DEMOGRAPHIC AND HEALTH DATA

45. The discussion on the problems of small states concerning demographic and health data was introduced by Professor Lindsay Davidson, whose Report on a visit to study health care delivery in a number of Western Pacific islands is included in the documents section of this report (see p.79).

46. Professor Davidson stressed the importance of adequate basic data for health planning and management. Since census data were available in most small states in fairly full detail, it was possible to obtain geographically-related demographic data and establish the populations of various districts and islands. Although communications data might not be available in convenient form, information on communications systems, on the types of transport available, on the time it would take to reach each outlying area, and on the costs of transport should be easily obtainable. Data on radio communication could also be collected.

47. What was not available in most countries was a local geographical breakdown of data on the patterns of illness, so that differences between particular areas or islands were not easy to identify. Information was also required, in relation to different sizes of communities, on the frequency with which various types of accident or illness or complications of pregnancy made the evacuation of patients desirable. By using sample surveys it was possible to collect the required information on these matters.

48. Few health administrations appeared to have given sufficient thought to the levels of treatment which could be given by the various categories of health service personnel, either on their own responsibility or after consultation by voice communication with more experienced staff. Decisions on this and on the circumstances in which referral or evacuation was considered necessary, were required.

49. Once the data had been obtained and the basic decisions had been made, the problem became one of management planning - of deciding on job specifications, arrangements for supervision, systems and frequency of travel and communication, and the allocation of available funds. Logistics planning, of the deployment of personnel and the distribution and maintenance of medical supplies, and special planning to cope with possible emergencies or disasters were also required.

50. Professor Davidson considered that it was desirable for a small country to make an economic evaluation of its proposed plan. For example, the frequency of disasters in a high risk area might justify the provision of a doctor for as

few as 500 people, even though he would be under-employed. Alternatively, in a similar situation it might be accepted that the lowest category of health worker would have to suffice, even though in the event of a serious casualty or disaster the small community would be without appropriate health care. There was an equation involving appropriate levels of health care personnel and their training and maintenance costs, on the one hand, and the availability and cost of communication by voice or transport by land or sea, on the other.

51. The constraints of the situation might require the training of categories of personnel for functions not generally recognised as normal for their level. Consideration would have to be given to the provision of suitable training facilities and curricula for this purpose on a national or a regional basis, to the revision of teacher training curricula, and to the appropriate administrative support.

Discussion

52. Participants pointed out that much of the data at present collected through existing systems was irrelevant and superfluous. Forms used for data collection were often too complicated. The information gathered was frequently inaccurate, particularly where births and deaths registration was not obligatory and mere estimates were used. Existing data on a national scale often assumed homogeneity and did not sufficiently take into account diverse pockets or small islands.

53. It was noted that to convince people of the importance of gathering data for future analysis was difficult, and that continuing collection, rather than sampling, was usually unjustifiably expensive.

54. The return of information to those at the periphery who were doing the basic collection of data was considered important, so that they could be made aware of the use being made of the data, and in order to maintain their interest and cooperation. Some illness patterns might be revealed as quite local.

55. It was agreed that all these points should be taken into consideration when planning the data-gathering processes, which should be made as simple as possible. The services of a fully-trained epidemiologist or a full-scale epidemiologically-accurate methodology were rarely required for reasonable health planning decisions in small countries. "Quick and dirty" data were often adequate for health service purposes, and could be collected by existing health personnel as part of their duties. A standard four-point system, APAR (acquisition, processing, analysis, retrieval), was mentioned.

56. The question of information on medicinal drugs was raised, and it was pointed out that, for economic reasons, more information was needed by health personnel on the cost of imported drugs and on cheaper alternatives available. There

appeared to be little information on the range of drugs considered adequate for isolated situations, and on the drugs actually used and their cost. These were matters which called for close attention by medical schools as well as ministries of health.

57. The processing of data in the planning unit of the ministry of health was also referred to. It was pointed out that where there was a government-owned computer available this was often under-utilised. Cooperation between the ministry of health and the department controlling the computer could greatly assist the processing and analysis of health data.

58. The importance of well-presented health data was emphasised as a means of securing a higher priority for health when there was competition between departments for scarce resources. It was recognised that administrators and managers at various levels must be taught to use data effectively. The application of commonsense could often cut through the data and planning jungle. It was suggested that a suitable motto for those concerned was: "Learn how the system works and then how to work the system".

Conclusions

59. The meeting agreed on the following conclusions.

National

(a) Each small country needs a simple system of data collection, to obtain basic information on the population and its distribution, on transport and communication facilities, on the patterns of illness, on the frequency of necessary evacuations and disasters. Much of this information can be obtained from existing sources, and it should be supplemented by sample surveys.

(b) The information collected should be no more precise than the nature of the health problems require. "Quick and dirty" data are often adequate for health planning purposes, and can be collected by existing health staff as part of their duties.

(c) Consideration should be given to the levels of treatment which can be given by various levels of health staff, particularly in isolated circumstances.

(d) Management decisions and logistics planning, for the deployment of health personnel and supplies, and also disaster relief measures, should be based on the information collected.

(e) Special attention should be given to the provision of services for small isolated communities, in the context of the cost and the health risks involved, and to the training of personnel serving such communities in a wider range of skills.

(f) More information should be compiled and supplied to health personnel, and to training institutions, on the cost

of imported drugs and on less expensive alternatives available Attention should be given to the range of drugs appropriate for isolated situations.

(g) For the processing of health data, planning units should be given access to any government-owned computer services which may be available.

(h) Administrators and managers at various levels should be taught to present health data effectively. This is important not only for good planning and administration but also as a means of securing a higher priority for health in the competition with other departments for scarce resources.

(i) Information based on data collected should be fed back to the personnel at the periphery to stimulate their interest and cooperation.

Regional

(j) Regional groups of countries should consider ways of collaborating in the development of simple systems of health data collection.

(k) The possibility of regional cooperation in training for health data collection should be examined, and universities and other training institutions should be involved.

(l) Regional arrangements for the training of health personnel (and their teachers) in a wider range of skills so that they may be better equipped to serve small isolated communities should also be considered.

Commonwealth Secretariat

(m) The Commonwealth Secretariat and other agencies should, on request, give whatever support is possible to the activities of individual countries and regional groups mentioned above.