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PRIMARY HEALTH CARE IN THE WESTERN PACIFIC

by

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My first health service experience as a young physician in the 1950s was to have the sole health responsibility for a very isolated largely Polynesian rural area where the nearest major hospital was more than a hundred miles away over secondary roads. I was "responsible" in as far as I was the salaried employee of the government health services but I was not told what my responsibilities were; I was unselected by the people with whom I would live, and I did not even speak the commonly used language. I had come from a medical school which had taught me how to treat people in a hospital and which had briefly explained some of the public health responsibilities for the registration of births and deaths, for clean food and water, and for childhood immunization in urban situations, but which omitted to make clear to me what my role should be as a health worker. In all my innocence I was meant to be the government's response to the primary health needs of the people and it appeared that my presence was sufficient to fulfil the government's legal and moral responsibilities.

My experience was extreme but not unique but what happened has influenced my whole life and is relevant to this technical presentation. On my arrival at my assigned area I set up a clinic with pride and pleasure and preened myself for professional action. Three months passed and while I came quickly to know the families of the policeman, the schoolmaster, the hotel keeper, the owner of the village store and some of the large scale farmers, hardly another person knocked at my door. Health service "demand" did not appear to exist. I asked myself whether the absence of the people requesting treatment was because the people were leading a healthy life in an idyllic situation, and the major health hazards had been removed. Possibly illness was now a matter of accident or unexpected disaster. Another possibility was that the need was there but that I was unacceptable. There was a wide range of explanations and in my restlessness I started to look around and ask questions.

Babies were being born unassisted by me and some of them died. Children and adults were dying too but none of them were my patients or people I had ever seen. It was said that there was a high rate of pulmonary disease which was thought to be tuberculosis; hydatid disease was prevalent; in some valleys many adults showed signs of rheumatic heart disease; the diet was changing as fish and crayfish became hard to catch due to commercial over-exploitation: and many children at school or walking down the road had pigmented impetiginous-like lesions on their legs of a kind I had never seen before. Things were clearly not "right" in the health sense and yet health service demands were negligible. I found myself, therefore, in a situation where my training was only partially relevant, where my role was to respond to a demand which did not find its expression in visits to a person such as me, and where there was clearly a complete disjunction between the services on the one hand and both perceived and unperceived health related needs of the people on the other.

That experience was from a far off corner of a rich developed country but it does not seem to be very dissimilar from what I later came to learn exists in much of the wider Pacific area. If one puts to one side the populations of the industrial cities of Australasia, Japan, Singapore and Hong Kong the remaining majority of people are largely in small discrete communities very similar to my own. For the most part they are small, humble, homogeneous groups with a heritage of local organization and independence plus an almost unique sense of dignity and pride. For many years I thought that this was because they were in the past seafaring groups who often lived on islands and were, therefore, forced by geography to be small and close-knit. This is clearly incorrect as later I have found similar qualities in rural Malaysia, in the Philippines and also in the communes and in the cities of the People's Republic of China. This intimacy and sense of social responsibility appears to be different from the usual European pattern and yet in health we assume that they should be the same and appear to be puzzled when European health service solutions do not appear to fit.

At present in much of our Region health services are something which are presented often as a right to the people by a benign government. Yet some countries are poor and have not the resources to reach all the people using "conventional" means; some areas are so isolated that they can rarely be reached; and some of the health services provide standard production professionals such as myself not so much as health workers but as health service responses to medico-political needs rather than to the health needs of the people themselves. Something is certainly wrong and while we must be conscious of the past and the present our major concentration of effort must be to try and think about what we can do to correct it.

Once more I must return for my inspiration to my own past.

In New Zealand Maori areas and elsewhere in Polynesia there used to be no clearly specified health workers. A birth was assisted by the husband and certain female relatives. The resident multi-purpose professional was the "tohunga" who was health worker, adviser upon the planting of crops or the catching of fish, and even the arbiter of what was anti-social behaviour. There were community concerns about health but there was no health service. Health and ill-health was thought of in a wide way and included many aspects of living, including what you ate and how you behaved as well as the inexplicable disasters of infection, accident or acute or chronic illness. I postulate that maybe we are turning a full-circle and are beginning to understand that our present views are fully compatible with such thinking from our past. I may even go further and say that the linkages which have now been described between the multiple primary causes of illness and their ultimate expression, plus the knowledge we have gained upon how to prevent and treat health failures, reinforce the idea that unless we adopt such a wide philosophy of health our other efforts will surely fail. We must be careful not blindly to accept the criticism that such a change is a step backwards rather than forwards as it is probable that some of the fundamental truths springing from our own societies have evolved over time with good cause and we can only ignore them at our peril.

If such ideas have a general relevance it should be possible to extract the essence which may help us to meet the needs and demands of our populations and to propose a course of action for governments. There appear to be three main general principles:

1. "Health" rather than health service orientation directed towards primary causes

A major emphasis must be given to the primary causes of ill-health and misery whether this is based upon such things as poverty, insufficient or improper food, the lack of water or its contamination, human and other pollution, lack of education, or physical or social isolation. This emphasis does not have to be justified only for health reasons as elimination of the causes of ill-health may as well be independent national goals or the high-ranking demands of the people themselves for their own sake. In the same way that the motivation for action may come from different sources the steps leading to change and implementation are also multi-sectoral. The accepted responsibilities of the health sector appear to have been contracting in the past decades and now we must start expanding them again. Such an expansion means involvement and the use of the organizations and skills that we have, to assist in countering these general evils in conjunction with others, plus a retraining and retooling of our health resources which have to be more effective in these areas too. It should no longer be acceptable for us to wait for these changes to happen rather than take active steps to correct them.

2. Community Organization and participation

Few of the above actions can be done to people, especially in the rural areas. Even if there were enough resources, and there are not, they do not arrive and blossom as presents from a central authority. It has been said that:[1]

"It is easy to say that food is what is needed by a malnourished child and that community development is a mechanism that can be used to supply it. It is hard to say that community development is a goal and that communities in the process of developing find a way of seeing that children get food. These concepts are not the same. The way in which change is assisted and results are obtained may depend to a crucial extent upon which approach is adopted."

A viable local community organization with full individual participation appears to be a major secret to success in health. If this is true then there are national implications. It must mean that a national decision is required to return health

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[1] World Health Organization. Health by the People, p. 192 (English text), Geneva, 1975.

responsibilities to the people themselves. This is a frightening and major political decision for any country because with such a decision must come the reversal of many national policies which were designed, or had their unwitting expression, to destroy local organizations and to discount local resources and initiative. Coupled with this is the overt statement that health decisions are to be made by society as a whole and not only by interested professional groups. Such a reversal of national policy requires more than a resolution from a national assembly. Years of mistrust and health dependence have made people suspicious; many local organizations may have already been destroyed and will need to be rebuilt. Such damage cannot be undone without encouragement and action in addition to national acceptance. Even where this has been started or been done there are thorny problems. To be effective local responsibility for action must be joined to local responsibility for a lot of decision making and mechanisms have to be found to resolve issues where a local priority or form of action differs significantly from national policy or the views of the experts in the capital city.

Such a proposal is very different from proposals for "regionalization" or other sometimes lip-service proposals which may be still centrally bureaucratic even though the site of the bureaucrats may have changed.

Such a building up at the periphery not only requires different sorts of people but different criteria to assist in deciding what is required. It could be that continuous residence and presence in the community and personal acceptance may be of greater importance to the primary health care worker than academic achievement or the level of competence in health technology. If local individual and community money or resources need to be used rather than taxation resources coming from afar, then some of the waste and stupidities which are presently tolerated may become unacceptable. People will have to be trained for what they have to do, to properly function and not to follow arbitrary professional establishment standards which may be of the greatest importance to the professionals themselves.

3. Appropriate health technology

The village health structure is required not just as a presence but because it has something to give. Past world research achievements have shown us that there are ways of helping people to improve their health, decrease their ill-health, treat the sick and prevent and assist the disabled. But while the principles are general for man as a whole the manner of expression of these principles of intervention is almost infinite. The choice of options must be made as an expression of that society's needs and structure but once this has been made the knowledge and tools must be made available to all those in need. This cannot be done with only a peripheral form of service. The village worker soon

fails unless there is a supporting structure of training and referral points, whether these be clinics, hospitals, specialist teams, production and distribution mechanisms for drugs, equipment, knowledge and skills, or a more knowledgeable colleague to teach and assist and act as the link. Too often this need has been inverted and what was designed as a support has become the inward looking monster with no direct population based contact and an insatiable appetite for money and manpower too often expended upon the favoured few selected by geography, wealth, social class or technological arrogance. Balance is incredibly difficult and must be as much a political as a technical decision.

What I have been describing is not a model for a health service which could reach all people. It is not an agreed or approved form of organization in a newer edition to be slavishly followed if a country is to be modern or up-to-date. Rather it is a listing of some qualities which would appear to be linked to success and which could have a wide spectrum of expressions in different sorts of countries and in many political systems. The emphasis upon central authority decision making which encourages a firm base of peripheral diversity is likely to mean the reverse and no two countries, or even two regions within a country, may make the same decision choices.

The qualities I have summarized are not a Utopian dream conjured up by theoreticians or worked out in abstract by planners. They have come from endeavours already taking place in countries in different regions of the world and many of them have been in existence long enough for us to be confident that they work and decrease ill-health at low cost and in an acceptable manner. The qualities themselves were brought together in 1975 by the Director-General of WHO and presented to the World Health Assembly as a response to an organizational study of the Executive Board in 1973. The group of qualities were given the Code Word "Primary Health Care" and are clearly different in their nature from other complexes whether they were called Basic Health Services or some other name. The ideas presented were debated by the World Health Assembly in 1975 and in 1976 and were endorsed by appropriate resolutions and all the background papers and the conclusions are freely available.

What is proposed is that within the wider world objective of health for all by the year 2000, there should be a series of national endeavours. These would include a reconsideration of the present and projected health service proposals within countries and an informed and in-depth national debate upon the problems in the health sector if it is to based upon social equity, and of possible solutions. Such a debate would properly include a consideration of the relevance, applicability, advantages and disadvantages of a direct expression of some of the qualities which I have summarized. I emphasize "informed" debate because some of these qualities imply a major change in direction and action from what is at present being practised and affect everyone. Such changes can never be thought of lightly or superficially. Hopefully, such a debate would be followed by appropriate action with the support of WHO and friendly countries, where this is required.

Up until this point I have been speaking as an individual and colleague from this Region. However, I cannot ignore that in my present WHO role I am employed to assist all Member States. From this standpoint I am acutely conscious that in the Western Pacific Region you have many advantages and the potential to be among the world leaders in the social and health evolution which will be necessary to bring health to all people. In this Region the social and political objectives of such ideas as I have mentioned are already accepted by all governments. Local social and health organizations already exist in most countries as part of their heritage. During the past decade some of your countries or areas are already among the world leaders in developing and applying innovations based upon qualities similar to those endorsed by the World Health Assembly, and have amassed an enormous amount of practical experience in the difficulties and the useful steps which could be taken to implement them. In most countries or areas there are already sufficient resources and trained manpower to move along this path. The extreme diversity which you have must result in similar diversity of expression and if you encourage and foster it, record your successes and failures, and open your doors with humility, others will be able to observe and learn and decide upon their own appropriate path. This could be of immense benefit not only to your own people but to others who are less fortunate than yourselves in this and in other Regions.

It is my opinion that there are few choices open to you as countries or areas or as a region. The direction is clear and the main questions are directed to the speed of change and whether the richer and leading countries are willing to help their less fortunate neighbours. In such assistance size is of less-significance. The world has not yet got a good working example of how an island or a small group of 50,000 or 100,000 people can organize itself upon primary health care principles. Such a leader could well come from the Western Pacific.

What is being discussed here today in this Technical Presentation is not a new statement of objectives - they are already agreed upon - it is instead a debate upon how to proceed, in what manner and the ways in which we can help ourselves and each other. I am quite confident that with goodwill and understanding we can reach agreement and proceed rapidly together.