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Micro macro integration: Reframing primary healthcare practice and community development in health

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Abstract
The idea of micro macro integration (MMI) provides a useful framework for thinking about primary healthcare (PHC) and community development in health (CD). PHC and CD are important strategies for addressing the structural determinants of health. They are each based on a powerful logic and have a significant body of support. However, while exemplary, even inspiring, instances of practice are common, attempts to replicate models of good practice (or 'scale up') often flounder. As frameworks for analysing this paradox, both PHC and CD have limitations, partly because they are overburdened with different and conflicting meanings. This paper explores an alternative framework based on a common aspiration of both PHC and CD: to effect change at both the micro level (meeting the immediate health needs of individuals, families and communities) and also at the macro level (of political, economic and social structures). The MMI framework assumes that health issues can be analysed at different levels of scale and of term (from the micro to the macro); that objectives and strategies can be conceived at these different levels; and that a coherent programme of activities can be conceived and implemented which addresses both the immediate and local problems and the larger scale and longer term phenomena that reproduce those patterns of need. The idea of MMI is less ambitious than either PHC or CD but (partly because of this) has value as a framework for analysing barriers to good practice.

Keywords: *Community developement, primary health care, micro macro integration*

Background

This paper argues for a reframing of the way we think about practice in primary health care (PHC) and community development in health (CD); proposes micro macro

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integration (MMI) as an alternative framework; and illustrates the MMI framework using case studies. The paper derives from a wider programme of research exploring the challenges of PHC and CD in health and the preconditions for good practice (CDIH, 2004). The paper draws on the authors' experience in Australia but we argue that the idea of micro macro integration is also applicable in other settings, including developing countries.

All societies face a significant burden of disease deriving from factors that are embedded in social, economic and political structures and processes. This ranges from the disease burden associated with socioeconomic inequality and social exclusion (Benzeval, Judge, & Whitehead, 1995; Marmot & Wilkinson, 1998); to the continuing poor health of Australian Aborigines associated with the legacies of colonization (Rowse, 1996; Saggers & Gray, 1991); and a range of threats to health associated with globalization (Butler, Douglas, & McMichael, 2001; Harris & Seid, 2004). The social determinants of health are complex and multifaceted but it is generally accepted that they include material factors such as poverty and unemployment (Marmot & Wilkinson, 1998) as well as psychosocial factors such as powerlessness (Wallerstein, 1992), alienation (Seeman, 1975) and social isolation (Marmot & Wilkinson, 1998).

Primary healthcare and community development are widely recognized as having an important role to play in addressing the social determinants of health (Green, Ross, & Mirzoev, 2006; Minkler, 2005; Rathwell, Godinho, & Gott, 1995; Wass, 1995). They are each based on a powerful logic and have a significant body of support.

The primary healthcare policy model, as declared at Alma-Ata in 1978, is explicitly oriented to addressing inequalities in health through its emphasis on community involvement, inter-sectoral collaboration and other policy strategies (Green et al., 2006; Rathwell et al., 1995; Werner & Sanders, 1997; WHO, 1978, 1998). The underlying logic of PHC envisages healthcare practitioners and agencies working with their communities to make the links between the burdens of ill health they carry and the environmental and social conditions that reproduce these patterns of disease and disability. It envisages bringing together the expertise of the practitioners and the political agency of communities to address the 'macro' issues even as they work together to address the immediate health problems associated with those macro or structural issues.

The community development model of practice originates from aid programmes in the developing world, where it was seen as an alternative to more top-down development programmes (CDIH, 1988; Midgely & Livermore, 2005). Community development became a social movement in Britain in the 1950s and'60s and was taken up in the health sector in Australia and other countries in the 1970s because of its potential for addressing the structural dimensions of health such as alienation and powerlessness (CDIH, 1988; Minkler & Wallerstein, 2005).

Community development theory is based on the view that the causes of disadvantage (including health inequities) are located in social structures and that social and structural change is required to enable disadvantaged people to gain control over their lives (Ife, 1995; Kenny, 1999; Minkler, 2005). The CD model aims to address disadvantage by empowering communities, improving access to power and resources to enable communities to make real choices about their lives (Ife, 1995; Kenny, 1999; Minkler, 2005). This involves the local identification of needs, priorities and strategies (Kenny, 1999).

PHC and CD share a number of core values including community accountability and local responsiveness. The logic of these approaches is partly about building a political constituency for the kinds of policies needed to change structures. It is partly about people (in communities) being the authors of their own lives—about shaping solutions locally.

Since the declaration of Alma-Ata, and its adoption by the World Health Assembly in 1979, this approach to PHC incorporating CD principles has been reaffirmed in the rhetoric of a number of international declarations and policy documents such as the Ottawa Charter for Health Promotion (WHO, 1986) and the World Health Declaration of 1998 (WHO, 1998). A review of primary healthcare undertaken by the World Health Organization in 2003 found that the principles of PHC continued to be relevant to the problems faced by communities and populations in both developed and developing countries in the twenty-first century, and that PHC continued to be a 'policy cornerstone' in most countries.

The potential of PHC and CD in health can be illustrated with reference to exemplary passages of practice in occupational health and safety, Aboriginal health care and women's health. We have documented many such episodes of practice in our case study collections (Butler, 1994; Butler & Cass, 1993; Butler, Legge, Wilson, & Wright, 1995; CDIH, 1988, 1989; Webster & Benger, 1993; Webster & Wilson, 1993). There are also a number of collections of case studies in other countries, including the developing world, which demonstrate the application of primary healthcare and community development in health (see for example, Minkler, 2005; Newell, 1975; Rathwell et al., 1995; Rohde, Chatterjee, & Morley, 1993).

The case for reframing practice in PHC and CD

PHC and CD are clearly powerful models for addressing the social determinants of health. They are based on a persuasive logic and are supported by many case studies of exemplary practice. The Centre for Development and Innovation in Health (CDIH) has been engaged for many years in research, policy analysis, teaching and consultancy activities to support capacity building in PHC (CDIH, 2004).

Over the last decade, we have been exploring the 'transplantability paradox': exemplary instances of practice are not hard to find, but attempts to replicate (scale up) good practice frequently flounder. Our research has become increasingly focused on exploring the difficulties practitioners face in trying to realize the principles of PHC and CD with a view to identifying more effective capacity-building strategies.

We have come to the view that the existing frameworks and conceptual paradigms available to us are limited in their usefulness and that there is a need for a new analytic and strategic frameworks for thinking about practice, not as exclusive alternatives but as additional resources. PHC and CD are overburdened and conflicted, which limits their usefulness as conceptual frameworks for investigating the practices through which practitioners and agencies seek to address the structural determinants of health.

Since the Declaration of Alma Ata (WHO, 1978) there has been extensive debate over the meaning and application of PHC (see for example, Paluzzi, 2004; Van der Geest, Speckmann, & Streefland, 1990). These debates arise in part from its somewhat disorganized articulation in the Declaration of Alma-Ata (WHO, 1978), where PHC is described both as a level of service delivery and as an approach to healthcare that incorporates a number of principles. In the PHC literature and in many key government policy documents the term has been used to refer (often interchangeably) to: a philosophy of practice; a policy model; and a sector of service delivery (Baum, 1998). A number of commentators note that these multiple meanings result in considerable confusion and in some cases contribute to frustration with and opposition to the PHC model (Baum, 1998; Gott, 1995; van der Geest et al., 1990).

In some degree the controversies surrounding PHC arise from the challenges that PHC represents in relation to more conservative policies and practices. In some degree the controversies arise from critiques of the PHC model itself.

Perhaps the most famous of these controversies are the debates between 'selective and comprehensive PHC' or between 'vertical and horizontal' policy models. In contrast to the comprehensive approach elaborated at Alma-Ata (a broad range of services, prevention as well as care, intersectoral collaboration, community participation etc.) the selective model gives priority to particular diseases or packages of interventions. The idea of vertical versus horizontal models focuses more on administrative control; in place of local level accountability (community control) emphasized in the PHC model, the vertical model sees local-level services functioning as the local arm of centrally controlled narrowly conceived vertical programmes (Paluzzi, 2004; Wass, 1995; Werner & Sanders, 1997).

There is a parallel debate as to whether the provision of primary-level clinical services ('primary care') is a sufficient realization of the PHC model. Advocates of PHC argue that it is not and criticize individual-focused clinical practice, which palliates and obscures social causes and outcomes (Wass, 1995; Werner & Sanders, 1997).

PHC is also subject to more direct criticisms focusing variously on the efficient use of resources; the need to focus on centrally determined policy priorities (rather than locally articulated priorities); and the importance of proper accountability (and scepticism concerning the aspirations to community accountability, which are part of the PHC and the CD approach). (See Baum, 1998; Green et al., 2006; Swerissen, 1997; van der Geest et al., 1990 for comment on some of these debates.)

Community development is also a complex and highly contested concept (Kenny, 1999; Minkler, 2005). Jackson, Mitchell and Wright (1989) describe a 'righteous rhetoric' surrounding the 'right approach to community development' and widespread confusion about how it is best practised. Underlying much of the confusion are some longstanding debates in social theory, encompassing different conceptualizations of power, of community and of the state. Debates over issues such as these permeate (implicitly) much of the discussion regarding community development.

Contested interpretations of power underlie the common debate as to whether the practitioner develops the community or whether the community just develops (is 'develop' a transitive or intransitive verb?). Can empowerment be 'done to' someone or is it the case that people can only empower themselves (Minkler & Wallerstein, 2005; Nelson and Wright, 1995; Wass, 1995; Werner & Sanders, 1997)? Gruber & Tricket (1987) argue that there is a 'fundamental paradox in the idea of people empowering others because the very institutional structure that puts one group in a position to empower also works to undermine the act of empowerment'. At the very least this power imbalance leaves open the option of reversing the 'empowerment'.

Efforts to resolve this paradox by focusing on the role of the health professional as facilitator rather than driver are not entirely satisfactory. In practice, practitioners struggle to negotiate a balance between being empowering and coercive (Kalnins et al., 1994; Minkler & Wallerstein, 2005; Nelson & Wright, 1995). CD techniques can be used to ensure compliance with an imposed agenda, rather than being used to empower communities to define and address their own priorities (Minkler, 2005).

The idea of 'community' itself is also contested. Within the community development literature there are many different constructions of community (Ife, 1995; Labonte, 2005; Petersen, 1994). These constructions are variously permeated by polemic and subtexts. Romantic connotations of 'community' may conceal more complex realities, which

include relationships of exploitation and conflict. Constructions of 'the community' as singular and homogeneous can obscure important differences between groups and the operations of power relations at the interpersonal level (Kenny, 1999; Labonte, 2005; Petersen, 1994; Wass, 1995).

Community development has a contradictory relationship with the state. CD workers are often paid by the state and may undertake their work as part of public sector health and welfare programmes. CD work, however, sometimes involves organization against state power where community needs conflict with agency expectations (Kenny, 1999; Minkler & Pies, 2005; Petersen, 1994). Where community development is funded as an element of state policy this involves the paradox of working 'in and against the state' (London Edinburgh Weekend Return Group, 1979), which can prove challenging for practitioners and feed criticisms on the grounds of public policy propriety.

These contradictions and complexities present significant difficulties in using PHC and CD as frameworks for exploring the conditions for more effective practice.

The search for new frameworks

In our search for alternative frameworks that might help to analyse some of the conceptual difficulties involved in trying to address the social determinants of health our attention has returned to the idea of different levels of analysis and strategy. This idea is central to both PHC and CD and while it is less ambitious in scope than either PHC and CD it is also less burdened by old slogans, loyalties and irritations.

Clearly PHC and CD in health are focused in the first instance at the micro level, motivated by pain, disability and distress and directed to supporting individuals, families and communities who carry these burdens in their daily lives. However, PHC and CD also aspire to effect change at the macro level of the political, economic and structural factors that shape people's health experiences and health chances. Most importantly, both PHC and CD aim to make their mark in the macro domain, through (and as a consequence of) their work at the local level, to address people's immediate health needs in ways that also contribute to redressing the structural conditions which reproduce those patterns of need (NCEPH, 1992).

Micro and macro: Integration or separation?

The relationship between analyses and strategies conceived at the micro level and those framed in macro terms can be considered in terms of two alternative approaches. One approach is to consider the micro and macro levels of scale separately, both institutionally and in practice. This approach can be seen in the longstanding separation of public health from clinical medicine. (See Buetow & Docherty, 2005 for a recent and vigorous defence of this separation.) It can also be seen in many community health organizations where certain practitioners are designated as having clinical care functions and others are designated as health-promotion or community-development workers.

There is a functional logic to compartmentalization but there are also risks. Forms of practice that are focused exclusively at the micro level and do not recognize or engage with the dynamics which reproduce those patterns of need can be seen to stabilize those dynamics by palliating the need and reducing the pressures for change (Waitzkin, 1991). The 'upstream/downstream' metaphor is often used to contrast the individual focus of repair and the community focus of prevention. It is a limitation of this metaphor that it

does not speak to the possible links between repair and prevention. Macro level responses that are not closely related to local-level engagement with the concerns of individuals and communities (including their concerns about illness and disability) are limited in their ability to engage with communities, to use community pressure as leverage for social or structural change or to build on community agency.

These criticisms highlight the need for empowering forms of clinical practice and forms of 'macro' practice where the needs of individuals and families motivate movements for change at the community level.

The 1960s slogan of 'the personal is political' carries the insight that the political, economic and social 'structures' that we refer to when we are speaking about the 'macro' are in fact constituted by the daily practices and behaviour of individuals, including our own. This is reflected in Giddens's (1984) notion of structuration: that the everyday activities of social actors both draw upon and reproduce social structures.

Social structures that disadvantage some groups and benefit others are unlikely to change without some pressure being exerted by the communities and individuals who stand to gain from such change. However, communities and individuals are more likely to engage in such processes of change when the links to their own experiences are clear and their immediate needs are being met (Baum, 1998). This argument is reflected in the 'community development continuum'—the idea that meeting people's immediate needs builds the trust and develops the skills needed for people to engage in pushing for social change (Jackson et al., 1989; Mitchell & Wright, 1992).

This is not simply a matter of practitioners' personal style of work. Organizations and networks can also address both micro and macro dimensions of health issues, as illustrated in the work of many community health centres and indigenous health organizations in building community partnerships to address the structural issues that shape the health of their communities.

These links between micro and macro responses and the interdependence of the two approaches argue for the principle of micro macro integration (MMI). We believe that the logic of MMI corresponds to the core principles through which PHC and CD aim to respond to the personal and the structural dimensions of health problems.

The micro macro integration framework

'Micro macro integration' provides a framework for thinking about how to address the social determinants of health, which adds value to the analytic and strategic frameworks provided by primary healthcare (PHC) and community development (CD).

Micro macro integration (MMI) refers to the integration of analyses, objectives and strategies derived at different levels (of term and of scale) within a single and coherent programme of activities.

This idea is not new. It is at the core of a range of social movements (such as the environmental movement and the women's movement) in which social structures are seen as constituted by everyday practice. It is reflected in the slogan 'think globally, act locally'. The concept of empowerment is commonly applied at different 'levels', including the individual, the organization and the community (see Zimmerman in Minkler & Wallerstein, 2005). Almost all representations of community development in primary healthcare settings include some concept of integrating micro and macro objectives and strategies (see, for example, Minkler, 2005; Mitchell & Wright, 1992; Wass, 1995).

The causes of health problems in developing countries are commonly analysed at different levels. An example is the United Nations Children's Fund (UNICEF) conceptual

framework for understanding the causes of malnutrition, where the causes are understood in terms of 'immediate causes' (such as low-energy diets and diseases such as malaria and diarrhoea); 'underlying causes' such as household food security and sanitation, and 'basic causes' such as political and economic structures (Kavische, 1993; Smith & Haddad, 1999). Efforts to improve nutrition in countries such as Tanzania have included strategies to address the causes of malnutrition at multiple levels, often within the same programme (Kavische, 1993). For example, strategies such as nutrition monitoring and provision of feeding stations (to address the immediate causes) have been combined with strategies to mobilize communities to acquire new skills and knowledge, to improve household food security and to provide education and clean water (Kavische, 1993).

A review of the role of primary healthcare in health promotion in Australia undertaken by the National Centre for Epidemiology and Population Health in 1992 identified the 'micro macro balance' as a key characteristic of good practice in primary healthcare. In a study of best practice in primary healthcare (CDIH, 1996a; Legge et al., 1996b) our research group identified the 'macro micro balance' as an important dimension of best practice. In around half of the 25 episodes of practice on which this project was based, micro macro integration was judged to have been present and to have contributed significantly to the outcomes achieved (Legge et al., 1996b).

The idea of micro macro integration is illustrated in the case studies taken from among those collected by our group and summarized in Box 1.

The idea of MMI rests on three propositions:

- The causes of health problems can be analysed at different levels (of scale and of term).
- Objectives and strategies can be conceived at different levels.
- Analyses, objectives and strategies cast at different levels of scale and of term can be integrated in a singular coherent programme of practice.

Each of these propositions is described below and illustrated using the case studies described in Box 1.

Health problems can be analysed at different levels

It is commonplace to analyse people's healthcare needs at different levels of scale (in terms of organization) and of term (time scale), from the micro level of analysis of immediate needs (heart failure, injury or hunger) to the macro level analysis of the dynamics that reproduce these patterns of need; for example, the role of economic inequalities in contributing to the prevalence of heart disease or cultural stereotypes jeopardizing the life chances of people with mental illness. The idea of different levels of analysis is similarly reflected in the distinction between 'upstream' and 'downstream' determinants (Mackenbach et al., 2002).

Many of the presentations of need being addressed in primary healthcare and public health practice can be understood in terms of causes and strategies operating within the immediate and local context (the 'micro'), and also in terms of the social structures, systems and cultures that help to reproduce such patterns of need (the 'macro').

In the case of the Northcote Hydrotherapy Group (see Box 1), the healthcare needs of the older people were understood in terms of their immediate presenting needs (arthritis, loneliness and isolation) and also in terms of stigma and discrimination against older people and the lack of appropriate social and recreational opportunities. The analysis of the health needs of the women with disabilities involved in the 'Paps I Should' project included both their immediate need to negotiate Pap tests, and the lack of understanding

The Northcote Hydrotherapy Group (McDonald, 1992)
This project was initiated by a physiotherapist (at the then Northcote Community Health Centre) who was using hydrotherapy to treat arthritis among older people. She soon had more clients than she had time for so she initiated a group programme out of which emerged the hydrotherapy self-help group. In due course (with the encouragement and support of the community health centre) the hydrotherapy self-help group also became a massage group and a socially supportive community of older people. An environment of purpose and meaning, of mutual giving and richer human relationships was created, the health effects of which went well beyond the physical benefits of exercise and massage. The group also became a small lobby group advocating for a broader understanding at the community and policy levels of the social and recreation needs of older people.

Paps I Should (Farnan, S. & Gray, J. in Butler, 1994)
A support group for women with disabilities associated with the Women's Health Service for the West approached the health service about the difficulties they were experiencing in negotiating Pap tests and accessing relevant information about cervical screening. These women were either having Pap tests without understanding what they entailed, or simply not having the tests. Women reported that few doctors were aware of alternative techniques for women with physical disabilities. The group made a video about Pap tests for women with disabilities, service providers and medical and nursing students. The women themselves created and acted in the video, thus challenging mainstream perceptions of women with disabilities. The group lobbied health services to increase wheelchair access and provide home visits to housebound women with disabilities. They also used a peer education programme to train women from the group to conduct education sessions with other women with disabilities.

Box 1. Two case studies of micro macro integration.

and awareness amongst health workers (and the general public) of the needs and aspirations of women with disabilities.

Objectives and strategies can be conceived at different 'levels'

The objectives and strategies of the Northcote Hydrotherapy Group were conceived both in terms of improving the physical health and reducing the isolation of the women themselves (through exercise, massage and other group activities) and in terms of creating a broader understanding at the community and policy levels of the social and recreational needs of older people, through activities such as lobbying and awareness raising. Similarly, the objectives and strategies of the Paps I Should project were clearly directed at both micro-level change (increasing knowledge and understanding about Pap tests and increasing access to Pap tests for women with disabilities) and macro-level change through strategies such as professional education, advocacy, peer education, curriculum development and lobbying.

Analyses, objectives and strategies cast at different levels can be integrated in a singular coherent programme of practice

The principle of micro macro integration suggests not only that we can analyse and plan at both the micro and macro levels, but also that we can often find ways of integrating the strategies suggested by these different levels of analysis within a singular and coherent programme of activities. This is where the idea of micro macro integration extends beyond existing ideas of multi-level analysis such as that offered by van der Geest et al. (1990), as well as the metaphors of upstream and downstream, which are usually posed as mutually exclusive alternatives or at the very least as institutionally separate activities.

This principle is exemplified by the two case studies provided above (see Box 1). These projects both integrated coherently the analyses, objectives and strategies conceived at

micro and macro levels. The programme of activities of the Northcote Hydrotherapy Group, from learning massage to lobbying local politicians, were addressing micro-level and macro-level objectives at the same time. Likewise the activities of the Paps I Should project, from providing Pap tests to making the video, were also addressing objectives conceived at both levels at the same time.

There are strong traditions within public health of primary healthcare practitioners working with community organizations to address the structural issues underlying the daily clinical presentations and the immediate health hazards. The Health of Towns movement in nineteenth-century Britain involved medical officers working with civic activists to address the housing, town planning and wider political issues that contributed to reproducing prevailing patterns of illness (Rosen, 1993).

Micro macro integration can be illustrated by the work of Australian Aboriginal health services, which provide clinical and preventive services to individuals and families; work with organizations in other sectors to address the problems of housing and unemployment; and work in ways which recognize the role of the colonial legacy in shaping these patterns of need (Foley, 1991).

This style of practice can be found in many sectors and regions of primary healthcare although it is far from typical. Case studies of such episodes of exemplary practice are documented in Newell (1975), CDIH (1988, 1993, 1994), SAHC (1992), Rohde et al. (1993); Baum (1995), Butler et al. (1995), Legge et al. (1996b), Rathwell et al. (1995), and Minkler (2005). It is the challenge of implementing better practice more widely that has focused our attention on the idea of MMI. There are many situations where analyses and strategies cast at the micro and macro levels can be integrated within a coherent programme or network of programmes. We argue that such integration is a feature of good practice in PHC.

Reframing PHC and CD in terms of MMI

We have identified a number of strategic advantages in using MMI as a framework for exploring the difficulties in PHC and CD practice and the preconditions for good practice.

The MMI framework abstracts a common aspiration of PHC and CD in very clear terms and in a language that is neither conflicted nor overburdened. It deals with practice in terms of objectives and tools rather than in terms of philosophies or outcomes. It is broader than PHC (which is 'sector specific') and CD (which is 'strategy specific') but it is less ambitious than both.

The language of MMI is not overburdened or conflicted. Unlike PHC, it has not been 'sloganized' or loaded with conflicting interpretations. Since it is not entangled with debates over the meaning of concepts such as power, community and the state, it leaves these issues open for exploration in relation to the contingencies of the case.

The idea of MMI encompasses much which is difficult about PHC and CD and provides opportunities for examining such difficulties using new conceptual paradigms and theoretical resources.

Conclusion

We argue for reframing PHC and CD practice in terms of micro macro integration—an additional framework of analysis, not an exclusive alternative. MMI lies at the heart of the

way in which PHC and CD address the social determinants of health. We have found MMI useful as an analytical tool for exploring some of the difficulties faced in PHC and CD practice. Our recent research has focused on testing the MMI framework by applying it to case studies of PHC and CD practice. We anticipate that a focus on the concept of micro macro integration will illuminate many of the barriers associated with PHC and CD practice. We anticipate that PHC and CD practitioners, policy-makers and researchers may find the MMI framework useful for thinking about practice in these fields.

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