Health Needs

Report of a Seminar held at Pokhara, Nepal, October 1977

Laura P. Shrestha, and Marilyn Campbell

(IDRC publication). Report on health service/s and needs in rural area/s of Nepal, including information on the Nepal Health Manpower Development Research Project. (1) examines survey, methodology and data collecting procedures; application of research result/s and role of applied social research in health planning. (2) presents country papers from selected countries of South Asia and South East Asia, examining basic needs, personnel, training, maternal child health, etc. (3) includes annotated bibliography, sample questionnaire/s.

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Cover: An interviewer with the Nepal Health Manpower Development Research Project questions an elderly woman about her health in a small village in the Pokhara Valley of Nepal.

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Rural Health Needs
Report of a Seminar held at Pokhara, Nepal, 6-12 October 1977

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The problem of defining the functional role of the doctor in meeting health needs in developing countries still remains a vexed and controversial one. Although there is general agreement that such health needs could best be met by the development of an appropriately constituted and trained health team, the role and function of doctors remains an area of dispute. At one level of discussion the problem is one of finding the appropriate point of balance between the division of responsibility between the different members of the health care team. Yet, at another level the question resolves into a controversy between those who support the proposition that health is a fundamental human right and those who tend to favour a more elitist point of view. The former hold that every society is morally responsible and therefore obliged to provide all its citizens with a measure of health care that its resources can support, a commitment that clearly should extend to the least privileged and most needy of its people. Few today would be so bold as to contest this, yet the opposite view still finds strong sympathy among those who would argue that such an egalitarian distribution would necessitate a lowering of “acceptable standards” and that every citizen is entitled to what they conceive of as the “highest standards of medical care.”

Though it would be easy to demonstrate that no society, not even the most affluent or developed, could in reality afford the resources that such objectives would demand, it is a point of view that continues to exert a decisive influence at all levels of policymaking. Thus it continues to justify the establishment of centres of excellence and the proverbial “disease palaces,” which in effect cater mainly to the health needs of a privileged and affluent minority. It attempts to rationalize the maldistribution of resources between urban and rural areas and the continuing disproportion between curative and preventive health care needs.

At another conceptual level these arguments fail to take cognizance of the fact that the overwhelming burden of disease and disability that prevails in all the developing countries is the direct outcome of poverty and its attributes, poor housing, malnutrition, gross environmental pollution, the absence of safe water, ignorance, illiteracy, and high fertility rates, all of which potentiate one another to give yet another twist to the vicious spiral of ill health, low productivity, social apathy, and poverty. They fail to recognize that curative care serves merely to reduce the severity and duration of disease and disability, doing little if anything at all to reduce the incidence of such disease.

Of even greater consequence is the fact that this argument fails to accept the view that radical and fundamental improvements of health status are rather the consequence of major social, political, and economic advances. All the
available evidence suggests that the dramatic improvements in health status in Britain occurring in the mid-18th century and the early 19th century were changes fundamentally due to improvements in social conditions rather than reflecting the efforts of any medical measures. In more recent times China and Cuba, both essentially poor countries with agrarian economies, have achieved spectacular success primarily as a direct consequence of political commitment, while in a much more limited context, a large number of other poor and developing countries have achieved varying measures of success by adopting primary health care workers as the major instruments of change.

Of the poorer countries of the world with pluralistic democratic political institutions, Sri Lanka and the state of Kerala in South India provide unique examples of countries that have achieved rapid and commendable improvements of health status as a direct result of effective preventive health measures complemented by a large number of other primarily "nonmedical inputs." Thus Sri Lanka in 1976 with an annual per capita GNP of approximately U.S. $140 at current prices ranks among the 20 poorest countries in the world. Yet within the short period between 1950 and 1975 it has achieved considerable success. In this 25-year period it has increased its average expectancy of life at birth from 48.3 to 64.7 years, reduced its infant mortality from 101 to 48.5 per thousand live births, the maternal mortality from 9.3 to 1.2 per 1000 births, birthrate from 38.9 to 29.4, crude death rate from 14.3 to 8.5, and its rate of population growth from 24.6 to 17.9 per 1000 midyear population. Over this period the state has provided approximately 60-70% of all health care costs, increasing its annual budgetary allocation by approximately 10% per year. In 1976, of a total national budgetary allocation of U.S. $85.3 per capita per annum, the State Health Services apportioned only U.S. $4.0, $2.6 of which maintained the patient care services while the preventive services were supported at a cost of U.S. $1.4 per capita per annum.

The available evidence suggests that a very significant component of this improvement has been its achievements in maternal and child care programs. In 1976 approximately 70% of all deliveries took place in institutions where state-trained midwives were in attendance, a very high proportion of pregnant women had antenatal and postnatal care provided by these midwives — resulting in the dramatic decline of infant and maternal mortality rates, a very significant change in the pattern of leading causes of death and morbidity in these two groups, and a marked improvement in the expectancy of life at birth. Several nonmedical developmental inputs provided during this period have also undoubtedly contributed to this improvement.

The precise effects made by each of these on the total health situation, however, cannot be delineated with any certainty, but there can be little doubt that a detailed inquiry into this would be of the greatest significance. Educational changes occurring during this period have had a major impact. A compulsory and free state-sponsored system of education introduced in 1943, from primary schooling extending through to university level, a radical revision of school science curricula to include substantial increments of time devoted to general science, biology, nutrition, and hygiene, has raised the literacy rate to approximately 80% in the late 1970s and led to a greatly increased awareness of the simple measures that promote and protect health and control fertility. A state subsidy on transport, effectively implemented land reform legislation, and the issue of subsidized rice on a rationing basis to every citizen have been the other major social advances, while political independence in 1948 coupled with
increasing political awareness of the rural people who make up 80% of the total population have made political decision-makers increasingly sensitive and responsive to the felt needs and demands of their rural constituents.

These observations tend to confirm the view that good health at a national level is related to hygiene, adequate food, sanitation, and safe water rather than to the absolute number of doctors or their density within a population. It also makes the point that there is no one model of a perfect health care delivery system tried and found effective in one country that can be easily transposed to another situation with the assurance that it would work as effectively. It is not difficult to appreciate that a large number of factors, economic, social, political, religious, cultural, climatic, and geographic, interact with one another to define in each state or country the particular nature and extent of its health problems and the characteristics of the delivery system that could cope most effectively with them.

There is no simple or easy solution to the problem; rather, it makes it imperative that each country should make its own efforts to formulate a rational policy for a national health care delivery system. It demands that each nation must make realistic efforts to ascertain its own health needs and set itself objective goals of improvement within the constraints imposed on it by the availability of resources. Such a matching of health care needs against resources must include a health manpower development policy that identifies the different types of health care workers, relates the relative and absolute numbers of each category, and describes their functional roles and responsibilities and the manner in which they would combine to form effective health care teams.

It is necessary to set in motion and maintain the continuing process of planning, implementing, monitoring, controlling, and reevaluating, for the planning process must in essence be a dynamic one. Strategic planning is required to select priority items from among a host of competing alternatives and operational planning is required to implement the selected programs. To be effective, planning must necessarily transcend the limitations of medical technocracy and become meaningfully integrated within the mainstream of political decision-making activity. Clearly, innovative approaches are urgently needed to assure that adequate basic health care services are easily available to everyone and at a price that each nation can afford. For people all over the world, and in the developing countries in particular, are becoming increasingly conscious of and impatient of the fact that the spectacular achievements of medical science are not being delivered to them, conscious too that new approaches are needed to distribute the benefits of these achievements to all who are in need of it, for only in this way will the claim of health for all become a reality.

Enlightened self-interest should generate the political vision, commitment, and courage that each nation needs to reorient its own internal health priorities according to their social relevance for the total national population and to ensure that everybody everywhere would benefit from all the knowledge and experience of health care accumulated down the ages. Nothing in the whole of our long history would have a better claim to be called mankind’s greatest achievement.