The Development of Health Services

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The fact that the South African Nutrition Society has seen fit to choose, as the central theme of its congress, the implications of nutrition in respect of the field of present-day developmental endeavours and, conversely, the implications of the contemporary development scene in its bearing on the field of nutrition, must be seen as a pointer of very real and practical significance.

We will realise, for one thing, that this laudable venture puts the seal of finality on our departure from time-honoured traditionalism, whereby, to take the case of nutrition as a medical discipline, our horizon was so often virtually confined to the study of the interactions, however complex, important and fascinating, between nutrients on the one hand and the physiology of a single organ or organism on the other. Instead, the theme you have chosen heralds the accelerating impact of a new dimension in our field of professional inquiry, a dimension in terms of which the whole vast, as yet largely amorphous, field of human and social development, irrespective of whether we are dealing with affluent or emerging communities, has become a high priority target of our concern. Not only does this unaccustomed field uncompromisingly demand a multidisciplinary approach, but, when it comes to certain parameters, such as grappling with the problem-fraught challenge of bringing purposive ferment into the attitudes and behaviour patterns of individuals, groups and whole societies, it has everything to do with nutrition as a scientific discipline. This new dimension has unquestionably come to stay, and the cumulative results of our endeavours in the field of nutrition, whether we are involved in a clinical or a research capacity, will depend as much on our proficiency in applying the laws governing human attitudes as on our virtuosity in cracking the secrets of yet another enzyme system.

THE RELEVANCE OF THE GENERAL SCENE IN DEVELOPMENT

In the course of the very topical quest for a clearer delimitation of the expanding boundaries of the responsible role of nutritionists and nutrition workers, it is indeed gratifying that the Society decided to take bearings from a very broad and comprehensive canvas, encompassing, in the present case, the contributions of experts in the singularly relevant fields of educational, agricultural and economic development. An attempt to round off the canvas by inserting some complementary highlights in respect of the more salient principles of general health development is now required.

In order to ensure that our involvement in such development is not in danger of being unrealistic and off-key, it is essential that we keep the basic features of our specific South African context in clear perspective. With this in view, the fact well merits mention, that the very jargon in respect of development, as commonly employed in the health team, is far too often a reflection on the shallowness of our grasp of the principles underlying the developmental process. We refer, for example, to the Black people in our midst as the '*developing* communities'. In a sense that is correct: they are indeed developing, and nobody has to tell us about the pressures which this process is generating. The alarming question-mark arises when we Whites, even in our professional ranks, fall into the temptation of referring to ourselves, in common with other Western people, as '*developed* communities'. True enough, we have developed countless skills and facilities which others are still aspiring to. But to use the perfect tense of the word, implying that our community has, as it were, achieved and completed its development, has a sickening ring of blind arrogance about it. Does it not reek of an unwarranted sense of finality, of stagnation, feeding on the delusion of 'having arrived'? The fact is that we all are 'developing communities', or should be, and if we are not, we can safely write off any prospects of a more worthwhile future. To take an example very close at hand: if we Westerners fail to achieve significant progress in developing our dietary habits, heaven knows what evils will descend upon us.

We must learn, each one in his specific field, to give conscious acknowledgement to the fact that development constitutes an ecological imperative. Human development can be described as the sum-total of processes whereby man adapts to the demands of never-ending change in all facets of his environment. If one takes the environment in its totality, the parameters of change are as infinite in their number as they are in their complexity and in their delicate pattern of interaction. If one or more disciplines serving a particular society are oblivious to the demands of change, or choose to ignore them, or for any reason fail to meet them, then the potential for disaster, whether on the micro- or macro-level, is introduced into the whole system. For this reason, whenever the gap between change in the fabric of the environment and our adjustment to such change is widened instead of narrowed, people will intuitively start talking frantically about accelerating the rate of development. It is for us, along with all scientific disciplines concerned, to ensure that such insipid talk is translated into purposive planning and action.

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THE CONTEMPORARY DEVELOPMENT SCENE — HEALTH

In the wide field of health services we are similarly confronted with the 'ecological imperative' of finding a formula for adjustments that will comply with the far-reaching, uncompromising demands of a rapidly changing environment. Among the multitude of factors operative in determining the extent, direction and urgency of adjustments demanded, those of major significance in the health field include the following:

(a) The rapid and still accelerating tempo of advances in all fields of science, technology and communications which is proceeding unabated.

(b) A dizzying spiral of industrialisation, urbanisation and unprecedented population pressures has been set in motion, and is running virtually out of control as a result of these advances.

(c) Serious question-marks and forebodings regarding the quality of human existence in terms of physical, mental and social well-being which have arisen as a result of the implications of the foregoing factors. It is this quality which counts in the end.

In this turmoil of transition and change, an awkward question arises: Have we in the health team developed in such a way that we are fully equipped, each one in his facet of the discipline or service, to meet the new needs, the new hazards and the new aspirations which (*a*) have already arisen, and (*b*) are clearly looming on the horizon? The answer is, obviously, that we have been caught on the wrong foot. It is cold comfort that we can claim, whatever discipline or service we are representing, that we are in good company, for everybody else is in the same boat.

It is symptomatic of man's stumbling progress along the thorny path of history, that he is always much better, and more enthusiastic, at constructing solutions backwards rather than forwards along the avenues of time and events. He has a strange and irrational inclination, when it comes to facing the future, to resist putting two and two together, and allowing himself, instead, to drift along passively, until he knocks his head, predictably, against predictable obstacles. When the world was still a good deal younger and emptier, this was fair enough, though still regrettable. In the world of today, however, high-pressured as it is in all respects, we cannot afford to uphold an obsolete tradition. The stakes are too high.

Our attitude to health services has, in the past, followed this classical pattern in a predictably stereotype fashion. The formula is gloriously simple: when the demands of change build up pressures, one adjusts on a short-term, stop-gap basis, managing, as it were, from crisis to crisis. One follows the law of short-term demand and supply. A memorable example of 'demand' was posed by the influenza pandemic of 1918, and by way of 'supply' we got the Health Act of 1919. This statement is in no way a reflection of anybody in particular. The picture is universal, and society has only itself to blame.

What we would do well to face up to, is the fact that we are challenged to transcend a heritage of health services with some very questionable attributes:

Firstly, the short-term, stop-gap pattern of adjustment is bound to result in a structure of services which, in spite of any amount of glamour and excellence achieved in individual segments, basically remains fragmented, arbitrary, unco-ordinated, with uncomfortable grey areas of neglected services, needs and peoples. In short, it lacks an all-embracing, well co-ordinated masterplan, which takes into informed account the realities of today and their projection into the future.

Secondly, uncritical compliance with the laws of demand and supply leaves the service standards of the system at the mercy of the layman's professional judgement, if there is such a thing. Not surprisingly, this has landed us in a predicament of which the end is not yet in sight, namely the irrational glamourisation and undisputed ascendancy of curative-orientated health services. Even today, in 1973, what a far cry it is from the opulent, chromium-plated temples of curative medicine to the forlorn little shrines dedicated to the humble pursuit of preventive and promotive community services! And if one expresses misgivings about the lopsidedness of the system, the preservers of the status quo brush them aside with imperious contempt: We can cure your pellagra, your tuberculosis; we can cut out your cancerous lung; and certainly we can deal with your psychosis. As if the fact that these conditions could and should have been prevented has little or no relevance! Or is it that less glamour and less 'reward' accrue to the dispenser of prevention than to the dispenser of cures, miracle or not-so-miracle?

Yet the writing is clearly on the wall. The pressures of an ecological imperative are unrelenting and inflexible, and the gap between change and the adjustment to such change, cannot be disputed. A clear realisation of the untoward implications of a fragmented, unco-ordinated health service with an unjustifiably one-sided stress on curative services has gained considerable ground and it is unquestionably beyond anybody's manipulation or control to prevent this realisation from snow-balling eventually. It is the challenging task of our generation to ensure the most meaningful, creative and timely adjustments to unprecedented pressures of change.

SOME PRINCIPLES RELEVANT TO 'HEALTH DEVELOPMENT'

It is beyond the scope and intention of this symposium to attempt an enumeration of all the principles involved, or to discuss their implications in any detail. Suffice it to sketch briefly some of the more obvious principles, to which we can gear our planning and action, if we have not done so already:

1. In the contemporary context, a health service with an inordinately heavy curative bias suffers from at least three obvious maladies, all of which are progressive and malignant: (*a*) apart from neglecting significant areas of known health needs, it renders its services at an increasingly uneconomical premium in terms of all relevant resources; (*b*) in endeavouring to shoulder the increasing burden of curing preventable conditions, it must sooner or later reach the critical point of over-extension, with results which are anybody's guess; (*c*) if pursued, it

promotes the questionable situation by which an increasingly sophisticated service is put within reach of an increasingly smaller percentage of the total population.

There is an undeniable indication for weaning the whole system away from the one-sided curative bias, and to embrace a balanced, comprehensive approach, in which curative, preventive, health-promotive and rehabilitative services are each allocated their rightful place and will put an optimal service, in terms of total available resources, within effective reach of the entire population.

2. The enactment of health regulations is patently essential. But when it comes to the task of modifying undesirable, yet deeply entrenched patterns of health behaviour, any attempts at health enforcement are as thankless, uneconomical and antagonising as they are futile. The voluntary participation and co-operation of the public has to be sought by a variety of ways and means, and there are no easy short-cuts.

3. No worthwhile progress is likely in a system where the sick patient or his disease is the ultimate target of the service. Such a system calls for a major re-orientation, whereby the ultimate objective is to maintain and promote the total health of the patient, as member of a healthy family, in an actively health-conscious community.

4. In order to gear the system to the attainment of this ultimate objective, the services may have to be restructured so as to reach right out into the community, in fact, so as to be integrated into the very fabric of community life. This calls for greater stress on the peripheralisation of more modest, but comprehensive services, even at the expense of slowing the proliferation of sumptuous curative palaces at assorted distances, on which at one stage, we placed all our pride and reliance.

5. If indeed health is to become a valued community asset, then certainly the principle of hand-outs is not likely to contribute in this direction. But where a community is activated and, of course, subsequently assisted, in expanding its own health services on a self-help basis, such a community will not only know and appreciate the value of what it has, but it will be put on the path of initiative and innovation, eager to attain ever new horizons.

6. Whereas a sound knowledge of disease, and its diagnosis and therapy, largely suffices to equip one for successful curative services, this is by no means the case in comprehensive community services. Here one's insight into peoples' attitudes towards disease and health is perhaps as important as one's insight into the disease itself, if all one's efforts are to bear the desired fruit. Without an understanding of attitudes and how to change them in a creative and a positive direction through judicious health education, one can achieve little or nothing in motivating people to adopt, on a voluntary basis, new preventive and health-promotive measures, nor, for that matter, any curative or other health measures that need to be sustained for any length of time.

7. The art of grappling successfully with peoples' attitudes will evade anyone who has not mastered the art of human relations and of communicating successfully with members of his own and other groups. As this art is generally not acquired spontaneously, it should form as integral a part of training as anatomy and physiology.

8. Where the objective of the service is total health care for the individual, family and community, the need for teamwork, more especially interdisciplinary teamwork, is basic and self-evident. There is such extensive and complex dove-tailing and overlapping between health needs and various needs in the fields of welfare, education, agriculture, administration, planning, economics and religion, that a co-ordinated team approach is an absolute prerequisite for achieving an optimal input-output ratio in this system.

9. A principle which, if ignored, will at some stage inevitably draw in its wake some regrettable setbacks or even violent backlash, is that in the case of any community project, there must be consultation at all stages, always starting at square one, the stage of preliminary planning. In the long run, no community takes kindly to any measures imposed upon it, regardless of the merits of such a project. People will absorb change only to the extent that they participate in it.

10. Finally, if a health service is to yield the most favourable dividends, there must be systematic planning, both short-term and long-term. This requires, *inter alia*: (*a*) identification of needs and problems, assisted, nowadays, by the judicious processing and utilisation of statistics and surveys; (*b*) periodic determination of priorities; (*c*) preparation and implementation of programmes with defined objectives; (*d*) evaluation during a project, so as to allow for modifications if indicated, as well as on completion of a project, so as to establish and quantify the results.

CONCLUSION

It is assumed that none of these principles, nor their bearing on successful health development, are unfamiliar to us. But on account of their delicate interaction and interdependence, as well as their urgency in view of their intimate link to the over-all development scene, it seems worth while to present them in context. During times when we are often still groping for new approaches to find new solutions, such an exercise may help to gain clearer perspective. To those who are not health workers, but still members of the wider, interdisciplinary team in the sphere of developmental endeavour, it may give some reassurance that we in the Department of Health are honestly trying to do our homework. Moreover, some of the principles may be of equal relevance in the field of application of their particular discipline.

If one puts these principles together, like pieces of a jig-saw puzzle, filling in the missing pieces through one's knowledge of local conditions obtaining from place to place, it will give a glimpse, in tentative outline, of what the Department is visualising in the development of comprehensive community health services in the homelands and elsewhere. Inasmuch as the vision is not yet realised, it is not through lack of endeavour and dedication.