Working Paper

HEALTH FOR ALL: AN ALTERNATIVE STRATEGY

A Note on the Current Tasks

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There are several positive aspects to the publication, 'Health for all: an alternative strategy'.[1] Firstly, it is seen as part of a process of analysis and sharing and not a discrete event in itself. Secondly, it is offered to the people at large to initiate and exchange ideas on alternatives; it is not seen as a final document enunciating a strategy on their behalf. It is a reflection of a gathering of concerned practitioners and professionals.[2] The Group's search for an alternative springs from its great dissatisfaction with the present - which it denounces spiritedly and is also the cause of its assertion about the need for a radically different alternative. Prescriptions related to the alternative offer a hope. But also some questions. This paper raises questions of implementation of the strategy and outlines the tasks to be done in the initial phase. The substantive content of the proposed services is not discussed in detail.

The diagnosis is that 'the situation is serious' and the prescription is that not more of the same, but more of something different is needed. The 'same' has not (and so will not) facilitate health. The Group then delineates the contours of a new national policy.

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[1] Health for All: An Alternative Strategy', Report of a Study Group, ICSSR, 1981.

[2] Referred to as the Group in this paper.

Five streams of thought seem to have influenced the identification of the present health care system as elitist, fragmented and dependency-creating: (1) Gandhian views on decentralised, democratic control over the political and economic system, revived by the experience with technology and state control over the past few decades and given momentum by Schumacher and others (2) Illich-like critique of the iatrogenic health care systems set up by men and of the professional mystification of life's problems (3) Critiques of the present inegalitarian society by a wide range of liberals and radicals, calling for systems in favour of social justice, access to and control by the poor (4) The push for comprehensive services mode of health service provision, propounded by those like Maurice King and Bryant (5) A Freirean concern for empowering the poor to fashion their own structures.

The environment created by these approaches and ideas therefrom, together with the cumulative impact of (1) reports of committees set up by the government such as the Bhore (GOI, 1946), Mudaliar (GOI, 1961) and the Srivastava Committees (GOI, 1975) and (2) the experiences of practitioners experimenting with alternatives has created a climate for the acceptance of the progressive vision of the HFA strategy as portrayed by the Group.

In terms of critical choices with regard to (1) the service or output of the health care system (2) the kinds of people it must serve and (3) the values it must promote the Group suggests the following:

(1) The type of service must not only be curative but comprehensive with emphasis on prevention and promotion;

(2) The values promoted must enhance people's capabilities for self-care rather than dependency on the system and professionals.

(3) Those who benefit from the services must be the poor

(4) In order to offer these services, promote such values and benefit the weak, the administrative organisation must decentralise.

Thus the group desires that the system must move in emphasis from a service provision role to an enabling role; from curative to educational functions; and the health bureaucracy needs to transfer its powers to the community and local institutions. Table 1 briefly presents the shift advocated.

Element	Shift	
	From	To
Service/Function	Cure	Comprehensive Care
Role/Task	Service provision	Enabling/Facilitative
Technology	Sophisticated and Western	Culturally relevant and appropriate
Organisation	Central Planning & Control	Local planning and control

Table 1

Desired Shift in focus by Study Group on Critical Elements

The call for a shift is not new as agreed upon by the Group. The principles outlined by the Bhore Committee in its recommendations (GOI, 1946; Banerjee, 1976) mentions access to the poor, rural focus, comprehensive care with emphasis on prevention, community based rather than hospital based services, self-responsibility of the citizen for his own health and the doctor as 'social

physician'. This is remarkable considering the period when the report was written. The Srivastava Committee (GOI, 1975) made similar references to enabling, educational and culturally appropriate health services and hence to appropriate education. The welcome additional emphasis brought by the Group seems to be in establishing the linkage between health and non-health aspects of living and the need for action on the economic (employment, wages etc.) and social (role of women) fronts.

The content of the alternative health services is not new, although some variations are suggested such as better hospital facilities at a community level. Focus on the Community Health Volunteer, MCH Services, Health Education, drug disabuse etc. is again a reiteration - necessary, but nevertheless a reiteration - f views of other groups and forums. However, the Group's enunciation of principles, approach and content of health services weaves together different strands and adds its emphatic touch to the exercise.

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The Group's repeated stress on the need for a radical change in health and other services and in the conception of health itself (p. 11, 84, 206-9, 211) reflects its desire to clearly underline that it is <u>not talking</u> of more of the same. A strong appeal is made to desist from 'tinkering with them (parts of the existing system) through minor reforms' (p 217), since 'misguided efforts as better training, better organisation, or better administration, will not yield satisfactory results' (p 84). Neither 'linear expansion of the present (p.84) nor 'marginal adjustments and changes such as more research, more hospitals, and dispensaries, more and better trained

personnel, more drugs and above all, more funds' (p 10) will deliver the goods. The thought looms up even as one reads the report: since the gap between the present and the desired future is so great, just where is one to begin? It is here that gnawing anxieties about change and implementation surface.

The 'present' after all is an inescapable reality. There are some 5000 PHCs, 6000 hospitals, 100 medical colleges, 2 lakh allopathic doctors, 3 lakh nurses, ANMs and mid-wives who are very much present and participating in the curative, 'western', disabling health services. Then there are the personnel and resources in the other sectors, where too, change is desired. The scenario presented in the alternative model (the less charitable will say) is an invitation to the present system to commit 'harakiri'. Others, more optimistic, may suggest that it is actually a plea for 'losing oneself to find oneself'. If, for 30 years, less radical measures have not been implemented adequately, how is one to expect different moves from the system? Hence the anxieties.

It is not that the Group is not aware of this question. The call for national consultations (p 14) and debate and the caution against a hasty view of the alternative model as an immediate programme for national health services (p 205) suggest that the Group too is anxious about creating a climate for change. Taking up the question of action steps in this direction is the first task of all concerned implementing agencies. To do this, the agencies will have 'to roam' in the present rather than 'soar' into the future to use Naik's (1977) appropriate imagery from another context.

This is not to say that the substantive services proposed are acceptable in their entirety. To take an example of the Community Health Volunteer's role, the Group highlights the non-curative functions (p 106). However, the responsibility most perceived by the key members in the volunteer's role set as executed by the volunteer (NIHFW, 1978, 1979) and desired by the community members, is the treatment of minor ailments. What is more, even with this desired function carried out by the CHV and the responsibility for selection and administrative supervision remaining with the community, it is not willing to materially support him (NIHFW, 1979). The question arises then as to the practicability of underplaying and negating the curative function in the CHV's repertoire. What may be more useful is to see how the CHV's functions can be widened after the performance of the curative function.

To take another example: With regard to health education, the Group reminds us that as far as the general educational system is concerned, elementary education should be compulsory and that health education should become its integral part (p 70). However, it is a fact that even with primary education, our actual experience is very unfavourable. Less than one-third of our children complete primary school. In fact, the Group notes this earlier (p 8). In the light of this experience, action with regard to elementary education as a whole again appears to have serious operational limitations. Later, when talking of health education by the health system, the Group is rightly concerned with the fact of the medical profession acting as a dispenser of drugs rather than as a facilitator of improved health (p 72). A critical question here is: How has the organisation structure of the health services valued health education? Education is a process of learning and growing and

educational tasks are difficult to programme. The educational task environment is not easily controllable and predictable. Hence visible results of an educational effort may take time to show its impact. The question arises whether the system of evaluation, which gives considerable importance to tangible results ("targets" is a byword) in the short run, helps or hinders such an educational effort.

The point is that the content of the services as proposed by the Group can be debated in its detail. However, if the strategy proposed by the Group is still acceptable in its broad directions and thrusts, then the next step is to consider the tasks involved in moving from the desirable future to the difficult present. What is necessary is to conceive of a programme of change of what is with us.

Three types of implementing agencies seem to be relevant in the context of change of the existing environment, structure and systems: (1) the State (2) the voluntary agency and (3) other agencies and individuals interested in evolving a different form of health care and a different way of healthy living. Four kinds of tasks suggest themselves for the consideration of these agencies in their efforts to work with one another and with the people at large. The tasks are inter-related and the explanatory notes below merely signify the potential.

(1) An educational task

If a large mass of people are to be involved in giving direction, planning and implementating the change, the first step surely is posing the problem facing the present system and building an awareness of the need for change.

Involving decision-makers, the agencies and the communities in a critique of the present situation is a major aspect of this task. Wihout this, on the one hand, the social climate for change may not emerge and on the other, an 'alternative health establishment' may soon formalise its interests. The decision-makers should include policy-makers and influencers such as legislators and bureaucrats. Excluding them would mean operating outside of the formal authority and influence system of the government. Research and dissemination as a support for this educational task is necessary. This is in line with the Group's concern for the creation of a 'social ethos' necessary for the success of an alternative (p 205).

(2) A pro-active action task

The proposal here is to review the present system to identify the positive programmes now being implemented. The Community Health Volunteer Scheme, MCH Services and the Minimum Needs Programme, for all their drawbacks, could be some of the state-initiated schemes warranting not only support from those looking for alternatives, but also vigilance to ensure that they are not the first casualty of false propaganda and financial stringency. Schemes such as the Minimum Needs Programmes may be the early victims of a cut in plan expenditures. The CHV scheme, demonstrably well accepted by the community (NIHFW, 1978, 1979) could easily become an easy prey of the professionals. An advocacy role related to these programmes could contribute to their protection from early assault and mortality. In other words, specific selected programmes which point in the right direction need to be identified and their implementation monitored along side of 'the educational task' being executed.

At the same time, there is a need for vigilance against moves to further promote the existing system. For instance, proactive action is needed to protect the growing elitism in the name of 'upgrading standards' by undue stress on higher and higher qualifications (Diploma/Degree in Pharmacy for all dispensing even in rural areas) or in well publicised sophisticated ventures (heart centres).

(3) A Programme Improvement Task

The organisational and operational weaknesses of these selected programmes will require study and assistance for the improvement of their performance. A possible cause for their downgrading may be the inefficiency, poor management and mal-distribution of benefits in the operational setting. At another more strategic management level, they will require help with effective strategies of planning and implementation. Those concerned with safeguarding and upgrading these programmes will need to devote their efforts to research and action at many organisational or community levels in health and related sectors. While an exclusive focus only on this task would stand the danger of 'tinkering' and making 'marginal adjustements', attempts to improve specific and selected programmes would be significant in the context of the other tasks. Successful programmes of this nature could be useful evidence and support for the educational and proactive action tasks.

(4) An innovative action-task

New projects or schemes of the State, voluntary agencies and individuals, which demonstrate the futility of autonomy-reducing, curative, elitist, centrally and professionally controlled health services while offering a glimpse of the alternative need to be further initiated and encouraged.

The innovative action may also be community's adoption of new measures such as effective non-drug therapies, trained 'dais' etc. Innovative action might also include not only successful micro projects but also collaboration with the macro system in order to help it to adapt innovations and implement them effectively. While this is implied in the programme improvement task mentioned, it would be indeed a breakthrough if experimenters at the micro level decide to link with the state bureaucracy to test their models.

The implication is that it is necessary to prepare for a long term change strategy, involving a synergistic movement and programmes related to these tasks. Michael's (1973) proposal of long-range social planning as learning about one's action in the present, given continually changing anticipations of the future is appropriate to meet the complexity of the tasks.

The appropriate organisation for the planning and execution of the tasks is the second question facing those interested in change. In the initial phase, when the ethos and the climate for change are to be created, it seems inappropriate to begin with yet another solution to be found in the organisation structure of the present health-services. Placing the responsibility for change in a Medical and Health Education Commission and a Population Commission as recommended by the Group, appears to be a hasty proposal. Any structure reflecting a transitional organisation which acts as a midwife in the creation of an alternative future must emerge from the initial educational phase and must evolve from the work of the concerned agencies. It is difficult to accept a structural device of a cell or a commission at the beginning of the initial phase of change. If the UGC is to be seen as an example, then surely its effectiveness must be analysed.

The tasks of change seem to require a network arrangement where wide participation is possible from many quarters of the country. It is this network which will have to accept the responsibility for change. Officials at various levels in the bureaucratic structure, activists, voluntary agency leaders and workers, academics and researchers, agents of communication - many of those searching for alternatives at various times and on various occasions would assume task-related responsibility for bringing about change. It is this group, laterally linked through task forces and temporary coalitions that must create the process and structures for change, appropriate to the demands of the situation.

It may be useful to learn from the experience of building such organisations. The Medico Friends' Circle's creation of a network of concerned individuals and groups for education and action could offer some lessons. In its brief period of existence and with shoe string finances, its attempts to bring together a number of health and other professionals interested in an enquiry into the present state of affairs require attention. The activities of the Family Planning Association of India and the Family Planning Foundation in carrying out the educational and programme improvement tasks and involving the state structure would offer another set of lessons. Similarly, the Voluntary Health Association of India's efforts to promote and further community based health care ideas and action could be looked at. The ICSSR's own activities of forging links among a set of concerned individuals - academics and activists in the health field could suggest the means of building a network. The learnings from these efforts and others such as these will throw up hints for designing the appropriate organisation for carrying out or participating in the tasks. Each of the implementing agencies will no doubt have to identify its own internal mechanism to facilitate the performance of the tasks.

It is proposed in this note that for a transformation to take place, the critical task now is to start with the present. A strategy of change has to evolve building on the present strengths and negating the weaknesses in the light of favourable and unfavourable aspects of the environment. Four tasks to initiate a change strategy and an appropriate network organisation to execute the tasks and facilitate a long range planning are suggested. A preoccupation with further speculations on the most desirable future could distract us from the onerous tasks of the present.

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