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Humanized care as a Public Policy. The peruvian case

Cuidado humanizado como Política Pública. Caso peruano

Cuidado humanizado como Política Publica. El caso peruano

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Abstract

An experience of knowledge exchange strengthened the implementation process of public policy for humanized care in the region of La Libertad, Peru, between 2007 and 2014. The aim of this intervention was to remodel power relationships between state and civil society as they relate to caring for life and freedom. These concepts that give meaning and purpose to a social and health policy. The experience consisted in developing and implementing a care model, beginning with the questioning of the current healthcare model in order to propose a model oriented towards health preservation and the development of citizenship. To this end, modeling processes of social and health care were implemented, structures were modified and healthcare management processes were re-invented. This experience must be further assessed, strengthened and improved, and its efficacy and efficiency must be determined and its impact on this population's health and development of the region must be evaluated to ensure sustainability and investment from the technical and political class.

Keywords: Humanization of Assistance; Growth and development; Public Health Policy.

Resumen

Es una experiencia de trasferencia de conocimientos que posibilitó fortalecer el proceso de implementación de una política pública de cuidado humanizado en la Región La Libertad-Perú en el periodo 2007-2014 cuyo objetivo radica en redimensionar las relaciones de poder entre Estado y Sociedad Civil respecto al cuidado de la vida y la libertad, conceptos que dan sentido y fines a una política socio-sanitaria. La experiencia se basó en desarrollar e implementar un modelo de cuidado, iniciando por cuestionar el actual modelo de atención con visas a proponer un modelo orientado a preservar la salud y desarrollo de ciudadanía. Para ello se implementaron procesos de modelamiento de la prestación socio-sanitaria, se modificaron estructuras y se re-inventaron los procesos de gestión sanitaria. Sin duda esta experiencia requiere ser evaluada, fortalecida y mejorar, siendo necesario determinar su efectividad, eficacia y valorar el impacto en la salud y en el desarrollo de la población liberteña para garantizar sostenibilidad e inversión por parte de la clase técnico-política.

Palabras clave: Humanización de la atención; Crecimiento y Desarrollo; Políticas Públicas de Salud.

Resumo

É uma experiência de transferência de conhecimento que possibilitou fortalecer o processo de implementação de uma política pública de cuidado humanizado na região de La Libertad no período 2007-2014, cujo objetivo é redimensionar as relações de poder entre Estado e sociedade civil em relação ao cuidado da vida e da liberdade, conceitos que dão significado e propósito para uma política sócio- sanitária. A experiência foi baseada no desenvolvimento de uma massa crítica de pessoal de saúde, a fim de desafiar o atual modelo de cuidados com vistas a propor um modelo de cuidado humanizado destinada a preservar a saúde e desenvolver a cidadania. Para os processos de modelagem de prestação social e de saúde desenvolvido, as estruturas foram modificadas e os processos de gestão de saúde reinventado. Sem dúvida, esta experiência precisa ser avaliada, reforçada e melhorada, presisando determinar sua eficácia, eficiência e avaliar o impacto sobre a saúde e o desenvolvimento da população liberteña para garantir a sustentabilidade e investimento por parte da classe política e técnica.

Palavras-chave: Humanização da Assistência; Desenvolvimento; Política Pública de Saúde.

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INTRODUCTION

The aim of this article is to present an experience regarding the implementation of a health policy centered on humanized care. In Peru, in accordance with the decentralization process of its health system, regional governments are responsible for guiding social-sanitary policies within their scope of action in alignment with the national directive framework. Since 2007, in La Libertad, a region in the north of Peru, a participative process has been taking place to implement humanized care policies aimed at providing the necessary health care and autonomy to ensure social well-being based on social capital accumulation via preliminary/initial processes.

Considering the need for social policies, initial stages were developed, which included processes aimed at raising awareness, socialization, and appropriation of health concepts and practices among health professionals. The goal of this work was to create a critical mass that would question the current model and propose innovation. The awareness-raising process took place by advocacy with the main decision-making political leaders, which served as the framework for approving the social health policy via a regional ordinance. A similar process was carried out with municipal government leadership, generating critical reflection and organized social networks to facilitate future implementation processes.

At the same time, health professionals participated in work to help them appropriate the conceptual underpinnings related to care and human development that guide the policy-making process. Then, a literature review was conducted and a conceptual framework developed to inform the health practice. Care concepts that prioritize critical and dialectical approaches were incorporated into the health policy, using the political theoretical contributions from a doctoral thesis.

THEORETICAL MODEL: THE EPISTEMOLOGY OF HUMAN CARE

For existentialist philosophers such as Heidegger,[1] being is caring; the capacity to care is related to how much and in what way the Being was cared for. Through care, the human condition can be transcended, through the perception of the "other's" existence. Furthermore, the "other" gives meaning to the "self." Caring is a form of being; it is the basis of meaning for the self. This includes behaviors, attitudes, values, and principles that are experienced by people in certain circumstances. However, above all, it refers to Being, or as Santin put it, it should refer to human beings.[2]

Transferring this dialectical approach to politics to the relationships that underpin our work thesis, It presents a dichotomy in which the state, with its social responsibility, takes on a caregiving role and civil society plays the role of care receiver. A humanized care policy encompasses this interactive relationship between its elements: state-health provider-caregiver on one side and, on the other side, person-collective-care receiver.

Heidegger[1] defined care as concern for the self, assuming destiny to be an existential rather than intellectual interest. Care is the essence of human beings and the way such care is provided has repercussions on our quality of life and freedom. Through care, humanity perpetuates itself; as a consequence, it must take care of itself and of others. These concepts generate deep reflection, inasmuch that the Peruvian and Latin American healthcare models prioritize assistance or healthcare to such a degree that its object-subject is the "patient."

The reflexive analysis of the theoretical concepts allowed us to establish differences between comprehensive healthcare models (guidelines to the healthcare policy in Peru) and the proposal of a regional care model that promotes well-being, and generates participation and social responsibility for its sustainability. The theoretical discussions led to establishing the characteristics of authentic care[3] defined as the process that enables the development of competencies of "Being" to take care of its "Self"; the opposite is to do for others what they could do for "themselves/their own selves."

Connectivity[4] is a trait of health care and autonomy, characterized as the "capacity of connecting or making connection." In fact, genuine care requires the elements interacting in the care process to establish a standardized symbolic structure, proper communication channels, and clear and accurate language to facilitate the intervening elements' process of interchanging interests. Sometimes it does not happen in the assistance model, but is an indispensable condition in the care model.

Reciprocity is another feature of care. Experience shows that, although service users demand one-time care (e.g., a medical appointment), health personnel are concerned with providing care. These different interests are decisive to achieve results and health objectives. Care is genuine when the subject-object to be cared for not only demands, but also develops the capacity for receiving and appraising care as necessary.

Human care is significant and transcendent both to the caregiver and to the individual cared for. Therefore, reciprocity is a condition that characterizes caring. It is defined as a process of mutual correspondence and exchange, to and from, regardless of whether between individuals or things.[4] Reciprocity is not always present in the health assistance model, because assistance is provided in situations of inequality.

In an article released by the PAHO, Tejada[5] tries to differentiate care from assistance. "Assistance" assumes a vertical and asymmetric relationship between someone who actively offers something and another who passively receives it. The one assisting knows everything, while the assisted individual not only does not know, but should not know. This is the origin of the term "patient". "Care" assumes a horizontal and symmetric

relation, where everyone knows or should know something and has responsibilities and duties.

The caring process is considered to be a process of transformation, where the caring and the cared-for beings grow and change. The first has a more positive and calmer attitude in face of his/her experience with illness, need, disability, and even death, fruit of an easy and friendly trust relationship with their caregivers. The caregiver experiences satisfaction, a feeling of work done, fulfillment, better self-esteem, confidence, and trust such as pleasure and well-being.[6] The lessons learned in each experience and in each meeting qualify the relationship, and increase the professional's sensitivity and knowledge.[7] Life history and experiences help in knowing others and the self better.[6]

Under this assumption, the caring process entails possibilities of change, making the being self-sufficient, responsible for his/her life and freedom; it equips him/her with competencies to meet their needs; self-determination to select their own values and ideas based on their experience and knowledge. It makes them self-critical, honest to the self, aware about their role and about the social and natural order where he/she participates.[8]

If we proceed on the assumption that care is a phenomenon of our consciousness, is manifested in our experience and shapes our practice, then care is learned and can be developed. It is about thinking and talking beyond how care is experienced and structured in society and in ourselves. Care as an interactive process can only be established in the relation with the other. The way of being cared for involves not only a subject-object relation, but also a subject-subject relation. This relationship is characterized by being learned and becoming professional, as it is systematized, probated, conducted, and exercised based on ethical working criteria.[9,10]

Being is caring and, therefore, all human beings somehow take care throughout our existence. We take care of the self, of the family, of collectives that are meaningful to us. As such, there is an empirical and inherent care that is passed from generation to generation, and a scientific-ethical care[11] that is learned and structured based on theoretical, methodological, and instrumental models typical to the professional category, which is operated and reinvented in the experience with being cared for.

HUMAN CARE MODELING - THE PERUVIAN CASE

Care principles

Following are the principles of the 2008 Regional Health Policy:

- Health is defined as a resource to preserve life and freedom.[12] Well-being requires fulfilling needs, and care is part of it.
- Health is a social product; it is not only a basic right, but also a civic duty and responsibility.

- The diseased population is also the one with limited access to basic services, a distorted view of their rights, poor participation, and great exclusion;[13] therefore, social determinants must be approached.
- Changing social structures through health care and autonomy allows moving away from the vicious circle of poverty-disease.
- Sustainable human development allows building personal and institutional skills to ensure well-being and a worthwhile life.

Health care and autonomy are powerful tools to achieve social and economic development. In this context, the Regional Policy tries to promote structural changes through the development of skills among citizens-collectives, improving access to and coverage of care practices. Strengthening regional and municipal governments' role is crucial, so they invest in models that acknowledge the participation of individuals, families, and communities as builders of social capital.

Policy implementation strategies

Improved access to health care is one of the main purposes of the regional policy for development. Therefore, it demands reassessing the socio-sanitary aspects of "by them, with them and to them" through a participatory and multiplier process that takes on and aggregates clear cross-sector political commitments.[14]

This strategy involves intervention in the different environments where individuals interact, incorporating different dimensions that can be physical, environmental, social, cultural, and/or institutional.[15] Approaching their everyday lives allowed getting in touch with the reality of families, educational institutions, workplaces, universities, and communities. Following up their development based on their potentialities and restrictions implies defining a baseline and devising a view of the future in a time horizon. This is a useful situation, because it allows setting socio-sanitary goals and objectives responsive to the legitimate desire for a future with development. Participatory planning is a huge challenge, where the state and civil society gather, review their reality, unify their vision of the future, channel resources, identify actors, define roles, and build consensus after hegemonic and counter-hegemonic processes.[16]

The policy sets priority interventions using epidemiological profiles from 2007 as follows: maternal and infant deaths, health, and nutrition; control of communicable diseases and of non-communicable diseases such as neoplasias. Other priorities were defined according to a survey applied to the population in 2005. These are: infant diarrhea and pneumonia; adolescent pregnancy; intra-family violence; and social problems such as delinquency and gangs.[17]

Building skills demands strengthening the development-based educational process. The strategy "health is education and education is health" attempted to put the education issue in play

as a human development axis. Education nurtures individuals capable of taking on and demanding health as a right and self-care as a duty. Care policy opened rooms of debate in sectors such as education, where participants started discussing the behavioral pedagogic model and thinking over the need for a new model capable of developing individual and collective skills, citizenship exercise, and active participation. This is what Freire[18] used to call a "pedagogic education model as a liberator practice."

Managing health care and autonomy requires a "new culture of institutional work" to ensure success. Clear goals, zero indifference, and results-oriented work were institutionalized.[17] Commitment occurred through defining positive development-related indicators in opposition to the negative or institutional indicators aimed to measure the state's efficiency. These last have consolidated a health culture aimed at recovery and rehabilitation in detriment to the culture of prevention and health promotion.

Intervention Axes

The Regional Policy was implemented around five axes aimed to instruct needs-based processes of changes. These were: on the external front, we must develop autonomy, managing the territory through decentralization and social mobilization; and the participatory evaluation of social and health services. On the internal front, we needed comprehensive, quality, and universal care.

The current process of decentralization and social mobilization in Peru assigns to local governments the role of primary healthcare managers. This builds an enabling environment to develop the model, because it allows remodeling the state-society relationship, bringing institutions closer to people to approach the restricting factors that generate underdevelopment and poverty.[14,17]

The territory management strategy, defined as a local planning process managed by the social-sanitary district, is crucial to develop autonomy through territory-based agendas and pacts used as participatory management instruments.[17] These spaces make effective the axis of agreement and social mobilization. This is understood as the coordinated work of institutions, sectors, and organizations active in the territory (public-private-civil society) that, through collective negotiations, agree on prioritizing and planning the intervention to change social structures, ensuring the population's well-being and quality of life.

The participatory evaluation axis aimed to organize the population's role in the identification of needs, expectations of ways, and conditions of service delivery, and to identify the improvements needed by social and health services. The "Endorsements by La Libertad's population" strategy was crucial to boost the quality-service evaluation under the community's perspective, contributing to increase transparency and quality of services.

On the internal front, managing care implied reviewing the conceptual frameworks that guide the policy; organizing the social-sanitary network; and developing techniques and instruments to make health care tangible. We have started our challenge by critically thinking through the current model and the opportunity for humanizing services. The legitimacy of knowledge and the leadership that assists us were crucial to gather forces in a work vision.

Our model of preventive, promotional, recovery, and rehabilitant care has three important attributes: comprehensiveness; quality; and universality.[9] It is "comprehensive," as it focuses on the basic need for well-being. It is determined by beliefs, values, and needs that exist within the social structure, culture, and organization. In other words, it has to do with thinking, feeling, and practices of persons/collectives. In brief, it is about what we are.

Comprehensive care is objective when it refers to the science that defines techniques and procedures to be followed, and is subjective because it has sensitivity, creativity, and art when delivered. To the model, it is an adjective that means the whole, the totality, and considers physical, biological, spiritual, and social aspects in consistent interaction with the family, the community, and the cosmos. It involves a comprehensive view of the human being-collective, with their singularities and complementarity. It demands organizing public services towards coordinated and proper participation, strengthening interdisciplinary and cross-sector work as required.[12]

"Quality" is one of the most important attributes of human care. In Peru, it was defined as a principle of the health policy, and is considered to be a citizens' right. Quality is perceived as a life dimension and, therefore, a fundamental condition for development and an inalienable right of people to grow with dignity and achieve individual-collective fulfillment. Health services users have these aspirations and, therefore, demand service delivery in a way that allows them to achieve a worthwhile and fulfilled life. However, health professionals also want these conditions and hope to find in their work their personal fulfillment, regardless of the cosmic vision and the social, cultural, or economic position of the social group.[17]

Quality services management demands stronger care processes, because that is where the indissoluble link of the technical, interpersonal, and environmental dimensions of quality is expressed. This is expressed in efficacious, ethical, and human performance of providers; due design of processes; and allotment of technology and resources required to provide quality care. A service provides quality care when it efficaciously manages processes in the production chain. No partial quality or inefficiency is acceptable; quality care is comprehensive. It implies providing services aimed to meet the very reason of the appointment, and the patients' needs. Quality care demands warm services as a core condition of being human.[11]

Health care must be universal-the whole population must have access to care services. In Peru, health insurance

processes are ruled by the principle of equity, focused on poor and extremely poor populations. It has developed from the offer of a basic package to full coverage (except for plastic surgeries). It has the objective of smoothing the consequences of poverty and exclusion. In this context, the policy was oriented to improve access to health through universal coverage, and the enrollment process was crucial, ensuring rights and eliminating economic barriers to access, under the motto "first provide care and then, if [the patient is] poor, enroll him/her".[19]

Modeling comprehensive, quality, and universal care delivery

The model of delivery is based on the intervention opportunity provided by users, depending on their surroundings and the reason for their appointment. The model was organized according to the type of care: promotional; preventive; recovery; and rehabilitative. Anthropologically, we take care of pain and the passage to death in addition to primary, secondary, and tertiary care, and the development of skills.

The object-subject of the care model is the person, its collective and the territory, and the provision of services according to contextualized needs. The model offers rehabilitative care focused on the delivery of services to subject-objects with conditions caused by: a need that has not been met; for example, a disease, disorder, or any change of health and autonomy demanding rehabilitant care in the form of individualized and/or collective therapy.

Handling the consequences of a need or disease aims at facilitating the individual's adjustment to the new situation, and developing competencies to perform personal-social roles that improve their quality of life. There is rehabilitative, preventive, restorative, supporting, and palliative care aimed to limit the impact, with therapy to reduce suffering intensity.[20]

Tertiary prevention strategies were implemented for this kind of users, aiming to limit or prevent the damage severity. Moreover, the third level was strengthened and integrated into a regional reference system. The opportunity and intensity of use of these services depend on rehabilitation and permanent disability. This service also relieves the family's social burden and the state's expenditures.

Recovery care is defined as the process of restoring health in an unbalanced, diseased, or damaged organism. Typically, it is a "very personal" process that supposes developing new meanings and purposes to life beyond the negative effects of the illness. It is a continuous process to recover aspects of everyday life that may have been lost because of the disease or adverse event.

The care practices oriented to recovery are focused on well-being and resistance to the disease. It encourages individuals to participate in their own self-care process and allows them to define their objectives and type of therapy. In Latin America, this care model is privileged in public policies that allot the required financial, infrastructure, equipment, and personal resources.

Intervention focused on recovery care aims to avoid and prevent the emergence of complications resulting from the morbid process of the disease or event of life. To that end, secondary prevention strategies have been implemented, where the main tools to prevent unnecessary complications are early diagnosis and timely therapy. Moreover, the secondary care response was strengthened as "supportive links" over the control of maternal, neonatal, and infant death; control of communicable and non-communicable diseases, and mental and social disorders such as violence and gangs.

Prevention is a measure taken or arrangement made in advance to prevent a negative situation, that is, aimed to minimize risk.[21] Primary prevention strategies are oriented to prohibit or reduce exposure to risk to levels that are not harmful to health. Our socio-sanitary care model attaches priority to preventive care, as it provides a priceless opportunity for the health system to preserve health by controlling its causes.[22,23] Following is the core strategy of the model: focus on and prioritization of the intervention, differentiating population at risk from vulnerable population. The preventive model focuses its intervention on the vulnerable population as a whole, controlling causes to preserve health.

Promotional care is relevant in the model, emerging as a development strategy. The process that allows individuals to control their health/autonomy to improve/develop themselves is known as health promotion, in opposition to prevention, where the focus is to control and minimize risks.[24] To be effective, it demands redesigning public services to make them genuine health services, and not as these are today due to the hegemony of the Flexner focus on recovery and rehabilitation. In addition, it encourages the development of participatory structures and mechanisms to empower civil society, and become state in the Gramsci's light.

Promotional care is focused on developing individual and collective skills, empowering civil society and making it self-determined. To the model, health promotion is a "process that creates capacities for individuals and communities to exercise more control on health determinants, and to improve health".[24,25] This kind of care is provided to the healthy or apparently healthy population, focusing on the development of cognitive, procedural, and attitudinal competencies aiming at their development.

This is the major challenge faced by the care model that requires the organized community's participation: promotion is not possible if the civil society does not play a protagonist role and the state does not take on its role as promoter and facilitator. Participatory strategies in health system management and evaluation, participatory planning of development through cross-sector agendas, and fostering a liberating education are effective mechanisms implemented by the model.

The effort towards a model of human care based on social development has already been started (2008-2010), but should be reinforced in a process of permanent construction.

Undoubtedly, a paradigmatic change and the implementation of a new health culture and practice take time; however, users need to be cared for today and jointly devise the care of tomorrow. Therefore, care demands a structural, organizational, and functional platform to manage, plan, execute, and evaluate the socio-sanitary system.

In the following years (2010-2011), we started restructuring the health system through a reengineering process to consolidate the care model and ensure that it achieves the purposes for which it was conceived. According to Grifin,[26] every care model needs a structure to manage and develop it. The current structure did not allow for consolidating the care model, much less develop it, because it complies with Flexner's welfare care model. Following we present the new organizational structure of health management.

ORGANIC STRUCTURE TO HUMANIZED CARE

The Regional Council - the highest authority of the La Libertad Government - passed the new organic structure and its regulations on organization and duties of the Regional Health Management, according to the Regional Order #004-2011-GR-LL/CR[27] to strategically align health management to compliance with the regional policy on human care. It has advisory, supporting, and executive bodies. Three line agencies were established: a comprehensive health care sub-department; a territory management sub-department; and a sector-oriented regulation sub-department, in addition to 16 executing units in charge of administering 12 health networks, 19 district and provincial hospitals, two regional reference hospitals, and two macro-regional reference specialized institutions, totaling 350 health centers.

The comprehensive care management sub-department is a line agency in charge of implementing, executing, and evaluating health policies and services; and of conducting, organizing, ruling on, and evaluating the provision of individual services of health prevention, recovery, and rehabilitation in the family and community surroundings.[27] To accomplish that, it counts on functional units: individual comprehensive care; health services management; and universal coverage. The first assembled teams for children's health care and nutrition management, women's health care, and control of communicable and of non-communicable diseases.

The health services management unit assembled teams for access to medications and inputs; services at the first, second, and third care levels; organization of public-private services; and management of urgent medical services. In the coverage unit, the following teams were assembled: information management; deliveries; and funding. The teams are responsible for managing care at different levels, defining who is responsible for comprehensive health care, territory management, and the information system at the different structures of the health system: networks, micro-networks, and health facilities.

The territorial management promotion sub-department is responsible for the implementation, execution, and evaluation of policies on management of collective interventions in its area of activity. It is in charge of carrying out, intervening in, and evaluating the approaches to social determinants, jointly with local governments; managing public policies related to environmental and occupational health; and promoting health and risk prevention in the family and community.[28]

Three functional units were defined: interventions on collective health; environmental and occupational health; and promotion of territory management. The first is responsible for proposing, conducting, and coordinating the complementarity of public policies oriented to maintain health and promote autonomy towards social development. The environmental and occupational health unit is responsible for organizing environmental and occupational risk control and services provision. The territory management promotion unit is responsible for proposing, conducting, and coordinating policies and strategies on education, community participation, organization, and empowerment of the social network.

The sector-oriented regulation sub-department is responsible for implementing, executing, evaluating, and ruling on health market and environmental conditions; and ruling on and inspecting public and private health markets concerning health services, medications, assets, and technologies. This sub-department organized three functional regulatory units on: medications, pharmacies and drugstores; health services; assets and technologies; and environmental and occupational health.[28]

Sanitary management model

Considering that the La Libertad Region is part of the Peruvian territory, different national and international initiatives were coordinated to maximize the health care model management.[29,30] To that end, four strategic objectives were defined (2008-2014):[29] OEG1. Strengthen comprehensive, universal, quality care according to national and regional priorities; OEG2. Strengthen mobilization and dialogue towards solidarity-based equity; OEG3. Strengthen the participatory evaluation of health services; and OEG4: Strengthen access to and ensure coverage within universal health services.

To ensure sanitary results, regional objectives were strategically aligned pursuant to the national policy and the millennium development goals. Moreover, this established which work stream was committed and which structure was in charge of managing it. The strategic alignment allowed triggering a coordinated schedule by level, ensuring the achievement of the country's and the region's sanitary goals that, many times, shared the same purposes.

Funding model

The new structure that manages care allows the allotment of logistic financial resources and the human resources required

to manage and deliver care in the sanitary network. Regarding funding in the last five years[31] (2010-2014), priority was attached to preventive promotional care with ordinary resources, through a results-oriented budget, donations, and transfers by means of the funding of universal health coverage that jumped from $12 million (2007) to $30 million (2013). The main objective is to benefit the most vulnerable population.[32]

FINAL CONSIDERATIONS

The experience in health management resulting from the transfer of knowledge involves improving the level of critical analysis about reality, as well as the search for new opportunities for socio-sanitary management, whenever technical-political social actors are involved at any level.

Incorporating a conceptual basis of human care and development into public policies is more than necessary. It gives a sense and purpose to the socio-sanitary policy, but must be consensual and participatory if it aims to preserve life and freedom as basic conditions for development.

The experience of managing care and autonomy as purposes of the socio-sanitary policy allowed identifying some care attributes: comprehensiveness; quality; and universality. Moreover, it identified the need for a structure favorable to management accountability, and to ensuring care provision at all levels. Finally, it demands financial support. This experience of policy implementation must surely be evaluated, strengthened, and improved, determining its effectiveness and efficacy, and assessing the impact on health and on La Libertad population's development in order to ensure sustainability and investment by the technical-political class. There is a long way to go.

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