

the
Canadian
Health
Psychologist

Spring/printemps 1997 Vol. 5 No. 1

le
Psychologue
Canadien
de la
Santé

The Canadian Health Psychologist/ Le psychologue canadien de la santé

Editor/Rédacteur en chef: Michael Murray

The Canadian Health Psychologist is produced by the Health Psychology section of the Canadian Psychological Association and distributed to all members of that section. It is designed to serve as a discussion forum for any issues of relevance to psychologists working in the area of physical health. The editor welcomes review articles, research and intervention reports, reports of events, letters, news of members, book reviews and announcements. Articles should ideally be no longer than 2500 words with about ten references. They should preferably include an abstract in English and in French. If possible, articles should be submitted on a computer disk.

The opinions expressed in this newsletter are strictly those of the author and do not necessarily reflect the opinions of the Health Psychology Section or of the Canadian Psychological Association, its officers, directors or employees. This is in no way affected by the right of the editor to edit all copy published.

The newsletter is produced two times a year, Spring and Fall. The deadlines for submission of articles are: Spring issue: 31 March; Fall issue: 31 October

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Le psychologue canadien de la Santé est produit par la section de psychologie de la santé de la société canadienne de psychologie et est distribué à tous les membres de cette section. Son but est de servir comme un agent de discussion pour des psychologues qui travaillent dans le domaine de la santé physique. Les articles revues, rapports de recherche et d'intervention, rapports d'événements, lettres, nouvelles des membres, des comptes rendus et des annonces sont le bienvenue chez le rédacteur pour soumission. Idéalement, les articles ne devraient pas dépasser 2,500 mots avec 10 références ou moins et, si possible, incluent un résumé en français et en anglais. Aussi, si possible, les soumissions devraient être présentées sur une disquette.

Les opinions exprimés dans ce bulletin son strictement ceux de l'auteur et ne reflètent pas necessairement les opinions de la section de psychologie de la santé ou la société canadienne de psychologie, ses officiers, ses directeurs, ou ses employés. Le rédacteur a le droit d'éditer toutes soumissions.

Ce bulletin est publié deux fois par année, c'est-à-dire en printemps et en automne. Les dates limités de soumission sont comme tel: printemps: le 31 Mars; automne: le 31 Octobre.

Les individus qui ne sont pas membres avec la section de psychologie de la santé s'abonner en envoyant 10\$ (payable à SCP Section de la psychologie de la santé).

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Indexed by the Canadian Periodical Index/répertoriée dans l'Index des périodiques canadiens
and on/et à CD-ROM Canadian Business and Current Affairs Fulltext.

**THE CANADIAN HEALTH PSYCHOLOGIST/
LE PSYCHOLOGUE CANADIEN DE LA SANTÉ**
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Editorial/Éditorial

The health services in Canada are undergoing tremendous changes. This is occurring for a variety of reasons including fiscal containment, program restructuring and an orientation towards community care and health promotion. Health psychologists need to be aware of these changes and to discuss the implications for the delivery of psychological services. This issue of the Canadian Health Psychologists considers some of these questions.

The first article by Evelyn Vingilis and her colleagues presents the results of a survey which are relevant for the design of community health program. They raise a number of interesting questions. The second article considers the very extensive role of health psychologists in Cuba. That country has a long tradition of community based health care. Health psychologists have played a central role in the implementation of these services. The model of community delivery of services is one which health psychologists in this country should study closely.

The third article by Renate Schober is an extended conference report. In it she considers two increasingly important issues in Canada - the cultural diversity of our population and the range of complementary health services now available. The final article by Roy Cameron considers the ongoing development of behavioural research in the National Cancer Institute of Canada.

Many of these and other related issues will be discussed at a very full section program which has been organised for the Annual Convention in Toronto. I hope that members will be able to attend the convention and to participate both in the symposia and the various social activities.

Des changements importants sont en train de se produire dans les services de santé au Canada. Ces changements surviennent pour une foule de raisons, y compris les coupures budgétaires, la restructuration des programmes, l'orientation vers les soins de santé communautaire et la promotion de la santé. Les psychologues de la santé devraient être conscients de ces changements et en discuter les implications sur la distribution des services psychologiques. Le présent numéro de Psychologue canadien de la santé traitera de quelques-unes de ces questions.

Le premier article, écrit par Evelyn Vingilis et ses collègues, présente les résultats d'un sondage pertinent pour le plan des programmes de santé communautaire et soulève de nombreuses questions intéressantes. Le deuxième article traite du rôle très important que jouent les psychologues de la santé à Cuba. Ce pays a une longue tradition en ce qui a trait aux services de santé communautaire. Les psychologues de la santé y ont joué un rôle central dans la mise sur pied de ces services. Ce modèle de distribution de services communautaires devraient être examiné de près par les psychologues de la santé au Canada.

Le troisième article écrit par Renate Schober est un rapport long de congrès. Elle étudie deux questions importantes au Canada, la diversité culturelle et la gamme de services de santé complémentaires maintenant disponibles. Le dernier article, de Roy Cameron, rapporte les nouveaux développements dans la recherche du comportement à l'Institut national du cancer du Canada.

Beaucoup de ces questions et d'autres seront discutées dans le programme très chargé de la Section au Congrès annuel à Toronto. J'espère que les membres pourront y assister et participer aux symposiums ainsi qu'aux activités sociales.

Myth Versus Reality: A Community's Knowledge of their Health Status

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ABSTRACT

The purpose of this study was to identify the extent of awareness of key local health issues among London, Ontario residents.

Method: A random digit-dialing telephone survey was conducted to query residents on their knowledge and opinions of the health and determinants of health status of their own community.

Results: 217 Londoners were surveyed. The results indicated that London residents had very limited knowledge of their community's health status. Generally, they underestimated their community's lifestyle and health problems. Contrary to the epidemiological findings on local determinants of health and health issues, residents felt that their community was wealthier, more educated and had fewer health problems than Ontario as a whole.

Conclusions: These results suggest that awareness of local health issues is poor among London residents. The results speak to the challenge of mobilizing communities to develop "healthy communities", as knowledge of local health problems may be a necessary, although not a sufficient condition for community mobilization.

RÉSUMÉ

Cette étude s'est donné pour objet d'évaluer parmi les résidents de London (Ontario) le "degré de connaissance" en matière de santé publique.

Méthode: Un sondage téléphonique a été effectué afin de déterminer auprès des personnes interrogées leurs connaissances générales dans le domaine de la santé ainsi que les causes déterminant l'état de santé de leur communauté.

Résultats: 217 Londoniens ont été interrogés et les résultats ont indiqué une nette lacune en matière de santé. Dans l'ensemble, les résidents londoniens ont sous-estimé les problèmes de style de vie et de santé de leur communauté. Contrairement aux résultats épidémiologiques sur le plan local, les résidents pensaient que leur communauté était en meilleure santé, plus instruite et avait moins de problèmes de santé que le reste de l'Ontario.

Conclusions: Connaître les problèmes de santé semble être une condition nécessaire, mais non suffisante pour mobiliser la communauté; Les résultats montrent que le "degré de connaissance" est faible et témoigne en ce sens de l'importance à donner à la mobilisation communautaire.

Keywords: community health, knowledge, health status

Mots-clé: santé communautaire, connaissance, état de santé

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Introduction

In recent years, the increasing concern over health care expenditures has driven virtually every country in the Organization for Economic Cooperation and Development (OECD) to launch major reforms of their health care systems (Evans, 1993). Canada is no exception. Improvements in individual lifestyles and the development of healthy communities have been identified as key methods to reduce health care costs (Evans, Barer and Marmor, 1994; Green and Raeburn, 1990). Fundamental to the notion of "healthy communities" is the mobilization of communities toward developing policies, programs and environments which promote health and well-being (Bracht, 1990). Yet, in order for communities to mobilize, there must be some basic awareness of and concern over their own health status and determinants of health. As Bracht and Kingsbury (1990) write: "activation of the community is a process whereby the community (a) becomes aware of a condition or problem that exists within the community, (b) identifies that condition as a priority for community action, (c) institutes steps to change the condition, and (4) establishes structures to implement and maintain program solutions" (p71).

Current models of community action are predicated on the mobilization of communities, followed by the gathering of a wide-range of health and well-being indicators (also known as needs assessment or community analysis) (Bracht, 1990; Braddy et al., 1992; Green and Kreuter, 1992; Kreuter, 1992; Rubin and Rubin, 1986). However, if community awareness of key health issues does not exist, community interest cannot evolve (Wallack and De Jong, 1995).

Evidence suggests that an understanding of the broad determinants of health and health consequences is not shared by the public. For example, a survey found that while Ontarians recognize that the environment, personal behaviour and health care are important determinants of health, they are less likely to see such factors as housing conditions, educational status and income as equally important (Ontario Ministry of Health, 1992).

Not only does the public at large have little understanding of health determinants, but communities seem to have

myths about the status of their own community's health. A classic example of the discrepancy between actual and perceived health problems comes from a Washington public housing health initiative (Rivio et al., 1992). To examine the community's health problems, the public health organizations together with the local community coalition reviewed District-wide morbidity and mortality data and conducted a community opinion and health survey. Although the residents' concern about violence and drugs was reflected in the responses on the survey, the data indicated a lack of awareness of a disproportionate burden of chronic diseases in their community. For example, 82% of the residents felt that drugs/alcohol abuse was a major killer in their community, yet only 6% of actual deaths were alcohol-related and only 1% were drug overdoses. Similarly, 57% of the residents felt that homicide/crime was a major killer, yet only 4% of the actual deaths were homicides. On the other hand, only 6% identified heart attack/stroke to be a major killer, while the reality was that 29% of the deaths were due to cardiovascular problems (Rivio et al. 1992). Clearly, there was great disparity between the community perceptions of their health status and the actual epidemiological evidence. Only when the information disparity within the community was lessened, did the community mobilize to place prevention of chronic preventable diseases and the promotion of health choices among their top health priorities (Rivio et al., 1992).

The identification of this information disparity is critical to the targeted development of public information programs directed toward creating awareness of health problems or issues in individual communities (Flay and Burton, 1990; Wallack et al. 1993). Community awareness and mobilization are becoming an important major public health component of the "new public health," representing a shift in power from bureaucracies to communities (Green and Raeburn, 1990; Vingilis and Sarkella, 1997). As Wallack et al. (1993) state: "The realignment of major players in public health and, to some extent, the redefinition of expertise and knowledge are critical tasks" (p.16).

The purpose of this study was to identify the awareness of health status and determinants of health among residents of a Southwestern Ontario community. A major health status report had identified a number of serious health problems, risky lifestyles, and increased rates of health care utilization and mortality for a number of conditions which warranted addressing (Alder, Vingilis and Mai, 1996). Furthermore, public health and social service agencies were having

difficulty attracting community members to join in coalitions, networks, etc., in support of various community-related issues. The need for the community to address these problems was made cogent by a local newspaper article on another report by the Institute for Clinical Evaluative Services, which similarly identified the highest health care utilization to occur in Southwestern Ontario (Egan, 1996). However, higher utilization rates were not hypothesized to be due to differences between Southwestern Ontario when compared to Ontario as a whole, on demographic factors (i.e., higher poverty rates, lower educational levels, higher rates of elderly), lifestyle factors (i.e., higher rates of smoking, fat consumption, inactivity, obesity, drinking-driving, student drug use, etc.) and a greater burden of illness (e.g., significantly higher rates of death due to myocardial infarction, ischemic heart disease and diabetes), as documented in the major local health status report (Vingilis, 1996a), but rather the higher rates were due to "the region's more ample bed supply," with the warning that the Ontario Ministry of Health's plans were "to eliminate wide variations in health services across the province" (Egan, 1996). That is not to say that bed availability does not play a role in hospital bed utilization. However, to assume that "bed supply" is the only determinant of hospital utilization without investigating the other common predictors of disease and disability could lead to questionable policies. Reduction in bed supply without a concomitant reduction in the health risk factors and burden of illness could potentially affect the current health status of the community.

The challenge was to try to unravel why the community seemed to show little interest in community health issues. An important first step was to identify community knowledge on health status in relation to the epidemiological evidence. If lack of awareness of key health issues was one factor related to community non-response, then baseline information would be vital to the development of a public education plan to create community awareness of and concern over key health issues with the view that this concern could provide the catalyst for community mobilization for disease prevention and health promotion (Bracht and Kingsbury, 1990; Budd and Rubin, 1988; Hiebert, Ungurait and Bohn, 1982).

Questionnaire development and execution

The survey was based on the **Community Health and Well-Being in Southwestern Ontario** report (CHWSO report) (Alder, Vingilis and Mai, 1996). Content validity

was established using the expert panel method (Kirshner and Gordon, 1985; Weiler et al., 1993). A panel of five researchers with social science, epidemiology, kinesiology and survey design backgrounds, and familiar with the epidemiological contents of the report and London region independently generated a pool of over 120 knowledge questions from the report. Using the principles of questionnaire design (Bradburn and Sudman, 1979; Converse and Presser, 1986; Sudman and Bradburn, 1982), the panel then reviewed all questions on the following criteria; focus, brevity, clarity, readability/vocabulary and adequacy of response options. In addition, items were assessed on whether the issues identified in the questions had been previously documented and well publicized within the last five years in various, local public health and other human services reports. Using consensual agreement, the items were ultimately reduced to produce a brief 18-item questionnaire which included a mix of open- and closed-ended questions¹. The telephone survey was both pre-tested and pilot tested and the results were further incorporated into the final questionnaire. The survey was conducted by the Telephone Survey Unit in the Department of Epidemiology and Biostatistics, Faculty of Medicine and two authors.

Method

The random digit dialling telephone survey was conducted from April 12, 1996 to April 26, 1996. Telephone

¹ The questions queried in a forced choice manner: perceptions of the most important health determinant (smoking, poverty, lack of exercise); the region with the highest percentage of people living in low income (London, Southwestern Ontario, Ontario as whole); the region with the highest percentage of population with a university degree (Southwestern Ontario, Ontario); whether people in Southwestern Ontario, when compared to Ontario as a whole, had higher, lower or the same rates of fat consumption, smoking and alcohol-related offences; what region had the highest rate of student drug use and delinquency (Metro Toronto, Southwestern, Northern, Centralwest and Eastern Ontario). In addition, open-ended questions asked opinions on the major cause of death in Southwestern Ontario; any diseases or health conditions that have at least 10% higher hospitalization rates in Southwestern Ontario; the first thing they would do, if they were given the task of improving the health of their community and information on age, sex and educational status.

numbers were randomly generated for the London municipality and conducted 7 days a week. The eligible sample consisted of 324 households in the city of London. The sampling method for respondent eligibility was to request for the household member who was over 17 years of age and who had the most recent birthday. A total of 217 questionnaires were completed for a response rate of 63.08%.

Results

Demographic Characteristics/Representativeness:

Table I presents the demographic information for the survey and the 1991 Census for London, Ontario (1991 Census). Comparing the demographics of the respondents to the survey to the 1991 London population census data, significant differences were found for age ($X^2=41.1$, $df=5$, $p<.001$), sex ($X^2=7.9$, $df=1$, $p<.01$), and educational attainment ($X^2=101.6$, $df=6$, $p<.001$). The survey sample was more likely to be female, younger or senior and better educated when compared to the census data, although the census data (1991) does not contain the newly annexed suburban areas of London, which encompass wealthier areas and an area close to the university, which were part of the survey sample.

Table I: Demographic characteristics of sample and census population

AGE CATEGORY	London Survey (Total=217) (%)	London Census (1991) (Total pop.= 303,165) (%)
18-25 yrs	19.6	11.76
26-35 yrs	15.8	26.25
36-45 yrs	21.1	20.98
46-55 yrs	12.4	13.74
56-65 yrs	4.8	11.17
Over 65	26.3	16.10
GENDER		
Male	38.3	48.0
Female	61.7	52.0
EDUCATION		
Elementary	2.9	7.64
Some high school	13.0	21.60
Completed high school	33.2	14.06
Some college	7.2	6.23
Completed college	13.5	18.01
Some university	6.7	18.90
Completed university	23.6	13.58

Survey Data:

Table II presents the number and percentage of correct and incorrect responses to the knowledge questions. For no question did more than one third of the respondents answer correctly.

The respondents were queried on a number of income/education questions as a strong body in local, regional and international research has found income and educational attainment to be the major determinants of health status (Evans, Barer and Marmor, 1994; The World Bank, 1993; Warren, 1994). In addition, the local newspaper and radio talk show had featured over the last couple of years a number of stories which expounded on the relationship between health status and income. The respondents were asked which factor is the most important determinant of one's health status. Only 20.1% respondents answered the question correctly to be poverty, while most (34.6%) answered lack of exercise and almost 30% stated smoking. London residents were also asked to identify the region with the greatest percentage of low income families. Less than 8% identified London (15.2% prevalence of low income), 20.6% stated Southwestern Ontario (11.7% prevalence) and the majority (62.6%) responded that the province of Ontario as a whole (13.1% prevalence) has the highest percentage of people living in low income (Sarkella, 1996).

The respondents were also asked their opinion on what the percentage of children aged 0 to 14 live in families headed by a lone parent in London (17.6%: Sarkella 1996). London respondents over-estimated this rate: the mean response was 39.3% (mode = 40%) and about 12% of the respondents provided close estimates of 15-20% as the correct figure.

However, the respondents felt that residents of Southwestern Ontario were more educated than Ontario residents: almost two thirds of the respondents believed that Southwestern Ontario had the highest percentage of people with a university degree, while the actual rates are 9.4% for Southwestern Ontario and 13.0% for Ontario (Sarkella, 1996).

Two lifestyle questions yielded similarly poor knowledge results. Despite the fact that about 90% of Southwestern Ontario residents consume too much fat (Vingilis, 1996b), less than 5% of respondents correctly identified the 90% figure, and over 80% of the respondents offered lower estimates for the percentage of Southwestern Ontario

residents who consume too much fat. The mean was 52.4% (mode = 50%).

The respondents were also queried on smoking rates as about 28% of Southwestern Ontario residents when compared to 25% of Ontario residents are daily smokers (Vingilis, 1996b). However, only about one quarter answered correctly that Southwestern Ontario had higher smoking rates; 27.8% stated lower and 41.5% believed the rates were the same. Similarly, when asked about the relative rates of alcohol-related offences, only 29.4% answered correctly that they were higher in Southwestern Ontario (Vingilis, 1996b), while 48.8% believed the rates were the same and 18% believed they were lower

Table II: Number and percentage of London respondents who correctly answered health status knowledge questions.

Questions	Correctly Answered	
	%	N ¹
Q2: Health Status Determinants	20.1	43
Q3: Low Income Families	7.9	17
Q5: Population with a university degree	32.5	69
Q7: Smoking rate	24.5	52
Q8: Alcohol-related offences rate	29.4	62
Q9: Student drug use rate	13.3	28
Q11: Student delinquency rate	21.0	44
Q12: Major cause of death	34.8	73
Q13A: Mortality rates	50.4	70
Q14A: Hospitalization rates	46.2	43

The questions that focussed on students asked for the region with the highest student drug use and delinquency rate among Metro Toronto, Northern, Southwestern, Southcentral and Eastern Ontario. The most common response was Metro Toronto at 61.0% for drug use and 47.6% for delinquency; yet this region has the lowest reported rates for drug use and delinquency. Only 12.4% and 21.0% of respondents in London answered that Southwestern Ontario students reported the highest rates of drug use and delinquency, respectively, while 10.5% and 16.2% reported Northern Ontario. Both Southwestern and Northern Ontario students are "neck and neck" in reporting the highest frequency of drug use and delinquency.

Respondents were also asked to estimate the percentage of students in their region who smoke, drink, use cannabis and LSD, and have a drinking problem. The percentage of students in grades 7 to 13 who have in the past 12 months (a) smoked tobacco was 28.4%, (b) used cannabis was 24.9%, (c) used LSD was 11.6%, (d) consumed alcohol was 67.5%, and (e) had a drinking problem was 7.2% (Vingilis, 1996b). The percentage estimates were high in relation to the actual figures. The mean percentage of students who smoked tobacco were estimated to be 52.4% (mode = 50.0%). The mean percentage of student cannabis users was given as 39.2% (mode = 50.0%). Similarly, the mean estimate of LSD use among Southwestern Ontario students was 21.3% (mode = 10.0%). Interestingly, alcohol consumption was underestimated while drinking problems were overestimated. The mean percentage estimate of alcohol consumption was 57.4% (mode = 50.0%). The responses that estimated those students with a drinking problem had a mean of 34.6% and a mode of 10.0%.

The morbidity and mortality questions queried on knowledge of higher rates of hospitalized health problems and deaths. When the respondents were asked to name the major cause of death in Southwestern Ontario, 34.8% answered correctly that it was coronary heart disease (Alder and Lueske, 1996a). Over 23% named cancer as the major cause of death and over 13% listed injuries. Over one quarter of the respondents named various life-style/risk-taking behaviours as major cause of death; namely injury, drugs/alcohol/cigarettes, poverty, violence, poor nutrition and drinking and driving. In addition, the respondents were told that Southwestern Ontario has higher rates of death for some diseases than Ontario, and were asked if they could name any: 66.2% said yes, and of those only 29.5% correctly answered heart disease and 2.2% diabetes (Alder and Lueske, 1996a). Similarly, 43.8% of the respondents said they could name health conditions for which Southwestern Ontario residents have at least 10% higher hospitalization rates. Of those 24.2% correctly stated heart disease, 7.7% listed lung/respiratory diseases, and 1.1% stated injuries. The actual higher hospitalization rates were for ischemic heart disease, stroke, acute respiratory infections, chronic lung disease, motor vehicle injuries, abdominal hernia and gall bladder disorders (Alder and Lueske, 1996b).

The data were also analyzed to determine if there were any differences in knowledge related to the demographic variables of age, sex and educational status. Previous

research has demonstrated that females, younger and more educated individuals tend to be more knowledgeable about health issues. The data were subjected to X^2 analyses. Since multiple comparisons were made, the significance level was adjusted, using the Bonferroni method. The analyses revealed no significant differences in response rates for the ten knowledge questions by age, sex or educational status.

Table III: Recommendations to improve London's Community Health

Response	%	N ²
Lifestyle changes	57.1	120
Tobacco	26.7	56
Education	24.8	52
Exercise	19.5	41
Nutrition	16.2	34
Child issues	14.3	30
Addictions/drug issues	13.8	29
Controls	12.4	26
Poverty	6.1	13
Environment	4.8	10
Community initiatives	3.8	8
Psychology initiatives	3.3	7
More treatment/health care	2.9	6
Research	2.3	5
Sexual education	1.4	3
Less health care	1.0	2
General education	0.05	1

Finally, the respondents were asked what would be the first thing they would do if they were given the task of improving the health of their community. A variety of responses were offered, although 11.4% stated that they didn't know. Table III presents the list of initiatives that the London respondents identified to improve the health of their community. The overwhelming majority of responses focussed on personal change initiatives as opposed to community-based initiatives. A greater percentage recommended the use of educational methods (19.5%) compared to control measures (12.4%) such as banning smoking, cigarettes, or raising the drinking age. Over 14% recommended initiatives for youth and almost 5% suggested anti-pollution/environmental activities. Only 6% identified poverty as the issue to be tackled and half a percent mentioned improving the educational status of the community. Improved access to treatment services was

suggested by less than 3% of respondents and 2.3% listed more research into health-related issues.

Discussion

It is important to point out that the telephone survey suffered, to some extent, from the traditional, methodological problem afflicting survey design of response rates and representative sampling (Bradburn and Sudman, 1981). The telephone survey response rate was reasonably high at 63%. However, the sample was biased towards females, younger and more educated individuals. Thus, these data cannot be generalized to all of London. However, normally females, young and educated individuals are more knowledgeable and are more likely to read on health issues. Therefore, these results may overrepresent the knowledge levels of the community, although it is important to point out that analyses of correct responses to the knowledge questions by age, sex and educational attainment, yielded no significant effects. It is also important to note that the sample size was small and similarly may affect generalizability.

Bearing these caveats in mind, the results of this survey suggest that the community of London has very limited knowledge and awareness of local determinants of health and health problems. The majority of Londoners surveyed felt that, as a community, they were richer, more educated than Ontario residents, smoked and had the same rate of alcohol-related offences as Ontario residents and that the highest levels of student drug use and delinquency was not in their own backyard but in Toronto. About one third of the respondents did realize that coronary heart disease was the major killer of residents of Southwestern Ontario, and the next two most popular responses were cancer and injuries, which indeed does reflect some awareness of the relative rates of death of various diseases and health problems (Adler, Vingilis and Mai, 1996). Interestingly, one quarter of the respondents identified lifestyle/behavioural causes of death, such as poor nutrition, drinking-driving, violence, alcohol, drugs and tobacco use, suggesting an awareness of the importance of personal lifestyle and behaviour to health and well-being, and confirming the findings of the Premier's Council on Health, Well-being and Social Justice (1994) that most Ontarians identify personal lifestyle change as the best ways to improve personal health. In addition, the report (Premier's Council on Health, Well-being and Social Justice, 1994) found in their focus groups that lifestyle choices were viewed to be a more important determinant of health than income. This finding was also substantiated in

this survey. Only 20 percent identified poverty to be the most important determinant of health; rather exercise and smoking were more commonly chosen. In addition less than 6% identified poverty as the major issue they would tackle to improve the community's health and virtually none mentioned the improvement of educational status. Despite the strong evidence that income and educational status are the major determinants of health and are more powerful determinants than lifestyles (Warren, 1994), the vast majority of Londoners did not identify these issues in need of addressing in order to improve the health status of the community.

Londoners were also limited in their knowledge of what diseases/health problems caused significantly higher rates of death and hospitalization in their community. Only one third were able to identify any disease for which Southwestern Ontario had significantly higher mortality rates, and similarly, only about one fifth could identify diseases/health problems for which Southwestern Ontario had significantly higher rates when compared to Ontario rates. This lack of awareness of the greater burden of illness that exists in Southwestern Ontario may explain the lack of organized concern and mobilization over disease prevention, health promotion and health care reform. Clearly, the Ontario Ministry of Health's statement "to eliminate wide variations in health services across the province" (Egan, 1996) has little meaning to a community which does not see their burden of illness and therefore, health needs as greater.

Finally, it is noteworthy that the vast majority of Londoners surveyed identified personal lifestyle issues to be addressed as methods to improve community health status rather than community-based methods, again supporting the findings of the Premier's Council on Health, Well-being and Social Justice (1994) and the recent federal National Forum on Health (1997). This way of thinking assumes that health is totally an individual responsibility. The persistent focus is on changing behaviour of individuals with little consideration of the larger environment that shapes and affects behaviour. The importance of the inter-relationship of the individual and the environment (Vingilis and Mann, 1986) seems to be ignored by the public. Social forces which include the political and economic climate, cultural patterns, values and norms were not mentioned as issues in need of addressing. Maybe they are viewed as impossible to change or maybe they are viewed as irrelevant. However, this strong public focus on the market-justice concept

which emphasizes individual responsibility and the pursuit of self-interest, and which is also well-suited to mass media portrayals, is a concept solidly based on traditional American ideals (Wallack, 1990b). In the current move toward encouraging the development of "healthy communities", the challenge will be to provide the public with an understanding of what affects health. This will be no easy task as Wallack (1990b) suggests that mass media reinforces the existing individual/behaviour focus and "potentially trivializes health issues by focussing on personal habits and the sole responsibility of the individual...The need for a quick fix, for simple cause-and-effect explanations, and for clear assignment of responsibility tend to promote clarity and conciseness of message but does little to enhance understanding or uncover the true nature of public health problems". (p.45)

In summary, the results from this survey are consistent with other studies which suggest that the public has limited knowledge on the determinants of health and on the health status of their own community. This large information disparity between perceived community health status and the region's higher burden of illness and risk factors may partly explain the seeming lack of interest in mobilizing in the London region. Clearly, more research is required to identify the predictors that determine community mobilization and to test health education programs in their ability to inform and mobilize communities.

Acknowledgements

This study was partially supported by a grant awarded by the Richard and Jean Ivey Fund. The authors would like to thank Scott Stevens for his assistance in the development of the questionnaire.

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Health Psychology in the Primary Health Care System in Cuba

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Introduction

Health Psychology in Cuba was born in the context of deep social changes. It emerged as a wide application model aimed at solving very different problems in the health-disease process. This model was based on the needs of the public health system in our country where the priorities are health promotion, health maintenance and rehabilitation. We aim to provide, using a multidimensional approach, an **integrated** approach to the care of healthy people, people at risk and sick people.

The identification of health problems in a particular community, details of family functioning, life-style, attitudes to illness and emotional stress situations are all important in the design and implementation of health programs. The health-disease process is a continuum where the interaction of social and biological factors are found at all stages. Psychology must play a role at every moment of this continuum: in the promotion of health, in the prevention of illness, in the health care of sick people and in their rehabilitation. Psychological interventions can be with a single person, with the family group or with a whole community; it depends on the main objective of the intervention and of the institution where it takes place.

Since 1968, the National Group of Health Psychology has been organized in the Ministry of Public Health. Health Psychology has taken its place at the top political level of our Ministry and in the institutional net of health care which covers all levels and types of institutions. Now,

nearly 1600 Cuban psychologists are involved in the application of this specialty in the National Health System. It has been periodically improved and its wide spectrum of intervention has been reaffirmed until at least the year 2000 (Minsap, 1987).

Besides nearly 30 years of experience, we have developed a post-graduate specialization in Health Psychology that permits the training and upgrading of psychologists throughout the country. We aim to promote the designation of "Health Psychology Specialist" in future years.

The majority of the Cuban psychologists work in the primary care system, integrated in health teams, specifically in the working program of the general practitioner in the community. Their aim is "to contribute with promotion of health to the wellbeing of the people, considering the psycho and the somatic aspects as one.....to help people develop their potentialities, their highest possibilities".

Psychology and Family Medicine

In the Program for Community Health Care, which is the basis of the Primary Health Care System in Cuba, the psychologist is one of the principal specialists who has a role of teacher and consultant. The aim of this Program is "to improve health in the population with integrated actions on the individual, the community and the environment in close relation with people". This would be impossible to achieve if it did not take into consideration the psychological factors that influence decisions about health behaviour or that are the cause or the consequence of

different illnesses, especially chronic illnesses, which have increased in prevalence and incidence in the past years.

At this level of health care, the fundamental activities are health promotion and disease prevention, with an emphasis on education. The first task is the psychosocial diagnosis of the community which permits the identification of its conditions and life styles, and their relationship with the main health problems. This provides the basis for the development of an action plan with the full participation of the community. The community participates in the identification and solving of their own health problems. We have developed a strategy based on the creation of a sense of identity among the formal and informal leaders, and the development of the best communication between the health team and the community. In this way the interventions in health education are focused on the problems found and can be aimed at specific at-risk groups.

In developing the psychosocial profile of a community we take into consideration not only the sociodemographic characteristics but also the popular feelings, beliefs and traditions. The school and labour attendance, the use of the free time in physical and other activities, sexual activities, and the use of health services, are analysed as indicators of life style and their relationship to social conditions and quality of life.

In primary care, psychologists diagnose and treat families and other community groups. They also conduct psychological evaluation and orientation, psychotherapeutic treatment of children, adolescents, adults, old people, and those with different stressful situations or conflicts, developmental problems, difficulties in relationship with changes in the life cycle, or stress coping problems. Sociopsychological research is also conducted and special treatments for behaviour problems or difficulties in school or work are implemented. All this is done taking into consideration the psychosocial diagnosis of the community to obtain some answers to the principal problems identified.

Specific Activities of the Psychologist in Primary Health Care

We can divide the activities that are carried out into four major groups:

1. Teaching activities

Psychologists are integrated into the basic work groups with the aim of transmitting their knowledge and

developing the abilities of residents, community general practitioners and nurses. This allows them to detect developmental, emotional and sexual problems, difficulties in family functioning, and social and community problems that interfere with the normal roles played by individuals or groups. We also consider adaptive psychological responses of people to illness and stress and the best orientation and management of some psychosocial situations that do not need the direct intervention of a psychologist.

2. Psychological activities

These activities are focused on the early detection and treatment of psychological problems and contribute to the creation and promotion of psychological wellbeing. We basically develop them in teaching consultations with the general practitioner and/or in homes or community institutions, such as schools, work centres, clubs for the elderly, etc. and also while developing consultations with the primary care units. We use different psychodiagnostic techniques. If it is necessary, psychotherapeutic treatments are carried out in different places such as community or sports centres, using community resources.

These psychological interventions are aimed at the identification, orientation and treatment of all sorts of psychological problems: development of children, behavioural problems and learning difficulties in children and adolescents, emotional problems in adolescents in relation to their family, school or social difficulties, emotional problems in chronic illness, etc. We participate actively in the Reproductive Health Program, in the treatment of psychological disturbances in pregnant women, whether adolescents or not, in couples with specific problems, and in women with gynecological disturbances.

Special attention is given to family problems caused by divorce, sickness, death or separation of parents or other family members, that could lead to a family dysfunction and require family therapy. In the treatment of difficulties in coping with stress we use different techniques such as stress inoculation, relaxation with or without biofeedback equipment, and the like. The psychologist also participates in the rehabilitation of patients with handicaps caused by different illnesses.

3. Health education activities

These interventions are part of the Health Promotion program of the Ministry of Public Health. We organize group programs concerned with poor health habits and

aimed at promoting healthy life styles in seniors organizations, among adolescents, parents and pregnant women as well as among other groups. We also work with persons or groups who engage in different risk behaviours, like smoking, bad nutritional habits, or with those that are in stressful situations.

Group work with pregnant women dealing with reproduction and the early stimulation of psychological development in children is carried out in almost all of our services. In addition, psychological services and counselling about sexual behaviour is provided.

4. Research activities

The main topics that psychologists deal with in their research are:

- a) knowledge of people about body care and incorrect health habits; motivations, feelings and beliefs about health and diseases, and the information that people have about the most frequent illnesses.
- b) perceived mobility by people.
- c) life style factors, personality and stress in relation to the etiology and evolution of chronic diseases.
- d) psychosocial factors related to different problems or disturbances in different population groups that could contribute to maladaptation or problems affecting the well being or the social role at different life stages.
- e) people's degree of satisfaction with the health services they receive in the primary care units.

Conclusions

The increased application of psychology with a varied and wide participation of psychologists and psychometric technicians in Health Teams in primary care has proved to complement medical attention, supporting and making real the integration of interventions, such as promoting health, preventing disease, and those of diagnosis, treatment and rehabilitation with mechanisms that contribute to improving the health of our people.

These years of continuous practice have brought an effective sympathy and comprehension on the part of the members of the health teams and in the different levels of management of our health system, concerning the need, relevance and usefulness of psychological interventions in relation to the health-disease process.

Health psychology has achieved in our country much

development that permits the creation and implementation of working techniques to solve our own health problems, and also, for the most general strategies, to achieve overall benefits in the primary health care system.

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Editors Note:

See also

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Complementary and Conventional Medicines Working Together

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Abstract: *In January 1997, Riverdale Immigrant Women's Centre (RIWC) and Toronto East General Hospital (TEGH) co-sponsored a conference titled "Complementary and Conventional Medicines Working Together". This work was undertaken in efforts to promote cultural diversities in health care service delivery and planning. In this report I provide an overview of some of the themes addressed by keynote speakers at the Toronto conference with the aim to describe ways of integrating complementary and conventional medicines in the interest of good health care. Opportunities to facilitate such integration exist at many levels, from health care policy and planning to multi-disciplinary research, training, and education as well as clinical encounters in allopathic and/or complementary care service settings. Health psychologists are in a unique position to participate in this process; areas of work in the field of complementary medicine are identified.*

Résumé: *En janvier 1997, le Riverdale Immigrant Women's Centre (Centre des femmes immigrantes de Riverdale) et le Toronto East General Hospital (Hôpital-Général de Toronto-Est) organisaient à Toronto un colloque sur la complémentarité des médecines douces et de la médecine officielle, dans le but de promouvoir la diversité culturelle dans la planification et la prestation des services de santé. Nous donnons ici un aperçu des sujets abordés par les principaux conférenciers en vue de dégager divers moyens d'intégrer les deux médecines dans un but d'amélioration des soins de santé. Tes possibilités d'intégration se présentent à la recherche multidisciplinaire, à la formation et à l'information, en passant pas les rencontres cliniques dans des établissements recourant à l'allopathic ou aux médecines douces. Les psychologues de la santé sont dans une position privilégiée pour participer à cette démarche; des sujets de travaux dans le domaine des médecines douces sont définis.*

Background

Canada is a multicultural nation; its diverse groups and communities have long histories and traditions of holistic health and they continue to practise some elements of their health heritages today. Holistic health care, supporting integrated relationships between body, mind, and spirit is a defining characteristic of complementary medicine (e.g., Chopra, 1995). The term "complementary medicine" is here used to refer to a broad range of health practices and therapies that people utilize in addition to the care they seek and receive from conventional allopathic providers; those whose work is sanctioned by Western education and health institutions (cf. Eisenberg et al., 1993). Examples of complementary therapies include ayurveda, chinese medicine, acupuncture, herbalism, homeopathy, naturopathy, massage therapies, and mind-body therapies such as meditation and therapeutic touch

(e.g., Chopra, 1995; Harden & Harden, 1997). Some of these therapies are based on long-standing medical traditions of the Orient and India; others have evolved from more recent psychological or metaphysical 'self-healing' approaches. Integration of these therapies with conventional care practises is beginning to taking place in areas of health care policy, service utilization and treatment outcome research, as well as service delivery and program planning.

Complementary therapies have potential health benefits (Ministry of Health Canada, 1993), and are reportedly being used by up to 1/3 of medical and general population samples in Canada (Berger, 1993; Verhoef et al., 1990), the United States (Eisenberg et al., 1993), and European countries (Lewith & Aldridge, 1991). Eisenberg et al. (1993) estimated that, in 1990, out-of-pocket expenditures for complementary therapies in the United States amounted

to 10.3 billion dollars. Users of complementary therapies most commonly seek help for chronic health problems (e.g., back problems, allergies, arthritis, headaches, anxiety, depression) and rely on the complementary approach as an adjunct to orthodox medical care (Eisenberg et al., 1993; Furnham & Kirkcaldy, 1996). Cultural background and sociodemographic characteristics such as age or gender do not consistently differentiate complementary service users from nonusers, although users reportedly have higher incomes and more education than those who rely exclusively on orthodox providers (Berger, 1993; Dunfield, 1996; Eisenberg et al., 1993; Furnham & Kirkcaldy, 1996; Sharma, 1992). There are suggestions in the literature that cultural background may play a role in complementary service use, perhaps because these services are perceived to be more culturally appropriate (cf. Kavanagh & Kennedy, 1992; Kleinman, Eisenberg, & Good, 1978; Yesalis et al., 1980).

In a recent study of health beliefs in complementary and orthodox medicine clients, Furnham and Kirkcaldy (1996) reported that users of complementary therapies were more critical and skeptical of the effectiveness of orthodox medicine, placed more positive value on complementary treatment, felt their health could be improved, were more loyal to their practitioner, and displayed more ecologically aware lifestyles. This study of a German population sample provided cross-cultural replication of earlier findings in British samples (Furnham & Bhagrath, 1993; Furnham & Forey, 1994; Vincent & Furnham, 1996), and is consistent with studies of reported reasons for complementary service use in other western cultures (Donnelly et al., 1985; Dunfield, 1996; Fulder, 1988; Wiesner, 1989). The congruence across cultures in patterns of complementary service utilization and reasons for use suggests a need for closer examination of nonconventional health practices and models as well as possibilities for their integration in conventional clinical medicine and research (cf. Landrine & Klonoff, 1992).

On Working Together

Addressing holistic health care within a multicultural society, Dr. Farah Shroff (Social Scientist at the Ontario Midwifery Education Program) argued that the Canada Health Act and the Multiculturalism Act give us the scope to examine possibilities to introduce holistic complementary care practices into existing service structures. Perhaps due to the existence of social and consumer lobbying movements aligned to the idea of

holistic health, some complementary care services (e.g., acupuncture, midwifery, chiropractic) are now regulated or becoming regulated in various provinces across Canada (see Harden & Harden, 1997). Based on international health care policy perspectives and research, Shroff argued persuasively that holistic paradigmatic care could be a cost-effective solution to some of Canada's most pressing health concerns.

Ayurveda is recognized by the World Health Organization as a comprehensive system of natural medicine (Sharma & Alexander, 1996). In India, ayurveda (or life knowledge) is practised by 70% of the population and hundreds of millions of people worldwide (including Canada) utilize this system of medicine as their primary (here, Alternative) or adjunctive (i.e., Complementary) health care. Ms. Selina Meghji, practitioner of Ayurvedic Medicine at the Toronto Healing Arts Centre, described ayurveda as a holistic health practise model that is based on goals to maintain or restore balance in an individual's energy system. Patterns of imbalance are corrected through preventive or therapeutic interventions related to diet, cooking, yoga, breathwork, bodywork, meditation, and/or herbal preparations. Within the context of the Toronto conference, Meghji's discussion suggested the importance of attending to culturally-based illness models in conventional care service settings (Kleinman et al., 1978; Kavanagh & Kennedy, 1992; Yesalis et al., 1980). Also suggested is a need to broaden the scope of health services, process, and outcome research to include diagnostic systems, therapies, and health practices not currently within the domain of conventional medicine (Sharma & Alexander, 1996).

Presentations on homeopathy and naturopathy at the Toronto conference suggested similar directions for future work. Dr. Fernando Ania (President of the Homeopathic College of Canada) described homeopathy as a system of medicine that originated in the 18th century and is thought to facilitate the body's own process of healing through the use of highly diluted natural botanical and mineral substances. By 1912, there were 195 homeopathic hospitals across North America, including one in Toronto. Homeopathy was a self-regulating profession in Ontario from 1859 to 1970 (Ania, 1995). In comparison to homeopathy, naturopathy is currently a self-regulating profession in Ontario and other provinces (Harden & Harden, 1972). Many naturopaths work with conventional medical doctors to complement their treatment; they rely on

natural methods and substances to stimulate the body's inherent self-healing ability, providing treatment in the form of acupuncture, botanical medicine, clinical nutrition, and lifestyle counselling, among others. At the Toronto conference, Dr. Anthony Godfrey (West End Holistic Health Care Centre in Toronto) addressed the clinical effectiveness of naturopathic medical care. He described differences between the allopathic and holistic medical approach, characterizing the latter as one which focuses on the person as a whole (including body, emotions, mind, and spirit), on treating "causes" instead of "symptoms", and on ways to guide those seeking care to their natural state of harmony and wellness (Chopra, 1995).

Opportunities to integrate holistic health practises and models with conventional psychiatric approaches were addressed by Dr. Jacques Bradwejn (1996), Head of the Psychobiology and Clinical Trials Research Unit at the Clarke Institute of Psychiatry. Bradwejn was the first to report that a natural brain protein, cholecystokinin (CCK) could induce panic attacks in sufferers of panic disorders. Speaking on the topic **Psychiatry and Alternative Medicine**, he described his current research on herbal compounds which act specifically on the CCK brain system and have been used for thousands of years in India and China to treat anxiety or tension. He emphasized the need for conventional providers to become familiar with cultural and metaphysical systems of alternative medicine, and suggested routes for integration in clinical practice (e.g., history taking, treatment decisions, respective responsibilities) and research (e.g., multidisciplinary and outcome research).

Ms. Nancy Levy, nurse practitioner and health resource consultant in Toronto, provided an insightful account of **mind-body approaches** that can be applied with benefit in the treatment of acute and chronic disorders and as a preventive. Those with background in psychophysiology and health psychology will be familiar with extensive literatures documenting relationships between emotional well-being, health complaints, and biological indicators of health and/or disease (e.g., Pennebaker, 1982; Skelton & Croyle, 1991). Levy described some of these literatures and brought them alive through fictional case discussions, illustrations of complementary techniques (e.g., visualization, guided imagery), and recommendations to make these therapies more fully accessible perhaps through training and education of conventional care providers.

Dr. Wah Jun Tze (CM, FRCPC), endocrinologist and

president of the Tzu Chi Institute for Complementary and Alternative Medicine at the Vancouver Hospital, described a service delivery model which provides for **integration of complementary/alternative approaches within a conventional care setting**. The Tzu Chi Institute has adopted the premise that efficacy and outcome research on promising nonconventional approaches is required in order to establish a valid scientific basis for integrating safe and effective treatments into mainstream medicine. Programs and areas of focus in the Institute include pain management, cancer, lifestyle changes, and acupuncture (applications of acupuncture were illustrated at the Toronto conference by Dr. Zhi Gang Sha). Tze gave a compelling account of some of the driving forces that lead to integration; they include: limitations in conventional medicine (e.g., chronic diseases); spiralling costs of high-tech health care; immigrant communities' demand for culturally-congruent care; and widening appeal of holistic and healing approaches.

Further to the driving forces that make integration possible, Ms. Shirley Dalglish RN (Coordinator of Palliative Care at TEGH) provided a glimpse of the process that led TEGH to open a **Therapeutic Touch (TT) Clinic** and admit TT into its policy and procedures manual in 1993. With theoretical bases in quantum physics and ancient eastern healing practices, TT involves working with a person's energy flow (through use of hands moving a few inches away from the body) to alleviate imbalances and create relaxation and healing. Community demand for the service (i.e., provided upon patient request), networking within and between professional groups, a supportive administration, and availability of trained practitioners to teach and promote the activity were among the factors leading to the integration of TT within the acute care hospital. Based on clinical experience and research suggesting efficacy of TT in accelerating healing and reducing pain and anxiety (e.g., Quinn, 1984; Krieger, 1979), Dalglish proposed that this complementary therapy may have valuable applications in the treatment of a broad range of acute and chronic conditions.

Future Directions

Medical pluralism in Canada is likely to become an item for discussion at all levels of health care policy, planning, and practice as we move into the 21st century (cf. Young, Ingram, Liu, & Macintosh, 1995; Stone & Matthews, 1996). Canadian health psychologists who offer health-related clinical (and/or "complementary") services are among the many groups of professionally trained providers

with potential interests in playing a key role in these discussions. Health psychology's basis in empirical research enables this discipline to work towards integration of services at levels of health care policy, service delivery and program planning, as well as professional and clinical practice (cf. Marks et al., 1996).

There is a need for interdisciplinary integration in health research (cf. Landrine & Klonoff, 1992). To this end, several areas of enquiry could be valuably pursued. First, biopsychosocial health research would benefit from evaluation of models and constructs derived from complementary approaches. For example, the term "energy", reflecting a holistic (as opposed to dualistic) model of wo/man, is one of the core constructs in complementary approaches. The extent to which conventional research paradigms and methods may be suitably applied to the study of complementary health practices and models is in need of critical evaluation. Second, patterns of help-seeking (i.e., self-selection to patient/"participant" status) and correlates of help-seeking in complementary and conventional care service settings require further investigation. Barriers to access are also in need of research attention. These directions in research are necessary to improve our current understanding of health care needs that are being addressed and/or met in different service settings.

Third, controlled outcome trials (comparing conventional, promising complementary, and placebo treatment controls) are required to establish cost effectiveness, treatment efficacy, and satisfaction with services received.

Fourth, studies comparing treatment efficacy and satisfaction in unidisciplinary vs. multidisciplinary service settings could be a valuable source of information about suitable models of service delivery under medical pluralism.

Fifth, cross-cultural research is necessary to obtain comparative data on health beliefs and practices under different models of health care policy and service delivery.

Sixth, increased attention to community-based health research is warranted. Such research could provide valuable information about self-care and lifestyle factors that limit the need for reliance on formal medical care.

The Toronto conference was successful in bringing

together health practitioners from complementary and conventional disciplines, researchers, community health advocates, consumers, and other interested parties. A broad range of topics and health care issues were under discussion. Future events could benefit from a focus on the following areas: women's health, immigrant communities' health, health beliefs and practices across cultures, and health problems most likely to benefit from complementary treatment modalities.

Acknowledgements: This work was facilitated by staff and volunteers in community, complementary, and conventional care service settings. I am particularly grateful to Nuzhath Leedham, Betty Wu-Lawrence, Colin Goodfellow, Bob Watson, Bill Lancee, Michael Murray, and all keynote conference speakers for their contributions.

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- Contact Dr. R. Schober, R.I.W.C., 1326 Gerrard Street, East, Toronto, ON.

OPPORTUNITIES FOR HEALTH PSYCHOLOGISTS OFFERED BY THE NATIONAL CANCER INSTITUTE OF CANADA

The National Cancer Institute of Canada (NCIC), which receives its funds from the Canadian Cancer Society and the Terry Fox Foundation, supports behavioural research related to cancer control. The field of behavioural cancer control is defined quite broadly. It encompasses work related to cancer prevention, early detection/screening, the diagnostic process, and psychosocial aspects of treatment, rehabilitation, and palliative care.

The following NCIC programs are likely to be of interest to health psychologists. Contact NCIC for a more complete listing of awards and programs.

NCIC Project Grants

Operating grants are available to behavioural researchers doing work related to cancer control. The ceiling for salaries and supplies combined is \$300,000 per year for behavioural, psychosocial, health promotion, and health services research.

Feasibility grants are available to support preliminary studies that may be required in order to lay the foundation for a full scale proposal. For instance, an investigator might apply for feasibility funds to test the psychometric qualities of instruments. Feasibility awards have a ceiling of \$35,000, and are non-renewable.

Project grant applications are due October 15.

NCIC Personnel Support

Career development awards are available to Ph.D.'s with at least 3 years of post doctoral research training, and no more than 7 years of independent research experience. These awards provide salary to outstanding young scientists. Investigators must hold an NCIC funded operating grant in order to establish and maintain their eligibility.

Terry Fox research fellowships provide post doctoral research training. The initial award is normally for 2 years, with renewal possible though not automatic. The minimum value of the fellowship (1996-97) is \$29,200. It is possible for candidates to receive training outside Canada with support from this fellowship.

Personnel award applications are due early February. Check with NCIC for the exact date in 1998.

Sociobehavioural Cancer Research Network

In 1993, NCIC established the Centre for Behavioural Research and Program Evaluation (CBRPE). CBRPE is concerned with (a) assisting in the development and evaluation of programs for the Canadian Cancer Society, (b) operating the Sociobehavioural Cancer Research Network (SCRN), and (c) increasing the quantity and quality of sociobehavioural research related to cancer in Canada.

The SCRN was established largely to provide access to study populations and to knit together appropriate expertise across the country. Five study populations provide the focus for network activities: schools, communities, people being treated for cancer, cancer survivors, and family physicians. A major barrier to

conducting behavioural research related to cancer is limited access to populations, and the network was designed specifically to ensure that important behavioural studies would not be impeded by poor access.

The SCRN has available a limited amount of pilot study money. Applications for pilot study funds are evaluated based on the relevance of the work to cancer control, the likelihood that the project will lead to a competitive operating grant, and the extent to which investigators from more than one province are involved in the project.

The SCRN is organized around nine Research Satellite Centres located in eight provinces. All provinces except New Brunswick and Newfoundland are represented. Membership in the network is fluid, so that any behavioural researcher working in the area of cancer control may contact the network to propose ideas or identify potential collaborators.

Contacting NCIC

For further information about project grants and personnel awards, contact the National Cancer Institute of Canada. The Centre for Behavioural Research and Program Evaluation at NCIC can provide more detailed information about the SCRN. Note that NCIC's "Support for Research and Training" is issued annually, normally in August. Applicants should be aware of the guidelines in the most recent version at the time they apply.

National Cancer Institute of Canada
10 Alcorn Avenue, Suite 200
Toronto, Ontario, M4V 3B1
Telephone: (416) 961-7223
Fax: (416) 961-4189
email: NCIC@cancer.ca

Submitted by Roy Cameron, Ph.D.
Director, Centre for Behavioural Research and Program
Evaluation
National Cancer Institute of Canada
and
Professor
Department of Health Studies and Gerontology
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**HEALTH PSYCHOLOGY SECTION PROGRAM
CANADIAN PSYCHOLOGICAL ASSOCIATION
ANNUAL CONVENTION
Toronto, June 12-14, 1997**

Thursday, June 12

8:30 - 10:30

Symposium I: Psychosocial factors and treatment in irritable bowel syndrome

Convenors: Brenda B. Toner, et al, University of Toronto

10:30 - 11:30

Conversation Hour I: The health care system: experiences of three different consumer perspectives.

Convenors: P. Reznicek, G. Johnston, T. Ricci, York University

1:00 - 2:00

Conversation Hour II: Training issues in health psychology

Convenor: G.S. Butler (Halifax)

2:00 - 4:00

Symposium II: Psychosocial intervention for medical patients

Convenor: P.L. Dobkin (McGill)

Friday, June 13

8:00 - 10:00

Symposium III: Health promotion and health psychology

Convenor: M. Murray (Memorial)

2:00 - 3:00

Section Annual General Meeting

3:00 - 4:00

Section Reception

Saturday, June 14

8:00 - 10:00

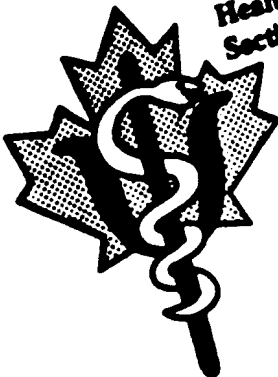
Symposium IV: Hospital psychology: thriving, surviving or dying

Convenor: M. Schwartz (Halifax)

9:00 - 11:00

POSTERS

**Health Psychology Section of the Canadian Psychological Association
Section de psychologie de la santé de la Société canadienne de psychologie**



January 6, 1997

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The Hon. Paul Martin, P.C., M.P.
Minister of Finance
Government of Canada
Room 515-S, Centre Block
Ottawa, ON
K1A 0A6

Dear Mr. Martin:

I am writing to you on behalf of health psychologists to express our grave concern about the steady deterioration in government support for health research in this country.

Historically, psychologists in Canada have been recognized internationally for the contribution they have made to enhancing understanding of the psychological processes involved in the development and maintenance of health and illness. Over the past few decades there has been a steady accumulation of evidence that an understanding of these processes is important for developing measures to improve the health of Canadians.

If we are to further advance our understanding of these processes it is essential that psychologists and other health researchers have access to research funding. It is now well established that there is a wealth of research talent available in this country such that an increase in funding would not only rapidly contribute to research productivity but also reduce the level of unemployment.

For these reasons we would ask that in preparing your budget for the coming year you allocate increased funding for health research and more specifically for research into the psychosocial and behavioural aspects of health and illness.

Yours sincerely,

Michael Murray, PhD, CPsych
Chair, CPA Health Psychology Section



APR 18 1997

Dr. Michel Murray
Chair
Health Psychology Section of the
Canadian Psychological Association
Division of Community Medicine
Memorial University of Medicine
St. John's, Newfoundland
A1B 3V6

Dear Dr. Murray:

Thank you for your representation regarding funding for medical research. I regret the delay in replying.

I have carefully noted your comments, and recognize the importance of medical research. Indeed, the federal government has been supporting research at Canadian post-secondary educational institutions and research hospitals for most of the past half-century. This is done primarily through the Granting Councils (the Medical Research Council, the Natural Sciences and Engineering Research Council and the Social Sciences and Humanities Research Council) and the Networks of Excellence (NCE). The federal government remains the single largest external contributor to university research, providing over \$750 million annually in direct grants.

As you will be aware, last year's budget announced the creation of a Health Services Research Fund to bring together partners from provincial governments, health institutions and the private sector who are interested in building a shared fund to make better use of the human and financial resources in the health care system. The federal government indicated it would provide \$65 million over five years to help get research underway and to help endow the funding for ongoing activities after the initial five-year period. The MRC was charged with administering the fund on behalf of the partners.

Canada

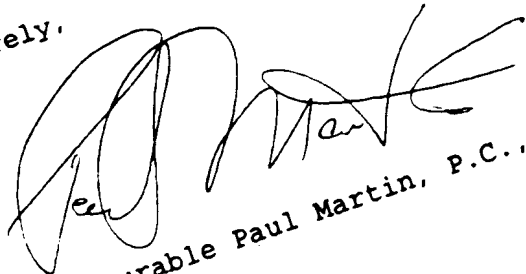
This government is keenly aware that the future economic prosperity of Canadians, as well as their health and the environmental quality of life, will depend increasingly on innovation -- on the generation of new knowledge and the ability to put it into productive use. That is why the February 18, 1997 Budget announced a number of important initiatives which will provide further support for research.

Foremost among these initiatives is the establishment of the Canada Foundation for Innovation. The government is contributing \$800 million to create this Foundation, which will support research facilities in our universities, colleges and teaching hospitals. The focus of the Foundation will be to support research in infrastructure in the areas of health, the environment, science and engineering. It will help provide our universities, colleges and research hospitals with the laboratories, and equipment they need to complement their own efforts at innovation.

The budget also announced that the Networks of Centres of Excellence program will now be made permanent, with funding renewed at the average level for Phase II as current awards run out -- over \$47 million a year when fully implemented in 1999-2000. The NCE program sustains national networks of university and private sector partners carrying out programs of research focused on areas of national interest. These programs both advance technology and promote technology diffusion by establishing working links between industry and university researchers and graduate students.

In closing, let me thank you again for providing me with your views and suggestions. Please accept my best wishes.

Sincerely,



The Honourable Paul Martin, P.C., M.P.

REPORTS

Health of Canadians

It would seem that many members did not receive copies of the Health of Canadians report. I would suggest that they contact the following address and request a copy:

Health Canada Communications and Consultation Directorate
Brooke Claxton Building
Ottawa, ON K1A 0K9
Address Locator 090124C
Tel: (613) 957-1398
Fax: (613) 941-5366

Healthy, Wealthy and Wise

A Framework for an Integrated Federal Science and Technology Strategy

Available from:

National Advisory Board on Science and Technology
235 Queen Street
Room 8176, West Tower
Ottawa, ON K1A 0H5
Tel: (613) 990-6260
Fax: (613) 990-2007
Email: nabst@ic.gc.ca

Canada Health Action:

Building on the Legacy

Final Report of the National Forum on Health

Available from:

National Forum on Health
P.O. Box 2798
4th Floor, 200 Kent Street
Ottawa, ON
K1P 6H4
FAX: (613) 954-0947
E-mail: Forum@hpb.hwc.ca
www: <http://www.nfh.hwc.ca>

Doing the Right Thing: A Research Plan for Healthy Living

Human Capital Initiative

Available from:

American Psychological Society
1010 Vermont Ave., NW, Suite 1100
Washington, DC 20005-4907
Tel: (202) 783-2077
FAX: (202) 783-2083
Email: aps@info.cren.net

THE HEALTH ACTION LOBBY - ELECTION '97

The Health Action Lobby or HEAL, is a coalition of national health care and consumer organizations dedicated to protecting and strengthening Canada's health care system. Seven organizations came together to form HEAL in 1991 to respond to cuts in federal funding for health care. Since then, 20 affiliate organizations have joined with HEAL to support the principles and objectives espoused by the coalition. Half a million Canadians, are represented by these organizations.

HEAL is concerned that if positive action is not taken quickly, Canadians are in danger of losing one of their most prized social accomplishments – medicare. But HEAL is not looking to maintain the status quo, we realize that the system is under stress, and that changes are required. HEAL believes that if governments, providers and the public work collaboratively, we can have a strong national health care system.

Election '97 – Why is HEAL Involved?

A federal election is just around the corner, and it offers an ideal opportunity for the HEAL message to be heard. A federal election is a time when national issues and priorities are debated, and the Canadian public have an opportunity to express their views. It is a time when platforms and policies are developed. It is a time to shape the future!

Health care promises to be a key issue of debate in the upcoming election. Over the last few years, Canadians have witnessed rapid restructuring in the health sector, closure of institutions, and delisting of services. Canadians are concerned about their ability to have access to quality care.

As health care providers and consumer representatives, members of HEAL have a responsibility to ensure that there is **informed** debate about health care. Active participation in election activities does not mean partisan support, it means encouraging healthy discussion about health care, influencing policy makers and involving the public. We all have a part to play in making health care the key issue of Election '97. Participation with HEAL also does not mean that you cannot promote your own organization's messages, you can participate in a variety of ways. To simplify our activities, HEAL has developed the following guidelines for election activity:

- HEAL's participation will be **non-partisan**.
- HEAL, as a lobby organization, will **not** endorse specific candidates; and
- If a member organization endorses a candidate in a specific riding, they must **not** participate in that riding

as a HEAL member.

The HEAL Lobby Kit

This information package has been put together to help you to take part in the election process. It outlines key HEAL messages, activities that you can become involved in, and questions to ask. It also provides some facts and figures about health care issues, and includes information that you can leave with candidates and other interested audiences.

Please feel free to copy this kit and share it with other providers, friends and family. The more people involved in this debate, the better!

Who to Target

There are four key audiences that you can target during the election campaign:

Political Parties and Candidates

- help candidates understand current health care issues and encourage them to adopt the HEAL vision;
- address misconceptions about transfer payments and funding of health care;
- seek their commitment to the principles of the Canada Health Act.

Other Health Care Providers/Organizations

- encourage co-workers to participate in the election process, form an election group;
- explain how they can promote the HEAL vision, plan your strategy;
- show them that they have a role to play in the future of our health care system.

Media

- use your local media to make health care an issue, provide facts and figures;
- talk about HEAL's activities and the HEAL vision;
- use the media to help spread your message.

Canadian Public

- talk to friends, families, clients and community;
- encourage everyone to participate in the health care debate;
- address misconceptions about funding of health care, stress the need for collaborative action;
- demonstrate how HEAL's vision can work as a solution.

What to Tell Them – Key Messages

Elections are a time when everyone is trying to put their message forward, and time frames are short. Candidates and the media are bombarded with information. So keep your message short and simple. Don't try to cover everything in a short meeting or telephone call. Remember, you can always provide written material later.

HEAL's Key Messages

- quality of care is being compromised, our health care system is in serious danger;
- cuts to transfer payments have gone too far; it is time to stop the cuts and re-invest in health;
- the federal government must establish and maintain a cash floor to ensure continued access to quality care, within the Canada Health and Social Transfer (CHST);
- we can maintain an accessible, affordable, comprehensive, portable, and publicly funded health care system – HEAL has a vision for a renewed system;
- Canadians want a quality health care system; we need to see strong federal leadership.

Your Participation

Members of HEAL will be meeting with national platform committees, political leaders and national media to promote the HEAL message. But it will take grassroots involvement of all Canadians if we are to successfully obtain a commitment to a renewed health care system. From letter writing to meeting with candidates, all activities are important. Do what you feel comfortable with, and work with others for support. Whether you do a little or a lot, it is important to do something!

Heal's Guiding Principles

Preamble

- Health and health care are valued by all Canadians.
- Health is broader than the provision of health care, embracing health promotion, disease prevention and the underlying determinants of health in the context of healthy public policy and healthy communities.
- Access to quality health care, irrespective of the individual's ability to pay, is a basic Canadian value based on the principle of social justice.
- Safeguarding the national health care system requires adherence to a common set of principles.
- Finite resources are available to preserve and protect the health of Canadians and to fund the national health insurance system.

Guiding Principles for Health and Health Care

Health Goals

National and provincial health goals are required. These are a prerequisite for the conceptual framework within which resource allocation for the continuum of health care can occur in a responsible and efficient manner.

Continuum of Care

Changing health needs of individuals and society require a broad range of community and institutionally-based services. An integrated continuum of care, providing coordinated access to a range of types and levels of services should be the model for the Canadian health system. Administrative and financial

arrangements should be designed accordingly.

Shared Responsibility for Safeguarding Canada's Health System

Federal and provincial governments share a time-honoured responsibility for safeguarding the five basic principles underlying an interlocking set of provincially/territorially administered health insurance programs. These principles are:

- portability of benefits
- universality of population coverage
- access to required services
- comprehensive benefits
- public (non-profit) administration.

Consumer Participation in Health Care Decision-Making

Health care consumers are partners in health care. As partners, they are involved in decision-making concerning their care, and are jointly responsible with health care providers for health promotion aimed at enhancing the health status of Canadians. It is imperative that health consumers share in policy planning and evaluation, self-help and mutual aid. The health care system should be responsive to the needs of consumers.

Individual Rights

While the basis of our health care system is community responsibility, individual rights and participation in the health care environment must be protected and promoted.

Cooperation

Interdisciplinary, intersectoral, intergovernmental cooperative action is required to build consensus around solutions to problems, affecting health and health care. Concerted collaborative action is required to address common challenges.

Stability of Funding

Stability of funding is a prerequisite for the provision of quality health services, health planning, research and innovations that improve the effectiveness of care and care delivery.

Efficient and Effective Management

To ensure the long-term availability of resources for the health care system, resources must be managed and allocated in an efficient and effective manner, and the system must provide incentives to do so.

Voluntarism

Voluntarism and community involvement are important components of healthy public policy and healthy communities. The continued encouragement and facilitation of self-help and mutual aid efforts is essential.

Professional Self-Regulation and Licensure

Public accountability is effectively discharged through rigorous self-regulation by health professionals. Public participation in self-regulation is valued by health professionals.

HEAL Secretariat, c/o 50 Driveway, Ottawa ON K2P 1E2
Fax: (613) 237-3520, E-mail: commdiv@cna-nurses.ca

Canadian Consortium for Research ELECTION STATEMENT

The Canadian Consortium for Research (CCR) consists of 22 organizations that represent 50,000 scientists and researchers and 400,000 university students across Canada. While the majority of the scientists and researchers are based in universities, the constituent organizations have numerous members in government laboratories and agencies, HOSPITALS AND OTHER HEALTH CARE INSTITUTIONS, and in private sector research centres. CCR's primary concerns are the development and funding of research in all sectors, and the support of post-secondary education.

Research in the natural and social sciences, in medicine and in the humanities are essential to the future of Canada, and provide the long-term, high quality opportunities and jobs that we need. Increasingly, the research community is working together to identify gaps to be filled and to provide consistent advice to government - such messages are being heard and science and research are beginning to receive more attention.

This statement provides you with clear messages to impress upon your local candidates - with all the competing demands for government funding, they must be convinced that developing the Canadian science and research enterprise through increased support is in the country's best interests. They must hear this from as many of you as possible.

Positive Steps

Through the following measures contained in the federal budget of February, 1997, the government has demonstrated A commitment to post-secondary education and to investing in Canadian research capacity and science and technology initiatives:

- * The creation of the Canada Foundation for Innovation, a fund for the renewal of research infrastructure in universities, hospitals and research institutes
- * On-going support for the Networks of Centres of Excellence program, which bring together university and private sector researchers
- * Continued funding for the Industrial Research Assistance Program, designed to make expertise in government laboratories and universities available to small and medium-sized companies
- * Tax and repayment changes to assist students - representing investments in people

Negative Steps

Reductions of more than \$4 billion since 1994-95 in the transfers to the provinces have placed universities in dire straits with respect to paying for operating costs. This situation has negatively affected the ability of universities to retain their best faculty members, maintain their physical plant and facilities,

sustain their libraries, and provide even minimal technical support for research. Concurrent reductions in granting council Budgets have compounded the problems.

Future Needs

Science informs policy and decision making. To realize this interchange, Canada needs a comprehensive S&T plan which expands on the federal S&T Strategy, launched in March, 1996. Major components should include:

- * Canada must compete effectively in the global economy. To do so, our investment in S&T, currently at the bottom end of all G-7 countries, must be significantly increased.
- * Direct support of basic and applied research in universities through the three research granting councils is dropping significantly - too much potential is being left by the wayside. Support of this research must be increased and stabilized at these new levels.
- * Transfers to the provinces for indirect costs of post-secondary institutions have been drastically cut. The means of supporting or covering These indirect costs of research at universities must be devised.
- * Research in the social sciences and humanities is critical to our understanding of the social, cultural and economic challenges facing Canada. Together with the medical and natural sciences, research in these fields will enable Canadians to adapt to the demands of a new knowledge-based society. Strong and stable support for the social sciences and humanities will enable Canada to meet these objectives.
- * Post-secondary education must be affordable. The CCR supports the measures put forward in January, 1997 by seven national organizations representing universities, community colleges, students, faculty and student aid administrators. These measures include special opportunity grants, deferred grants, a work-study program and tax changes.
- * Government laboratories are an integral part of our S&T capacity. Cuts to federal departments are resulting in drastic reductions to the work of these laboratories with little apparent regard given to the implications of the changes for universities, other government departments, or the private sector. A comprehensive assessment, with external input, is urgently needed.

CONFERENCES/CONFÉRENCES

AUSTRALIA

Second World Conference on Stress
October 25 - 29, 1998
Melbourne, Australia

Contact: c/-ICMS Pty Ltd
84 Queensbridge Street
Southbank, VIC 3006, Australia.

UK

Special Group in Health Psychology
Annual Conference
July 2 - 4 1997
University of Southampton, England

Contact: Conference Office,
British Psychological Society
St. Andrews' House
48 Princess Road East
Leicester LE1 7DR, England, UK

FRANCE

11th Conference of the European Health Psychology
Society
September 3 - 5, 1997
Bordeaux, France

Contact: M. Phillippe Meriaux,
10 Rue de Nuits
33100 Bordeaux, France

DENMARK

5th International Congress of Behavioral Medicine
August 19 - 22, 1998
Copenhagen, Denmark

Contact: International Conference Service A/S
P.O. Box 41, Strandvejen 171
DK-2900 Hellerup
Copenhagen, Denmark
email: icbm98@ics.dk

THE COMPLEMENTARY MEDICINE SATELLITE CONFERENCE SERIES

The first of the series features *The Clinical Practice of Traditional Chinese Medicine in China*. It is offered in 22 hospital sites across Canada on October 23, 1997. This half-day educational initiative presents:

- 1 A Video-Presentation on Acupuncture, Herbal Medicine, and Qigong specially produced in China for this event;
 2. An Interactive Question and Answer session with Chinese medical faculty direct from Beijing via Satellite;
 3. Live Demonstrations by Local Experts at each Conference site.
- Recommended for physicians, health care professionals, complementary and alternative medicine practitioners, policy makers, insurers, and consumers.
 - Organized by the Chinese Medical Association (China), Trans Pacific Interface Inc., and Healthsat Inc. Hospital Sponsor: Toronto East General and Orthopaedic Hospital Inc.
 - For information and registration call Toll free 1-800-376-3331; in Toronto: (416) 321-2077.