Health Psychological Self-Sufficiency (Health-PSS): A Bottom-Up Human-Social Development Approach to Health Equity

Philip Young P. Hong

This article presents a community-based participatory action research process in a mixed-methods study to uncover a holistic perspective on what constitutes "good health and well-being" as one of the United Nations Sustainable Development Goals. This bottom-up approach to defining health from the community perspective challenges the general government and health industry assumptions and practices to promote top-down health equity. Applying the definition of social development as "achieving a civil society based on freedom and justice", the emerging findings adds to the social determinants of health framework in health disparities research. As multiple stakeholders added to the definitions of health and well-being, a process-based understanding of health emerged. Health psychological self-sufficiency (Health-PSS) is a process of recogniting various individual and structural barriers and reaching for improved health-related goals with hope actions leading to health empowerment in literacy, access, and outcomes. Human-social development implications for promoting health equity by building an inclusive health system with a culture of co-sufficiency that align individual and organizational processes are discussed.

Keywords*: social development, poverty of culture, psychological self-sufficiency, health hope, perceived health barriers, process, empowerment*

Introduction

The top-down model is essentially an elitist structure designed to govern the masses in an authoritarian state. The bottom-up one is posited in the opposites in regard to governmentality, its force, ideology and possible outcomes (Mohan, 2010, p. 209).

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It is well established in the literature that health is concomitant of social and economic development (Juliá & Kondrat, 2005). Over the last two decades, a consistent and clear message is conveyed by world leaders regarding health being central to the development and the importance of investing in health to promote economic development (Ruger, 2003). For example, socioeconomic problems like hunger, poor living standards, and environmental pollution can be attributed to low health (Madu, 1992). Health itself is one form of human capital, and it also affects other human capital development at the individual and economic development at the macro levels (Bleakley, 2010). Investing in health as a human capital positively influences the growth rate in per capita income (Barro, 1996; Gyimah-Brempong & Wilson, 2004).

Good health as a personal resource suggests livelihood; on the other hand, poor health is associated with poverty and underdevelopment (UNDP, 1997). Health increases the productivity potential of individuals and thereby fuels economic growth (Howitt, 2005). At an individual level, human capital investment to improve worker health will yield higher returns in earnings (Hong & Pandey, 2007). In contrast, a common cause of poverty is the decreased earnings power due to poor health (Bloom & Canning, 2003). Here health is associated with the quality of labor participation and economic well-being (Jayakody, Danziger, & Pollack, 1998; Olson & Pavetti, 1996; Pindus, Koralek, Martinson, & Trutko, 2000). Workers with good health enjoy higher earnings through less interruption in the labor market (Marmot, Ryff, Bumpass, Shipley, & Marks, 1997; Smith, 1999; Strauss & Thomas, 1998).

As such, health has been a central focus for development. Hence international organizations and national governments are concentrating more to "reduce morbidity and mortality either universally, or through a focus on specific population subgroups" (Buse & Hawkes, 2015, p. 1). United Nations (UN) Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs) identified the specific targets of an acceptable condition for health outcomes at the global level and operationalized the indicators for evaluating success. The UN General Assembly adopted eight MDGs in 2000, three of which were health-related goals to be met by 2015: reducing child mortality (MDG #4), improving maternal health (MDG #5), and combating HIV/AIDS, malaria, and other diseases (MDG #6). In 2015, a new development agenda, "Transforming our world: the 2030 agenda for sustainable development," was adopted, and health remained to be viewed as a primary contributor to and beneficiary of promoting sustainable development (WHO, 2015).

The UN resolution on SDGs, among the overall 17 SDGs, devoted Goal #3 to "Ensure healthy lives and promote well-being for all at all ages" (UN, 2015). While it retained MDGs #3 to 6 as key targets, the 2030 sustainable development agenda ambitiously expanded the scope of health like neonatal mortality, other infectious and noncommunicable diseases, mental health, tobacco use, substance abuse, injuries, hazardous chemicals, water contamination, soil pollution, universal

health coverage, reducing and managing national and global health risks, health financing, and healthcare workforce development (WHO, 2015). The SDG resolution comprehensively defines health and commits to coordinated global actions in the following way:

> To promote physical and mental health and wellbeing, and to extend life expectancy for all, we must achieve universal health coverage and access to quality health care. No one must be left behind. We commit to accelerating the progress made to date in reducing newborn, child and maternal mortality by ending all such preventable deaths before 2030. We are committed to ensuring universal access to sexual and reproductive health-care services, including for family planning, information and education. We will equally accelerate the pace of progress made in fighting malaria, HIV/AIDS, tuberculosis, hepatitis, Ebola and other communicable diseases and epidemics, including by addressing growing antimicrobial resistance and the problem of unattended diseases affecting developing countries. We are committed to the prevention and treatment of noncommunicable diseases, including behavioural, developmental, and neurological disorders, which constitute a major challenge for sustainable development. (UN, 2015, Paragraph 26)

Also, recognizing that health is not a standalone outcome, it was intentionally integrated into the other 16 SDGs. The success of MDGs and SDGs may be evaluated based on the level of goal achievement against the proposed timeline. Both have been instrumental in improving health-related resources and accountability for low- and middle-income countries with unprecedented results (Buse & Hawkes, 2015). Setting the global minimum standard for targeted health areas is critical to addressing the North-South divide and reducing global health disparities. At the same time, the SDG resolution also suggests that national governments should "set their national targets guided by the global level of ambition but taking into account national circumstances" (UN, 2015).

While health viewed as a commodity to increase the gross national product or personal income may have been critical in elevating the importance of health-related investments, it falls short of addressing the intrinsic value of health within the broader concept of development (Ruger, 2003). Also, prioritizing health outcomes in MDGs and SDGs—as comprehensive as they have been designed—comes with the risk of inviting a top-down rush to the finish line and race to the bottom by government actors in enacting loose interpretations and applications of key performance metrics. Driving a set of health outcomes may be effective in counting the numbers in development by identifying and tackling the problems' conditions but not necessarily the source of the problem. These metrics often are tied to the quality of healthcare services (Rubin, Pronovost, & Diette, 2001), whereas

factors such as nutrition, environment, lifestyle, poverty, and social structure have been found to have significant effects on health (McKeown, 1979; Wilkinson, 1996). Health outcome differences could be confounded by "case mix, how the data were collected, chance, or quality of care" (Mant, 2001, p. 475). Therefore, serious investigation on the quality rather than the achievement of health outcomes needs to be focused on (Mant, 2001). Process evaluation helps disentangle from theoretical constructs to identify pivotal components and factors that ensure successful health outcomes (Steckler & Linnan, 2002).

Juliá and Kondrat (2005) emphasized the importance of "indigenization and grassroots participation in designing and implementation of social development programs" (p. 527). In health care, indigenous practices refer to "approaches to wellness, health and rehabilitative care that include practices, knowledge or resources locally derived" (Juliá & Kondrat, 2005, p. 543). Along the lines of this recommendation, this paper presents a community-based participatory action research (CBPAR) process in a mixed-methods study to uncover a holistic perspective on what constitutes "good health and well-being" as one of the SDGs. This bottom-up approach to defining health from the community perspective challenges the common government and health industry assumptions and practices to promote top-down health equity.

Background Literature

Health Disparities and Equity

According to the U.S. Centers for Disease Control and Prevention (CDC), health equity has to do with everyone having equal opportunity to be as healthy as possible. Health equity is defined as a state "when every person has the opportunity to 'attain his or her full health potential' and no one is 'disadvantaged from achieving this potential because of social position or other socially determined circumstances'" (CDC, 2021). Health disparities, on the other hand, refer to the differences in health outcomes and their causes among groups of people "reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment" (CDC, 2021). Healthy People 2020 suggested that health disparities result from economic, social, or environmental disadvantages experienced by groups of people who have:

> systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. (HealthyPeople.gov, 2021)

Equity is about justice, and health equity is "social justice in health" (Braveman, 2014a, p. 7) and pursuing health equity means "reducing disparities in health

between groups of people who are more or less advantaged economically or socially" (Braveman, 2014b, p. 366).

Social Determinants of Health

Discussions of health disparities and equity go hand in hand with social determinants of health. There has been growing acknowledgment and attention provided to the social determinants in the context of health care services and delivery (Butler, 2017; Davidson & McGinn, 2019). The U.S. National Academies of Sciences, Engineering, and Medicine (2019) recommended the integration of social care—defined as "activities that address health-related social risk factors and social needs"—into healthcare settings to focus on "addressing health disparities in communities with greater social need" (Bibbins-Domingo, 2019, p. 1763). The social determinants of the health framework posit that "health follows a social gradient: higher the social position, the better the health" (Marmot & Wilkinson, 2005, p. 2). Education, neighborhood (zip code), transportation, environment, discrimination, and socioeconomic status are indicators of structural causes of individuals' health outcomes.

Capability, Empowerment, and Structuration Theories

As an approach to advance social justice in health, Ruger (2004) introduced the concept of health capability, defined as "an individual's opportunity to achieve good health and thus to be free from escapable morbidity and preventable mortality" (p. 1076). Influenced by the works of Amartya Sen (1999) and Martha Nussbaum (1990; 1992; 2000), Ruger (2010) conceptualizes health capability as comprising both health functioning and health agency. She defines health agency as "individuals' ability to achieve health goals they value and act as agents of their own health; health agency achievement represents what one's realized actions are compared with potential actions" and health functioning is "the outcome of the action to maintain or improve health" (p. 42).

Empowerment theory brings together psychological, organizational, and community levels of analysis (Rappaport, 1987) in examining structural inequities as the source of social problems instead of blaming the victims (Zimmerman, 2000). Empowerment as a Freirian (2000) praxis process comprises "critical consciousness" of the oppressive system through critical reflection and awareness and the "self-efficacy" and "agency" to mobilize the resources for social action and change (Diemer, McWhirter, Ozer, & Rapa, 2015; Gutierrez, 1995). Structuration theory defines the agent-structure relationship whereby each influences the other recursively through social practices of agents and organizations that make up the structure (Giddens, 1991). At both the agent and structural levels, consciousness raising through an empowerment-oriented social work practice can help break the recursive cycle of maintaining oppression by recognizing and altering the social practice (Wheeler-Brooks, 2009).

Human-Social Development and Psychological Self-Sufficiency

Mohan (2020) defines social development as eradicating "the sources of inequality and unfreedom toward achieving a civil society based on freedom and justice" (p. 48). Without transforming oppressive systems, social development becomes a delusional myth that remains passive and subject to the top-down implementation of the Eurocentric global agenda (Mohan, 2008). The poverty of culture (PoC)—institutionalized through politics and ideologies engaging in moral dissonance—sustains and perpetuates the oppressive economic systems by leaving them unchallenged to shape human behavior and wellbeing (Mohan, 2011). To Sen's (1999) ideas of enhancing individual freedom as a social commitment through capability, function, and agency, Mohan (2020) critically argues that "annihilation of the forces of oppression entails heavy burden on 'individual agency'" (p. 49). To address the PoC dilemma, Mohan (2010) proposes the new social development (NSD), "conceptualized as a postmaterial process of human-societal transformation that seeks to build identities of people, communities and nations" (p. 205).

NSD can provide an exploratory framework to imagine a nontraditional bottom-up process of identity building by achieving a human-centered civil society based on freedom and justice (Mohan, 2020). Hong (2008, 2013a) posited a structural dependence of poverty thesis by unpacking how structural poverty is marginalized in the US and identified the following two reasons: (1) Structural poverty not being accepted as a public problem by the split public views on the causes of poverty. (2) Structurally dependent political system, ideology, business power in public policy, and truncated labor market policy (see Figure 1). Hong and Song (2010) proposed a 'glocalization' approach, thinking globally about the structural causes of poverty and acting locally with transformative solutions to combat structural poverty. To combat globalization's negative consequences, a solution of forming a global civil society accompanied by a global social policy system and sub-systems was presented (Hong & Song, 2010).

Psychological self-sufficiency (PSS) is a human-social development theory that could potentially bring together aforementioned various streams of knowledge—health disparities and equity and social determinants of health framework, and capability, empowerment, and structuration theories. PSS explains the ways in which individual agents create transformative systemic change within the glocal context of PoC and structural dependence of poverty (Hong, 2008, 2013a; Mohan, 2010). PSS theory advances Mohan's (2020) NSD as a bottom-up transformative model of social change to advance freedom and justice by centering on the agents' structural and individual barriers and developing goal-oriented forward movements that are manifested at the individual, organizational, and societal levels as hope action processes (Hong, Gumz, Choi, Crawley, & Cho, 2021). This is in keeping with Hong and Song's (2010) conceptualization of the agent-structure relationship in which individuals hold identities as global citizens not acting independently but as agents embedded within "family, locale, neighborhood, and community" that can operate as global actors to "enter the global

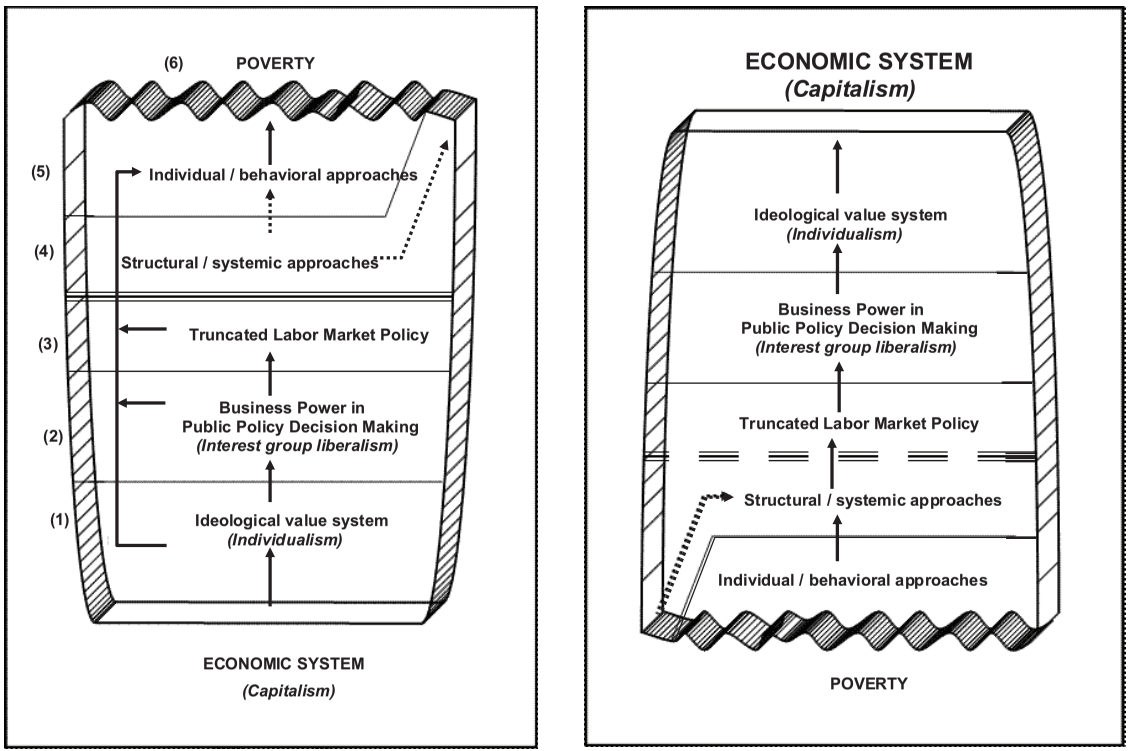


Figure 1 The poverty wound (left) and new social development (NSD) for poverty alleviation (right).

circuitry as a unit with a partial but entirely representative presence" (Simpson, 1996, p. 199).

What then are the primary freedom- and justice-focused health qualities not as a means but an end itself (Ruger, 2003) that can help transform the healthcare system to be an integral part of reducing disparities in health literacy, access, and outcomes? What factors make up the internal system that could impact the outer system and transform the healthcare system from a human-social development perspective? To answers these questions, this study engaged multiple community stakeholders through a CBPAR process to seek a bottom-up definition of health that can be owned by the community for building health-related identities of people, communities and nations to bring about a transformative NSD process (Mohan, 2010).

Methods

Burns, Cooke, and Schweidler (2011) describe CBPAR as "a collaborative approach to research that involves all stakeholders throughout the research process, from establishing the research question, to developing data collection tools, to analysis and dissemination of findings" (p. 5). Planned, systematic collaboration is the key between the community residents (community knowledge workers) and university researchers (university knowledge workers) to codevelop and involve a framework that defines a community's issue and proposes problem-solving actions and sustainable social change strategies that are supported by community-based and community-engaged research (Hills, Mullett, & Carroll, 2007). CBPAR tends to be a democratic process that is "equitable and liberating as participants construct meaning in the process of group discussions" (Koch, Selim, & Kralik, 2002, p. 109). Therefore, positive outcomes of CBPAR are "methodological innovations favoring collaboration, and locally driven theories and models" (Schensul, Berg, Williamson, 2008, p. 102).

Janes (2016) calls out the CBPAR literature claiming its approach to hold "the potential to democratize and decolonize knowledge production by engaging communities and citizens in the research enterprise" (p. 72). Interrogating the CBPAR praxis, she warns that the commonly understood golden standard for participatory techniques may be critically reflexive yet complicit to sustain academe's epistemic privilege through "producing, subordinating and assimilating difference; claiming authenticity and voice; and dislocating collaborative knowledge work from the historical, political, social and embodied conditions in which it unfolds" (Janes, 2016, p. 72). She echoes Hilsen's (2006) recommendation to move toward democratic praxis which will "require reflections on ourselves and our practices" (Janes, 2016, p. 74). CBPAR may propose an emancipatory epistemology, but, knowledge hierarchies inevitably exist between the universities and the community.

Providing an ethical guideline for CBPAR, Maiter, Simich, Jacobson, and Wise (2008) suggest a notion of reciprocity, defined as "an ongoing process of exchange with the aim of establishing and maintaining equality between parties" (p. 305), instead of claiming proximity to the community, Janes (2016) suggests

"theorizing distance and a more humble knowledge project" with more transparency in the location of knowledge workers and power flowing in both directions (pp. 83–84). With an attempt to utilize a humbler and more transparent CBPAR approach, a critical reflection of the researcher's positionality was made with a commitment to enter into the process as a colearner of the dialectical "truth" that exists within the distance as others, but proximity as one human race whose rights to good health and well-being are universal.

Sample and Data Collection

Community-university knowledge workers participated in a CBPAR process by engaging multiple healthcare stakeholders and collaborators of health promotion and equity from a large US city located in the Midwest. The group comprised eight large human service agencies (two staff from each agency): two major private philanthropic organizations (one program officer from each foundation), three multisite health promotion and healthcare enrollment organizations (a director and a staff from each organization), one community-based health learning collaborative (57 representatives from multiple healthcare providers including large, midsized, and small hospitals and clinics, insurance, and health advocacy groups), three hospitals' chief executives; three community-based health trainer and educator, three university researchers, and 78 program participants. Through a series of community forums, workshops, interviews, and focus groups, a bottom-up definition of good health and well-being was sought collectively.

To anchor the CBPAR process on health and well-being towards human-social development based on freedom, justice, diversity, equity, and inclusion (Mohan, 2007, 2020), the following engagement questions were used as prompts:

1. What is your definition of good health and well-being?
2. What makes up the concept of health?
3. What can you do to improve health for yourself and others?
4. What do you expect from healthcare institutions, employers, and governments to improve health and well-being for you and your family?

Based on qualitative content analyses of field notes, transcripts, interviews, and focus groups gathered through stakeholder engagement, a survey instrument was developed, revised, and administered to explore the extent to which quantitative data support the qualitative findings. Pre- and post-test survey data were gathered from the 16 representatives of eight human service agencies who participated in a pilot health promotion training.

Analysis

This study employs a mixed-method approach by integrating qualitative (Qual) and quantitative (Quant) methods. According to Creswell and Plano Clark (2011),

there are three approaches to mixed methods research: merging data, connecting data, and embedding data. This study involves connecting data using an exploratory sequential design (Qual&Quant; Lieber, 2009). Here qualitative analyses of in-depth interviews and focus group data and quantitative analysis descriptive and pre- /post-test of survey data will be combined. Replicating the study by Hong, Sheriff, and Naeger (2009) and Hong (2013b), integrating CBPAR with a mixed-methods approach will provide a bottom-up process of redefining health and well-being as human-social development toward a social transformation to enhance human freedom and justice (Mohan, 2020).

Results

As multiple stakeholders contributed their understandings of health and well-being, an overarching process-based, community-centered, and empowerment-based definition of health emerged. In essence, it is the process of recognizing (being aware of) various context-specific health barriers and moving forward with hope actions toward individualized health goals by overcoming these barriers. This process emerged as the necessary and core condition to reach visible improvements in health-related goals such as health literacy, healthcare access, and health outcomes. The CBPAR process began with a commitment to community-university partnership in collaboration on promoting health and well-being. Community forums and meetings were organized by local leaders who saw the need for improving the health status of underserved community members in the statistical metropolitan area.

A Top-Down Individual and Organizational Outcome

With two major private foundation's program officers in health sharing their strategic priorities, the introductions of the university researcher were made to the foundations' grantee organizations and the community-based projects they are involved in. The university knowledge workers entered the space of listening to the needs of multiple stakeholders. A top-down definition of health and well-being was revealed with more focus on health outcomes and the quality of patient-centered health services delivery. It rested more on the top-down assumptions about the community as being plagued by lacking health resources, positive health-related self-care, preventive habits and practices, health literacy, and healthcare access while having to manage the burden of family caregiving, multiple chronic illnesses, medical costs, and community violence.

Health literacy as an individual level educational and awareness outcome topped the priorities of the three community-based health trainers and educators with the notion of "knowledge is power." Self-management and self-care of chronic illnesses and adhering to medication were the behavioral commitment induced by understanding the severity of consequences. Health literacy as having access to health services as human rights by way of increasing health insurance

enrollment was endorsed as the definition of health and well-being by the three multi-site health promotion and healthcare enrollment organizations (one director and staff from each organization). Empowerment-based health literacy was conceptualized as knowledge, attitude, and behavior, contributing to improved health and well-being. The attributes to be focused on were: confidence in navigating the healthcare system; confidence about the ability to achieve health-related goals; commitment to achieving health-related goals; awareness of constructive general health practices (such as healthy eating and exercise); awareness of resources for good health; awareness of general health risks of certain behaviors and conditions (such as smoking and obesity); utilization of preventive medical services such as annual physicals, mammograms, and prostate exams; appropriate utilization of medical services for treatment of health conditions; and perceived ability to obtain health services as needed.

Recognizing the health disparities that exist in many of the serviced regions of the statistical metropolitan area, health and well-being were seen as organizational performance outcomes. The two program officers from the private foundations were knowledgeable of social determinants of health, health disparities, and equity and saw themselves as having to follow the philanthropic strategies of each organization. While they were both clear about the community needs for health outcomes and access, there seemed to be the bottom line for programmatic deliverables of reducing emergency visits, increasing health insurance enrollment, reducing health disparities, and health outcomes improvement to the extent that the assigned scope of work for grant-funded projects could address.

While there was attentiveness to health and well-being as experienced by the communities in need, funding was provided to the health service providers for their investment in outreach of the underserved communities and providing inclusive medical services to address the treatment needs. A comprehensive vision was developed for multiple health providers to work together for an inclusive health system development. Community-based health learning collaborative including 57 representatives from the healthcare provider, health advocacy, and health insurance communities came together to share their best practices in recruiting and serving the vulnerable and disconnected members of the community. Patient-centered care and patient satisfaction were the top organizational goals of the three chief executives of large medical centers whose missions were to serve the community by active engagement and inclusion for improved health literacy, access, and health status.

A Bottom-Up Transformative Process

Health and well-being are about personal and family life journeys for 16 staff from eight large human service agencies and the 78 program participants who participated in six focus groups. Access to quality health services and health literacy—knowledge, skills, and behaviors—are necessary to maintain a healthy life. The existence of an ultimate health outcome, state, or condition that could universally

define good health and well-being was unacceptable. Health and well-being are an individualized process that involves a constant negotiation with oneself on one's commitment to being healthy by which intermittent and long-range health goals emerge. These health goals may change in their orders of priorities or the weight of significance based on how the life journey unfolds for individuals and their families.

Moving forward toward the health goals involves recognizing the barriers that may stand in the way of achieving these health goals and overcoming with committed hope actions that will take one closer to the goals with each step. It is often the case that community members withdraw from any effort to pursue health-related goals for themselves or their families due to the structural and individual barriers disallowing health and well-being to be placed at the top utility priority over other immediate needs in life. In the busyness of surviving through the socio-economic conditions that determine health outcomes, community members may find the default option of subscribing to the top-down solutions and activities provided as health resources for improved health literacy, access, and outcomes.

The counter-narrative to this powerless adherence practice emerged as an awareness of how one moves forward with manageable hope actions even in small steps against the odds of failing health, strength, resilience, stamina, and spirit. This practice makes health and well-being, not a luxurious concept that only a few in society can afford but one that everyone can enjoy including the most vulnerable community members. Health and well-being contextualized and applied to each individualized process can find a comfortable place in everyone's life journey. Cyclical daily struggles that may have been confined by health barriers can be transformed into a momentum for growth and rise with health hope that can manifest as personal health goal achievement at the individual level and collaborative culture of health developed within family and community.

Identifying Health Barriers and Health Hope

Health barriers

Many people do not realize the barriers they face in their everyday life that prevent them from achieving health goals. Even if they can identify them, recognizing and accepting them is not easy as they end up in life situations that are impossible to get through. Participants were given an additional opportunity to reflect on barriers to health goal achievement and assess the degree to which they are impossible or possible to overcome. Participants received a sheet of paper and a pen to write down personal barriers they were currently experiencing when trying to achieve their health goals. This activity allows participants to reflect on the impact of hindrances in their lives. It helps visualize what barrier-filled life situations everyone together brings to the room. After writing down the barriers, the participants were asked to fold the paper and drop them in the barrier container. Accumulating the paper strips in a clear container allowed participants to join in a symbolic ritual to evade the barriers as one would focus on health goals.

Health hope

Participants were asked to reflect on health hope actions that they will commit to achieving health goals. Health hope is not an easy concept to consider, given the structural and personal nature of health barriers that participants wrote down from the earlier activity. Similarly, participants were given a sheet of paper and a pen with the instruction to write down any manageable health hope actions that could put them in forward progress to reach their health goals. This activity contrasts the identified health barriers with positive steps that require each member to be an active agent in utilizing their resources and skills to achieve their health goals. It helps visualize what health goal-directed hope actions will bring to participants collectively as they commit to moving forward together. After writing the hope actions on paper, participants were asked to drop them in the hope container. Accumulating the paper strips in a clear container allowed participants to join in a symbolic ritual to collectively build hope as they focus on health and well-being.

Table 1 Health barriers. After reading some statements, please rank the following by circling a number on a scale of 1 (not a barrier) to 5 (strong barrier) according to how each item affects your good health maintenance

	Not a barrier				Strong barrier
1. Not understanding what being healthy really means	1	2	3	4	5
2. Not knowing how to take care of myself	1	2	3	4	5
3. Not trusting doctors	1	2	3	4	5
4. Not having health insurance	1	2	3	4	5
5. Lack of transportation to healthcare facilities	1	2	3	4	5
6. Lack of child care to go see a doctor	1	2	3	4	5
7. Racial discrimination in healthcare	1	2	3	4	5
8. Lack of information about accessing healthcare	1	2	3	4	5
9. Lack of clean living environment	1	2	3	4	5
10. Drug/alcohol addiction	1	2	3	4	5
11. Not trusting medicines	1	2	3	4	5
12. Not having enough money for medical treatment	1	2	3	4	5
13. Feeling depressed about life	1	2	3	4	5
14. Being around sick people	1	2	3	4	5
15. Having a weak body system to fight illness	1	2	3	4	5
16. No doctors/hospitals in the community	1	2	3	4	5
17. No healthcare facility that will take my appointments	1	2	3	4	5
18. Not knowing who to go to when I am sick	1	2	3	4	5
19. Not having the time to go to the doctors	1	2	3	4	5
20. Cannot speak English very well	1	2	3	4	5
21. Cannot read or write very well	1	2	3	4	5
22. Problems with keeping appointments	1	2	3	4	5
23. Loneliness	1	2	3	4	5
24. Poor eating habits and diet	1	2	3	4	5
25. Lack of coping skills for daily struggles	1	2	3	4	5
26. High stress level	1	2	3	4	5
27. Lack of exercise	1	2	3	4	5

Table 2 Health hope. After reading some statements about access to healthcare, please rank the following by circling a number on a scale of 0 (strong disagreement) to 10 (strong agreement).

		Strongly disagree					Neutral					Strongly agree
1.	Thinking about maintaining good health, I feel confident about myself.	0	1	2	3	4	5	6	7	8	9	10
2.	I feel good about myself as someone who deserves to have a healthy life.	0	1	2	3	4	5	6	7	8	9	10
3.	When trying to stay healthy, I am respectful towards who I am.	0	1	2	3	4	5	6	7	8	9	10
4.	I am worthy of enjoying good health.	0	1	2	3	4	5	6	7	8	9	10
5.	I can take care of myself to be healthy.	0	1	2	3	4	5	6	7	8	9	10
6.	I have the strength to overcome any obstacles that may limit my health.	0	1	2	3	4	5	6	7	8	9	10
7.	I can maintain good health in whatever circumstances.	0	1	2	3	4	5	6	7	8	9	10
8.	I am good at maintaining good health status if I set my mind to it.	0	1	2	3	4	5	6	7	8	9	10
9.	I feel positive about staying healthy in the future.	0	1	2	3	4	5	6	7	8	9	10
10.	I don't worry about struggling due to poor health in the future.	0	1	2	3	4	5	6	7	8	9	10
11.	I am going to maintain good health for a long time.	0	1	2	3	4	5	6	7	8	9	10
12.	I will be healthier in the future than my current health situation.	0	1	2	3	4	5	6	7	8	9	10
13.	I can tell myself to take steps toward improving my health.	0	1	2	3	4	5	6	7	8	9	10
14.	I am committed to reaching my health-related goals.	0	1	2	3	4	5	6	7	8	9	10
15.	I feel energized when I think about future improved health status.	0	1	2	3	4	5	6	7	8	9	10
16.	I am willing to give my best effort to reach my health- related goals.	0	1	2	3	4	5	6	7	8	9	10
17.	I am "knowledgeable" about how to improve my health.	0	1	2	3	4	5	6	7	8	9	10
18.	I am aware of my "resources" to help me become healthier.	0	1	2	3	4	5	6	7	8	9	10
19.	I can utilize my "knowledge" to move toward health-related goals.	0	1	2	3	4	5	6	7	8	9	10
20.	I can utilize my "resources" to move toward health-related goals.	0	1	2	3	4	5	6	7	8	9	10
21.	I am on the road toward my health-related goals.	0	1	2	3	4	5	6	7	8	9	10
22.	I am in the process of moving forward toward becoming healthier.	0	1	2	3	4	5	6	7	8	9	10
23.	Even if I am not able to be healthy right away, I will find a way to get there.	0	1	2	3	4	5	6	7	8	9	10
24.	My current path will take me to where I need to be in my health.	0	1	2	3	4	5	6	7	8	9	10

Survey Development

Following the CBPAR process, qualitative analyses of the field notes, meeting transcripts, interviews, and focus groups informed the survey development. A survey instrument was developed to measure the process-based, bottom-up definition of health and well-being with health barriers and health hope serving as the key components. The Perceived Health Barrier Scale (PHBS; see Table 1) and Health Hope Scale (HHS; see Table 2) were drafted based on elements found in the qualitative data, the health barrier/health hope activities, and the previous validated employment related barrier and hope scales. PHBS includes 27 items that were contextually identified to quantify the degree to which individuals perceive barriers to being healthy and well. It used the Perceived Employment Barrier Scale (PEBS; Hong, Polanin, Key, & Choi, 2014; Hong, Song, Choi, & Park, 2018) as the baseline structure to incorporate the health-specific barriers. HHS comprises 24 questions adopted from the Employment Hope Scale (EHS; Hong, Choi, & Polanin, 2014; Hong, Polanin, & Pigott, 2012; Hong, Song, Choi, & Park, 2016), revised with health-specific hope items, to measure the level of health hope to reach the health goals. These hope/barrier measures are the two main components of the theoretical framework of psychological self-sufficiency (PSS; Hong, Choi, & Key, 2018).

Survey Results

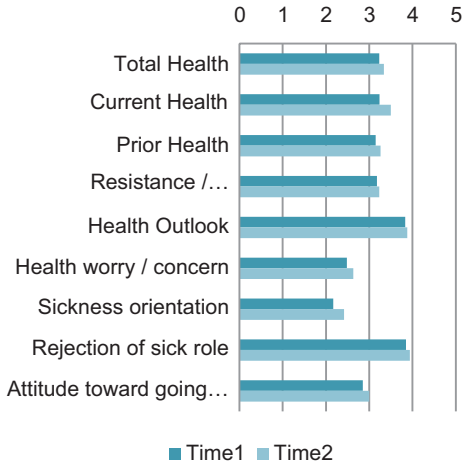
The newly developed survey instrument was distributed to 16 human service staff representatives who were invited to participate in a pilot health promotion training that included reflection activities on health barriers and health hope along with various mindful healthy living exercises on breath, food, hydration, movement, touch, and rest. A total of 26 pre- and post-test surveys were collected from 13 staff members with three completing only the pre-test survey.

Staff members' health status in the workplace was measured using the World Health Organization Health and Work Performance Questionnaire (HPQ) scale (Kessler et al., 2003). HPQ is developed to measure people's health status, and it consists of 32 questions with eight sub-factors. HPQ is a five-point Likert scale ranging from 1 (definitely true) to 5 (definitely false). There are 15 reverse questions that were recoded to interpret the results in the same direction with higher scores indicating better health and well-being. Results show that the mean of eight HPQ subfactors increased and the total mean of HPQ also increased consistently (see Table 3).

Staff members' health barriers and health psychological self-sufficiency (Health-PSS) were measured at pre- and post-test by PHBS, and HHS, respectively. Health-PSS captures the time change in the distance between HHS and PHBS, operationalizing the process-based, bottom-up definition of health and well-being. Results indicate that health barriers slightly decreased, and health hope increased between Time 1 and Time 2. Combining the two differences, Health-PSS increased between Time 1 and Time 2 (see Table 4).

Table 3 Results of Health and Work Performance change between Time 1 and Time 2

Staffs	*N* = 13 (Both cases)				
	Time 1		Time 2		Difference (T2–T1)
	Mean	SD	Mean	SD	
Total health	3.23	0.33	3.34	0.37	0.11
Current health	3.24	0.83	3.50	0.57	0.26
Prior health	3.15	1.35	3.26	1.23	0.11
Resistance/susceptibility	3.18	0.40	3.23	0.35	0.05
Health outlook	3.83	0.71	3.88	0.77	0.05
Health worry/concern	2.48	0.46	2.63	0.59	0.15
Sickness orientation	2.17	0.81	2.42	0.91	0.25
Rejection of sick role	3.85	0.57	3.94	0.64	0.09
Attitude toward going to the doctor	2.85	0.47	3.00	0.68	0.15

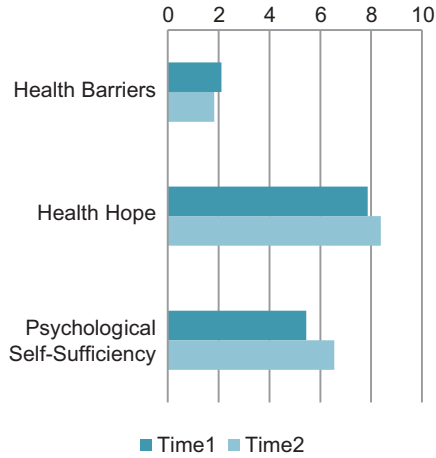


The staff members were categorized into two groups based on the decrease and increase of PSS scores between Time 2 and Time 1. Then the average HPQ scores by its subfactors were analyzed. Results show that six sub-factors: current health, health outlook, health worry or concern, sickness orientation, rejection of sick role, and total health were found to improve in average scores improved for the increased PSS group, while only two subfactors (current health and sickness orientation) for the decreased PSS group (see Table 5).

One limitation of the survey data was that the lack of information on the staff members' agency affiliation and the changes observed for each staff could not be triangulated with how the change affected staff performances, job satisfaction, morale, and health promotion engagement with agency participants. The non-inclusion of HPQ, Health-PSS, and other scales in the agency participant survey made it impossible to see how the participant-level data corresponded to the

Table 4 Results of health psychological self-sufficiency change between Time 1 and Time 2

Staffs	*N* = 13 (Both cases)				
	Time 1		Time 2		*T*
	Mean	SD	Mean	SD	
Health barriers	2.11	0.75	1.83	0.62	–0.28
Health hope	7.87	1.47	8.38	1.02	0.51
Psychological self-sufficiency	5.45	1.64	6.55	1.51	–1.54



changes shown in the staff Health-PSS and HPQ. The availability of only 13 pairs of pre- and post-test surveys made the sample too small to infer statistical implications. Lastly, HPQ is a good measure of health knowledge and status, but it does not cover the full range of health literacy, access, and outcomes as the health outcome measure which was suggested in the qualitative part of this study. Therefore, the health self-sufficiency (HSS) items were drafted for possible future use in the context of validating the theory of change from Health-PSS to HSS (see Table 6).

Discussion and Conclusion

The Affordable Care Act of the U.S. intends that health centers need to adopt a patient-centered model that has not been widely accepted. The goal of the act is to provide coordinated care through a health home for individuals with chronic conditions (Townley & Takach, 2012). The National Committee for Quality Assurance (NCQA) describes Patient Centered Medical Home (PCMH) as:

> A foundational model for the organization and transformation of primary care that aims to improve quality of care, patient outcomes, patient experience, staff satisfaction, and healthcare efficiency—while at the same

Table 5 HPQ sub-factors by psychological self-sufficiency change groups

Sub-factors	*N* = 8					
	Increased PSS Group (*N* = 5)		I/D	Decreased PSS Group (*N* = 3)		I/D
	T1 Mean	T2 Mean		T1 Mean	T2 Mean	
Total health	3.19	3.40	I	3.06	2.93	D
Current health	2.93	3.71	I	2.74	2.78	I
Prior Health	3.80	3.20	D	3.44	2.78	D
Resistance/susceptibility	3.19	3.15	D	3.50	3.25	D
Health Outlook	3.50	4.05	I	3.42	3.17	D
Health worry/concern	2.30	2.65	I	2.58	2.42	D
Sickness orientation	2.20	2.40	I	1.50	1.83	I
Rejection of sick role	3.75	4.00	I	4.00	3.83	D
Attitude toward going to the doctor	3.00	2.80	D	3.00	3.00	–

*I or D, increased or decreased.

> time reducing costs. Successful PCMH program can accomplish these aims by establishing processes and systems that enable stronger relationships between clinicians and patients, clinical care teams, and across care sectors; increasing care coordination and integration; and decreasing care fragmentation (Philip, Govier, & Pantely, 2019, p.4).

The PCMH is an improvement from the antiquated "chronic care model" that focused on tertiary care rather than primary or preventative care (Ortiz & Fromer, 2011). One main feature of the PCMH is chronic disease management that works with the individual on preventative care and treatment. The health centers do this by comprehensive care management, care coordination, health promotion, comprehensive transitional care (including follow-up from inpatient to other settings), patient and family support, and referral to community, and social support services using health information technology (Townley & Takach, 2012).

These are responses to the growing concern over how health is seen more as a commodity in the U.S. rather than a pivotal inalienable human right. Who has the right to have a medical home? Mere existence by institutionalizing them does not automatically create a "safe" home for an unfree person's medical care. How can one trust any health institution when historically, one has been subject to unjust experiments in the name of advancing medical science? Decommodification of health and well-being outcomes or desired conditions could be the first place to start to help advance human freedom and justice. A health or medical home must be nurtured from the bottom-up and earned from the top-down. Imposing transactional fix solutions to ill health and well-being will miss the mark in promoting holistic health as an end itself by limiting health to simply be a means to economic development. The relevance of health as a process in economic development provides the opportunity for it to be a human capital at the individual level and an asset at the aggregate level for a collective gain in a free and just society.

Table 6 Health self-sufficiency (HSS). Think about your personal health situation over the past 1 month. For each of the following items, circle the number that most clearly indicates where you rate yourself, using the scale

My situation allows me to		No, not at all	Occasionally	Sometimes	Most of the time	Yes, all the time
1.	Have a primary healthcare provider that I visit regularly	1	2	3	4	5
2.	To utilize support services offered by my provider or healthcare institution	1	2	3	4	5
3.	Schedule my medical appointments	1	2	3	4	5
4.	Make it to my medical appointment on time	1	2	3	4	5
5.	Have access to healthcare services	1	2	3	4	5
6.	Exercise on a regular basis	1	2	3	4	5
7.	Access health insurance	1	2	3	4	5
8.	Utilize all of my health insurance benefits	1	2	3	4	5
9.	Eat healthy food on a regularly basis	1	2	3	4	5
10.	Drink plenty of water each day	1	2	3	4	5
11.	Navigate the healthcare system to address my needs	1	2	3	4	5
12.	Seek assistance from someone to navigate the healthcare system	1	2	3	4	5
13.	Pay for my medication as prescribed	1	2	3	4	5
14.	Take my medication/s as prescribed	1	2	3	4	5
15.	Understand why I am taking medications	1	2	3	4	5
16.	Not fear if people will judge me because I have a medical condition	1	2	3	4	5
17.	Attend to my medical needs in an emergency situation	1	2	3	4	5
18.	Seek medical attention without going to an emergency room	1	2	3	4	5
19.	Cope with living with a health condition (HIV, diabetes, cancer)	1	2	3	4	5
20.	My living habits will keep me healthy	1	2	3	4	5

> Good health enables individuals to be active agents of change in the development process, both within and outside the health sector. Increased investment in health requires public action and mobilisation of resources, but it also brings individuals opportunities for social and political participation in health-system reform and implementation. Agency is critical for development overall and for the development and sustainability of effective health systems, and individuals should have the opportunity to participate in political and social choice about public policies that affect them. (Ruger, 2003, p. 678)

Using a CBPAR process and a mixed-methods approach, a bottom-up and participant-centered definition of health and well-being was sought by engaging various stakeholders who serve health disparity populations. With multiple stakeholders adding to the health and well-being definitions, a process-based understanding of health—a process by which individuals recognize of various health barriers and improved reach for health-related goals with health hope—emerged as one that affects individuals' health literacy, healthcare access, and health outcomes. These were in line with the PSS theory as it has traditionally been empirically validated in the context of workforce development among low-income jobseekers. Health-PSS is defined as activation of and improvement in health hope and reduction of perceived health barriers as one stays engaged in pursuing individualized health goals.

Theoretically guided by PSS, this study focuses on how health hope and health barriers may serve as precursors to health outcomes; there is potential to better address empowerment as the primary missing piece in the health promotion puzzle. Findings could help promote programs and policies that foster growth in PSS as it relates to short-term, intermediate, and long-term health-related outcomes. This approach may seem like putting too much burden on the agency of grassroots. But high-quality health systems in the SDG era will require optimization of health care in each given context by "consistently delivering care that improves or maintains health, by being valued and trusted by all people, and by responding to changing population needs" (Kruk et al., 2018, p. e1196).

In this regard, this study advances knowledge in the field of research that examines the empowerment process among vulnerable community members who are at high risk for illnesses and experience comorbidity. These findings have the potential to invite more evidence of how process metrics can help health services stay anchored and grounded on the human-social development framework (Mohan, 2020). It adds to the social determinants and health disparities research with an understanding of health that is a perceptive yet dynamic capital called PSS to combat the oppressive system of care that does not include the most vulnerable to have a fair share of the commodity. Bringing the "human-centeredness" to social development to promote health equity can be achieved by building a PSS-based inclusive health system. Anchoring on PSS and building up an inclusive system of care could mean that policy focus shifts from individual deficiencies

to empowerment that could be activated for individuals to start the engine for reconnecting with a health or medical home.

This type of positive change cannot end with individuals becoming empowered merely with PSS at the individual level (PSS-I)—the process of switching the barriers to hope actions toward individualized health goal achievement. The bottom-up change ought to challenge the other side of the equation to match the success of the individual transformation. It needs to be supported by inclusive opportunity structures of the healthcare system—promoting a proequity organizational culture of psycho-social sufficiency (PSS-O) or co-sufficiency that embrace the PSS-I process of each member agent—to sustain long-term success with adequate positive reinforcement and returns from healthcare institutions (see Figure 2). It would be important to aligning the PSS-O process with PSS-I's barriers-to-hope movement that strengthens individual's meaning, purpose, values, belonging, satisfaction, trust, commitment, and intrinsic motivation in the journey toward success goal achievement. This could help drive the culture of inclusion and diversity which could help achieve organizational success goals that may be defined by performance and business outcomes.

As seen in Figure 1, the poverty wound may seem to depict the dominance of individual definition of poverty with the structural roots confining the public view and limiting available solutions (Hong, 2013a). However, the NSD framework allows the picture to be flipped to bring about the post material process of human-societal transformation (Mohan, 2010). This process could allow a bottom-up building around the identities of people the new development structures in communities and nations. By centering on structural and individual barriers for social development (Hong, Gumz, et al., 2021), PSS-I opens the door for system transformation to begin at the individual level and nudge the next system to respond with PSS-O. In the same vein, Viswanathan, Duncan, Grigortsuk, and Sreekumar (2018) suggest that "a bottom-up approach grounded in micro-level understanding of the thinking, feeling, behavioral, and social aspects of living with low income and associated low literacy can lead to greater understanding and improvement of interactions in the health arena" (p. 658).

FIGURE 2 Reducing institutional/system barriers and advancing proequity organizational culture.

At the onset of implementation of SDG, Buse and Hawke (2015, p.1) warned that its success requires a paradigm shift in addressing global health to surmount the following five challenges: (1) Ensuring leadership for intersectoral coherence and coordination on the structural (including social, economic, political, and legal) drivers of health. (2) Shifting the focus from treatment to prevention through locally-led, politically smart approaches to a broader agenda. (3) Identifying effective means to tackle the commercial determinants of ill-health. (4) Further integrating rights-based approaches. (5) Enhancing civic engagement and ensuring accountability. Mohan's (2018) seven pillars of social practice mission: education, service, empathic humility (EH), liberatory assistance (LA), transparent effectiveness (TE), and buoyance can provide a good framework in filling the gap in current knowledge and practice to reduce health disparities and increase health equity among disadvantaged populations in a fast-changing globalized world. In order to promote a culture of health and empowerment, one recommendation would be to incorporate and adopt Transforming Impossible into Possible (TIP) as a bottom-up system change model to enhance PSS for health and well-being—as have been found to be effective in other contexts (P. Y. P. Hong, Choi, & R. Hong, 2020; Hong, Kim, Marley, & Park, 2021; P. Y. P. Hong, Lewis, Park, R. Hong, & Davies, 2021), TIP could provide opportunities to put in practice the seven pillars on the ground to promote bottom-up, empowerment-based health processes and outcomes (Hong, 2016a, 2016b).

> One of the puzzling aspects of development theory is its fallacious premise that societal conditions will improve in proportion to the knowledge and resources that we employ to uplift the human condition. On the face of it, it is a positivistic and promising hypothesis. However, human banality defies its logic. This perhaps is the single most important reason why top-down approaches have not delivered as expected. (Mohan, 2010, p. 217)

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