Thoughts on barriers and enablers for incorporating ordinary theorising into the community participation in health debate

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Community participation

The primary health care approach (World Health Organisation 1978) nominates community participation as one of its underpinning principles. Similarly, a socio-environmental model of health promotion encourages people to participate in health development and foster collective action for health (Labonte 1992). People can only participate fully in decisions about research, services and programs that influence their health if their voices are heard and taken into account.

The four types of community participation summarised by Baum (1998) differ in the extent to which participation involves a transfer of power from the state or experts to communities, as follows.

1. Consultation as a means asks for people's opinions and reactions to plans for services and policies. The consultation is limited, initiated by organisations outside the community and usually controlled by the organisation initiating consultation. Examples include consultation on policies by governments and surveys on the quality of services.
2. Participation can also be used to achieve a defined end. Again it is initiated by organisations outside the community. It is instrumental in that it lasts for the life of the initiative and does not lead to shifts in power. An example is the establishment of community panels for priority setting in health services.
3. Substantive participation occurs when people are actively involved in determining priorities and implementation, but when the initiative is externally controlled. Although people outside the community may initiate it, this type of participation may lead to structural participation over time. If the initiative becomes developmental it may involve a shift in power to the community. Examples include self-help groups initiated by a community health centre's staff and community heart health programs working with local agencies.
4. Structural participation is an engaged and developmental process in which community control predominates. The initiative may have come from outside the community initially, but eventually control is handed over to the community. It is a developmental, ongoing relationship, which is driven by the community and potentially hands back power to individuals, organisations and communities. The scope of activities is as broad of as the community wishes. Examples include Aboriginal-controlled health services and resident action groups.

A recent development in Australia designed to increase opportunities for community participation in the health system is the *Consumer Focus Collaboration*. This emerged from a *National Expert Advisory Group on Safety and Policy in Australian Health Care* that was established by health ministers at the Australian Health Ministers Conference in October 1996 (Consumer Focus Collaboration Strategic Plan 1997/8-2001/01 1998).

The expert group was asked to make practical suggestions to improve safety and quality in Australian health care services. It was also expected to direct and influence some important initiatives addressing the recommendations of a previous Task Force On Quality In Australian Health Care that had recommended redesigning health care systems with stronger focus on, amongst other factors, more involvement from consumers.

The *Consumer Focus Collaboration* was established in 1997 to implement recommendations highlighting the key importance of consumer participation in health care. The vision of the consumer collaboration is for health care system which:

- focuses primarily on the needs of potential and actual users or health services in order to achieve optimal and acted health care and Australia;
- provides frameworks and opportunities for health consumers to participate collaboratively with health organisations and service providers in health service planning, delivery, monitoring and evaluation at all levels in a dynamic and responsive way.

Ordinary theory and community participation

However, there are some fundamental barriers to entrenching community participation within the health system. It has been argued that when research uses a biomedically derived definition of health to explore people's attitudes and behaviours it implicitly, if not explicitly, separates individuals from the complex social physical and economic environments in which they live (Milburn 1996). To overcome this problem, it has been argued that the "questioning of the derivation of the existing theoretical base in health promotion could begin with the process of attributing greater validation to lay theorising as an essential feature in the development of culturally relevant theory and practice (Milburn 1996, p.42)."

Pierre Bordieu uses the term practical logic to describe the way popular medical knowledge exists in ways that help ordinary people to remember, manipulate and apply their theories to everyday life (Bordieu 1990). Abrums (2000) deliberately uses the term theory to describe what others have called lay or popular beliefs in order to acknowledge that both experts and ordinary people go through a process of testing their explanations. The difference is that ordinary people do not just test explanations historically and empirically, but by reference to their own everyday experiences (Abrums 2000). In the process, ordinary people may give more weight to what is reasonable for them and people like themselves than what is defined by experts as rational. The decision by people about what is reasonable takes more account of the person's personal and social contexts than does the decision for people about what is rational (Backett and Davison 1992).

Many studies are now exploring practical logic or ordinary theories in order to inform policy and health promotion (Backett and Davison 1992; Backett, Davison and Mullen 1994; Commonwealth of Australia 1995; Woodgate and Kristjanson 1996; Williams and Barlow 1998; Abrums 2000; Commonwealth of Australia 2000; Craig 2000; Pawluch, Cain and Gillett 2000). However, these studies use qualitative methods with long, relatively unstructured interviews or focus groups that take considerable time and resources to record and analyse. They typically adopt interpretivist, constructionist or critical theory paradigms (Baum 1998) which deliberately limit the extent of generalising an objective truth from one study to populations.

Barriers and enablers of ordinary theorising

I can see four barriers and enablers to taking ordinary theories seriously in the dominant structures that shape the day to day research, system design and professional practice:

1. Researchers and practitioners who adopt a positivist paradigm are less likely to use results or methods that take the time to distil ordinary theories from in-depth interviews or focus groups (Baum 1998). We need research methods that can rapidly explore ordinary theorising in hectic and messy practice structures.
2. Bureaucratic structures frequently do not value community knowledge and seem impenetrable to community members (Putland, Baum and MacDougall 1997). We need research on how to develop an organisational structure and culture that values and uses community knowledge.

3. In many countries health promotion approaches operate within free market inspired policy settings that require evidence-based practice in organisations that either charge a fee for service or which have won a contract to provide a service at the lowest price (Wise and Signal 2000; Ziglio, Hagard and Griffiths 2000). We need research on whether it is possible to build in use of ordinary theory as best practice within evidence based and tendering out policy milieux.
4. Professional training is more likely to prepare workers for a role of professional dominance than one of enhancing community participation (Baum 1998). We need research on curriculum design and teaching and learning methodologies that will critique professional dominance and promote the values and skills in a range of professions that promote community participation.

The adoption of these suggestions will go a long way towards answering what I think is an important question for those of us who advocate for community participation, that is:

How do we design the practice, professional education and organisational structures that take seriously practical logic and ordinary theorising and systematically entrench the structural community participation that underpins the primary health care approach?

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