THOUGHTS ON HEALTH CARE

Over the past thirty years we have seen a dramatic change in the world map, with the emergence of increasing numbers of countries who now have the right to govern themselves and decide their own futures. The regimes that have emerged as the governing elite represent a wide range of ideologies, including socialistic and communistic approaches on the left, the Westminster type of parliamentary democracy exported during British colonial rule in the middle, and right-wing systems at the other end of the spectrum.

The dilemma faced by the governments in many of these countries with new-found independence was: where should the meagre resources available be concentrated to give the best possible return to the country itself to further development and improve the standard of living for the population? As we now know from experience, the decisions taken were in many cases not the best.

In the countries with free enterprise-type systems, the emphasis was on industrialization and education, leading to increased urbanization at the expense of the development of rural areas, where most of the people in developing countries live. Health in this scenario, much like in the early industrialization of the West, was usually not considered worth mentioning. In the developed world, health has only in recent times become an important consideration in the overall well-being of the individual. A health care structure, however weak and limited in coverage, did exist in most countries at independence. With limited resources and inadequately trained manpower, Ministries of Health have struggled to react to the demands of rapidly increasing populations, but in rather conservative ways with emphasis on doctor-oriented approaches to health care delivery.

In countries which have adopted a more socialistic approach, far greater emphasis and resources have been given to the health sector, at the expense of more rapid development in the industrial sector, leading to remarkable improvements in health indices in most of these countries. Where these successes have been recorded, authoritarian regimes are predominant; controls are evident and adhered to. This, however, is not the case for many other countries, where discipline at the national level is low or nonexistent.

With this background, how best can large international agencies, such as USAID, CIDA, SIDA and the World Bank, and the smaller agencies, such as Rockefeller, Ford, and IDRC, function in this field? It is clear that there is no one approach which is suitable for all the varying situations and cultures which exist in developing countries today. However, I do believe that some guidelines for agencies can be laid down which, with adaptation, can have benefits in the better promotion of health in the less privileged regions of the world.

Agencies must recognize that most developing countries have some health structure run by the Ministries of Health. Although the latter are weak, they are going to be the main avenue for delivering health care for the foreseeable future. We must discourage the support of large programs or research activities which have no real commitment in resources or manpower from the ministry responsible for health. These programs and research projects must be designed to strengthen the infrastructure of the existing health services to enable them to deliver improved health care and extend overall activities to those most in need. Many projects, programs and research activities undertaken by agencies today receive token gestures of local commitment rather than serious intentions of support. As a result, projects are instituted in artificial circumstances (eg. large expatriate inputs) and are unlikely to be implemented on a wide scale. This type of activity can relieve the pressure on the Ministry when confronted with questions about what they are doing to improve care. It may be necessary to accept a minimal, but realistic, local commitment at the start of the program which would increase with each succeeding year. We must also be aware that most outside-supported programs last 3-5 years; institutional support lasts 5-10 years. In realistic terms, the local agency cannot hope to take over completely in this time frame. I would suggest that agencies should consider contributing to the local costs during and well after the actual program is in place and functioning, to allow time for the local institution to take over the maintenance and recurring costs. In this way, programs which improve the health care or delivery system can be integrated into the overall health care system of the country and help to strengthen the infrastructure for the delivery of care.

The primary health care conference at Alma Ata in September 1978 focused on improved delivery of primary health care (PHC) to meet the increasing demands of the less privileged in the Third World, as opposed to the present emphasis on large curative complexes in cities to meet the needs of a few, with recurrent costs so high that little is left for expansion and improvement of rural health care. I do not see the development of health care systems as an either-or proposition, as do many proponents of PHC. Health care must be looked at from its totality, which includes primary, secondary and tertiary care; if large efforts are to be made in the primary sector, we had better make adequate provision for adjustments in the secondary and tertiary systems; if not, chaos and disillusionment will follow, bringing attempts to deliver a better system through PHC into disrepute. The unhealthy atmosphere which has sprung up among professionals regarding curative and preventive care must be contained; otherwise, this polarization will lead to declining standards of care. Curative and preventive must work hand in hand if we are to see systems developed to deliver the technologies which exist and will be forthcoming. I think we would all agree that prevention is better than cure; however, the conditions that exist today in many parts of the developing world are such that the disease load is very high in populations, and unless you can do some curative work, prevention is likely to fall on deaf ears.

Much enthusiasm has been created by the apparent success of vaccination in the eradication of smallpox, which demonstrates what can be done globally with a well-organized, government-supported approach to control a problem disease. On the other hand, the recurrence of malaria in epidemic forms in many areas is a good example of an eradication program which has, after 20-30 years, proven a failure. Why was this so? Was it because of the better planning of the smallpox program or because of greater commitment by governments to smallpox than malaria eradication? Or was it because the technology in the case of smallpox (vaccination) was more specific than in the case of malaria (multiple measures, no one of which offered adequate protection to control the disease)? Or was it that vaccination required little motivation on the part of the population who received the vaccine as compared with long-term continuous motivation required in the battle against malaria? I would suggest that the success of the smallpox eradication campaign was due to a more specific technology, a well-planned global and country approach (at times military in execution), and little motivation being required at the community level.

There is no doubt that vertical programs have a place in the overall delivery of health care, especially in immunization programs against such diseases as measles, whooping cough, polio, neo-natal tetanus, and probably diarrhea. But what do the vertical programs do to the health care delivery systems of many developing countries? In Nepal, 50% of the budget was, for years, spent on malaria control at the expense of the development of the health infrastructure and improved health care generally. This is the tendency of vertical programs: to take away the cream of health staff and resources for the short-term goal of lowering morbidity and mortality for a specific disease at the expense of the overall general improvement of health in the population. There is a further problem in vertical programs of what to do with the personnel after the program terminates or breaks down, as we have seen in malaria and schistosomiasis programs.

The horizontal approach is not by itself the complete answer, but perhaps resources can be more evenly divided to apply a broader attack on conditions such as water and sanitation, family planning, mother/child health, immunization and better nutrition. In this way, structure can be developed in an integrated way so that the programs complement one another rather than plunder one another's services; cadres of health workers who are capable of participating in various health activities can also be developed.

A good deal of study has been done on the different types of personnel recruited from varying walks of life to improve the delivery of health care. They range from illiterates to persons with primary education to the more educated members of the community. While I agree that the medical doctor alone is not capable of delivering health care to everyone, neither do I agree that by simply giving illiterate or minimally educated villagers some training, they can do a better job, as many experts of this approach advocate. When I hear this nonsense,

I often wonder how many have themselves been treated by the village or auxiliary health worker. Damned few, I would suppose! The thing that is lacking is a real attempt to build a system where the highly trained doctor and the auxiliary can complement one another and, by so doing, deliver better health care. If we are to use low-level personnel to deliver health care, an active, supportive supervisory mechanism must be built in from the beginning, or it is doomed to failure, resulting in quackery which makes traditional medicine look very good.

We are facing an increasing demand to divert our resources into the field of traditional medicine. I find this a cop-out, as it makes us take our eyes off the real task, namely, the strengthening of the structure to deliver better health services within the country. At present in most of the poorer developing countries, a health care delivery system is, at best, spotty below the district hospital level. But it is now advocated that we should in some way try to improve this traditional medicine system, when we ourselves are incapable of reaching down to the village level. I suggest we should learn from it, but keep our hands off unless we have something very specific to offer, and concentrate on the real task.

Some key areas of future research in health care which I think vital are:

Middle management: Decisions are made at the top. How do they percolate to the periphery for execution, and likewise, how are changes in the peripheral scene transmitted back to the top so that decision making can be more meaningful? The dearth of trained middle-level personnel both at the administrative and functional levels (e.g. administrative assistants, accountants, nurses, health inspectors) in most health services is frightening, so the system cannot function with any degree of efficiency. It is all right to allocate new cadres of health personnel and new capital expenditures for facilities, but unless middle management has the capability to handle these increases in developing forms of administration and supervision, adequate channels of supply and proper reporting, the situation is doomed to failure.

What I would like to see done in many health services is a complete review of activities of the staffs at the ministry, provincial, district, health centre, and peripheral levels, to check duties carried out on a day-to-day basis. I think we would find that perhaps a great deal of effort was being focused on tasks which had become routine but are irrelevant to the present health situation. A retraining process could be instituted to meet the changes and avoid adding another category of personnel to be paid from the already meagre budgets of most Ministries of Health. I am sure there is great room within structures in most countries for improved efficiency through redirection of available resources and manpower.

From our experience, it is difficult for outside agencies to engage in middle management studies, owing to their political implications, but efforts should be made to encourage countries to investigate this area using their own nationals with inputs from outside.

Logistic support: Investigations into the type of drugs relevant to disease patterns of a specific country, drug manufacture, and the purchase and flow of supplies, including a system of reordering, are necessary. An adequate supply system must be developed to minimize the cost of maintaining a large cadre of health personnel in the field - where in most circumstances today, they operate only partially because of lack of supplies and equipment.

Intersectoral schemes: This I presume is another term for "multi-disciplinary" or "rural development" approaches. While this approach is ideal, it is at best difficult and costly; it may well be outside the range of budgets for most ministries. However, a start could be made if, when large development programs such as irrigation schemes, dams, etc., are being prepared, the feasibility studies include the social and health implications for the population involved. These studies should be part and parcel of development projects and adequate funds should be made available in the projects themselves to carry out the necessary readjustments to improve the health and social well-being of the people involved. This may be a beginning to the acceptance of health as an important part in overall development and a lesson to leaders in health that they cannot hope to develop a health care system in isolation from these other important sectors.

I am afraid that primary health care is going to become isolated from the rest of the health care system. This must be avoided from the start at all costs, by treating the health care system as a whole with primary health care as an essential part. Surely we have learned some lessons over the past 10-15 years from family planning programs, where in many cases, we built the roof and forgot the foundation.

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