UAHC with 'Community Participation' OR 'People Centre-stage'?

Implications for Governance, Provisioning and Financing

Ritu Priya

In our people-oriented model for universal access to health care (UAHC), is the vision to be of people's role as 'participation' in pre-designed services, or should the model itself keep 'people centre-stage'? This is the central issue for governance being addressed in this paper.

Some considerations for an 'Indian Model of UAHC'

UAHC is the latest initiative in a series of endeavours that is meant to help India and other low and middle income countries break out of the prevailing situation of distress due to lack of access to quality health care when there is a felt need for it. Being in agreement with several of the issues taken up in the concept note for the MFC meet, I would like to take the discussion forward on two points: One relates to the intent stated in the note that it attempts to break the myth of the TINA syndrome; that There Is No Alternative to privatisation of health care and the health service system working on commercial principles, since the state cannot provide universal access to health care. The second is about the meaning of 'commodification' in health.

1. **The TINA Syndrome and an Alternative Discourse for UAHC**

As stated in the concept note for this meet, "***The idea of this whole exercise is not just the development of a model but of creating an alternative people-oriented discourse in the present claustrophobic atmosphere of "TINA" and problematic 'PPPs' when it comes to 'development'***." (Shukla et al, 2010)

My contention is that we have the opportunity at this point of time to do much more 'alternate' thinking and model building than in the model proposed for discussion. In fact the world is almost looking to India to generate a bolder alternative, since it is a 'felt need' of all countries and India has historically given pluralist alternative visions to the world in several areas, including in public health. We must address the challenge to the maximum possible.

The TINA syndrome to be broken in health care today is not so much about the desirability of UAHC as a responsibility of the state, as it is about 'how' the state is to ensure UAHC. There is a global discourse pushing for publically funded UAHC in all countries, as much with the intent of people's wellbeing as with the intent of ensuring financial returns of the highest order on investments in health care and allied industries. Recognising the positive potential of this trend, we need to bring all the synergies together and use all spaces possible for the former objective. The TINA syndrome being propagated is that it is only through public financing and private provisioning that UAHC is possible with efficiency and quality and therefore is the desirable principle for building health systems with UAHC. The predominant discussions and the model being proposed across the world demonstrate a remarkable similarity across very different contexts revealing some common characteristics that fall well within the neo-liberal paradigm: they are highly medicalised and doctor-

centred, commodify health, and propose social insurance and purchase of services as the means to UAHC. What is the 'alternate discourse' that our 'model in the making' presents?

There is another perspective available to build a model for UAHC, as being articulated in the discussions on 'revitalising Primary Health Care', which though weaker in their salience and visibility, are also alive and kicking in the global discourse. We will have to consciously chose which one we adopt as our framework for UAHC--one that is currently being most widely propagated internationally in the neo-liberal paradigm or the other which espouses the spirit of the Primary Health Care approach and is closest to the 'MFC perspective' available in the statement in the MFC website. Features of the two are tabulated here after analysis of recent documents on UAHC and Revitalising PHC). It should be recognised that such characterisation is always fraught with ideal type reductionism, and there will in reality be an overlap of the two.

Features of Two Frameworks for Developing Systems of Universal Access to Health Care

S.No.	Current Dominant UAHC Discourse & Proposed Models in the Neo-liberal Paradigm	Proposed Alternative Discourse of UAHC with PHC Approach/MFC Perspective
1.	Medicalised perspective	Socio-biological perspective and multi-dimensional approach to dealing with health
2.	Doctor-centred	People as primary actors for health; providers as supports. Doctors and other providers equally important in appropriate roles
3.	Top down	Bottom up
4.	Commodification of health (purchasing of services)	People empowering; addresses the knowledge hierarchy in health
5.	Financing through social insurance/ private insurance/cess/ tax revenues	Financing through tax revenue based budgetary allocations /health cess
6.	PPP under a private sector framework	PPP under a public service framework
7.	Efficient, feasible and effective services from institutional and clinical perspectives.	Cost effective and safe health care under the context specific people's life conditions.
8.	Universalist and singular technological content that reinforces bio-medical hegemony is sought to be made 'affordable'	Context specific and pluralist technological content of services that is appropriate, cost-effective and deliverable at the closest point possible.
9.	Community participation is an externally generated involvement of people in services planned top down as ritualistic committee members oe as users.	Community participation is more than 'community monitoring', it is inherent in the structures and content of provisioning, financing and governance.
10.	Governance mechanisms being proposed (such as the National Health Authority) are more corporate compatible than	Structures of deliberative democracy have to be actively nurtured and mechanisms for assessment and articulation of people's felt needs

	conducive to people's control or political control.	have to be made central to the policies and implementation.
11.	Incrementally escalating costs despite cost-cutting exercises due to structures that are promoting profit-based provisioning and iatrogenesis despite systems for reporting of side-effects and defensive practice by doctors (as in the USA).	The only inherently non-commercial health interventions are home remedies and community services of local health care providers. Besides helping in cutting costs, they keep the possibility of a different vision alive. The danger of accessing medical help later than desirable has to be dealt with by a simultaneous strengthening of services to ensure access to primary and referral levels with quality. In addition, primary level workers who could facilitate self-care should also give information and skills about when to seek professional help.
12.	Addressing the social determinants of health is not a concern of the institution based medical care service systems and therefore are ignored, an issue of concern in contexts such as ours where water, sanitation and nutrition have yet to be addressed.	Possibility of inter-sectoral coordination and addressing the social determinants of health only in public systems with community level mechanisms.

While we adopt one of these frameworks, components of the other will continue to be elements within it. It seems safe to assume that MFC's predilection will be for the second approach. While adopting it, we cannot afford to be romantic about public systems or community initiative, and must recognise the importance of examining the experiences of implementing the first approach and learnings of analyses from its perspective, drawing upon the lessons wherever relevant within the second framework. In fact there is no country among the low and middle income countries that has demonstrated the feasibility exclusively of the first or second design. Brazil and Thailand offer some degree of success and examining the relevance of these models for India shows that an eclectic mix of the two has worked to an extent. Experience of these two countries also shows that Social Insurance is inadequate in 'developing' country settings and tax based financing is essential. But they go further, demonstrating that comprehensive services with strengthening of community level and outreach initiatives is crucial for UAHC among the most marginalised. Between them, Brazil is the more medicalised (urbanised as well) but it has evolved some form of deliberative democracy (would it be difficult to replicate or sustain as some analyses suggest?). Thailand's is a more rooted rural-based model though with less procedural democracy.

2. **Defining 'commodification' in health and thereby the content of 'health care'--** Moving away from the definition given in the concept note, it is proposed that commodification is not only about public and private provisioning, or payment and non-payment at point of service, it is about how we conceptualise health care. Is health care only about something to be 'delivered' so that technology

and services by experts have to be purchased, whether by governments or by individual households? In which case does it not remain a commodity?

Definitions of health care given in recent publications view it as only professional services , or even as 'goods and services'.

"The prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions" (The American Heritage Medical Dictionary).

Health care embraces all the goods and services designed to promote health, including preventive, curative and palliative interventions, whether directed to individuals or to populations" (WHO, 2000).

In some instances there is a further shift, from 'universal health care' to 'universal health coverage' and then seemlessly on to 'universal health insurance' (as observed, for instance, from documents related to the Montreux symposium)!

An alternative people-centred discourse has to go beyond this kind of definition and the following may be more useful from the Primary Health Care/MFC Perspective:

'Health care is a continuum from everyday activities and self-care by people to primary, secondary and tertiary levels of care provided by those with specialised knowledge about health who support the individual appropriately as and when necessary.'

This definition significantly changes the contours, content and functional design of a system for UAHC from that being widely propagated through the current discourse that views health care as only 'services to be delivered'. The two perspectives may accommodate the same services, but the functional quality and culture of health care they generate could be dramatically different. Can we develop this alternative discourse that goes beyond the professionals and medical institutions to a wider imagination that builds on and furthers the strengths of 'ordinary' people ?

If people are doing it themselves, why do we have to think about self-care in a system for universal 'access' ? It is important because even self-care requires certain pre-requisites for it to be accessible to people, it requires the knowledge, the confidence to use the knowledge on one's own and the material inputs required for it. Depending on their orientation to the issue, health professionals can dissuade people from self-care or facilitate effective and rational self-care. "Supporting self care is about increasing people's confidence and self esteem, enabling them to take decisions about the sensible care of their health, and avoiding triggering health problems. Although many people are already practising self care to some extent, there is a great deal more that they can do. The key is having health and social care professionals enthusiastically supporting self care." (Chambers et al, 2006)

Widening the boundaries of 'health care' to include self-care would change the meaning of 'participation' and the 'culture of citizen's participation' that the concept note refers to. If people's felt needs are given centrality, it takes us beyond mechanical 'community participation' to a more organic basis for the community's active involvement in health care. It also requires an active change in the

approach of clinicians and other health care providers, to what the patients and communities can and should be supported to do.

A separate note attempts to illustrate this approach by outlining the principles and possible model of evidence-based health service development with UAHC -- 'Conceptualising UAHC Bottom-up: Implications for Provisioning and Financing'. Some implications for governance are being discussed in the next part of this note.

II

Implications for Governance

A distinction has to be made between 'governance' and 'management'. In the present mainstream discourse there is much discussion about governance, but the content is almost entirely about management issues.

Governance is about setting down of the vision and objectives, the policy, principles and priorities of any institution or organised system. ***Management*** is about operationalisation of the principles to address the priorities set out in the governance exercise. This would require another set of policy/principle/priority issues/indicators to be decided for the more operational dimensions. For instance, financing such that there should be no out of pocket payment at the point of service is a governance issue, while working out of the mode of payment and the accounting systems to ensure this is more of a management exercise. Both are important and overlapping.

One of the primary governance issues is the process to be adopted for planning of the health services. Is it to be a top down process of building health service structures, giving primacy to the institutions and technologies, or is it to be a bottom-up process starting from the people's knowledge and possibilities of 'empowerment'? What are the decision-making structures and who gets primacy? Is it to be only about giving them membership in structures that function such that it becomes ritualistic 'community participation' eg as one of several members of the RKS which is otherwise composed of and headed by officials who not only do not value their opinions but actually find it a 'problem'? Or is it also possible to give them power by giving weight to their perceptions and priorities, eg. by designing some indicators used for assessing quality based on community understanding. The process would then have to be based on both, official policy and planning giving consideration to people's 'felt needs' and demand (as expressed through the findings of studies on people's perceptions and health seeking behaviours and through community monitoring) as well as on direct participatory decision making.

Empowerment comes by valuing their valid health knowledge and allowing their critical thinking to be given weight in official decisions, rather than only by giving them the capacity to buy commodified health care.

A second issue of vision and policy is about assigning roles to the public and private sector in UAHC. The non-fragmented, unified approach to the entire health service system requires that

public, private, NGO, community action for health--all be considered together. In a market economy, regulation of the private sector can only be through the market principle of competition and the public sector must be strengthened to provide it in the people's interest. The issue is of primacy to the public services framework under which all providers should become part of a unified system, or should the private sector framework be the unifying frame? The Primary Health Care approach suggests a public services-cum-community action framework. To move towards giving concrete shape to such an approach in health services development and management, an outline is given below:

The Planning Paradigm & Health Care Development

If the bottom-up paradigm of planning is to be adopted, then community needs in terms of AYUSH and LHT have to be the starting point for consideration of people's health care and 'architectural correction' of the health care system as a whole should be designed with this perspective. Governance and management strengthening of the public services, along with people's empowerment, will be essential components of action for UAHC from this perspective.

National / State Level

The national and state policy framework may be based on the following considerations:

i. All providers of health care be viewed as interacting parts of the whole health service system--public, private, not-for-profit, and self-care; modern and traditional medicine; home to tertiary care.

ii. The service structure be designed in broad terms with flexibility for state, district and block levels.

iii. The service structure be designed with consideration to the linkages and dynamics of :

- an epidemiological need assessment for elements of comprehensive care
- people's felt needs, and perceptions of quality health care
- a mapping of existing sources of health care and utilisation patterns
- practices and perceptions of providers of all segments of the health care system

iv. Administrative structures should allow for contextual flexibility, be sensitive to people's perceptions and take community monitoring feedbacks seriously, as well as be generous towards doctors and all cadre of health workers in terms of their work conditions and dignity as well as their views on strengthening of the services.

v. Management mechanisms be developed for the various sub-systems, such as:

- infrastructure planning based on population coverage and time taken by people to access services
- procurement and supplies that are need based and transparent

- human resources in line with the vision, with required levels and number of cadre, orientation and training, conditions of work etc. and systems for supportive supervision
- an effective HMIS that provides rapid information for monitoring and quick responses as well as periodic evaluation and course correction
- sentinel surveillance for diseases, with the information feeding into the ongoing evaluation and planning process, as well as a rapid response in epidemic situations

vi. Develop technical support structures that assist in assessment of technological options and system design at all levels, from the national to the block, with wide involvement of interdisciplinary expertise.

vii. Setting of Standard Treatment Guidelines that include from home remedies to validated therapies of all 'pathies' at each level of care, with indications for referral to higher levels and/or cross-referral. The Essential Drugs List could include the validated medicines of traditional medicine as well (as in Thailand).

viii. In light of the framework adopted, appropriate changes should be brought about in the curriculum and pedagogy of modern medical as well as AYUSH graduates, nurses and paramedical cadres. Highlighting the evidence on advantages of self-care to patients and to the health care providers and equipping them with the orientation and skills to support self-care along with minimising its risks would be key components.

The MOHFW must strengthen its institutional technical capacity for its policy making and oversight role; to assess technologies and programme/scheme designs as well as innovative systems development on an ongoing basis. This will require more in-house consultants who can work on their own and are enabled to coordinate external expertise as and when required. The budget must allocate sufficient funds so that the ministry does not have to depend on international agencies for hiring consultants for it, as is currently the practice. This is important as a governance issue if we want to move towards independent, objective, professional expertise to guide the decision making processes.

In addition, more officers are required for adequate attention to the various sub-systems within the overall health service system. Presently each officer is handling so many of them that they cannot do justice to any, having to coordinate all across 35 states and UTs for a billion plus population.

In the present context, the NRHM is the largest currently on-going initiative for strengthening of the public services. While variable in implementation and outputs across the states, it can provide a number of negative and positive lessons that need to be built upon while attempting UAHC.

District Level Planning

In this framework, the District Health Services and district planning would be central to the service system. A framework for an approach to District Health Planning is outlined below, based on the experience of analysing and participating in state and district planning under the NRHM, the principles of public health planning discussed in the previous section, and the findings of an 18 state

study on the 'status and role of AYUSH services in the public system as well as use of local health traditions':

1. Map the epidemiological profile of the district-- using institutional data on morbidity profile of patients attending, causes of mortality data and priorities identified in consultation with community level health workers and community mobilisers (AWW, ASHA, ANM, MPW, VHSC members, traditional local health practitioners, ...)

2. Map the prevailing health-seeking behaviours of all sections -- including use of LHT, AYUSH and Modern medicine, related to the most common and epidemiologically identified priority health problems. Studies of perceptions must be conducted to understand the reasons for the observed behaviour. Documentation of the health perceptions and behaviour should be an ongoing task at the district and state levels.

3. The documentation should be followed by validation of people's practices and locla health traditions based on the locally prevalent systematised traditional medicine by the AYUSH doctors at district level. Validated effective practices should then be promoted for use by the community as well as put to use at the health centres. This would not only revitalise the LHT but also contribute to strengthening the knowledge base of AYUSH and promote its non-commercial practice using local herbs.

4. The IPHS requirement of a herbal garden in each sub-centre and PHC provides the opportunity to facilitate the linkage between the cultivation of medicinal herbs and plants and their local use, involving the local traditional practitioners for this activity and linking it with the AYUSH doctor of the co-located facility. This should be one of the community linked processes and the panchayat and VHSC should be associated with this activity.

5. Use of the LHT and AYUSH for MCH, NCDs and any other conditions found suitable must be identified and promoted for self-care, home-based care and institutional care as appropriate. They must be made part of the Standard Guidelines for Treatment for all health care providers (including the doctors of Modern medicine and AYUSH, ANMs and ASHAs), stating the role of AYUSH and LHT in primary care and the points of cross-referral.

6. Assessment should be made of the additional support required through home-based care by the paramedical workers, the support required from OPD services provided by a doctor, whether of the Modern medical system or the AYUSH. Further planning of services should then optimise the work load and role of the HR of both Allopathy and AYUSH in the institutions.

7. A consultative process of block planning be undertaken with the doctors and health workers as well as community members, with mapping of existing services to identify their optimal utilisation, the gaps and barriers in service delivery and thereby identify priority needs for health service development in the immediate and longterm.

8. The principle should be that the point closest to the patient/community where the required appropriate care can be provided, should be equipped to handle the condition. No activity

that can be performed at a lower level should be planned for the higher level. This would be the most cost effective and accessible health care that can be made available.

9. The extent of complications arising, or the incidence/prevalence of serious illnesses requiring higher levels of care, should be assessed and infrastructure, human resources etc. planned accordingly.

10. The orientation and knowledge of providers of all cadres should be assessed and in-service trainings planned according to the vision for UAHC.

Technical and administrative support structures will be required at district and block levels, working in tandem with those at the national and state levels. All this is to ensure provisioning of appropriate, quality health care to all. Finally, multiple check and balance mechanisms in place will lead to an incrementally strengthening, pluralist, flexible and transparent service system that generates trust and effective outcomes.

As Goldberg (2005) has argued after analysing health service developments in the USA and Canada in the early years of this century, it may be advisable to first define health care and then discuss its funding rather than the other way round. "We need to agree on the core princples, values, and practices of the health-care system. There must be frank discussions about what type of healthcare we will deliver in the future. The qualitative as well as quantitative parameters of the system must be defined. The expectations of the patients must also be clarified..... Only after there is agreement by all parties on the core-values and quality of healthcare can there be a meaningful discussion about how the society will fund such a system."

[See companion paper 'Conceptualising UAHC 'Bottom Up': Implications for Provisioning and Financing]

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