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DE-WESTERNIZING HEALTH PLANNING AND HEALTH CARE DELIVERY: A POLITICAL PERSPECTIVE[1]

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To understand why a de-westernization process of health services seems to be urgently needed in our Western societies, we have to begin by looking back into the history of western medicine.

1. Understanding the roots of the problem: Western Medicine and its hierarchy:

The western approach to health maintenance and delivery departs from the one-sided and elitist assumption that "Doctors know best" - either as individuals or as leaders or members of a health team. One can, therefore, certainly expect some of the physicians' ideological biases to be mirrored in the health related policies of a country.[2]

It is to no surprise, then, that western health planning is based on a top-to-bottom decision-making process in which the "experts'" interpretation of the surrounding reality prevails, although they themselves are outsiders to the problems considered.

All this situation has created an unhealthy dependence of the health sector on the professionals, and the health establishment has definitively had a role in generating this dependence.[3] (Lella 1977.)

For one of the authors that has explored this topic deeply, the above dependence is created by the capitalist mode of production and consumption:

"Medical bureaucracies are not the generators, but the administrators of these dependencies. Social relations determine the type of organization of medicine to be chosen and the type of technology to be used. Technology reinforces the already existing division of labor.

In the health team the hierarchy observed is the following:

-physicians (upper-middle class extraction)

-nurses (lower-middle class)

-attendants, auxiliaries and service-workers (working class extraction).

Responsibilities in the team are primarily due to the class background and sex roles of the members and only secondarily to their technological knowledge. Education and training is the mere legitimation of that class and sex hierarchical distribution of power and responsibilities. This class structure and hierarchy militates

against the provision of comprehensive medical care. A strategy for better care requires, not the authoritarian (vertical), but the collaborative (horizontal) distribution of responsibilities, including the patient. Further, it should be pointed out that since the health industry is administered, but not controlled by the medical profession, the main conflict in the health sector is nothing but replicating the conflict in the overall social system, and that conflict is not primarily between the providers and the consumers. Therefore, the deprofessionalization of medicine and its democratization are not possible within our class-structured society." (Navarro 1975:351).

From this perspective, one can accurately say that in modern times the types of health services have continuously changed and been redefined according to the needs of the capitalist mode of production.

The medical profession is thus a guardian of the definition of these bourgeois values, but not its ultimate definer. (Navarro 1975:351).

Now, looking at the situation from the consumers' side, it is interesting to note that societies most often complacently accept the resource allocation for health services proposed by doctors. While this may provide a steady-state, it also represents a set of implicit priorities which, while lending stability, may well be blinding to the potential benefits of resource allocation to other more pressing needs. Without explicit popular pressures to alter comfortable implicit priorities, resource reallocation in the production of health will occur slowly, if at all. (Dunlop 1977:471).

The question that inevitably comes to our minds following this brief analysis is whether all what we have said so far means that the socialist countries solved the problems we described for western medicine. The answer is a partial no. Socialist societies also have full fledged bureaucracies as the controllers of

social activity. These bureaucracies - including the medical bureaucracies - are not the primary controllers and planners of this social activity, but are subservient to a larger authority, the political party.

> "When the accumulation of capital became a primary goal in those socialist countries they used their political control not to decentralize and democratize services but to optimize control by increasing centralization and hierarchisation. The party and its bureaucracies determined the replication of similar, although not identical, class relations to those in western societies. Although there is a considerable overlapping of membership among party and bureaucracy, still the bureaucrat and technocrat are both dependent on the political party. The democratization of the former would require the democratization of the latter. One might then say that the socialization of the means of production is a necessary, but not sufficient

condition for its democratization. The political centralization of power can bring about a reappearance of class relations."[3](Navarro 1975:351).

2. The participation issue:

Participation is not immediately and automatically exercised by people when the opportunity is offered to them, especially in rural areas. Peoples' expectations to fulfill their felt needs have to rise objectively in order for them to participate and offer their collaboration.

The question of how to create viable alternatives for peoples' expectations, that suit both national leaders and villagers, remains probably the most important issue for future development in this area.[4](Gish 1975).

The first principle of community organization and participation is to start with people as they are and where they are. If one wishes to help a community improve its health, one must learn to think like the people of that community and understand their habits. Questions like: How does a human community accomplish its business? What keeps it in its course? How does it see and solve its problems? How does it perceive and receive efforts from the outside or the inside to improve its health? must be addressed. Vast stores of information about measures useful in solving health problems are actually found within the community. It is in the public part of public health that we are the weakest.[5] (Paul 1955).

The question, then, arises: can government schemes alone do anything to help villagers to fulfill their own health care requirements? The planners' skills and wisdom are most often not very relevant to local village-level problems:

"What is required are people in each village who know something about the environmental health care needs of their fellow villagers: such people would come from the village and remain part of its day to day functioning. There is no way to put the large number of people needed for such work on ministerial

payrolls; therefore, they must continue to make their livelihood from within the village itself. Most ministries are not only incapable of giving the kind of support needed at the village level, but are themselves actually destructive of the possibilities of self-reliant village development." (Gish 1975).

3. Decentralization

Better coverage of the population with basic health services need to be achieved through a set of deliberate policies that place value on the health of all citizens. In countries with limited resources, this will necessarily mean a redistribution of emphasis towards the traditionally more deprived areas, often those that do not get any health coverage at all. The latter, definitively means more emphasis on the provision of decentralized primary health care services. It also means getting away from medical specialization, closed urban hospital-care, and intensive and curative, highly personal, health services.

This, is bound to hurt the feelings of a number of the involved professionals, and therefore, calls for the

training of new intermediate health personnel, strongly attached to the areas where they are going to be working.

Of course, one important added requirement for this new decentralized approach to work more efficiently, is the delegation of authority to more local decision-making bodies.

4. Steps towards de-westernization:

Solving the existing health problems is not primarily a technological task or challenge. It is importantly an ideological problem in which the challenge is to offer the services objectively needed. But the latter depends on a number of different perceptions of reality about the most pressing health problems in a given community. To provide the needed health services, this incongruency and the contradictions it creates have to be resolved. Since the process of de-westernization of health planning and delivery is necessarily political, de-westernization efforts have to create instances that

allow the beneficiaries of health services to give their inputs and views of reality, from their perspective, before decisions are made. In this context, de-westernization is nothing but the more logic reaction to reverting alienation in the health sector.

In order to attain health, the people must change their way of living, not just "buy more medicine". But lifestyles are deeply rooted in the way in which society operates economically, politically and culturally, therefore, a change in lifestyle means profound changes in all three of these parameters. (Lella 1977).

The greatest potential, then, for improving the health of the majorities, is not primarily through changes in the behavior of individuals, but primarily through changes in the patterns of control, structures and behavior of the economic and political system of a country. The latter could lead to the former, but the reverse is not possible. (Navarro 1975:351).

Popular participation, it seems, can become real only in nations that have organized themselves in keeping with the needs of the whole of the population. (Gish 1975). This is probably demonstrated by the fact that the countries that started the process of national change (in health) by a political process have so far shown a clear advantage in speed and coherence. (Newell 1975).

De-westernization efforts, to be successful, have to simultaneously attack two fronts. One, has to do with enhancing all positive trends and currents that lead to a more participatory health planning and delivery system, and the other calls for decisively acting on the factors that oppose or put brakes on such an effort.

In the end, the positive trends will, most probably, only be actively persued by governments politically commited to overcome the inequalities of capitalism.

Several of the areas that need to be simultaneously attacked in this "positive trends" front are:

A. Community Organization and Participation in overall local improvements:

This participation, in the case of health, has to be at several levels:

a) Grass roots (the community itself): Here is where the major emphasis is needed. Work should be channelled through the local natural leaders, creating awareness and raising conciousness to stimulate real involvement of the people. Also, at this level, the training of local health promoters can be a positive step. The same is true for popularizing health education, in order to elicit participation and responsibility in health related matters; conventional and non-conventional educational means should be used to this end. The challenge is to bring people from a state of self-interest to the crystallization of self-help initiatives.

b) Other local levels: Local organized labor and local units of political parties and, in general, any other living organizations of the community should also have a mechanism to express themselves in terms

of their reactions and priorities towards health programs.

c) Regional and provincial health councils: This level definitely requires greater political awareness and education of its active members, given the executive power these councils should have. Their main task is to bring to the central levels the feelings and demands of the beneficiaries of the health services and on the other hand, they discuss, pass down to the implementation levels and supervise new policies.

B. Overall Democratization and Decentralization of the Health Bureaucracy is a must, so that the organized community and the health service workers can really participate in the planning of new policies and have some kind of control over the process. An advisory role alone is not enough.

Since for most of the underdeveloped countries it will be impossible to train enough physicians in the decades to come, to cope with the present and future health delivery needs, one of the highest

priorities in the democratization process is a decisive move towards the training of intermediate health personnel in order to be able to staff new health care facilities in deprived areas.

C. Changes Towards a more Equitable Distribution of Income and Health Services in the Country: These changes are also a must. Participation alone will not solve the health problems of the poor.

In general terms, income redistribution could be achieved through one or several of the following deliberate mechanisms: (Schuftan 1979:29).

a) Differential salary adjustments following inflation (proportionately higher raises for lower income groups).
b) Progressive taxation system on income and property.
c) Land reform
d) Transfer of technology and credit discrimination towards small enterprises.
e) Other (vocational and technical education, nationalization of natural resources and financial institutions, etc).

In terms of more equitable distribution of health services, four interconnected interventions should be considered: (Newell 1975).

a) More equitable reallocation of health resources between all segments of population.
b) Introduction of programs of self-reliance and self-help (urban and rural).
c) Allocation of a larger percentage of the health budget to the development of peripheral primary health care services.
d) Redesigning of the overall health services to support primary health care as a priority in rural and periurban areas.

These components represent possible different levels or approaches to de-westernization in the health sector. Each country should choose its priorities starting, whenever possible, from the people's felt needs, trying to compatibilize them with the technical measures that make best sense in each case.

D. A new Doctor-Patient Relationship:[6] Although this is difficult to impose by decree, some efforts towards this end have to be made. A change of attitudes towards patients should occur, both, at an individual and a collective level. At the individual level, reducing the "distance" between doctor (or health provider) and patient is the final goal; also, the patients should be encouraged to gain more "control" over their own bodies as part of this process. At the collective level, the whole health team needs to become more involved in community affairs and problems to, hopefully, share health priorities and felt needs with the community that can be translated into specific effective demands. Only if this process is successful, and it will take quite revolutionary changes to get there, will "the" local doctor or clinic become "our" doctor or clinic

As for the factors that oppose a more participatory health planning and delivery system, important

sources of conflict can be expected in the de-westernization process in any country. Often it is professional organizations that respond resisting the changes; in our case, mainly the medical establishment.

But there are also other forces opposed to the de-westernization process of medicine, if sometimes acting indirectly. Without going into any detail, at least one such force can be mentioned here briefly. That force is behind the expanding trend in the use of western-type medications and medical technology around the world. This trend is mainly the result of the agressive marketing attitudes of transnational pharmaceutical houses and other medical technology corporations in the third world. Perhaps the most dramatic example of this is the westernizing trend in infant feeding that is being observed in Africa, Asia, and Latin America as a result of agressive promotion of infant formulas and bottle feeding done by these companies. The whole system is often build on heavily influencing physicians and other health

personnel through the use of general advertising, the handing out of free samples and generous gifts and through the use of other "incentives".

Therefore, if de-westernization is to succeed, active and decisive measures have to be taken to counter the internal opposing forces as they rise. Political steps will almost always be needed to do this successfully. Moreover, the whole de-westernization process has to be implemented quickly, letting the community representatives take early control of the democratization process and of the newly created structures. The pressures from without, that stand in the way of de-westernization will also need to be neutralized early and decisively, i.e. letting the government take into its hands the purchase and distribution of drugs and baby foods.[7] (Waitzkin 1974: 171).

Finally, it has to be emphasized that it is difficult to generalize about measures or steps towards de-

westernization from the political point of view. Each country is different and each country can only go so fast as its political conjuncture will allow at the time the decisions are made to democratize and decentralize their health services. No imported "prescriptions" will be valid or applicable to the local reality. Overall health cannot improve as an "island" without an overall improvement in the socioeconomic conditions of the poor majority.

NOTES

1. When talking about de-Westernization from the political point of view, as we intend to do here, we will be actually talking about Democratization and Decentralization movements in the health sector.
2. "Industrialization of medicine has actually lead to the creation of a corps of engeneers, the medical profession. Because of their technical expertise, physicians have come to believe that professional dominance over health policies is justified. The medical profession has, therefore, a monopolistic power of definition of what is health and what method of care may be publicly funded. This fact is bound to create conflict between the medical profession, the medical care system and the consumers." (Illich, I. "Medical Nemesis: The expropriation of Health", Caller and Boyars, London, 1975). Illich's whole thesis of de-westernizing medicine seems to "leak" because he does not spell out his thoughts causally and he refuses to discuss real remedies. (Lella 1977). Therefore, no more attention is given to his approach to de-westernization in this paper.
3. The experience of Cuba, at present, is interesting to note at this point. After their initial phase of de-westernizing medicine, infectious deseases became a secondary problem in Cuba, in terms of patient consultations. Now, more grass-root desires have arisen for higher technology medicine. Therefore, a shift in policy towards the more traditional practice of doctor-centered responsibility for individual patients has occured. (For more details see Guttmacher, S. and Danielson, R. "Changes in Cuban health care: An argument against technological pessimism", Intl. Journal of Health Services, Vol 7 #3, 1977).
4. "The relationship between rural hopelessness and health is a complex one. Ill health adds to hopelessness, but its removal does not mean there is hope ... The problem and the priority have to be the total rural hopelessness complex and not just ill health. We are only slowly beginning to

understand that people themselves are aware that health may have a low ranking among the starting points for change." (Newell 1975).

5. People basically "do for themselves" with regard to their own health requirements, this meaning a departure from the accepted technological approach to health. Villagers have at least the potential, if not the capacity, for organizing their own lives to produce sufficient skills to do most of what is required to create a healty environment. (Gish 1975).
6. For an excellent review of this topic, see Fanon, F. "Medicine and Colonialism", Chapter 4 in "Studies in a dying Colonialism", Monthly Review Press, N.Y. 1965.
7. Algeria, Guinea and New Guinea, for instance, have drastically reduced their imports of infant formulas and have made these products available only by prescription.

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