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ABSTRACT

The complex issue of health care delivery is of continuing concern among health care volunteers. Trends in health services that affect the volunteer include those resulting from government or funding policy; changes in the structure of the health professions; increasing consumer interest in health care; and the growing demand for health care information. Volunteer roles include direct service, administeration, and policy setting. The planning and implementing of community health volunteer programs can follow one of two models. The first includes six steps: exposure-reflection; problem identification, analysis, and data gathering; goal setting; strategy and planning; implementation; and evaluation. The second focuses on the broad situation but can use the same steps as the first. The attitude to volunteer work should be that of professional commitment to the particular job and should be accompanied by a commitment to interpersonal skills in working with others and sometimes also advocacy for community health. Administering a community health care program involves: recruitment; using the available skills of the volunteers; orientation of volunteers; task design, assignment, and scheduling; and supervision. A form for community survey for a comprehensive approach to health concerns is included. (EC)

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CONTENTS

CHURCH WOMEN UNITED is a national movement through which Protestant, Roman Catholic, and Orthodox women express the ecumenical dimensions of their faith and work. Units of the national movement are organized in more than 2,000 local communities and in every state. Participation is open to all Christian women who wish to manifest their unity through fellowship, study, and cooperative action. Church Women United seeks the development and renewal in every community of a commitment of Christian women to one another across all lines—race, age, education, denomination. It also aims to enable women to make their full contribution to society and to venture in new forms of witness and service in the community.

Participants in Church Women United celebrate together annually on three special occasions: World Day of Prayer, May Fellowship Day, and World Community Day. A national Ecumenical Assembly is convened every three years to elect national officers and a board of managers. At the April 1971 assembly held in Wichita, Kansas, Clarie Collins Harvey was elected as President to head a Board of Managers of 140 women from nearly 40 denominations and representing all ethnic groups in the United States. The national office is located in New York City with Margaret Shannon as Executive Director and with a staff of approximately 25 persons.

Health Services - An Arena for Action

Concerned response to personal and community health needs flows as naturally from the life of the person of faith today as it did when Christ ministered to the pressing needs of the sick. The fundamental nature and importance of a healthful quality of life for all people is an acknowledged part of our heritage as Christians, and it is also a present day imperative.

Our common life together as citizens in a community requires a recognition of the underlying interaction between physical health and mental well-being. The individual and the community alike have a responsibility for action which "binds up the wounds" and at the same time works to prevent future tragedies or difficulties.

When reaching out in response to the needs of people in poor health and in suffering, the woman of faith knows how important it is first of all to be responsible for the quality of her own personal health. The "helper" always has a primary responsibility to look to her own state of "wholeness"! Another part of today's action is to engage in an appraisal of the role of church women in helping the community and the nation to rethink the health goals for all citizens.

Any action should be labelled pure dreaming, however, if it does not result in the actual *delivery of the health services* which are needed by *all* segments of our population. The church-related volunteer has a tremendous opportunity to help bring idealistic theory out of the sky and put it to work for health programs which truly serve all the people—promptly, effectively, compassionately, and with a measurable degree of permanence.

As a matter of fact, many church groups have been taking a new look at the way the health care system is operating. There is general recognition that criticism of the system is not enough. The focus increasingly is on feasible solutions to problem situations. There must be provision for a whole range of health services in every community, ranging from preventive care through primary treatment to specialized care. Much thought is being given to the way church-related health institutions, such as hospitals and nursing homes, fit into the total health care picture in a given community. Some church groups have nursing homes which are open to medicaid patients. Other church groups are seeking out the gaps in services to low-income groups and are organizing efforts so that these services are available to the people. For example, Church Women United in Boston, Massachusetts, is aiding the development of an inner city neighborhood health clinic, which operates under community management and provides primary care in a medically deprived area.

Several denominations have staff persons whose role is to help local people, living in places with little or no health services, to initiate and operate their own comprehensive health care program. On John's Island, near Charleston, South Carolina, the health services officers of several denominations have given major support over a period of years to an "island-managed" comprehensive rural health program which now receives governmental as well as private sector funds. Denominational health services staff members also provide guidance in making community assessment of needs, in writing proposals for government funding, in organizing boards of directors for community health programs, in distinguishing between policy decisions and management decisions, and in hiring medical personnel. With church groups acting as catalysts, a collaborative, cooperative, community approach to the solution of health care problems is bringing forth exciting new developments.

Church Women United, as a movement, is currently emphasizing health concerns as an arena for action by volunteers in the community. Two regional workshops were recently held in Buffalo and in Boston during which representatives from local units participated in a variety of learning experiences.

The workshops had three main elements. The first provided for reality-experiences or exposures to actual conditions and actual people. In this way, a "feel" for the

needs and the problems as seen in the lives of real people emerged. On-the-spot visitations were made to drug therapy program sessions, crisis intervention centers, mental health programs of inner city schools, neighborhood health clinics, nursing programs for minority women, school nutrition and health education programs, hospital services, etc. Opportunities were opened up so that church women could talk to the "consumers" of health services in many different types of neighborhoods and to doctors and program directors who were the "providers" of the services.

The second element featured in the workshops was an intensive updating of current knowledge on the trends and developments in medicine and health care. Outstanding professionals from the Boston University and Harvard Medical Schools, the State University of New York at Buffalo, regional medical organizations, the National Health Service Corps, health insurance groups, maternity and infant care programs, and community action projects all contributed their analysis and insights. The various proposals for national health insurance were also analyzed and discussed. This section of the workshop made it possible for the participants to have an overall view of the total health care situation *before* deciding upon any particular form of local action for their own community.

The third part of the workshops featured a training session in goal-setting skills for health field action by local units of Church Women United. The importance of setting realistic and appropriate goals was stressed. Small groups considered ways to carry out goals and develop projects locally.

The information and suggestions within the "Church Women United Guidelines for Health Care Volunteers" is the distillation of the knowledge gained from experience with the workshops and with the various health projects initiated or supported by local units of Church Women United. It was apparent that women have an insatiable interest in the whole issue of health care, matched only by their eagerness to find their own responsible piece of action!

Trends in Health Care Affecting the Volunteer

Knowledge of current trends in the health care fields can be important to the volunteer in a number of ways. If, for example, the volunteer is aware of the new directions in the field, she is more likely to be able to channel her energies in constructive and meaningful ways. Without this knowledge, she might spend a lot of time and woman power on programs or ideas that are either on the way out or that work at cross purposes to developing trends. Since the volunteer often performs an educational or community awareness function for society as a whole, she should be alert to the most effective utilization of the new approaches. For example, had the policy-making board members of Joint Health Venture, a voluntary agency in Hollywood, California, not been aware of the value of and need for paramedical workers, and as a result provided training classes for health aides, an important new opportunity would have been lost.

The trends outlined here for consideration by volunteers and voluntary agencies are listed according to various groupings; namely,

- *trends influenced by government or funding policy*
- *trends in the health professions*
- *trends arising out of grass roots concerns*
- *informational trends*
- *some miscellaneous trends which do not seem to fit into the other categories.*

Such a listing is not intended to be rigidly exclusive, since many trends have been influenced or will be affected by forces in more than one category. It seems easier to conceptualize the great variety of changes occurring in the health field with some organization however. Hopefully the outline used here will be of use in thinking and planning for volunteer action in the various sectors of the health care field.

I. Trends Influenced by Government or Funding Policy

Federal influence in the provision and delivery of health services has been a significant force for some time. Enormous programs of research and control have been in existence and have had important influence on the directions of research and the provision of services in the past. The new federal emphasis seems to be away from a primarily research-based concern and federal agency control of drugs, food purity, etc., toward a more active influencing role in the delivery of services to the health consumer. As a result we are seeing large cutbacks in research and training programs and the probable demise of a number of federally supported programs, some of them direct service types of programs. Mental health programs in general and the role of NIMH (National Institute of Mental Health) may change and move over into the local or private sector of influence. However, there are significant new areas of positive concentration in governmental health planning and these may provide new opportunities for volunteer participation. These opportunities, however, would be for the experienced volunteer with a background in community health programs and a definite flair for personal influence in the community.

Perhaps the most all-encompassing new trend, and one which will provide for important improvements of service and delivery of health care, if it can be carried off and implemented, is *comprehensive health planning and care*. The basic idea of comprehensive health planning is to involve providers of medical care (nurses, doctors, nursing home administrators, etc.) and consumers in the planning of area-wide health services. There is an emphasis on identifying and providing for the health care

needs of the entire area without duplicating services or omitting any important services. It is a good concept and in theory could involve the comprehensive health planners in providing not only traditional health care but also the planning for environmental health, prevention of disease and disability, industrial safety, alcohol and drug abuse prevention, etc.

Comprehensive health planning is not a brand new concept—it came on the scene in 1966 when Congress passed a law saying that there should be "Comprehensive Health Planning." Since then, over 170 health planning agencies have been developed across the country. They are regional in nature, usually including several county groups. The intent of the law acknowledged that our national purpose depends upon promoting and assuring the highest level of health attainable for every person in an environment which contributes positively to healthful individual and family living. To carry out such a purpose Congress indicated that comprehensive health planning for health services, health manpower, and health facilities was essential. The Regional Medical Program, established by a separate law, had similar broad goals and was an administrative arm designed to facilitate regional improvement of health services. The program of the Regional Medical Program has been limited by recent budget decisions.

Comprehensive health planning is funded 50% by Federal sources and 50% by local sources. New emphasis on increasing local sources of funding in all Federally funded programs dealing with local services, plus the trend toward revenue sharing, is likely to put CHP agencies in uncertain positions for a while. Most informed leaders in the health field feel that the concept of comprehensive health planning is here to stay and should expand as consumers continue to get involved in planning for efficient and comprehensive health services to their own communities.

Comprehensive health planning is closely related but distinct from another major trend in health care, namely *comprehensive health care*. Comprehensive health care is the goal of comprehensive health planning, but there are many other means of working toward its attainment. Most of these involve similar agency and consumer involvement but may be initiated at local government or private sector levels. In essence, comprehensive health care refers to the provision of health maintenance and prevention services through a unified system. It has been going on a long time in isolated clinics, medical care plans, etc., but the concept is gaining in importance as the cost of medical services, the fragmentation of delivery systems, and the shortage of medical personnel continues. Comprehensive health care occurs in the large private clinic with multi-specialty physicians and rehabilitative and diagnostic services, and also through existing health maintenance organizations such as the Kaiser Permanente plan in California.

Ideally, comprehensive health care involves several elements—prevention of disease, maintenance and provision of health care services in a central location with centralized referral, personalized attention, and an awareness of the total health care services needed by the client. In other words, the patient doesn't have to go to five different specialists, in five different places, with a wait of two weeks between each appointment, with different (and possibly conflicting) diagnoses from some of those professionals, with no one to explain what is happening, what the health professionals are finding out, and why all the different tests and procedures are necessary. In contrast, the client should be able to have one referral source in a central location. There is someone who takes a personal interest not only in the individual's problem but in the prevention of illness and the health maintenance and care of the individual's entire family.

The provision of comprehensive health care is not a new idea. It goes back to the old family doctor idea. But it has been a serious lack for a considerable time and the trend is to try to design new structures and methods for dealing with the problem in a highly urbanized specialized society. This trend is taking many forms. One of the basic ones which we will all be hearing more about in the future is through what is called *Health Maintenance Organizations (HMO's)*. HMO's were first defined in the President's health message of 1971. The HMO can take a variety of forms under a variety of sponsors, but however it is organized, it assumes responsibility for meeting the broad health care needs for a defined population, living within a specified geographical area, in return for a predetermined sum of money for each enrolled person.

HMO's need not involve centralization of care in a single facility but the idea does require a network of services structured to meet the multiple health needs of a defined population. The idea behind it is that HMO can plan for health needs based on that population and the available income from predetermined fees of that population. The client population, on the other hand, knows that it can obtain needed health services without concern with unexpected high cost. It appears that health delivery personnel has no incentive to use expensive services when less expensive ones would serve, since the care offered is on a fixed fee basis, and the entire system is oriented toward prevention as well as care. Because it is cheaper to prevent illness and disability than to cure it or treat it once it has happened, the HMO concept is attractive.

A similar type of program which is beginning to come about is *Family Health Centers*. These centers are being supported by Federal monies and are designed to meet health needs where severe shortages exist and to discover solutions to the problem of providing care in such areas. Family health centers must provide a broad range of

health services and focus on care outside the hospital, although enrollees are assured of the availability of hospital care when it is needed.

A third type of organization of health services within the scope of comprehensive health care is the development of the *National Health Services Corps.* This Corps was created by Federal legislation to meet the health care personnel needs of areas where personnel shortages are critical—primarily rural and inner city areas. The National Health Services Corps is an arm of the Public Health Service. Medical service personnel is employed by the Public Health Service and assigned to areas where critical shortages exist. There is careful matching of the professional with the community. A community health planning organization is part of the program. Doctors and other Corps personnel are encouraged to settle in the areas of need after their period of employment with the Public Health Service ends. Depending on community needs, the persons assigned may include doctors, dentists, nurses or other supporting health workers. Corps personnel are paid a federal salary but receive fees for service, comparable to other local area fees, which are returned to the federal government. Thus the government is not establishing a "soft money" type of dependence on the community. It is hoped that the period of support by the Public Health Service, during which community health planning is being carried out, will lead to the establishment of systems in which ongoing health care will be able to be provided without federal support.

In addition to attempts to provide support for new systems and organizations of health care delivery, government is also providing *incentive support* to *agencies and institutions* in an attempt to bring the nation's total supply of health manpower into better balance with demand. Towards this end, government support will undoubtedly influence trends toward expansion of enrollment in medical and other professional schools, the development of projects to train second-level health professionals such as physicians' assistants, nurse practitioners, dental therapists, and other new types of health personnel, training in the team approach to health delivery, and expansion of the use of technology by physicians and other health personnel.

A fourth trend in the area of new organization of health care delivery is the emphasis on *comprehensive emergency care networks.* Very few locations have facilities or expertise to deal with all types of needed emergency care. Consequently, there has been a linking of individual locations into an arrangement whereby a central referral source can designate the location to which an emergency should be taken. The best available expertise is given advance notice to be ready for that specific emergency case. For example, Chicago has an experimental emergency network already in operation, involving the many hospitals in the area, the state and local police units, emergency notification of specialists in the area, and emergency helicopter service throughout the state. This type of network is saving the lives of accident victims and preventing permanent maiming.

An increase in such emergency care systems can be expected in the future. The best in specialized care will be possible for rural and suburban areas on short notice since there will be greater use of the most efficient "high skill" facilities which are generally located in only a few urban places. This trend should help reduce the need for duplication of expensive but infrequently needed facilities in hospitals—thus eventually reducing the cost of hospital care while increasing the availability of specialty care to the entire population.

A few more specific trends may also be of importance to the volunteer concerned with health care in our society. Consistent with increased attention to better delivery of health care services and the shift in focus from federally sponsored basic research, there is a new emphasis on *cancer research* through cancer treatment centers. How best to wage the war on cancer has been a subject of much controversy among researchers and practitioners, with many suggesting that the new emphasis on applied research will seriously weaken the chances of discovering more effective treatments and understanding the causes of cancer. Nevertheless, there will be an increased emphasis on application of present knowledge and the development of new applied technologies and techniques for dealing with cancer in the coming years.

Other serious social and medical problems which are influenced by Federal policy and support include *the Venereal Disease epidemic* which is the subject of increasing concern among the public and the Public Health Service personnel. It may well become an issue to which the Government will have to respond if public pressure is sufficient. *Alcohol and Drug Abuse* will continue to be a major area of concern. The emphasis of the Federal government in these areas, particularly in the area of drug abuse, seems to have shifted from education and treatment to law enforcement. In order to assure that the problems of drug and alcohol abuse continue to receive support as medical social problems requiring health care services, the private sector will need to maintain vigilance.

Heart disease prevention will continue to be a major but probably low key focus of Federal health care funding. This program is well established and continued research and dissemination of the principal factors in heart disease will occur through federal sources.

Another highly significant trend which looms on the horizon is the whole area of *Federal Health Insurance.* The current design of some form of federal health insurance is extremely uncertain and it is clear that there are major differences in the various plans being proposed. Somewhere between 84% and 93% of the

civilian population in 1970 had health insurance. Medicare was a move toward universal insurance and Medicaid covers some groups in the over 65 age group. It is apparent, however, that there are certain groups in our society who are without protection. About 64% of those with family incomes of less than $3,000 were uninsured, while 43% of those with family incomes of $3,000 to $5,000 were uninsured. Some volunteers may decide to pay special attention to the health care bills and the national health insurance proposals before Congress as their unique contribution to the quality of health care in the USA. Rather than initiate new health services in the community or serve as volunteers in existing health programs, these local church women may want to inform themselves about the major legislative proposals in the health field.

This type of citizen action should involve efforts to let legislators know which basic principles should be included in legislation before it is written. It goes without saying that a knowledge of the existing situations in the health care field would be essential to this type of advocacy. Those who want to influence legislation should also have a clear understanding of which groups are lobbying for certain bills and why. As informed church women, they will also consider the financial implications of the various bills as they relate to other national priorities. This is very important in the case of the costs of the various national health proposals.

II. Trends in the Health Professions

Tremendous changes are occurring in the structure of the health professions and these trends will have considerable impact on the health care field and probably on the role of the volunteer in the health care area. Familiarity with the trends in this area will be most useful to the layman in attempting to deal with the structure of the health professions and individual relationships with various health professionals.

The health professions are organized according to which profession one is a member of, the amount of training one has in that profession (eg. nurses with degrees vs diploma nurses), and the degree of specialization within the profession, etc. Frequently, there are overlapping responsibilities for several groups of health care professionals which can result in friction and inadequate treatment. For example, the roles of obstetrical nurses, nurse midwives, and obstetricians have recently been examined by the leaders in these fields. New guidelines on their respective responsibilities have been adopted. There is a trend toward giving the newer health professions more responsibility for treatment of patients with the doctors continuing to supply diagnostic service and supervision.

Trends within the health professions can be roughly divided into two types—the development of new health manpower professions and institutional rearrangements of the ways in which the health professions relate to one another and to the client. These trends are closely related but can be discussed somewhat independently.

The new health care professions which are developing have great promise for the health consumer as a means of reducing the specialization and fragmentation of the present health delivery structure. Most of the new health manpower professions are developing out of an awareness of the fragmentation of function in the present health care delivery system, and the need for more personnel to provide the basic primary health care formerly given by the family doctor. Other factors have been the need to make better use of the abilities and potential of highly capable and highly trained persons such as nurses, medics returning from military service with extensive training and knowledge obtained from experience, and community personnel who are able to give consumers more understandable and more complete health information than some highly trained specialists can. Some of these newer health professions and their functions are mentioned below.

A. Professional Nurse-midwifery (pronounced like "sm[illegible]")

According to the American College of Nurse-Midwives in New York, there are 1,500 American trained nurse-midwives now living in the United States compared with fewer than 500 in 1962. In addition, there are between 2,000 and 3,000 foreign-trained nurse-midwives living here, but there are no statistics available as to how many of them are practicing. Nurse-midwives are professional nurse-practitioners who receive special training and are certified by the College of Nurse-Midwives to practice prenatal, delivery, and postnatal care. They usually work in hospitals and most frequently with lower income women, but they also practice in rural areas and are becoming more in demand by middle-class women as well. The nurse-midwife handles the entire period of pregnancy, delivery and post-partum care. The existence of this new health profession relieves overworked obstetricians of many of the normal deliveries and gives many women much more personal care through their pregnancies and deliveries. Although nurse-midwives must generally follow the procedures outlined by the hospital they work in, many believe that their presence has encouraged the trend toward more personalized care with less emphasis on what is convenient for the hospital management. The profession of nurse-midwifery has grown very rapidly during the past decade in the United States, and this trend will probably continue.

B. The Physician's Assistant

Physicians' assistants represent another new health profession. They are trained in various medical specialities such as obstetrics, pediatrics, internal medicine and emergency medicine for varying periods and are then employed to work under the supervision of a fully licensed physician. Many of the men who learned considerable amounts about health care in the military service are being recruited into these programs, as are some nurses who wish to be certified to provide more complete primary care but may be unable or unwilling to undergo the arduous years of training necessary to become a doctor. Physicians' assistants have not been in practice for very long—it is truly a new concept in medical man-power. It is envisioned that they will serve in a number of capacities—from doing the basic diagnostic workups on patients in a private physician's office to carrying out various health maintenance procedures for a clinic until a fully licensed medical physician is available. The development of this new health profession should relieve highly trained and specialized doctors of the necessity of spending too much of their time in routine procedures and should also allow doctors more time to take a personal interest in patients and explain things to them. The physician's assistant will be able to carry out most routine procedures with less delay and less expense than if the specialist himself had to do them. Hopefully the trend toward the use of the physician's assistant will improve the ability of many citizens to obtain adequate primary medical care promptly and reasonably.

C. The Nurse-practitioner

The development of nurse-practitioners in a number of medical fields can also be expected to increase and to provide another mid-level primary care position in the medical personnel ladder. Nurse-practitioners receive additional specialized training and certification in particular specializations beyond the nursing degree and are certified to carry out a number of procedures formerly permitted only to physicians. We can expect such developments particularly in areas where nurses already have extensive responsibilities and where there is a shortage of physicians available for the intensity or amount of care needed. For example, in the field of coronary care, where there is intensive and continuous monitoring of cardiac patients and every second saved can mean saving lives, nurse-practitioners are able to perform some kinds of emergency procedures which the nurse may not. Other promising fields for nurse-practitioners are pediatric nursing and geriatric nursing.

D. Allied Health Personnel

At a somewhat lower level on the health personnel ladder we can expect to see the continuation of the development of a number of para-professions and allied health personnel occupations. Special training programs are being developed for people serving as health associates, health assistants for ambulatory and in-patient care, emergency room associates, and outreach health workers. The continued expansion of the population over age 65 and the increased life span will undoubtedly bring an increase in the number and types of occupations related to care of the elderly, in and out of institutional settings such as nursing homes. The past ten years has seen a tremendous expansion of short term training opportunities for nursing home administrators, primary care workers in nursing and other long-term care facilities, and the upgrading of non-medical personnel who work with the aged infirm. New developments in geriatric rehabilitation have created the need to train rehabilitation workers. Most of the development related to the aging population will probably occur in the area of paraprofessional and allied health personnel, but there will also be a continuation and rapid expansion of training for nurses, doctors, hospital administrators, nutritionists, etc. to be more prepared to respond to the health care needs of the aging who now comprise 10% of the total population.

Along with the advantages which the aforementioned new professions will bring to the scene, there are dangers in the proliferation of the health care occupations. The system might become even more fragmentized and unmanageable. As new health care occupations are developed, students recruited and trained, the system may not have places for them when they are graduated. Resistance on the part of some doctors and members of the health care establishment may delay changes which need to be made. The consumerism movement in the health field and the new approaches by forward-looking professionals, however, are bringing about significant alterations.

Two factors will influence the degree to which new health careers can be effectively utilized toward the goal of comprehensive health care for every American. An informed and thoughtful public will be required if the new mid-level professionals are to be accepted in their new roles and if the proliferation of health care personnel titles and occupational designations is not to get out of hand. If the rush for new levels and position types is allowed to develop randomly, at the whim of each training institution's proposal writer and with no overall planning within the medical establishment, the result could be the production of trained, motivated and eager manpower with no place to go and a rapid disillusionment with the idea of a more diversified set of health careers.

E. Other Trends in the Profession

Several other trends within the health professions are occurring at a different level than the individual profession. There is an increasing willingness and a developing *ability to use technological breakthroughs* in the delivery of health care. From computer scheduling of patients to extensive communication networks linking specialists from far flung locations to deal with emergency cases, to computer diagnosis of disease, to fully computerized patient-centered medical record keeping, to the use of home-based heart monitoring with portable electrocardiagram machines, to the use of helicopters in emergencies—many new and expanded uses of technology are occurring in health care. Some are still in experimental stages, but as they prove useful there appears to be a willingness to put them into practice for the good of the many, and to adapt their use from one situation (a large research hospital for example) to the areas of greatest need (such as rural sparsely populated areas). The implementation of such technological developments is often expensive initially, but the effective span of scarce medical personnel can be expanded so that they are worth the initial investment.

Another trend which should be of particular significance to the health consumer is the *increasing emphasis on preventive medicine* within the medical profession and the various health insurance proposals. Preventive medicine is not a new concept and has certainly been practiced by many doctors all along. We have all seen or heard pronouncements about having a complete physical examination once a year or visiting a dentist regularly. For women, the importance of using self-examination techniques to detect breast cancer, and of seeing a gynecologist every year after age 45 has been stressed. Perhaps the most significant aspect of preventive medicine up to this period has been the mass inoculation programs, sponsored primarily by public health agencies. This kind of public health preventive medicine has long been an accepted part of the health care delivery system.

The preventive medicine trend goes beyond this, however, and it is closely linked to new structures such as Health Maintenance Organizations and comprehensive health planning. It is also closely related to financing patterns. When the health service consumer pays for service on a flat rate basis, as in a health maintenance organization, it is to the advantage of the health practitioner to maintain the patient's health and avoid the need for costly services such as hospitalization. Programs in which this approach has been taken, such as the well known Kaiser-Permanente program, have shown that the cost of services provided through such a system are lower than those provided on a fee-for-service basis and that illness and disability rates are lower in the program population than with comparable client populations.

Another trend related to the new health professions is the *reorganization of the health career ladder*. The traditional health care occupations have been severely separated from one another. The nurse's aide cannot apply her training and experience to become a practical nurse, the diploma nurse can only occasionally apply her three years of training and experience to become a "degreed" nurse, the nurse cannot apply her medical training to become a physician. In each case, the individual profession or occupation is distinct from the other within the system but not within the functions performed. For example, if the hospital is short of degreed nurses, they might use diploma nurses in administrative positions. If they are short of practical nurses, they might use nurses aides in practical nurse positions. The functions within the medical professions and paraprofessions overlap. A system of patchwork certification for special functions based on short-term training has been developed in some places, and has helped to fill the gaps in delivery of service. But the idea of a career ladder within the medical service professions needs more attention. There are some interesting experiments occurring in the development of a career ladder within the nursing profession (e.g., Cook County Hospital in Chicago) and in the development of some of the new health service categories such as the physician's assistant and the nurse practitioner. A complete career ladder requires new training patterns and new certification practices. It would make provision for the gradual movement up the ladder from the lowest paraprofessional position to the highest professional position, with appropriate training and certification procedures along the way, giving credit for formal and practical learning at various levels on the career ladder as they are applicable to the higher levels. For example, the nurse's aide learns the basics of patient care which the RN also must know. There is no need for the nurse's aide to sit through a class on how to give a bath to get credit toward a nurse's diploma. The same principle applies at much higher levels of the ladder and its application would do much to relieve the shortage of more highly certified health service professionals. (See Figure 1.)

Hand in hand with the attempts to develop a career ladder in the medical professions is the trend toward organizing licensing practices in a more sensible way. In all the recognized health service professions there is an increasing emphasis on continuing education courses or seminars as a basis for updating skills and maintaining a license. At the same time, many of the health professionals are aware of the dangers of overly rigid licensing requirements which might lead to meaningless additional schooling.

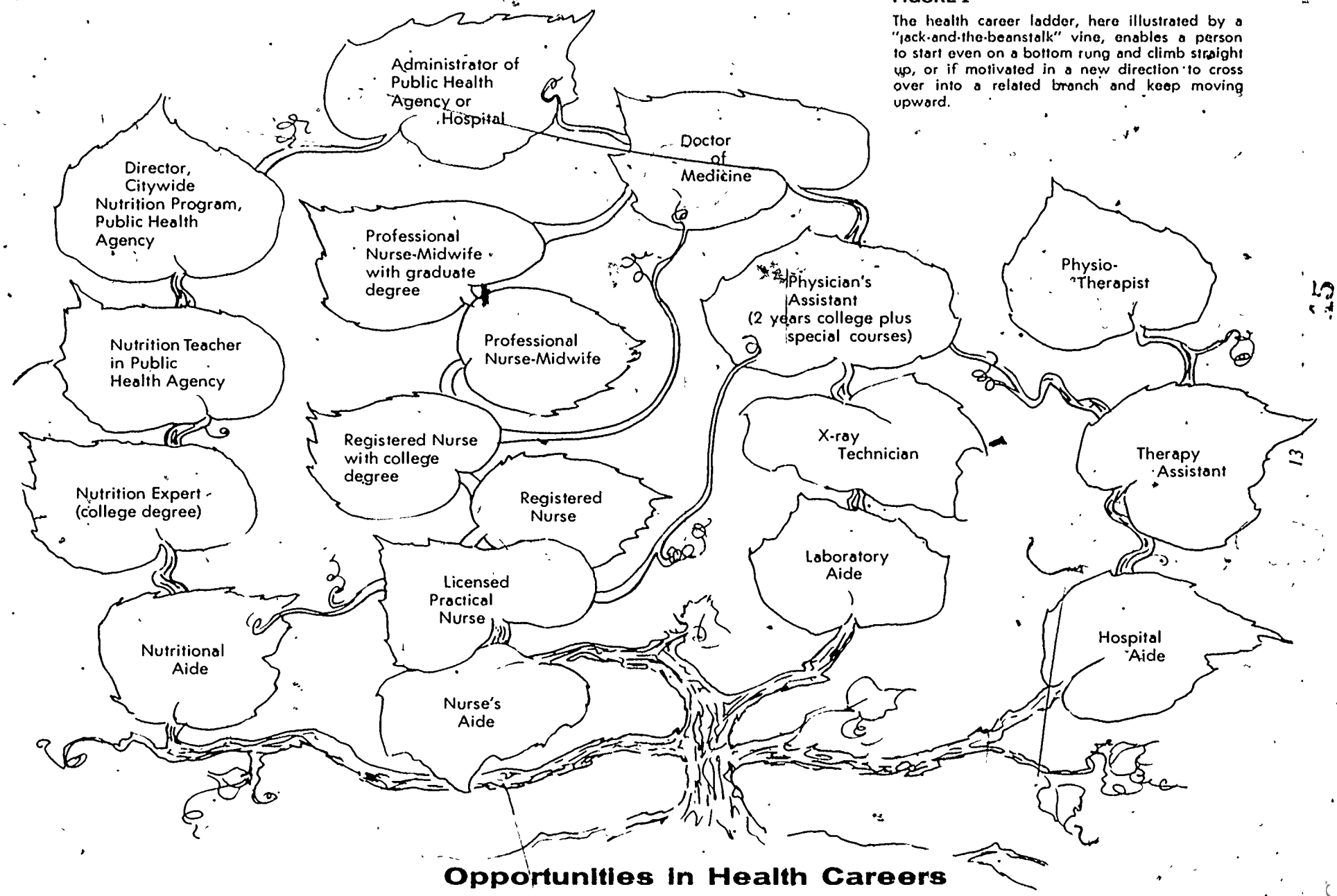

FIGURE 1

The health career ladder, here illustrated by a "jack-and-the-beanstalk" vine, enables a person to start even on a bottom rung and climb straight up, or if motivated in a new direction to cross over into a related branch and keep moving upward.

III. Trends Based on Grass Roots Interest

A number of health care trends have grown out of the interests of the consumers themselves. Some of these are truly grass roots based, some are developing partially because of consumer involvement, and some because of incentives from other sources, such as the government. Many of the trends toward more grass roots participation in the design, delivery, and evaluation of health care services are related to other grass roots movements, such as the women's liberation movement, the organization of new labor coalitions and community-based action groups. There may be some decline in grass roots involvement as a result of recent cutbacks of Federal support for community-based health programs. However, many of the grass roots trends are just beginning to take hold and can be expected to continue to influence the health care picture for some time.

There are a whole series of new developments related to the health of women and children. One of these is the development of special services related to childbirth. Classes in natural childbirth, or in preparation for childbirth, have become very popular. Natural birth groups and breast feeding groups continue to expand their membership. Nurse-midwives help women experience their childbearing functions in the way selected by the women themselves as much as this is possible. Rooming-in provisions are increasing in maternity wards and husbands are allowed to participate in the whole process more and more. The whole natural childbirth phenomenon is not just a fad. It has shown itself to be a long-term trend which has advantages for mother, child, hospital, and medical practitioner. This trend will continue to grow and become an even more accepted approach to childbearing.

There is also a major development occurring in the area of the diagnosis and prevention of birth defects, especially those of genetic origin. The National Foundation, famed for its March of Dimes, has kept the loyalty of its community volunteers as it moved from polio research and prevention into the research and prevention of birth defects, including sickle cell anemia, Tay-Sachs disease and other conditions.

The trend toward abortion reform, however, has been marked by heated discussion and divergent points of view. The recent Supreme Court decision has allowed for abortions up to the third month of pregnancy with the agreement of the patient and physician, but there will be many challenges to the new interpretation of the law, and the medical profession will still be responsible for implementation of the law. Many of those who support a woman's right to choose for herself whether she will or will not bear a child see the decision as a positive step in the right direction. Other women are raising the issue of the right to life of the unborn child. Still others are advocating counselling services which give the unwed mother-to-be a wider range of choices than just abortion. As a result of the legal decision, however, there probably will be an expansion of facilities as well as some improvement in methods and greater access to medically safer, less expensive procedures.

There is also the development within the women's liberation movement of self-examination training for various conditions, self-testing for pregnancy, and the use of laypersons as counsellors. This is a true grass roots movement, frequently occurring through the medium of free clinics set up by voluntary organizations of women. There is often a propagandizing function attached to participation in the clinic, with special classes on awareness and acceptance.

Other free clinics appear to be developing, although their viability and permanence are questionable. The free clinic movement takes many forms. Some are walk-in services in store-fronts designed to reach particular populations such as alienated youth. Free clinics are usually staffed with professional medical personnel and are essentially outreach arms of established medical service facilities. They serve a wide variety of populations and are in fact reaching the varied health care needs of communities, in addition to the special needs of the VD patient and the drug user. If the multiple usage of these clinics is recognized and their functioning protected from excessive backlash, they may continue to expand and respond to the health needs of an otherwise unserved clientele.

A major focus toward increased awareness and attention to the problem of venereal disease can be expected to grow out of the grass roots concern with the present epidemic. As mentioned earlier, there is considerable concern about the VD epidemic among public health service personnel but little political clout behind that concern. As a result, control through case finding (the major method of tracking down VD carriers) has actually been reduced because of inadequate funding. Research into potential cures and prevention of venereal disease is poorly funded. Part of the reason for this is that public awareness of and willingness to discuss venereal disease is very low. However, as venereal disease increasingly affects people from all walks of life and all economic strata, we can expect to see an increased concern on the part of the public for information and action to combat this epidemic.

An information explosion in the next few years is also likely to occur on the subject of venereal disease. New methods of presenting health information on TV have already been pioneered around the issue of the VD epidemic. The recent educational TV marathon on VD was a real innovation in programming about a major health problem in an attempt to reach the public directly rather than through the mechanism of the health professions.

Another trend originates in people's concern with

terminal illness. It is the *"Death with Dignity" movement.* Among the critically ill, their families, and some members of the legal and medical professions are those who are raising various issues. Should life be maintained at all costs, even when it is medically evident that survival will result in absence of mental faculties? Suppose life is impossible without "heroic" measures, with artificial life supports on a continuing basis for weeks on end? Since life can be artificially maintained in the sense that the organ systems of the body are kept functioning at some level and the wastes are purged through mechanical means, when is the person dead? To what extent should a person in great pain with terminal cancer be forced to accept medication, food, and other life supports if he or she prefers to allow the end to come naturally rather than as slowly as possible? These are the questions that are being pondered by the Death with Dignity movement. There is also a growing awareness of the psychology of dying and the aid and comfort which can be provided to the dying and their families by appropriately trained and motivated personnel. Hospital chaplains have been in the vanguard at this point.

IV. Trends in Health Information

Perhaps the most significant trend of all in the area of health care is the growing demand on the part of health service consumers for more and better information about their own health care, plus their determination and awareness that the consumer can and should have a voice. For example, the consumer movement in the health field is responsible to a great degree for the emphasis on comprehensive health services. The public is learning about "one-stop" health care where many specialists are coordinated under one roof.

The demand for more and better information cuts across many of the earlier mentioned trends. Many women are demanding more information and more control over the sources of that information. Many parents are demanding better health education for their children through the public schools. The aging want more and better information about the structure of medicare and their rights as dying patients. Individual patients are asking intelligent, well-thought-out questions about their individual conditions. Women are insisting on opportunities to learn about what goes on during childbirth, what different alternatives they have, what the effects are with regard to anesthesia during childbirth, and what kind of nutrition they should practice for themselves and their families. Men are learning and asking for more information regarding heart disease prevention, diet habits which are practicable within a working schedule and exercise regimens which will keep them fit. Many of these are not new, but the general trend of more education and more consumer awareness appears to be spreading to the health care fields as well as throughout other aspects of society.

One extremely significant new breakthrough in the information area is the new Food and Drug Administration requirement that the contents of the food we eat be listed on the container. This new labeling regulation will require a tremendous educational effort if it is to be fully utilized by the consumer. The whole list of chemical terms and food additives will be available on the container. If the consumer is to make the wisest use of this information to maintain health, there will have to be additional information available about the research, the known effects of the various additives, and the food value and nutritional balance needed in the various components of the food we eat.

A similar effort is likely to occur within the near future with regard to the *generic prescription of drugs.* New York City recently required that physicians prescribing drugs to be paid for by Medicaid or Medicare be prescribed under their generic labels rather than the more expensive brand names. Consumers, particularly the elderly and those with low income, should be informed about this trend so that they can be vigilant and continue the pressure to reduce health care costs through the generic prescription of drugs.

In addition to the traditional written formats of presenting information within the health field, the future will see expansion of public information broadcasts on television, the improvement of films and their availability to parents and children, the general wider distribution of health related information through various public, private and voluntary sources. Even today, almost every woman's magazine has at least one feature on health or a closely related topic and TV documentaries on health concerns are very popular.

There will probably be an expansion of information in the whole area of birth control. As this develops and as more voluntary associations work toward the goal of stabilizing population, we can expect to see a continued emphasis on getting information to the public about various birth control methods and problems in a variety of ways.

Still another area which may involve an information explosion related to health is the subject of environmental health. Voluntary groups have been formed to monitor air pollution control or water pollution enforcement. Such groups require extensive information while learning to do their jobs effectively. It is probably too soon to be sure whether the environmental protection concern is a fad or will continue in more permanent and consistent forms. But it is clear that if the quality of air and water continue to deteriorate, environmental health will be a major area of concern and will require a more educated public. We can, therefore, predict that there will be an expansion of health related information

concerning the environment in the coming decade.

In the whole area of health education, hospitals are now taking definite leadership in programs for the community, for local schools, and for patients. Children's Hospital in Boston has pioneered in health education and was one of the first hospitals to place a qualified person on the staff to serve as a health educator for the community and for their own patients.

V. Other Trends

Some trends can be identified which have received wide-spread attention in the media. For example, the continued rise in hospital costs and shortage of hospital beds in some locations has been predicted many times. Some of the trends mentioned above are designed to help counteract these negative cost trends, but it is unlikely that any major change in the soaring cost of medical care will come about easily.

One area of particular concern in some states is the matter of local legislation regarding blood products and the methods through which they can be obtained. Several court cases have now been won in which the providing agency has been held responsible for contaminated blood supplies, and there have been attempts to force the discontinuance of paid donors as sources of blood in some states. These efforts will undoubtedly raise the cost of blood (already high) and reduce the supply (already low) and will have important implications for the need for continued volunteer donation of blood.

In summary, the person who makes a genuine effort to understand the major trends and developments in today's health care system—many of which were summarized in this chapter—will have a valuable asset in selecting the most constructive action for a volunteer to pursue in her own community.

Planning Volunteer Activities

Improved health care for all members of the community will be the end result of the many and varied efforts of all the health services volunteers in the U.S.A. today. Without doubt, their present contributions are already much appreciated by the leaders of voluntary health agencies and by the medical and nursing professions. Effective volunteer service, however, requires that volunteers be knowledgeable and skilled in a number of ways. This is even more the case in the health care fields than in other types of volunteer action, since health volunteers, paraprofessionals and professionals must work closely together in a team approach. It follows that health volunteers must have a clear picture of both their responsibilities and their opportunities.

I. Types of Volunteers

Before outlining the planning process for volunteers, it might be useful therefore to distinguish among *the different types of volunteer* roles which are possible. Volunteer groups are not very different from other types of organizations in that a variety of functions need to be performed and a variety of roles and skills are needed. One volunteer may have administrative and planning skills but be a complete disaster at working in direct service types of roles. Another may be a tremendously warm affectionate person who works very well in direct service with children. Put her on a community health board and she may be completely tongue-tied. In planning volunteer programs, then, it is useful to think about the various volunteer roles and the functions involved in each.

Essentially, there are three types of volunteer roles. The first is the *direct service* role. This is the "primary care" unit of voluntarism. It is the basic form of most volunteer effort and is what we normally picture in our minds when we hear the word "volunteer." The direct service role involves many functions, the specifics of which depend largely on the actual volunteer setting. The direct service volunteer may roll bandages, teach first aid to a scout troop, assemble family medical histories in a neighborhood clinic, translate physician's instructions to a Spanish-speaking patient, give one-to-one attention to an institutionalized child, and so forth. The direct service volunteer is usually recruited, trained, supervised and in some way evaluated by an administrator (volunteer or paid) who is related to a specific program. In some settings direct service volunteers will be organized into various levels of supervision with one volunteer performing some direct service and some supervision of other direct service volunteers. The direct service volunteer does not make policy (though her ideas and experience will, hopefully, be sought to help inform the policy makers of the way things are in the "real world"). She does not administer the volunteer program, though she may need administrative skills in her direct service function. The skills needed by the direct-service volunteer are as varied as the particular functions she may perform, and there is always a place somewhere for special individual skills.

The second major category of volunteer roles is *administrative*. For example, the volunteer director of a hospital fund-raising project is primarily performing an administrative role. Among the major functions of the administrative volunteers are organization, delegation,

planning, training, supervision, and evaluation. The administrative volunteer plans, organizes, and arranges for the implementation of the policy set by boards and other policy-making bodies. She may be asked to advise policy-making bodies, but she does not, at least in her administrative role, set policy herself. To some degree she needs analytical skill, decision-making ability, and a great deal of tact. She also needs to know how to design group leadership and guidance programs, delegate, supervise, evaluate, and frequently undertake financial management. It is not usually a major part of the administrative volunteer's role to give direct service (unless it is for purposes of teaching or guiding other volunteers). Church Women United is encouraging women to develop their talents as administrators of voluntary action programs.

The third type of volunteer is the *policy-setter*. This volunteer would serve on the Board of a neighborhood health center or as a member of a comprehensive health planning committee. This is a very common role for the community-minded volunteer, but it is also one which is often carried out inadequately because the policy-setting volunteer often performs functions which are more appropriate to the other volunteer roles.

"Policy-making" gets confused with implementation. Policy-making involves analysis of problems and issues, broad vision, decision-making within a well-defined social framework, and a deep understanding of the goals of the organization. It may also involve dealing with sensitive issues of precedent, of major redirection of a project or agency, of compliance with internally set requirements, or with personnel decisions. It is a sensitive and demanding role. The policy-making volunteer must have a broad understanding of both the possibilities and the realities within the particular situation for which policy is being made. She must have analytical skills and probably will be called upon to exercise diplomacy in many situations. She must be able to make decisions for the good of the whole; to mesh conflicting goals and priorities, all within the limits of reality of the program, but without losing sight of the larger values and goals the project is intended to serve.

It is inappropriate for the policy-making volunteer to be overly concerned with the details of direct service or even with the details of administration. The policy-making volunteer who is more concerned with how many people she has personally helped than with the effectiveness of the entire program or the agency's efforts either needs to be retrained as a policy-making volunteer or to be assigned to the administrative or the direct service type of volunteer role.

After identifying and clarifying the various roles of volunteers, then the task of planning comes to the fore. Planning for the most effective utilization of volunteers requires a recognition of and planning for the assessment of the various functions to be performed. The planners must take into account the skills available in the volunteer population and the matching of skills to the work which must be done.

II. Planning for Effective Action

Planning for effective volunteer action has been the subject of a number of lengthy books and papers, and we can only treat the subject in a limited way in this booklet. There are many specific planning processes which can be described. Two have been selected for brief description here. The first has been used by Church Women United for planning and implementing community health volunteer programs and is easily adaptable to local situations. The second is an adaptation from a general model for designing educational programs. It has been developed and tested over many years and by many groups. The first model involves some particular approaches not necessarily involved in the more general second model.

MODEL A — Planning Voluntary Action for Volunteers in Community Health

This planning process model involves six steps:

1. *Exposure—reflection*
2. *Problem identification, problem analysis, and data gathering*
3. *Goal setting*
4. *Strategy and planning*
5. *Implementation*
6. *Evaluation*

Each step will be briefly described below.

1. Exposure—reflection

The first phase or step of this planning process is to become familiar with various aspects of the health problems, services, and facilities in the target community. The purpose of this step is to provide volunteers with a background knowledge of what the health care system is all about. Activities which can be used for this phase include visits to community facilities, talking with various providers/consumers of health care, meeting with other individuals or groups involved in the health struggle, seminars and workshops which focus on health, and reading about health care problems. Attention should be paid to arranging for the planners to have a variety of exposures. For example, volunteers should not just meet with the director of the local hospital clinic, but should observe the clinic waiting room, try to talk with consumers of the clinic services, and even, if possible, with persons who are not, but perhaps should be, consumers of that service. A variety of agency types should also be included. Seminar programs and reading should include representative statements about a variety of

issues and problems and where an issue is controversial, should present more than one viewpoint about that issue.

The exposure-reflection phase of the planning process can vary enormously in breadth and depth. The more exposure obtained before identifying the problem, the more likely it is that the problem can be clearly and precisely stated, but the practical need to get on with the more specific planning necessitates that some realistic limits be put on Step 1. Don't worry about not having all possible information. The accumulation of information and exposure to real situations should be continued throughout the whole planning process and, indeed, constantly.

2. *Problem identification, problem analysis, and data gathering*

Once there has been exposure to the reality of the existing health care situation in the community, reflection and analysis will lead to the identification of a number of problems. The specific problem on which your group wishes to work must be identified, stated, and analyzed. The process of problem identification and the decision about which problem to select for action may be simple or complex. For example, it may be very obvious to your group that a major need exists which you want to plan to meet. There may, on the other hand, be a number of needs identified through the exposure processes. It may be necessary, therefore, to identify and analyze several problems before making a decision as to which will actually be the focus for the voluntary action effort. Each potential problem should be stated and analyzed carefully: Some guides for this process are to:

a) State as clearly as possible the health problem to be addressed. State it in a complete sentence. This is a tentative statement and may be revised as the group becomes more knowledgeable about the problem. It is important to write the statement of the problem as precisely as possible, however, in order to guide the further collection of information related to *that* problem.

b) State why it is a problem, including a list of the economic, political, and social factors which keep it a problem. Documentation needed to help others understand why it is a problem should be included. This background information should be as specific and factual as possible. It might, for example, include statistical summaries of the demographic nature of the population in the target area (such as income, race, age, sex, family size, density), documented evidence of disease rates in the area, statements from individuals about the need for a particular health service, reports from governmental agencies about the quality of housing in the area, etc. The documentation should be clearly related to the problem. In addition to factual documentation, it is useful to state what, in your opinion, are the conflicting beliefs, values, social patterns, or attitudes which contribute to the problem. For example, if the problem is that the children in the "X" school show nutritional deficiencies, it would be useful to state your opinion (hopefully based on observation) that the cultural values of the low income population in the area do not seem to emphasize eating breakfast to the same extent that nutritionists think is important.

After a clear statement of the problem has been made and background information as to why it is a problem has been accumulated, the next step is to analyze the problem and its relationship to your group. Three questions are useful in this analysis:

- Why should the problem be solved? What benefits will result from solving it? What will be better or worse as a result and what effects will these results have?
- Why do you or your group want to solve the problem? How does the problem fit in with the goals and purposes of Church Women United, with your values, with the skills and abilities in your local unit? It may be, for example, that the problem identified is a real problem, but one in which your group has little competence or interest. It might then be advisable to decide that your group should not try to solve this problem by itself but that it would be better to work on it in coalition with some other group.
- Who is affected by the problem and its solution? These people can become important resources (or obstacles) in the solution and should be involved, wherever possible, in later planning. It may also turn out that the problem your group has just identified and analyzed is being worked on by three other groups. You then must decide whether you want to add your group's efforts to the others or drop this problem, etc.

It is clear that throughout the process of identifying and analyzing the problem that the group has been collecting and organizing data. Much of this data can now be organized in a variety of ways.

All of the factors identified in the analysis of the problem can be put into a kind of system showing which forces keep the problem going and which forces act to reduce or solve the problem—in other words, the forces on your side can be listed, and those that are against you can be listed. Such an analysis can help give you a picture of the overall difficulty of solving the problem and provide a framework for deciding where action needs to be directed. Figure 2 is an illustration of how these forces can be put together on paper to help clarify the overall picture.

In addition to the listing of forces operating to maintain and solve the problem, it is useful to specify the actual structures (groups, organizations, or institutions) that will be involved in or be affected by the problem if you decide to act on it. The use of such a format will help

FIGURE 2

FIELD FORCE ANALYSIS FORM State the health problem:

Forces which help to **maintain** the problem	Forces which help to **solve** the problem

Directions: ——→ actual force

- - - - - - - - → potential force

The **LENGTH** of the line indicates the estimated power of the force

Each force has an actual or potential counter force. Line up these forces opposite one another on the form above

A force can be economic, political or social factors operating in this particular situation or a set of beliefs, or a structure's policy and/or practice.

An illustration: State the health problem: There are no health facilities in the southeast area of Redwood City.

Politicians want to develop area and don't want to increase services to people	——→	←—— Community Health organization has organized and is demonstrating before Council meetings
Apathy of health professionals	——→	←- - - - New community awareness programs in medical and nursing schools in Redwood City

you identify specific groups and individuals which might have been overlooked in the earlier analysis. For example, if your group filled out the form in Figure 3 and found that the section for "structures that will not support action" was empty, it would show that you were so enthusiastic about solving the problem that you had neglected to list your opposition. Taking a hard look at the policies and practices that need changing if the problem is to be solved is also very useful for planning the direction of future action.

At this point of the planning process, the group has been exposed to the health care reality in the community and has identified, stated, analyzed, and collected data relevant to one or more health problems it might work on. One step which it may or may not have made yet is deciding to go ahead with a particular problem. This decision can be made at any stage of the planning process, but it will be a better informed decision if it is made at the end of the problem identification and analysis phase of the planning process than if it is made earlier. For without sufficient understanding of the real nature of the problem, there will be very little realism in the action.

3. *Goal setting*

Once the decision to go ahead with a particular problem has been made, the next step is to decide on a specific action goal. The action goal grows out of the health problem identified and decided upon, but it is not just a restatement of the problem. It is a "working goal" which includes specifics of what, by whom, and when a particular outcome will be accomplished. (For those of you who are familiar with educational jargon, this is analagous to setting behavioral objectives.) The process of setting an action goal can be guided by the following:

What is your action goal?

a) State as specifically as possible your group's action goal with regard to this particular health problem. An action goal is an operational goal and must be distinguished from an ideal goal. "To start a clinic" is an ideal goal. "To start and operate a clinic in the southeast area of Redwood City by June 1972" is an action goal. An action goal is a target which a group can use. State your action goal by answering the following questions:

   WHO—(Involvement for whom, by whom, and with whom)

   WHAT—(What skills, information services, etc. will persons be able to demonstrate or obtain when goal is reached?)

   HOW MANY—(Numbers of persons reached, involved, taught, or served)

   WHEN—(Target date when goal will be accomplished)

b) State goal, pulling together answers to questions above as clearly as possible.

4. *Strategy and Planning*

Now you have a well defined action goal, which will contribute to the solution of a clearly understood health problem as it exists in a real community. The next step is to decide on a strategy or plan of action to be used in implementing the goal. There are many types of strategies. For example, your group may decide to approach the problem through influencing political and social leaders, or, you might decide to work with other organizations and structures, or, you might decide to mount a fund raising drive and publicity program to mobilize the community.

Deciding on your strategy and broad planning will depend, to a large extent, on the nature of the problem, the type of community, and the other structures involved in the situation. You already have accumulated a number of facts to help in the process of planning specific strategy. You know what community structures are involved and who the key people are. You have identified who is affected by the problem. You have examined the skills and abilities within your group as they relate to the problem. You have looked at the forces which are working for and against the solution of the problem and you have a clear action goal. The strategies for reaching that goal will grow out of an examination of the information you already have.

In addition to this information and analysis, you will want to identify the persons in your action group and their resources (skills, abilities, contacts, etc.) related to the problem. Particularly, you will want to identify the cross-linkages between your members and the other structures—i.e., the name of each person in your group and her position and/or close contacts in any of the structures listed on the form shown in Figure 3.

Secondly, you will want to list the strategies of other agencies and individuals working on this problem, including the key persons involved, their action goal, and their plan for accomplishing it. Much of this information will be available from the data-collection phase of the planning process, and the listing in this strategy planning phase may only require filling in some gaps in what you already know and being more specific about the strategies being worked on by other agencies.

It is important in this, as in other phases of planning for community health, not to overlook organizations, groups, and individuals involved in the problem which may not be formally organized or part of the bureaucratic structure of the community. For example, there may be an active mother's group working on the problem of providing school lunches for undernourished children. This group may not have an office, a volunteer director, or even a formal membership, but the success of any plan to solve the nutrition problem in that community may be powerfully influenced by whether this mother's group is involved or not.

FIGURE 3

DATA GATHERING

Identify the structures (groups, organizations, or institutions) that will not support, will support, and should support this action goal, together with their key actors (decision-makers), and the policies and / or practices of these structures that need changing.

	Structures Name of group, organization, or institution	Key Actors	Policies and / or practices that need changing
Will not support	1. 2. 3. 4. 5. 6. 7. 8. 9. 10.		
Will support	1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11.		
Should support	1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.		

5. *Implementation*

Once you have established an action goal and outlined your strategy or plan for achieving the goal, the next step is to plan for the specific implementation of the strategy. This is a stage where all your creativity and imagination can be brought to bear. You are, by now, well informed about the problem, have a specific goal and a general strategy for accomplishing it, and now there is real need for your skill and creativity in deciding various ways of actually implementing your goal and strategy. Brainstorming techniques may be useful in getting a wide variety of ideas out on the table for discussion. It is especially important, at this stage, to get the ideas of all your group members. That member who doesn't say anything at the implementation session may well have the idea which would have been the key to successful accomplishment of the goal! It is also a well established principle of adult motivation that people will be much more likely to follow through on ideas to which they have publicly committed themselves than they will if they are passive recipients of another's ideas.

Implementation plans can be organized according to:

a) the means to be used
b) the leadership responsible
c) the resources required (manpower, money, special expertise, facilities, etc.)
d) resources available
e) time required and in what sequence

For example, if the action goal was to provide nutrition which meets minimum Federal standards for all individuals over age 65, in Census Tract XXX by September 1, 1975, a strategy could be developed to provide background material to all local politicians regarding the availability of Federal support for nutrition for the elderly. Another might be to influence local church leadership to investigate the possibilities of applying for Federal funding for such a nutrition program. Another strategy might be to develop a publicity campaign to make the public aware of this health need in the community. Dates should be specified where possible, as well as estimates of time required.

6. *Evaluation*

The final step in the planning process is evaluation. This step usually occurs after some of the specific plans have been implemented but evaluation should also be an ongoing process. One approach to evaluation which can be followed involves eight questions.

a) What happened?
b) What were the positive results?
c) What were the negative results?
d) Will the program be continued? With modifications? By whom?
e) What future outcomes may be anticipated?
f) What new concerns, issues, problems were identified?
g) What next steps should be taken?
h) What learnings about problems and strategies may be drawn from your experiences?

It is important to think about how to evaluate your program throughout the planning process because you need to be thinking about what information will be necessary to provide answers to the questions you ask in your evaluation. For example, you need to be aware of what is happening, negatively and positively, as the implementation takes place in order to answer the first three questions in the suggested evaluation. Perhaps one part of the plan of action aggravated the problem—you need to have some information about why this occurred if the evaluation is to be most useful for future planning.

As can be seen from items f, g, and h of the suggested evaluation, the evaluation process is not intended as the end of the planning process. It is, rather, a step from which a new planning process takes off and provides a new input of information for the early stages of the next round of planning.

The foregoing model has been designed primarily for use in planning for voluntary action related to community health, education, and social service needs. The focus of Model A is on a broad base of knowledge and cooperation within a community. While Model A can certainly be adapted for use in planning many types of voluntary action in the health field (primarily by defining "community" as narrowly or broadly as desired, for example, as a hospital or as a large metropolitan area), Model A also emphasizes the process of using the influence of group members through their involvement in other structures. While this is an effective approach to planning for major goals and for broad based community needs, it is but one specific example of a more generalized approach to planning programs which all organizations and individuals use in some form or another. The specific goals, strategies, implementation plans, and evaluation approaches can vary tremendously depending on the nature of the voluntary activity being planned, on its scope, on whether it is primarily a direct service or a policy-changing type of activity, and on many other factors.

There is another option which can be considered by a health task force. Cyril O. Houle of the University of Chicago has developed a Program Planning Model which can easily be adapted by Church Women United locally. It is related to adult educational activities and yet has a broad, general applicability to planning for all types and levels of voluntary programs. The following is an adaptation of the framework of this model.

MODEL B — General Program Planning Model

Model B involves several basic assumptions and a listing of the types of situations to which these apply. Specifically, these assumptions and their relevance to volunteer work are as follows:

1. Any voluntary activity occurs in a specific situation and is strongly influenced by that fact.

Each volunteer and each volunteer episode is unique and can be analyzed separately but it is a part of a larger whole which has innumerable influences on that volunteer and on the specific voluntary activity.

2. The analysis or planning of voluntary activities must be based on the realities of human experience and upon their constant change.

Since each volunteer episode is unique, planning must be based on realities rather than on abstractions or empty forms. No plan can take into account all the realities in advance and, therefore, the planner must constantly reshape the plan to take into account the changes in the situation.

3. Volunteer activity is a practical activity.

The purpose of voluntary activity is the *practice* of some action, not its contemplation. In actuality, volunteers and community leaders of social and economic development programs understand this fact better than some theorizers do.

4. Volunteering is a cooperative rather than an "operative" activity.

Cooperation has two meanings here. In the profoundest sense it means that the volunteer and the recipient of service or action both act within the dictates of nature. Both have limitations and resources with which they tackle common goals and within which they must work. In its second sense, cooperative refers to the interactive nature of volunteer activity. The volunteer *works with* people, not on them. Both these meanings of "cooperative" must be taken into account in planning volunteer programs.

5. The planning of a volunteer activity is usually undertaken in terms of some definite period of activity "taken out of" the total, ongoing process.

The effective planning of a voluntary activity is aided by the selection of a time dimension which sets limits to what is sought, observed, or accomplished. Such time dimensions are useful for planning. It must be recognized, however, that they are really only arbitrary selections of units from what is an ongoing, constant process of responding to needs and to acting in various voluntary ways.

6 The planning or analysis of a voluntary activity may be undertaken by the volunteer (or volunteers), the prospective recipient, and an independent analyst or some combination of all three.

The importance of this assumption for planning voluntary activity is simply that we must recognize that it is not only the volunteers who should plan a voluntary activity. The administrator of the hospital (a prospective beneficiary of service in an institutional sense) may initiate a plan for volunteer activities or may hire an outside consultant to do so. Effective planning for voluntary activity must involve the volunteer herself and the prospective recipient, but some *initial* planning can take place independently.

7. Any design of volunteer activity must be understood as a complex of interacting elements, not as a sequence of events.

There are a number of elements which must be accounted for in planning any effective volunteer program but the exact sequence of accounting for these elements can, and does vary, depending on any number of things. The idea of looking at the elements as interacting—affecting one another—helps us keep in mind the total picture. There is constant interaction and constant learning about better ways to act.

The nature of the situation does influence the purpose and process of planning for voluntary action. For example, the individual planning a voluntary activity in the health care field will undoubtedly have different reasons for identifying a particular activity as appropriate than the director of volunteers of a neighborhood health clinic would have, but there are major elements both need to consider. These major elements, seven of them, are listed as follows:

III. Components or Elements of a Volunteer Activity

1. A possible voluntary activity is identified
2. A decision is made to proceed
3. Objectives are identified and refined
   a) Resources
   b) Leaders
   c) Methods
   d) Time frame
4. A suitable format is designed
   e) Sequence of events
   f) Social reinforcement (group or community support)
   g) Individualization (meeting personal needs of client and volunteer)
   h) Roles and relationships
   i) Criteria for evaluation
   j) Clarity of design
5. The format is fitted into larger patterns of life
   a) Guidance

b) Life style
c) Finance
d) Interpretation
6. The plan is put into effect
7. The results are measured and appraised

As can be seen from this brief outline, the specific steps described in Model A can easily be fitted into the more general Model B. Steps 1 and 2 in Model A would be included in component 1 of Model B, since awareness of a possible activity arises from a variety of kinds of exposure to individuals, groups, communities, and society as a whole. Goal setting is parallel to identifying and refining objectives in Model B. The strategy and planning step in Model A is parallel to component 4 in Model B. The fifth component of Model B, fitting the format into the larger pattern of life, does not seem to be included specifically in Model A, but is certainly an important consideration in the fitting of the volunteer activity plan into the larger social structure of both the volunteer *and* the potential recipients of the activity. The implementation phase of Model A is parallel to the sixth component of Model B. And the last component of Model B refers to two types of evaluation, measurement, the determination by objective means of the extent to which the criteria of program success have been attained, and appraisal, a subjective judgment of how well the goals of the activity have been achieved. Appraisal may incorporate information provided by measurement, but it may also take into consideration other factors such as a reappraisal of how realistic the initial goals were, the unexpected obstacles encountered, and the unexpected (and unmeasured) benefits resulting from the program, etc.

The major differences between the two models is that Model B allows for a planning of a wider variety of volunteer activities. It can apply to the individual planning her or his direct service activity in the health field, to a small committee planning a mass volunteer program where the volunteers are not directly involved in the planning or to a voluntary policy-making group planning its own activities. Model A focuses more heavily on volunteers planning a community volunteer program where there is sizable community resistance to change and therefore may be more useful in that particular volunteer situation.

Planning for volunteer action in the health fields may require particular knowledges and sensitivities to the nature of health care institutions, problems, and structures, but the planning models described are applicable to the volunteer in any field. Close attention to good planning technique will go a long way towards assuring your group of a successful outcome. And a sense of success is very important to the volunteer.

Planning can be done by anyone—direct service volunteers, administrative volunteers, and policy-makers. In fact, it is probably wise to involve all volunteer functions in the planning process, particularly when community-wide or other large projects are being considered.

It is also very important, as was pointed out earlier, to involve potential recipients of the proposed action program in the planning for two major reasons. First, their support for the activity is much more likely to be forthcoming if they have had a real contribution in planning it. Second, community members can bring an awareness of the nature of the problem, the resources available, the probable obstacles to its solution, etc., that might otherwise be very difficult to obtain.

It may be necessary to train volunteers and community representatives in the various planning techniques as they become involved in action. Such training can occur on the job, while the planning is going on, or it can be designed as a separate activity. It is a mistake, however, to assume that all volunteer planners and/or community members are equally prepared in using good planning techniques! On the other hand, let's not assume that they are incapable of learning such skills and therefore should not be involved!

The Volunteer in Action

Volunteers usually have a great desire to get into high gear, go with the green light, and immediately carry out a special mission! In previous chapters we have, in a sense, stressed the importance of "braking for the yellow light." The cautionary preparations of pausing long enough to clarify purposes, looking carefully for the trends in health care, examining various volunteer roles, and "planning before plunging" are well worth the time and effort they take.

We will now deal more specifically with the core of voluntary activity, the actual volunteer service itself. What does the health care volunteer in the community actually do? And how does she do it well? Even though the subject is potentially endless, some guidelines can be given regarding the "how to's" of volunteering in health care programs in the community.

These guidelines are applicable primarily to the direct service and administrative roles of the volunteer. They have implications for policy-making volunteers as well. After discussing the conduct and administration of volunteer activities, we will mention briefly what we can do in our own lives to assure better health care for ourselves and our families and hence for our communities.

I. Direct Service Volunteering for Community Health Care

Direct service volunteering is the building material of all volunteer programs. Without the front line workers in the field, providing services of many kinds, all the rest—planning, administering, policy-making—is worth very little. What then does the direct service volunteer do? Just about everything and anything. We all know of many familiar forms of volunteer services in the health field: Red Cross workers at blood banks, candystripers and hospital auxiliaries, the women of the church group who visit shut ins or patients in the hospital, and the hospital fund raisers. There are many less well publicized and new forms of direct volunteer service in the health field as well. They range from the VISTA worker in a rural area helping the community organize itself to get an improved water supply, to the volunteer driver for a nutrition program for the elderly, to the outreach workers for a Community Health Clinic in a predominantly Spanish-neighborhood, to a Nursing Home Ombudsman.

Each such health-related volunteer service performed, no matter how large or small, is an important contribution to the improvement of health care in the community. We have already talked about how a community volunteer program gets decided upon and planned. So, let's assume for a moment there is such a volunteer program in operation. We need not specify what the actual volunteer job is because the principles of being a good direct service volunteer will apply for any task. Let's look at some of these principles and see how they apply, particularly to volunteering in the community setting.

A. The Volunteer as a "Professional"

Perhaps the first principle of volunteering is to take it seriously as an important and rewarding job to which you have a "professional" type of commitment. No matter how small the particular task, or how much time you volunteer to give to it, it is important to approach it with the attitude that it is worth doing well. The volunteer is a co-worker with paid personnel (not a servant or second class citizen), and she will be reliable, knowledgeable, ethical, responsible, and growing in the performance of the task.

For example, a good volunteer, particularly in community health care programs, never discusses with other volunteers or friends any bits of "news" about individual recipients, the back room gossip about Dr. X and the nurse, or the financial problems of Clinic Y. She is ethical in that she respects the confidentiality of in-

formation picked up in her work. This is particularly important when working in a community based program where the direct service volunteer must establish herself as a trustworthy individual. If community members think their private concerns will become "office gossip," they won't tell a volunteer anything, and consequently, one's effectiveness will be destroyed. Personal health matters are highly confidential in our society, and it is therefore important that confidentiality be scrupulously observed by volunteers.

Under the general heading of behavior in a professional manner, we include such things as being prompt for appointments, not bringing one's personal concerns to the volunteer job, being clear and specific about the amount of time you are willing to commit to the task and following through by giving that much time, completion of assigned tasks, doing the best job one is capable of, seeking and using supervision and training for the job, being self-evaluating about personal strengths and weaknesses and about how to improve one's own performance.

There is a second way in which to think of the volunteer as a "professional." There are many volunteer jobs which require professional skills. Women who are trained and employed in a profession can volunteer the use of their particular professional skills. In many of these types of volunteer tasks highly technical abilities can be important contributions but may not require very large time commitments. For example, the new Nutrition Act (Title VII of the Older American Act of 1973) provides for the use of volunteer services as part of local matching contributions. Thus if a retired accountant volunteers to keep the books of the local nutrition program, her contribution is a double service in that it not only provides a highly technical service on a volunteer basis but also serves in the place of cash contributions for matching fund requirements.

If we extend the notion of the volunteer as a professional worker in a slightly different way, we see its implications for the personal development of the volunteer. Volunteer "career ladders" can be designed into the volunteer program so that the woman who has chosen to remain out of the labor force to raise a family can have opportunities to maintain old knowledge and skills and to develop new ones. Volunteering is a great way to keep current in one's field, to learn about new fields, and to explore (without much investment) new areas of possible future vocational interest. More and more, married women are choosing to enter the labor force for the first time or to re-enter it after the children are in school. For the woman with an interest in any of the health fields as possible occupational choices, volunteer experience can provide an excellent, safe, inexpensive way of exploring vocational aptitudes and of gaining valuable experience and knowledge prior to the time of paid employment.

For example, in a program designed to help mature women establish mid-life educational and career goals, one woman volunteered to serve as an assistant counsellor of adolescents before deciding to enroll for a graduate school course in counselling. Another entered the program with much volunteer experience with retarded children. She decided to undertake graduate work that would make her more qualified for the type of professional employment her volunteer experience had shown she would enjoy. A woman who left her nursing career to raise her family and did volunteer work with a community health clinic decided she would rather do that kind of thing professionally than hospital nursing. Another woman who started out doing volunteer work at a very local level found "committee work" frustrating, looked for administrative volunteer work, and eventually was hired by the agency in a professional staff position. There are many examples of such success stories built on the concept of a volunteer job as a potential stepping stone in a woman's career development. Community health care volunteer programs include many such opportunities.

Seeking and using training for the volunteer job is important for both the volunteer who has a professional type of commitment and for the "professional" who volunteers her skills. Those responsible for administering the volunteer program should provide a variety of training opportunities. It is particularly important that training include an orientation to the overall goals and structure of the health care program, how the volunteer fits into it, what the community is like, and some information about the particular people needing the services of the program. In addition, depending on the tasks you are to do, you may also need training in specific skills. For example, interviewing techniques, record-keeping, and how to approach "problem" individuals could all be special skills requiring training. If the volunteer approaches her job in a professional manner, she will not only use whatever training is provided but will also request training in skills which have not been anticipated by administrators.

B. The Volunteer as a Worker in a Particular Job

In addition to the above aspects of volunteers as "professionals," there are some specific guidelines which can be pointed out regarding the volunteer as a worker in a particular job. The direct service volunteer has a right to expect certain "working conditions." The Oregon State Board of Health has formulated one statement of such rights with regard to volunteers in nursing homes and homes for the aged in its publication, *Being a Trained Volunteer*, which has been called a "Bill of Rights for Volunteers."

VOLUNTEER BILL OF RIGHTS

1. The right to be treated as a co-worker by the staff of the home.
2. The right to training for the job and a suitable assignment.
3. The right to know as much about the home and its residents as is necessary for successful service.
4. The right to sound guidance and continuing education on the job.
5. The right to a place to work.
6. The right for recognition and appreciation for work done.

The basic ideas incorporated in these statements apply in most, if not all, volunteer positions.

Once the volunteer thinks of herself as a person with a "professional" attitude to the volunteer job, she will want to look for a volunteer opportunity which incorporates the above "bill of rights." She will also want her volunteer job to be clearly and specifically defined as to function, tasks, supervisory relationships, amount of time expected and scheduling of that time, "fringe benefits" or costs of volunteering (such as free lunch, travel expenses, and training opportunities), and opportunities for mobility within the various volunteer (and perhaps paid) positions. Having such things defined does not mean that they need to be the same for everyone. They can be individually specified. But it is important to know the answers to such questions, and, even more importantly, that they fit the volunteer's needs and interests. If a volunteer agrees to work as an outreach worker for the community crisis intervention clinic without knowing that she is expected to be available Saturday evenings (and that is the night she goes square-dancing or has theatre tickets), she may either perform the task inadequately (go out on Saturday night) or resent the "imposition" of the task on her schedule. This may seem like an extreme example, but it could easily happen. It need not, if the volunteer is aware of the need for clear and specific definitions of the volunteer job and the way in which the job fits one's own needs and interests.

Volunteering in health care fields and in community settings will require flexibility, too. The direct service volunteer is frequently needed *most* to do jobs that really need to be done but which everyone else is too busy to do. Such jobs can range from visiting elderly residents of a nursing home, to delivery of flowers in a hospital, to becoming a member of a "demanding" planning board, to tacking up posters in the community. Such jobs are important and though they may not all give a sense of really working at full capacity or working in the area of greatest interest, direct service volunteering is, after all, *service*. To be most effective in a community volunteer effort, it is important that the direct service volunteer be willing to do what is needed.

Perhaps we can summarize the last two principles by saying that it is important to select a volunteer job that is clearly defined and that is satisfying to the individual. But it is also important for that individual to be willing to do what is really needed. If what is really needed to meet the health needs in one given situation is truly uninteresting, it may be better to look for another volunteer opportunity than to work half-heartedly at a job from which there is no satisfaction.

C. *The Volunteer and Interpersonal Skills in Working With Others*

As a direct service volunteer concerned with health care in the community, one needs to be particularly aware of the relationships with at least four groups of people—paid professionals, community members, paid community aides or non-professional staff, and recipients of service. Good interpersonal skills are, of course, basic; if one has them with one group she is likely to have them with others. But there are some specific things to keep in mind in relation to each of the above groups which may require particular sensitivity on the part of the volunteer health worker.

Volunteers in the health field come into direct contact with many health professionals. The health professions have frequently been characterized as having a "pecking order" structure, based largely on the length and presumed difficulty of the training period. The responsibilities for each professional level are clearly defined. For example, registered nurses with diplomas tend to have less status, responsibility, and opportunity than registered nurses with Bachelor's degrees. Interpersonal relationships take on particular significance for volunteers within such a hierarchical structure. The volunteer will need to be particularly sensitive to the status level of the paid health professionals with whom she works. The more clearly one is able to see the picture of whose opinions, advice, etc., are sought by whom, the easier it is to avoid antagonizing someone unnecessarily by going outside the accepted "chain of command."

For example, if you are working side by side with the nursing staff in a diabetes screening clinic and a physician who is an old friend of yours is also on the staff, it would probably be important for your relationship with the nursing staff to avoid being too friendly with the physician while on the job. Such cautions may seem obvious, but the success of the total health program is the paramount consideration. Frequently the volunteer can use her own sense of personal confidence and the "authority of competence" to help break down some unnecessary status barriers of effective communication among co-workers.

As a volunteer working directly with community members, it is important to be very sensitive to the community members' feelings, expectations, fears, life-

skills, and even prejudices. In many of the areas where community health care is most inadequate, volunteers from outside the community have some real challenges to face. If you work in such a program, several hints regarding your interpersonal relationships might be useful.

1. Be careful not to make assumptions about community members as belonging to stereotyped categories. The elderly paid aide in the program may not always have been poor and may have run his own business for 40 years; the Chicano nurse may not relate well to the Cuban immigrant, even though they share a common language. There are all kinds of resources within each community which only will be used effectively if we treat each community person as a *person* first and get to know their individual strengths and problems.
2. We need to accept the fact that the community member has a vested interest in maintaining his or her place in the community. We all have a negative picture in our minds of the do-gooder volunteer who comes to the "deprived" community to do *her* brand of good, but is not eager to find out what the community member really wants. Community members know more about their own community than outsiders do. They have a place in that community which must not be undermined by your presence. Thus we must be careful not to weaken the community member's position by arguing publicly, by imposing *our* ideas on them, by criticizing them behind their backs, by going over their heads, by being unwilling to do the things *they* think are important, etc. Your ability to develop accepting and mutually respecting relationships with community members can go a long way toward helping to avoid problems within the program.
3. The interpersonal skills needed to work with community members apply even more to working with minorities. Minority groups have seen volunteer programs come and go, frequently leaving behind chaos—hard feelings, unfinished work, and undermined social organization when the program ends.

Members of many low-income and minority groups frequently feel that they have been manipulated, used, studied, volunteered *on*, and misled by many members of the majority culture. They may be angry and resistant to any efforts by members of the majority. If the volunteer recognizes that such attitudes and reactions have some legitimacy in experience, she will be particularly sensitive to the need to work *with*, rather than on minority members of the community. She will be willing to forego public recognition of her contribution in favor of recognition of the minority member's contribution. She will be particularly sensitive to the need to listen and learn about the attitudes and feelings of the minority community members. She will be willing to put her personal ego second to the real needs of others. This does not mean, however, becoming a door-mat or abdicating what she really believes. It is just as bad to be patronizing through being overprotective of the minority group's needs as it is to be overbearing and unaware of them. Treating each individual as a person, learning as much as you can about people as individuals, respecting their experience, traditions and values, and meeting them half-way by being true to yourself are perhaps the most basic approaches to interpersonal relationships with everyone, including minorities.

The interpersonal skills needed in relating to paid staff are similar to those one needs with fellow workers in all kinds of work. There must be a willingness to listen to ideas, and approaches, a willingness to be cooperative and work together on common issues, an ability to accept minor annoyances without blowing them out of proportion, a willingness to pitch in when help is needed but a willingness to do so without "taking over," and a willingness to learn from and take direction from those who are more knowledgeable.

In the health care fields there may also be some special kinds of problems associated with being a volunteer working with paid staff. The community aides or paid non-professional staff may be less well trained for their work than the volunteer. They may also be poorly paid and have inadequate working conditions. On the other hand, they may also be very dedicated, efficient and hard working, and take great pride in their paraprofessional status. The volunteer must take care, therefore, to respect the competence of all staff members, to recognize that some staff members may wish for better training opportunities, and to respect the fact that paid non-professional staff persons are on the beginning levels of the health professions, and therefore have to answer to many "bosses." In such a situation it is easy to create resentment unwittingly by not respecting the status that the staff member does have as a paid member of the health care program. Again, we are not suggesting that the volunteer become a doormat or follow unreasonable orders if they come from a paid but clearly incompetent staff person. But there is a need for sensitivity to these issues and one should try her best to respect the particular problems faced by the non-professional staff.

In relation to interpersonal relationships with clients or recipients of the health care program, most of the points already mentioned apply. In addition, be aware of the importance of the relationships formed in some situations. If one agrees to be a friendly visitor to a shut-in's home, the visitor agrees to the establishment of a significant relationship with the client. Friendship may become extremely important to that person and the visitor needs to recognize that it is cruel to allow such relationships to be established beyond the limitations of what one is willing to commit. One way of dealing with this potential problem is to be aware of it and to set the

limits with the client—for example, by telling the disabled person that she will have a visit once a week for a specified time. If she knows the visit is for one hour, she will not be so disappointed when the volunteer leaves at the end of the hour.

Another special concern requiring interpersonal skills in the volunteer recipient relationship is related to the status issue raised above. Patients or clients in health care delivery programs may not grant the volunteer the status granted to paid members of the staff and, as a result, may be reluctant to be completely honest with the volunteer or, in extreme cases, to deal with a volunteer at all. This situation requires that the direct service volunteer working with clients or patients listens with a "third ear," to be sure the client is not avoiding important points or disguising real problems. The nature of the volunteer role means that some people will be more direct and open with a volunteer than with a public health nurse or doctor, but in some cases it can also set up barriers. We need to be sensitive to the possibility that Ms. Jones will tell only *the Doctor* what is bothering her about her health situation. In such cases the volunteer aide can do her best to reassure the client, but at the same time she must respect the right to privacy and attempt to assure that the client gets attention from the person in the system who can meet her needs.

The interpersonal skills needed for the volunteer in community health care programs are not, as we have pointed out, very different from those needed in other kinds of work or relationships. Awareness of the needs of other individuals, a willingness to listen and to withhold making judgments about people's differences, and a willingness and ability to give recognition to others all are important in other areas of life as well as in volunteer activity. By keeping them in mind we can prevent any interpersonal problems from ever arising.

D. The Volunteer as an Advocate for Community Health

Advocacy can take many forms—from soliciting for money for a hitherto unrecognized national or community health need, to pressuring state legislators on the necessity for better health care in correctional programs, to supporting a drug rehabilitation program in a suburban community. Obviously the extent to which each individual volunteer is willing to take an advocate position must be left to that individual to decide. But we may as well recognize that we are all in positions to be advocates of things we believe in and that we often join with others to make that advocacy more effective.

As advocacy becomes more commonplace in our society, it is probable that most of us will find ourselves confronted with choices about whether or not to become advocates of some particular cause. The volunteer working in community health services is more likely than many other citizens to know what is happening locally, to have an exposure to deplorable conditions, and to understand the results of public apathy and red tape. There are ways of using influence to advocate change within the system and there are ways of organizing people for political and social action. How far to go as an advocate depends largely on your individual personality and the particular situation. The scope of the guidelines presented here relates primarily to voluntary services, but some guidelines specifically related to advocacy may be in order.

First, investigate both sides of the issue and know, as far as humanly possible, the background of the problem, what has previously been done to solve it, who else is concerned about it, what is the official rationale for why the problem cannot be solved, and what are the weaknesses which can be perceived in this rationale.

Second, check to see if the advocacy is really desired by the community, the clients, or the particular target group. One may think the conditions in the clinic waiting room are appalling but one may find after checking that the patients are far more concerned about the length of time they wait than how comfortable the surroundings are. Advocacy would be wasted on the wrong issue if one neglected to check out the third party perceptions with the recipients of service and concern.

Third, advise the voluntary group to which you are related, or, in the case of Church Women United, the local unit of any intended advocacy. The board of directors or the officers may support and add strength to the advocacy position, may request a resignation before taking an intended action, or request that the advocacy be clearly personal and individual. The volunteer has a responsibility not to put the whole volunteer organization in jeopardy because of an unshared personal conviction.

If the direct service volunteer concerned with health services in the community approaches her volunteer job in a "professional" manner, if that job is clearly and adequately defined and supported, and if she recognizes and uses good interpersonal skills in doing the job, the quality of the service contributed to the community will be high and the goals of the volunteer program will have a high chance of succeeding.

II. Administration of Volunteers in Community Health Care

The administration of a community health care volunteer program involves application of the generalized principles of good administration which can be found in many sources. There are, however, some particular aspects of administering a community health volunteer program which deserve special mention.

A. Recruitment

Health care is a subject of interest to everyone, and it is a mistake to assume that only a narrow group of people are interested in the health problems of the local community. During the planning process a wide range of problems should have been considered by the local unit of Church Women United or by the health task force, and one should have been selected which was of interest to a known population of volunteers.

There may be many additional sources of expanded volunteer capacity which have not previously been tapped. These should be explored for interested volunteer workers. It is particularly important not to neglect groups such as community residents or residents of the target program area. They may be poor, old, young, black, Puerto Rican, poorly educated, on welfare, rich, professional, busy, lethargic. Health care in the community affects them all, and it is important to involve people from as wide a community base as possible in all volunteer roles. Volunteers can be recruited at surprising locations. College youths may be excellent "friendly visitors" for ill and housebound people. An older person may have time and interest in volunteering in the health care field but might not want to associate only with older people. This person might be a good worker with children, as in the case of the Foster Grandparents program. An inner-city "gang" may provide outreach volunteers for a neighborhood clinic. In short, there are as many sources of volunteers for community health care as there is imagination on the part of the recruiters.

The recruitment of volunteers into the program from as wide a spectrum of the community as possible is important for several reasons. The volunteer program is likely to be improved by their input of knowledge about the various segments of the community. The program is likely to have greater community acceptance if it involves members of various segments of the community in volunteer activities and, at the same time, the program can provide the individuals with the opportunities to obtain the personal rewards of service to individuals and community, and of personal development.

B. Using the Skills of Volunteers

If volunteers are to be recruited from a wide range of age, educational, racial, cultural, geographic, and experiential backgrounds, it becomes very important to plan carefully for their most effective use. It is important to "start where they are." Everyone has some skills she is willing to share and the effective volunteer administrator will use the skills available in the population. For example, the outreach worker in a comprehensive health care facility in a predominantly Spanish-speaking neighborhood probably doesn't need to have a high-school diploma or to understand complicated medical jargon. The young Puerto Rican mother who is looked up to by other young women in her neighborhood and who has shown a concern with the maintenance of her own children's health may be the most effective outreach worker with other young mothers even though she may not be as effective with the men in the community. The use of this woman's existing skills of close contact, interest in, and ability to communicate with other young women in her community could well be the basis for extremely productive volunteer service.

It is not, however, always necessary to match volunteer characteristics to recipient characteristics. It depends on what will be effective in the particular task to be accomplished. An example of non-matched workers is the Good Companions Nutrition Program for the Elderly in New York City where young, black, ex-gang members have been successful as paraprofessional outreach workers with predominantly white elderly! It is probably good to include volunteers from a variety of backgrounds in any one type of task. In this way the administrator will be able to respond to the needs of various segments of the community. (See "Health Volunteering: Let's Broaden the Field" by Lila Cockrell, *The Church Woman*, March, 1973.)

C. Orientation of Volunteers

If such a wide range of people, with varying skills and abilities, are to be utilized effectively in a community oriented volunteer program, they will all need some common knowledge and skills. They can be recruited, assigned, and used in terms of their particular interests, skills, and backgrounds. In order to be fully effective, however, they will need a common core of factual information and a common point of view regarding the goals of the program. The orientation given to all volunteers should include the program point of view, its structure and goals, general facts and knowledge about the community, information about the particular tasks being performed by volunteers within the program, the supervisory relationships to be maintained, etc.

It is very important not to "talk down" to volunteers at this state—but to *listen to them* as well as to provide them with information. Although they may know a great deal more about some specific things than the administrator does, there will be perspectives on the community and the health problem itself which should be commonly treated. The orientation should also include background material as to the types of obstacles to be expected if the program is one dealing with community service which has controversial aspects. (See the section on strategy and planning.)

D. Task Design, Assignment, and Scheduling

The next step is assignment of volunteers. It is important to specify the tasks of the volunteer just as is the case for a paid employee. Time available, hours to be scheduled, specific supervisory relationships expected, and the type of reporting expected should be spelled out along with the particular "job responsibilities" of the volunteer in terms of task performance.

The volunteer from outside the target community *must* be acceptable to members of that community to be effective. For this reason it may be useful to arrange preliminary meetings of a volunteer with the key community members with whom she will work. Trial periods in a given responsibility might be arranged to give the volunteer and community members a chance to size each other up before making major commitments. Participation as an observer at community meetings could be set up before assignment. Such efforts may go a long way in avoiding hurt feelings on the part of a volunteer who might feel ineffective and unwanted as a result of poor placement. Community acceptance of the volunteer and of the overall program will be enhanced. It is particularly important to take steps to assure that the volunteer worker has community acceptance when dealing with minority groups or culturally diverse populations. It may be necessary to follow similar steps in assignment of volunteers to work with professional medical personnel. It is essential, in either case, that the volunteer assigned have the respect and acceptance of the people she will be working closely with, even if that means a volunteer cannot be assigned to a particular task for which she might be otherwise well qualified.

Tasks or volunteer "positions" should be consciously designed and clearly defined. The volunteer worker is a worker whose major motivations are mainly altruistic and self-actualizing. As was pointed out in the section on direct service, there are many rewards and opportunities for self-development and satisfaction in volunteer work through which women may attain their own goals. The paycheck need not be the only source of a sense of selfworth. But if the volunteer job is to facilitate such growth, it must include opportunities to perform tasks which have intrinsic meaning for the volunteer's selfhood. It is therefore very important to build into the volunteer job an opportunity to see the results of one's work, to understand its meaning and its contribution to a larger goal, and to obtain the particular satisfaction which will fill that individual volunteer's needs.

Most work motivation theories accept three major sources of motivation related to paid work—a desire for extrinsic rewards such as money and status, a desire for intrinsic rewards such as a sense of helping others or pleasure in performing the task for its own sake, and a desire for social rewards such as companionship and the approval of others. Abraham Maslow's theory, discussed in more detail in Section III of this chapter, can be roughly divided into the same kinds of categories, with the extrinsic rewards falling in the bottom half of the motivation hierarchy. The particular motivations of given volunteers may not be the same. A new arrival in the community may volunteer in order to make new friends, to get away from her children for a few hours a week, to obtain intellectual stimulation, to gain status in her new community, and so on. It is not always easy to find out what a person hopes to gain for herself through volunteering, but the administrative volunteer needs to keep in mind that the motives of each volunteer are different and that the volunteer will probably be both more effective and more satisfied if the task assigned to her is designed to be one which will meet that person's particular needs.

It is also important to remember that volunteers change and grow as people. It is important to build in opportunities for the volunteer to expand her abilities, knowledge, and sensitivity. It should not be essential that the volunteer change or grow to perform the assigned task at an exceptionally high level, because not all volunteers will choose to grow in this area of their lives. There should be, however, opportunities for growth within the scope of the task.

Flexible scheduling of assignments is important for the most effective use of volunteers. Many people with various skills, time, and interest can only commit a limited amount of time to voluntary effort. With the increasing proportion of women who work at paid jobs, serious concern has been expressed that the American volunteer tradition, largely carried out by women, will suffer. Part of the answer to this problem as well as a corollary of the idea of starting where the volunteer is with what she has to offer, is to plan volunteer tasks which can be performed at various times, with various amounts of total time, and in various locations. The concept of two part-time employees having joint responsibility for a single job is just beginning to be accepted in paid employment and has ever greater application in a voluntary effort where the job has traditionally been more or less tailored to the individual volunteer's available time and skills.

E. Training and Supervision

There are two basic reasons for including a concern with supervision and training of volunteers. One is that there will always be tasks to be done which require new skills and abilities not present in the volunteer pool and therefore it will be necessary to create those skills and abilities through training. The other is that volunteers are frequently growing, learning persons who are "rewarded" for their efforts by opportunities to learn and develop new knowledge and skills. They usually want to do the best job possible, and are eager for help in improving their own abilities to perform the tasks.

In community health care volunteering, ultimate supervision and training of volunteers may be done by another volunteer or by a paid professional director of volunteer services. But the supervisory responsibilities are built in at a number of levels of volunteer activity. For example, assume that Church Women United in community X has decided to organize a group of volunteers to work in the new neighborhood health clinic. A special Task Force on the Clinic Volunteer Program has been established by CWU. The chairwoman of this Task Force has the responsibility of supervising the recruitment of volunteers and the training of volunteers. Both of these activities have their own chairwoman, responsible for their respective activities. The chairwoman for recruitment supervises recruitment. The chairwoman for training supervises training. Then the chairwoman of the Task Force on the Clinic Volunteer Program supervises the work of both the recruitment committee and the training committee. The details of the supervisory and training responsibility will vary from one level to another, but the principles remain essentially the same.

Supervision and training in a volunteer program are closely interrelated. All supervision should be carried out with the idea of helping the person being supervised to learn to do the job better. In other words, supervision should be positive rather than negative. Supervision should be planned into the volunteer assignment so that the volunteer knows to whom to go for assistance and feedback and what are the accepted procedures. Such planning should help minimize problems of the over-dependent volunteer who is forever calling or turning up asking for help with minute decisions and the overly independent volunteer who never lets anyone know what she is doing. If supervision is a regularly planned part of the volunteer job, it provides for a predictable opportunity to get assistance and feedback and to report on current successes and problems.

Training of volunteers in community health service programs may be formal or informal, or, more likely, both. Orientation, mentioned earlier, is one particular focus of training, but plans for continuous volunteer training and development should be included in any organized volunteer program. Most of the large voluntary health agencies with national networks have their own training programs. Volunteers in programs which are mainly local can use the training suggestions found in manuals of the National Center for Voluntary Action or in the various books on volunteer development which are now on the market. Church Women United has provided training experiences which are applicable to health concerns through 30 or more regional Response-Ability workshops. The national office of Church Women United will answer individual letters requesting suggestions for implementation of health programs.

Rather than repeating the general material on training volunteers here, we will, instead, point out some of the important content which should be included for volunteers working in community health service delivery and planning. The content of training whether formal, through organized classes or informal, on-the-job supervision, independent reading, observation etc.—should pay particular attention to the following:

1. *Providing an adequate knowledge of the clientele to be served by the program.*

This should include as much information as possible about economic status, health status, social patterns, cultural traditions, values and beliefs, leadership patterns, plus basic demographic data on age, sex, education, income, housing patterns, family size, employment status, and everything else that seems relevant to the specific clientele and the specific volunteer program. The content should be provided in a way to maximize understanding of the meaning of this information rather than as abstract "facts about" the clientele.

For example: The volunteer program may have as its goal increasing the percentage of community women who obtain prenatal care through the neighborhood clinic early in their pregnancy. But it is known that the social/cultural pattern in a portion of this community is to rely on a local granny-midwife for prenatal advice. And older women in the community strongly support this practice. In this case the usefulness of the cultural knowledge can be made clear to the volunteer by building into the training program action planning to overcome the social/cultural pattern.

2. *Examining the common stereotypes about poor, welfare, racial, ethnic, sexual, and social groups.*

In order to work effectively in any community it is important to understand its cultural, economic, and social nature. It is even more important, in order to work effectively with the *people* in the community, to avoid stereotyping persons because they fit into some particular social or economic category. For example, old people may be poor because of loss of the opportunity to work, but they may still have the values and the life style of the middle-class people they once were by virtue of previous income. One welfare mother may have one preschool child and be attending college, while another, of the same age and race, may have several preschool children and be making no attempt to improve herself educationally or vocationally. On the other end of the income scale, an elderly widow who is rich, lives in a big house on the hill, and has a car and chauffeur, may be as lonely and as in need of participating in a nutrition program for the elderly as a poor elderly person living alone in a small room in the inner city. Stereotypes are generalizations which are seldom justified when applied

to any particular individual. It is very important to help volunteers, who are working in a community setting, to examine their own stereotypes and attempt to learn not to make assumptions about individuals based on those stereotypes.

3. *Providing an adequate knowledge of the community in which the program takes place.*

Knowledge of the community includes knowledge of the organizations and agencies within the community, the availability of facilities and resources (such as meeting places, churches, hospitals, clinics, schools, ongoing programs related to program goals, etc.), and the community problems affecting your programs. For example, inadequate public transporation may make it extremely difficult for community residents to get to the clinic. As with the kinds of content discussed above, this information should be provided in such a way that it is seen as meaningful and useful in meeting the program goals and in assisting the volunteer to perform her particular job.

4. *Assuring that community health care volunteers have the necessary attitudes and interpersonal skills to work* with *members of the community.*

It is essential that a volunteer working in a community health program recognize the need to *work with,* not on, community members. Frequently, the volunteer works for them, in the sense that the program goals and strategies should be those chosen by community members rather than imposed from outside. It happens more and more frequently that minority communities will only accept volunteers who are willing and able to work for the community's goals and do so under rather direct supervision of a minority community person. This arrangement will present no problems if the volunteer and the supervising community members are both operating on the basis of sound principles of volunteer administration and services, but training and supervision should include content designed to aid the volunteers at all levels to develop attitudes and interpersonal skills which facilitate acceptance and positive performance toward a common goal. A variety of techniques are available for developing such skills, such as role-playing, listening exercises, recognition of diversity exercises, group discussions, audio-visual materials. etc.

Another content area under this general heading is the area of learning to discover and use community members as resources for the volunteer program. Again, this will happen automatically if creative recruitment and non-stereotyped assessment of resources is being practiced. It is only repeated here because it is an important facet of the content of training of all volunteers if the community health volunteer program is to be truly a program accepted by the community rather than one imposed on the community from outside. In summary, supervision and training should be a planned, ongoing part of the administration of volunteer programs. When in community settings, the programs *must* have supervision and training if they are to succeed. Particular attention should be paid to including content, methods, and procedures designed to help the health volunteer *know* the community and *work with* it. The administrative functions of supervision and training exist, with various specifics, at many levels of the volunteer enterprise and should be of concern to many volunteers.

III. Service of Self as a Health Care Volunteer Goal

It may seem strange to think of service to one's self as a legitimate goal related to volunteer service on behalf of community health care. In a very real sense, we can think of whatever we do as motivated by a desire to meet some need which is within the self. Abraham Maslow's theory of motivation identified a hierarchy of needs with basic needs at the bottom and other, higher level needs further up. The most basic needs were seen as those needed for survival (food, shelter, water, etc). The next higher were for safety or security (such as predictability, a secure job, protection from enemies, etc.). The third level was for love (such as affection, sense of belonging, a relationship with others). These three levels of needs were thought by Maslow to exist in everyone and to take precedence, if they remained unmet, over the higher level needs. But for most of us, these three basic levels of needs are met to a great enough extent so that we are motivated largely by the higher levels of needs. Maslow defines these as: fourth level, esteem needs (stable, firmly based, usually high evaluation of self, self-respect, and respect of others), and fifth level—"self-actualization needs" (the need to know and understand, and aesthetic needs). It is usually these two upper levels that motivate most of us to engage in volunteer action for others. We give service to others which eventually comes back in some form of esteem (feeling good about ourselves or recognizing that what we are doing is valued in our society). It should be recognized, however, that the "need to be needed" can be so intense that it may actually handicap a volunteer. We may also, as was pointed out in the section on the direct service volunteer as a "professional," be motivated by self-actualization needs such as a need to know or understand. Our own needs for self-development and self-actualization should be respected, and we should seek volunteer opportunities which help meet these needs.

In addition to volunteering for others, there are many ways to "volunteer" in our own lives. Perhaps the most basic is to keep informed about current trends in health care, to be continuing learners—self-directed, self-developing human beings. There are many means of

doing this. We needn't wait for anyone to provide training courses; we can read, attend formal and informal educational programs, think about things, talk with others, practice skills, etc. Social control and change in a society such as ours depend very heavily on an informed public. We are uniquely fortunate in having an open, informative system and many available means of keeping informed. However, public knowledge about health care issues and personal health is generally very poor. We somehow seem to feel that "only the professionals can understand." This attitude is a direct disservice to the accomplishment of better community health care in America, so each person who "volunteers" to keep informed and, directly or indirectly, to inform others, is potentially meeting her own self-actualization needs as well as meeting an important community health need.

In a somewhat more direct way, we can volunteer to help improve community health through improving our own and our family's health care and health knowledge. The following list of ways in which we can contribute to improving community health care includes some very widely known ideas. They are not new or difficult. Neither are they widely enough practiced. If each reader of this material volunteered to carry out each of these suggestions in her own life, there might well be a significant improvement, in time, in an entire community's health.

- Maintain a family health check list on a regular basis for purposes of preventive maintenance and medical history.
- Learn about the practice of good nutritional principles for oneself and the family, including attention to special nutritional problems such as family history of heart disease, diabetes, obesity, etc.
- Faithfully get an annual pap smear for cervical cancer.
- Keep records of immunization for oneself and one's family; get boosters when needed.
- Become informed about and do whatever is possible to protect the environment, such as recycling, not using paper products excessively, not burning trash or leaves in the backyard, not littering, using less electricity and gasoline, using non-phosphate detergents, using less water, using safe insecticides, etc.
- Make the effort to participate in, and get the family to participate in periodic free screening programs for various diseases such as diabetes, T.B., V.D., lung cancer, etc.
- Learn as much as one can about the physiology and functioning of one's own body.
- Learn about good principles of positive mental health for individuals and families, seek short-term counselling for oneself and/or family if needed, talk with children's teachers and school counsellors, etc.
- Keep poisons, medicines, etc., locked up and out of reach of children and throw away old, unused prescriptions.
- Reduce or eliminate the intake of harmful or allergic reaction drugs, including alcohol, nicotine, diet pills, aspirin, etc.
- Learn first aid skills, perhaps to an advanced level, and keep up the skills by practice; also keep a basic first aid and resuscitation guide handy and in an easy-to-reach place in the home and car.
- Have a family physician and/or physicians (internist, pediatrician, gynecologist, etc.) and go for regular checkups.
- Have adequate emergency medical supplies on hand.
- Keep emergency telephone numbers in an immediately accessible place.
- Learn about and practice fire drill, tornado, flood, etc., procedures in one's own home.
- Reduce, by all means possible, the noise pollution in the home.

Every reader of this list will undoubtedly be able to think of things to add. The point is that if each of us volunteered to make the effort to take as good care of our own and our family's health as we know how, we would be making a significant contribution to community health care.

COMMUNITY SURVEY
for a Comprehensive Approach to Health Concerns

Compiled by Patricia Nelson, MPH, Director of Health Education of the Department of Health Education, Children's Hospital, Boston, MA

Section 1 PREVENTIVE HEALTH CARE: These items deal with the prevention and early detection of physical or mental illness.

	A. Does this service exist in your area?			B. If you should need this service, would it be easy to obtain (even if you had to leave the area)?			C. How important is it to establish or improve this service in your area?			
a. Periodic Examinations and Screening Programs	Yes	No	Don't know	Yes	No	Don't know	**Very** important	Important	**Not** important	Don't know
( ) General Medicine										
( ) Dental Examinations										
( ) Gynecology (women's diseases)										
( ) Psychological Testing										
( ) Eyesight (including glaucoma)										
( ) Hearing										
( ) Diabetes										
( ) Sickle Cell Anemia										
( ) Tuberculosis (T.B.)										
( ) Venereal Diseases (V.D.)										
( ) Learning Disabilities										
( ) Other: (specify)										

Of all the above listed services, do you believe some are more available for children than for adults? If so, please place a check mark (✓) next to each service that you think is more available for **children.**

Are there provisions for screening or other preventive medical care in your area schools?
☐Yes ☐No ☐Don't know

If you answered "yes," are these programs adequate? ☐Yes ☐No ☐Don't know

Do you feel there is a need for more or better school health programs?
☐Yes ☐No ☐Don't know

Remarks:

SECTION 1—continued

	A. Does this service exist in your area?			B. If you should need this service, would it be easy to obtain (even if you had to leave the area)?			C. How important is it to establish or improve this service in your area?			
	Yes	No	Don't know	Yes	No	Don't know	**Very** important	Important	**Not** important	Don't know
b. Counselling Services										
Alcoholism (AA, church, etc.)										
Family Service										
Pregnancy										
Abortion										
Genetic Counselling (Heredity)										
Big Brother										
Big Sister										
Hot Line										
Information & Referral										
Nutrition										
Psychological Counselling										
Marital Counselling										
Other: (specify)										
c. Health Education for Adults										
Drug Education										
Family Planning										
Prenatal (for pregnant women)										
Sex Education (adults)										
General Health Education										
Other: (specify)										
d. Health Education for Children or Adolescents										
( ) Drug Education										
( ) Sex Education										
( ) General Health Education										
( ) Family Planning										
( ) Prenatal										
( ) Other: (specify)										

Please place a check mark (✓) in front of those services for children which are available in your area **schools.**

Remarks:

Section 2. PRIMARY TREATMENT: These items deal with the treatment of illness on an outpatient basis.

	A. Does this service exist in your **area?**			B. If you should need this service, would it be easy to obtain (even if you had to leave the area)?			C. How important is it to establish or improve this service in your area?			
	Yes	No	Don't know	Yes	No	Don't know	**Very** important	Important	**Not** important	Don't know
a. Emergency										
Ambulances										
School Health Unit										
24-Hour Emergency Center										
Doctors' Offices										
Neighborhood Health Center										
Poison Hot-Line										
Referral Service for Emergencies										
Psychiatric Hot Line										
Other: (specify)										
b. Non-Emergency										
Mental Health Center										
Hospital Out-Patient Dept.										
Pharmacy										
Neighborhood Health Center										
Other Clinics										
Health Department										
Doctors' Offices—General Practice										
Doctors' Offices—Women's Diseases										
Doctors' Offices—Other Specialties										
Dentists										
Other: (specify)										

Remarks:

Section 3. SEMI-DEPENDENT CARE: This section deals with special programs which are neither all inpatient nor all outpatient.

	A. Does this service exist in your area?			B. If you should need this service, would it be easy to obtain (even if you had to leave the area)?			C. How important is it to establish or improve this service in your area?			
	Yes	No	Don't know	Yes	No	Don't know	**Very** important	Important	**Not** important	Don't know
General Categories										
Housing for Elderly										
Hot Lunch Programs for Elderly										
Halfway Houses for Drug Addicts										
Halfway Houses for Alcoholics										
Halfway Houses for Mentally Ill										
Child Care Centers / Nursery School										
Day Care Centers for Physically Ill or Mentally Ill or Handicapped Persons										
Special Schools for Exceptional Children (blind, deaf, palsy)										
Special Schools for Retarded Children										
Partial Hospitalization (inpatient care; day only or night only)										
Foster Homes										
Other: (specify)										

Remarks:

Section 4. INPATIENT SERVICES: These sections deal with acute (short-term) or chronic (long-term) care in hospitals or other inpatient facilities.

a. Acute (short-term) Hospital Care (30 days or less)

General Medical										
General Surgical										
Complicated Medical										
Complicated Surgical										
Diagnostic										
Maternity										
Newborn Care										
Pediatric (Child Care)										
Intensive Care										
Other: (specify)										

SECTION 4—continued

	A. Does this service exist in your area?			B. If you should need this service, would it be easy to obtain (even if you had to leave the area)?			C. How important is it to establish or improve this service in your area?			
	Yes	No	Don't know	Yes	No	Don't know	Very important	Important	Not important	Don't know
b. Short-Term Psychiatric In-Patient Care (2 months or less short-term)										
Drug Detoxification										
Alcohol Detoxification										
Psychiatric Care (Mental Illness) (Adult)										
Psychiatric Care (Children or Adolescent)										
Diagnostic Services										
Social Services										
Other (specify)										
c. Long-Term Care (In-Patient)										
Chronic Disease Hospital										
Nursing Homes or Extended Care Facility										
Rest Home or Home for Aged										
Psychiatric (long-term)										
Other (specify)										

Remarks:

Section 5. TERMINAL CARE: This section deals with care of the dying.

Institutional Care										
Home Care										
Psychological Services										
Social Services										
Other: (specify)										

Remarks:

Section 6: HOMEBOUND CARE: This section deals with care that is given in the home.

	A. Does this service exist in your area?			B. If you should need this service, would it be easy to obtain (even if you had to leave the area)?			C. How important is it to establish or improve this service in your area?			
	Yes	No	Don't know	Yes	No	Don't know	**Very** important	Important	**Not** important	Don't know
General										
Visiting Nurse Association										
Homemaker Services										
Special Education										
Home Tutoring (health needs)										
Transportation Services										
Meals on Wheels										
Volunteer Companion Programs										
Public Health Department										
Housecalls by Doctors										
Other (specify)										

Remarks:

Section 7. REHABILITATION SERVICES: This section deals with services after an illness to bring a person back to his fullest functional ability.

Physical Therapy										
Occupational Therapy										
Vocational Counselling										
Social Services										
Speech & Hearing Therapy										
Recreational Therapy										
Psychotherapy										
Special Education (for blind, retarded, emotionally disturbed, other physically handicapped)										
Volunteer Associations (organizations of persons experiencing similar disabilities)										
Other (specify)										

Remarks:

Section 8 GENERAL COMMUNITY SERVICES AND CONDITIONS. This section deals with public health services that are for the common good rather than for a specific individual.

	A. Does this service exist in your area?			B. If you should need this service, would it be easy to obtain (even if you had to leave the area)?			C. How important is it to establish or improve this service in your area?			
	Yes	No	Don't know	Yes	No	Don't know	**Very** important	Important	**Not** important	Don't know
a. Sanitation										
Food Inspection (restaurants, markets, etc.)										
Pest Control - Insects										
Pest Control - Rodents										
Other (specify)										
Pollution - Air										
Pollution - Noise										
Pollution - Water										
Sewerage										
Solid Waste (garbage, public dumps)										
Other. (specify)										
b. Safety										
Occupational Safety (job conditions)										
Safety at Recreational Facilities (perils, supervision)										
Traffic Safety (pedestrian / motorist)										
Crime Prevention										
Other: (specify)										
c. Subsidization Programs (Private or Public Funding Assistance)										
Housing										
Food Stamps										
Food Distribution Centers										
Medical Care—Medicare										
Medical Care—Medicaid										
Other Services: (specify)										
d. Miscellaneous										
Housing Inspection										
Adoption Services										
Public Transportation										
Other: (specify)										

Section 9 GENERAL OPINIONS

a What do you feel is the **greatest single** health care need in your area? (You may list one item selected from this questionnaire or one item that is not included in the questionnaire lists.)

b What do you feel are the **three** next most important health care needs in your area?

c. In what health subject do you feel the greatest need for additional knowledge?

d What suggestions would you make for the improvement of the 'Health Planning Council' in serving its membership and the community?

Once again—thank you very much for your help in compiling this important data.

LIST OF RESOURCES

Committee for Economic Development, *Building a National Health-Care System*, 477 Madison Ave., New York, N. Y. 10022. Single copy $1.75. A 1973 publication which analyzes the present health care system and makes suggestions for improving the organization of the delivery system, especially as it relates to primary care.

Elizabeth Kubler-Ross, M.D., *On Death and Dying*, The Macmillan Company, New York, N. Y. Paperback $1.95. Deals with therapy with the terminally ill on what the dying have to teach doctors, nurses, clergy, and their own families.

Government Printing Office, Washington, D.C. 20402, *A Selective Annotative Bibliography for Continuing Educators of Health Manpower*, prepared for HEW by Syracuse University Adult and Continuing Education as an aid in decision-making related to the health care system in instructional guidance for health manpower programs.

National Foundation—March of Dimes, *Family Medical Record*, Box 2000, White Plains, N. Y. 10602. A six-page, free leaflet designed to help individuals and families keep vital health information organized and in permanent record form.

Oregon State Board of Health, *Being a Trained Volunteer in Nursing Homes and Homes for the Aged*, Oregon State Board of Health, P.O. Box 231, Portland, Oregon 97207.

Scientific American, *Life and Death and Medicine*, September, 1973. Entire issue devoted to aspects of health care, such as the hospital, the drug industry, problems of aging, and the organization of medical care. Available in all public libraries.

Felice N. Schwarts, Margaret H. Schifter and Susan S. Gillotti, *How to Go to Work When Your Husband is Against It. Your Children Aren't Old Enough, and There's Nothing You Can Do Anyhow*. New York: Simon and Schuster, 1972. A Catalyst Publication. See particularly, Chapter IX, "Professionals Without Pay," which advocates professional volunteerism—doing a professional job without pay—and development of voluntary *careers*.

Anne R. Somers, *Health Care in Transition. Directions for the Future*, Chicago: Hospital Research and Educational Trust, 1971. Discusses major trends in health care in the 70's, particularly related to hospital care and the cost of health care.

Ann K. Stenzel and Helen M. Feeney, *Volunteer Training and Development. A Manual for Community Groups*. New York. The Seabury Press, 1968. Primarily about developing and implementing training programs for volunteers at all levels, based on an adult education model.

Voluntary Action News. National Center for Voluntary Action (NCVA), 1785 Massachusetts Avenue, N.W., Washington, D.C. 20036. Monthly publication which includes reports of many interesting health related volunteer activities.