

FIFTH COMMONWEALTH MEDICAL CONFERENCE

New Zealand, November 1977

PROVISIONAL AGENDA

THEME	COMMUNITY HEALTH
ITEM	
I	REVIEW OF ACTION TAKEN FOLLOWING THE FOURTH COMMONWEALTH MEDICAL CONFERENCE
II	COMMUNITY PARTICIPATION
III	FOOD AND NUTRITION
IV	THE ROLE OF HEALTH MINISTRIES AND MEDICAL SCHOOLS
V	CHANGING HEALTH CARE DELIVERY SYSTEMS

ANNOTATIONS

Attached are annotations to the Provisional Agenda, the object of which is to indicate the proposed scope of the discussions under each item and to guide Governments in the preparation of their papers.

Commonwealth Secretariat
London

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ANNOTATIONS TO PROVISIONAL AGENDA

The theme and topics proposed for the Conference have been chosen as a result of consultations with Commonwealth Governments from 1975 onwards, both at the Pre-WHA Meetings in Geneva and at liaison meetings in London. The annotations given below incorporate views expressed during those consultations, as approved by the Preparatory Meeting in Geneva in May 1977.

The Commonwealth Secretariat will prepare papers on all the items of the Provisional Agenda. These papers will take into account regional discussions in which the Medical Adviser has taken part.

Commonwealth Governments have already been invited to contribute papers on Items II, III, IV and V; contributions on Item I will also be welcome.

THEME COMMUNITY HEALTH

There is no question about the increasing emphasis that is being placed in most countries on community orientation of their health programmes. The choice of Community Health as the theme of the Conference should focus attention on national resources for community health development including:

- (a) the community itself
- (b) food and nutrition policies
- (c) teaching and service institutions
- (d) the operational framework most appropriate for the effective implementation of national health policies.

AGENDA

I REVIEW OF ACTION TAKEN FOLLOWING THE FOURTH COMMONWEALTH MEDICAL CONFERENCE

Papers incorporating replies from member Governments to the questionnaire circulated by the Commonwealth Secretariat and reporting on action taken by the Secretariat itself will be submitted to the Conference. The reports of three studies by consultants – on brain drain, on drug procurement and quality control, and on the maintenance and repair of medical equipment – and a report on abortion law and practice in member countries will also be submitted.

This item could with advantage be taken in plenary, thus providing an opportunity for ministerial speeches at an early stage. Because of the addition of the consultants' reports the item is likely to give rise to more extensive debate than at previous Conferences, and the Conference may therefore decide to entrust a committee with a thorough examination of issues raised in the studies.

II COMMUNITY PARTICIPATION

It is recognised that a high level of community participation is essential for the effective delivery of health care. In planning for such participation, Governments and other health agencies need to consider a number of factors. Techniques for community education and motivation, the roles of special groups and national health policies are important examples.

(a) *Education and motivation*

What are the basic requirements for involving local people in the improvement of community health? What educational methods should be adopted and at what levels? What are the strategies for motivating communities towards sustained participation in the health field? What has been the experience with health education programmes involving the community? In what aspects of health development are local people most likely to be interested and in what aspects can they make a special contribution? Are there programmes for training health educators, school teachers and similar groups? How essential is the health education specialist to the programme of health education and what is his or her role?

(b) *Special groups*

How far is education and motivation being undertaken by local organisations? What is the particular contribution that can be made through special community groups – women's groups, youth clubs? Where there are private organisations, local or international, that are concerned with community service, to what extent have they been encouraged to take part in community health activities? In what aspects of health development are such groups likely to be most interested and in what aspects can they make their most useful contribution? Is there a positive policy for health education in schools? What steps are being taken to incorporate traditional medical workers into the national system of health care delivery?

(c) *National health programmes*

What are the roles planned for community participation in national health plans and programmes? How do Ministries of Health ensure that community participation is obtained? How far are government institutions used to promote community involvement? What is the national policy on family planning and related matters and what steps are taken to involve the community?

III

FOOD AND NUTRITION

The availability of food and its nutritional value are clearly important determinants of a community's health. A wide range of factors relate to them:

(a) *National policy*

Is there a well formulated government policy on nutrition? In what way is such a policy implemented? Is there a national organisation which supervises its implementation? What is the role of the Ministry of Health in this connection? What steps are being taken to encourage the production of more food, and of foods of high nutritional value?

(b) *Local conditions*

What is the state of nutrition in the country, particularly among children? What surveys have been made? What is the position with regard to breast feeding, weaning foods, school meals etc? What is the relationship between the types of food generally produced and consumed and their nutritional value?

(c) *Special considerations*

How far can the consumption of foods of high nutritional value be encouraged by education (and particularly health education) policies? What problems (e.g. communications, marketing) are encountered in the production of foods of good nutritional value and how can these be overcome? What assistance is needed and available for food and nutrition programmes?

IV

THE ROLE OF HEALTH MINISTRIES AND MEDICAL SCHOOLS

Ministries of Health and medical schools play a central role in national health programmes. It is surprising how slender are the links between them in many countries and how little co-ordination of their activities has been achieved in support of national health objectives. It is logical that there should be close collaboration between them.

How can this be achieved? Do medical schools function adequately as instruments of national health development, apart from the training of doctors? Are the training programmes for medical and other health professionals appropriate to meet the qualitative and quantitative needs of their communities? Do their graduates perform adequately in the national health system?

Is there recognised machinery for effective co-operation between the medical school and the Ministry? Do Health Ministries involve medical schools sufficiently in the planning and implementation of their health programmes? What provision is made to enable medical schools to participate directly in the national system of health care delivery? What measures would be appropriate to achieve these objectives?

V

CHANGING HEALTH CARE DELIVERY SYSTEMS

Complex systems of health care designed for the richer and more urbanised western countries cannot be expected to meet fully the health targets of the developing world, or targets for remote and needy areas in developed countries. These require new and innovative approaches and experimentation based on locally defined needs. Such approaches may include revising administrative procedures, ensuring that manpower training programmes are effective and related to national objectives, introducing innovations in the training and use of health personnel, strengthening health planning capacity and mobilising political and community support for agreed health programmes. A check-list of the main considerations to be taken into account would include the following:

(a) *Health manpower training policies*

Is there a health manpower training programme and does it provide for an appropriate mix of health professionals? Is their training relevant to national needs? Are their roles consistent with national objectives? What steps are taken to ensure national self-reliance in manpower training and health care delivery? Are there realistic attempts to identify new and non-traditional roles for health personnel?

(b) *Planning and administration*

How adequate are the national health planning and executive capacities? What measures need to be taken to strengthen them? Is there a national health plan with defined objectives? Are there effective means of monitoring progress towards these objectives? Is the national system of health administration the most appropriate for meeting the country's health targets? What revisions would be appropriate?

(c) *National support*

What is the position of health in the Government's overall development plans? How far has it been possible to secure political commitment at the highest level for national health programmes? What methods have been used to mobilise popular support for these policies and how effective have such methods proved?

The Conference may wish to consider what national, regional, inter-regional and Commonwealth-wide initiatives are possible for improving health care delivery systems, and how the Commonwealth Secretariate might contribute to these initiatives.

The use of traditional systems in health care delivery, the use of health workers other than doctors, and inter-regional co-operation in health manpower training might be taken into account in the context of this item.

Introduction to Background Papers prepared by the Government of Canada

In order to understand any analysis of health services in Canada, it is important to understand the constitutional arrangements and respective roles played by each level of government in the country.

2. Provinces have the responsibility for the provision of health care services for most of the civilian population, with the exception of Indians and Inuits and all residents of the Yukon and Northwest Territories. The responsibility for health sciences education and for the regulation of the health professions has also been acknowledged to lie with the provinces.

3. Nevertheless, through its financial arrangements with the provinces, the Federal Government has influenced the development of the health services in Canada. In 1948 the Federal Government initiated a series of grants which enabled it to assist the provinces in the fields of hospital construction, training of health professionals, public health research, general public health programmes, and programmes for the control of specific diseases. These grants paved the way for the introduction throughout Canada of basically uniform programmes of insurance against the costs of hospital and medical care. The Hospitals Insurance and Diagnostic Services Act (1957) and the Medical Care Act (1966) enabled the Federal Government to pay the provinces half the costs of insurance programmes on condition that they met the criteria of public administration, universality, comprehensiveness and portability from one province to another.

4. Recently a new financing arrangement was negotiated between the provinces and the Federal Government which will give the provinces greater flexibility to organise and finance their health services according to their own particular circumstances, being required to meet only the very general programme conditions outlined above.

5. This new financing arrangement, known as "Established Programs Financing", became effective 1 April 1977. Under that arrangement there will continue to be a substantial per capita cash contribution made by the Federal Government. In addition, about one half of the federal contribution will be made as a tax transfer. These new financing arrangements also include a federal cash contribution specifically designed to enable provinces to develop alternative forms of health care such as home care and various types of residential care other than hospital care.

6. As well as providing financial assistance for these health insurance programmes, the Federal Government provides grants for research and demonstration projects and the development of training facilities, health promotion and fitness programmes, consultative services, and support for national voluntary health agencies.

7. Finally, the Federal Government plays a major role in health protection, with activities relating to food and drug standards, environmental health and non-medical use of drugs.

8. As noted earlier, the primary responsibility for planning, financing and delivering health services rests with the provinces. The structure varies greatly from province to province – from a single ministry of health to a number of separate commissions.

9. Provincial Governments usually delegate responsibility for specific health services to individual agencies (including municipalities) and health professionals. However, most provinces have retained direct responsibility for some services. Examples: psychiatric hospitals, public health laboratories, chest clinics. With virtually all financing for hospitals and medical care now flowing through provincial ministries, decision-making has become increasingly centralised. The powers of local government bodies tend to vary widely from one municipality to another. Their responsibilities are often limited to public health (i.e. mainly health protection and prevention).

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