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## Some aspects of the relationship between self-help and primary health care

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## Some Aspects of the Relationship between Self-Help und Primary Health Care

### I. The Status of Self-organization for an effective Health Policy

In a very broad sense the activating and mobilizing of those persons affected are a component part of every progressive strategy for maintaining good health:

- The common chronic illnesses which dominate morbidity as well as mortality after the panoramic change of illnesses in the industrialized countries cannot be effectively combated with curativemedical means. It is therefore necessary to identify the individual and collective constellations of risk before their physiological manifestation in order to change them by political, behavioral and medical means. In view of the multitude of objective and subjective variables which affect health, the most valid indicator of identifying such constellations is the subjective condition of the respective persons affected. In order to maintain good health, such conditions are therefore important under which people are sensitized as regards their state of health, can also articulate their perceptions and then, with persons in comparable living and working conditions, collectively process central issues for the purpose of changing inhibiting factors and structures.
- Neither life style and working conditions nor the medical care system are presently set up to stimulate and promote this sensitization and activation. Consequently, this task must fall for the most part to the persons affected themselves and their organizations. Since the health-impairing structures in the worksite and in life styles as well as in public services are occupied by strong economic interests, the interest in one's own health must stand up for the most part against economic and political power. Individual resistance - rebellion, refusal or withdrawal - has little chance of success with this asymmetric constellation. It is more necessary to organize the interest in one's own health. This historic task to secure the health and living conditions of all of society in opposition to the dominant political struc-

tures falls once again primarily to the labor movement. The trade and labor unions in the developed capitalist countries have almost not yet devoted the priority to this historic task which it deserves.

- Activation and mobilization are under given circumstances often the only health policy approach to identify groups with health problems at all. Depending on social class and situation the various health threats require search and mobilization strategies which correspond to the problem area, the life style and the significance ascribed to "health" determined by these factors. The health propaganda and education based on the health ideals of the middle classes mostly overlooks this problem area. Therefore, differentiated strategies for various sub-groups have to be developed depending on their social situation.
- An identification of the constellations of concrete health problems is for the most part not possible without the persons affected. The multitude, variance and combination of miscellaneous factors which strain health, but which can also further it, elude a schematic depiction because of their complexity. Epidemiological and social science research can at best provide a rough framework and criteria for searching for problem groups and dangerous constellations. The participation of persons affected is indispensable for the concrete analysis of their health situation.
- The persons affected are the best experts for drawing up health-related strategies for reducing health risks. They know the health strains and the objective conditional structures which cause them as well as the obstacles for their removal as a rule better than external experts.
- Since the health-impairing factors are predominantly produced by economic and political structures, the pushing through of forms with due consideration for health in life and in the worksite as well as in the public health services as a rule requires political forms of struggle. Primarily the persons affected come into question as resistance and conflict potential for this engagement.
- The change attitude caused by activation and mobilization

towards illness-causing life and working conditions also produces a modified view as regards one's health. This change represents an autonomous contribution towards coping.

- On the basis of an aggressive attitude on health as regards the environment, the interrelations between objective health strains and individual destructive behavior, which often functionally correspond and mutually escalate, can more easily be made conscious to the persons affected and thus be handled systematically, i.e. from both sides.
- Health policy strategies for changing illness-causing life and working conditions do not only require a single impulse, but long-term organized struggles and continuous control of the experiments and measures which were introduced and carried out. There is no better control potential than the persons affected themselves.
- In view of the complex correlations the evaluation of health policy measures and strategies cannot be limited to the selective measuring of successes attained. The continuous feedback between all participants and the flexible determination of the next respective steps dependent of changing environmental conditions is imperative. The evaluation accompanying the process represents a prerequisite for health strategies which can be generalized and cannot be carried out without the persons affected.

The concept of primary health care takes this orientation for the most part into account. This is valid for the Declaration of Alma Ata in 1978 (cf. above all Principles IV and VII) as well as for the concretization of this strategic starting point by the European Regional Office of WHO in Copenhagen in 1979.

Since governmental health policies and the professional public health services of the Western European countries for the most part did not take notice of these principles, the question thus arises as to what other political representatives, i.e. organizations, political movements, etc., come into question for this task. The self-help movement thus becomes the focus of attention to thoughts on health policy strategies.

## II. Scope and Importance of Health Related Self-Organization in the Federal Republic of Germany

According to an empirically-based projection there are at present approximately 29 000 self-organizations in the Federal Republic of Germany which can be broken down into areas of action. Accordingly, in the area

- personal / cultural identity (with the sub-groups: education and training, health and psychotherapy, anti-discrimination, communication/culture)      work ca. 17 500 or 60 %  
of the groups
- residential and living area (housing, surrounding area, district of the city)      work ca. 9 500 or 30 %  
of the groups
- environment (nature, urban development, transportation)      work ca. 2 200 or 7 %.

Approximately 7 200 groups have health, including psychotherapy, as their leading subject. It must be kept in mind, however, that this calculation is based solely on data from the reproduction sphere and that the beginnings of organization in the worksite are not taken into account. There is no data on the quantitative scope of such groups. They are, however, still relatively rare, since an approach in the Federal Republic of Germany, comparable to the Italian concept of the "homogeneous group", has not yet been achieved.

The existing groups cannot only be differentiated according to their areas of action, but also according to their forms of action. They can be roughly divided - depending on their behavior towards the political environment - into "self-help" and "contradiction".

The results for the health-related groups is an estimate of 15 000 groups (85 %) in the more limited area of self-help and 2 5000 groups (15 %) with an more or less aggressive external orientation.

These figures are to be viewed, of course, as being rather uncertain as to the numbers involved as well as to the

distinguishability of categories. They can only provide an idea of the dimension of this potential.

This suffices nevertheless for determining that the self-help movement at present and in the foreseeable future solely by its quantitative dimensions cannot represent a power which could change the principles of health policy in the direction of primary health care. This is admittedly no argument against the importance of such beginnings in the sense of concrete help in individual cases, the testing of new forms of sensitization for health problems, the collective coping of health-related everyday problems and the (mostly small) effects on public health service and social policy. In this sense the self-help groups with a rather aggressive concept represent the liveliest part of the health movements in the Federal Republic of Germany.

The following points of view speak furthermore against an overestimation of the significance of existing self-help beginnings for orienting health policy towards the principles of primary health care:

- The quantitative and qualitative dynamism of their development and growth is systematically overestimated. The cause for this is to be found primarily in the interest of the media, social scientists and politicians (of almost all convictions) who want to make use of the innovative potential of these beginnings for their own respective aims. At present there seems to be in effect only weak quantitative growth taking place with a simultaneous trend towards retreating into personal and subjective problem areas.
- The reason why a considerable part of public attention has been paid to these groups and the overestimation of their dynamism is that numerous groups which have existed for decades have been "newly discovered" in the past few years, e.g. Alcoholics Anonymous, and through new definitions have been added to the self-help movement, e.g. youth and old people's clubs in the established welfare organizations.
- The existing and newly developing groups of the self-help movement have a strong middle class bias. Access is gained primarily by problem-conscious, communicative and articulate

people of the respective illness and problem circles. Especially the underprivileged are the ones who remain under-represented. He who propagates self-help as a comprehensive instrument for dealing with health problems runs the risk of leaving the most difficult problem fields and groups without attainable aid. The self-help groups are also of only limited use as supporters of "navigator programs", i.e. in the sense of introducing hitherto inarticulate groups to the benefits and policies of the social welfare state.

- According to available studies and experiences the internal structure of the existing self-help groups does not seem particularly suited for influencing the hierarchy of articulateness in the sense of reducing the dominance of the experts. There are rather more indications that a relatively small and stable core of members coming predominantly from the middle class is formed within these groups which assumes the organizational, political and communicative tasks. In part, new and uncontrollable structures of an informal dependence on (informal and formal) experts are developed which run counter to the groups' own anti-professional and egalitarian claims.
- The political efficacy of self-help groups beyond their immediate area of influence is also limited by the almost non-existence of beginnings through which the self-help organizations could develop effective forms of cooperation ("network") and representation of their interests in the political system.

Whether the "Contact and Information Offices for Self-Help Groups" founded recently and a loose nation-wide association, e.g. with the "Health Shops" ("Gesundheitsläden"), can change anything, is questionable. The prevalent anti-organizational and anti-centralist attitude which predominates in the movements speaks against it.

- The transferring of health care functions to self-help groups fails because of their instability and fluctuation as regards their composition as well as the existence of the groups themselves. The illusion propagated primarily by conservative



politicians of a comprehensive network of such groups for the needy without thereby incurring costs for the government is generally nothing more than a veiled announcement of dismantling of government-financed institutions.

- Heterogeneous ideological elements and the lack of an accepted theory of society in the self-help movement make it susceptible to being taken over ideologically by different sides and partially leads to extreme forms of opportunism towards processes and institutions in the political environment. If namely 1) bureaucratic structures, 2) the dominance of experts, 3) private business organizations which offer health services, 4) clogged and entangled political structures, 5) lack of neighborly warmth, 6) dismantling of government social benefits, 7) reglementation by government-run health policies, 8) deregulation of government policies in the health field, 9) incapacitation by institutions of the social welfare state determine the image of the opponent alternatively, interchangeably and without regards to internal contradictions, than even the different status of these levels and their relationship to each other can no longer be determined. Every attempt to develop a health policy strategy and embed individual steps in it is thus frequently doomed to numerous ambiguities and to failure.

Typically, those ideas, plans, and campaigns are all too often given priority in such situations which at least promise visible results in the short run and thus help to suppress the lack of strategy which is essentially also a lack of theory.

### III. Some trends

The development of self-help groups as part of the "new social movements" does not take place in a vacuum, but is more or less subject to the dictates of social welfare state development. In almost Western European countries the concepts of supply-side economics, based on the principles of neoclassical economic theory, are dominant. The cyclical and structural economic crises have to be overcome by improving business exploitation and profit conditions. Despite the prevalent trends of destruction of jobs through technology, decreasing sales possibilities on the world market and weak growth as a consequence of the drop

in mass purchasing power in the home markets of the industrialized countries the credo of this philosophy is: today's profits are tomorrow's investments and therefore the jobs for the day after tomorrow. An integral component of this concept are the "insights" that unemployment is caused by too high wages and that social benefits weaken the will to self-help and the readiness of the dependent employees to adapt. The position of the (still) employed is weakened by massive cuts in social benefits and the support situation during phases of involuntary non-earning, i.e. youth, education, training, illness, joblessness, disability, retirement, deteriorates. The degree of wage dependency increases, an effective combating of mass unemployment is - despite all the claims of the politicians to the contrary - not a component part of these policies because unemployment has a function in the pushing through of an unrestrained market economy on the labor market and in social policy.

The dismantling of social welfare benefits in the Federal Republic of Germany is impressive and comprehensive; cutbacks or tightening of the prerequisites of benefits for unemployment compensation, maternity leave, welfare, retirement, support for the disabled and all kinds of educational and training aids, increases in fees for daycare centers and other social welfare institutions, limited coverage for medicines, hospitals and spas etc. Of the more than two million unemployed who are registered only about one third can claim unemployment payments. A new kind of poverty is spreading. Between the end of 1981 and the end of 1983 approximately 250 amendments in the tax and social policy laws were made by Federal officials. According to calculations made by the German Federation of Trade Unions (DGB) the cutbacks of benefits amount to 25 billion German Marks for 1983 and 1984 alone. A University of Cologne study claims that social welfare income for the period 1982-1985 will be reduced by 75 billion German Marks.

The catchwords for using the concept of supply-side economics in social welfare and health policies are: subsidiarity, re-privatization, deregulation; more market, less government.

The supporting philosophy is derived from concepts of reverting social and health programs to the family, the "small networks" and to the individual in the sense of "personal responsibility for one's own health and social situation" and even stretches to a quite frank "blaming the victim".

At first glance the concept of subsidiarity and the priority given to the small networks on the one hand and the predominant self-perception of the self-help groups on the other overlap to a great extent as regards content. Nevertheless, one cannot count on large segments of the self-help movement consciously accepting this type of social welfare policy which their social sensitivity opposes. This sensitivity will not allow them to overlook this dismantling of health and social welfare benefits. Their basic anti-organizational attitude as well as their ideological vagueness, especially in their relationship to government, to government social welfare benefits and to the role of market economy in public health services, have hampered so far the adoption of an aggressive political attitude towards this dominant tendency in social welfare policy.

On the other hand, social welfare politicians who are advocates of the internationally prevalent political view at present need groups such as the self-help movements for two reasons:

- In the ideological struggle as displayable examples of the ability, which is superior to that of the social welfare state, of people to self-regulate their own social and health problems.
- As concrete possibility which can be referred to when dismantling social welfare and health benefits.

Of course, the structural weaknesses of these beginnings (cf. above II) are thereby almost always "forgotten". A certain financial promotion does indeed ensue from the fact of the mostly ideological applicability of the self-help groups. However, this promotion is always highly selective, i.e. it does not refer to politically aggressive organizations, and always remains - measured against the real problems - in sym-

bolic orders of magnitude.

Much greater than the danger of an ideological takeover of these groups is presently the tendency to allot to the self-help movement more and more social problems, while at the same time reducing government-financed benefit systems, so that the self-help groups collapse from qualitative and quantitative overloading.

The self-help movement with its present structure (scope, goals, social composition) is not suited for assuming greater social policy or benefit tasks in the (greatly extending) area of marginalized groups of society.

A third danger results from the confluence of mass unemployment in social help professions and the political-ideological strengthening of the market economy in the field of health care services: More and more groups, which once started as self-help organizations, see themselves compelled to at least secure the material existence of their "cadres". Consequently, many groups in the alternative and self-help movement find themselves at present in a stage of transition between "self-determined collective" and "small market-oriented business".

Such groups increasingly develop into organizations which are set up according to division of labor and are market-oriented for production of goods and services for health and well-being (process of marketization).

As a whole, production and application of services for health and well-being are thereby expanded. The share of direct market relations in this area of society thus increases (process of market orientation).

This tendency coincides with the topical tendencies in government social welfare and health policies. The economic framework thus increases the pressure to decide between market orientation or unpaid work in social services (process of takeover).

The approximately 6 000 "alternative economy" businesses in the Federal Republic of Germany are continually augmented in this way form the health sector. The share of market distribution of goods and services for health consequently increases.

On the whole, the perspectives for the self-help movements provide a rather dismal picture. This is firstly due to the change in model in economic and welfare politics towards the end of the 1970's and secondly, to the "built-in dead-ends" of these movements.

They arose, at least in the Federal Republic of Germany, when a reform phase as a serious reflection on the necessity and possibilities of prevention, and thus also on primary health care, led to a relativization of the role of medicine for health. A new determination resulting therefrom of the role of professional health professions and of the structures of public health care was discontinued almost completely in official political practice. The spontaneous rise of new beginnings in the layman and self-help movements was therefore also one - unintentional - result of the half-hearted health policies of the 1970's.

Whether relevant segments of these movements can survive the pressure and suction effects of the political framework, which has changed dramatically since their origin, without losing their political substance, is still quite open at present.

If this question is to be denied by the further development, then an important field for experimentation and experience for new forms of primary health care will vanish.

## BIBLIOGRAPHY

- ABHOLZ, H.H.: Welche Bedeutung hat die Medizin für die Gesundheit?  
in: H.U. DEPPE (Ed.): Vernachlässigte Gesundheit, Köln  
1980
- BEYWL, W., H. BROMBACH: Neue Selbstorganisationen, zwischen kultu-  
reller Autonomie und politischer Vereinnahmung,  
in: Aus Politik und Zeitgeschichte, Beilage zur Wochen-  
zeitung "Das Parlament", Nr. 11/1984
- BORGERS, D., H.H. ABHOLZ: Obstacles to Primary Health Care in  
the German Health System, Ms, Berlin 1984
- HAUSS, F., R. ROSENBROCK: Occupational Health and Safety in the  
Federal Republic of Germany: A Case Study of Co-Determination  
and Health Politics,  
in: International Journal of Health Services, VOL. 14, 2,  
1984
- HAUSS, F., F. NASCHOLD, R. ROSENBROCK: Schichtenspezifische Ver-  
sorgungsprobleme und leistungssteuernde Strukturpolitik  
in Gesundheitswesen,  
in: ibid. (Eds.): Schichtenspezifische Versorgungsprobleme  
in Gesundheitswesen, Forschungsbericht des Bundesministers  
für Arbeit und Sozialordnung, Bonn 1981
- LABISCH, A.: Medizinische Versorgung ohne Konzept, Kassel 1982
- ROSENBROCK, R.: Gesundheitsforschung aus der Defensive,  
in: Wie teuer ist uns die Gesundheit?, Argument-Sonder-  
band AS 119, Berlin 1984
- ROSENBROCK, R.: Industrial Health Policy in a Crisis - Regressive Ten-  
dencies and New Tasks for the Professionals, in: Wintersber-  
ger, H., R. Misitis (Eds.): Direct Workers Participation  
in Matters of Work Safety and Health (1985)
- ROSENBROCK, R.: Arbeitszeitverkürzung und betriebliche Gesundheits-  
politik  
in: Die Mitbestimmung, 30.Jg., Nr. 1/1984
- ROSENBROCK, R.: Selbsthilfe und Marktökonomie - unheimliche Begeg-  
nungen der dritten Art,  
in: Ambulante Gesundheitsarbeit, Argument-Sonderband  
AS 102, Berlin 1983

- ROSENBROCK, R., H.H: ABHOLZ: Arbeitermedizin, Arbeitsschutz und  
Streßprävention, WZB-IIVG/pre 83/213 Berlin 1983
- ROSENBROCK, R.: Arbeitsmediziner und Sicherheitsexperten im Betrieb,  
Frankfurt/New York 1982
- TROJAN, A.: Jenseits der Grenzen des Sozialstaats ... Selbsthilfe-  
gruppen aus dem Blickwinkel der Sozialpolitik, Ms, Hamburg  
1984
- WINDHOFF-HERITIER, A.: Selbsthilfeorganisationen - eine Lösung  
für die Sozialpolitik der mageren Jahre?,  
in: Soziale Welt XXXIII, Heft 1/1982
- WINTERSBERGER, H.: Participative Approaches towards Work Safety  
and Health, in: Wintersberger, H., R. Misitis (eds.):  
Direct Workers Participation in Matters of Work Safety  
and Health (1985)