
STRENGTHENING NATIONAL AND REGIONAL INSTITUTIONS

93. The discussion on strengthening national and regional institutions to enable them to deal more effectively with the special health problems of small countries was introduced by Professor Kenneth Newell, author of the paper Some special health problems of island developing and some other specially disadvantaged countries (see p.93).

94. Professor Newell began by emphasising that most small countries shared a number of problems which it was advantageous for them to tackle in collaboration, through a continuing relationship and common programmes.

95. General principles put forward as world health policy were not always applicable to small states. A multi-tiered referral system, for example, which might be appropriate for larger countries, might be seen to be based on unrealistic assumptions if applied to such countries as Kiribati, Seychelles or Western Samoa, where a single "monopolistic" system might be more appropriate. Another consideration was that in some small countries ill-health was inextricably linked with poverty, so that the abolition of poverty through multi-sectoral action had to be a primary health goal.

96. In many small countries the questions to be answered were: how could "usual" health services best be provided, and how could the isolated community deal with the "exceptional" event?

97. For small isolated communities it was possible to provide a suitably-trained health worker who could deal with most of the usual medical conditions. The level of care provided depended on the level of training of the health worker and on the form of supporting, linked services. The type of health worker and the form of supporting services would depend on local circumstances, but a more highly trained person would be required at the periphery than was at present normal.

98. To deal with exceptional events, however, specialised persons and equipment were required, and more referrals and better communication arrangements were necessary. The number of referrals could be reduced if the peripheral health worker was more highly trained and provided with suitable equipment and pharmaceuticals, and if voice communication by radio with a secondary facility was possible.

99. Professor Newell said that at present many of the smallest countries were facing their special problems in isolation, and were insufficiently aware that these were shared by their neighbours. A forum for the discussion of

common problems and for strengthening existing resources was therefore desirable. The initial organisation of this was best promoted by a neutral body such as the Commonwealth Secretariat.

100. As had already been discussed, improved data collection for health planning was needed in small states, and for this similar countries could adopt common methods. Then national health system models needed to be prepared, reflecting the existing system, its successes and shortcomings, and constraints, including those relating to the existing type of health worker and to communications facilities. Such models were most important and should provide alternatives to the three tiers of the existing system. Outside assistance for this process might be required.

101. Constraints should be identified and clearly described, in components, so that common problems could be more effectively tackled on a regional basis or the assistance of appropriate problem-solving organisations (e.g. universities, WHO, Commonwealth Secretariat, Appropriate Technology Group) could more effectively be sought. Most small states needed assistance to finance their health development costs and some might need help in preparing proposals for submission to international or bilateral donors; the Commonwealth Secretariat might be able to provide such help. Few small countries could hope to be self-sufficient and in the long run they would continue to be at a disadvantage unless they collaborated with neighbouring countries.

Discussion

102. The meeting was in complete agreement with the approach outlined in the Secretariat's introductory paper. It considered that the first priority was for individual countries to consider the appropriateness of their national health care systems, and that the strengthening of existing institutions was likely to be a major element in any national or regional health programme.

103. There was some discussion on how to mobilise the political commitment on which national and regional health policy decision-making depends. The need for accurate health data on which to build a case for political decisions in relation to health was underlined, as also was the importance of close collaboration by health authorities with those in other sectors where there were common interests.

104. Curative services were recognised to be more easily "saleable" than preventive services and the need to improve the health infrastructure. The need was seen for doctors and other health personnel to be more positive "health salesmen" and for the creation of more widespread public demand (including that of women) for better health services at the periphery rather than expensive sophisticated hospitals at the centre.

105. The inter-relation between health and other development sectors was also stressed. A health element should be

included in development schemes in all sectors wherever appropriate, and each country should also have a national health council which should include representatives of such sectors as agriculture, education, finance and public works.

106. Weaknesses in middle-level management were seen to be common in the health services of small countries. It was suggested that this was partly due to methods of recruitment and partly to the difficulties of developing a suitable career structure. Suitable training was also lacking. Innovative and even unconventional methods of training were worth considering; these might include in-service training and periodic pairing between officers with similar responsibilities in different countries within the region, as well as formal training on a national or regional basis, using case study techniques.

107. The meeting agreed that most small countries needed support in order to develop programmes for training sub-professional personnel. Regional programmes for this purpose, which made possible the pooling of resources, were often the best option. The Commonwealth Secretariat and other agencies were urged to respond favourably to regional requests for assistance with such programmes.

108. Attention was drawn to the "ladder" approach which was being tried in a new university in the Philippines, in four stages:

- (i) students half-way through high school were trained to work at the lowest level of the health system;
- (ii) from this level people were selected for further training (e.g. as nurses or medex);
- (iii) from these people there was further selection for training as "super-medex";
- (iv) finally super-medex were selected for training as medical practitioners.

Objections were raised to this approach, however, on the ground that it gave rise to expectations of advancement which often could not be met; it had been tried elsewhere and not found successful.

109. One suggestion made was that an exchange scheme might be started for policy-forming staff in small countries to exchange short-term visits to make an assessment of the appropriateness of the respective health service structures and thereby stimulate thinking.

110. The next priority was to consider how national health systems could be supplemented through regional cooperation. Participants took the view that existing regional institutions including universities, needed to focus more attention on the health problems of the smaller countries. It was noted that regional institutions might need strengthening for this purpose.

111. The role of universities, some of which had the advantage of transcending national boundaries, was viewed as important, but it was recognised that they had to be provided with additional resources to enable them to undertake non-traditional activities in the regions. Many small states could not hope to have a university of their own, but where there was a regional university it was sometimes found possible to establish a faculty presence in a small country.

112. Some small countries experienced difficulty in placing their medical students in the universities of neighbouring countries; regional cooperation and sometimes external assistance were important in this connection.

113. It was also pointed out that few universities had involved themselves in health service (as opposed to scientific medical) research, and that research could help countries which lacked suitable resources to undertake it. Universities had so far taken little part in the training of health staff other than doctors. Given the required financial resources and inter-departmental cooperation, they could play a useful role in this connection, and also in health management training (which had been started in the University of the West Indies).

114. Universities could play a part in the establishment and activities of regional technical assistance groups. They could assist the collection and distribution of reference information relating to health needs. They could participate in the planning, implementation, surveillance and evaluation of programmes designed to meet these needs - particularly education and training programmes. They could organise workshops, seminars and study courses to assist the development of health programmes. They might also be able to identify sources of support and to provide special technical assistance themselves.

115. It was accepted that the expansion of the university role in the health training field called for policy and planning decisions within universities. It was considered that the universities should be agents of change in the developing world, not least in relation to health services. The Commonwealth Secretariat and other agencies might be able to supplement their resources for this purpose.

116. From the point of view of its regional institutions, the South Pacific was once again seen to constitute a special case, as its University had no medical faculty and the Fiji School of Medicine was not a fully-fledged medical school. The result was that, with the exception of a few nationals of the developing countries who had undergone the whole of their medical training elsewhere, all the specialists in the developing countries were expatriates. Some participants wondered whether the time might be ripe for the Fiji School of Medicine to be up-graded into a full medical school, affiliated to the University of the South Pacific which would then award full medical degrees.

117. Participants saw a need for national professional associations to be encouraged to articulate their views on how health care systems might be improved within existing resources. There was a special need in small countries for members of the health professions to take a full part in discussion of questions involving health service management.

118. The importance of promoting meetings of health professionals at both national and regional level was underlined. Assistance for such meetings, and also for the exchange of information on research and medical technology, was seen as a suitable role for foundations and other donor bodies. It was also thought desirable that representatives of professional associations should be invited to attend national and regional health meetings.

119. The inadequacy of medical and health information resources in small countries, particularly where there were no libraries, was mentioned. It was considered that health ministries and professional groups should do everything possible to improve such facilities - for example, through providing isolated health workers with basic books, manuals and journals, if necessary with regional assistance. The improved dissemination of health information was suggested as a suitable subject for examination at regional meetings.

120. A recent Commonwealth Foundation scheme, in which the Secretariat was also involved, to provide bursaries to enable senior medical students to spend their elective period in Commonwealth countries other than their own, was warmly welcomed. This was seen to be of possible assistance to small states with inadequate medical manpower.

Conclusions

121. The meeting reached the following agreed conclusions.

National

(a) The appropriateness of national health care systems and the adequacy of national health planning capability should be examined in all small states.

(b) Attention should be given to the requirements for mobilising national commitment for health improvement. These requirements include adequate health data, representative multi-sectoral health councils and satisfactory arrangements for collaboration between sectors with common interests.

(c) More attention should be given to the improvement of health management at the middle level, using in-service and unconventional training methods as well as formal training courses.

(d) Meetings of health professionals at national level should be encouraged. Professional associations should be invited to take part in national discussions concerning health service management and to articulate their views on how health care systems might be improved.

(e) Everything possible should be done by health ministries and professional groups to improve medical information facilities for health personnel, and isolated health workers should be provided with basic books, manuals and journals.

Regional

(f) Existing regional institutions, including universities, should focus more attention on the health problems of the smaller states. Recent moves in some regions to do this through special committees were welcomed.

(g) There is a parallel need to strengthen universities and other regional institutions in order to expand their capabilities for being effective focal centres for regional planning and action in the health field. The requirements for achieving this in each region should be identified.

(h) Previous recommendations concerning regional action on data collection and the improvement of travel and communication facilities are particularly important for strengthening institutions. Similarly, the training and deployment of doctors to provide secondary and tertiary care also call for regional attention and collaboration.

(i) The possibility of regional exchange schemes to enable policy-forming staff of small countries to exchange short-term visits to assess the appropriateness of health service structures merits consideration.

(j) Because weaknesses at middle management level are common among small states, arrangements should be considered for promoting innovative and unconventional methods of training (including, for example, the use of case-study techniques and short-term pairing with officers in neighbouring countries) on a regional basis.

(k) Representatives of universities and professional associations should be invited to attend regional health meetings, and encouraged to examine their capacity to perform a regional health role.

(l) Improved dissemination of medical and health information material, particularly to isolated health workers, is suggested as a suitable matter for attention at regional meetings, which might consider how small countries could be assisted in this respect.

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(m) The Secretariat should do everything possible, within the limits of its resources, to support the activities of existing regional institutions and universities, designed to help small, disadvantaged countries.