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PERIODIC REPORTS ON HUMAN RIGHTS

Memorandum prepared by the World Health Organization

The Secretary-General has the honour to circulate herewith a memorandum prepared by the World Health Organization.

1. During the debates of the Commission on Human Rights at its fourteenth session, the question was raised as to whether the World Health Organization might not assist the Commission in its consideration of periodic reports on certain rights embodied in the Universal Declaration of Human Rights. Reference was made, in this connexion, to the medical and hospital care of the sick and to the protection of people against the potential danger of ionizing radiation.

2. In an endeavour to meet the Commission's wishes with regard to the first of these two subjects, medical and hospital care of the sick, the Director-General of the World Health Organization communicates herewith a document,[1/] the substance of which is drawn from the "First Report on the World Health Situation". This report, which was prepared in conformity with article 61 of the Constitution, concerning reporting by each member State "on the action taken and progress achieved in improving the health of its people" and in pursuance of the decision of the Ninth World Health Assembly (May 1956), inviting member States of WHO to prepare a report covering as far as possible the period 1954-1956, was noted by the Eleventh World Health Assembly in May 1958.

1/ Annex I.

3. With regard to the second subject, the protection of people against the potential danger of ionizing radiation, the World Health Organization has approached this matter in a number of ways. The question of radiation effects on human heredity, for example, is being considered in detail, and there is attached the report of a study group on this subject, published in 1957.[1/] Also the Organization, in close collaboration with the United Nations Scientific Committee on the Effects of Atomic Radiation and two competent non-governmental organizations, the International Commission on Radiological Protection and the International Commission on Radiological Units and Measurements, has been attempting to draw the attention of all concerned to the hazards involved in indiscriminate use of ionizing radiation in medicine and in other fields. As an illustration of this action, there is attached volume 11 Nr 8 of the Chronicle of the World Health Organization,[1/] issued in August 1957. This publication received a particularly wide distribution and was addressed to governmental authorities, health agencies, medical faculties and medical schools, research institutes and laboratories in all parts of the world. Realizing the importance of giving more emphasis to questions of radiation protection in the training of medical and health personnel, the World Health Organization convened two Expert Committees in 1957 to consider post-graduate training in the public health aspects of nuclear energy and the introduction of radiation medicine into the under-graduate medical curriculum. The reports of these two committees, published in 1958, are attached.[1/]

4. It should be realized that none of these documents have been prepared for the purpose of aiming at the protection of a human right. However, it is the hope of the Director-General that the documentation communicated hereunder will assist the Commission in the discharge of its high responsibilities.

1/ A limited number of copies of this report, in English and French, is available; it will be distributed to members of the Commission only.

ANNEX I

MEDICAL AND HOSPITAL CARE OF THE SICK

(excerpt from the First Report on the World Health Situation)

1. Medical care, including hospital, clinic, rehabilitation and home services

Hospitals

The organization of medical care among the nations of the world has followed several different patterns. Some of these are the legacies of old tradition, and others are related to the degree of social and industrial development. In a number of countries, for example, the hospital has won a unique place in the loyalty and affection of the people, while in others it has been looked on as a temporary unit run up hastily to meet the threat of some pestilence and discarded when the immediate danger is over. In many of the highly industrialized communities today the local hospital is constructed and tended with lavish care, and its design and capacity, its up-to-date equipment and services, are objects of pride to the community. It is hardly doubted, in all these varied circumstances, that the purpose of the hospital is to heal the sick, or at least to provide the highest possible quality of therapeutic care. Where the ravages of the far-reaching communicable diseases are barely held in check, it is natural that the urgent cure of the sick should occupy the minds of government. Nevertheless, the introduction of large-scale methods of protection against the wide-spread scourges like malaria has begun to alter the more conservative attitudes. The treatment of the sick still assumes the first place in medical care, but the success of campaigns against malaria, yaws, leprosy, and tuberculosis has begun to catch the imagination of those responsible for the health of their people.

These advances, important though they are, do not carry us far enough into the realm of preventive medicine. The question that arises in many countries, in both urban and rural communities, is the proper place of the hospital in a comprehensive public health programme. It is in the first instance dedicated to the treatment of the sick, but its functions in the restoration of sick and

injured persons to the fullest possible mental and physical capacity have not yet been very widely realized. It is to be observed that, with the decline in the seriousness of the commoner infectious diseases on the one hand and the increase in the speed, hurry and anxiety of modern life on the other, accidents have acquired an unenviable prominence as a cause of disability in the industrialized countries. Recent statistics prepared in the Netherlands and a number of other populous and industrially developed countries indicate that accidental injuries at home and on the road are creeping up to the first place in the records of morbidity, especially among children. Industrial injuries, and the long train of incapacities following war, are prominent causes of anxiety in many countries. There are, in addition, a number of diseases which have recently become menacing even in remote areas; the most serious of these from the point of view of disability is poliomyelitis, which is leaving its trail of cripples all over the world. There is one more cheerful aspect, however, in the discovery that a large number of people afflicted by paralytic disorders resulting from such accidents as cerebral haemorrhage and thrombosis, or from chronic degenerative conditions of various origins, can be greatly helped towards functional recovery by modern methods of medical care.

The above considerations bring us to the second function of the hospital as we see it today: the restoration of the disabled to the fullest possible mental and physical activity. This process of rehabilitation constitutes an important advance in medical care. The complete process involves a co-ordination of services if the best results are to be achieved. In the medical world of tomorrow rehabilitation will be one of the great contributions of the hospital to health. But governmental returns today show that the real difficulties lie, not in accepting the idea of restoration, but in the shortage of trained personnel. In general it may be said that training could well be carried out in most of the countries themselves.

Reference has already been made to the chronic degenerative diseases; and the hospital has an important part to play in prevention as well as rehabilitation. This group includes the long-term rheumatic diseases, cardiovascular disorders,and the neoplastic conditions. It is for the time being a somewhat sinister reflection that the proportion of chronic degenerative

diseases in a community is a positive measure of the state of its health, for these conditions affect mainly the older age-groups, which are only slightly represented in the less advanced peoples. On the other hand some of the long-term infectious diseases such as tuberculosis and rheumatic fever do their worst at the younger ages. Reports from island peoples with hardly any industry suggest uneasiness about the spread of both these diseases, especially in recently developed townships. In the countries where environmental conditions have been brought up to a high standard, especially as regards water supply, waste disposal, housing and the relief of overcrowding, the worst features of rheumatic fever and tuberculosis are disappearing.

Carcinoma, another disease of the later age-group, has been giving rise to increasing concern in the more fully industrialized countries. Cancer is a disease in which early detection and skilled treatment may save life, and in this way it is part of the hospital's function to secure regular clinical examination as a routine, particularly at the middle years of life.

An important group of chronic diseases is associated especially with industrial hazards. The most serious of these is pneumoconiosis. Some of the more recently industrialized countries have not yet reached the stage of taking the full precautions for the protection of the worker against this disease, or for his continued care when it has made its appearance. It is clear, however, from the replies of governments that an increasing number of countries are becoming aware of these risks and are taking legislative action to secure a high degree of safety under working conditions.

There are two further elements in hospital care which have long-term effects for better or for worse. The first of these is intelligent hospital planning according to the needs which a hospital will have to meet within its own community. In many of the economically advanced countries in the past, and in some of the rapidly developing areas in post-war years, there has been a tendency to insist on the construction of elaborate buildings for relatively simple purposes, with the result that money is spent unnecessarily on structural work which ought to change and expand year by year with the advance in scientific technique and discovery. It is true that in areas of high density where land is at a premium it is necessary to build a costly many-storeyed

structure; but this should be regarded as a stern necessity and not as a virtue of planning. The secret is to design the simplest unit that will function well for the comfort of the patients, the work of the medical and nursing staff, and the general requirements of administration - in that order of importance. The hospital should at the same time be capable of rapid adjustment to emergency needs, and of adaptation and, if necessary, of enlargement to meet the changing requirements of medical progress. It is not far from the truth to say that the worst kind of hospital is the one that is likely to outlast a generation; in the planning work of today one of the oustanding difficulties has been the reorganization of outdated hospital buildings. In a number of the returns from individual countries one notes now and then with relief a statement that the old hospital is being demolished and replaced by a building of simpler construction which will have much greater adaptability.

The second element is in a sense the opposite of the first: it concerns the need for making the administrative and residential accommodation relatively permanent. The patients come and go, and their needs are met by the provision of comfort with, of course, all the skill that great professions can supply. The staff, on the other hand, are relatively permanent, and it is desirable to provide for them all the requirements for healthy recreation and for the pursuit of personal interests and hobbies. The administrative offices also require a greater degree of solidity and permanence than the wards and the technical services. On the whole, hospital plans seem to pay too much attention to the heavy construction of patients' accommodation and to the housing of apparatus which may be obsolete in a short time or require extensive additions and modifications, and to give too little care to the needs of the more permanent residents, medical, nursing, and auxiliary.

These considerations lead us to the question of providing for the training of personnel in the larger institutions. It is impossible to establish a sound pattern of hospitals and clinics in a country or region, unless staff of all kinds are properly trained both in the practice of their own skills and in working as a team. Hospital administration itself is a profession of increasing importance as the system expands throughout so many countries. Hitherto, the training schools in the United States of America have been all but alone in

this work, but in recent years schools of hospital administration have been created in widely spread cities of the world.

In the training of medical, nursing, and other professional staff it is encouraging to observe from the replies from the more scattered areas that there is a constantly increasing degree of co-operation between territories, to avoid the expense of overlapping and at the same time to ensure the provision, at a central training school, of a high quality of teaching staff. A steady improvement in curricula is also noticed, with full-length courses for the professional groups. This has the additional advantage that the men and women who have been trained at these centres are in a position to return and take part in relatively simpler courses of teaching for assistants, in districts where it would be impossible to achieve a full quota of qualified staff.

Up to this point we have been discussing the hospital as a single institution; but in a growing number of areas this concept of the hospital is being steadily enlarged to cover an area or region. In this setting the hospital is no longer a unit but a service. Its influence spreads through the area in the form of out-patient clinics, often with a few beds in the remoter and less accessible districts, and health centres in towns and villages. In addition, many countries are developing regional schemes by means of which all the hospitals and other medical care services are joined together to render a two-way service to the community. That is to say, the central hospital receives from all over the region patients suffering from complaints which require highly specialized diagnosis or treatment and is prepared to send out specialists to the local hospitals and health centres for consultation. The peripheral areas, for their part, help to keep the general practitioner in touch with the centre, and at the same time they are the best units for the creation of a combined service of treatment, prevention, and the promotion of health. The rural centre should be a pillar of a hospital system. Both centre and rural clinic have equal parts to play in the service, but the former concentrates its attention on the skills of diagnosis and treatment of the individual, while the latter is primarily devoted to the prevention of disease and the promotion of health, both in the individual and in the group.

The hospital serves an important public health function in the maintenance of accurate records. These medical records are the nucleus of sound research and field epidemiology, and they should serve as a basis for extended trials and studies by general practitioners in the course of their practice and in their work at health centres.

Hospital records are also most valuable indicators of the end-results of hospital treatment - surgical and medical - through follow-up in the out-patient department. A surgeon (let us say) has performed a series of operations, using a new technique. Was this method justified by the immediate and the long-term results? The records of the hospitals and the subsequent investigations in the homes of the people are evidence of the first order. So it is with a new drug or a new form of treatment introduced by the physician.

Clinics and home services

Many countries report that, while their proposals for new hospitals have been subject to financial restrictions, they have been able to go forward boldly with the creation of a chain of out-patient clinics linked with a general hospital. In the more populous townships these clinics are of solid design and fulfil the object of making a meeting-place for the general practitioner, the health officer and the "visiting" specialist. They also undertake strictly preventive work through maternal and child health clinics, as well as arrangements for health education. There has not yet been any remarkable extension of mental health and child guidance clinics, but the foundations are at least laid, ready for building up when time, staff and circumstances permit. In some of the more difficult areas great use has been made of travelling clinics, and they have been organized by road, river, sea and air. In islanded areas the sea-going vessel has again and again proved its value as a clinic, and its staff are usually on call by radio.

In some tropical countries and in scattered villages elsewhere a more stable project is the rural health unit. This unit, which generally serves a group of villages, is at its best a fine example of team-work. Its full staff consists of a general practitioner, a group of public health nurses and their assistant, together with engineers and sanitarians, and the necessary auxiliary personnel.

A unit of this kind not infrequently becomes the focus for a group of smaller "health stations", each in charge of a public health nurse, and visited routinely or according to need by the clinic physician. During these visits prevention, health promotion, and treatment can be combined without difficulty.

The last bulwark of defence against sickness is home care under the family doctor. This is especially applicable in chronic illness and in the medical care of the aged and infirm. There are, however, certain important limitations to the acceptance of home care as a substitute for hospital. These will be considered later.

2. Hospitals, out-patients departments, health centres, rural health units, etc.

Historically speaking, it is probable that out-patient medical care is much older than hospitals. The treatment of the sick has been undertaken in temples from remote antiquity, and the bringing of the sick to a healer in the market place has in some territories survived to this day. The Aesculapiae represented a form of out-patient care, and this system prevailed until it was superseded, under an edict of Constantine in 335 A.D., by the gradual development of Christian hospitals. The healing of the sick in the open air was a feature of Christianity from its birth; and among the hospitals set up in the fourth century A.D. was the celebrated foundation of St. Basil at Caesarea in Cappadocia, about 500 miles east of Antioch. This hospital, which stood as a model for many others, consisted of a large number of buildings, including houses for doctors and nurses, rehabilitation workshops, and industrial schools.

Among the earliest of the residential institutions were hostels for lepers, but simple nursing homes for sick travellers and the afflicted poor had been known in Asia for many centuries before Christ. In Europe also there are a number of mediaeval foundations. Among the oldest are St. Bartholomew's Hospital (1123) and St. Thomas's Hospital (1200) in London. During the fourteenth and fifteenth centuries hospitals spread all over Europe, and a limited amount of specialization of function took place; but it was not until the first half of the eighteenth century that hospitals with the present-day outlook of cure rather than custody began to emerge. It took more than a century after that, when the great discoveries of bacteriology were applied, before hospitals could

be regarded as reasonably safe for the patient. From this time onwards a large construction programme was carried out, mostly by voluntary agencies. The chief exception to this rule was the mental hospital (or asylum) for which the state generally undertook financial responsibility. In many countries provision for the poor was made on a similar basis, the principle being that governments should be expected to take over only what might be described as "residual responsibility", making public provision for those whose care lay outside the ordinary range of voluntary effort. For practical purposes this included the treatment of the major communicable diseases, the care of the aged sick and of persons suffering from mental defect or disorder to an extent requiring public care, and general provision for the destitute. These last comprised a miscellaneous group, such as neglected children, deserted mothers and families, the unmarried mother in need of special care, and the aged sick for whom home care was barred on social grounds.

Voluntary effort was principally concerned with providing for the care and treatment of those suffering from acute illness, medical or surgical. Sickness in its active stages is dramatic and has a much greater appeal to the charitable than chronic illness or even old age. Urgent illness and accident have always won sympathy and practical help. The kind of hospital to which people of means offer assistance is of less account: philanthropic gifts are made to the tiny rural hospital as well as to the great teaching institution. Indeed, it sometimes causes a little embarrassment to the authorities when a village unit is provided with an elaborate operating room far beyond its needs, or an X-ray set that no one in the area knows how to use. In a very large number of countries, however, the voluntary hospital is still the centre of medical care, in cities, towns and villages. Until fairly recently not a few of these hospitals have been maintained almost wholly by voluntary funds, subject only to small payments by patients or in return for special services rendered to public bodies. Since the end of the war, in most countries, the constantly rising costs of medical care have rendered purely voluntary support no longer possible, and considerable subsidies are now being given from public funds, central or local.

The steadily rising costs of hospital care have served as a stimulus for new financial expedients. By far the most important of these is the system of pre-payment under which a small sum paid at regular intervals ensures for the worker and his family coverage for a defined part, or the whole, of the cost of treatment in hospital. Pre-payment schemes appear in many forms. The best of them are the simplest and most inclusive, covering the entire family and all its hospital needs. Short of this, a number of schemes are limited in one way or another - for example to a restricted number of days' treatment, or to the exclusion of certain diseases, or even to a predetermined maximum in a given year. In a few countries the appearance of commercial pre-payment plans, offering a wide range of benefits and at times varied conditions of acceptance, has complicated the issue of health insurance in general and hospital payment in particular. In an increasing number of countries, especially those in which there is little background of voluntary provision, the hospitals have now become a government service. The system may be part of a general insurance scheme, or a separate responsibility directly financed and controlled by the state. In some cases all treatment is free of charge at the time of need, but in others a relatively small number of pay-beds has been retained. Where a hospital system has long been established, local bodies may be the real owners, but they receive a government subsidy to cover their inevitable deficit.

The number of hospital beds which a country requires depends upon many factors apart from the basic items of disease prevalence and the age composition of the population. In the more remote areas the educational level of a people and their attitude towards sickness are important. The hospital may be regarded with suspicion, or for various reasons home care may be preferred; and even in the economically advanced areas the existence today of a comprehensive medical care organization, and a tendency to treat all but the most serious illnesses outside the hospital may considerably reduce the public demand for institutional care. Effective community services in preventive medicine and the promotion of health will have the same effect in the long run. Not only that, but the modern provision in clinics and out-patient departments of experienced staff and the equipment for prompt diagnosis, and early treatment of disease, will have a further effect in lowering the demand for in-patient care and in shortening the period of treatment.

In the environmental sphere the housing of the people, and particularly the size and accommodation of the individual dwellings, may be the determining factor, on social grounds, in the choice between hospital and home care. From the point of view of the nation as a whole, however, the economic level of the people is critical. There are many countries in Asia and Africa, for example, in which the number of beds of all types amounts to fewer than one per 1,000 population. In 1954 Iran had about 0.5 beds per 1,000 population, and Nigeria as few as 0.35. On the other hand, France had at the same time about fifteen beds per 1,000, and the United Kingdom had ten. It is a notable fact that some of the smaller countries which have only recently accepted hospital provision as a state responsibility have already made remarkable progress in hospital construction.

How many beds are required? A federal study in the United States of America, published in 1953,[1/] drew a short distinction between general beds for acute illness and those provided for long-term illness, such as mental disorder, tuberculosis, and general chronic sickness. It was suggested that, under the conditions obtaining in the United States, a figure to be aimed at was between 4.4 and 4.7 beds per 1,000 for acute disease, and an additional 2.3 - 2.6 per 1,000 for chronic disease and convalescence. The Bhore Commission in India, which found an existing supply of 0.24 beds per 1,000 in 1946, recommended an expansion to 5.65 beds, including provision for special diseases. The corresponding figures for the United Kingdom were 4 per 1,000 in rural areas rising to 6 in urban and an additional 2 - 2.5 to cover chronic and special diseases. Since that time certain important changes have taken place, both in practice and in outlook. In the first place, the recent victories against the common infectious diseases of childhood, the promise of success in fighting malaria, tuberculosis and a number of other causes of serious disability have tended to lower our estimate of the number of beds to be provided in these categories. Secondly, the growing co-operation at the local level between the general practitioner and the hospital, and the combination of preventive measures and health promotion with treatment, have placed new emphasis on the value and extended possibility of home care undertaken by a health team. In other terms, the increasing stress being laid upon community development may

1/ Reed, L.S. and Hollingsworth, H. (1953) How many general hospital beds are needed? A Reappraisal of bed needs in relation to population. (US Public Health Service Publication 309), Washington, D.C.

well have a decisive influence on our estimates of the need for cottage care as opposed to hospital treatment.

It would be premature to emphasize too strongly the possibility of any substantial reduction in hospital requirements for many years to come. The serious gap between needs and their fulfilment is only too obvious in many lands. And further, as has been mentioned already, as a country develops economically and industrially, its first cry is for treatment rather than for prevention and health promotion. In African territories, for example, the urge to proceed with the construction of elaborate and costly hospitals has been very great, if only on the ground that a hospital carries prestige and is evidence of material advance in the social field. It is at least doubtful whether the number of hospital beds is a good index of social field. The steady development of rural health units and of corresponding establishments in the more populous areas, should in time go far to meet the needs of all but those who require urgent treatment or complex diagnosis. The most urgent matter, however, is not the absolute number of beds, but the integration of the service at national, regional and local levels.

Hospital organization

The general tendency in hospital organization is in the direction of increasing control and supervision by local, provincial, or national governments. There are notable exceptions, such as the Netherlands, where the voluntary tradition in health services is exceptionally strong; and the United States of America, where the pattern of voluntary hospitals built by local civic groups, or religious organizations, is highly developed, and the tradition of private medical care is strong. In both cases the rising costs of hospital care have led to special planning with the object of preserving the voluntary principle. The most important of these is, of course, insurance in one form or another. The "Blue Cross" scheme in the United States, and the older "Cross" organizations in the Netherlands might well have been adopted in the United Kingdom and in a number of other countries had it not been for the disruption caused by the war. Even in the United States, however, the federal and state governments have found it necessary to contribute financially to the construction of new hospitals

since 1946. A great deal is accomplished by voluntary action, notably the work of the American Hospital Association in promoting improvement in the standards of hospital service. Hospitals in Canada also are largely independent institutions run on a voluntary basis, but they are gradually coming under the indirect influence of government through systems of inspection and licensing. In some cases the provincial authority contributes up to 90 per cent of the hospital costs, and it is inevitable that it should exercise a considerable degree of supervision.

In the Scandinavian countries the pattern differs to the extent that practically the whole of the hospital system is under government control, primarily under the various units of local government. Except in the smallest units, the Swedish hospitals have a full-time salaried medical staff. About 90 per cent of the expenses are paid by tax funds, and 10 per cent are paid by the patient, or, more usually, by his voluntary insurance. The principles of medical care have been stated in the clearest terms:

> "All necessary medical care shall be available to everybody in need of it, without special cost at the moment when the treatment is received. The community shall be responsible for the accomplishment of this benefit by the maintenance of a fully developed health service, which shall include public health, hospital care, out-patient care, and preventive medicine."

In the Scandinavian countries there is little central control over the daily operation of institutions, especially the large general and teaching hospitals, but planning and design, as well as general policy, are under the supervision of the central authority.

Among the nations of the British Commonwealth there are plenty of variations, but mostly within a common pattern. In the United Kingdom itself hospital care is financed almost wholly from the general revenues of the central government. The junior medical staff is on a full-time salaried basis, but senior specialists and consultants are part-time to some extent and undertake private practice, in addition to their salaried hospital appointments. The general practitioner was at first virtually excluded from hospital work, but the present trend is towards offering him clinical appointments, at least in the small units. There is a growing co-operation between the hospital service and the family doctor. The central control of hospitals is delegated to a large extent to Regional Hospital Boards, and the day-to-day executive responsibilities are carried by smaller units

called Managements Committees. All the members of Hospital Boards and Management Committees serve on a voluntary basis and receive no remuneration whatever. In addition, there is a steadily increasing army of voluntary workers who give their time and energies to the National Health Service, for example in maintaining libraries, providing occupations and other interests for patients, and supplying transport for patients and their relatives.

In other parts of the British Commonwealth a similar design can be seen. In New Zealand, for instance, the hospitals are under the direct control of the Department of Health. As a result of consolidation of the law, the new system will achieve greater integration at the level of the Hospital Boards, and at the same time provide for financing the entire service from central sources. In Australia the various states follow their own pattern of executive control, but there is a tendency to increase the amounts of central subsidy and indirect control of this kind. In the Union of South Africa all types of hospital are predominantly governmental, and hospital care is virtually complete as a public service. In a number of the provinces, however, the provincial authority contributes up to about half the cost of the service.

Countries which have more recently reorganized their services tend on the whole towards centralization. In Egypt, for example, nearly all the hospitals are now under the Ministry of Health, although the two great teaching hospitals have a good deal of autonomy. Direct control of minor administrative matters is apt to lead to delay, and it is important to get the right balance between freedom and integration. A similar plan of central control is to be found in other Arab countries such as Syria and Lebanon. Nations which have recently become independent have shown a strong trend towards the governmental control of hospitals. This is true of Ceylon, and the same general arrangements operate in Burma and Pakistan and in the three neighbouring realms of Viet-Nam, Laos and Cambodia. In a very large country like India considerable delegation of hospital control to the states is necessary and desirable, but funds for construction and development are being found from central sources to a considerable extent.

The non-self-governing territories are, as a rule, centrally controlled and financed in relation to the hospital services. Often there are a few private institutions in city areas, but the mass of the people receive medical care from government dispensaries, clinics and hospitals. Private medical practice is

relatively uncommon. In the smaller units, as in many of the Pacific islands, the situation gives strength and purpose to the combination of preventive and curative work at the local level, including, where necessary, the provision of a small number of beds in rural health units.

The rich development of social security schemes in some of the countries of Latin America has provided opportunities for new hospital construction. For the rural populations in these countries public hospital care is the rule, and these units are under the direction of the central authority. Under these authorities there has been a considerable expansion of institutional provision, and a welcome movement towards integration.

In conclusion it may be said that, while local and regional patterns of hospital care differ considerably in detail, the governmental tendency in most countries is unmistakably in the direction of increasing central participation. No doubt the primary reason for this is the high and rising cost of hospital care, but in principle the most important factor is the recognized need for greater integration to achieve a rational distribution of the available services. A further principle, and one which underlies much of the thinking in this sphere today, is the desirability of securing closer integration of the health services - treatment and restoration of the patient, and in the same context, the prevention of sickness and the promotion of health.

Out-patient departments, rural stations, etc.

For many years the out-patient department of a hospital has been its main link with the outer world. It has been the admission channel for accidents and emergencies, and in most cases the checking point for routine admissions to the wards. The out-patient department has also been one of the chief teaching centres for medical students, and in the larger units it has often been provided with small demonstration rooms in which groups of undergraduates have received their first clinical practice under qualified supervision. On the whole, however, the out-patient department has been regarded as an ante-room to true medical care, and it has been the custom from time immemorial for the clinical chief to see his patients for the first time in the wards of his units, after the

resident medical officers have made a provisional diagnosis. It was the great heart specialist, Sir James Mackenzie, who first put forward the idea that the senior consultant should be in the out-patient department rather than in the wards of a hospital. This concept of functions was stated at the beginning of the present century, but is only now claiming acceptance. In accordance with this approach the out-patient department has become the most important element of the system, and eventually the major emphasis will be placed on ambulatory patients rather than on the bedridden. The hospital is no longer a fortress for the bedfast sick, but rather a community centre in which the higher medical skill is concentrated. The enlargement and improvement of the hospital out-patient department is the most obvious way in which a hospital can extend its influence beyond its walls to the homes of the people. By such means it can be brought into an intimate relationship with general practice and also with the preventive work carried out by the health officer and his nursing and sanitary staff.

A study of the replies received from many countries reveals that the use of hospital out-patient departments to provide home care services is still in the stage of cautious experiment. In the promotion of this idea one can learn a good deal from the practice in a large number of the smaller territories, as well as from that in the remoter areas of the more industrialized countries. In northern latitudes, for example, it is usual to combine in a single "rural health unit" the home care services of the general practitioner, a few beds for patients in need of short-term care, and the public health work of nurse and midwife. The various clinics are held at different times on the same simple premises, and the whole range of health and medical care is combined. Plans of this nature, suitable for the differing circumstances, are in operation in the scattered village groups of Indonesia, the islands off the coasts of Scandinavia and Scotland, and the great archipelagos of Oceania. The situation in populous areas is always held to be fundamentally different. It is frequently assumed that the pattern of the city or large town should be designed to provide one or more great general hospitals, and in most cases, a group of specialized institutions such as mental hospitals, orthopaedic institutions, and hospitals for communicable diseases. In some of the more recently developed plans these

units are being grouped together to create "hospital cities"; but more commonly the general hospital is situated in or near the most populous area of the city, while the specialized units have the benefit of less congested surroundings. In a number of countries there has been a movement lately to transfer the general hospital also to the more healthy outskirts of the city, leaving in its place a highly organized polyclinic or out-patient department. It has been found that only a small proportion of hospital beds mainly for the care of casualties and urgent cases needs to be situated in city surroundings. The great majority appreciate, and benefit by, a hospital unit of simple design, in "country" sourroundings, although not far from the city. This provision however, does not solve the main problem of providing out-patient services for urban dwellers at a reasonable distance from their homes. The most acceptable solution, it seems, is for the authority to build health units within the new estates and on the urban fringe generally, on the same general principles as in the rural health units referred to above. In the huge urban conglomerations of today people cannot be expected to leave their homes for lengthy periods in order to visit a central out-patient department for diagnosis or care as ambulant patients. On the other hand it is not difficult or unduly expensive for the hospital authorities to go out to meet the patients, by setting up simple "urban health units" primarily under the charge of a group of local general practitioners, but linked closely with the main hospital on the one hand and the public health department on the other. The aim of the service would be to make and maintain contact with the family and home life of the people. In a number of countries which have introduced hospital insurance plans it has been found that there is increasing pressure on bed accommodation as a result. The conclusion reached is that only the extension of insurance to cover the general practitioner's services in the home and dispensary will reverse this process and reduce the excessive cost of hospital care. In recent years several hospitals have deliberately introduced "home care programmes" on their own account, to reduce the pressure on hospital beds. One of the features in some of these programmes is the skilful use of transport, by means of mobile clinics, special ambulance transport, and, in widely scattered districts, the "flying doctor service". It is worth bearing in mind that the mobile clinic, except in certain river and island services, is rarely a good substitute for a permanent rural unit. The

latter gives to its area a feeling of security that mobile services cannot supply. One of the principal uses of the mobile clinic, to which reference will be made later, is its application to medical care in a group of factories. The clinic truck is able to move quickly from one workplace to another, and this saves a great deal of waiting and loss of working time. It can be used for daily dressing and other forms of minor surgery, and also for routine medical supervision - for example, during a period of sickness prevalence.

Health centres, rural health units, etc.

There is some confusion in the various reports from governments as to the precise meanings of such terms as "health centres", "polyclinics", and "health stations". The expression "health centre" is, perhaps, subject to the greatest variety of interpretations. It was applied in 1920 in the United Kingdom to an institution which provided under one roof both general medical care of patients by a group of medical practitioners, and preventive services under the public health authority, such as maternity and child health, school clinics, and communicable disease control. In certain countries, the provision of "health centres" (or polyclinics) is a matter of state policy, and the institutions are generally maintained by the government through its local department. In the United Kingdom, the creation of health centres was made a statutory undertaking under the English National Health Service Act of 1946, but in point of fact very few of these centres have been erected, mainly for financial reasons. One of the principal difficulties in practice was that the provision of public health services in a health centre involved a much greater expenditure in money and space than the establishment of half a dozen or so consulting rooms for general practitioners. The result of this was that the general practice organization represented only a very small part of the whole centre, and employed only a few of the practitioners in a given area. Yet to have admitted more than six to ten practitioners to one centre, would have caused too great a congestion of patients. Perhaps the principal hindrance to success was that so many doctors of the area were left out of the scheme, either by their own choice or because of lack of room.

It should be observed that the term "health centre" is used in reports to denote a whole range of services from the most elementary rural health unit to the most complex polyclinic; perhaps the simplest way of approaching this question is to go back to the basic unit and build up definitions from that. A rural health unit has been defined as "an organization providing or making accessible, under the direct supervision of at least one physician, the basic health services of a community". With this definition in mind we should refer to any smaller unit, served by a nurse or other health officer, as a "rural health station". This would apply, so long as a physician paid an appropriate number of regular visits and supervised the station. In the same manner one would define an "urban health unit" and its corresponding station. It is evident that units of this kind should be closely associated with a larger administrative and technical organization, so that specialized assistance could be obtained without question and with as little delay as possible.

It has been suggested that the rural health unit should supply the following services, which are regarded as basic:

(1) Maternal and child health;

(2) Communicable diseases control;

(3) Environmental sanitation;

(4) Health education of the public;

(5) Public health nursing;

(6) Medical care (varying to some extent with the needs of the area and the accessibility of the larger hospital centres).

The word "clinic" ought by its derivation to mean an institution providing beds for the sick, and indeed it would be best to limit its use to this essential feature. In practice, however, "clinic" is often used to describe the office of a clinician in the physical sense, or even the consultative session which he holds in that office. It was no doubt for this reason that a group of clinics, rendering to patients a wide range of services in the same building, was described as a polyclinic, and the derivation once more makes the meaning quite clear. The term "health centre" should in these circumstances be defined to buildings in which preventive and curative services are combined. The essential feature of a polyclinic is the combination of highly specialized

diagnostic and curative services - with perhaps bed accommodation for cases under observation - in a single building. The word "health" in this context implies the integration of preventive and curative services in one building or group of buildings, and it should not be used to denote an institution where only therapeutic services are provided.

In a large number of countries the provision of rural health units, by whatever name they are called, is widespread. So far as hospital accommodation is concerned, the remoter units would be expected to make arrangements to include a few beds for maternity cases, and for medical and surgical emergencies only. A high proportion of these units, especially in Asian countries, have made provision for maternal and child health, but in fact few of them appear to have sufficient nurses or even auxiliaries. It had been suggested that, in order to secure the greatest efficiency, there should be, in addition to the physician, some five to ten nurses, several sanitarians, and a substantial number of auxiliary workers. Units of this type are especially suitable for such countries as India, Nigeria, Indonesia, and indeed in all areas in which communications are poor and wide stretches of country separate one village or settlement from another.

The situation in the bigger cities has been causing anxiety. In many of these a rush of immigration has given rise to difficulties in providing medical care for families living on the crowded fringe areas. It has been found possible in some areas of this kind to set up local health units, as in Singapore and Hong Kong; in other cities use has been made of group practice to meet the deficiency, but it is financially difficult for a group of general practitioners to make special arrangements to deal with such a situation. The trouble lies deep enough to demand special investigation and, in appropriate cases, the provision of some form of subsidy.

The meaning of the word "dispensary" also is subject to varying interpretations. In many of the old-established towns the public dispensary is simply the ancestor of the modern out-patient department. This term has been widely used, in addition, to denote a doctor's "surgery", especially when the latter was detached from the physician's home. In time past the designation

was apt enough, because it described a place in which the doctor dispensed his own drugs - and dispensaries of this kind are still extant. At the present time it is common for that part of an out-patient department which is concerned with issuing medicines to be called "the dispensary". It would be desirable to retain this name for use in its proper derivatory sense, as a place where treatment in the form of medicine is given. The term "out-patient department" is much more satisfactory (O.P.D.) as a designation of this vital hospital service - the essential link between hospital and home. The term "dispensary", however, is widely used in Africa to designate simple establishments employing auxiliary staff for the treatment of minor ailments and for the supply of first-aid dressings.

3. Domiciliary Health Services

The reports submitted by many countries indicate that there is an extensive movement in the direction of bringing medical care to the homes of the people. The method of reaching the home has been undergoing a process of evolution during the past few years. Until comparatively recently general practitioners were accustomed to work in isolation and in competition. In a large number of countries today competition is being steadily replaced by collaboration, and isolation is giving way to the formation of the group and the team. These two words do not mean the same thing: the "group" is best represented by a number of doctors who voluntarily work together in the same general practice whereas the "team" comprises a number of health workers who, under the guidance of the physician, operate a local health unit. Units of this kind are now well developed in some countries, notably in Asia and Latin America. They are also well suited to the conditions of many island territories, and to the rocky fringes of north-western Europe. Group practice, on the other hand, is being organized more extensively in industrialized countries, both by private practitioners (as in the United States of America) and by doctors in public services - in cities, towns, and even in groups of villages. The advantages claimed for the group system are: that it enables prospective patients to feel sure that they can obtain medical attendance at any time of day or night and during public holidays; that to several practitioners working

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together are given the opportunity for consultation among themselves, and for getting the immediate help of a colleague in a difficult case; and that the group can maintain better premises with more nursing and auxiliary assistance than any one practitioner can provide on his own behalf. In addition to this a group of practitioners can often achieve some degree of minor specialization - for example in midwifery or paediatrics - and obtain a larger range of modern equipment than a solitary general practitioner. From the point of view of the doctors concerned there is the additional advantage that they can have regular periods of recreation and adequate holidays.

Practitioners attending health centres may be on a whole-time basis, but more commonly they enter into part-time contracts. The essence of the health centre principle is that a number of general practitioners work together, and combine with their general service the preventive work which is associated with the public health department. Preventive and curative care are carried on side by side in the same building.

Another method of approach, which is gaining ground in some countries, is for the local hospital through its out-patient department to organize a system of home care in relation to its own services; this includes follow-up care of the chronic sick in their own homes, supervision of the aged and arrangements for them to be admitted to hospital when occasion requires. The family doctor retains his personal responsibility for the welfare of his own patients and for continuity of care in the family setting. The special feature of the system is that the out-patient department becomes recognized as the proper channel through which the family doctors of the area can obtain help for their patients, either in social care or in laboratory diagnosis. In a few areas the out-patient department also brings the local general practitioners into contact with the health officer and with the services which his department is ready to render.

A general practitioner has been defined as "a doctor in direct touch with patients, who accepts continuing responsibility for providing or arranging their general medical care, which includes the prevention and treatment of any illness or injury affecting the mind or any part of the body".[1/] One advantage

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1/ Hunt, J.H. (1957) The Renaissance of General Practice, Brit. Med. J. 1, 1075-1082.

of this definition is that it brings out an essential feature of general practice - namely that the doctor provides continuity of care. In some respects this continuity is more important than the practitioner's coverage of the entire family. In certain countries, such as the United States of America and Poland, the extensive practice of paediatrics as a speciality has already created a division in total family care; and, in any case, the principle of free choice of doctor would allow younger members of the family to choose their attendant, applying their own rather than their parents' criteria. The "family doctor" tradition is strong in France, the Netherlands, and some other European countries.

Irrespective of the importance attached to the maintenance of health and the prevention of disease, the real starting point for any discussion of the physician's task is the care of the sick. Most medical practitioners are called in by a family when one member of the family is sick, and the doctor's first obligation is to establish a diagnosis and to institute the remedies which he believes to be appropriate. Good clinical practice, although based on scientific medicine, has always included much besides. Clinical examination in the narrow sense tells less than half the story of sickness. Diagnosis is rarely complete and treatment is generally wanting in a vital respect, unless the doctor's conception of medicine relates the patient to his environment. That environment contains his home and family, his work and play, and the social conditions in which he lives and moves. It is clear, then that the doctor's diagnosis is both clinical and social, and one of the qualities of a good doctor is his ability to assess the social situation.

In everyday practice the doctor is not alone in this medical work. Among the most striking advances in domiciliary health services today is the movement towards providing the general practitioner with what might be described as "help in the home". One of the first assistants of the doctor in time past was the district nurse. It is she who has carried out all the functions that the doctor is able to delegate. She undertakes the care of midwifery patients, either as a midwife or as a maternity nurse, or, more commonly, in both capacities; she attends to the needs of the aged, and often pays regular nursing visits, perhaps to dress a chronic wound or to provide some service such as massage which could not be otherwise obtained. The district nurse also helps

the doctor indirectly by calling him in when she feels that a patient requires medical attention. Doctors in practice have relied a great deal on the work of the district nurses.

In the more rural areas, and particularly where communications are difficult, the district nurse usually combines her nursing duties with health visiting. She then becomes a general health worker often to an even greater extent than the doctor. The reason for this is that she visits mothers, infants and young children at regular intervals, whether they are sick or healthy; whereas, by the very nature of things, the doctor himself is able to visit only when called in on account of illness. This does not mean that the doctor does no health work: on the contrary, the good country doctor uses the opportunities given by his visits to "see the family" answering many questions about health and giving a great deal of practical advice on these occasions.

The combination of doctor and district nurse has created certain difficulties. These are mainly due to the fact that there might be two or more doctors in competition in a given area, all perhaps seeking the services of the same nurse. And again, the district nurse is able to call at the homes of the people only at limited intervals, at most perhaps once a day, but in scattered villages the intervals might be considerably longer. In order to meet this difficulty, quite a number of countries, especially in South America and in parts of Asia, and, in fact, in all the less populated areas of the world, are setting up under various names, what might be conveniently called "rural health units". The essential feature of this plan is that it provides an accessible nucleus for a real integration of health and medical care. The physician is in charge of the health unit, and must be responsible for its organization. Nevertheless, he is the head of a team which may consist of several nurses, one or more sanitarians and some auxiliary staff. The doctor may be in charge of a group of rural health units of this kind, and it would be his duty to arrange with the nurse for regular visiting periods, and with the sanitarian for special visits. In addition to this he will always be on call for any real emergency. A common arrangement is for one nurse to be resident in or near each rural health unit, with appropriate arrangements for holidays, time off, etc., with her neighbouring nurses attached to the same

group. The doctor, for his part, is in charge of a group of units and has the same kind of liaison with his fellow physicians who are responsible for other groups. In this way a network of health units is formed with a true integration of responsibility. It should be understood that this is not a substitute for home care but rather a means of making home care more efficient and reliable as a service. People able to reach the unit would normally be expected to attend as they would any dispensary, health centre, or polyclinic; but the rural health unit is a flexible organization, linking general practitioners with an accessible hospital on the one hand and with the area health services on the other. Reference has been made to the district nurse. It is always desirable that in rural areas she should be specially trained as the public health nurse and combine the duties.

In urban areas the position is different. Communications are better, and there is, in all probability, a hospital with its out-patient department near at hand. In considering domiciliary health services, the question at once arises: "Is this an adequate provision?". In the effort to extend their services to the community, a number of hospitals have gone beyond the expansion of their out-patient departments and have organized home care programmes by which the staff and facilities of the hospital are brought directly to the patient in his home. This idea has been implemented, for example, in the well-known scheme of the Montefiore Hospital, New York. This institution, it is true, initially served a special function: it was devoted mainly to the care of chronic diseases. In the course of this pioneer work, it was found that many patients who either were suffering from long-term illness or had passed the summit of an acute illness could be cared for with more understanding and less expense in their own homes. This was always subject to the proviso that the home met certain minimum physical and social standards in such matters as cleanliness and the absence of overcrowding. The system implied that physicians, nurses and medical social workers from the hospital staff would pay regular visits to their patients at home. This system was applied to municipal hospitals in New York City, and in 1952 it was calculated that there was a saving in hospital beds of about 16 per cent. It was also observed that these home care programmes not merely saved beds; they rendered a better quality of medical care in circumstances more agreeable to the patient and his family.

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What was begun as an experiment in the care of the chronically ill has also been applied to patients convalescing from acute illness or a surgical operation. The essence of success is collaboration between the hospital, the general practitioner and the medical social workers. The special function of the last-named is to visit the home in advance and report on its suitability, and later to make periodic visits in order to ensure that there is a proper adjustment of medical care. It is perhaps an over-elaboration for the hospital to organize a system of home care of this kind; such a procedure is suitable in special cases where the general practitioners of the area have entered into a voluntary agreement for this purpose, but it would not apply happily to any intervention of the hospital in the homes of the people and would not be a happy arrangement without full collaboration of the general practitioner. A good modern example of the home care system has been developed in parts of France and in Belgium where the assistantes sociales are well qualified to follow up patients, since they are trained both in nursing and in medical social work. On the whole it seems that a home care programme of this kind might be especially appropriate to populous districts on the urban fringe of a city. Transport is always a difficulty and accessibility to a hospital is an essential feature of this scheme. In the more widely scattered rural areas the network of health units appears to be the system of choice.

The provision of nursing and medical care is not the only method by which the shortage of hospital beds can be relieved. In recent years the idea of getting patients up within a few days of a surgical operation is gaining strength, as it has been found that there are less risks of circulatory disturbances when a patient is moved as soon as possible. It is a good thing to get a patient on his feet. The same idea has been applied to maternity, and it is now common for a woman to be up and about within two or three days of her confinement. This is probably satisfactory enough so long as the home conditions are carefully watched so that the mother does not return immediately to the full round of domestic life.

In the United Kingdom the shortage of hospital beds has also been met to some extent by the development under the National Health Service Act of a domestic help service. This enables many patients to get home earlier than they would

otherwise have done, and it provides safeguards against overwork. The system also enables many patients to remain at home when they would otherwise have had to go to hospital. A similar service has recently been launched in Denmark on a national scale, and the practice has spread to a number of northern countries. The "home-maker" service in North American cities is being provided mainly by voluntary social agencies.

One of the advantages of these methods of extending the services rendered by the out-patient departments of hospitals is that it is serving the ultimate need to integrate curative with preventive medicine. The resources for early diagnosis, treatment and after care are strengthened within the community itself. There are always dangers in extension of this kind. Excessive pressure for economy in any branch of health administration might lead, if it were not carefully watched, to an over-development of home care service at the expense of the sick. One of the functions of the out-patient department should be to ensure that its outward services of this kind are designed for the better care and comfort of the sick and not merely in the interests of administrative saving. A further duty of the out-patient department in its liaison with general practitioners is to improve the quality of medical care in its area. Hospital and specialist services in most countries have developed separately from general practice and the family doctor has been late in sharing with them the advances of medical science. Where the hospital is run on a "closed staff" system the risk of leaving the general practitioner out in the cold is substantial. Many hospital authorities are, in fact, aware of this and, often under governmental arrangements, conduct systematic post-graduate training for general practitioners who are not on any hospital staff.
