

Public involvement in health care: Lessons from developing countries

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Sir, The multifaceted experience of community participation in developing countries could enlighten the issues pertinently raised by Florin and Dixon (1). Community participation has been strongly promoted in public institutions for over 25 years since the 1978 Alma Ata Declaration. Approaches range from health facility committees, management of locally generated income (e.g. Bamako Initiative), devolved elected governments with health responsibilities and community meetings. Their effectiveness in achieving change, democratic accountability, and dialogue with professional and bureaucratic powers depends on the adjustment of participation design to the context. The rationale for community and patient participation differs - the latter entails negotiations on diagnosis, treatment, follow up, life mode, and individually tailored prevention. The two strategies are thus not, as suggested in the article, substitutes but different in their purpose.

Experience suggests that pluralistic boards of trustees combining community representatives, civil servants and health professionals can contribute to: improve quality of care and coverage; reduce corruption, and patronage; define and apply patients' rights; monitor access to care; encourage payment modes consistent with solidarity; organise credit for indigents; penalise irrational utilisation of services; control costs; favour use of essential drugs; select priority disease control programmes; organise mutual aid associations and link them to the management of health facilities (2,3,4). To do this effectively, community representatives require access to accurate information provided by motivated managers and professionals willing to collaborate with them.

What are the lessons for industrialised countries? Firstly, medical practice and health management differ structurally according to whether they are performed in the public interest or for profit (5). Public funds should be used in the interest of both the individual patient and the public. Together with democratisation of management and responsiveness of health care, public involvement should contribute to the selection of quality standards for health care delivery and management. Secondly, transcending the concept of "community", the social composition of participatory bodies is critical, at all levels. Strategic planning can help identify social organisations to be involved in co-management. Thirdly, biomedical methods alone applied to the evaluation of "interventions" fall short of reasonable assessment and planning of participatory mechanisms. A multi-disciplinary (including political) approach is needed to conceive them. Finally, continuous education, professional bodies and pressures exerted by social organisations can lead some health professionals to provide user representatives with information likely to make public involvement in health care relevant.

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