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Editorial

Health Services in Bahrain in relation to the Concept Health For All By The Year 2000 Historical and Future Perspective

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The World Health Organization's goal of "Health For All By The Year 2000" has served as a major force in determining the National Health Policy Plan of Bahrain. This paper describes the historical roots and development of health services in Bahrain, how these services have evolved and prospective concerning development of the National Health Plan.

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Major Ingredients of Health for All

The concept of "Health For All (HFA) By The Year 2000" as presented by the WHO is a remarkable goal. It carries rigorous demands particularly for primary health care (PHC). Inspite of the skepticism about its conceptual soundness and its practical possibilities, many countries have ratified the concept and have established national policies directed towards its implementation. While many ingredients are involved in the pursuit of HFA, three components of the health sector are crucial: Better services, health manpower issues, and higher education. But what they do through that involvement must not be seen as a series of loosely constructed choices.

First, the essential elements of PHC, as defined in the declaration of Alma-Ata, include: education concerning prevailing health problems and methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; appropriate treatment of common diseases and injuries; and the provision of essential drugs[1]. Further, the requirements of PHC go beyond programmatic content to the specific purposes towards which they should be directed.

Thus, it is intended that PHC should be developed to ensure that there be universal coverage; that services cover promotive, preventive, curative and rehabilitative activities, that services involve communities to promote self-reliance and lessen dependencies; and that services integrate health with development more generally[2].

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Development of Health Services in Bahrain

Three evolutionary stages in the development of health services in Bahrain can be identified. Each phase has left impressions on the objectives, functions and capabilities of the health service.

1. Individual care

This stage witnessed the introduction of medical services in 1892, when cholera, plague and other communicable diseases were prevalent in Bahrain and the Gulf[3]. During this time there were major advances in public health that benefited the population of Bahrain, but care of the individuals was clearly the dominant theme in health care. From the point of view of health services, care was mainly provided in hospitals in the capital and health clinics or dispensaries. From a manpower perspective, care was physician centered; nurses and auxiliaries were seen as aides to assist the doctor rather than providers of care.

2. Extending care to the community

During the second phase, attention was given to extending health services to larger portions of the populations and to increasing the emphasis on public health and preventive programmes including environmental sanitation, mass immunisation and health education.

In the manpower sector there was a shift towards the notion that non-physicians could fill some functions of the physicians. While doctors and nurses provided care at hospitals and health centres, other community workers (nurses, health educators, etc) provided immunisations, mother and child care, family planning and health education. However, the community at large was still not engaged or involved in the process of developing health-related programmes.

3. **Universal coverage**

The foremost goal of health service in relation to HFA is to explicit universal coverage with PHC for a defined population. The second goal is that PHC be relevant and effective with respect to the current and emerging health problems of the population.

The crucial factor for achieving the above two goals was the government policy in support of HFA manifested by the strategic construction of 21 health centers so that the farthest centre is 10-15 minutes walk from its catchment area[4]. But the services are physician-centered and curative in their orientation.

Preventive aspects of the services and health promotion have been recently added to the responsibilities of the PHC, but it is generally not yet fully developed and policies still place the physician at the centre of its commitments as the provider of PHC.

Progress, results and challenges

Bahrain has responded well to WHO's directions and guidelines for achieving medical access for its people and is well ahead of schedule in meeting most of WHO's strategies. Education, technology and facilities have continued to improve and not only offer increased access but also improved quality. However, all of these improvements and growth have not been achieved without an increased demand on financial and human resources. Between 1975 and 1989, there was a four-fold increase in health expenditure[5]. Perhaps Bahrain now shares with the rest of the world, the benefit and burden of having a more enlightened and better educated public who are demanding even greater improvement in access, quality and physical facilities. They may no longer be willing to wait for hours and even days to see a doctor or nurse and then days and weeks for laboratory investigations to be completed. The health care system may not be willing or able to continue treating primary care problems in secondary care facilities[6].

While Bahrain has served as a leader in health care delivery and has made significant progress on the Health for all by the year 2000 strategies, the job is not finished. The challenge has become complicated by a glaring realisation that future population growth and shrinking resources will place an overwhelming demand on economic and human resources.

Therefore, the answer to continued progress in achieving quality health care standards for the people of Bahrain can no longer be solved by adding more medical personnel, technology and facilities. The never-ending spiral of "increased demand equating to increased resources" has peaked and virtually disappeared around the world. Most systems have focused their energies on conserving resources through better organisation, management and utilisation of manpower.

Systems such as Continuous Quality Improvement, Total Quality Management and Business Process Re-engineering are founded on the belief that improvement and growth can be achieved without increased resources.

The declaration of Alma-Ata, adopted on 12 September 1978 by the International Conference on Primary Health Care, which was jointly sponsored and organised by WHO and UNICEF, clearly stated that primary health care is the key to attaining the target of health for all by the year 2000[2]. At least part of the answer to Bahrain's challenge for continued growth lies in the sorely needed changes in the primary care system. This system has produced noteworthy successes in health care delivery and its founders and leaders should take great pride in the accomplishments to date. However, it is time to take advantage of the opportunities that exist to improve this system.

Currently in Bahrain the ratio of primary care doctor to patients is approximately 49.2/100,000[6]. Delivering health care services to 70-80 patients per day per physician drastically limits the quality of services that can be administered. A high percentage of the presenting problems of these patients are minor and do not require the skills of a doctor. But, tradition and organisational design have prevented the creation of an alternative for this overwhelming and ever increasing problem. The panacea of adding more doctors has often been proposed but is no longer economically feasible nor would it genuinely improve the situation. Adding more doctors, like Boyle's law of expanding gases, would only send a message to patients that more services are available and more people can present with more ailments. Consequently, service demand will expand like a gas, to fit the size of its container. It is the organisation, shape and design of the container that must be improved and not the size.

Nurses in Bahrain are well equipped to take on more responsibility for direct patient care as their counterparts around the world have done. Nurses are better educated today than ever before and can play a very different role than was previously expected in the days of Florence Nightingale. It should be no threat to physicians to have nurses participate in the physical assessment process and triage patients towards the appropriate levels of treatment. A multidisciplinary team approach is the appropriate and effective way of providing health care. An example for such responsibilities is management of simple and superficial wounds and injuries, cases of common cold, follow-up of managed hypertension and diabetes.

Health management programmes which rely on maximising the number of contacts, such as those used in other countries to manage preventable diseases like diabetes, rely heavily on nurses and less so on doctors.

If in fact the Ministry of Health nursing education programme can produce community health nurses and nurse practitioners to work as physician colleagues rather

than assistants, there is a good chance that patient/doctor ratios can be brought into some realistic norm for quality services. Of course, there must be guidelines and safety precautions to administer this kind of paradigm shift but in controlled local trials (Sitra Health Centre project), it has proved to be a viable and feasible solution. Most Western countries have adopted this quality improvement strategy in order to provide better services at either current or reduced cost levels. Although this kind of strategy redefines the roles of nursing and in many cases threatens many doctors, it is well worth considering in Bahrain.

In one health centre in Bahrain (Sitra) where this approach has been piloted, the following major outcomes were noted[7]:

1. The number of patients seen by physicians was reduced by 33 %, thus allowing doctors to concentrate on the more serious cases.
2. Increasing the average consultation time from 5 to 7.5 minutes and improving the quality of individual patient care.
3. Unmanageable and unruly queuing was essentially eliminated via better scheduling and nurse filtering and screening.
4. Better patient satisfaction was achieved.
5. Nurses felt more professional, more a significant team member, along side physicians.
6. A savings of 5.5 % (BD 20,891) over a one year period of time was noted while providing an increase in both quality and quantity of services.

Summary and Recommendations

The achievement of "Health for All By The Year 2000" is not complete in Bahrain, but progress is being made. Increased economic demands, patient expectations, changing technology and needed quality improvements will continually provide challenges to this never-ending noble and vital goal.

Bahrain has demonstrated in at least one situation, that services in primary care settings can significantly be improved through better organisational management and expanding the role of nurses to a much higher professional level than has previously been expected in Bahrain. This kind of paradigm shift challenges many traditional and historical beliefs about nurses and health care delivery. Consequently, this kind of change must be well planned, supported from the top and implemented with great sensitivity. Physicians may feel threatened, patients unsure and nurses themselves confused about this new role. Team work, cooperation and support must exist throughout the organisation in order for this approach to be successful. The educational system must be capable and willing to supply health professionals who are prepared to handle this kind of professional responsibility.

A National formulation of Primary Health Care strategies is still to be finalised and should emphasise that continued success of "Health for All by the Year 2000" is not dependent on more resources but by the ability to better utilise the existing resources to maximise outcomes in primary care settings.

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