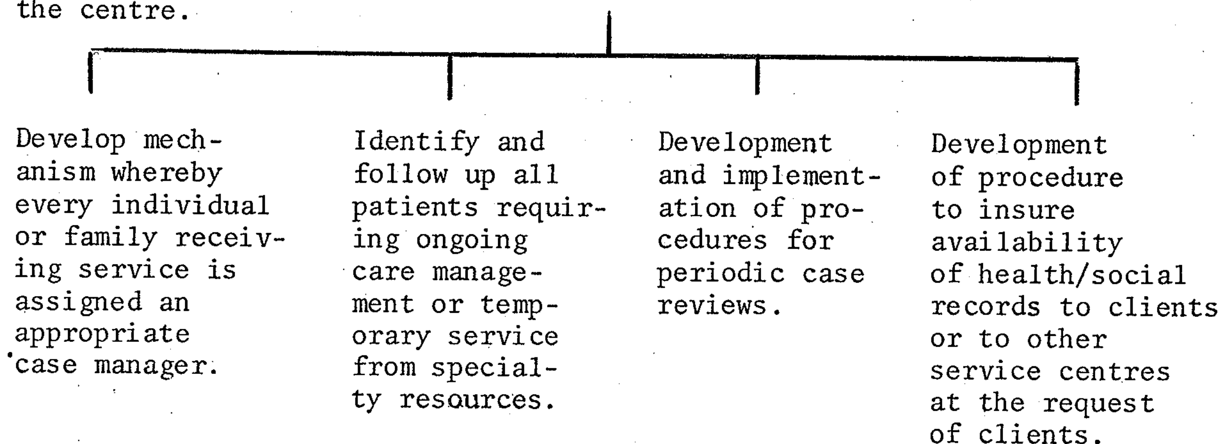
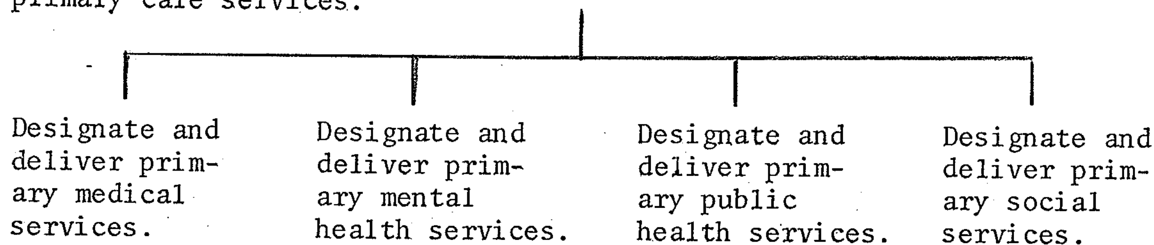


Figure 5f

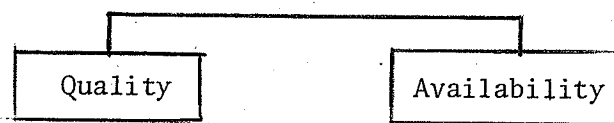
<u>Goal 6</u> - To identify and deliver an appropriate comprehensive range of primary care services.



Product goals describe the desired characteristics of the goods or services being delivered. The two major product goals of a primary care centre are illustrated in Figure 6 and elaborated in Figures 6a and 6b.

Product Goals of a Primary Care Centre

Figure 6



Operational Objectives of Product Goals

Figure 6a

<u>Goal 7</u> - To deliver and maintain high quality primary care service delivery to the area/target population.

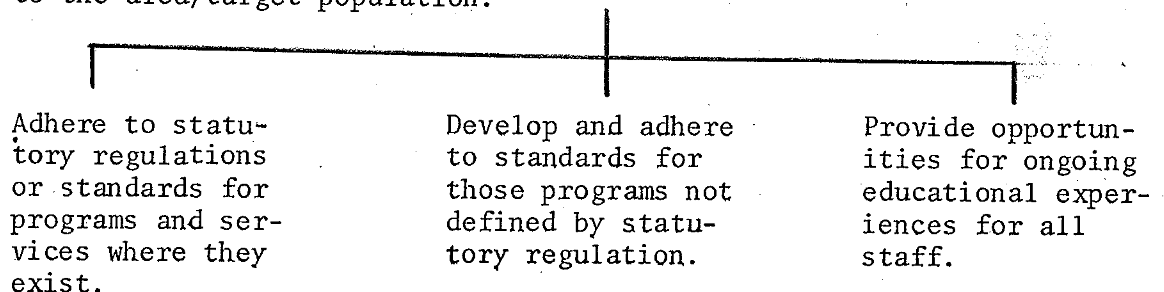
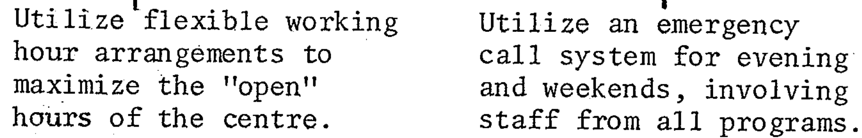


Figure 6b

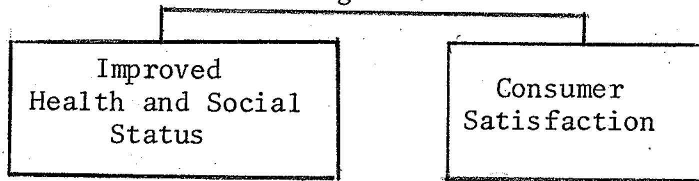
Goal 8 - To ensure maximum availability of primary care services to the area/target population.



Output goals relate to the consumer group to whom service is being provided. They state the purpose of delivering services in terms of the desired consumer response. Output goals rarely change as they represent the long term expectations which the organization is attempting to achieve. The two output goals are presented in Figure 7 and elaborated in Figures 7a and 7b.

Output Goals of a Primary Care Centre

Figure 7



Operational Objectives of Output Goals

Figure 7A

Goal 9 - To improve the overall health and social status of the target population.

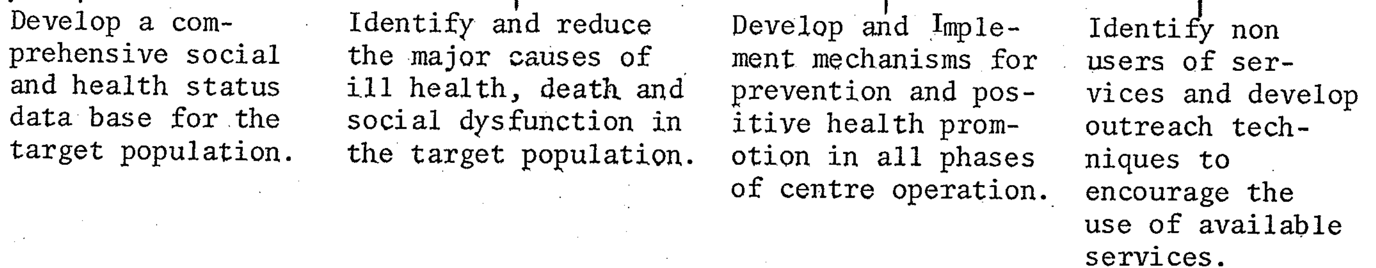
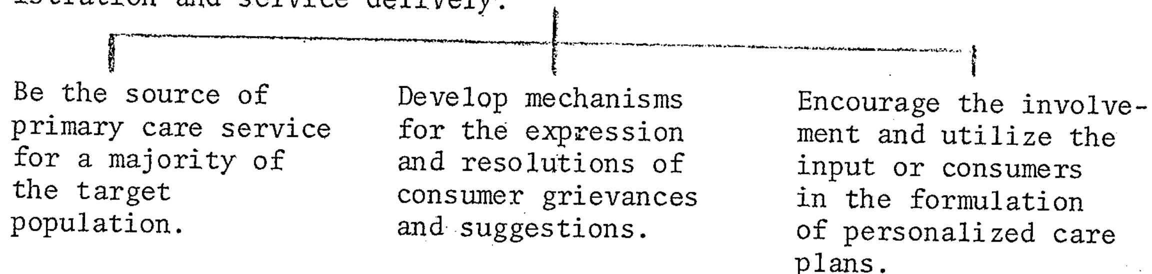


Figure 7b.

Goal 10 - To achieve general consumer satisfaction with centre administration and service delivery.



Organizational Design

The theoretical discussion of organizational design issues and description of the primary care centre's mandate, goals, and objectives, leads one to propose three organizational features as characteristic of a model primary care centre. Those features are:

i participatory management,

ii participatory planning procedures, and

iii teamwork.

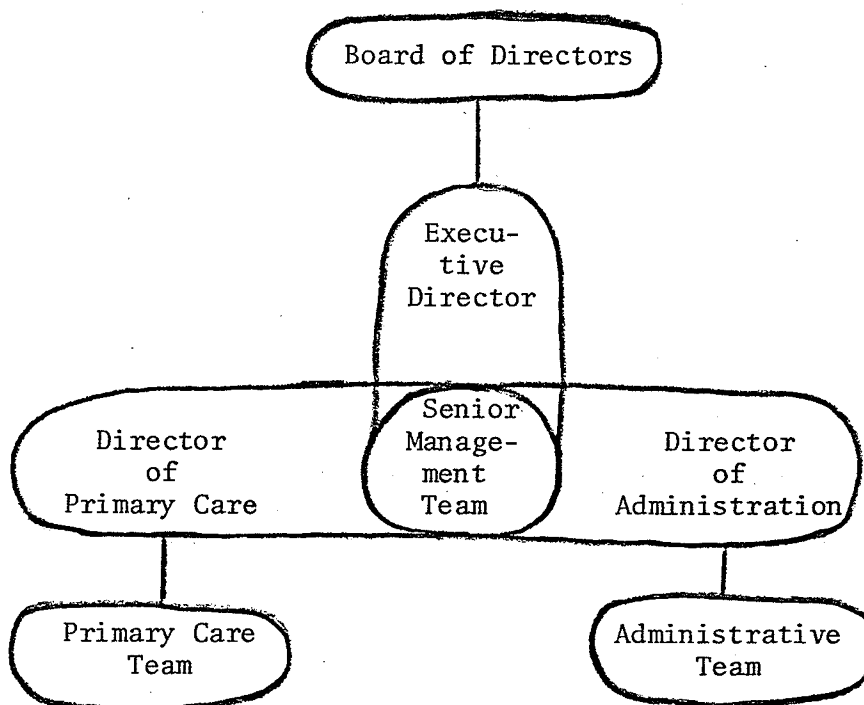
As earlier suggested, (Beckhard, 1971; Krohn, 1966) decision-making in an organization such as this should occur as close to the source of the problem as possible. Two operational arms are suggested for the primary care centre, one responsible for primary care services and the other responsible for administrative support. Each division would be headed by a director and would have an internal accountability system to ensure that its primary purposes are met, (e.g., The payroll clerk would be accountable to the Director of Administration for his/her job performance. The public health nurse, on the other hand would be accountable to the Director of Primary Care).

The Executive Director of the centre would be the chief administrative officer of the board of directors and would be ultimately responsible for the centre's operation.

To implement the commitment to integration and participatory decision-making, the formation of a senior management team comprised of the Executive Director and the Directors of primary care and administration is suggested. Figure 8 provides a diagramatic illustration of the senior management team:

Figure 8

Organization of the Senior Management Team

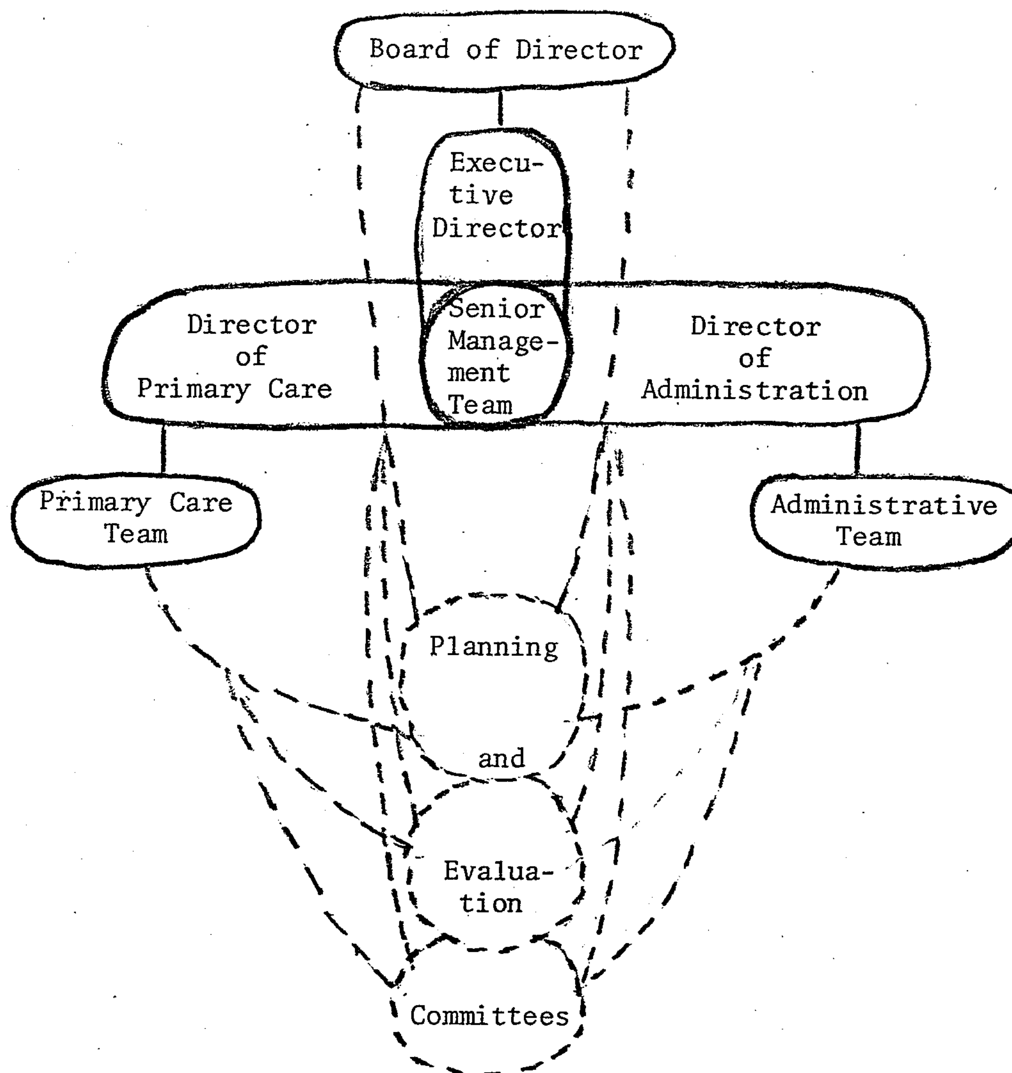


The initial and long term planning and evaluation functions of a primary care centre should be undertaken with the maximum participation of the board (consumers) and staff (Parker, 1972; Beckhard, 1971). Short term task committees are recommended for this purpose. The committees should include representation from the staff of both primary care and

administration as well as the board of directors. Figure 9 illustrates the suggested organizational structure.

Figure 9

Organization of Primary Care Centre



This structure allows for a balance between line accountability for job performance and participation in centre policy development and management.

Finally, it is proposed that the two working arms of the primary care centre be organized into interdisciplinary teams. The administrative personnel of the centre play a critical role in determining whether

effective and integrated service delivery will take place. Numerous tasks (such as reception, the processing of written materials, and plant maintenance) are undertaken by administrative personnel and will require differential staffing. The basic administrative team should consist of the Director of Administration, receptionists, bookkeeper, secretarial staff, medical records librarian, and maintenance staff.

It is imperative that a sense of internal teamwork be developed among the administrative staff. For example, consideration should be given to having the secretaries who type case notes and the medical records librarian who organize and files them, work together in the establishment of appropriate work procedures that will facilitate the development of an interdisciplinary recording system. Furthermore, in a centre committed to the appropriate utilization of manpower, it is important that administrative staff understand each others' roles and that they accept responsibility to substitute for one another under certain conditions.

The direct service staff will undoubtedly share many concerns which will necessitate continuing communication and coordination. Some of the issues could include: task assignment, case management, case reviews, file recording, case conferencing and team meetings, staff evaluation, training and supervision of local resident workers, and the delivery of group and community programs.

An integrated primary care team structure, headed by an effective team leader is proposed for the resolution of these and future issues, and for the promotion of innovative service responses to new community needs. The team leader should be a direct service provider who is appointed with the concurrence of the team. The position may be full or part time depending upon the size and complexity of the centre's operation. The

specific responsibilities to be carried by the team leader should be determined by a planning committee of the type previously discussed.

The following four programs are suggested for a primary care centre:

1. Community and Staff Education
2. Physical Health program
3. Mental Health program
4. Social Health program.

These categories have been proposed because they encompass the full range of services and tasks implied by the term comprehensive primary care. Each category is meant to suggest a general area of interest as opposed to a narrow, discipline (oriented) specific classification. (i.e., Medical program, Nursing program). An examination of each category will be conducted to establish the potentiality offered by each area. Examples of the tasks associated with each program will then be presented followed by a discussion of the suggested staffing requirements of a primary care centre.

The Community and Staff Education Program

A major concern of a primary care centre is to ensure consumer participation throughout its operation. It should be the responsibility of this program to develop and maintain community awareness and interest in the centre and create a responsive environment within the centre to the needs identified by consumers.

A second major concern of the centre is to ensure a high quality of service. The organization and provision of continuing educational and skill development experiences for all staff should be a component of this program.

Some of the tasks associated with Community and Staff Education are: conducting (promotional) media campaigns, organizing individual, group, and community education events, resolving consumer grievances, developing a current community health and social status profile, developing and implementing board education techniques, establishing liaison with community interest groups regarding existing programs, unmet needs, and future planning, and organizing staff orientation and educational opportunities.

A consultant epidemiologist and a professional health educator would be useful staff resources for these tasks. The Executive Director would also be involved in this program.

Physical Health Program

This program should be directed at the physical health needs of the centre's target population. The factors which impinge upon physical health include human biology, environment and lifestyle. These factors require broad program responses. The services and strategies employed in the physical health program should attempt to:

i eliminate or prevent physical health problems.

ii promote and maintain positive physical health conditions,

iii provide treatment for diseases, injuries, or conditions of a primary care type, and

iv provide primary rehabilitative services to convalescing or disabled patients.

Examples of tasks associated with each aspect of the physical health program are provided in Figure 10.

In order to deliver the full range of physical health tasks, a primary care centre will require the skills of general practitioners,

nurse practitioners, public health nurses, clinic nurses, health auxiliaries, lab and X-ray technicians and consultants in a variety of specialized fields.

Mental Health Program

This program should be aimed at meeting the primary mental health needs of the centre's catchment area. This program must also employ broadly based strategies which attempt to:

i eliminate or prevent mental health problems,

ii promote and maintain positive mental health conditions in the community,

iii provide treatment to clients/patients with mental health problems which can be managed within the community, and

iv provide primary rehabilitative services to post mentally ill patients.

Examples of the tasks associated with each aspect of the mental health program are provided in Figure 11.

This program will require the involvement of mental health counsellors (ie. a psychologist and a community psychiatric nurse) and a consultant psychiatrist.

Social Health Program

A social health program should be directed at the needs of individuals, groups, and the community in terms of their social functioning. The program in a primary care centre must demonstrate a broad understanding of the social problems which threaten to develop or which already exist in the community. The issues may be identified by patients/clients who present their individual social concerns to the centre directly. Through an analysis of the problems which they witness in their daily practice, staff of the primary care centre

Figure 10

Physical Health Program - Task Example

PROBLEM SOLVING PROCESS	STRATEGIES			
	PREVENTIVE	HEALTH PROMOTION	TREATMENT	REHABILITATION
DATA GATHERING	Perform visual screening on school age children.*	Determine the number and the preparedness of families expecting newborns.	Inspect/palpate male genitalia.*	Interview recuperating disabled person concerning limitations.*
ASSESSMENT AND EVALUATION	Assess and evaluate results of vision screening tests.*	Assess and evaluate families' preparedness for their newborn.*	Assess and evaluate findings of examination of male genitalia for normality or abnormality e.g. discharge, edema, tumor.*	Assess and evaluate needs and limitations of recuperating disabled person.*
DIAGNOSIS	Determine the nature and extent of vision problems in the tested group.*	Determine the needs of families awaiting the arrival of a baby.	Diagnose following problems and related signs and symptoms: inguinal/scotal swelling, ulcerations in genital area.*	Determine the nature of care problems of a recuperating disabled patient.*
STRATEGY SELECTION	Develop a strategy to address the causal factors of the vision problems.	Develop a prenatal education program for centre clients.	Select a treatment and management strategy for urinary tract infection.*	Develop a strategy to ameliorate care problem.
STRATEGY IMPLEMENTATION	Organize a parents' group to lobby for improved lighting in school rooms.	Deliver a range of prenatal education sessions.	Massage prostate gland to express secretions; prepare or prescribe medications.*	Provide information; explain patient's illness/disability to family, teacher, employer, etc.*

* Indicates the task example comes from the Primary Care Task Inventory (Golden, 1976)

Figure 11

Mental Health Program - Task Examples

PROBLEM SOLVING PROCESS	STRATEGIES			
	PREVENTION	HEALTH PROMOTION	TREATMENT	REHABILITATION
DATA GATHERING	Interview patient/ client to enable that individual to express feelings about areas of emotional concern.*	Determine the availability and nature of marriage enrichment courses.	Observe individual's level of consciousness, orientation to time, place, and person, memory reasoning.*	Determine the number and the condition of post mentally ill patient in the centre's catchment area.
ASSESSMENT AND EVALUATION	Assess and evaluate the nature of the client's emotional concerns.*	Assess and evaluate the utilization patterns of existing courses.	Assess and evaluate the findings of mental status and related systems.*	Assess the vocational status of these individuals.
DIAGNOSIS	Determine patient's needs in terms of dealing with these and future emotional concerns.	Determine the appropriateness of existing courses and the nature of the utilizing and non-utilizing population.	Diagnose the nature of the patient's mental health on the basis of signs, symptoms and test results.*	Diagnose the needs and capabilities of post mentally ill people in terms of vocational planning.
STRATEGY SELECTION	Encourage client's involvement in a Life Skills program.	Develop marriage enrichment handbook and/or locally oriented course material.	Select a management and treatment plan for the specific mental illness problems.*	Devise a proposal for a sheltered workshop in the area.
STRATEGY IMPLEMENTATION	Motivate and provide support to the client during the Life Skill course.	Provide in-service education to primary care workers regarding the utility of the handbook. Encourage referrals to courses.	Prescribe appropriate medication and/or provide appropriate psychiatric therapy.	Organize a patient and community action campaign to establish a sheltered workshop.

* Indicates that the task example comes from the Primary Care Task Inventory (Golden, 1976)

may conclude that a negative social condition is seriously affecting the community. Finally, board members may identify a social issue which they feel requires the intervention of primary care personnel.

The broad purposes of a social health program should be:

i to eliminate social conditions which contribute to the development of social problems,

ii to promote and maintain positive social conditions in the community,

iii to provide primary therapeutic services to individuals or families with interpersonal and social problems, and

iv to provide primary rehabilitative services to individuals or groups who are attempting to improve their social conditions.

The social health program should utilize many different interventions dependent upon the nature of the condition being addressed. These interventions could include counselling, education, organization, and support. While primary, generalist services would be rendered by staff of the centre, the program should be closely co-ordinated and linked with the specialized social service resources that exist in the community to ensure appropriate referrals are made and integrated social planning for the community occurs.

The social health tasks presented in Figure 12 are simply examples of many tasks which could be undertaken in a comprehensive social health program.

Social work staff should be employed to fulfill most of the tasks associated with this program. The health educator, public health nurse, and health auxiliaries should also participate in certain tasks associated with social health.

Summary

This chapter initially summarized the common principles of primary health care planning and organization which emerge from the review of current American,

Figure 12

Social Health Program - Task Examples

PROBLEM SOLVING PROCESS	STRATEGIES			
	PREVENTION	HEALTH PROMOTION	TREATMENT	REHABILITATION
DATA GATHERING	Collect census and housing authority data re housing stock in the area.	Interview patient/ client about his/her recreational activities as part of a social history.*	Determine intra-familial relationship by interviewing family members.*	Interview patient/ client about his/her educational status as part of a social history.*
ASSESSMENT AND EVALUATION	Assess and evaluate the quality and availability of housing in the catchment area.	Assess and evaluate client's interest, motivation and capability to utilize recreation resources.	Strengths and weaknessess of interpersonal relationships among family members.*	Assess educational and occupational goals of the client in light of educational status.
DIAGNOSIS	Determine the need for additional or improved housing resources.	Diagnose the client's needs and the barriers to using recreational resources.	Determine the nature of interpersonal functioning problems among houshold and family members.*	Diagnose the feasibility of client goals in light of available educational resources and financial support programs.
STRATEGY SELECTION	Develop a tenants' association to lobby for housing improvements.	Develop a rotating babysitting service among housewives wishing to undertake afternoon recreational pursuits.	Select a management strategy for family dysfunction due to poor communication patterns among them.	Develop a systematic plan with the client regarding the achievement of his educational and occupational goals.
STRATEGY IMPLEMENTATION	Provide information and support (organizational and administrative) to the tenant s'association.	Organize a system for scheduling the babysitting service and recruiting voluntary aides (e.g., grandfriends).	Plan and hold family conferences for the purpose of teaching and practising new approaches to intra-familial communication.	Support client's application to educational facility; assist in locating financial assistance.

* Indicates the task example comes from the Primary Care Task Inventory (Golden, 1976)

British, Swedish, and Canadian experiences in health system reform. This was followed by an examination of the conceptual components of an organizational model: mandate, goals, objectives, organizational design, program design, tasks, and manpower. On the basis of the planning principles and the conceptual model, a model of a primary care centre was developed as an ideal type. The model was intended to reflect a comprehensive view of primary care which would promote innovative and interdisciplinary responses to community and individual problems.

CHAPTER III

FOOTNOTES

1. The term "health" as it is used for the duration of this study, is to be interpreted as including physical, mental, and social components.

2. This conceptual model was developed by Dr. J.C. Ryant, Director of the School of Social Work, University of Manitoba and presented in a course lecture in Social Welfare Services (47:401) in October, 1976.

CHAPTER IV

SOCIAL WORK IN PRIMARY CARE

The preceding chapters have been devoted to an exploration and development of the concept of comprehensive primary care and a translation of that concept into an ideal primary care centre. The suggestion has been made that an interdisciplinary team of health manpower could most appropriately fulfill the fundamental purposes of a primary care centre. Social work has been proposed as one of the disciplines required on the primary care team even though social workers have rarely been involved in health settings other than hospitals.

The traditional approach to defining the role of social work in various settings was briefly discussed in Chapter I. Research into the difficulty associated with legitimating and institutionalizing social work in health settings has been conducted by Rushing (1964) and Oslen and Oslen (1967). These studies concluded that social workers assume a passive position during the role defining process, allowing the more dominant professions in the setting to specify what the nature and extent of social work activities should be.

Subsequently, social workers express frustration with their role definition, feeling they are inappropriately utilized and limited to residual, auxiliary tasks.

The primary care centre is proposed as a new setting which offers social workers an opportunity to define and to implement a more developmental and independent role within the context of an interdisciplinary primary care team.

This chapter will discuss social work in primary care , first, substantiating the need for this type of contribution. This will be followed by several case examples which contrast the experience of social workers in settings which have different levels of commitment to comprehensive primary care. Finally, several proposals are made regarding the nature of social work practice deemed necessary in an ideal primary care centre.

A. The Need for Social Work in Primary Care

1. Health has a social component.

Chapter I examined numerous definitions of health for the purpose of determining how they influence the philosphical orientation of the service delivery system. While the traditional health system has clearly illustrated a disease control orientation, contemporary recommendations for reform are based upon a much broader understanding of the total nature of health. These reform proposals have undoubtedly been influenced by the World Health Organization which defined health as including social and emotional, as well as physical factors. In addition to recognizing the three components of health, more attention is being given to their interaction with one another in the achievement of general well being.

Social work has consistently adopted a holistic view of human functioning. The interaction of physical, emotional, and socio-environmental factors is regarded as equally, if not, more important, to the achievement of positive functioning, than the condition of each component independently. William Schwartz's description of the social work mission illustrates this concern.

> Social work mediates the process through which the individual and his society reach out for each other through a mutual need for self fulfillment. (Schwartz,1961:150-151)

In addition, systems theory is fundamental to the social work knowledge base and provides an interactional perspective on practice which is most compatable with the aims of a primary care centre.

Thus, the philosophical commitment of social work is consistent with the newly emerged holistic perspective on health. This coincidence of perspective suggests that components of professional social work can be extremely valuable in the implementation of comprehensive primary care.

2. Current morbidity and mortality patterns are related to social conditions.

It has been previously established that most of the health problems now experienced are preventable. Our most prevalent problems are related either to an environmental condition or to a lifestyle choice. These issues have strong social implications. Medical interventions are required to treat the physical effects of these conditions. However, strategies which attempt to alter environmental conditions or change human behaviour are also necessary. The social work profession is fundamentally concerned with these issues. The practice methods employed by social workers evolved from a knowledge base which is rooted in the social and behavioural sciences. (Herbert Bisno's (1969) formulation of social work methods is described in Appendix H). Therefore, social workers have particular capabilities which could be valuable in a primary care centre that is oriented to preventive health goals.

3. Comprehensive primary care requires manpower oriented to co-operative teamwork and consumer participation.

Throughout this study, the themes of teamwork and consumer participation have consistently emerged as important ingredients of a comprehensive primary

care centre.

Health care teams are task groups. However, like all small groups, the interpersonal dynamics are critical to efficiency and overall performance. A team must develop procedures and resolve interpersonal conflict which may arise between its members. Because of their skills in conflict resolution, social workers can provide assistance to primary care teams in this regard. (Boehm, 1958: 10-18; Kendall, 1957: 9-14; Perlman, 1957: 65-84; Pincus and Minahan,1973: 69-73).

The issue of consumer participation is particularly important in a comprehensive primary care centre. An aim of the centre is to assure a health system which is responsive to real consumer needs and therefore, consumer involvement is to be encouraged at all levels of centre operation. (ie. board, staff, personal health management).

Social workers could be helpful in facilitating consumer involvement since they are trained to work with and to mobilize community forces. The principle of client/self determination is one of the fundamental value premises upon which the social work profession is based. (Compton and Galoway, 1975:114). Social work practice encourages the active participation of clients (ie. individuals, groups, or communities) in the problem solving process. The purpose of this "doing with" philosophy is to develop the client's ability to solve problems independently. This principle of practice renders social work not only compatable but useful in a primary care centre oriented towards consumer participation.

B. Examples of Social Work in Primary Care

The practice of social work in primary care settings is not particularly widespread. In fact, it is rather disturbing to note the findings of a recent

study conducted with all general practise physicians in a borough in London, England.

> Only five percent of the survey population reported regular or frequent contact with psychiatric social workers or mental health workers...while over eighty percent responded that they had no contact with local voluntary social service bodies. Many stated they were unaware of the existence of these services. (Harwin, Cooper, Eastwood, Goldberg, 1970:559)

However, this same study suggested there is reason for some optimism regarding future prospects for social work in general practise since,

> Forty percent of those surveyed stated they would welcome collaboration with social workers, while an additional fourteen percent suggested they would like the direct attachment of a social worker to their practise. (Harwin, Cooper, Eastwood, Goldberg, 1970:560)

The three case examples which follow provide various illustrations of social work practise in settings that view the aims and the scope of primary care differently. The first shows an extremely traditional approach to medical social work which has been patterned after hospital-based practise. The next example illustrates a minor expansion of this traditional role. The practise setting in the final example more closely approximates an ideal primary care centre. This centre reflects a comprehensive view of health and that view is apparent in the approach to social work practise which has been adopted.

Case Example 1 - Devon County, England

The Devon county clinic employed six general practitioners, one social worker, and two health visitors. The centre served a population of 14,400 patients. The social worker had been attached to the group practise for a three year trial to assess the need for, and the contribution of,

a Master's level social worker in this type of setting.

Although the purposes of this project were broadly stated, the activities of the social worker fell into very narrow and traditional categories. Her primary contributions were in the areas of:

> i casework services for complex social/emotional situations surrounding illness or presenting in the surgery in the guise of physical illness, and
>
> ii effectively mobilizing social services.
> (Forman and Fairbairn, 1968:10)

It has been suggested that this social worker was in a position of excessive demand[1] and was therefore forced to limit her practise to those activities which could be managed most reasonably. However, most of the leading actors in the project thought that the therapeutic aspect of the social worker's role was particularly important. A deliberate attempt was made to refer only those cases which were considered to be normal reactions to disease or social/emotional stresses. Known multi-problem families and psychotic patients were not referred. As a result, most of the casework was intense and short term. The social worker herself suggested the management of long term, chronic social problems would be inappropriate in a general practise because of the time required.

Although the social worker appears to have provided some needed service to the patients of this group practise, her experience represents a very limited exploration of the potentialities which exist in such a setting.

Case Example 2 - Caversham Project, London, England

The original practise team in this project consisted of four doctors, a part time consultant on marital and sexual problems, a practise nurse, a health visitor, a social worker, and supportive clerical personnel.

The practise served a patient population of 9,000.

The social worker dealt with,

> 1,353 episodes during a period of four years. This meant an average of twenty eight per month or six to seven referrals per week. (Goldberg, Neil, Speak, Faulkner, 1968:53)

Table 6 illustrates the nature of the problems presented to the social worker and the action taken.

Table 6

Main Problems and Action Taken

Action Taken	MAIN PROBLEMS													
	Problems in Family Relation-ship		Problems at Work or School		Financial need, housing problem, need for domicil-iary services		Anxiety about Health, Personal crisis		Psych. illness, Personal-ity problem, Social relations problem		Others not Known		Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Clarifica-tion, Assessment, Advice, and Information	72	24	31	31	36	19	38	20	41	23	32	45	250	24
Casework in the Practise	122	40	46	47	74	40	99	53	78	45	15	21	434	43
Referral to Outside Agencies	99	33	18	18	67	36	40	22	45	26	17	24	286	28
Other	10	3	4	4	10	5	9	5	11	6	6	9	50	5
TOTALS	303	100	99	100	187	100	186	100	175	100	70	100	1020	100

Source: (Goldberg, Neil, Speak, Faulkner, 1968:97)

As the table indicated, casework services accounted for the largest proportion of the services rendered. This is similar to the previous example. However, these casework services reflect a broader focus than simply patients' reactions to disease conditions. The social worker in this project was able to participate with patients and families in the resolution of problems related to their social or environmental circumstances.

The social worker also played an important role in providing information and in motivating clients to utilize available resources. Some overlap was perceived between the social worker and the health visitor in this respect. This was resolved near the end of the project when the health visitor assumed most of the responsibility for general health education with clients and the social worker retained primary responsibility for formal referrals to outside agencies. The social worker's referral patterns became increasingly more selective as she became more aware of the resources available and the effectiveness of particular agencies.

The social worker also assumed responsibility for on site teaching of general practise, social work, and health visitor students. This was regarded as extremely important because it helped to ensure that new health care providers became aware of the work and the potential contribution of social work in general practise/primary care.

Although the social worker adopted a more expanded work role in this project, she was still primarily limited to problem solving tasks with individuals, families, or staff. While this approach to social work practise appears to have met the expectations of the particular setting, it would not be adequate in a comprehensive conceived primary

care centre.

Case Example 3 - Martha Elliot Family Health Centre, Boston, Massachusetts

The social work services of this centre were provided in conjunction with obstetric and pediatric services, dental, psychiatric, nutritional and public health nursing services. All personnel were assigned to health teams. Team meetings were held regularly for the purpose of discussing case problems, decision making, and joint planning.

Five principles of care were adopted by the health teams as the philosophical basis of centre operation. (Cowin, 1968: 3-4)

1. The Right to Medical Care - removal of obstacles to accessible health care.
2. Principle of Reaching Out and Case Finding - attempt to prevent the development of serious health and social problems by outreach methods and early detection.
3. Family Centred Approach - develop holistic view of clients in their total social and environmental circumstances.
4. Coordination of Services - prevent unnecessary stacking of services and fragmentation of services.
5. Use of Auxiliary Personnel - extension of centre services, ensure appropriate utilization of personnel staff, provide community liaison and case follow-up.

The practise of social work in the centre was strongly influenced by these commonly accepted principles of care. The social workers attached

to the health centre perceived themselves as,

> doing something different....it's not really casework but results happen. (Cowin, 1968:2)

They worked as generalists utilizing all known interventive methods for solving problems of individuals, groups, and/or the community. The social workers conducted many individual case assessments but were generally more varied in their choice of action than those discussed in the previous examples. Community workers were often deployed to conduct specific tasks with the individual or family in the context of an overall plan which went beyond the particular case. The social worker assumes an advocacy role with community institutions or leaders when this was required. Special group programs (e.g., Boys Activity group, ages 6-11) and community resources (e.g., Day Care Facility for brain damaged children) were developed by the social workers when the need was indicated.

The social workers also undertook the role of consultant to other team members. As consultants they were:

> free to raise questions without waiting to be asked - questions which may, at once or later, result in widening the scope of the inquiry and thus affecting the assessment of the problem. (Cowin, 1968:6)

Finally, the social workers in this health centre were not in the position of having to wait for case referrals. They undertook an aggressive role in case finding, by maintaining continuous contact with numerous social agencies, by attempting to be accessible and visible in the community, and by developing expectations within the centre regarding social work's role in ongoing screening programs.

This example illustrates some of the potentialities that exist for social work in a setting which is committed to a broad conceptualization

of its primary care responsibilities. The examples of social work activity in this centre demonstrate the beginning of a preventive developmental orientation. However, this area requires more attention and innovation. Social workers should become more actively involved in organizing community projects which address and attempt to eliminate causal factors of health breakdown (e.g. poor nutrition, poor housing, inactivity, inadequate parenting). They must also develop mechanisms by which positive social conditions in communities, groups, and individuals can be effectively promoted and maintained (e.g. block parent, program, meals-on-wheels, friendly visiting).

The following discussion summarizes the nature of social work practise which is proposed for an ideal primary care centre.

Social Work in Primary Care - A Proposal

1. Social Work in primary care should be of a generalist type.

Primary care has been described in a very comprehensive way throughout this study in order to illustrate the range of health care issues which may require intervention at the point of entry into the personal health care system.

The suggested programs of a primary care centre were presented in Chapter III. It became apparent that health manpower with a broad base of knowledge and skill would be required to fulfill the tasks associated with these programs. Although the intent of the centre is to employ primary care staff to undertake those activities most befitting of their training and aptitude, it will be necessary for the staff to maintain an overall sense of the centre's operation and to be prepared to undertake various innovative tasks as the need arises.

It is proposed that social workers in a primary care centre not carry extensive responsibilities for statutory programs.[2] This is to ensure the workers do not become inadvertently preoccupied with categorical tasks, leaving insufficient time to develop the preventive and community outreach aspects of practise. To some extent, the social workers' practise will be determined by the service requests initiated by consumers and by the referrals made by members of the health team. However, social workers must be constantly attuned to the full scope of social need presented in the centre and the larger service community in order to achieve an appropriate balance of activity within their practise. As generalists, social workers in primary care should be prepared to undertake any appropriate activity for which they are trained if it will contribute to the achievement of primary care goals.

2. Social Work in primary care should emphasize the preventive and developmental aspects of practise.

The achievement and maintenance of positive health status among all members of the service community is the principle aim of a primary care centre. This connotes a need for interventions which:

i identify and eliminate factors which cause or contribute to poor "health", and

ii identify and promote factors which cause or contribute to general well being.

There has always been a great deal of rhetoric within the social work profession regarding the need to move away from a crisis orientation to practise. However, few suggestions have been made concerning how to

implement a preventive orientation. It is the author's belief that the primary care centre offers the social work profession an opportunity to pursue a preventive/developmental approach to practise. In this setting, social workers can participate in, and possibly expand, certain traditional preventive activities such as the annual "physical" checkup. With gradual consumer and staff education, this activity may come to be accepted as an opportunity to assess one's "overall" functioning, thereby facilitating the early identification of many potential problems. Furthermore, the mandate of a primary care centre not only allows but also encourages program indications which address problem-causing factors. Social workers in a primary care centre should be involved in community outreach activities in order to develop an awareness of these factors in their community. This information should be shared with the members of the health team to promote cooperative planning of new preventive approaches. For example, a social worker may receive information from students, school personnel, businessmen, _et cetera_ that serious problems are beginning to surface among teenagers (e.g., alcohol abuse, delinquency) due to a lack of social and recreational outlets in the community. This information could provide the basis on which a social worker in conjunction with the primary care team could plan strategies to address the problem.

The nature of the preventive and developmental activity undertaken by social workers in primary care centres should result from a careful assessment of the needs of the community in general as well as of the patients who seek services from the centre.

3. Social Work in primary care should play a major role in identifying and mobilizing the needed resources of other community agencies.

A primary care centre, while comprehensive in terms of entry level services, must have connections with many other services and facilities. The physical-and-mental health staff will require specific relationships with secondary and tertiary health care facilities (e.g., medical specialists, mental health centre). Social workers will need relationships with specialized social service resources for the purpose of consultation and direct referral.

A primary care centre must strive to avoid unncessary duplication of services. Therefore, all staff must be constantly aware of the agencies operating in the community and the nature of their respective mandates and programs. Social workers in a primary care centre should become highly visible in the community, initiating and maintaining contacts with personnel in all human resource fields (e.g., education, law, religion, social service, recreation). Through these contacts, social workers can gain an understanding of the services available and some idea of their effectiveness. This information should be given to all health team members to assist them in making referral decisions. The information should also become part of a composite community profile which can be utilized in the long range planning of new programs and services for the centre.

4. Social work in primary care should have a therapeutic and rehabilitative component.

In addition to its emphasis on preventive and development health services, a primary care centre will also provide treatment and rehabilitative services for physical, mental, and social problems. As previously indicated, these will be basic services meant to solve or ameliorate relatively common conditions. It is reasonable to expect that many of these services will be

performed by means of one-to-one interaction between a staff member and a patient/client. Problems are most often presented in a primary care facility on an individual basis. Thus, much of the initial contact and short term problem solving work will be in the form of crisis intervention and will involve a dyadic relationship between a consumer and a provider.

Problem-solving through counselling relationships is a familiar part of traditional social work practise. A social worker practising in a primary care centre could reasonably be expected to provide counselling services under a number of circumstances. He/she should provide problem-solving assistance to individuals experiencing acute interpersonal problems. A worker might also provide supportive counselling to persons adjusting to some social or physical condition. Counselling oriented to the management of a chronic social problem could also be undertaken. On request, a social worker might participate as a co therapist in specific cases which are being managed by a fellow team member. However, individuals or families who require specialized counselling or structured treatment programs should be referred to appropriate secondary or tertiary service agencies.

Social workers may consider organizing groups for some treatment or rehabilitation purpose if none are effectively operating in the community. Other primary care workers may be able to contribute to the groups dependent on the nature of the problems being addressed. For example, in a group organized to deal with problems of chronic alcholism, a physician may provide a needed perspective on the implications of alcohol abuse on physical health.

Limited counselling and innovative team approaches to treatment and rehabilitation are proposed as components of the social worker's role

in a primary care centre.

Summary

This chapter has attempted to summarize the arguments which support the need for social work in a primary care centre. Several case examples were presented to contrast different ways that social work could be implemented in primary care settings. Finally, four general themes were presented under which the proposed nature of social work in an ideal primary care centre was discussed.

CHAPTER IV

FOOTNOTES

1. On the surface, this position may appear to be inconsistent with the general theme of integration in a primary care centre. It is desirable for all social service programs which are being delivered in an area to be coordinated. The primary care centre could facilitate linkages between the various programs by organizing interagency meetings, case conferences, *et cetera*. The social worker in the centre might assume the role of case manager for clients who are receiving services from several agencies. The social worker might also provide primary counselling and support to clients in certain statutory programs. The major purposes of a primary care centre are to provide entry level services and to coordinate service plans and this focus should be retained in the practise of the generalist social worker. General practitioners deliver primary medical care and refer patients in need of specialized services to consultants. The same principle should apply to primary social work practise. Certain aspects of statutory social programs could be considered as requiring primary level service, (e.g., probation supervision) but others require more specialized skill, (e.g., child abuse counselling) and should be handled by more specialized personnel.

2. Data from other projects in Great Britain, similar to this one, has suggested that one worker who performs the functions of diagnosis, of mobilizing social services, as well as case work therapy, can barely handle the socio-medical problems associated with a 9,000 patient practise. (Goldberg, Neil, Speak, Faulkner, 1968:552)

CHAPTER V

SUMMARY AND CONCLUSIONS

This study has examined a number of issues related to health care planning, organization, and manpower. The examination was initially exploratory to gain an understanding of:

i the philosophical foundation of the traditional health delivery system and its influence on organizational structure and priorities;

ii the health care reforms being introduced in several countries; and

iii the common trends in conceptualizing and organizing primary care which are emerging internationally.

Secondly, the study was developmental in that it proposed a model of an ideal primary care centre and suggested guidelines for the practice of social work in such a setting.

There are several reasons why the issues examined in this study are considered to be important. Health is an issue of concern to virtually everyone. Health care has come to be viewed as a basic human right. People want access to health services when they require them and want to be assured that the services they receive are of high quality. Governments have attempted to fulfill these expectations and in so doing, have created the situation where a large proportion of tax revenues are now spent on a highly sophisticated and complex health system.

Numerous reviews of health care services and organization have been conducted in recent years. The reviews have consistently recommended that:

i health service priorities need to change in order to reflect current needs and realities more adequately, and

ii the health care system needs to be more rationally organized.

This study was focused on primary health care because of the implications of these recommendations. It is at the primary care level that the majority of personal health care services are delivered. Furthermore, much of the disease, injury, and dysfunction which is treated at more sophisticated levels of care might well have been prevented or more quickly treated if mechanisms for early problem identification had been developed and promoted within the primary care level.

There is an immediate need to assess the capabilities of current primary care organizations and to propose reforms which would support their expansion and development. This study represents a beginning analysis of primary care. It provides the reader with an understanding of the issues involved in philosophically and organizationally reorienting the health system.

The examination of social work in primary care reflects the author's belief that many of the organizational and service delivery problems which have confronted the traditional health system are also problematic in the social service system. Such problems include, but are not limited to, fragmentation, crisis orientation, and over specialization. Many of the proposals regarding the organization of comprehensive primary care (eg. integration of services, emphasis upon delivered and health promotion, increased consumer involvement) could have positive implications for social work practice.

The study has considered the advantages of social work practice in primary care for the social work profession and for the primary care centre.

Two major advantages could accrue to the social work profession from an association with primary care. First, because an ideal primary care centre places significant emphasis on the preventive and developmental aspects of service delivery, all primary care workers would be expected and encouraged to undertake innovative activities to achieve these goals. There are too few

opportunities presented to social workers to realize the objectives of prevention and development and to refine the techniques by which to do so. The primary care centre represents the point of entry into the personal health care system and as such, offers social workers excellent opportunities for the early identification and intervention into emerging social problems. Secondly, the establishment of an autonomous role for social work is more probable in a primary care setting. The centre would necessitate the establishment of interdependent and mutually acceptable role expectations for each member of its staff. Each primary care worker would then be aware of his/her specific task responsibilities and being secure in that knowledge, could participate as a peer on the primary care team.

The primary care centre would itself benefit from social work involvement. For a truly preventive orientation to be realized within primary care organizations, the contributing and causal factors of ill health must be determined. Social workers could assist in this process through their awareness of the effects of environmental conditions and individual decision-making on health status. In addition, social workers could provide expertise in the areas of interpersonal problem-solving (eg. counselling) and group process. (eg. team development, treatment groups). Finally, an ideal primary care centre has a special interest in developing effective consumer participation and in undertaking activities which address needs identified by the community. Social workers have skills in community development and outreach which could prove most useful in a primary care setting.

A final comment concerns the advantages which accrue to the general public when comprehensive primary care is visualized in the manner herein proposed. First and foremost, the public can potentially improve its collective health status if "primary care" prevention and health promotion services are

successfull developed and "primary care" treatment services are of high quality. Consumers would enjoy better accessibility and convenience if all basic human services were made available through a single, local facility. Finally, consumers would have the opportunity to assume a measure of control over the planning and organization of services which vitally affect them.

The study has supported the growing interest in reorganizing the health care system so that greater emphasis is placed upon the level of primary care. It has suggested that a complementary interest has emerged in the social services. The profession of social work is poised to serve as an effective bridge between the two systems. What is now required are opportunities to test these assumptions so that they may be verified and refined through experience. It is to be hoped that the model of a primary care centre presented herein will serve as a useful point of departure.

Major causes of death for each sex and age group
Causes principales de décès pour chaque tranche d'âge et de sexe

Canada 1974

0-4 | 5-9 | 10-14 | 15-19 | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 | 65-69 | 70-79

Male – Hommes

causes not indicated here, as most are specific to infant mortality

Age	d	p
0-4	3 658	905,8
5-9	504	1 012,5
10-14	599	1 202,8
15-19	1 977	1 161,6
20-24	2 041	1 022,2
25-29	1 437	926,5
30-34	1 180	768,4
35-39	1 481	648,0
40-44	2 283	651,4
45-49	3 594	622,9
50-54	5 351	579,0
55-59	6 908	472,1
60-64	9 455	417,1
65-69	11 110	318,2
70-79	23 277	370,9

Female – Femmes

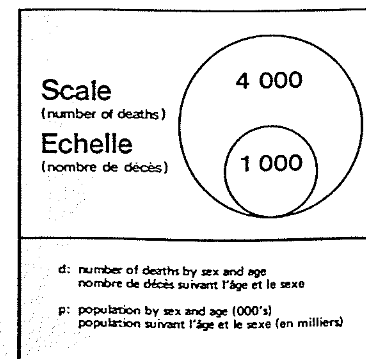
causes non indiquées ici, la plupart étant spécifiques de la mortalité infantile

Age	d	p
0-4	2 704	860,0
5-9	326	966,5
10-14	340	1 149,3
15-19	655	1 115,5
20-24	607	1 010,5
25-29	571	929,8
30-34	608	737,3
35-39	776	627,0
40-44	1 171	622,5
45-49	1 967	621,5
50-54	2 832	600,1
55-59	3 532	495,3
60-64	4 922	437,4
65-69	6 133	354,6
70-79	17 081	474,1

Legend - Légende

- Motor vehicle accidents / Accidents de véhicule à moteur — AE 138
- All other accidents / Autres accidents — AE 139-146
- Suicide — AE 147
- Respiratory diseases / Maladies respiratoires — A 89-96
- Cirrhosis of liver / Cirrhose du foie — A 102
- Coronary heart disease / Maladies coronariennes — A 83
- Cerebrovascular accident (stroke) / Maladies cérébrovasculaires (congestion cérébrale) — A 85
- Other arteriosclerotic diseases / Autres formes d'artériosclérose — A 86
- Leukemia / Leucémie — A 59
- Breast cancer / Cancer du sein — A 54
- Congenital anomalies / Malformations congénitales — A 126-130
- Diseases of nervous system and sense organs / Maladies du système nerveux et des organes des sens — A 72-79
- Cancer of respiratory organs / Cancer des organes de l'appareil respiratoire — A50, 51, 58B
- Cancer of digestive organs / Cancer des organes digestifs — A46 - 49, 58A
- Cancer of uterus, ovary & other female genitalia / Cancer de l'utérus, de l'ovaire et des autres — A55, 56, 58D,E
- All other causes (each causing less than 5% of deaths within each sex and age group) / Toutes les autres causes (responsables individuellement de moins de 5% des décès dans chaque tranche d'âge et de sexe)

Source: Vital Statistics, Statistics Canada / La Statistique de l'Etat Civil, Statistique Canada



d: number of deaths by sex and age / nombre de décès suivant l'âge et le sexe

p: population by sex and age (000's) / population suivant l'âge et le sexe (en milliers)

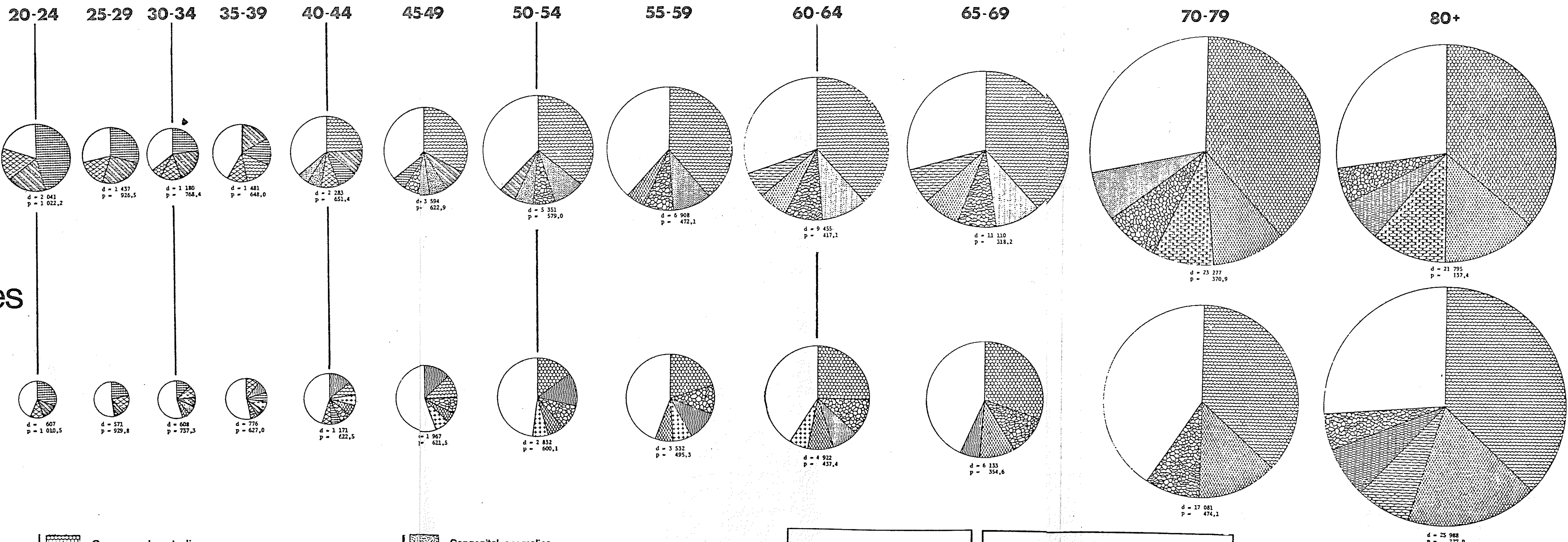
Notes

1) – In each circle major causes of death are arranged in decreasing order of magnitude.
– Dans chaque cercle les causes principales de décès sont indiquées par ordre décroissant.

2) – The area of each circle is proportional to the number of deaths in each sex and age group. (The death rate can be calculated using the two figures under each circle).
– Les surfaces de chaque cercle sont proportionnelles aux nombres de décès de chaque tranche d'âge et de sexe. (Les taux de décès peuvent être calculés en utilisant les deux nombres figurant sous chaque cercle).

eath for each sex and age group
de décès pour chaque tranche d'âge et de sexe

Canada 1974



Coronary heart disease
Maladies coronariennes A 83

Cerebrovascular accident (stroke)
Maladies cérébrovasculaires (congestion cérébrale) A 85

Other arteriosclerotic diseases
Autres formes d'artériosclérose A 86

Leukemia
Leucémie A 59

Breast cancer
Cancer du sein A 54

Congenital anomalies
Malformations congénitales A 126-130

Diseases of nervous system and sense organs
Maladies du système nerveux et des organes des sens A 72-79

Cancer of respiratory organs
Cancer des organes de l'appareil respiratoire A50, 51, 58B

Cancer of digestive organs
Cancer des organes digestifs A46-49, 58A

Cancer of uterus, ovary & other female genitalia
Cancer de l'utérus, de l'ovaire et des autres A55, 56, 58D, E

All other causes
(each causing less than 5% of deaths within each sex and age group)
Toutes les autres causes
(responsables individuellement de moins de 5% des décès dans chaque tranche d'âge et de sexe)

Scale
(number of deaths)
Echelle
(nombre de décès)

4 000

1 000

d: number of deaths by sex and age
nombre de décès suivant l'âge et le sexe

p: population by sex and age (000's)
population suivant l'âge et le sexe (en milliers)

Notes

1) — In each circle major causes of death are arranged in decreasing order of magnitude.
— Dans chaque cercle les causes principales de décès sont indiquées par ordre décroissant.

2) — The area of each circle is proportional to the number of deaths in each sex and age group. (The death rate can be calculated using the two figures under each circle).
— Les surfaces de chaque cercle sont proportionnelles aux nombres de décès de chaque tranche d'âge et de sexe. (Les taux de décès peuvent être calculés en utilisant les deux nombres figurant sous chaque cercle).

Health and Welfare Canada
Santé et Bien-être social Canada

Long Range Health Planning
Planification à long terme (santé)

APPENDIX B

CURRICULUM OUTLINE FOR FAMILY HEALTH WORKER AND MEDICAL ASSISTANT TRAINING

Total Hours:
Family Health workers 600
Medical Assistants 425

1. Nursing* (Family Health Workers - 100 hours; Medical Assistants - 90 hours)

   a. Nursing skills
   b. Reproductive system and sex education
   c. Maternal and child care
   d. Family planning
   e. Pediatrics
   f. Nursing aspects of internal medicine
   g. Family life
   h. First aid
   i. Nutrition
   j. Specimen collection and laboratory tests
   k. Home nursing and visiting procedures
   l. Medications
   m. Ethics and conduct

2. Health and Disease* (60 hours)
   a. Pediatrics
      1. Health maintenance
      2. Common problems
      3. Special problems
   b. Reproduction
      1. Anatomy and physiology of male and female
      2. Common female problems
      3. Venereal disease
      4. Sex education
   c. Internal Medicine
      1. Health maintenance
      2. Problems in internal medicine
   d. Special Topics

3. Community Resources * (Family Health Workers - 80 hours; Medical Assistants - 70 hours)
   a. Study units - criminal procedure, welfare problems, housing, consumer problems, social insurance, narcotics addiction, problem of the aged and physically handicapped, juvenile delinquency,

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* A detailed curriculum follows for this course.

marital problems of unwed mothers, child care, recreation, education, employment, job training, alcoholism, legal advice
B. Written summaries of trips, films, and speakers

IV. Medical Terminology* (36 hours)
A. General medical terms
B. Prefixes and suffixes
C. Pharmacological terms

V. Communication and Interviewing Skills (10 hours)
A. Letter writing
B. Telephone technique
C. Summarizing important facts
D. Interviewing techniques—approaches, listening, setting priorities, planning action

VI. Patients' Rights (4 hours)
A. Patients' Rights Manual
B. Patient's right to welfare
C. Patient's right to Medicaid, Medicare
D. Social Security

VII. Laboratory (5 hours)
A. Types of tests—urine, stool, blood, nose culture, throat culture
B. Specific tests done
C. Procedures for obtaining specimens
D. Storage

VIII. Family Charts (5 hours)
A. Forms
B. Problem-oriented record

IX. Pharmacology (5 hours)
A. Review of Core curriculum
B. Medications and dosages for common childhood illnesses
C. Medications and dosages for common adult illnesses

X. Field and Team Experience* (Family health workers—270 hours; Medical assistants—115 hours)
A. Team work with teams at MLK
B. Field visits to a hospital, a clinic, a visiting nurse service and an electrocardiogram unit

XI. Miscellaneous
A. Films
B. Study periods
C. Counseling periods
D. Family assessment classes

NURSING

Time: Family Health Workers–100 hours
Medical Assistants–90 hours

Note: We try to schedule similar topics in the Nursing course and Health and Disease course on the same day or within the same week so that the material in one class supplements the other.

I. Nursing Skills
- A. Vital signs
  - 1. Body temperature
    - – Measurement
    - – Regulation
    - – Types of fever
    - – Care and cleaning of the thermometer
  - 2. Pulse
    - – Rate, rhythm, volume
    - – Respiration
  - 3. Blood pressure
    - – Systolic
    - – Diastolic
    - – Sphyngomanometer
- B. Recognizing illness
  - 1. Observation techniques
  - 2. Signs and symptoms
  - 3. Inspection of throat
- C. Simple treatments
  - 1. Reduction of temperature
  - 2. Hot and cold compresses
  - 3. Irrigations (wounds, bladder, ear, eye)
  - 4. Decubitus ulcer care
  - 5. Diabetic skin and foot care
  - 6. Colostomy care
- D. Personal services
  - 1. Oral hygiene
  - 2. Bed bath, back rub, and bed-making
  - 3. Care of hair, hands, skin, feet, and nails
- E. Preventing spread of infection
  - 1. Handwashing
  - 2. Aseptic technique and glove technique
  - 3. Sterilization

II. The Reproductive System and Sex Education
- A. Anatomy
  - 1. Male
  - 2. Female
- B. Physiology of menstruation
  - 1. Ovulation
  - 2. Implantation
- C. Conception
- D. Development of fetus and placenta
- E. Sex education
  - 1. teaching the young
  - 2. sexual problems and therapy

III. Maternal and Child Care
- A. Antepartum
  - 1. Signs of pregnancy
  - 2. Importance of early medical care
  - 3. Danger signs (bleeding, swelling, headache, persistent nausea and vomiting, pain in abdomen, back pain)
  - 4. Common problems and discomforts (nausea, urinary frequency, constipation, fatigue, faintness, heartburn, backache, muscle cramps, dyspnea, insomnia, leukorrhea)
  - 5. Minor complications (edema, varicose veins, hemorrhoids)
  - 6. Serious complications (toxemia, pre-eclampsia, eclampsia, etopic pregnancy, placenta previa)
- B. Labor and Delivery
  - 1. Normal delivery
  - 2. Emergency delivery
  - 3. Prematurity
- C. Newborn
  - 1. Inspection
  - 2. Care
  - 3. Illnesses
    - – diarrhea and constipation
    - – dehydration
    - – infections

IV. Family Planning
- A. Facts and fallacies
- B. Birth control
  - 1. Methods and effects
  - 2. Attitudes toward use
  - 3. Abortion

V. Pediatrics (including relevant nutrition and pharmacology)
   A. Growth and Development
      1. Physical
      2. Emotional
      3. Intellectual
   B. Illnesses
      1. Respiratory diseases and infections – asthma, tuberculosis
      2. Congenital and rheumatic heart disease
      3. Gastrointestinal diseases and anomalies
      4. Genitourinary tract disease and anomalies
      5. Neuromuscular diseases
      6. Special senses
      7. Glandular disorders
      8. Special topics
         – Anemia (nutritional, sickle cell)
         – Diabetes
         – Leukemia
         – Failure to thrive
         – Genetic disorders – Tay-Sachs disease, Cooley's anemia
   C. Vaccination and immunization schedules
   D. Child rearing
      1. Feeding
      2. Love and the child
      3. Learning and the child
      4. Discipline and the child
      5. Responsibility
      6. The effect of a single parent family
   E. Other problems
      1. Medical problems
      2. Allergies
      3. Common exanthems (rashes)
      4. Obesity
      5. Dental care
      6. Developmental problems
      7. Mental retardation
      8. Minimal brain dysfunction
      9. Specific learning disabilities
      10. Lead poisoning
      11. Battered child syndrome

VI. Nursing Aspects of Internal Medicine
   A. Problems of care
   B. Health maintenance
   C. Treatment of chronic disease

   D. Common illnesses and problems – colds, anxiety, depression, insomnia, heart failure, heart attack, diabetes, hypertension, obesity, urinary tract infections, prostate, asthma, constipation, alcoholism, drug addiction, rheumatoid and osteoarthritis, low back pain, glaucoma, tuberculosis, emphysema, strokes
   E. Common symptoms in internal medicine – pain, fever, headache, insomnia, dyspnea, fatigue, cough, edema, palpitations, blood in stools, jaundice, loss of weight, discomfort with eating, diarrhea
   F. Psychiatric disorders
      1. Schizophrenic reactions
      2. Personality disorders (including alcoholism and drug abuse)
      3. Depression
      4. Neuroses
   G. Aging patient
   H. Dying patient

VII. Family Life
   A. Family structure and cultural roles of family
   B. Economics of the family
   C. Father-husband-male partner
   D. Mother-wife-female partner
   E. Conflict in the family
   F. The family in crisis
   G. Family diagnosis
   H. The fatherless family
   I. Crisis intervention
   J. Child-rearing and parent education

VII. First Aid
   A. Shock
      – Signs and symptoms, treatments
   B. Wounds
      – Types, treatments, procedures for first aid
   C. Burns
      – Types, prevention
   D. Bone, joint, and muscle injuries
      – Fractures, sprains, dislocating strains
   E. Poisoning
      – Universal antidote
      – Use of Poison Control Center
   F. Coma
      – Definition, causes
      – Differentiation between shock and coma
   G. Convulsions

H. Identifications of and action in response to real emergencies

IX. Nutrition
- A. Ethnic and cultural differences
- B. Psychological meaning of food
- C. Basic four food groups
- D. Special diets (low sodium, diabetics)
- E. Comparison shopping and consumer knowledge
- F. Use of food stamps

X. Specimen Collection and Laboratory Tests
- A. Types of tests
  - – Urine, stool, blood, throat culture
- B. Specific tests done
- C. Procedure for obtaining specimens
  - – Proper equipment, labeling, handling (aseptic technique, clean technique), storage

XI. Home Nursing and Visiting Procedures
- A. Preventing spread of infection
  - – Handwashing, wearing of aprons, sickroom waste (discarding)
- B. Bedmaking
- C. Personal services
  - – Oral hygiene including dentures, bed bath and back rub, bed pan or urinal, hair, skin, hands and feet including nails
- D. Simple treatments
  - – Reduction of temperature, hot and cold compresses, irrigations, decubitus ulcers, skin and foot care for patients with diabetes
- E. Recording of visit
- F. Follow-up visit
- G. Bag technique
  - – Equipment, procedure

XII. Medications
- A. Self treatment
  - – Follow directions
  - – Use of medication prescribed by doctor
- B. Disposal of medication
- C. Demonstration and practice
  - – Use of eye ointments, nose drops, pouring oral and liquid medications
- D. Types of medications

  - – Oral, injectables, inhalation, suppositories
- E. Prescription abbreviations
- F. Improvisation in home situation
- G. Teaching – related to medicine and side effects
- H. Common medications in internal medicine – digitalis, antihypertensives, diuretics, insulin and oral medications, medicines for "nervousness," symptomatic medicines, folk medicine

XIII. Ethics and Conduct
- A. Confidentiality
  - – Records, medical information, patient information
- B. Openness and empathy
- C. Appearance
  - – Uniforms, neatness

HEALTH AND DISEASE

Time: 60 Hours
5 Hours/week for 12 weeks

Objectives:

- Provide a core of information on various topics
- Outline medical knowledge useful for the job
- Familiarize the trainee with basic anatomy and physiology of the body's systems
- Provoke questioning in medical areas

Method

The course in Health and Disease is taught by doctors from the Department of Social Medicine of Montefiore Hospital who are serving their internships and residencies at MLK. The course is taught during a period of 12 weeks for one hour each day. The first 45 minutes of the hour is an overview of the topic; the last 15 minutes is open to questions. One doctor coordinates the course and arranges for others to lecture on the topics in which they are specializing. The nurse often attends these lectures so that points made can be expanded in the Nursing class. Each doctor is asked to make up a quiz covering his major points. These quiz questions are then incorporated into the Nursing examinations. Doctors are also asked to submit notes of their lectures to distribute to the trainees.

Topics:

I. Pediatrics
  A. Health maintenance
    - Growth and development
      physical—newborns, well-baby exams
      intellectual
      emotional
    - Immunizations
    - Screening tests: blood, urine, TB, vision, hearing
  B. Common Problems
    - respiratory illness
    - gastrointestinal problems—vomiting, diarrhea, colic
    - nutrition and feeding
    - heart disease
    - commons rashes
    - skin disease
    - childhood diseases—measles, mumps, chicken pox, German measles

    - blood problems
    - genitourinary problems
    - neurological problems
    - orthopedic problems
  C. Special problems in children
    - accidents
    - poisoning
    - trauma
    - battered child
    - sudden infant death syndrome

II. Reproduction
  A. Anatomy and physiology of male and female
  B. Common female problems
  C. Venereal disease
  D. Sex education

III. Internal Medicine
  A. Health maintenance
  B. Problems in internal medicine
    - Respiratory—asthma, tuberculosis, emphysema
    - Eyes, speech, hearing
    - Cardiovascular
      heart disease, myocardial infarction, hypertension, stroke
    - Gastrointestinal
      ulcers, colitis, acute disorders
    - Genitourinary
      kidney, bladder
    - Orthopedic (bones and joints)
    - Nervous system
      seizures, common illnesses
    - Blood
    - Skin
    - Endocrine including diabetes and thyroid

IV. Special Topics
  A. Constitutional factors—predisposition to illness
  B. Epidemiology
  C. Patient encounter—healing role
  D. Family and disease
  E. Aging—care of chronically ill, disabled
  F. Death and dying
  G. Medical ethics
  H. Psychosomatics
  I. Cancer

Sample Topic

GASTRO INTESTINAL SYSTEM

Jo Boufford, M.D.

Time: 1 hour

I. Functions of the gastro intestinal system
   - refines fuel (food we eat) and changes to a form we can use

II. How is food "refined" (broken up)?
   A. Juices chemically break down food. They convert sugar to different kinds of sugar which bodies can handle better.
      1. Saliva breaks up sugar
      2. Liver–bile
      3. Pancreas–pancreatic juices are *alkaline*
      4. Stomach–hydrocloric *acid*
      5. Gall bladder juices
   B. Enzymes
      1. Convert raw food to other substances
      2. Are contained in digestive juices
      3. Secreted from different organs

III. Function of different organs
   A. Mouth–teeth–shredder
   B. Esophagus–tunnel
   C. Stomach – vat into which chemicals are poured; converts food – gastric juices – acid and enzymes
   D. Intestine (20 feet long) absorbs what we need (nutrients)
   E. Appendix–no known function
   F. Colon–storage; compacts feces
   G. Liver-stores sugar; filters; produces bile; inactivates and eliminates chemical poisons
      1. Has two blood supplies
         - blood coming from intestine with nutrients go to liver
         - blood directly from heart (red blood cells with oxygen and CO_2)
      2. Two things that leave liver
         - blood through veins
         - bile flows through canals to gall bladder where it is stopped. Bile goes from gall bladder (which contracts) to intestine after we've eaten.

IV. Diseases of the G.I. Tract
   A. Ulcers–sores
      1. Location usually in intestines–duodenum
      2. Caused by aspirin (irritant), worry, coffee (caffeine), alcohol, cigarettes (nicotine)
      3. What happens–pain one hour or so after eating
      4. How diagnosed
         - x-ray (gastrointestinal series)
      5. Treatment
         - six small meals a day
         - antacids–Maalox, Gelusil after eating; before bed drink milk
         - discontinue aspirin, alcohol
         - can be cured only when we know what's causing it
      6. If bleeds and won't stop–operate, sew it up
   B. Jaundice–yellowness
      1. Means something is not functioning right; something is preventing bile from getting from liver to gall bladder; bile backs up. Could be problem in liver or in gall bladder.
      2. Bile is spilling over from liver and gets into blood
   C. Hepatitis
      1. Alcohol–liver enlarged, inflamed; yellowness of skin
      2. Viral hepatitis
   D. Cirrhosis
      1. End of the road – liver cells are killed usually from too much alcohol
      2. When cell dies–scar tissue builds up and liver gets hard
      3. When fewer and fewer liver cells are functioning, the liver cannot do its usual job of cleaning chemicals from the system. Patient is poisoned by his own chemicals.

COMMUNITY RESOURCES

Time: Family Health Workers: 80 hours
Medical Assistants: 70 hours

Objectives:

To teach the trainee:

- To identify the social and legal problems of families
- To identify the community resources available to help families with social and legal problems
- To help community residents help themselves and each other by making better use of community resources
- To understand and communicate with professionals
- To better assist professionals in providing service to families
- To teach families how to establish priorities
- To evaluate an agency as a resource for the community

Methods of Teaching

The Community Resources course for family health workers followed the format of the Community Resources classes in the Core (see page 26). The study units in the Post Core covered in more detail some of the topics which had been introduced in the Core and included additional topics. Trainees were allowed more freedom in organizing the unit for study, setting up appointments and inviting speakers.

The Community Resources classes were held two afternoons each week. One afternoon was usually spent at the agency and the second class period was spent reporting on the evaluating the agency.

The teaching techniques used during these classes included the following:

1. Guest lectures – to understand the goals and functions of the agency
2. Field trips – to see the physical set up and to assess the work of the agency
3. Films – to see agencies at work
4. Pamphlets – to have secondary information to refer to
5. Reading and writing assignments – to see how well the trainee can get information and to make use of the information
6. Buddying with senior family workers – to get first hand experience
7. Seminars – to give each committee the opportunity to teach a class, exchange information and hold discussions

Study Units

The units included the following topics. Usually one unit was covered per week–one afternoon to visit and one afternoon to report and evaluate. Sometimes a topic might be covered in one class session. This became necessary towards the end of training when the trainees were occupied with on-the-job training or were visiting hospital wards or clinics.

1. Criminal procedure (civil court, Vera Institute of Justice)
2. Welfare problems (local welfare center, welfare right groups)
3. Housing (labor and housing offices)
4. Consumer problems (comparative shopping, attorney general's office, Better Business Bureau)
5. Social insurance (social security office, Medicaid)
6. Narcotics addiction (drug rehab centers, State Narcotics Program)
7. Problem of the aged and physically handicapped (recreation centers for the aged, Division of Vocational Rehabilitation)
8. Juvenile delinquency (youth house, Bureau of Child Welfare)
9. Marital problems of Unwed Mothers (Salvation Army counseling, family court)
10. Child Care (day care centers, foster parents' programs)
11. Recreation (neighborhood centers, public schools)
12. Education (local school boards and schools)
13. Employment (local school boards and schools)
14. Job Training (Urban League, manpower programs)
15. Alcoholism (local Alcoholics Anonymous)
16. Legal Advice (legal aid offices)

In conjunction with the Nursing course, trainees also visited organizations that were medically related, such as:

1. Mental health centers
2. Tuberculosis clinics
3. American Cancer Society
4. Venereal disease centers
5. Muscular dystrophy and multiple sclerosis associations
6. Guild for the Blind
7. Agency for the Deaf

SUGGESTED REFERENCE:

Directory of Social and Health Agencies of NYC 1971-1972. Published for the Community Council of Greater New York, Inc. by Columbia University Press. 1971.

MEDICAL TERMINOLOGY

Time: 36 hours
3 hours/week for 12 weeks

Goal

To introduce the student to the field of medical terminology to teach him or her how to recognize word parts, such as roots and compound words, and to build medical words for them.

Objectives

When the student completes the program s/he should be able to build many medical words from Greek and Latin prefixes, suffixes, word roots and combining forms. S/he should also be able to recognize medical words from the Greek and Latin parts and spell medical words correctly.

The method used to teach is programed instruction. The first step, therefore, is to teach the student how to use the materials. The student is then taught what the word-building system is and is shown how to study medical terminology. The book used to teach the course is *Medical Terminology, A Programed Text*, 2nd ed. (Smith, G.L. and P.E. Davis. New York: John Wiley & Sons, Inc. 1967.) We recommend that approximately 25-30 hours be provided for the teaching of medical terminology to permit completion of the book, use of the medical dictionary, and time to look at diagrams and pictures. Two-hour lecture periods with a short break are usually more beneficial than one-hour time periods. If the work in the Medical Terminology course is integrated with the work in other courses, active learning is more likely to take place.

The following assignments were based on the number of frames the teacher felt could be completed by the student each week:

Week 1:	How to Work the Program – Frames 1-27 (class) The Word-Building System – Frames 28-68 (homework)
Week 2:	How to Study Medical Terminology – Frames 68-112 (class) Medical Terminology – Frames 113-174 (homework)
Week 3:	Frames 113-174 (reviewed) – Test (class) Frames 175-232 – Homework
Week 4:	Frames 175-232 (reviewed) – Test (class) Frames 233-301 – Homework

Week 5:	Frames 233-268 (reviewed) – Class Frames 269-335 – Homework
Week 6:	Frames 269-335 (reviewed) – Class Frames 336-421 – Homework
Week 7:	Frames 336-421 (reviewed) – Test Frames 422-516 Homework
Week 8:	Frames 422-516 (reviewed) – Test Frames 517-599 – Homework
Week 9:	Frames 517-599 (reviewed) – Test Frames 600-650 – Homework
Week 10:	Frames 600-650 (reviewed) – Test Frmaes 651-702 – Homework
Week 11:	Frames 651-702 (reviewed) – Test Frames 703-754 – Homework
Week 12:	Frames 703-754 (reviewed) – Test Frames 755-798 – Homework
Week 13:	Frames 755-798 (reviewed) – Final

We prepared our own weekly tests to determine whether the student could recognize material out of the context of the programmed text. This is an example of one such quiz:

MEDICAL TERMINOLOGY TEST

In the following questions circle the best answer.

1. The suffix ectomy means
   a. to open
   b. to cut out
   c. to cut into
   d. to repair

2. A bluish discoloration of the skin is
   a. cyanoderma
   b. dermatome
   c. dermatosis
   d. cyanosis

3. Cytology is the study of
   a. blood
   b. extremities
   c. cells
   d. mind

4. Inflamed skin is called
   a. appendicitis
   b. cyanosis
   c. acroderma
   d. dermatitis

5. Abnormal whiteness of the skin is called
   a. leukoderma
   b. leukocytosis
   c. dermatosis
   d. leukemia

Match the following with their correct meanings by writing the correct letter of the matching work next to its meaning.

1. leuko	a. cutting into
2. dermato	b. red
3. cyto	c. removal
4. cyano	d. cell
5. ectomy	e. skin
	f. white
	g. blue

ON-THE-JOB TRAINING AND FIELD WORK

On-the-job training

In the third week of the Post Core program, family health worker and medical assistant trainees begin their on-the-job training on the Center's health teams and units. Each family health worker trainee reports to a health team and is placed under the supervision of a family health worker. Medical assistant trainees report to the units and are supervised by medical assistants. The Nursing instructor is responsible for overall supervision of the trainees at their sites. For five weeks the trainees report to their teams and units for two hours a day, three days a week. By the tenth week of the Post Core trainees are spending over half of their time on units and teams or in the field (see Sample Schedule, page ,).

Family health workers spend approximately one-third of their total training time on the health teams. After spending two week-periods with different teams, each trainee is assigned to a permanent team. Most of her time during these last weeks is spent on the new team. Nursing review sessions are scheduled during this time, and in the last week the final written and practical examinations are administered. Medical assistant trainees spend approximately one-third of their time working under supervision on different units. During the last two weeks of their training they report to their permanent assignments and take the written and practical examinations.

Field Work

In the sixth week trainees begin their field assignments. It is at this point that training for the two group diverges, as indicated below.

Family Health Worker Field Assignments

1. Pediatric ambulatory care unit of the out-patient department of a city hospital – 4 afternoons

   Trainees observed the pediatric patient in a hospital setting in order to become acquainted with the kind of follow-up work to be done in the home or in the Health Center. They also observed the pediatric emergency room to become familiar with the kinds of problems children coming to the MLK emergency room might present.

2. Medical wards of a city hospital – 4 days

   Trainees learned and practiced nursing procedures, such as taking vital signs, measuring in-take and out-put, changing dressings, and accompanying patients to rehabilitation ser-

vices. This experience was oriented towards the type of patients the family health worker might have in the home.

3. Community health nursing agency – 4 days

   Trainees practiced bedside-care techniques by making home visits and observing the nurse give care and counseling.

4. State mental hospital – 2 weeks, when available

   Trainees observed mentally ill patients in order to learn how to deal with the depressed and mentally disturbed. Each trainee worked with a nurse from the hospital, observing two or three specific patients during the two weeks. This amount of time was necessary because it often takes at lease this long before trainees began to feel comfortable with the patients. As family health workers deal with depressed or mentally disturbed patients in the home, this was an important part of their training.

Medical Assistant Field Work

1. Pediatric ambulatory care unit – 4 afternoons

   Medical assistants spend four afternoons in the pediatric ambulatory care unit, in order to be familiar with pediatric problems.

2. Hospital EKG unit – 3 days

   Trainees observed EKG technicians and learned the fundamentals of doing EKG's.

APPENDIX C

COMPREHENSIVE DISTRICT HEALTH PLANS

3.15 The basic management unit in the integrated NHS will be the District, defined as a population served by community health services supported by the specialist services of a district general hospital. The District is the lowest level at which it will be possible to make a comprehensive assessment of the health needs of the community and to plan and deploy a broad range of health services required to meet these needs, and it will be at the District level that clinicians will be directly involved in the planning process.

3.16 Here and elsewhere, it is stressed that plans should be prepared on an District basis. It is hoped that plans will be developed by staff working at this level with the guidance and help from Area, Region and Department. However, it would be naive to imagine that all Districts will immediately become fully competent in a difficult process. Thus higher levels must help develop this competence and, in the early years, provide it. Higher level plans will consist of a consolidation of lower level plans, together with plans for services provided at the higher level. Thus AHA's plans will consist basically of plans for each of their Districts, with plans for Area-level services such as the school health service. Similarly, while RHAs should assemble Regional plans, these too should consist of a consolidation of plans for their Districts and Areas with plans for Regional services, and with a greater focus on the development of major building projects, for which RHAs carry primary responsibility.

3.17 To be effective and useful, the health plans prepared for each Distict will have to satisfy a number of requirements described below.

(1) They must cover all services and look up to 10 years ahead.

3.18 Each District's plans should cover the whole range of the community's main needs for health care and of the services that are to be provided to meet these needs. A single "master plan" must therefore be prepared, that encompasses all of these aspects and places them within the context of the level of resources expected to be available to the District, identifying the total revenue expenditure, capital building and personnel requirements necessary to achieve the planned level of service.

3.19 Furthermore, planning and implementing significant changes in health services usually takes a number of years. District health plans should therefore extend forword to cover the full period within which it is necessary and realistic to plan for the future provision and improvement of the community's health service. This period varies depending upon the type of service involved; however, three periods can usefully be singled out.

a. The short term, within which it is possible to bring about changes through deploying or changing the use of existing resources or changing working procedure.
b. The medium term, within which it is possible and realistic to estimate the resources that will be available and plan their deployment, within the context of the constraints imposed by the existing buildings etc. This period is about 4 years.
c. The long term within which it is possible to implement radical changes in the District's health services - in particular, changes that require the design, building, and commissioning of major new buildings. This period is about 10 years.

3.20 Thus the basic plan for the development of each District's health services should be drawn up four years ahead, setting out for each year the estimated extent of the health needs of the different sections of the community, the deployment of the main services of each kind that will be provided to meet them, and the demands that these plans will put on the resources of skilled personnel, buildings and revenue finance (to match the revenue allocations assigned to the District). In addition, a long-term forward look to Year 10 should be included, setting out, in more summary form, the main ways in which the District's health needs are expected to develop and the outline of the services to be provided to meet them, with particular reference to building and other requirements that must be planned well in advance (the capital programme being decided mainly at RHA level).

(2) They must plan for identified needs and explicit standards of service.

3.21 Health services can only be evaluated in relation to the identifiable needs of the community for different kinds of health care, and, with integration, it will become possible for single management units to draw up health plans in this light. In practice, the health care needs of the community are highly diverse and a single individual or family may simultaneously require health care for several different conditions. However, it is useful for planning purposes to distinguish a limited number of broad "health care groups" with special needs, and to differentiate some categories of care, such as specialties, so as to quantify the services required.

3.22 The concept of "health care groups" has been presented in Chapter 1; examples are the care of elderly, maternity, mentally ill, mentally handicapped, acute secondary care, dental care, etc.

3.23 The first step in developing a District plan will be to estimate the extent of local needs in such health care categories. For this purpose, each District should have a defined population and area (or set of areas) assigned to it for each of the main specialities, for which population and area it will generally be responsible for providing health care in that specialty (without of course, implying that in individual cases patients will always be treated in the places that this would suggest). Ideally, each District would have a single population and area for all its specialties and services. In fact, it will be one of the objectives of the reorganizaed Health Service to develop so far as is reasonable, a comprehensive health service within each District to meet the needs of its local community. At present, however, this ideal is seldon likely to be possible, especially for services involving

large long stay hospitals. Thus one District will frequently have to rely heavily upon long stay psychiatric hospital facilities provided by another District or Area, while it may itself provide certain branches of acute secondary care to a wider population than its own. It will be the responsibility of RHAs and AHAs to assign such population and areas to each of their Districts and to ensure that they have adequate information on their population, its composition and likely future trends.

3.24 Secondly, the plans prepared should, so far as possible, be based on standards or targets for the level of care of all kinds to be provided to each of these health care groups, in terms of the quality of care as well. At this point, the important thing is that the plan should be expressed in terms of whatever standards of care chosen. Thus the first main section of the District health plan should contain an assessment of local needs and explicit standards of service.

(3) They must define the services to be provided to meet needs and standards.

3.25 Although planning must start from the needs of the population, it must be expressed in terms of the proposed developments of the component parts of the NHS to meet the required standards, for example, specialist services, nursing, or the ambulance service. An important characteristic of the Health Service is the intricate way in which a limited number of component services are combined to meet the needs of individuals. In some cases (eg. dentistry) there is a reasonably clear correspondence between the need for care and the service provided to meet this need. In other cases (eg. care of the elderly, or maternity), a wide range of different services are required to provide a complete programme of health care, including social services provided by the local authorities. This intricate inter-relationship between health needs and health services adds unavoidable complexity to the task of planning in the Health Service.

3.26 The second main section of the District health plan should draw together the implications of the needs established in the first part for the services to be provided. It should set out how each service is to be developed , what changes in the quantity and use of resources (money, buildings, manpower, equipment) are planned, what changes in working procedures are necessary etc. These service plans will indicate the demands on basic resources to be made by proposed developments taking account of the likely availability of resources.

3.27 Each District should therefore have a plan for the development of its services which is based on (but presented separately from the plans for the main health care groups).

(4) They must plan the use of basic resources.

3.28 Planning can only be realistic if it is conducted within the framework of the resources that are expected to be available, in particular revenue and capital finance (and the new facilities that can only be provided from capital finance), and the various types of

skilled manpower that services require, notably medical and nursing staff. Thus having set out the planned development of each main service, the plans must identify the total demands that these put upon these resources and must have been prepared within the context of the level of these resources that is expected to be available. (eg. the forward revenue allocation assigned by the AHA to the District).

a. Revenue costs. District plans should estimate the expected total revenue costs of the services to be provided. These estimates do not need to be so detailed as the annual budgets prepared for the coming year and cannot be expected to be so accurate. However, they should be sufficiently sound to establish that the planned levels of service are realistic within the District's revenue allocations (and to assist the AHA in determining how revenue allocations should be assigned among its Districts.)

b. Capital costs. District plans should be framed within the context of the expected availability of capital facilities, based on the existing supply of hospital beds etc. and taking account of planned reductions and of the additions or replacements that can be envisaged from the Region and Area's capital budget. The strategy for scheduling the starts of major building projects will be largely the responsibility of the Region based on the requirements identified by each of its Areas and Districts in their plans and formulated in consultation with them. Thus complete capital programmes need not form a part of the plan prepared at the District level, but the consolidated Regional plans should be accompanied by a capital programme.

c. Manpower. Finally, District plans should include projections of the levels of skilled staff required to provide the planned levels of service - in particular, nursing and medical staff by specialty. As well as providing confirmation that the service plans developed are feasible from the manpower point of view, these manpower projections will provide the basis for planning the recruitment and training programmes necessary to ensure that the required supply of skilled manpower will be available when it is needed. They will also provide a basis for setting firm establishmnets for the coming year. (as described below in the section on personnel)

(5) They must define what needs to be done in the coming year.

3.29 Finally, although planning must be concerned with the pattern of services to be provided some years in the future, its real value to management lies in the guidelines it provides on what needs doing now, or during the coming year, to work towards this future pattern. The plans prepared must provide a basis for identifying what is to be done during the coming year, in terms of detailed budgets, establishing performance targets for next year's regular operations. They

must also define the other things that need to be done in order to achieve longer term objectives - for example, what building work must be initiated, what cost reduction exercises must be completed, etc. and by whom within the organization. These immediate action programmes are the real products of the planning process and it is against that actual performance can subsequently be monitored.

3.30 In summary, each District should have a comprehensive forward plan, setting out (as shown in Exhibit X):

a. The extent of the needs for health services of the different sections of the community or health care groups and the standards of care to be provided to these groups.
b. The resulting planned development of the major health services of the District to meet these need, at the standard assumed within available resources.
c. The resulting required supply of skilled manpower, capital finance and revenue finance (to equal the forward allocations assigned to the Districts).
d. What needs doing during the coming year, in terms of budgets, establishments, other operating targets and "action programmes" to achieve longer term growth.

APPENDIX D

FOREWORD to REPORT OF THE NATIONAL COMMITTEE ON COMMUNITY HEALTH CENTRES IN CANADA

The Community Health Centre Project was set up by the Minister of National Health and Welfare on behalf of the Conference of Health Ministers of Canada for three reasons:

1. A growing concern of both federal and provincial governments about the accelerating rate of spending in health services. During the 1955-68 period the average rate of annual increase in the cost of providing all health services in Canada was approximately 10.7 per cent. In 1968, government sources accounted for 69 percent of combined oeprating and capital spending in health services in Canada. Spending from all sources in the same year represented some 6.6 percent of the gross national product. In the last three years, the rate of increase was running well above the 10 percent average and for 1971 the indicated rate of increase in spending is about 12.5 percent. The rate of increase in the expenditure on acute hospital care has been around 14 percent and shows no sign of slowing.

2. A growing belief that some shift from the present emphasis on acute hospital in-patient care to other forms of health care, including types of community health centres, offer a means of slowing the rate of increase in health services spending. This idea has arisen in part from a few recent Canadian reports on the Saskatchewan community clinics and on two

Ontario group health centre programs. These reports have indicated that such programs can achieve important reductions in hospital in-patient bed use. This finding is similar to American reports on the experience of the various group practice prepayment programs and on the experience of the Office of Economic Opportunity health centres in that country. The current proposals for Health Maintenance Organizations in the United States are also in part based on potential savings which it is hoped will result from a reduction in in-patient hospital use.

3. A growing belief that community health centres, variously defined, offer an effective response to many problems other than costs to the existing ways health services are provided. It is suggested that they offer a setting in which the community's resources can be brought to bear in a more dynamic relationship with the health professionals and services in trying to solve people's health and related problems. This newly aroused interest in "people-centred" and "problem-centred" approaches to health care has arisen among other sources from the Castonguay-Neuveu (1) and Celdic Reports(2) in Canada, the American O.E.O. and H.M.O. experience, current developments in the United Kingdom and elsewhere as well as from a general awareness that better ways are needed for meeting the many-sided problems people, families, and communities now face and will be facing in the future.

In summary, community health centres are increasingly seen as an important means for slowing the rate of increase in the cost of health services and for more fully reflecting the objectives, priorities, and relationships which society wishes to establish for health care in the future.

The Committee's task was to examine available evidence, to seek opinions,

to consider proposals, and then to make specific recommendations on the provision of health services through community health centres and the possible role which governments and others might play in encouraging their development. We have done our best to fulfill our mandate. The choice is now for Society to make - in other words for each of us as responsible Canadian citizens.

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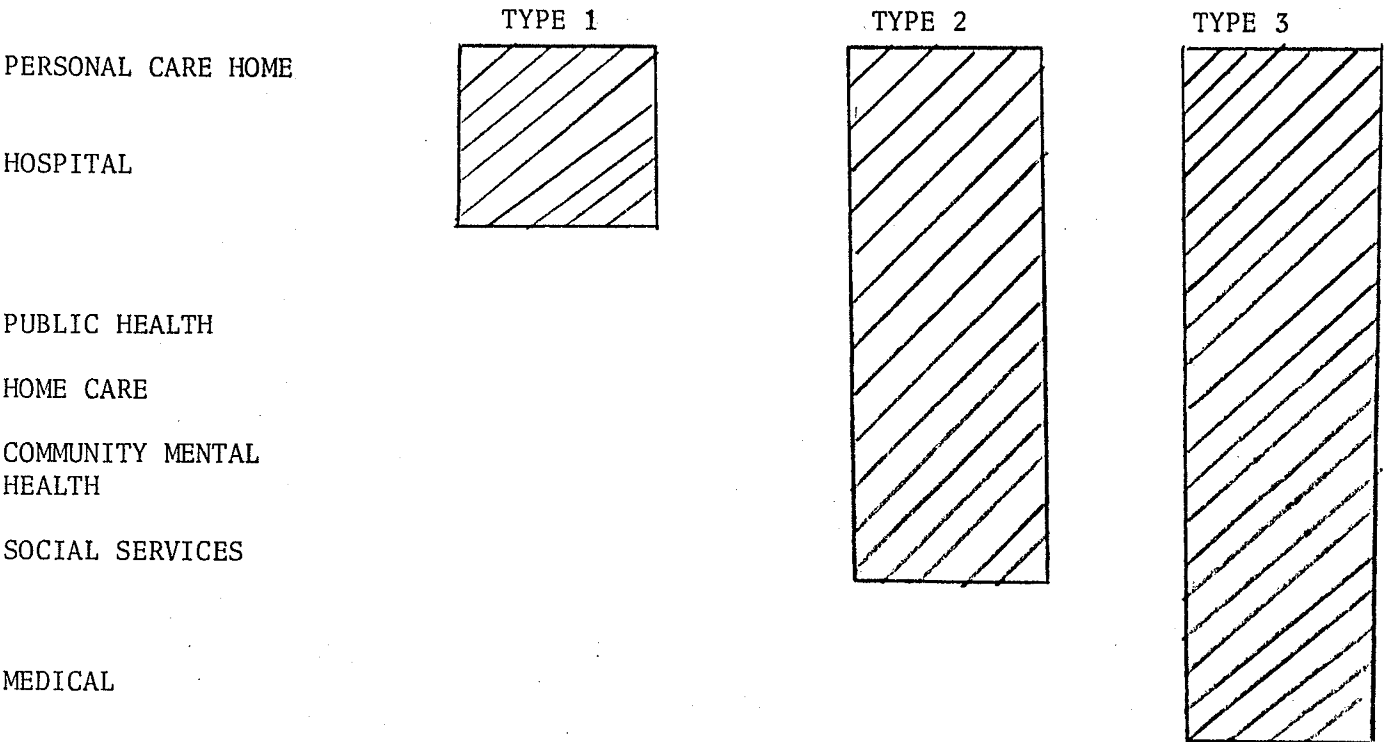
(1) Commission of Inquiry on Health and Social Welfare, Quebec, 1970.

(2) Commission on Emotional and Learning Disorders in Children, Toronto, 1970.

APPENDIX E

MANITOBA DISTRICT HEALTH SYSTEM CONCEPT



Part I a

DATA GATHERING TASKS: HISTORY

Task Statement		Educational Domain Levels		
Action	Objective	Cognitive	Affective	Psychomotor
Interview patient over the telephone	In order to gather a data base	4	2	1
Receive and screen patients	In order to gather a data base for purposes of triage	4	2	1
Review patient's medical record	In order to gather a data base	4	1	1
Record findings of data gathering	In order that data base is maintained	2	1	2
Interview patient to determine chief complaint and history of present illness	In order to gather a data base	5	2	1
Conduct a review of body systems by interviewing patient	In order to gather a data base	3	2	1
Interview patient to obtain a family medical history	In order to gather a data base	3	2	1
Interview female patient to obtain a history of pregnancy, labor, and delivery	In order to gather a data base	3	2	1
Interview patient to obtain a sexual history	In order to gather a data base	3	4	1
Interview family to obtain a developmental history of a pediatric patient	In order to gather a data base	3	2	1
Interview patient to obtain past medical history including general health, illnesses, injuries, hospitalizations, operations, immunizations, medications, allergies	In order to gather a data base	3	2	1
Interview patient to obtain a marital/household profile as part of social history	In order to gather a data base	3	2	1
Interview patient about household composition as part of social history	In order to gather a data base	2	2	1
Interview patient about economic status of the family as part of social history	In order to gather a data base	3	4	1
Interview patient about housing status as part of social history	In order to gather a data base	3	2	1
Interview patient about legal problems as part of social history	In order to gather a data base	3	4	1
Interview patient about occupational history/status or employment problems as part of social history	In order to gather a data base	3	2	1
Interview patient about educational status as part of social history	In order to gather a data base	3	2	1
Interview patient about recreational activities as part of social history	In order to gather a data base	3	2	1
Interview patient about personal habits, e.g., diet, drugs and medications, tobacco, alcohol	In order to gather a data base	3	4	1

(Continued)

DATA GATHERING TASKS: HISTORY (continued)

Task Statement		Educational Domain Levels		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Interview recuperating/disabled patients concerning limitations	In order to gather a data base	3	4	1
Determine household preparation for newborn by interviewing patient and family	In order to gather a data base	2	2	1
Interview senior citizen about care given in the household	In order to gather a data base	2	4	1
Interview family about terminally ill patient in that family	In order to gather a data base	3	4	1
Interview the individual about the past attempts to resolve social problems	In order to gather a data base	3	4	1
Interview individual about the resistances within community resources which hinder their utilization by individual/family	In order to gather a data base	3	4	1
Interview individual about resistance within family which hinders utilization of community resources	In order to gather a data base	3	4	1
Observe parent's attitude toward his/her child(ren)	In order to gather a data base	3	4	1
Observe actions and interactions between family members	In order to gather a data base	3	4	1
Determine intrafamilial relationships by interviewing family members	In order to gather a data base	3	4	1
Interview patient about interim history since last visit	In order to gather a data base	3	2	1
Interview patient about feelings related to his/her condition	In order to gather a data base	5	4	1
Interview patient about his/her ability and willingness to participate in his/her treatment	In order to gather a data base	5	4	1
Interview patient to enable that individual to express feelings about areas of emotional concern	In order to gather a data base	5	6	1
Observe patient's emotional response to treatment and care	In order to gather a data base	4	4	1
Interview patient to determine cultural/value systems as it might affect patient care	In order to gather a data base	5	4	1

Task Statement		Educational Domain Levels		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Observe patient's general appearance	In order to gather a data base	3	2	1
Observe nonverbal behavior/affect	In order to gather a data base	5	2	1
Observe level of consciousness, orientation to time, place, and person, memory, reasoning	In order to gather a data base	4	2	1
Test the functions of the cranial nerves	In order to gather a data base	4	2	4
Inspect/palpate the skin	In order to gather a data base	4	2	4
Inspect/palpate body hair and scalp hair	In order to gather a data base	4	2	4
Inspect/palpate/percuss the head/skull	In order to gather a data base	4	2	4
Inspect/palpate the face	In order to gather a data base	4	2	4
Palpate/transilluminate sinuses utilizing a flashlight	In order to gather a data base	4	2	4
Palpate/observe eyes utilizing a flashlight	In order to gather a data base	4	2	4
Observe fundus of the eye utilizing opthalmoscope	In order to gather a data base	4	2	4
Palpate/inspect nose internally and externally utilizing a "scope"	In order to gather a data base	4	2	4
Palpate/inspect mouth, oral mucosa, gums, and teeth utilizing light and tongue depressor	In order to gather a data base	4	2	4
Inspect the pharynx/tonsils utilizing tongue depressor and light	In order to gather a data base	4	2	4
Palpate/inspect ear externally and internally utilizing otoscope	In order to gather a data base	4	2	4
Inspect/palpate neck	In order to gather a data base	4	2	4
Inspect/palpate axillae	In order to gather a data base	4	2	4
Inspect/palpate/percuss the chest and lungs area and auscultate utilizing a stethescope	In order to gather a data base	4	2	4
Inspect/palpate/percuss over heart areas and auscultate heart utilizing a stethescope	In order to gather a data base	4	2	4
Inspect/palpate breasts	In order to gather a data base	4	2	4
Inspect/palpate/percuss/auscultate abdomen	In order to gather a data base	4	2	4
Perform a digital rectal examination utilizing glove and lubricant	In order to gather a data base	4	3	4
Inspect/palpate the external female genitalia, vagina, and cervix, utilizing glove, speculum, and lubricant	In order to gather a data base	4	3	4
Perform a bimanual pelvic examination utilizing glove and lubricant	In order to gather a data base	4	3	5
Inspect/palpate male genitalia	In order to gather a data base	5	3	4
Inspect/palpate joints, observe range of motion of joints	In order to gather a data base	4	2	4
Inspect/palpate extremities/muscles	In order to gather a data base	5	2	4

(Continued)

DATA GATHERING TASKS: PHYSICAL EXAMINATION (continued)

Task Statement		Educational Domain Levels		
Action	Objective	Cognitive	Affective	Psychomotor
Inspect/palpate/percuss back	In order to gather a data base	5	2	4
Inspect/palpate inguinal area	In order to gather a data base	4	3	4
Measure deep tendon reflexes utilizing a reflex hammer and superficial reflexes	In order to gather a data base	4	2	4
Determine presence of abnormal reflexes	In order to gather a data base	4	2	4
Determine presence of nuchal rigidity, spinal rigidity, Kernig's sign, Brudzinski's sign	In order to gather a data base	4	2	4
Test coordination, gait, and associated movements	In order to gather a data base	4	2	4
Measure superficial and deep sensation	In order to gather a data base	4	2	4
Perform neurologic exam of newborn	In order to gather a data base	4	2	4
Perform a digital rectal examination on a pregnant patient at term utilizing glove and lubricant	In order to gather a data base	4	3	4
Perform a vaginal examination on a pregnant patient at term utilizing glove and lubricant	In order to gather a data base	5	3	4
Palpate the abdomen of a pregnant patient to establish the position of the fetus	In order to gather a data base	4	2	4
Measure the height of the uterine fundus in a pregnant patient utilizing a tape measure	In order to gather a data base	1	2	3

DATA GATHERING TASKS: PHYSICAL EXAMINATION—SCREENING PROCEDURES

Task Statement		Educational Domain Levels		
Action	Objective	Cognitive	Affective	Psychomotor
Perform developmental screening of children utilizing a formal test, e.g., Denver Developmental Screening Test	In order to gather a data base	2	3	3
Measure temperature utilizing a thermometer	In order to gather a data base	1	2	3
Count pulse by palpation of radial artery and other arteries	In order to gather a data base	2	2	3
Count fetal heart sounds utilizing a fetoscope	In order to gather a data base	2	2	3
Count respiratory rate	In order to gather a data base	2	2	3
Measure head circumference of an infant utilizing a tape measure	In order to gather a data base	2	2	3
Measure length of an infant utilizing a tape measure or infantometer	In order to gather a data base	2	2	3
Measure chest circumference of an infant utilizing a tape measure	In order to gather a data base	2	2	3
Measure blood pressure utilizing a sphygmomanometer	In order to gather a data base	2	2	3
Measure the height of a patient utilizing height apparatus	In order to gather a data base	2	2	3

(Continued)

DATA GATHERING TASKS: PHYSICAL EXAMINATION—SCREENING PROCEDURES (continued)

Task Statement		Educational Domain Levels		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Measure the weight of a patient utilizing a scale	In order to gather a data base	2	2	3
Record height and weight on a growth chart	In order to gather a data base	3	1	1
Measure bleeding time utilizing lancet and ear puncture technique	In order to gather a data base	1	3	3
Measure clotting time utilizing test tube	In order to gather a data base	1	1	3
Perform hearing screening utilizing audiometer, tuning fork, crinkled paper, watch	In order to gather a data base	2	2	3
Perform visual screening utilizing a Snellen Chart	In order to gather a data base	2	2	2
Perform visual screening utilizing Titmus apparatus	In order to gather a data base	2	2	2
Inject allergy skin test material intracutaneously utilizing syringe and needle	In order to gather a data base	2	2	2
Observe/palpate/measure results of allergy skin tests	In order to gather a data base	2	2	3
Inject tine test material utilizing tine puncture	In order to gather a data base	1	2	2
Observe/palpate/measure results of tine test	In order to gather a data base	5	2	4
Inject PPD tuberculin material intracutaneously utilizing syringe and needle	In order to gather a data base	2	2	2
Observe/palpate/measure induration from PPD test	In order to gather a data base	2	2	3
Perform electrocardiograph test utilizing electrocardiograph machine	In order to gather a data base	1	2	3
Measure pulmonary function utilizing a spirometer	In order to gather a data base	2	3	4
Observe a skin lesion utilizing a Wood's light	In order to gather a data base	2	2	3
Apply topical florescein to eye to visualize corneal lesions	In order to gather a data base	3	3	3
Measure intraocular pressure utilizing tonometer	In order to gather a data base	3	3	4
Inspect rectum utilizing a proctoscope	In order to gather a data base	4	5	6
Inspect rectum and sigmoid colon utilizing a sigmoidoscope	In order to gather a data base	5	5	6

Part. I : C

DATA GATHERING TASKS: CLINICAL LABORATORY RELATED PROCEDURES

Task Statement		Educational Domain Levels		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Perform venipuncture on adults or children using syringe and needle or vacutainer	In order to obtain blood specimen for examination	3	3	5
Perform venipuncture on infants and young children using syringe and needle or vacutainer	In order to obtain blood specimen for examination	3	4	6
Perform finger stick for blood using lancet	In order to obtain blood specimen for examination	2	3	3
Explain how to collect a regular urine specimen to adult/child	In order that adult/child patient can collect specimen for examination	2	2	1
Collect urine specimen from an infant utilizing a pediatric urine collector	In order to have a urine specimen for examination	2	2	2
Collect clean catch urine specimen from child utilizing a sterile container	In order to have a urine specimen for examination/culture	2	3	2
Explain to adult/child how to collect a clean catch urine specimen	In order that adult/child can collect specimen for examination/culture	2	3	1
Collect urine specimen from an indwelling catheter by aspiration utilizing a syringe and needle	In order to have a urine specimen for examination culture	2	2	3
Scrape skin lesion	In order to have a specimen for examination	2	3	3
Perform thoracentesis	In order to obtain a specimen of pleural fluid	4	5	6
Perform paracentesis	In order to obtain a specimen of abdominal fluid	4	5	6
Perform lumbar puncture	In order to obtain a specimen of cerebrospinal fluid	4	5	6
Perform joint aspiration	In order to obtain a specimen of joint fluid	4	5	6
Perform skin biopsy	In order to obtain a specimen of tissue	4	3	5
Assist other health worker with proctoscopy	In order that procedure is accomplished	2	5	2
Assist other health worker with sigmoidoscopy	In order that procedure is accomplished	2	5	2
Assist other health worker with thoracentesis	In order that procedure is accomplished	2	5	2
Assist other health worker with paracentesis	In order that procedure is accomplished	2	5	2
Assist other health worker with lumbar puncture	In order that procedure is accomplished	2	5	2
Assist other health worker with joint aspiration	In order that procedure is accomplished	2	5	2
Assist other health worker with biopsy	In order that procedures are accomplished	2	3	2
Measure hematocrit utilizing centrifuge and capillary tube	In order to gather a data base	1	1	3
Measure hemoglobin utilizing photometer	In order to gather a data base	1	1	3

(Continued)

DATA GATHERING TASKS: CLINICAL LABORATORY RELATED PROCEDURES (continued)

Task Statement		*Educational Domain Levels*		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Measure total white blood count utilizing hemocytometer	In order to gather a data base	1	1	3
Measure differential white blood count utilizing slide, stain material, and microscope	In order to gather a data base	1	1	3
Perform monospot test for mononucleosis	In order to gather a data base	1	1	3
Obtain specimen of secretion from ear, nasopharynx, throat, wound, vagina, urethra, skin lesion, utilizing a sterile swab	In order to gather a data base and obtain a bacterial culture	2	2	3
Plant specimens from ear, nasopharynx, throat, wound, penis, vagina, skin lesion, in a proper culture medium	In order to obtain a bacterial culture	2	1	3
Inspect a throat culture plate and assess/evaluate findings	In order to gather a data base	4	1	2
Prepare wet mount of specimen from vagina	In order to gather a data base and determine presence of certain organisms	2	1	2
Scrape cervix utilizing a wooden spatula	In order to obtain material to be smeared for Papanicolau study	2	3	3
Test stool for occult blood using guaiac method or hematest	In order to gather a data base	2	1	1
Request chest x-ray by completing proper form	In order to obtain chest x-ray	2	1	1
Request long bone, skull, or abdominal x-rays by completing proper form	In order to obtain long bone, skull, or abdominal x-rays	2	1	1
Inspect chest and long bone x-rays	In order to gather a data base	4	1	1
Measure urine pH, sugar, protein utilizing a dipstick	In order to gather a data base	2	1	3
Measure urine sugar content utilizing clinitest tablet or testape	In order to gather a data base	2	1	3
Measure the specific gravity of urine utilizing urometer	In order to gather a data base	2	1	3
Observe urine sediment utilizing a microscope	In order to gather a data base	4	1	3
Perform gram stain of urine	In order to gather a data base	2	1	3
Observe gram-stained organisms in urine	In order to gather a data base	2	1	3
Provide information to individual about the collection of stool specimen utilizing a stool container	In order to gather a data base	2	2	1
Observe stool grossly	In order to gather a data base	3	1	2
Perform KOH examination of scrapings from skin	In order to gather a data base	4	1	1

Part 2

ASSESSMENT/EVALUATION TASKS

Task Statement		Educational Domain Levels		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Assess/evaluate:	**In order to determine normality or abnormality, e.g.:**			
Observations of general appearance and related symptoms	Under or over nutrition, apathy, abnormal speech, distress, abnormal affect	4	1	1
Findings of examination of mental status and related symptoms	Aberration or loss of consciousness; memory loss; disorientation to time, place, person; confusion; delirium	4	1	1
Findings of examination of cranial nerve function and related symptoms	Paralysis of facial muscles, loss of facial sensation, visual field defects, ptosis, absence of gag reflex	4	1	1
Assess/evaluate findings of examination of:	**In order to determine normality or abnormality, e.g.:**			
Head/skull	Small or large size, deformity, disproportion, crepitance, tumor, edema, tenderness	4	1	1
Face	Edema, tenderness, discoloration, deformity, crepitance	4	1	1
Sinuses	Density, shadow	4	1	1
Eyes	Discoloration, deformity, increased-decreased tension, decreased pupillary reaction, constricted/dilated pupils, strabismus, edema, tenderness, erythema, ptosis, field defects, color change, densities, shadows, hemorrhage, vascular change, disc changes, tumors, decreased visual acuity	4	1	1
Nose	Deformity, edema, tenderness, discoloration, bleeding, discharge, foreign body	4	1	1
Mouth/teeth	Edema, tenderness, discoloration, bleeding, deformities, caries, tumors, breath odor	4	1	1
Pharynx/tonsils	Erythema, deformity, exudate, discoloration, bleeding	4	1	1
Skin	Erythema, color change, hyper-hypopigmentation, macules, papules, nodules, vesicles, bullae, tumors, pustules, cysts, warts, keratoses, erosions, urticaria, petechiae, purpura, decreased turgor, hyper-anhidrosis, hirsutism, hyper- hypotrichosis, alopecia, increased-decreased temperature	4	1	1

(Continued)

ASSESSMENT/EVALUATION TASKS (continued)

Task Statement		*Educational Domain Levels*		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Assess/evaluate findings of examination of:	**In order to determine normality or abnormality, e.g.:**			
Hair	Color change, hirsutism, hyper-hypotrichosis, alopecia, brittleness, maldistribution	4	1	1
Ears	Tenderness, swelling, discoloration, erythema, exudate, deformity, loss of landmarks, light reflex, foreign body	4	1	1
Neck	Tenderness, deformity, edema, tumor, deviation of trachea, distended veins, discoloration, enlargement, tumor, abnormal consistency of thyroid	4	1	1
Axillae	Tenderness, deformity, edema, distended veins, discoloration, tumors	4	1	1
Chest/lungs	Assymetry, deformity, tenderness, tumor, dullness, flatness, abnormal rate/rhythm of respiration, rales, rhonchi, wheezes, decreased air movement, hyperresonance	4	1	1
Heart	Abnormal rate/rhythm, increased heart size, increased/decreased pulsations, thrills, murmurs, altered/split sounds, rubs	4	1	1
Breasts	Discoloration, erythema, tenderness, deformity, asymmetry, masses, tumors	4	1	1
Abdomen	Deformity, discoloration, dilated veins, scars, enlarged/irregular organs, masses, increased/decreased bowel sounds, herniation, tenderness	4	1	1
Inguinal area	Tenderness, deformity, edema, hernia, discoloration	4	1	1
Reflexes	Hyper- hyporeflexia, presence of abnormal reflexes	4	1	1
Sensation	Decreased/increased sensation, paresthesia	4	1	1
Other parts of neurological examination	Discoordination, abnormality of gait and coordinated movements, signs of meningeal irritation	4	1	1
Anus, rectum, prostate	Fissure, bleeding, tenderness, edema, tumor, change in texture	4	1	1
External female genitalia/vagina/cervix	Discharge, deformity, erythema, discoloration, edema, tenderness, erosion, distended veins, tumor, hypertrophy, scarring, ulcers, nodules	4	1	1

(Continued)

ASSESSMENT/EVALUATION TASKS (continued)

Task Statement		*Educational Domain Levels*		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Assess/evaluate findings of examination of:	**In order to determine normality or abnormality, e.g.:**			
Male genitalia	Discharge, discoloration, erythema, tenderness, edema, tumor	4	1	1
Joints	Edema, deformity, decreased range of motion, tenderness, increased temperature	4	1	1
Extremities/muscles	Deformity, tenderness, edema, increased/decreased temperature, discoloration, shortening, atrophy, atonia	4	1	1
Back	Tenderness, deformity, edema, discoloration, spasm	4	1	1
Pelvis	Tenderness, edema, masses, tumors, malposition of organs, small pelvic measurements	4	1	1
Common behavioral complaints of infancy/childhood	Eating, sleeping, crying, night terrors, toilet training, negativeness, school phobia, bed wetting, fears, increased activity, decreased activity, anger, destructiveness, temper tantrums, jealousy, sibling rivalry, selfishness, nail biting, head banging, masturbation, learning problems, thumb sucking, attitude towards strangers, constipation	5	1	1
Common behavior changes of adolescents	Loneliness, aggressiveness, mood swings, embarrassment, sleeplessness, sexual interests, self-consciousness	5	1	1
Growth and development of adolescents	Short stature, delayed onset of puberty, delayed menstruation	5	1	1
Sexual problems	Painful intercourse, impotency	5	1	1
Common problems of pregnancy	Spots on face, sunken eyes, pallor, leg cramps, headaches, gas pains, tiredness, weight problems, vaginal discharge, nipple/breast soreness, difficulty breathing, irritability, depression	5	1	1
Assess/evaluate:	**In order to determine:**			
Economic problems of patient/family	Functional/dysfunctional situation	4	1	1
Housing problems of patient/family	Functional/dysfunctional situation	4	1	1
Legal problems of patient/family	Functional/dysfunctional situation	4	1	1
Employment problems of patient/family	Functional/dysfunctional situation	4	1	1
Educational problems of patient/family	Functional/dysfunctional situation	4	1	1
Recreational problems of patient/family	Functional/dysfunctional situation	4	1	1

(Continued)

ASSESSMENT/EVALUATION TASKS (continued)

Task Statement		*Educational Domain Levels*		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Assess/evaluate:	**In order to determine:**			
Needs and limitations of recuperating/ disabled patient	Whether present or potential dysfunction/abnormality exists	5	1	1
Care of senior citizen in household	Whether present or potential dysfunction/abnormality exists	5	1	1
Needs and home situation of terminally ill patient	Whether present or potential dysfunction/abnormality exists	5	1	1
Strengths and weaknesses of inter-personal relationships among family members	Whether present or potential dysfunction/abnormality exists	5	1	1
Family's preparation for newborn	Whether standard preparations for newborn have been made	5	1	1
Facilities in home for the care of the newborn	If facilities are adequate for proper care	4	1	1
Resistance within community resources which hinder their utilization by individual/family	The degree to which a dysfunction exists	4	1	1
Resistance within individual/family that hinders utilization of community resources	The degree to which a dysfunction exists	4	1	1
Past attempts to resolve social problems	The degree to which a dysfunction exists	4	1.	1
Adolescent's reaction to normal growth and development	Whether present or potential dysfunction/abnormality exists	5	1	1
Level of anxiety	Whether present or potential dysfunction/abnormality exists	5	1	1
Level of depression	Whether present or potential dysfunction/abnormality exists	5	1	1
Level of environmental stress	Whether present or potential dysfunction/abnormality exists	5	1	1
Findings of rectal examination on a pregnant woman	The status of pregnancy and labor, and determine normality or abnormality, e.g., abnormal fetal presentation	4	1	1
Fetal position	Normality or abnormality, e.g., breach, transverse position	5	1	1
Height of the fundus	The status of the pregnancy and normality or abnormality	4	1	1
Assess/evaluate:	**In order to determine normality or abnormality, e.g.:**			
Results of developmental screening test	Mental retardation, environmental retardation, developmental problems	5	1	1
Temperature measurement	Fever, hypothermia	3	1	1
Rate and rhythm of pulse	Fast, slow, irregular, diminished	3	1	1
Rate and rhythm of fetal heart sounds	Fast, slow, irregular, muffled	4	1	1

(Continued)

ASSESSMENT/EVALUATION TASKS (continued)

Task Statement		*Educational Domain Levels*		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Assess/evaluate:	In order to determine normality or abnormality, e.g.:			
Respiratory rate	High, low, irregular rate	3	1	1
Blood pressure	High or low blood pressure	4	1	1
Head circumference of infant measurement	Small for age, large for age	4	1	1
Chest circumference of infant measurement	Small for age, large for age	4	1	1
Results of height/length measurement	Short for age, tall for age	3	1	1
Weight measurement	Overweight, underweight	3	1	1
Results of hearing screening	Hearing loss	5	1	1
Visual acuity measurement	Decreased vision, loss of vision, shortsightedness (myopia), farsightedness (hyperopia)	3	1	1
Results of allergenic skin test	Positive, negative or doubtful results	3	1	1
Tine test	Positive, negative or doubtful results	3	1	1
PPD test	Positive, negative or doubtful results	3	1	1
Pulmonary function studies	Decreased air exchange	4	1	1
Electrocardiography	Arrythmia, tachycardia, abnormal waves	5	1	1
Hematocrit	Anemia, polycythemia	3	1	1
Hemoglobin	Anemia, polycythemia	3	1	1
White blood count (total and differential)	Low count, leukocytosis, shift to left or right	3	1	1
Nasopharyngeal, throat, ear exudate, wound, stool, vaginal, penile cultures	Presence of pathogens	5	1	1
Urine tests	Elevated sugar/protein, high or low pH, low or high specific gravity	2	1	1
Urine sediment observation	Increased white blood cells, casts, and other formed elements	3	1	1
Papanicolau study of cervical scrapings	Suspicious or abnormal cells	3	1	1
Examination of wet mounted vaginal specimen	Presence of pathogens	3	1	1
Gram stain of pus, urine, other secretions	Presence of pathogens	2	1	1
Stool examination	Blood, pus, parasites, increased fat content, abnormal color	4	1	1
KOH examination of scrapings from skin	Fungi, yeast	2	1	1
Long bone/chest x-rays	Fractures, density, shadow	5	1	1

Part 3 a

DIAGNOSIS TASKS—GENERAL PROBLEMS

Task Statement		Educational Domain Levels		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Diagnose the following problems and related signs, symptoms, and test results:	In order to select a treatment and management strategy			
Fatigue/lethargy/weakness/apathy	In order to select a treatment and management strategy	6	1	1
Abnormality of the cranial nerves	In order to select a treatment and management strategy	6	1	1
Headache	In order to select a treatment and management strategy	5	1	1
Dizziness/fainting/tinnitus/vertigo	In order to select a treatment and management strategy	6	1	1
Excessive thirst/hunger	In order to select a treatment and management strategy	5	1	1
Fever	In order to select a treatment and management strategy	5	1	1
Growth problems in infants and children	In order to select a treatment and management strategy	6	1	1
Developmental problems of infants and children	In order to select a treatment and management strategy	6	1	1
Overweight	In order to select a treatment and management strategy	5	1	1
Weight loss/low weight for age	In order to select a treatment and management strategy	6	1	1
Failure to thrive syndrome	In order to select a treatment and management strategy	6	1	1
Abnormal allergy skin tests	In order to select a treatment and management strategy	5	1	1

Part 3 b

DIAGNOSIS TASKS—PROBLEMS OF SKIN, HAIR, NAILS

Task Statement		Educational Domain Levels		
Action	Objective	Cognitive	Affective	Psychomotor
Diagnose the following problems and related signs, symptoms, and test results:	In order to select a treatment and management strategy			
Common skin problems of adults, e.g., pruritis, scaliness, redness, roughness, peeling, rash, hives	In order to select a treatment and management strategy	5	1	1
Abnormalities of the hair	In order to select a treatment and management strategy	5	1	1
Abnormalities of scalp/skull	In order to select a treatment and management strategy	5	1	1
Abnormalities of the nails	In order to select a treatment and management strategy	5	1	1
Rashes in children	In order to select a treatment and management strategy	5	1	1
Common skin problems in infants, e.g., diaper rash	In order to select a treatment and management strategy	5	1	1

Part 3 c

DIAGNOSIS TASKS—PROBLEMS OF EYE, EAR, NOSE, MOUTH

Task Statement		Educational Domain Levels		
Action	Objective	Cognitive	Affective	Psychomotor
Diagnose the following problems and related signs, symptoms, and test results:	In order to select a treatment and management strategy			
Earache/draining ear	In order to select a treatment and management strategy	5	1	1
Hearing loss	In order to select a treatment and management strategy	5	1	1
Nasal congestion/coryza/obstruction/ discharge	In order to select a treatment and management strategy	5	1	1
Nose bleeds	In order to select a treatment and management strategy	5	1	1
Decreased visual acuity/loss of vision	In order to select a treatment and management strategy	5	1	1
Blurred vision	In order to select a treatment and management strategy	5	1	1
Eye discharge/redness of the eye	In order to select a treatment and management strategy	5	1	1
Increased intraoccular pressure	In order to select a treatment and management strategy	5	1	1

(Continued)

Other diagnosis tasks include d) neck & throat problems e) cardiovascular f) respiratory g) neurologic h) gastrointestinal i) urinary tract genital k) problems of pregnancy l) back & extremity problems m) hematologic problems (GOLDEN, 1976: 58-69)

Part 3 n

DIAGNOSIS TASKS—MENTAL HEALTH PROBLEMS

Task Statement		Educational Domain Levels		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Diagnose the following problems and related signs, symptoms, and test results:	In order to select a treatment and management strategy			
Impotency, dysparunia, other sexual problems	In order to select a treatment and management strategy	6	1	1
Depression	In order to select a treatment and management strategy	6	1	1
Anxiety	In order to select a treatment and management strategy	6	1	1
Personality change	In order to select a treatment and management strategy	6	1	1
Environmental stress/maladaptive disorders	In order to select a treatment and management strategy	6	1	1
Psychophysiologic conditions	In order to select a treatment and management strategy	6	1	1
Chemical dependencies, e.g., drug abuse, alcoholism, smoking	In order to select a treatment and management strategy	6	1	1
Suicidal tendencies	In order to select a treatment and management strategy	6	1	1
Common behavior problems of infancy/childhood	In order to select a treatment and management strategy	5	1	1
Common behavior problems of adolescence	In order to select a treatment and management strategy	5	1	1

Part 3 o

DIAGNOSIS TASKS—SOCIAL PROBLEMS

Task Statement		Educational Domain Levels		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Determine the nature of:	In order to establish a management plan			
Economic problems	In order to establish a management plan	5	1	1
Housing problems	In order to establish a management plan	5	1	1
Legal problems	In order to establish a management plan	5	1	1
Employment problems	In order to establish a management plan	5	1	1
Educational problems	In order to establish a management plan	5	1	1
Recreational problems	In order to establish a management plan	5	1	1
Interpersonal functioning problems among household/family members	In order to establish a management plan	6	1	1
Needs and/or limitations of recuperating/disabled patient	In order to establish a management plan	5	1	1

DIAGNOSIS TASKS—SOCIAL PROBLEMS (continued)

Task Statement		*Educational Domain Levels*		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Care problem of senior citizen/infant/ill person in household	In order to establish a management plan	5	1	1
Needs and home situation of terminally ill patient	In order to establish a management plan	5	1	1
Resistances within community resources that hinder their utilization by individual/family	In order to establish a management plan	5	1	1
Resistances within the individual/ family that hinders utilization of community resources	In order to establish a management plan	5	1	1

Part 4 a

STRATEGY SELECTION TASKS—GENERAL DISORDERS

Task Statement		Educational Domain Levels		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Select a treatment and management strategy for:				
Fever	In order to improve the condition	5	1	1
Mild dehydration	In order to improve the condition	5	1	1
Acute migraine	In order to improve or cure the condition	6	1	1
Chronic stabilized migraine	In order to improve or cure the condition	5	1	1
Failure to thrive syndrome	In order to improve or cure the condition and prevent complications	6	1	1
Underweight	In order to improve or cure the condition and prevent complications	5	1	1
Exogenous obesity	In order to improve or cure the condition and prevent complications	5	1	1

Part 4 b

STRATEGY SELECTION TASKS—COMMUNICABLE DISEASES OF CHILDREN

Task Statement		Educational Domain Levels		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Select a treatment and management strategy for:				
Mumps	In order to improve the condition	5	1	1
Chicken pox	In order to improve the condition	5	1	1
Rubeola	In order to improve the condition	5	1	1
Rubella	In order to improve the condition	5	1	1

Other Strategy Selection Task - sub categories not included in appendix include: c) disorders of the skin, d) eye disorders, e) disorders of upper and lower respiratory tract, f) cardiovascular disorders, g) gastrointestinal disorders, h) genitourinary disorders, i) disorder of back, joints, extremities, & muscles, j) endocrine disorders, k) hematologic disorders, l) neurologic disorders (GOLDEN, 1976: 76-89)

Part 4 m

STRATEGY SELECTION TASKS: NEUROLOGIC AND MENTAL HEALTH DISORDERS OF CHILDREN

Task Statement		Educational Domain Levels		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Select a treatment and management strategy for:				
Mental/motor retardation in children	In order to improve the condition and prevent complications	6	1	1
Learning disorders of children	In order to improve or cure the condition and prevent complications	6	1	1
Hyperactivity in children	In order to improve or cure the condition and prevent complications	6	1	1
Common psychological problems of infants and children e.g., night terrors, fear school phobia, sibling rivalry, jealousy, abnormal pain	In order to improve the condition and prevent complications	6	1	1
Environmental deprivation of children	In order to improve the condition and prevent complications	6	1	1

Part 4 n

STRATEGY SELECTION TASKS: DISORDERS OF MENTAL HEALTH

Task Statement		Educational Domain Levels		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Select a treatment and management strategy for:				
Anxiety reactions	In order to improve or cure the condition and prevent complications	6	1	1
Mild depression	In order to improve or cure the condition and prevent complications	6	1	1
Maladaptive disorders	In order to improve or cure the condition and prevent complications	6	1	1
Environmental stress	In order to improve or cure the condition and prevent complications	6	1	1
Personality disorders	In order to improve or cure the condition and prevent complications	6	1	1
Psychophysiologic conditions	In order to improve or cure the conditions	6	1	1
Alcoholism	In order to improve or cure the condition and prevent complications	6	1	1
Drug abuse	In order to improve or cure the condition and prevent complications	6	1	1
Smoking problems	In order to improve or cure the condition and prevent complications	6	1	1
Impotence/dyspareunia/sexual problems	In order to improve or cure the condition and prevent complications	6	1	1
Intrafamilial conflicts	In order to improve the condition and prevent complications	6	1	1

Part 4 O

STRATEGY SELECTION TASKS: CONDITIONS ASSOCIATED WITH PREGNANCY

Task Statement		*Educational Domain Levels*		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Select a treatment and management strategy for:				
Pretoxemia of pregnancy	In order to improve or cure the condition and prevent complications	5	1	1
Depression associated with the perinatal period	In order to improve or cure the condition and prevent complications	6	1	1
Common complaints associated with pregnancy	In order to improve or cure the condition and prevent complications	5	1	1
Contraception	In order to prevent pregnancy	6	1	1

Part 4 P

STRATEGY SELECTION TASKS: SOCIAL PROBLEMS

Task Statement		*Educational Domain Levels*		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Select a management strategy for:				
Lack of sufficient income to meet family needs	In order to improve function of the individual/family	6	1	1
Poor housing	In order to improve function of the individual/family	6	1	1
Unemployment/underemployment of individual/family	In order to improve function of the individual/family	6	1	1
Legal needs of a family	In order to improve function of the individual/family	6	1	1
Family dysfunction due to under-education/poor education	In order to improve function of the individual/family	6	1	1
Family inability to utilize recreational facilities	In order to improve function of the individual/family	6	1	1
Poor care of disabled patient/senior citizen	In order to improve function of the individual/family	6	1	1
Resistance in community resources that hinder individual/family utilization	In order to improve function of the individual/family	6	1	1
Resistance in family to utilizing community resources	In order to improve function of the individual/family	6	1	1

Part 5 a

IMPLEMENTATION OF STRATEGIES TASKS: TECHNICAL PROCEDURES

Task Statement		Educational Domain Levels		
Action	Objective	Cognitive	Affective	Psychomotor
General:				
Screen and drape patients	In order to prepare patient for examination/procedure	2	2	2
Handling Injured Patients:				
Lift, turn, position patients with injuries	In order to prevent extension and complication of those injuries	3	3	3
Assuring Cardio-Respiratory Function:				
Insert an oral airway	In order to improve patient's respiration	3	4	4
Perform articificial respiratory ventilation using mouth-to-mouth breathing techniques	In order to restore patient's respiration	4	2	6
Perform closed chest cardiac massage	In order to restore cardiac action and blood volume	3	2	4
Apply tourniquets or pressure bandage	In order to control external hemorrhage	3	3	3
Apply rotating tourniquets to patients with pulmonary edema	In order to decrease blood flow to the heart	3	2	3
Set defibrillator intensity and charge	In order to have the defibrillator ready for use	3	1	2
Compress positive pressure Ambu bag	To assist patient respiration	3	3	3
Set up and regulate oxygen equipment	In order to administer oxygen to the patient through a mask or tent	3	1	3
Insert a nasal catheter	To be able to administer nasal oxygen	3	3	4
Suction nose utilizing catheter	In order to remove excess secretions from the nose	3	3	3
Suction mouth utilizing catheter	In order to remove excess secretions from the mouth	3	2	3
Suction deep posterior pharynx	In order to remove secretions from the pharynx	3	3	4
Suction trachea via tracheostomy	In order to remove excess secretions from the tracheostomy and trachea	3	3	4
Remove and clean innercanula of a tracheostomy	In order to insure cleanliness and prevent infection	3	3	4
Assist patient to turn, cough, and deep breathe	In order to loosen bronchial secretions	3	3	2
Assist patient with postural drainage	In order to remove lung secretion	3	3	2
Set up and regulate vaporizer and nebulizer	In order to deliver vapor to a patient	3	3	3
Perform a venous cutdown	In order to place catheter in vein	3	4	6
Handling Medications:				
Prepare medications	In order to give them to a patient	3	1	3
Give patient medication to be taken orally	In order to improve or cure an illness	3	2	2

(Continued)

For additional listing of technical procedures see (GOLDEN, 1976: 100-111)

Part 5 b

IMPLEMENTATION OF STRATEGIES TASKS—HEALTH EDUCATION AND COUNSELING — GENERAL PREVENTIVE CARE (continued)

Task Statement		*Educational Domain Levels*		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Encourage/recommend/motivate groups and individuals to comply with methods to prevent home accidents	In order that problems are prevented	3	5	1
Give information/explanation/presentation to groups and individuals about the use of seat belts and special automobile seat restraints for children	In order that individuals can act in accordance with that information	2	4	1
Encourage/recommend/motivate groups and individuals to comply with the use of seat belts and seat restraints for children	In order to prevent injury in case of an accident	3	5	1
Give information/explanation/presentation to groups and individuals about lead poisoning	In order that individuals can act in accordance with that information	3	3	1
Encourage/recommend/motivate groups and individuals to comply with methods to prevent lead poisoning	In order that these problems are prevented	4	4	1
Give information/explanation/presentation to groups and individuals about the prevention of poisoning (ingestion)	In order that individuals can act in accordance with that information	2	4	1
Encourage/recommend/motivate groups and individuals to comply with methods of poisoning (ingestion) prevention	In order that these problems are prevented	4	5	1
Give information/explanation/presentation to groups and individuals about first aid measures	In order that individuals can act in accordance with that information	2	3	1
Give information/explanation/presentation to groups and individuals about dieting and exercise	In order that individuals can act toward a weight control program in accordance with that information	2	4	1
Give information/explanation/presentation to groups and individuals about proper nutrition	In order that individuals can act in accordance with that information	2	4	1
Encourage/recommend/motivate groups and individuals to take part in tuberculosis prevention programs	In order to identify the condition at an early stage and decrease transmission of tuberculosis to others	3	3	1

Part 5

b

IMPLEMENTATION OF STRATEGIES TASKS—HEALTH EDUCATION AND COUNSELING ACUTE CONDITIONS

Task Statement		*Educational Domain Levels*		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Give general information/answer questions of individual about minor injuries, e.g., superficial abrasions, wounds, cuts, contusions, burns, splinters, bites, sprains, strains	In order that the individual can act in accordance with that information	2	3	1
Encourage/recommend/motivate individual to care for minor injuries	In order that the individual comply with therapy and the condition is improved/cured	3	3	1
Give general information/answer questions of individual about upper respiratory infections, e.g., rhinitis, pharyngitis, laryngitis, sinusitis, otitis	In order that the individual can act in accordance with that information	3	3	1
Encourage/recommend/motivate individual with upper respiratory infection to comply with treatment plan	In order that the condition is improved/cured	4	3	1
Give general information/answer questions of individual about bronchitis/pneumonia	In order that the individual can act in accordance with that information	3	3	1
Encourage/recommend/motivate individual with bronchitis/pneumonia to comply with treatment plan	In order that the condition is improved/cured	4	3	1
Give general information/answer questions of parent about bronchiolitis	In order that the individual can act in accordance with that information	3	3	1
Encourage/recommend/motivate parents of child with bronchiolitis to comply with treatment plan	In order that the condition is improved/cured	4	3	1
Give information/explanation/presentation to groups and individuals about the care of communicable diseases	In order that the individuals can act in accordance with that information	2	3	1
Encourage/recommend/motivate groups and individuals with communicable diseases to comply with treatment plan	In order that condition is improved/cured	3	3	1
Give general information/answer questions of individual about nosebleeds	In order that the individual can act in accordance with that information	2	3	1
Give general information/answer questions of individual about conjunctivitis	In order that the individual can act in accordance with that information	2	3	1
Give information/answer questions of individual about gastroenteritis	In order that the individual can act in accordance with that information	3	3	1
Encourage/recommend/motivate individual with gastroenteritis to comply with treatment plan	In order that the condition is improved/cured	3	3	1

(Continued)

IMPLEMENTATION OF STRATEGIES TASKS—HEALTH EDUCATION AND COUNSELING ACUTE CONDITIONS (continued)

Task Statement		*Educational Domain Levels*		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Give information/answer questions of individual with urinary tract infection	In order that the individual can act in accordance with that information	3	3	1
Give information/explanation/presentation to groups and individuals about venereal disease	In order that the individual can act in accordance with that information	3	4	1
Encourage/recommend/motivate individuals to seek early care for venereal diseases and comply with treatment plan	In order to improve/cure the condition, prevent complications, and decrease disease transmission	4	5	1
Give general information/answer questions of individuals with vaginitis	In order that the individual can act in accordance with that information	2	3	1
Encourage/recommend/motivate individual with vaginitis to comply with treatment plan	In order that condition is improved/cured	4	4	1

IMPLEMENTATION OF STRATEGIES TASKS—HEALTH EDUCATION AND COUNSELING CHRONIC CONDITIONS

Task Statement		*Educational Domain Levels*		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Give general information/answer questions of individual about headaches	In order that the individual can act according to that information	2	4	1
Encourage/recommend/motivate individual with chronic headaches to comply with treatment plan	In order that condition is improved	3	5	1
Give general information/answer questions of individual about common skin problems, e.g., acne, cellulitis, eczema, hives, infectious dermatitis, moles, pruritis, psoriasis, warts	In order that individual can act in accordance with that information	2	4	1
Encourage/recommend/motivate individual with common skin problems to comply with treatment plan	In order that the condition is improved/cured	4	5	1
Support/advise/counsel individual with chronic skin problem	In order that individual is better able to cope with the condition	5	5	1
Give general information/answer questions of individual about anemia, e.g., iron deficiency, sickle cell	In order that individual can act according to that information	3	4	1

(Continued)

IMPLEMENTATION OF STRATEGIES TASKS—HEALTH EDUCATION AND COUNSELING CHRONIC CONDITIONS (continued)

Task Statement		*Educational Domain Levels*		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Encourage/recommend/motivate individual with anemia to comply with treatment plan	In order that the condition is improved/cured	3	5	1
Support/advise/counsel individual with chronic anemia	In order that individual is better able to cope with the condition	4	5	1
Give general information/answer questions of individual about obesity	In order that individual can act in accordance with that information	2	4	1
Encourage/recommend/motivate obese individual to comply with treatment plan	In order that weight loss occurs	4	5	1
Give information/answer questions/ demonstrate planning of weight reduction diets	In order that individuals can act in accordance with that information	3	4	1
Support/advise/counsel obese individual on weight loss regimen	In order that individual is better able to cope with the condition	5	5	1
Give general information/answer questions about malnutrition	In order that the individual can act in accordance with that information	3	4	1
Encourage/recommend/motivate individual to comply with treatment for malnutrition problem	In order that the condition is improved/cured	4	5	1
Give general information/answer questions of individual about allergies, e.g., hay fever, asthma, hives	In order that the individual can act in accordance with that information	2	4	1
Encourage/recommend/motivate individual with allergies to comply with treatment plan	In order that condition is improved	4	5	1
Give general information/answer questions of individual about asthma	In order that the individual can act according to that information	2	4	1
Encourage/recommend/motivate individual with asthma to comply with treatment plan	In order that the condition is improved	4	5	1
Support/advise/counsel individual with asthma	In order that individual is better able to cope with the condition	4	5	1
Give general information/answer questions of individual about vision problems	In order that the individual seeks early attention of such problems	2	4	1
Encourage/recommend/motivate individual with vision problems to comply with treatment plan	In order that vision is improved and complications prevented	4	5	1
Support/advise/counsel individual with chronic vision problems	In order that individual is better able to cope with the condition	5	6	1
Give general information/answer questions of individual about hearing problem	In order that the individual seeks early attention for such problem	2	4	1
Encourage/recommend/motivate individual with hearing problem to comply with treatment plan	In order that hearing is improved and complications prevented	4	5	1

(Continued)

IMPLEMENTATION OF STRATEGIES TASKS—HEALTH EDUCATION AND COUNSELING CHRONIC CONDITIONS (continued)

Task Statement		*Educational Domain Levels*		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Support/advise/counsel individual with chronic hearing loss	In order that individual is better able to cope with the condition	5	6	1
Give comprehensive information/explanation/presentation to groups and individuals about diabetes mellitus	In order that individual can act in accordance with that information	3	4	1
Encourage/recommend/motivate individuals with diabetes mellitus to comply with treatment plan	In order that the condition is stabilized and improved	4	5	1
Demonstrate injection of medications	In order that patient/family can accomplish the procedure	2	3	1
Support/advise/counsel individual with diabetes mellitus	In order that individual is better able to cope with the condition	5	5	1
Give information/explanation/presentation to groups and individuals about hypertension	In order that individuals can act in accordance with that information	3	4	1
Encourage/recommend/motivate individuals with hypertension to comply with treatment plan	In order that the condition is controlled, complications prevented, and life prolonged	5	5	1
Support/advise/counsel individuals with hypertension	In order that individual is better able to cope with the condition	4	5	1
Give information/explanation/presentation to groups and individuals about cardiovascular problems, e.g., arteriosclerosis, angina pectoris, myocardial infarction, stroke	In order that the individual can act according to that information	3	4	1
Encourage/recommend/motivate individual with angina pectoris to comply with treatment plan	In order that condition is improved and complications prevented	4	5	1
Support/advise/counsel individual with angina pectoris	In order that individual is better able to cope with the condition	5	5	1
Encourage/recommend/motivate individual who has had a myocardial infarction to comply with treatment plan	In order that condition is stabilized and complications prevented	4	5	1
Support/advise/counsel individual who has had a myocardial infarction	In order that individual is better able to cope with the condition	5	6	1
Give information/explanation/presentation to groups and individuals about tuberculosis	In order that individual can act in accordance with that information	2	3	1
Encourage/recommend/motivate individual with tuberculosis to comply with treatment	In order that the condition is improved/cured	4	5	1
Support/advise/counsel individual with tuberculosis	In order that individual is better able to cope with the condition	4	5	1
Give general information/answer questions of individual about musculoskeletal and joint problems, e.g., low back syndrome, arthritis, gout, lumbosacral sprain, tendonitis, bursitis	In order that the individual can act in accordance with that information	3	4	1

(Continued)

IMPLEMENTATION OF STRATEGIES TASKS—HEALTH EDUCATION AND COUNSELING CHRONIC CONDITIONS (continued)

Task Statement		*Educational Domain Levels*		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Encourage/recommend/motivate individual with musculo-skeletal and joint problems to comply with treatment plan	In order that the condition is improved/cured	4	5	1
Support/advise/counsel individual with musculo-skeletal and joint problems	In order that individual is better able to cope with the condition	5	5	1
Provide information/answer questions of individual with peptic ulcer	In order that individual act in accordance with that knowledge	2	4	1
Encourage/recommend/motivate individual with peptic ulcer to comply with treatment plan	In order that the condition is improved/cured	5	5	1
Support/advise/counsel individual with peptic ulcer	In order that individual is better able to cope with the condition	5	6	1
Give information/explanation/presentation to groups and individuals about the reproductive system	In order that individual can act in accordance with that information	3	4	1
Encourage/recommend/motivate individual with dysfunction of the reproductive system to comply with treatment plan	In order that condition is improved/cured	4	5	1
Support/advise/counsel individual with chronic problems of the reproductive system, e.g., meno- metrorrhagia, tumors, sterility, menopausal difficulties	In order that individual is better able to cope with the condition	5	5	1
Support/advise/counsel individual with sexual dysfunction, e.g., impotence, dyspareunia, frigidity	In order that individual is better able to cope with the condition	6	6	1
Give information/explanation/presentation/demonstration to groups and individuals about breast self-examination	In order that individuals can act in accordance with that information	3	3	1
Give information/explanation/presentation to groups and individuals about family planning and contraceptives	In order that individual can act in accordance with that information	2	4	1
Encourage/recommend/motivate individuals to apply family planning contraceptive methods	In order that unwanted conceptions are prevented	4	5	1
Give general information/answer questions of individual about abortion	In order that the individual can act in accordance with that information	3	4	1
Support/advise/counsel individual who is making a decision about an unwanted pregnancy	In order that individual can better cope with situation	6	6	1
Give information/answer questions of expectant mothers/family about bodily and psychological changes and minor discomforts that normally occur during pregnancy, e.g., back pains, leg cramps, mood changes	In order that the expectant mother and family know what physical and psychological changes to expect	2	4	1

(Continued)

IMPLEMENTATION OF STRATEGIES TASKS—HEALTH EDUCATION AND COUNSELING CHRONIC CONDITIONS (continued)

Task Statement		*Educational Domain Levels*		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Give information/answer questions of expectant mothers/family about areas related to pregnancies, e.g., diet, weight, personal hygiene, fetal development, fears, "old wives tales"	In order that the individual can act in accordance with that information	2	4	1
Give general information/answer questions of expectant mothers about postnatal physical and emotional events, e.g., breast enlargement, vaginal discharge, "blues," episiotomy	In order that expectant mother knows what to expect postnatally and can act in accordance with that information	2	4	1
Give information/demonstrate prepartum and postpartum exercises to expectant mother	In order that expectant mother can perform these exercises	3	3	1
Give information/answer questions of expectant mother about breast feeding	In order that mother can act in accordance with that information	2	4	1
Encourage/recommend/motivate interested mother to breast feed	In order that breast feeding is carried out as desired	4	5	1
Support/advise/counsel breast feeding mother	In order that mother can better cope with the situation	5	5	1
Give information/answer questions of expectant mothers about labor and delivery	In order that expectant mother and family know what to expect during labor and delivery	2	4	1
Give information/explanation/presentation to groups and individuals about early and regular prenatal care	In order that individual can act in accordance with that information	2	3	1
Encourage/recommend/motivate individual to seek prenatal care	In order to prevent complications of pregnancy	4	4	1
Give information/explain/demonstrate to parents how to hold infant	In order that parents can act in accordance with that information	2	3	1
Give information/explain/demonstrate methods of bathing newborn	In order that parent is able to bathe newborn correctly	2	3	1
Give information/answer questions to parents about umbilical cord care	In order that parent can act in accordance with that information	2	3	1
Give information/answer questions of parents about nutrition of infant	In order that parents can act in accordance with that information	2	4	1
Give information/answer questions/ demonstrate to parents how to prepare formula	In order that formula is prepared correctly	2	3	1
Give information/answer questions/ demonstrate to parents how to feed infant, including when to expand diet	In order that infant is fed correctly	2	3	1
Give information/answer questions of parents about alternate feeding techniques, i.e., scheduled versus demand	In order that parent can act in accordance with that information	2	3	1
Give information/answer questions of parents about common problems of infants, e.g., colic, thrush, cradle cap, spitting up, constipation, sleep problems, feeding problems, diaper rash, teething	In order that parents can act in accordance with that information	2	4	1

IMPLEMENTATION OF STRATEGIES TASKS—HEALTH EDUCATION AND COUNSELING CHRONIC CONDITIONS (continued)

Task Statement		*Educational Domain Levels*		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Support/advise/counsel parents of infants with common chronic problems, e.g., sleeping and eating problems, constipation	In order that parents can better cope with these problems	4	5	1
Encourage/recommend/motivate parents of infants with common problems to comply with treatment plan	In order that the condition is improved/cured	4	5	1
Give information/answer questions of parents about immunizations for infants/children	In order that parents can act in accordance with that information	2	3	1
Encourage/recommend/motivate parents to obtain immunizations for their infants/children	In order that immunizations levels are maintained	4	5	1
Give information/answer questions of parents on growth and development of infants, e.g., motor, language, social development, height, weight	In order that they are able to distinguish between abnormal and normal growth and development in their own children	3	4	1
Give information/answer questions of parents about toilet habits of young children	In order that problems related to toilet habits can be prevented	3	4	1
Give general information/answer questions of parents about childhood problems, e.g., enuresis, school phobia, hyperactivity, fears, sleep problems	In order that parents can act in accordance with that information	3	4	1
Encourage/recommend/motivate parents of children with childhood problems to comply with treatment plan	In order that the condition is improved/cured	5	5	1
Support/advise/counsel parents of children with childhood problems	In order that parents can better cope with these problems	5	5	1
Give information/answer questions of parents about day care	In order that parents can act in accordance with that information	2	3	1
Give information/answer questions of parents of handicapped child, e.g., congenital anomaly; mental, motor retardation	In order that parents can act in accordance with that information	3	4	1
Encourage/recommend/motivate parents of handicapped child to meet child's needs and comply with treatment plan	In order that parents provide care independently in the home whenever possible	4	5	1
Support/advise/counsel parents of handicapped child	In order that parents are better able to cope with child's condition	6	6	1
Support/advise/counsel handicapped child	In order that child is better able to cope with condition	5	5	1
Coordinate treatment plan of chronically ill child with school, as prescribed by health team by communicating and consulting with appropriate school officials	In order that optimum environmental, care, and learning opportunities are available	4	5	1

(Continued)

IMPLEMENTATION OF STRATEGIES TASKS—HEALTH EDUCATION AND COUNSELING CHRONIC CONDITIONS (continued)

Task Statement		*Educational Domain Levels*		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Give information/answer questions of parents about children's needs for love and discipline	In order that parents can recognize and respond to children's needs for love and discipline	3	4	1
Encourage/motivate parents to meet children's needs for love and discipline	In order that parents are better able to respond to children's needs	4	5	1
Give information/answer questions of parents about sex education of children	In order that parents are better able to respond to children's needs	3	4	1
Provide information/answer questions of adolescent about normal growth and development, including sexual maturation	In order that adolescent can act in accordance with that information	3	4	1
Encourage/recommend/motivate adolescent who is having problems with normal growth and development, including sexual maturation, to take steps to deal with those problems	In order that the problems are improved/resolved	5	5	1
Support/advise/counsel the adolescent who is having problems with normal growth and development, including sexual maturation	In order that adolescent is better able to cope with the problems	6	6	1
Provide information/answer questions of parents about normal growth and development problems of adolescence	In order that they can act in accordance with that information	3	4	1
Encourage/recommend/motivate parents of an adolescent who is having normal growth and development problems to help him/her deal with the problems	In order that problems are improved/resolved	5	5	1
Support/advise/counsel parents of an adolescent who is having normal growth and development problems	In order that they are better able to cope with the situation	6	5	1
Provide information/answer questions of adolescent about common behavioral problems of adolescence, e.g., loneliness, agressiveness, mood swings	In order that adolescent can act in accordance with that information	3	4	1
Encourage/recommend/motivate adolescent with common behavioral problems of adolescence to take steps to deal with the problems	In order that the problems are improved/resolved	5	5	1
Support/advise/counsel adolescent with common behavioral problems	In order that adolescent is better able to cope with the problems	5	6	1
Provide information/answer questions of parents about common behavioral problems of adolescence	In order that they can act in accordance with that information	3	4	1
Encourage/recommend/motivate parents of an adolescent with common behavioral problems to help adolescent deal with the problems	In order that adolescent is receiving help from his/her parents in dealing with problems	4	5	1
Support/advise/counsel parents of an adolescent with common behavioral problems	In order that they are better able to cope with the situation	5	6	1

(Continued)

IMPLEMENTATION OF STRATEGIES TASKS—HEALTH EDUCATION AND COUNSELING CHRONIC CONDITIONS (continued)

Task Statement		*Educational Domain Levels*		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Provide information/answer questions of individual about depression	In order that the individual can act in accordance with that information	3	4	1
Encourage/recommend/motivate individual with mild depression to comply with treatment plan	In order that condition is improved/cured	5	5	1
Support/advise/counsel individual with mild depression	In order that individual is better able to cope with the situation and condition is improved	6	6	1
Provide information/answer questions of individual about psychosis, neurosis, and organic brain syndromes	In order that the individual can act in accordance with that information	3	4	1
Encourage/recommend/motivate individual with psychosis, who has been referred, to comply with treatment	In order that condition is improved	5	5	1
Support/advise/counsel individual under treatment for psychosis	In order that they better cope with the condition	6	6	1
Provide information/answer questions of individual about anxiety reactions/maladaptive disorders	In order that individual can act in accordance with that information	3	4	1
Encourage/recommend/motivate individual with anxiety reactions/maladaptive disorders to comply with ~~treatment plan~~ treatment plan	In order that condition is improved/cured	5	5	1
Support/advise/counsel individual with anxiety reactions/maladaptive disorders	In order that individual is better able to cope with the condition	6	6	1
Support/advise/counsel individual with psychophysiologic problem	In order that individual can identify relationship between psychological and physiologic states and can take action to alleviate stress/anxiety-producing life situations	6	6	1
Give general information/answer questions of parent about child abuse	In order that parent can act in accordance with that information	3	4	1
Support/encourage/motivate parent to seek assistance for child abuse problem	In order that parent obtain appropriate assistance in resolving the problem	5	6	1
Give information/explanation/presentation to groups and individuals about chemical dependency, i.e., drugs, alcohol, tobacco problems	In order that individuals can act in accordance with that information	3	4	1
Encourage/recommend/motivate groups and individuals with chemical dependencies, i.e., drugs, alcohol, tobacco, to comply with treatment regimen	In order that condition is improved/cured	5	5	1
Support/advise/counsel individual with chemical dependency	In order that they are better able to cope with the situation	6	6	1
Provide information/answer questions of elderly individual about normal changes of aging	In order that individuals can act in accordance with that information	3	4	1
Support/advise/counsel elderly individual who is having problems adjusting to normal changes with age	In order that individual is better able to cope with normal changes of aging	5	6	1

(Continued)

IMPLEMENTATION OF STRATEGIES TASKS—HEALTH EDUCATION AND COUNSELING CHRONIC CONDITIONS (continued)

Task Statement		*Educational Domain Levels*		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Provide information/answer questions of senescent individuals about their condition	In order that they can act in accordance with that information	3	4	1
Support/advise/council elderly individual who is having problems adjusting to senescence	In order that individual is better able to cope with this process	5	6	1
Provide information/answer questions of family about dealing with an elderly person	In order that they can act in accordance with that information	3	4	1
Support/advise/counsel family members dealing with an elderly person	In order that they are better able to cope with the situation	5	5	1
Instruct/demonstrate to elderly patient in the performance of daily living activities, e.g., housekeeping, cooking, bathing, etc., commensurate with his/her health status and physical limitations	In order that individual has the knowledge and ability to maintain his independence	3	4	1
Provide information/answer questions of elderly individual about improving the physical environment of his home, e.g., how to obtain repairs, housekeeping services	In order that elderly individual can act in accordance with that information	2	4	1
Encourage/recommend/motivate elderly individual to improve the physical environment of his/her home by [illegible] the needed repairs	In order that individual continues to live safely in his/her home	4	[illegible]	1
Encourage/recommend/motivate elderly individual and/or family in long range planning for physical and social needs	In order that the strategies selected are appropriate for the elderly person and the family	5	5	1
Provide information/answer questions of elderly individual about budgeting on a fixed income and other economic measures	In order that individual can act in accordance with that information	3	4	1
Support/advise/counsel patient's family with a terminal illness	In order that patient and family can deal most functionally with impending death	5	6	1
Support/advise/counsel family in which a member has died	In order that the family can deal most functionally with the death	5	6	1
Plan and hold family conferences, based on family member(s)'s health problems	In order to provide an opportunity for communication between health worker and family as a unit	5	5	1
Give information/explanation/presentation to groups and individuals about cancer	In order that individuals can act in accordance with that information	2	4	1
Encourage/recommend/motivate individuals to take part in early cancer detection programs	In order to identify the condition at an early stage	4	4	1
Support/advise/counsel individuals with cancer	In order that they are better able to cope with the condition	5	6	1
Give information/answer questions about physical and psychological aspects of "ostomy"	In order that the individual can act in accordance with that information	3	4	1

(Continued)

IMPLEMENTATION OF STRATEGIES TASKS—HEALTH EDUCATION AND COUNSELING CHRONIC CONDITIONS (continued)

Task Statement		*Educational Domain Levels*		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Support/advise/counsel individual with ostomy	In order that individual is better able to cope with the condition	4	5	1
Provide information to recuperating/disabled patient and family about patient's needs and limitations and any alterations in the home that may have to be made	In order that the patient/family can make adjustments and alterations in accordance with that information	3	4	1
Provide information/explain patient's illness/disability to family, teacher, employer, etc.	In order that important figures in patient's life have understanding of patient's capabilities, and so that their cooperation may be enlisted	3	4	1
Coordinate patient treatment plan at place of employment	In order that patient can continue to work at pace appropriate to condition	4	5	1
Give information/answer questions of individual about laboratory/therapeutic procedures	In order that individual can act in accordance with that information	2	3	1
Provide information/answer questions of individuals about surgical procedures	In order that individual can act in accordance with that information/know what to expect in surgery	2	4	1
Support/advise/counsel patient after surgery	In order that patient can better cope with the situation	4	5	1
Give information/answer questions of individual about medications and reactions to medications	In order that the individual knows what to expect when taking medications	3	3	1

Part 5 c

COMMUNITY HEALTH TASKS

Task Statement		Educational Domain Levels		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Identify community leaders	In order to have the knowledge of individuals who would be instrumental in effective community health improvement	4	5	1
Consult with community leaders about community health problems	In order to enlist their cooperation in initiating appropriate and effective actions to improve the quality of community life	5	6	1
Provide information to health services providers about community health problems	In order that they have the knowledge necessary to develop appropriate services and action programs	3	3	1
Organize community groups to work on community health problems	In order that community participation is increased and community health is improved	5	6	1
Provide information to health services providers about the social patterns of the community, e.g., dietary practices, religious customs, social customs, habits, norms, values	In order that they have the knowledge necessary to deal appropriately with individual, family, and community health problems	4	4	1
Provide information to health services providers about community resources, e.g., legal services, consumer protection services, health and welfare agencies, and social and recreational activities	In order that they have the knowledge necessary to refer and advise individuals and families appropriately	4	4	1
Provide information to health services providers about community leaders	In order that they have the knowledge necessary to establish relationships with community leaders for effective community action	3	3	1
Provide names, addresses, phone numbers, application procedures of appropriate community resources to individual/family	In order that individual/family is referred to community resource best equipped to handle identified problem	2	3	1
Consult directly with appropriate community resource personnel, ask questions, request help, when a working relationship between the individual/family and resource is not established or maintained	In order to establish and/or maintain a relationship between individual/family and community resource which allows for resolution of individual/family problem	3	6	1
Participate with community leaders and public health officials in setting priorities for action	In order that community health problems are resolved	5	5	1
Set up immunization campaigns with community leaders and public health officials	In order that the immunization status of the community is kept at maximum levels	4	6	1
Set up ongoing community health education programs with community leaders and public health officials utilizing public meetings, posters, displays, newsletters, slides, schools, and the media	In order to maintain the health information of the community	5	5	1

COMMUNITY HEALTH PROBLEMS

Task Statement		Educational Domain Levels		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Analyze the organization of health services in a community	In order to aid individuals in obtaining those services	6	1	1
Analyze the organization of health related community services	In order to aid individuals to work their way through agencies and obtain necessary services	6	1	1
Motivate/recommend/persuade individual to act upon strategies arrived at by joint agreement between community resources and individual	In order that problem can be resolved	3	5	1
Aid/participate with public health officials in community health surveys	In order that a data base is obtained on health problems affecting the community	4	1	1
Aid/participate with public health officials in the analysis of the community health data base	In order that a diagnosis of the health of the community is made	5	1	1

COMMUNITY HEALTH TASKS

Task Statement		Educational Domain Levels		
Action	*Objective*	*Cognitive*	*Affective*	*Psychomotor*
Set up communitywide or age-specific screening programs, e.g., blood pressure, tuberculosis, vision, hearing, urine, weight, with community leaders and public health officials	In order to identify the individual/family with certain conditions	5	5	1
Informs community of results of community health diagnosis	In order that community can act in accordance with that information	3	3	1
Works as a member of the health care team	In order that team objectives are met and health problems solved	3	5	1

APPENDIX G

TABLE 3–1. The Affective Domain Scale For Health Care

This scale indicates the levels of human interaction related to each task. It allows a measurement of interpersonal skills and of the values, feelings and beliefs that are related to those skills. There is increasing utilization of interactional skills to overcome emotional, cultural, and interpersonal barriers between the provider and the patient and family.

LEVELS	EXAMPLE
1. *Reviewing and reacting to nonhuman stimuli* There is no human interaction involved in performance of the task.	1. Measure hematocrit utilizing hematocrit tube and centrifuge in order to gather a data base.
2. *Receiving information from and responding to people* There is basic responding to immediate, expressed or implicit, needs of another person. Also, exchanging information with others and responding to feedback in an ongoing encounter.	2. Interview patient to obtain a past medical history in order to gather a data base.
3. *Changing immediate behavior* There is influence exerted to encourage and/or persuade individuals to make immediate behavior changes. Also, diverting an individual in an anxiety-producing situation to diffuse fears.	3. Give information, explanation, presentations, demonstrations to groups and individuals about breast self-examination in order that individuals can perform the technique and act in accordance with that information.
4. *In-depth interviewing and teaching* There is action to define, clarify, or enlarge upon patient or provider responses. Also, creating conditions conducive to long term behavior change through teaching.	4. Give information, answer questions of individual about asthma in order that individual can act according to that information
5. *Managing complex interpersonal situations dealing with specific context* There is interaction with individuals or groups in responding to situational demands while systematically observing total results of management. Also, motivating, supporting, and using bargaining skills when necessary.	5. Coordinate with school the treatment plan of chronically ill child by communicating and consulting with appropriate school officials in order that optimum environmental care, and learning opportunities are available.
6. *Actualizing human potential:* The highest levels of interactional skills are utilized here, including those of motivation, persuasion, support, and counseling.	6. Encourage, recommend, motivate groups and individuals with chemical dependencies—i.e., drugs, alcohol, tobacco—to comply with treatment and management regimen in order that condition is improved/cured.

TABLE 3-2. The Cognitive Domain Scale For Health Care

This scale indicates the level of recall or recognition of knowledge and the abilities in independent reasoning necessary for performance of a task.

LEVELS	EXAMPLES
1. *Comprehending and following orders* Very little reasoning is required. The health provider must be able to follow uninvolved written and verbal instructions. Some knowledge of specific facts may be necessary, as well as basic level of comprehension.	1. Measure temperature utilizing a thermometer in order to gather a data base.
2. *Choosing sequences of functions* Minimal independent reasoning and knowledge utilized; knowledge of specific facts is necessary as well as trends and sequences. Both the action and objective of the task are specified, but the health provider has some leeway as to sequence.	2. Apply a dry dressing to a wound in order to prevent infection.
3. *Choosing Methods and Procedures* Independent reasoning sufficient to choose between specified alternatives is necessary. Although action and objectives are specified, there is considerable choice as to method and procedures. Basic analytic skills are utilized. Knowledge of criteria is needed, and a basic knowledge of classifications and categories.	3. Perform closed chest cardiac massage in order to restore cardiac action and blood volume.
4. *Planning Task Performance* The objective of the action is specified; the health provider must develop a plan for performance of the task. Knowledge of criteria is necessary, as well as that of classifications and categories at a more complex level. Basic analytic and evaluative skills are utilized here.	4. Observe/define level of consciousness, orientation to time, place and person, memory, and reasoning in order to gather a data base.
5. *Investigating and Defining Conclusions* Considerable knowledge and independent reasoning are utilized at this level. As well as the knowledge in the above categories, knowledge of methodology, principles, generalizations, and theories is utilized. Analysis, synthesis, and evaluation are utilized at a high level of complexity.	5. Diagnose overweight, obesity and related signs, symptoms, and test results in order to select a treatment and management strategy.
6. *Evaluating Alternative Solutions/Conclusions* Considerable knowledge and independent reasoning and a high level of intellectual skills are required. The health provider must investigate varied aspects of a situation in order to evaluate the problem, consider possible alternatives, and then select the optimum course of action. This is the highest level of complexity and utilizes all categories of knowledge and reasoning in above categories but at a higher level.	6. Select a treatment and management strategy for stabilized angina pectoris/arteriosclerotic heart disease in order to improve the condition and prevent complications.

TABLE 3-3. The Psychomotor Domain Scale For Health Care

This scale indicates the level of motor and manipulative skill necessary to accomplish the task. It includes dexterity, coordination, agility, endurance and speed. Different types of equipment of increasing refinement is utilized.

LEVELS	EXAMPLES
1. *No motor skill necessary* Motor skills generally not required, but if so, they are limited to the casual use of standard equipment and reflex movements. Objective is not evaluated.	1. Assess/evaluate height measurement in order to determine normality or abnormality.
2. *Minimal motor skill necessary* Tasks are performed with simple fundamental repetitive movements and simple equipment. The level of precision required is of the grossest sort. At most, one piece of equipment at a time is involved. The objective must reach certain general standards.	2. Make an unoccupied bed in order to improve patient comfort.
3. *Simple adaptive motor skill with more refined equipment* Some precision necessary. More than one piece of equipment may be necessary to perform tasks at this level. The objective must reach certain specified standard within a range.	3. Perform electrocardiography test utilizing an electrocardiograph machine in order to gather a data base.
4. *Various functions performed within one task* More perceptual-motor coordination necessary at this level. Several pieces of equipment used in a definite order. Objective must reach all specified standards.	4. Test functions of the cranial nerves in order to gather a data base.
5. *Complex movements* Various types of functions performed within one task with refined equipment. There are established guidelines for the use of equipment; however, workers may determine alternative methods when necessary. The objective may or may not be specifically stated. The first level where outcome is clearly stated. Dexterity is necessary.	5. Suture a minor laceration in order to enhance wound healing and minimize scarring.
6. *Highly skilled coordinated movements:* Worker may utilize alternative methods. Strength, endurance, and speed are more important at this level. Objective only generally specified. Outcome is clearly stated.	6. Perform artificial respiratory ventilation using mouth-to-mouth breathing techniques in order to restore patient's respiration.

APPENDIX H

THE METHODS AND TRANSACTIONAL SYSTEMS

METHODS

(Subsuming techniques and skills)

ADVERSARY
Processes, techniques, and skills involving articulation and resolution of conflicts of interests and commitments.

CONCILIATORY
Processes, techniques, and skills involving the maximizing of associative processes

DEVELOPMENTAL
Processes, techniques, and skills involving the creating, mobilizing, and use of resources for purposes of development

FACILITATIVE-INSTRUCTIONAL
Processes, techniques, and skills involving teaching, supervision, etc.

KNOWLEDGE DEVELOPMENT AND TESTING
Processes, techniques, and skills involving research, evaluation, and dissemination of findings, data, programs and policies

RESTORATIVE
Processes, techniques, and skills involving the remedying and healing of impaired functioning

REGULATORY
Processes, techniques, and skills involving adherence to rules and norms

RULE-IMPLEMENTING
Processes, techniques, and skills involving the operationalizing and administering of laws, policies, and programs

RULE-MAKING
Processes, techniques, and skills involving the making of policies, laws and other rules

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