PERSPECTIVE

Where is 'Public' in the Public Health Discourse?

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ABSTRACT

The origin of modern public health as an academic discipline goes back to the 19th century. However, a concern towards the health of masses has always existed in all societies. The principles of public health in earlier times were guided more by the notions of the commons, wellbeing, and local knowledge. In recent times, our understanding and practice of public health is guided more by technological advances and the market forces. In such a situation, the present public health prescriptions fail to understand the importance of local knowledge systems and practices. As a consequence, people's dependence is increasing on technologies which are accessible to a limited group of people who can afford and controlled only by the few multi-national companies and trans-nationals. Despite our commitment to decentralization, democracy, communitisation and people's participation, public health policy planning is guided by top down approach and privatization agenda. In this context, the paper is an attempt to bring people into the public health discourse and redefine it from a people's perspective.

Key Words: Public health, People's participation, Decentralization

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Introduction

The public health discourse entails an extended dialogue[i] on the health of the population and communities. However, in recent times, the dominant discourse in the field has been shaped by vested interests who have been powerful and have controlled the resources and institutions. The views of the common masses are hardly heard in the designing, planning and the implementation of public health programmes. Despite the political activism by many individuals and the advocacy groups like People's Health Movement (PHM)[ii] or Jan Swasthya Abhiyan (JSA - the Indian circle of the People's Health Movement), people's concerns are hardly heard by the state, policy makers and even by the mainstream media. This clearly shows that the public in public health discourse has yet not been recognised by the public health practitioners and policymakers as an important tool or methodology for the success of public health programmes.[1] The Institute of Medicine (1988) in their report 'the Future of Public Health' has defined public health as 'what society does collectively to assure the conditions for people to be healthy'.[2] The definition emphasises the role of society and people in shaping the health of the population. Thus, it is important that the public should be brought back into the public health discourse with focus on their socio-cultural and political context. It will help common people and social groups to articulate their interests, their legal rights, to meet their obligations and to mediate their differences and ensure that each individual or community irrespective of their ethnicity, gender, class status, existing or emerging, receives the universal health care services as per their actual needs through a process of good governance at an affordable cost.[3]

The public health discourse

The history of public health can be traced back to the evolution of human society. Since its inception, human civilizations have been challenged by illness and the outbreak of infectious diseases and other health emergencies that have spread, and caused death at unprecedented levels. Different societies and civilizations responded it differently based on their experiences, knowledge and learning. The Indus Valley Civilization's

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i. Often interactive which may be expressed in speech, writing or in other forms.

ii. The People's Health Movement (PHM) is a global network of grassroots health activists, civil society organizations and academic institutions [particularly from low and middle income countries having presence in around 70 countries] to promote universal access to quality health care, education and social services according to people's needs and not their ability to pay.

drainage and sanitation system is one such example of an ancient public health system in India. The ancient practices of healthy living and wellness such as the Ayurveda and Yoga are practiced since 1000 BC in India. Quarantine, the practice of separating people with illness from the healthy population is an ancient practice which can be found in Biblical and Quranic references. Isolation of lepers from healthy population is one such example.[4] These ancient practices may be considered as the real beginning of "socialized medicine" or "social medicine" emphasising "the organized community efforts" and "the development of social machinery" where the people were in the centre of affairs in taking care of individual and community health. This approach emphasizes the role of the society including the people, the state, the community and the governance structure.[3]

One may assume that in the ancient societies, public health approach was guided by the notions of commons good[iii], human existence, survival, and social capital. In short, they tried, putting the people in the centre of public health concerns. These notions were guided by the strong belief that for ensuring common good and by extension public health, people's participation, social capital, trust, and indigenous local knowledge is indispensable. This commons approach guided by collective ownership and participation was the only way to ensure the good health. It was also believed that commons good approach will bring people together to think collectively for their survival and wellbeing including public health. This commoner approach also generated trust in the public health system which was owned, managed, developed, and practiced by the people, and for the people. Although this evolutionary public health approach and practices were not known as public health, but the intent and goal were similar to the intent of modern public health.

The evolution of modern public health in India as a discipline can be traced back to 1835 with the establishment of the Calcutta Medical College which was an era of colonization and industrialization.[5] It also marked the advent of the germ theory of disease, and several scientific and technological advances.These developments changed the perception and understanding of human beings as a producer or the consumer. The human value was redefined in terms of their economic value which was transgression from the notion of common good. These developments in the West significantly influenced the understanding and approach towards the public health in India, which led to the development of present day models of public health which are technology oriented, patented, and controlled by the powerful players and stakeholders such as large multinational companies and pharmaceutical companies.[6-8] Public health became important for production and labour rather than for common good. The centre stage was taken by the technology and the market and the people were pushed to the periphery. Little space was left for the people's participation in designing public health programmes and interventions. Given this historical context, this paper will discuss three questions-firstly, where is the public in the public health discourse; secondly, whether public can be brought back to public health discourse; and thirdly, what role the public can/will play for improving public health.

Where is the 'public' in the public health discourse?

Today, the public health debate and direction in India is mostly guided and shaped by the developments in the West, where multi-national companies, pharmaceutical companies and university research departments are key stakeholders and their presence can be felt by the funding in public health research, and designing public health policy and programmes. The shaping of public health policies appear to be an endogenous process but unfortunately, the policymakers in India and in other non-western parts of the world too speak the language of the West and make the policies which echo the interests of these giant multinationals.

In the last one decade, a number of public health institutions have come up offering the public health courses, particularly the Masters in Public Health (MPH) Programmes.[9] Interestingly, all these institutions are offering the content which is more leaned towards the Western understanding of public health with less emphasis on contextual issues or even indigenous/traditional health practices. These institutions fail to understand that rather than focusing on technology and medicine, emphasis should be on people and their social institutions which cannot be understood and addressed without having a social and behavioural perspective. We need to understand that the context of public health in India is different from the social, economic and political environment in the West.[10-11] We are still struggling to provide clean water, proper sanitation, nutrition and housing to our people. Without ensuring these basic needs, technological, bio-medical interventions will only provide short term solutions to public health. Interestingly, the emerging new lot of public health professionals in India have a framework which is largely Western-oriented. Many new public health institutions which have come up in India are offering courses in health management, hospital management, health economics, health human resource management, epidemiology, biostatistics, demography, health statistics/management information system (HMIS), health marketing, health insurance, advocacy, bio-design, information and communication, program communication, and information technology (IT), etc. Evidently, the courses are highly technical and they tend to marginalize the basic concepts of social sciences and about lay/traditions/indigenous system of public health. One can imagine a public health professional or practitioner who is supposed to work with people for improving their health without any orientation to the

iii. Commons good are any set of resources or services that are owned in common or shared among people/communities for common good and benefit such as public education, health, public space, and the infrastructure (including the public health delivery systems).

concepts of class, caste, culture, tradition, values, norms, etc. Interestingly, in this model of public health, (where, in fact, there is little or no place for public), the notion public gets marginalized and is mostly outside the debate. In such a scenario, there is a need to reorient and contextualize the modern public health curricula, programming and service delivery. The indigenous or lay practices of public health system which were developed during the ages by the people locally, based on their experience and effectiveness are disappearing. Similarly, most of these indigenous public health prescriptions are also guided by the principles of commons which are locally available from nature and within the reach of everyone. Although the government has started recognising it and has been promoting AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy) under National Health Mission (NHM) programme[iv], but the effort needs to be strengthened and inappropriate practices curtailed (eg. Ayurvedic doctors are prompted and encouraged to prescribe allopathic medicines in States like Maharashtra). There is growing demand for the Indian System of Medicine (ISM) or traditional medicine. However, the State has little faith in the efficacy of these systems or the drugs. As a result, the health delivery systems lack coordination, even for meeting commonality of objectives.[12] These are primarily because the field of public health in India and in low and middle income countries are highly medicalized relegating the people out of the mainstream public health discourse.[10]

Whether 'public' can be brought back to the public health discourse?

Before the advent of modern public health, the initial knowledge of public health was developed by the indigenous or lay people who were guided by a perspective based on the principle of common public good (public health). Unfortunately, it is missing in the modern public health practices and prescriptions, not in intent but in reality. These indigenous and locally developed practices of public health are based on experiences, often time tested over centuries and if these practices are integrated with modern scientific knowledge, it will help in developing technologies which would be more appropriate, suitable, and easily acceptable to the people. We need to understand that without involving the people in dominant public health discourse, the whole effort of promoting good health and reducing the burden of disease would be a futile exercise. People should be brought back to the centre stage of public health planning, and promotion of good health which is very much possible. Thus, to improve the health of population, people and communities need to be empowered to utilize their skills, affirm their rights and take up the responsibility to improve their own health and public health.[13]

In principle, people have a presence in the public health policy making and planning through various committees and institutional representation such as the Village Health and Sanitation Committee (VHSC) to look after the community health at village level, Primary Health Centre (PHC) Monitoring and Planning Committee to monitor the functioning of sub-centre under PHC and developing the PHC health plan, Block Monitoring and Planning Committee, District Health Monitoring and Planning Committee, and State Health Monitoring and Planning Committee, and Rogi Kalyan Samiti to manage the health institutions at sub-district, district and state level and many more committees. The NRHM programme proposes several monitoring and planning committees at different levels to ensure people's participation in the public health programming and the delivery of its services. However, in reality, at many places these institutions are not functional, or they are weak and their roles are limited to approving the finances. They are not the real decision-makers, neither they have the expertise or the capacity to perform these role. Although these structures are there to improve people's participation in the planning and delivery of health services, the evidences show that successfully establishing a VHSC and other committees is a long and formal process. It takes time to gain acceptance and generate community participation and ownership and there are complex local socio-political issues that may need to be addressed.[14] The Comptroller and Auditor General's Report (2010) mentions that district and block level community monitoring committees had not been constituted in many of the selected districts and blocks in five states of Assam, Jharkhand, Karnataka, Madhya Pradesh and Maharashtra.[15] The report further mentions that the non-formation of community planning and monitoring committees at various levels adversely affects the monitoring of the programme by various stakeholders. In other words, it disempowers people to become the part of public health planning, delivery of services and ultimately the discourse in shaping their health and wellbeing. In such a situation, it is important to build the capacities of these people's institutions and make them more functional, effective, and accountable. There are cases where people have brought change through people's participation in public health. The case given below is one such example of public or community participation in promotion of public health.

Case: Community gear up for tackling epidemic

Basghatta is one of the undeveloped villages of Katra block in Muzzaffarpur district of Bihar having poor health and hygiene conditions. Literacy among the people is also low. The village is dominated by the scheduled caste population. In April 2011, cases of measles were observed in the village which affected many children. People followed the local remedies but situation remained unchanged. One of the community leaders of the village Smt.

iv. National Rural Health Mission (NRHM) is an Indian health program for improving health care delivery across rural India.

> Poonam Devi thought that she along with villagers should do something. She mobilized the villagers and organized an emergency community meeting with the help of other villagers and convinced the villagers to come forward to combat this measles outbreak. She suggested to the community that we should contact the Primary Health Centre and ask for immediate attention and help in controlling the disease. On her initiation, a public petition was prepared and submitted to the Medical Officer in Charge. On their initiation, medical team got active and visited the village to take necessary action to control the measles outbreak in the village. When Poonam Devi was asked about taking so much pain, she replied with a smile that *"Agar thora pareshani uthane se gaon ka kuchh bhala ho jata hai to pareshani ka ehsas nahi hota bulki achha lagta hai* (Even if I take a little effort it helps the people [villagers] and I hardly feel the pain. In fact, it gives satisafction)"[v].

People's participation in ensuring and delivering public health services should be made essential which will provide them opportunity to utilize their knowledge, skills and resources available in the community. The Bhore Committee (1946) report also emphasised that 'no permanent improvement of public health can be achieved without active participation of people in local health programs'.[16] This will not only maximise the benefits and reach of public health services but also prepares people for delivering and participating in public action.[17]

What role the public will play or expected from them?

Our present public health system is influenced and controlled by 'the medical model' and supply driven system where experts decide what the public health problem is and what should be done.[18-19] People are silent recipients of these expert services and advice. This expert-driven biomedical framework of public health has been criticised by many in the past, like, feminists and Marxists, for invidualising and depoliticizing ill health, and for obscuring its social, economic and environmental context.[20] One needs to understand that the overemphasis on technical dimensions takes people away from a commons perspective. The emphasis on laboratory and techniques is undermining the importance of a social science perspecive to public health.[21] The whole focus of modern public health is on developing new technologies, program models and delivery mechanisms rather than promoting public health with community orientation. We need to understand that the health of the people is not only the concern of health care providers. It is also the responsibility of the community to identify and solve their own health problems through their active participation and involvement.[22]

In such a scenario, engaging people in co-producing health and wellbeing will not only help in bringing the public health benefits to the public but will also help in tackling the health inequalities by improving connections with less advantaged groups and by shaping provisions and services to better meet the community needs.[17] Further, it will also help to engage, support and sustain a community in improving their health. South et al (2010) have suggested in their study that the people should be engaged in delivering public health programmes to achieve the following objectives.

- Fulfilling a bridging gap to reduce barriers between services and communities, particularly where groups are at risk of social exclusion.
- Providing peer support to help community members participate in activities that might or will improve their health.
- Breaking down communication barriers as members of the public have the potential to reach some communities where professionals cannot.
- Providing opportunities to the common people to gain better public health services directly in terms of increased confidence, health literacy, social contact, etc.[17]

The issues raised above clearly show that in our present public health discourse public representation is missing or in other words *there is no public in public health discourse and in shaping of the public health policies and programmes.* This statement contradicts the whole concept and philosophy of National Health Mission programme of Government of India. Although the NRHM mission document in its preamble mentions of *'decentralization and community participation'*, but it fails to recognise and ensure the role of people in implementation and delivery of services, even after a decade of implementation due to various reasons pertaining to poor planning, lack of political will and leadership, corruption, lack of infrastructure and human resources, etc. The cases of corruption and scams in many states under NRHM clearly show that people are not in the centre-stage but at the periphery and their voices are unheard.[23-24] The institutional mechanism and arrangements are as such which provides a limited space to people. The designed and proposed role of public in the NHM programme is geared towards smooth implementation of the programme rather than bringing in people for policy making, programming and implementation. It is guided to strengthen the supply side of the programme rather than the demand generation for better people-

v. The case is based on Community Leadership programme (CLP) intervention in Bihar. CLP is an important component of Leadership Development and Organisational Effectiveness (LDOE) program funded by the David and Lucile Packard Foundation. CLP focuses on strengthening the community leadership in select districts of Bihar and Jharkhand state of India. This programme was funded by the Jamset Ji Tata Trust and implemented by the International Council on Management of Population programmes (ICOMP), Malaysia, Xavier institute of Social Service (XISS), Ranchi, Integrated Development Foundation (IDF), Patna, and Nav Bharat Jagriti Kendra (NBJK), Hazaribagh.

centric public health programme and services. In such a scenario, it is necessary to reexamine the whole strategy of peoples' participation and communitisation[vi] (community ownership) of the programme. The idea that public health is a fundamental right has still not permeated to different levels. We need to understand that public health and medical care for all will only become a reality when people start demanding it as their right.[25] Jacob (2009) has rightly said that "public health should be located within society and politics rather than within medicine".[10]

Conclusion

We need to understand that public health is not limited to advances in immunisation, new drugs and technologies. Indeed, other factors, such as social determinants are more important, which still need to be emphasised and incorporated in our public health policy and programmes.[26] We need to learn from people before writing the prescriptions and those prescriptions should be culturally and socially relevant and acceptable to them. We know that vaccines work and we prescribe it whole-heartedly without understanding factors which stops people from accepting it.The present public health model talks about the people and the public but misses to incorporate them fully in designing the health policy, programme and implementation. As a result most of our public health interventions are not very successful because it is not owned by the people. It is guided by the principle of supply rather than demand. If we want a functional public health system, our prime focus should be on the demand generation and people's participation. This will not only ensure a responsive public health but also help in bridging the gap between health services and communities, particularly where people have little say or are seldom heard.

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vi. Communitisation is a process to increase people ownership and participation in health policy making, planning, implementation, and in delivery of health services.