

## CHAPTER 7

# Concluding discussion

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### The balance sheet

The early 1990s witnessed a continuing commitment on the part of governments, international development agencies and NGOs to the promotion of effective community participation across a wide spectrum of development activities. In 1990, for example, UNICEF undertook a review of the participatory approach with relation to its work (UNICEF, 1990); in 1993 the OECD similarly undertook a detailed review of the concept with regard to its effectiveness in improving the work OECD supported (OECD, 1994) and in 1994 the World Bank issued a major statement on the importance of community participation to its work and incorporated a participatory approach into its loan operations (World Bank, 1994). The Forty-seventh World Health Assembly agreed on the need for a more action-oriented focus on community participation. It argued that more could be done to pool the energies and resources of communities with those of the formal sector and to bring about the behavioural change necessary to make community participation a reality. It concluded that effective community participation could transform health care and delivery at the district level.

Where it has occurred, participation in the decision-making process and in determining how resources are allocated within the health sphere has also enhanced the public's sense of responsibility for specific projects. It has also helped ensure that people's felt needs are covered and that the approaches taken are consistent with local social characteristics and preferences, while building on the important indigenous knowledge base and expertise which exists in every community (WHO, 1994a).

In the 1990s the debate concerns the ways in which the fundamental paradigm of health care and health development needs to change. There has been a modification of the understanding of CIH which dates back to the mid-1980s, and which should be seen in the context of the

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emerging agenda of health sector reform. The general tone of the statement is one of “partnership” between communities and formal health services, with the former assuming greater responsibilities, both administrative and financial, for the maintenance and development of these services. Some might argue that this is an inappropriate direction. The recent past has seen intense activity in the field of community involvement in health development: a great deal of information, publications, research and workshops have contributed to pushing the work forward. What, then, have been the general outcomes of this activity? In this respect, perhaps several areas of achievement should be emphasized.

### Achievements in CIH

- In comparison with, for example, the early 1980s, there is now a more widespread awareness of and, although to a lesser extent, a commitment to the concept of people having both the right, and the knowledge and skills, to play a role in the health care and development of their families and of the communities in which they live. The reasons for and the arguments behind this situation have been looked at in Chapter 1. The language of “participation” has become common currency in the field of health development, as in other sectors, culminating in the notion of community action for health (CAH), which was discussed at the Technical Discussions of the World Health Assembly in 1994 (WHO, 1994a). Major health policy-makers and professionals are likely to be at least aware of the concept of community involvement as it applies to the health field. This is a substantial achievement, even if there may now be conflicting interpretations of what CIH means in practical terms at the health district level.
- In parallel with the above and, probably often as a result of it, there has been a recognizable, although not great, advance in the practical understanding of the concept of community involvement and experimentation with it as a methodology for health development. The case studies in Chapters 2–4, the literature used in the other case examples and WHO documents (1994a and 1994b) all attest to the fact that in many countries health services and different local groups are trying to make a practical reality of the concept of CIH. The literature on health care and development in the 1960s and 1970s, for instance, starkly contrasts with that of the 1980s and 1990s. The Alma-Ata Conference is largely responsible for the change, and its vision and message appear to have been embraced at operational level, although senior administrators and policy-makers may still find the discourse uncomfortable.
- CIH has also resulted in a wider understanding and interpretation of

issues related to health care and health development. It has “prised open” the health field, so long the unique preserve of the medical profession, and introduced, for example, political and sociological analysis. Better health can no longer be seen purely in medical terms: the reasons for poor health need a broader analysis. Similarly, CIH has demonstrated the relevance of terms such as “empowerment” in matters of health and suggests how powerlessness might be the root cause of poor health. The issue of power and health is now raised whenever people intend to find meaningful solutions to poor people’s health problems. Furthermore, “equity”, “solidarity” and “political framework”, for instance, are terms which have entered the jargon of health development and attest to the growing influence of participatory approaches (WHO, 1995).

- Doing more with less money: in the context of a substantial decline in the resources available for health and health services in the past decade, particularly in developing countries, there is the increasing suggestion that CIH can help health services to extract the maximum from the limited resources they have. While the notion of greater effectiveness in the use of resources has always been at the heart of the participation debate, the evidence for this assertion is not yet overwhelming. It could perhaps be argued that where health services have promoted CIH, this has led to wider health coverage with existing resources: however, this argument has yet to be proved.

### **Problems facing CIH**

It would be wrong to assume that community involvement is now a widely accepted and implemented principle of health development. The debate, dating back to the 1980s, on the performance of primary health care as a strategy of ensuring minimum access to and availability of basic health services at the district level, remains inconclusive (Macdonald, 1993). Community participation is a basic tenet of PHC but some question whether the strategy has been widely and faithfully implemented. Werner (1993) and Werner & Sanders (1997), for example, have consistently criticized the failure to adhere to the Alma-Ata Declaration and to adopt PHC as a basic health strategy, with the resources necessary to make it effective. Thus, the impediments to the promotion of CIH remain formidable but not insuperable.

- The concept of community involvement has always been subject to a wide range of interpretations and the absence of a common working understanding at the health district level can be one of its biggest weaknesses. Some interpret CIH in terms of a real transfer of authority and responsibility; others limit it to a form of sponsored collabo-

ration with a built-in reward system. The former is the more authentic interpretation; the latter does little to build up long-term community skills and understanding of health development. Indeed it is in the area of interpretation that most unresolved debate lies. Earlier interpretations of CIH were couched in such terms as “rights” and “ownership”; today, many see the concept more in terms of its usefulness as a strategy for cost-recovery (Toonen, 1995).

- Despite more extended coverage with community health workers, the building of health posts, national-level structures of “citizen participation” and the existence of many types of community organization, it is probably accurate to state that the vast majority of the world’s people continue to have little or no access to any kind of structure that might give them the opportunity to get involved. Cassels (1995) points to this crucial issue of access and argues the need to understand why, at the country level, access is denied to so many people. To date, there is little evidence that national health services are putting much effort into promoting the means of community involvement. If a sound base already exists, CIH can begin to develop; if not, there is often little momentum for change.
- Much has been written about the enormous and genuine problems which formal health services encounter in trying to come to terms with the implications of community involvement for their own management structures, method of operations and training needs. The issue was discussed in detail by the WHO Study Group in 1989 (WHO, 1991) and the observations of that group are still valid. Many would argue that the fundamental obstacle to any redefining of the paradigm of health care and development lies in the entrenched thinking and practice of traditional health services. These services are still wary of local communities which seek to define health problems, prioritize them and contribute to their solution. Zwi & Mills (1995) rightly point to the issue of accountability and the critical need to open up entrenched health services to allow representatives of local people to become involved.

### **WHO’s agenda for action**

Rifkin (1996) has questioned whether CIH has lived up to its early expectations. She affirms its critical importance for PHC and health development in the resource-poor countries of the world, but concludes that the lack of a “common frame” has reduced its impact upon national health services. But CIH is an evolving concept, and thinking and practice will adapt to the overall political and economic climate in which health development takes place. The still-endemic nature of poverty in many parts of the world, the “different” perspectives on health and health development between “developed” and “less developed” coun-

tries, the gulf between increasingly technologically driven health care and indigenous practices and the hard demands of economics — these will all be issues which will influence the course of future health development strategies. In this respect, a number of relevant questions might help to determine this course (WHO, 1994a):

- How best to strengthen people's effective participation through, and as part of, the health-for-all strategy?
- How best to encourage the community to enter into a viable and sustainable partnership with the formal health sector?
- How best to facilitate the formal health sector's active involvement in enhancing community initiatives for health?
- How to ensure that development activities are viewed holistically, and health truly seen as one of the integral and essential components of the development process?
- How to "translate" scientific data into the type of information that can be used by the community in reaching technically valid decisions together with the health sector?
- How best to ensure that resources can be generated and sustained in support of community action for health?

If the above questions were answered, it would substantially advance the cause of community action, since there still seems to be a need for a dynamic and radically different agenda addressing the health needs of the vast majority of the world's population and based upon strategies which seek to ensure the effective participation of communities.

### Health sector reform

The above issues relating to CIH are relevant to the ongoing debate on health sector reform. Changes in people's health and in the patterns of disease, political changes favouring decentralization, the ever-increasing cost and the ever-diminishing prospect of universal access to health care, combined with increasing economic pressures, are all critical elements. Against this background, the future is neither clear nor certain. Strategies for health sector reform vary from country to country. However, a number of common elements have emerged. The role of government has tended to change from that of a provider of health services to that of a *regulator*; health could be seen in economic terms as a commodity whose supply and quality depends upon the financial resources of the "consumer". However, there is evidence that health service decentralization programmes lack adequate resources, are rarely supported by appropriate research and usually fail to meet their stated objectives (Bossert, 1996). Nevertheless, the *decentralization* of government health services is seen as critical to improving efficiency and to ensuring that

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services respond to local health needs and conditions. There has been major debate on the roles of the public and private sectors in health care. In most countries, the state, despite its inefficiency, remains the only credible provider of the basic services required by millions. Thus, new ways of *financing* health care and services will be crucial, given the changing role of government. While the policy options will vary depending on the country context, debate has focused on *user charges*. The alternatives appear to be either a charge at the time of treatment, a prepayment system or some form of collective community financing of health services. The question of charges not only raises issues such as "equity", but has in the past undermined broader and more active approaches to CIH, and reduced community participation to an exercise in cost recovery.

In a major review of the health sector in 1993, the World Bank suggested that there were three main lines of action for governments (World Bank, 1993):

- *Foster an enabling environment for households to improve their health*: this includes economic growth policies which it is hoped will result in more direct income for the poor and greater investment in education and public health activities and policies designed both to recognize and to strengthen women's position and role in health development. In low-income countries in particular, the emphasis upon the need for widespread involvement in education is underlined in order to increase the potential of the population both to respond to, and to take some lead in, policies of economic growth. Economically sounder communities and families will be better able to take some financial responsibility for their health needs.
- *Improve government spending in health*, both in terms of the management of public health services and the provision of essential clinical services to the poor. In recognition of the immediate health needs of the majority of the people of most developing countries, this improvement would also include a reduction in government expenditure on such things as tertiary care facilities and specialist training. Finally, there is the recommendation that more government spending should be allocated to public health where, it is suggested, the greatest health development impact could be made.
- *Facilitate the involvement of the private sector in health care delivery*, making use of incentives such as *privatization* of health services, *cost-recovery* for services and the extension of national or private health *insurance* schemes. It is argued that community financing, in the form of user charges and prepaid insurance schemes, is the only viable solution to the problem of providing sustainable health services to huge populations in resource-poor countries. In this respect the Bamako Initiative, which was launched in 1988 and which seeks to capture, for the

public sector, resources that people have to spend on health, is being studied with interest (UNICEF, 1990).

Clearly, health sector reform is a complex debate which already puts pressure upon national health services to respond. In particular, there are concerns about placing the burden of health care costs on the shoulders of the poor, the consequences of increasing privatization of health services and the implication that reduced government spending, as a result of adjustment policies, could lead to a narrower — i.e. more selective — approach to health care. Strategies appropriate to more developed countries may be inappropriate in less developed ones. While the overwhelming cost of health care provision may be the issue in one country, in another it may be more availability and access. Although such reforms as those mentioned above are rooted in the efficient use of economic resources, it is unclear in what ways *people* are seen as a basic resource in them.

In these reforms “health” ceases to be seen as an intrinsic right, but instead becomes more like a consumer good for those who can afford it. On the other hand, health as a “right” emphasizes access and the development of appropriate health services on the basis of people’s involvement. Technocratic proposals for health sector reform seem to address the problems associated with increasing demand for increasingly expensive health care in more developed countries, but their relevance to the health needs of the majority of the world’s population is questionable. Issues such as “prevention”, “equity”, “access” and “affordability” are still very relevant to health sector reform in a lot of countries, and these are issues that may not be appropriately handled by market mechanisms.

### **Whither CIH?**

The above reform proposals need to be judged against the overwhelming inability of desperately poor peoples, in particular in the least developed countries, to pay for their health service needs over and above the taxes they pay to their governments. It is difficult to see the link between these proposals and the realities of the largely non-monetized economies in which half the world’s population lives. Privatization, cost-recovery and insurance are biased towards curative care; the health needs of most of the world are still concerned with prevention and public health.

In this latter scenario, the concept of community involvement remains valid, and it could be argued that, in its original conception, it is still a viable strategy for bringing health services to, and promoting better health among, the world’s population. CIH essentially sees people as a resource for, and not merely as users of, health services; the current

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proposals for health reform tend to see health care in purely economic terms. Furthermore, health development is not concerned merely with trying to provide economically sustainable curative services; it has a much wider remit and it is concerned with the health of people and how they can contribute to health development. In particular, CIH can help promote a number of key concepts which should be important in any concept of health reform:

- *Equity* of distribution in the provision of health care is, given the inherent divisions in any social structure, almost an impossibility. However, CIH offers the best opportunity to begin to redress what, in many countries, is a marked imbalance. Market forces alone, by their very definition, will be much less responsive to issues of equity. Walt (1994), for example, has noted the increasing role of special-interest groups in securing access to and influencing health service policy, thus skewing such services even further in favour of the more politically and economically powerful.
- The mobilization of *support* and *resources* both to sustain and to extend the coverage of basic health services; remarkably, some suggestions for reform seem to overlook this in their concern to get the professional health structure functioning better. If proposals for health reform addressed the issue from the opposite perspective, a more balanced (and realistic) set of proposals might be established. While nobody argues about the need for economic efficiency and effectiveness, there is much debate about whether they can be only professionally led. In this respect, the pioneering work of PAHO in its promotion of the concept of co-management at the district health level (SILOS) is providing invaluable insights into effective community participation (PAHO, 1994).
- The creation of *community will* and *values* to decide what is important in health development. Such concepts are both qualitative and frustratingly unrigorous but, even so, they offer an antidote to the potential lack of values of exclusively market-led and professionally led health services. Whatever the context, it is probable that most people have an explanation for poor health and views on what needs to be done; involving people will promote good health as an important value and will show that people can at least try to do something about it.
- The *integration* of health into the other areas of development work which are also important to people. The concept of community involvement is not unique to the health sector; it has emerged as a fundamental principle of much development activity. The more widely it is adopted in development work, the greater the prospects of revolutionizing entrenched methodologies of project invention.

At the time of the late 1990s, the health sector risks reverting to a disease-based, technical and positivist approach to health care and development. Whereas community involvement is increasingly influential in other development sectors, in the health sector it has not made a breakthrough with regard to national systems and policy-makers. However, there is strong evidence that when local communities have a sense of ownership of a development initiative, it has a greater chance of making an impact. For this reason, community involvement in health should be accepted as a key principle of any proposal for health sector reform. Its achievements to date have been solid if unspectacular; the difficulties of implementation are increasingly well understood. CIH as a vision, a guiding principle and a strategy has earned its place in debates on the future of health care and development. Good health is a basic human right, and community involvement is a basic prerequisite for ensuring that poor people have the chance to enjoy this right.

In a review of primary health care, Werner & Sanders (1997) underscored the importance of community participation. They concluded that the relative success of health programmes and policies which maintain a community-oriented approach, and the failure of those which do not, highlights the importance of community participation in attaining health for all.

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