WORLD HEALTH ORGANIZATION

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DISCUSSION GROUP REPORTS ON ORGANIZATION AND ADMINISTRATION OF RURAL HEALTH SERVICES

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REPORT OF GROUP A

The members of this group are as indicated in the document WP/RC11/TD6.

Rapporteurs are Dr. P. H. Teng and Dr. C. Marcus.

RURAL HEALTH SERVICES

I. Planning and Assessment of Health Services

Survey of Needs and of Resources and Aims

The group agreed that some form of vital and statistical data should be available to indicate a general disease pattern and the problems related thereto. It was evident that the content of this information would vary with the degree of development of any particular area or rural community. It was recommended that the first essential step would be to introduce legislation for the registration of births and deaths, although the registrar need not necessarily be a member of the health staff so that a headman of the village, a teacher or a police officer, etc., can carry out such a function.

On the question of resources, any rural health programme should only be planned within the financial resources and the availability of trained medical and ancillary personnel. It should also explore the possibility of encouraging the employment of local persons for rural health work. The point was raised that due consideration should be given to the demands of pressure groups as a guide in the planning programme. The question of communication between local rural health units and the central health services was stressed. In short, the local disease pattern should lead to a harmonious co-ordination between the preventive and curative services. In any rural health programme there should be co-ordination between the governmental health activities and the other voluntary agencies which, therefore, should include also close liaison with environmental sanitation and housing schemes. Such a close relationship should also be fostered between the government, private and international agencies. There should be efficient planning in all community development schemes.

Contents of Integrated Health Services

1. Basic Health Services

Various members gave detailed accounts of the basic health services in their countries. These accounts touched on the organization of local health centres and subcentres in the various rural health units of these countries.

2. Special Health Services

Certain specialties, such as trachoma, mental health, leprosy and cancer, were mentioned as possible fields of integration into a general rural health service.

3. Medical Care and Rural Hospitals

Mention was made that medical care is generally provided in the dispensaries in rural areas. There are provisions in Sarawak and Malaya of "rest beds" and "sick bays" in rural health centres for the care of non-urgent cases which do not require special institutional care. It was stressed that communications between field units in the remote areas and the main general hospitals should be maintained. In Malaya, for the remote areas, a scheme of "mercy flights" is in practice.

Co-ordination with Education, Welfare, Agriculture and Community Development Facilities and Utilization of Community Resources

It has already been pointed out earlier that there should be co-ordinated planning between all community services and health development. It was emphasized that in planning health services, educational and other developments must go hand in hand so as to attain a balance of these essential services. In this connection, one should also bear in mind that pressure groups should not overlap in functions to avoid duplication of services.

Assessments

Assessment of rural health activities should be carried out at either the regional or provincial level which, in turn, must be answerable to the national health administration. It was recommended that staff should be rotated in order to maintain a uniform standard of assessment and evaluation.

II. Organization and Administration

Financing

All rural health units can be financed in one of the three ways:

1. Central government funds from general revenue.
2. Local government funds from general revenue.
3. Voluntary donations or grants from local and/or international agencies.

Care must be taken to ensure that funds are available for the annual recurrent expenditure for the continuation of the programme. The type of programme will depend on the socio-economic circumstances of the areas to be served and whether the local population will demand and support such services.

Costs

The estimated cost would vary in each situation and it would be difficult to apply a uniform standard. An example of the type of services was discussed. There are two types of rural health centres:

1. Static centre
2. Mobile unit

In the Philippines, by field experience there are eight categories of static centres:

1. Population up to 2000 – one midwife
   one sanitarian

2. Population between 2000 – 5000 – one public health nurse
   one midwife
   one sanitarian

3. Population between 5000 – 10 000 – one municipal health officer
   one public health nurse
   one midwife
   one sanitarian

4. Population between 10 000 – 20 000 – one municipal health officer
   one public health nurse
   two midwives
   two sanitarians

5. Population between 20 000 – 30 000 – one municipal health officer
   two public health nurses
   two midwives
   one sanitarian

6. Population between 30 000 – 40 000 – two municipal health officers
   two public health nurses
   two midwives
   two sanitarians

7. Population between 40 000 – 50 000 – two municipal health officers
   two public health nurses
   three midwives
   three sanitarians

8. Population over 50 000 – two municipal health officers
   four public health nurses
   four midwives
   three sanitarians

In Malaya a large type of rural health centre costs in the region of US$100 000. A centre staffed by a midwife costs US$1000. Current average annual expenditure for one rural health unit in Japan is US$45 000.

Mobile Units

Various mobile units were discussed. In certain specialized mobile units, dental, x-ray, ophthalmic and curative services are offered in Hong Kong. In addition to these, two floating clinics cater to the population of the surrounding islands. This is also the position in the Philippines and Singapore. In certain rural areas in Australia, there is a flying doctor's service available.

Staff Qualification

In the majority of areas there is a major programme for the training of medical personnel at all levels. In Malaya, Hong Kong, Singapore and Australia, British standards of training and qualifications are adhered to. In the Philippines, a similar standard is in use, but with local adaptation using different designations. It was generally agreed that a certain minimum standard of training should be aimed at for rural health workers. One member, however, disagreed with this view point. He postulated the theory that in a given set of circumstances all available personnel however deficient in training, should be utilized in countries to initiate health programmes rather than to delay implementation which may take some considerable time to mature if the high standards of professional training is to be insisted upon. The chair opined that the key personnel in any health programme is the public health nurse who could with adequate training establish local training school associated with a general hospital and would be able to supply the required complement of trained personnel.

Supervision at Different Levels

The role of health educators was raised. Some members agreed that a health educator is an essential member of the medical team. It was generally felt that unless he could work closely with other members of his team, his role is not easily defined.

Supervision at Various Levels of Administration

It was generally agreed that there should be supervision of the rural health services personnel by staff from the central health services. It was felt that this supervision should not be limited to fault finding but should rather be an added stimulus to the workers in the field. Another aspect of training was touched on. It is in connection with the subject of refresher courses to ensure that the field personnel are given these courses from time to time in order to keep them informed of the advances in the health field, so that they could be given the feeling that their standard of knowledge is up to date.

REPORT OF GROUP B

The members of this group are as indicated in the document WP/RC11/TD6.

Rapporteur is Dr. Y. S. Kim.

I. Planning and Assessment of Health Services

Survey of Needs and Resources:

The central authority with collaboration of local authority should define the needs at the periphery.

Following methods of survey are suggested:

(1) The central health authority should assume responsibility for surveying the needs and resources.

(2) The medical school can be co-opted to survey the rural health need.

The sampling survey by central authority is also necessary.

(3) The international planning team is suggested to advise the determination of needs. The WHO Area Representative can be a possible member of the team.

(4) In determining the health needs, the dental health need should be included.

Aims:

The aim should concentrate by priority on the problem greatest in the community as shown by the survey.

Contents of Integrated Health Services:

The health service in a rural area should be one which meets the total needs including preventive as well as curative aspects. In doing so, the following points are to be borne in mind:

(1) In planning, the interest of private practitioners should not be neglected as they will be valuable medical resources in many areas.

(2) The Government should take as much responsibility as possible to subsidize rural health units. Every effort should be given to provide the necessary help such as housing, medical journals, etc.

(3) No fixed pattern of basic health services can be suggested as the needs will be different according to the country and the priorities determined.

(4) Midwifery service is suggested to be included in the basic service.

As regard the special health service, care should be taken not to overload the rural health unit.

II. Organization and Administration

Financing:

Funds should be obtained from all possible sources. National health act or any other form of legislation to secure health funds is desired.

Distribution of Services and Training:

(1) Size of population served by the local health unit will depend on geography, etc. Health centres should reach back into the homes.

(2) In areas where a fixed health unit cannot be established, the system of communication to nearby health units is necessary.

(3) Provision of adequate means of transportation is desired. Maintenance must be provided adequately.

(4) Recommend to WHO to hold training course for midwives in areas where facility and number of delivery are not adequate.

(5) There is a need for formulating the training programme on midwifery by some international body.

(6) Although there is a desirability to have full-time services of maternity beds in health centres where beds are established, there are countries and territories where even simple domiciliary midwifery service is not available.

(7) Workload such as number of tuberculous cases, number of babies, etc., and geographical areas are considered more important than population numbers. Should not have fixed criteria.

(8) In areas where there are no licensed doctors or midwives, the training of unlicensed personnel has some value. The traditional village aids, such as "hilot" or herb medical practitioners should be utilized with great care for close supervision and control.

(9) It is emphasized that in maternal and child health service there must be continuity of service,

REPORT OF GROUP C

I. Planning and Assessment of Health Services

Statistics

(1) Accurate statistics are necessary in the planning and assessment of health programmes.

(2) In areas where the gathering of accurate data is difficult due to faulty mechanics or lack of trained personnel, it is necessary that health officers evaluate the available data carefully.

(3) Gathering accurate data through sample surveys is also advisable.

Aims and Contents of the Service

(1) The aims of the rural health unit can be divided into (a) general and (b) specific aims. General aims refer to the basic health activities, while specific ones refer to certain special problems in the area.

(2) In establishing programme priorities attention must be given to important disease problems against which effective control measures are available.

(3) The control of certain diseases may give rise to other more pressing problems, such as population increase, malnutrition and others.

(4) Should local health personnel be concerned with raising the standards of living of the population? The sentiment of the group on this question is reflected by its stand that health activities should be co-ordinated with education, welfare, agriculture and community facilities in the area.

(5) Integration means that all services (both preventive and curative) should be rendered by the rural health unit.

(6) While the rural health unit should be more concerned with preventive services, yet it is necessary in many localities that it provides also curative services. A happy balance between preventive and curative services should be arrived at.

Assessments

(1) Assessment of health work is very essential.

(2) There is need of gathering certain essential data that can be used as indicators for assessing health work, the nature of the data depending upon what is being assessed.

(3) Although no specific criteria could be set as to the frequency of evaluation, it was agreed that it should be done regularly and frequently.

II. Organization and Administration

Financing

(1) Realistic financial estimates should be made.

(2) There is need to "health educate" persons responsible for funds.

(3) Voluntary sources of funds should be encouraged as much as possible.

Distribution of Services

This should be based upon:

(1) Size of population

(2) Administrative set-up

(3) Receptibility and readiness of the population.

It is not advisable, however, to give a definite population-rural health unit ratio. Rather the distribution of the unit should be based upon local situations.

Personnel

(1) The health unit should be headed by a physician and should include in addition a nurse, midwife and a sanitarian.

(2) In areas where it is difficult to recruit medical officers, other para-medical personnel who should be under supervision by medical officers may be employed. The work of such type of workers, however, is generally not satisfactory.

(3) For better co-ordination of services it is essential that the duties and responsibilities of the various categories of health personnel should be well defined.

Training

(1) Training should be adequate and should be dependent upon the needs of the personnel.

(2) Training may be done at the national, intermediate or at the local levels, depending upon the training needs of the personnel.

Supervision

Supervision must be integrated at the local level to avoid confusion.