Chapter 13
Conclusion: A Re-evaluation of Institutionalized Health Care

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Introduction

Community-based health care is a growing interest to academics and policymakers. As questions are raised about the status of the Affordable Care Act and rising healthcare costs, scholars and practitioners are exploring the benefits that community-based models can offer healthcare delivery, service, and management. The nature of health care is thus changing, and alternative, "local," solutions are being integrated into the mainstream.

In *The New Public Health*, Baum (2016) emphasizes the growing scope of a new public health vision. Health and environment planners are faced with challenges to improving community health outcomes. In this vein, scholars have examined the link between theory and practice in community-based health care, with some providing general guidelines (Bartholomew, Parcel, Kok, Gottlieb, & Fernandez, 2016; Minkler & Wallerstein, 2008). Others have highlighted community-based theory in various professions, such as nursing (Billings & Halstead, 2016) and social work (Gould & Baldwin, 2016). Still others note the importance of community-based theory across disciplinary boundaries (Nelson & Stagger, 2018).

A trend found in the literature is the "institutionalization" of alternative health models in the professional sphere. However, investigations are lacking that have explored the theoretical and practical considerations of institutionalizing a community-based model. In other words, community-based theory is designed to overcome the limitations associated with traditional organizations of health care. In

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this respect, a theory of organizations and institutions is implied by community-based theory that is often overlooked.

The aim of this volume, accordingly, is to focus on the theoretical and practical implications of institutionalizing a community-based approach to health care. Discussions of community-based work often are focused on human agency and community well-being. And these traits should not be overlooked. A problem, however, is that community-based practitioners' work in institutions is assumed to have a unique status, more significant than either individuals or communities. Nonetheless, discussions of institutional challenges to community-based work are rare. The goal of this collection has been to remedy this shortcoming and address some important institutional issues in community-based projects.

The chapters in this volume emphasize the benefits of institutionalizing community-based health projects, but in a manner different from the past. To the extent that community-based efforts are described as substantially different from conventional practices, service institutions must be conceptualized and operationalized to preserve the intention of communities. Furthermore, an entirely new ethic of health care is presumed by institutionalizing a community-based philosophy. In short, a careful examination of how community-based projects can be institutionalized has the prospect for advancing effective strategies for community health planning.

A recurring theme in this book is that planning should not be reduced to simply assisting communities or managing health services within certain locales. At the center of community-based theory is also a new image of social planning that goes beyond traditional models of leadership and management. Rather than developed and controlled by expert professionals, planning efforts emerge from below or, as Ulrich Beck (1997, p. 157) suggests, from a "sub-politics" that represents the direct action and goals of community members.

Reimagining Institutions Through Community-Based Philosophy

Clearly, community-based approaches seek a deeper involvement of community members because their biographies and contextual perspectives on community life shed important light on discussions about community well-being. However, the radical centering of community members in social planning suggests a reimagining of how these efforts are institutionalized. In short, being community-directed supplies important insight into how organizational life is transformed and a style of health organization emerges that is different from traditional health interventions. An important part of this movement toward self-directed projects is a need to reconceptualize the institutional contexts in which health projects take place.

Perhaps important to appreciate is the traditional descriptions of institutions, particularly their social imagery for the operation of organizations and the implications

for the delivery of health services. Most often, institutions are understood to give stability and regularity to society. Institutions are meant to restrict idiosyncratic behavior and foster predictable interactions. As Anthony Giddens (1987, p. 11) notes, an institution represents "patterns of social activity reproduced across time and space." In short, institutions offer the continuity necessary to organize social life.

This description of institutions emerges alongside the positivist thinking of the latter half of the nineteenth and early part of the twentieth century. The continued development of industrial capitalism and the growing prestige of science led to a preference for scientific management as a means to regulate institutional behavior. In particular, specialization and technical knowledge became favored tools to guide how persons run businesses, economies, political organizations, and schools (Bentley, 1908). Using the techniques and guidelines of science to bring rationality, efficiency, and objectivity to any endeavor is thought to be a welcomed contribution to any organization.

Important for this discussion is that formalizing the practices of human organization has been presumed a positive development. By the 1930s, the Human Relations School began to argue that successful organizations train a cadre of professional managers (Whitley, 1984). For example, through principles of standardization and formalization characteristic of bureaucracies, managers can better regulate key individuals (workers) by developing discrete roles and clear lines of communication. The message becomes that human organizations simply work better when managed by an elite group of individuals who possess technical skills. These talents, moreover, allow them to think beyond their individual experience, so as to conceptualize the broader needs of the organization.

This image of human organization, nonetheless, is anathema to a community-based approach to health care. The problem is that a penchant for technical and formalized skills leads to the marginalization of the non-initiated. In the context of social research in academic and health institutions, professional researchers or health practitioners are in charge of most projects (Leitz & Zayas, 2010). Particularly insidious about this conceptualization of institutions is how the hierarchical system of authority, which situates professional experts on top of the organizational structure, means that inequality and marginalization of laypersons gain a sense of legitimacy. Because institutions and their leaders are presumed to be impersonally guided by formalized rules, they are not implicated in the process of prejudice or exclusion.

Considering the emphasis on self-direction in community-based theory, institutions and the hierarchy between professional and community members cannot be justified easily. Following the linguistic turn to knowledge, no perceptive is unbiased, even those of scientific professionals (Ugalde, 1985). The organization of institutionalized research pursued by academics and health professionals is no exception. As opposed to being objective, institutions and roles that make them up represent just one rendition of how social interaction should take place. The cultural hegemony of research is difficult to sustain, since their standardized methods are not neutral nor do they offer persons a more privileged position to judge reality.

Making Institutional Health Planning Transparent

From a community-based perspective, the institutional context where community health planning takes place needs to be made transparent. Here transparency is used in a way similar to Jean Gebser (1985, pp. 6–7), who defines this term as "everything latent behind and before the world" is revealed. Put differently, what Gebser means is that human action is recognized to pervade all that is known and thus nothing is preserved as an unbiased foundation. Thinking in terms of community-based institutions, this claim means that all persons can be legitimate participants in fomenting a vision of how social behavior should unfold.

This view of institutions is grounded in what Marx called *praxis* or human action. In this light, Tervalon and Murray-Garcia (1998, pp. 117–125) argue that from a community-based perspective, professional practitioners, researchers, and other social service agents should base their work in "cultural humility." They suggest that rather than centering the views of experts, these individuals should work toward a "lifelong commitment to self-evaluation and self-critique" so as to not obscure the views of community members through a power imbalance (Tervalon & Murray-Garcia 1998, pp. 117–125). This attitude is meant to curb the impact of professional cultures that can unnecessarily shadow the ideas and efforts of the community.

When institutions are reclaimed through collective praxis and partnership with communities, the rationale for community-based work becomes visible and a pathway is available for its actualization. Simply put, with collective praxis at the heart of institutions, the behavioral repertoire that goes along with community health research is expanded and power differentials minimized between communities and health professionals. When the deliberative process is opened in this manner, a democratic view of institutions is promoted, which is consistent with the aim of community-based social planning to have community members direct all local projects.

Instead of representing universal standards, the institutional context of community-based health care represents a human endeavor that may include competing views of need, risk, and illness. The point is that institutions are not sacrosanct; they are rooted in human actions and local language games. Institutions are thus made out of human praxis and do not represent a set of idealized traits. Treating institutions as monuments can promote the idea that certain skilled individuals best characterize the properties of institutions (formalism, standardization, technical), and thus, professionals should be granted special status.

And yet this type of hegemony is antithetical to community-based theory. What community-based strategies emphasize is that institutional arrangements are positional in nature and, thus, emerge from the outcomes of debate. As Stanley Fish (1992, p. 261) describes, institutions should be imagined to be "always emerging and re-emerging in response to historical needs and conditions." Rather than structural and mechanical, institutions are based on contingent understandings. In this way, institutions are never finalized, but always available for modification arising from local initiatives.

Issues of Power and "Community-Driven" Health Institutions

A central focus of community-based health planning is self-governance; self-regulation is the hallmark of a community-based style of institutionalization. To the extent that institutions represent human praxis, persons have nothing else to rely on but themselves for order. Institutions are thus discursive and represent the record of human activity. An important element of participatory health care is the idea that the community should drive health planning at all levels. Given the nonrealistic stance that community-based practitioners adopt, institutions and the power concealed by these entities can be examined. Subsequent to the demise of dualism, a neutral or universal standpoint is not possible to attain. Institutions are not an exception; they do not carry inherent autonomy due to their formal character. Institutional arrangements, instead, represent a set of specific assumptions made about human organization. Given the perspectival origin of institutions, these organizations should be receptive to local challenges and become polyvalent.

When community health projects unfold, however, a range of challenges often emerge. Most notably, community health initiatives "paradoxically … would not occur without the initiative of someone outside the community" (Minkler, 2005, p. ii8). And as is often noted, these individuals have the time, skills, commitment, and privilege to engage in these endeavors (Minkler, 2005, p. ii8). This reality, in turn, leads to "insider-outsider tensions," which has been discussed by community-based practitioners for some time (Ugalde, 1985). In this situation, community members remain on the periphery of the decision-making process, such as in the selection and understanding of health issues, the research process, and intervention strategies. At worst, these persons are used and exploited for information and labor, with the local communities seeing few benefits. As Wallerstein (1999) argues, community-based researchers and practitioners do not recognize the degree of power that is embedded in the privileges of professionals and other outsiders.

A key philosophical ingredient behind the insider-outsider dynamic, however, is often overlooked. The metaphysical claims that have been used to describe and justify institutions and the hierarchal relationships within them need to be exposed. To paraphrase Marx (1952), individuals create institutions but not always in terms of their own interests. More esteemed discursive formations gain power over institutions, such as those of technical experts, and may begin to inferiorize others. Here certain behaviors are institutionalized and are allowed to discriminate against community members who do not carry organizational positions or possess specific competencies. Moreover, this type of inequality carries the allure of neutrality given that they are associated with formal, institutional relationships.

But when institutions are reclaimed through human praxis and reflection, the rationale for institutional hierarchies is made visible for critique. Community-driven planning thus should include a new raison d'être for institutions, as well as for the health work accomplished within these settings. With institutions imagined to be mediated fully by human interpretation and action, these organizations should represent collective deliberations and the choices made to pursue one course of action

or another. However, now these choices cannot be understood to be value-free but rather as political. In this context, political refers to the idea that human involvement and intentionality are inextricably tied institutions (Lyotard, 1993, p. 5). Community-based planning, accordingly, involves a re-evaluation of how persons and their communities have been positioned with respect to health-care institutions and the policies that emerge from these organizations.

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