

The committee has just published a discussion document containing many useful proposals for improving our organisation of health services to better meet current health problems. This discussion document is the basis for a pilot health scheme in the northern part of New Zealand. Such a scheme will only be set up in the light of consultations to be held, first, with the people of the Northland region, the health professionals and the various agencies involved in the delivery of health care in the region. I am confident that this open approach will enable our health problems to be tackled more effectively. In the process, the country as a whole can only benefit from the experiment.

On behalf of the Government and people of New Zealand, it is now my privilege as Minister of Health – and my pleasure – to welcome delegates to the Fifth Commonwealth Medical Conference. May your attendance at the various working sessions be professionally rewarding and your presence at associated social functions a time of relaxation and enjoyment.

Address by H. E. Mr. Shridath S. Ramphal Commonwealth Secretary-General

My first words could not but be of gratitude to you, Acting Prime Minister, for being with us at the start of this important Commonwealth meeting. Ministers of Health, in my experience, whatever their earlier professional or political background, rapidly become members of the medical fraternity. You and I today are the outsiders. I am personally grateful for your company.

But, of course, all of us are grateful for your presence at this opening ceremony as the symbol of the Government of New Zealand, for we are all deeply indebted to your Government and welcome the opportunity publicly to acknowledge it to you. We are indebted, of course, for New Zealand's initial gallantry in undertaking the responsibilities of host to the Commonwealth's Health Ministers; but indebted also for the high order of care and commitment that has characterised the discharge of those responsibilities over many months of preparation. My only concern now is lest any be discouraged from seeking to follow where New Zealand has so excellently led. Please convey to the Prime Minister and your colleagues generally our collective appreciation.

This has been a significant and, I may add, unusual year for the number of meetings of leaders concerned with the making of government policies in Commonwealth countries. Apart from the summit meeting of Heads of Government, last June in London, the importance of whose discussions and decisions hardly needs amplification, there have been meetings of Ministers to review progress made and decide new ways of strengthening activities that constitute the basis of Commonwealth co-operation in a variety of fields. Commonwealth Education Ministers met in West Africa in Accra, Ghana, in March; Commonwealth Law Ministers met in Winnipeg, Canada, in August, and Commonwealth Finance Ministers met in September in Barbados. As was the case in these other meetings, I am sure that this meeting in Wellington, concerned as it is with an area of major importance in the life of Commonwealth countries, will be a milestone in the progress towards more effective and beneficial Commonwealth co-operation.

The theme of this Conference is Community Health. That it is, reflects not only the reality of its being at the threshold of your consciousness and your concern but the need as well that it should cross that threshold and enter the domain of practicality and programming. In both respects we are fortunate in having as our guest speaker Professor S. R. A. Dodu, Professor of Medicine and former Dean of the Ghana Medical School, whose innovative work in the field of community health has done so much to promote both awareness and action. It is a pleasure for me to welcome him to this Conference on your behalf and to thank him for agreeing to give the lead address this afternoon.

Together, Ministers and Delegates, you have come here from the veritable corners of the earth – note, not *to* a corner, for in our new Commonwealth we have outgrown concepts of centre and perimeter. You have come from all the continents and the oceans and from societies that reflect almost every facet of the human condition. It may well be asked – not by you, who know, but by our wider publics – how discussions among so diverse a gathering of Health Ministers can assist the search for solutions to the health problems of individual Commonwealth countries.

Each of your own national societies has its own unique economic, political, social and cultural mix – individuality which bears on even so universal a matter as community health, which makes generalisation impossible and uniform solutions unlikely. But, of course, a concomitant of this diversity is that there is hardly a Commonwealth country or region that does not have something to contribute to and something to gain from another. And amidst all this variety there are threads which tend to form common patterns. Sharing a common experience of health education, organisation and administration, Commonwealth countries tend to share also a wider field of similar needs and more readily to perceive likely ways of meeting them by similar and sometimes by collaborative action.

And of course, all this is enlarged by the facility for frank, friendly and informal dialogue that is the Commonwealth's special heritage. It is little wonder that, over the years, these Conferences and your consultations in Geneva between them have grown in their potential and in their importance to you. And to not only you are they important. You are, after all, the custodians of the health care of one billion people: one in every four of the world's men, women and children look to you for meeting their basic needs in the area of health.

And among them all – from rich countries and from poor, from north and south as it is now more fashionable, if less accurate, to say – the level and urgency of expectation is rising faster than your capacity to meet it. More pertinent to your theme, perhaps, it is expectation sharpened by awareness of the dramatic advances in medicine in recent years and knowledge born of experience that those advances have done little to meet their real needs – the health needs of the masses of the people. Large sections of the world's population – and therefore millions who dwell within the Commonwealth – still have no access to any form of medical care whatever; others who have simply cannot afford the cost of a service rendered progressively more expensive by an increasingly elaborate technology; while for a preponderant majority the services provided fail utterly to be relevant to their real and basic needs.

Today, 80 per cent of health care facilities are centred in urban areas where some 20 per cent of the population live. And even in the larger cities where these facilities are concentrated, substantial segments of the population have virtually no access to them.

And this is to say nothing of the fact that drainage systems and levels of sanitation as primitive as any in rural areas are commonly found in major urban centres. Indeed, the provision of health care for rapidly expanding and largely under-privileged urban groups is producing an accelerating health problem of world-wide dimensions and implications.

While health needs proliferate, our relatively few sophisticated centralised facilities tend to attract the graduates of our nursing and medical schools whose professional training has been geared to their level of care. And it is to such facilities that most modern medical research activity is beamed. For decades this has been the model of medical development in all our countries. It is a model which in most has failed to deliver health care to all, and which threatens to widen still further the gap between aspiration and performance. In terms of material resources the waste is enormous; and this is particularly critical for poorer countries who – to a greater degree than more developed ones – must allocate proportionally larger segments of their national budgets to health care. But perhaps most critical of all is the waste of human resources – the diminishing returns in terms of national health care from all the enthusiasm, dedication and often self-sacrifice which our medical men and women bring to their vocation.

It is becoming increasingly clear that health care for all will not be achieved by mere adherence to orthodox approaches. In the final analysis, of course, national resources will determine not only what can be done but how it can be done. In most countries available resources are almost bound to dictate radically different systems from those hitherto adopted or inherited. The urgency for meeting these challenges in his own country has been recently emphasised by the Minister of Health, the Hon. T. F. Gill, in the words that might well provide the keynote of this Conference. Opening the Conference on Women and Health held in Wellington earlier this year, he said:

- “ The New Zealand Government is endeavouring to change the direction of the health juggernaut which, having spent its money well on providing a public and private hospital service, must move out into the community where use can be made of everybody who can contribute. Doctors, nurses, physiotherapists, health assistants and other personnel must move into the community. It is essential that our services be re-orientated and that money for health services be wisely spent.”

The answer to the dilemma of individual versus community health care, as he saw it, was not to be found in choosing one in preference to the other but in arriving at a balance, appropriate to the local circumstances and resources, between the two.

Nor will the answers be found only in the area of health administration and policy planning. For most countries, those answers have at least as much to do with the price of jute, or tea, or copper – or lamb – as with medical curricula or the design of hospitals. The external constraints on capability can be just as disabling as any lack of vision or of will – and can be decisive even where the latter exist. As members of your cabinets you know this well enough. Every bit as important to the fulfilment of your agreed goals for community health as anything you discuss here could be the outcome of the negotiations on the Common Fund for Commodities now taking place in Geneva or the dialogue on the Law of the Sea or Western responses to inflation or OPEC's rejoinders on the price of oil.

It is one of the realities of our ever more interdependent world that just as within societies health care is inseparable from a wide range of social conditions so in our planetary community the health of people world-wide is inevitably bound up with man's capacity to accommodate a much wider range of needs that touch on the human condition – needs rooted in poverty, in illiteracy, in unemployment, in food shortages, in population growth, in a despoiled environment. I allude to these pre-conditions for effective approaches to community health that lie in the domain of others not to discourage the search for solutions but to encourage a search that is illumined by realism and guided by practicality.

Resources vary greatly between individual Commonwealth countries. It is almost certain, however, that they will continue to be in short supply for all in relation to the dimensions of national health problems. For the majority, certainly, narrowing the gap between health needs and their fulfilment will only be achieved in the short run by a shift in priorities from the pursuit of more resources to the better use of existing resources. And this, of course, is what in large measure your Conference is about. The challenges to which these considerations give rise will not be met for any of your countries merely by a series of conference recommendations. Grappling with them will require sustained and determined effort for many years after your deliberations are completed. But your Conference can offer practical guidelines for assisting member countries in making some of the basic changes that assuredly will be required. And it can help by highlighting that some of the difficulties likely to be encountered will probably be attitudinal and psychological rather than material; that new approaches rather than new knowledge are likely to be required – greater flexibility, adaptability, independence of thought and innovation than has perhaps been customary in the past.

For all of you I am sure there will be lessons to be taught and learned during this Conference. Merely identifying these lessons, however, and the benefits that might drive from them would hardly be adequate return for your efforts. It will be important also for the Conference to determine what follow-up action by member countries and the Secretariat would be appropriate for implementing its recommendations. It would be a pity if your discussions contributed only to further dialogue and did not help to set clearly defined goals and make practical proposals for reaching them.

This might also be an appropriate occasion for Commonwealth countries to review how best to extend and maximise the contributions made by Meetings of Commonwealth Health Ministers and the work of the Secretariat to sustain the impetus of improving health policies and programmes which is generated by the meetings. The Colombo Conference, with its emphasis on the health of rural communities, made a major contribution to the plans of Commonwealth countries for broadening the basis of their health programmes. This Conference should provide added momentum in this direction. An even broader and more lasting achievement from your discussions might be their contribution towards harmonious and co-operative action in health, not only among Commonwealth countries but in the larger world society. Given that you have in your charge the health care of one quarter of the world's people, your deliberations cannot but be of significance to that wider global community.