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SPEECH BY DR TOH CHIN CHYE, MINISTER FOR HEALTH, AT THE FIFTH COMMONWEALTH MEDICAL CONFERENCE, WELLINGTON, NEW ZEALAND ON 16 NOVEMBER 1977

Mr Chairman, may I make a few comments on Professor Dodu's inspiring call for "common health so that there will be common wealth". Health is everybody's personal aspiration and the distribution of wealth the inspiration of ideologies. I believe it was Malthus who in 1798 concluded that these objectives are incompatible. Health meant more population which grew in geometric progression and must be regulated by war, famine and pestilence if there is to be a fair distribution of wealth because wealth grew only in arithmetical progression.

It was a pity that Professor Dodu in his address omitted the significant role of population in health, as he has obviously read Ivan Illich's "Limits to Medicine" but has disregarded a much earlier prognosis "Limits to Growth" made by Meadows and his co-workers.

So when continual emphasis is made that 80 percent of the poor in the world inhabits the rural areas and they aspire to the wealth of the remaining 20 percent who live in the cities, I suspect that we have overlooked iatrogeneses of economics, politics and culture. While wealth appears to be centred in the commercialism of the cities, cities too are faced with problems of decay and social pathology just as much as ill health or malnutrition occurs in the countryside.

If this conference is to achieve the possible and the feasible in strengthening cooperation in matters of health, it is not possible for us to ignore changing issues of politics and economics that are the major current concerns of the world today. Domestically social security which includes health care are election issues. An electorate accustomed to virtually non-payment for medical care or food is not inclined to arguments that there are limits to nutrition or medicine.

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Medical practitioners like others who offer their professional services expect to be paid. It is not to be unexpected that they are great lobbyists for more universal health care and the pressure is greatest in countries where curative medicine is more emphasized than preventive medicine. Ministers of Health do not really wield the power that we like to believe that we have got as the Chancellor of the Exchequer or the Minister of Finance or the Treasurer has the final say. President Carter postponed his promise of a National Health Service when his economic advisors warned him the perils of inflation. Helmut Schmidt has increased pensions at the expense of health care. In all countries where it was widely believed that providing more health care would reduce the number of sick people and thereby not only diminish future health expenditures but increase the wealth of the country through the greater productivity of healthy workers, it has been a sorry tale of a social security system gone wrong.

How did such a system of guaranteed health security first introduced by Bismarck over 100 years ago has today become the target of economists? It would be wise for developing countries to learn the history of social medical care and its sequelae before literally copying similar systems into their social infrastructure.

Just as the military-industrial complex seeks survival by the introduction and sales of new weapons so also does the medical-industrial complex of practitioners, manufacturers of hospital equipment and pharmaceutical companies. But the medical-industrial complex does so in a more subtle fashion. To the uninitiated the doctors create their own image that they are little gods because they pass judgment on how patients should be treated. The fly in the ointment is that lawyers who live by their wits are only too happy to sue the gods on behalf of patients for negligence. The idea of common health available to all is therefore impracticable. It is even more impracticable because doctor practitioners concentrate in the cities because it is the city dwellers who can afford to pay not the 80 percent of the poor who live in villages.

As I was told hospitals had their origins in ancient monasteries and nunneries, where those who took the habit tended to the poor, the infirm and the sick as service to God. Such monasteries became hospitals when they came under the domination of the professional medical practitioners

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and to the simple patient they became their new gods. So it is not surprising that the role of nurses and other paramedicals is downplayed and they became priestesses to the demi gods, aided and abetted by the manufacturers of drugs and hospital equipment from whom the gods obtained their supplies. Today hospital care or medical treatment is no longer an act of charity but a service to be paid for.

Basic medical research is an on-going process. New drugs, new medical technology are the products of research and development in the health industry. Developing countries are urged by WHO to use no more than 150 essential drugs and to go back to natural cures. This is but a reflection on the concern of the rising costs of medical care in both developing and developed countries. It is improbable that developing countries will heed this advice as they well may find themselves in a situation where the old standard drugs are no longer in production and old prescriptions have been replaced by new types of treatment. Surprisingly the rave over acupuncture anaesthesia was started not by medical practitioners but by a newspaper columnist. In the last six years modern basic science has found that when needles are stuck in suitable meridians nerve fibres are stimulated to cause the pitvitary gland to release polypeptides called endorphins and which have morphine-like analgesic properties. When endorphins can be synthesised on a commercial scale it is not unlikely that they will be used to treat drug addicts. Parkinson's disease was once upon a time treated by brain surgery. It is now treated medically by the administration of large doses of a neurotransmitter found in the brain. Medical research is inevitable and will render some types of treatment absolescent and some medical practitioners out of date.

My contention against medical technology is that we are spending more and more money on fewer and fewer people. Professor Dodu has made his point on the neglect of health care for the world's 80 percent impoverished people. It is those who live in the cities who are accessible to sophisticated medical technology. An example is the invention of the brain scanner. A city patient with a headache can have his head scanned but the village peasant has no alternative but to take aspirin as the best possible treatment. If his headache disappears the diagnosis is correct. So Ministers of Health need to keep an observant eye that not all drugs can only be prescribed by medical practitioners. It makes availability of health care more expensive. For the same reason Ministers of Health have to listen

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to warnings by medical practitioners against self-medication with a degree of critical judgment, otherwise the medical lobby will pressurise for relatively harmless medicaments to be placed on the poisons list.

Preaching the idea of common health leads to the question of how much medical care is necessary? I touched previously on the use of medical auxiliaries. Necessity is the mother of invention. In China barefoot doctors with periods of training varying from 3 months to two years have been deployed to treat a population of 800 million people, 80 percent of whom are in the countryside. In Bangladesh young female auxiliaries have been trained only in one speciality - to perform a simple laparatomy and ligate fallopian tubes, as part of an intensive family planning campaign in the villages. It is excellent proof that some simple medical procedures need not be performed by highly trained obstetricians and gynaecologists who are already rare in numbers. In Singapore we have successfully used dental nurses to extract teeth and perform simple fillings for primary school children. The ratio of dental nurses to professional dentists working in school clinics is 16 nurses to 1 professional dentist. Without these dental auxiliaries it would not have been possible to carry out this enormous risk.

The ratio of doctors to population, the number of hospital beds per 10,000 population, the percentage of GNP spent on medical care are used as standard indicators of the social infrastructure of a country and the health of its population. More recently among the EEC countries a comparison was made on the number of patients per million population who are on haemodialysis. I have come to suspect that these indicators are an index of sickness or an inefficient use of medical facilities. We do not eat steel or electricity but their consumption per million population is used as an indicator of economic development even though many kilowatts of power may be put to wasteful use by huge neon signs and bad architectural buildings which require to be lit even during the day. I feel a future conference on health could usefully compare the significance of current health indicators in use, the systems of medical care practised in different countries, effectiveness in the use of both manpower and material resources in the delivery of health care and health education.

Over-concentration on curative treatment, if a disease is hard to cure or cannot be cured makes ministries of health into ministries of

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of sickness. Promotion of health and demystifying some of the jargon and practices of our demi-god practitioners has never been a strong plan of action in many countries. There are many vested interests at stake, professional and political. But developing countries admittedly have committed iatrogenic diseases by sending their nationals to be trained in areas of medicine which have little or no bearing on the major sicknesses present in their country. It would be more cost effective in investing in the training of public health officers when communicable diseases are prevalent than in a team of cardio-vascular surgeons. I must confess that even Ministers of Health need to be conscious of the increases in the price of energy, the North-South dialogue on aid and trade for they compel us to organise ourselves best and make the most use of our resources for health care.
