Book Reviews

Current Health Policy Issues and Alternatives (An Applied Social Science Perspective), Carole E. Hill, Editor, Athens, The University of Georgia Press, 1986, 212 pages.

This collection of ten papers, most of which were given at the meeting of the Southern Anthropological Society in 1984, are, according to the editor, "directed to the intersection of health policy issues with approaches of applied social sciences for the purpose of delineating alternative policies for health care organization and delivery." The majority of the papers discuss policy issues from the standpoint of empirical data on one hand and from a policy view on the other—the latter intended to be derived from the writing of Robert Alford[1,2] whose seminal writings were given to all authors as a common frame of reference. A health policy context for the book is also provided by the first author, Thompson, who, incidentally, makes no reference to the work of Alford and who concludes that "without question, economics ranks as the dominant social science within policy circles." This having been said in the first chapter, all subsequent authors discuss specific health policy problems, programs and issues, seemingly avoiding as much as possible any reference to economics as the "dominant social science."

Be that as it may, the nine case examples that follow the policy context paper cover a wide range of issues including environmental health, mental health, primary health care, ethnicity and health care of individuals with alcohol problems, nutrition, traditional and western medicine, and professional preparation of public health workers.

These are presented within cultural contexts that include Mexico, Micronesia, Peoples Republic of China, and Costa Rica in addition to the United States with its country context and selected cultural or ethnic groups. The perspective of most papers is interdisciplinary, and indeed one finds history, political science, education, and sociology as discipline viewpoints represented in the presentations and discussions of the empirical data as well as anthropology which is the home discipline of the editor.

Although the title implies that "policy" is the "glue" that binds the articles together, policy here is very broadly defined to include micro, mezzo, and macro level policies, as well as issues related to programs, services, and facilities. Indeed, it would appear that almost any administrative or organizational decision can be and is interpreted as policy making. Many readers will not have any difficulty with this broad perspective, but some would have preferred a more narrow focus—which was probably intended by providing Alford's references to the authors as a frame of reference. Very different and diffuse interpretations of policy are employed throughout and it would have been helpful had the authors followed the original aim. Some readers will be more comfortable than others with this vagueness in conceptualization of policy.

To health educators and perhaps many others working in the community or at state and national levels it can be assumed that health policies can be initiated by people in the community, by staff members within agencies, by administrators, by politicians, by organized groups in the community, and a whole host of other individuals and

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groups at state and national levels. Some of the authors in this volume, however, Angrosimo and Whiteford for example, seem to find this idea a radical one, and attempt to make a case for throwing out a so-called "classical" model of policy process of "top down" policy development and using a new "cyclic" model, which to many readers will seem very similar to traditional community organization and advocacy with policy as an end-product. Their findings to the effect that people can channel criticism through bureaucracies without jeopardy and that agency policies can be influenced by middle management and people outside the agencies will seem a little naive to readers accustomed to the literature on policy development, advocacy, and community organization practice.

Four of the nine papers are actually derived from experiences in countries outside the United States, but the editor emphasizes that the other five, which are based on U.S. policy issues, actually have relevance for international health policy as well. It is a moot point, this reviewer believes, whether or not this is so, but, as in many issues of determining what is relevent in one culture or another, in truth it is "in the eye of the beholder." The article by Bloom on "The Impact of Applied Social Sciences on International Health Policies" comes about as close to achieving this goal of all articles in the book. The article by Strauss and Conrad on "Contemporary Issues in Education for Public Health: Alternative Policy Proposals" seems hardly related to the international health policy theme at all. In fact, while the Strauss and Conrad article stands on its own as a very useful review of issues in education for public health, it does not seem to fit the intent of the book or focus on the "intersection of health policy issues and applied social sciences."

The article by Couto on "Failing Health and New Prescriptions: Community-based Approaches to Environmental Risk" breaks some new conceptual ground by suggesting revisions of Alford's assumptions that all interests are equal in competition for health policy outcomes. Indeed the experiences of community groups working on environmental issues, as noted by Cuoto, have refuted this assumption. Consideration of the actors in the conflicts over health and pollution raise additional question for both theory and practice of advocacy.

The remainder of the chapters, whether based on information from inside the United States or outside, follow very much the pattern of case material material from Benjamin Paul's *Health, Culture, and Community*[3] and the many books of that genre that followed on the importance of making health policies, programs and services "fit" the specific cultures in which they are provided.

The placement of references for all the case studies at the end of the book instead of after each case detracts from their usefulness and even suggests that the use of references by some authors was uneven.

The value of this book will be probably greatest in undergraduate and graduate courses where students are learning fundamentals of policy development in the health field, particularly as it relates to the international aspects or application of social science theory to broad and diverse issues in health. Practicing health educators, administrators, policy makers, and social scientists will find it somewhat less relevent to their work generally and somewhat uneven.

References

1. Alford, RR: The Political Economy of Health Care: Dynamics Without Change. *Politics and Society* 2:164.
2. Alford, RR: *Health Care Politics: Ideological and Interest Group Barriers to Reform* Chicago, University of Chicago Press.
3. Paul, BD: "Health, Culture, and Community." New York, Russell Sage Foundation.

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Patient Education and Health Promotion in Medical Care, by Wendy Squyres and Associates. Palo Alto, California, Mayfield Publishing Company, 1985, 410 pages.

The provision of patient education and health promotion services within medical care has come a long way in the past 25 years.[1-4] The 1960s increased awareness of planned educational experiences as a solution to some of the problems encountered in chronic illness (e.g. diabetes, tuberculosis). It also began the era of rising health care costs and ushered in some powerful societal changes that permanently altered our expectations about patient-provider relationships. The civil rights movement, women's movement, rise in consumerism and self-help gave new impetus to patient education and the concept of the activated patient. The patient was now part of the health care team, the social distance between professionals and the patient was reduced.[1]

By the 1970s hospitals were not only providing many disease-specific patient education programs, but had designated personnel to "coordinate patient education activities." A background in health education, however, was not a prerequisite for the role.[5]

The 1970s also saw the publication of the *Patient Bill of Rights* and *Professional, Accreditation and Legal Statements about Patient Education* by the American Hospital Association. The professional organizations within medicine, nursing, pharmacy and dietetics incorporated statements about roles and responsibilities for patient education. The Society for Public Health Education published a position statement on Patient and Family Education in 1976. Responsibility for providing patient education was clearly multidisciplinary.[1] Statements regarding the accountability for the quality of these services first appeared in the 1976 edition of Joint Commission *Manual on Accreditation of Hospitals.*

By the late 1970s and early 1980s the influence of lifestyle on health had been well documented.[6] In 1981 the American Hospital Association developed a policy statement on the *Hospital's Responsibility for Health Promotion.* Hospitals were encouraged to think of themselves as health rather than illness centers. Risk reduction, health risk appraisal, disease prevention, lifestyle education services are now commonly provided by hospitals, although the motivations for providing them may vary. In the past 10 years there has been tremendous growth in outreach services to the community, business and industry fueled by the increased need for alternative revenue sources.