# Editorial

## "Health for all by the Year 2000"

*Ceylon Medical Journal*, 1980, 25, 53-55

The WHO has called on its member states to commit themselves to a target of "Health for all by the year 2000". This resolution is mainly directed at the many countries where large numbers are denied elementary health facilities, and it sets a reasonable time limit to these countries to harness their hard pressed resources for achieving this goal. Primary health care for all implies adequate servicing of the rural sector where the majority of people in developing countries live.

In Sri Lanka 80% of a population of 14 million people live in rural areas. Provision of an adequate health service to this large sector of our people is a duty that the state owes them, but at the same time the difficulties in achieving this have defied an entirely satisfactory solution so far. It is not a problem that is peculiar to this country, for many governments are grappling with the question of how best to serve the rural people. The existence of an international awareness of this situation was shown by the acceptance of this issue as a major theme at the Fourth Commonwealth Medical Conference held in Sri Lanka in 1974.

The disparity between the quality of medical facilities available in the rural and the urban sectors is apparently an ever widening one. It is unrealistic to expect this gap to be completely bridged, but it is reasonable for villagers to aspire to a fair share of the facilities enjoyed by their brethren.

Many of the shortcomings of a rural health service are due to the inadequacy of resources in the way of trained personnel and funds. Transport facilities, literacy of the people and their economic status too have a bearing on the subject, but it cannot be denied that a major consideration is the attitude of the doctor.

Only a young doctor at a time when he is normally free of family obligations such as the education of his children could be expected to serve in the outposts of the health service. But such a doctor, fresh from the university, will have his own aspiration which have been moulded by the type of training he has had. When he embarks on his career at a rural hospital he may be denied the opportunity of practising what he had learnt with such dogmatic zeal. He is deprived of simple laboratory, radiographic and electrocardiographic facilities which to him form the base of a diagnostic pyramid. Many of the drugs which he may have looked upon as the *sine qua non* of good medical practice may not be available in the rural institutions. Frustration born of such shortcomings may find vent in a desire to seek greener pastures.

The majority of the present day doctors aspire to some form of specialisation. A large hospital rather than a small peripheral one is more likely to provide the necessary training towards this end. Medical libraries which are vital for the pursuit of postgraduate education are found only in the larger hospitals, and here too only the ones in teaching hospitals are worthy of the name. Consequently there is a tendency for the movement of young medical talent from the peri-

phery to the urban centres, specially the teaching hospitals.

Village life has very little to offer the young doctor. There may be a few who, fired by an almost missionary devotion to their vocation, may satisfy their sublime aspirations by a period of service among the needy villagers. Some others may be happy to commune with nature and study its many facets. Places of archaeological or other interest in the neighbourhood may keep some doctors occupied. But, by and large, such interests can seldom compete with the materialistic demands of a contemporary medical career.

A decade or two ago the majority of the peripheral hospitals were manned by assistant medical practitioners (AMPs) who earlier went under the familiar name of apothecaries. It was argued that the rural sector would be better served if medical graduates were appointed to these hospitals in their place. There was some justification for this optimism, for it was hoped that with the opening of the second medical school at Peradeniya the supply of doctors would be sufficient to meet this demand. However, all these calculations were put to shame by an unexpected and unprecedented exodus of young doctors to foreign countries. Spurred on by the realisation that their services were capable of fetching very high remuneration in these countries they left our shores in increasing numbers. Such a depletion of valuable manpower which a developing country can ill afford left its mark mostly on the rural sector.

The training of AMPs was suspended, but as their numbers dwindled the authorities were faced with many vacant stations where doctors could not be induced to remain. The AMP by the very nature of his training, did not have to depend on special investigations for the diagnosis of diseases, nor was he trained in the finer uses of scarce drugs. He was in a way content to live among the simple villagers and be one with them. On realising that AMPs were best suited to man the periphery their training was resumed recently. Several other countries too have begun to think on these lines and the training of medical assistants has assumed a new perspective. Even some of the developed countries are taking an interest in this category of workers who could be trained in a short time. Prof. Fendall discusses this aspect in this issue.

**General practitioners**

While authoritarian methods have often failed to yield the desired results, it is gratifying to note that some of the young doctors in the private sector have, of their own free will, settled down in practice in small towns where they cater largely to a rural population. It may be that once a young doctor decides to take to general practice he finds few openings in the large towns where senior colleagues have already established themselves. The evident success of these young general practitioners speaks for the popularity of the service they provide the villagers at a nominal charge.

These young doctors have eschewed specialisation in a narrow sense, and have really found both intellectual and materialistic contentment in a sphere which is rather outside the pale of the usual career of a medical graduate. It is for the community and the state to recognise their contribution to the rural health of our country. Their services should be taken into account in the formulation of any rural health scheme.

**Preventive health**

In a situation where the delivery of curative health has been strained to the utmost, prevention of disease should assume a special meaning. The onus for this aspect of work rests with the medical officer of health. But there is an ingrained reluctance on the part of the young doctor to adopt public health as a career. Having been brought up to regard patient as his rightful charge many a doctor may find it difficult to reconcile with a situation where a whole community and not an individual becomes his responsibility. The yardstick of success in clinical medicine is usually the cure of the patient but such a ready reckoner is not available in the field of preventive medicine where the effort has to be sustained over a long period and the results are imperceptibly slow in appearing.

It is thus seen that the task of providing an adequate health care service to the rural sector is a challenging one. However, we are fortunate in having a rich network of health centres throughout the country. A good public transport system brings them within easy distance of most villages. They provide at least elementary primary health care, for all our people as was observed by Dr. Wallooppillai in his presidential address published in this issue. What is difficult to foresee is how its quality could be improved within the limitations imposed by the availability of resources.

C. G. U.

## ERRATA

**Reye's syndrome and a Reye's syndrome-like illness with early seizures – their pathogenesis and treatment by J. Eric J. Aiyathurai**

*Ceylon Medical Journal, 1980*, **25**, *5-25.*

Page 7 after line 30 "seen such children is due to alimentary starvation. However, we observed that the degree of ketoacidosis" should be inserted.

Page 7 column 2 line 16 should read "ketostix, clinistix and clinitest tablets".

Page 10 column 1 line 12 should read "II, III and one in stage IV".

Page 25 reference 20 should read "Cahill, G. F., Jr. (1970) *New England Journal of Medicine*, **282**, 668".

Page 25 reference 21 should read "Lehninger, A. L. (1977) Comp., *Biochemistry*, 2nd ed., p. 779 New York: Worth Publishers Inc.