**GOOD INTENTIONS: GOOD ENOUGH?**

Observations on the Sociocultural Aspects

of Health Care Delivery in Micronesia

Joseph A. Flear, MD

Medical Graduate Support Program

Pohnpei

Federated States of Micronesia

April 1997

**Introduction**

This paper considers some of the problems that arise when a western country tries to develop a health care system for a developing county for which it is responsible. The author has had extensive experience as a physician working in several of the Federated States of Micronesia (Chuuk, Pohnpei, and Yap), and has spent some time observing health care delivery in the remaining FSM state (Kosrae), and in the Republic of Belau. The author has neither worked in nor visited the Republic of the Marshall Islands, though suspects that much of what is found in the rest of Micronesia is characteristic as well of the RMI. Within Micronesia, the quality of health services and the degree of disorganization can vary markedly from one jurisdiction to another, so that what may be true of one may be characteristic, but to a lesser degree, of another. Another point that should be made is that health services, as a government function, share with the rest of government services in the region certain fundamental defects: the problems that characterize health services provision are true of education and other government departments as well. The paper concludes with some suggestions as to the direction future assistance to the region might take.

**Historical background**

The current health care system in the American-associated Pacific is an outgrowth of what the US Navy, and subsequently the Department of the Interior, established in the region following the second world war, when the islands reverted to US control. A central hospital, called at the time a dispensary, was established on the main island of each jurisdiction to serve the main population. Sub-dispensaries were built on some of the remote outer island atolls, staffed by health assistants and supported and supplied by occasional trips to the atolls by a field trip ship. Services made available included acute medical and surgical care of a reasonable standard at the main hospital, provided for the most part by ex-patriate doctors. Public health clinics, offering such services as dental care, well baby and prenatal care, and immunizations, were conducted regularly at the main hospital, but were available only sporadically in the outer islands with the arrival of the field trip ship several times a year. In addition to providing health care, the US administration trained health care workers to staff the hospitals and dispensaries. Nurses were trained in Guam, (eventually this was done in Saipan, and in recent years in Majuro). Medical officer candidates were trained in Guam and then in Fiji (and more recently in a local training program in Pohnpei). Health assistants for the dispensaries received several months of training at the main hospital before being sent out on their assignments.[[1]](#endnote-1)

There have been several attempts over the years to decentralize the provision of health care from the hospital to community dispensaries. The first attempt in the 1970s included the construction of dispensaries and the training in Hawaii of a group of middle level health care providers, called medexes. The initiative was a short-lived one, however, and came to a halt in the early 1980s: the dispensaries were closed, the buildings reverted to the original land-owners, the medexes retreated to the hospital outpatient departments. A more recent move toward decentralization in the 1990s is currently threatened by uncertainty about whether such a move is the best cost-effective strategy in an era of shrinking funds.

**Concepts of Illness and Health**

Central hospitals, peripheral dispensaries, outpatient departments and public health clinics, all represent attempts to address the problems of health and illness in individuals and populations. The model of illness and health introduced to the islands by the US half a century ago was based on a scientific understanding of health and disease, on anatomy and physiology to explain the pathology of disease processes, on the germ theory to explain infectious diseases, on theories of cholesterol and lipid dynamics and, more recently, genetics to explain non-communicable diseases such as hypertension and diabetes. The attempt to transfer this model to Pacific island jurisdictions, however, where indigenous cultural beliefs still hold sway, was bound to meet with obstacles. Scientific explanations and theories make little sense in a culture which views disease as evidence that disgruntled family ghosts are returning once again to interfere in the affairs of daily life. And while it is true that hospital OPDs are full, that dispensaries are often well attended and hospital wards are never empty, in apparent contradiction of the claim that these indigenous beliefs are still as strong as they once were, the hospital consultation is often the last resort after local herbs and brews have been tried to no avail. Patients, too, are clever enough to hedge their bets and try the western cure on the off-chance that, this time, the germ theory might be the correct one. The herbal brew, however, is readily at hand in the bedside table, and serves as a chaser for the diuretic or the antibiotic. This is not to discount the role that traditional remedies play in the treatment of disease, but rather to point out conflicts that arise when traditional and western methods of treating illness are mixed. Indeed, practitioners of the traditional methods of healing are often more tolerant of their methods being used together with the western ones, than are western practitioners of any joint approach.

Despite these differences in perception and the continued reliance on traditional methods of healing, great strides have been made in certain areas. In the years since the US Navy era, infant mortality rates have dropped and life expectancy has risen, mainly because infectious diseases are no longer the specter they once were several decades ago. Polio, diphtheria, and tetanus have virtually disappeared (although, to be sure, there are still periodic outbreaks of measles and whooping cough, and rates of tuberculosis and leprosy are still high); even bacterial meningitis, as recently as the early 1990s a killer and crippler of Micronesian children, has been drastically reduced in the islands. And all of this has been accomplished primarily through the use of vaccines. But while infectious diseases in the region have declined, they are being replaced by non-communicable diseases, at rates that could be considered epidemic in proportion. The *USS Whidbey*, surveying the Navy-administered territories of the Pacific just after the war, reported no cases of diabetes, and few if any cases of hypertension.[[2]](#endnote-2) Today, these diseases are the cause of significant morbidity and mortality among adults who are dying from myocardial infarctions, strokes, and peripheral vascular diseases, at an age which people in the West say is when life begins. Nor are these non-communicable diet- and life-style-related diseases of the last half century confined to the adults. Malnutrition, including cases of kwashiorkor as severe and deadly as any in Asia or Africa, is seen in a growing number of Micronesian children,[[3]](#endnote-3) while rates of vitamin A deficiency in one Micronesian jurisdiction are higher than those found anywhere else in the world.[[4]](#endnote-4) The current situation is thus a curious mix, where certain infectious diseases of the past, like tuberculosis and leprosy and occasional outbreaks of measles and whooping cough, are now joined by many of the diseases of modernization, leaving the islands with the worst of both worlds.

**Economic development and its impact on health**

This current state of affairs is due in large part to the economic development that has come with westernization. Economic development of the last several decades, primarily via the transition from a subsistence to a moneyed economy, has undermined the use, development and appreciation of local resources, with food being foremost among them. A list of the Federated States of Micronesia’s top ten import items for 1993 shows that food and beverage items accounted for seven of the ten, and one item – canned fish in the heart of paradise – reminds us of coals carried to Newcastle[[5]](#endnote-5). So pervasive has been the move away from local to imported food that many people who still do fish will often sell their catch for cash to buy imported food available in the stores. Several years ago, a bill introduced into a state legislature banning the importation of rice (a bill whose passage was doomed from the start, since store owners and legislators are often the same people), panicked the Public Health Director, who tried to enlist my support against the bill: he was convinced that the local population would starve to death were the bill to become law. Imported food has indeed become the standard diet, despite the dangers this poses for the economic survival of individuals and communities, and for their overall health and well-being.

This change in diet, from the traditional one of locally available foods to one of imported foods, and a change in daily routine, from vigorous activity to a sedentary lifestyle that comes with the moneyed economy, is thought to be the single most important factor in this increased morbidity among the adult population. Foods with excess amounts of animal fat, such as is found in canned meat (spam and other local favorites) and turkey tails lead directly in the adult population to the current high rates of obesity, diabetes mellitus, and hypertension. Children’s diets of Cheese Whiz, soft drinks, rice and soy sauce have led to vitamin A deficiency which, on islands rich with a perennial supply of papayas and mangoes, should be as rare as malaria in Iowa. Bottle feeding of infants within the first several months of life is so widespread that workshops now are necessary to convert hospitals back into “baby-friendly” ones that promote breast feeding and discourage the use of formula milk.

Economic development has caused island communities to shed many of the things that kept them healthy in the past, and to adopt habits that are killing them. Economic development, usually considered a good and desirable thing, certainly *can* be as long as it respects and fosters self-sufficiency and self-reliance. Instead it has often undermined these, and brought with it things that have unwittingly been considered good and desirable, despite the dangers posed. And people in the islands have had difficulty discriminating between the dangerous and the safe. A mother once asked me, when I pointed out to her the dangers of bottle-feeding her baby, “Then why do they sell baby-bottles if they’re not good?”. While our jaded American cynicism disbelieves that anyone could ask such a question, such questions are asked. And if we substitute spam or soft drinks or a sedentary life style for “baby bottles” in that sentence, then we begin to appreciate the nature of the problem.

**Government-provided health care**

The use and appreciation of local resources were undermined in more subtle ways as well, once such things as education and the provision of health care were made functions of a government, which itself was not necessarily recognized as representative of the community it governed. The US administration, with the best of intentions, constructed central hospitals and peripheral dispensaries, stocked and supplied them, staffed them with its own personnel until indigenous people could be trained, and made health care provision from its inception a government service provided essentially free of charge to the community. The Navy, cognizant of the dangers of free medical care, instituted a policy of charging patients nominal fees for services, since “services for which one pays are likely to be better utilized and more appreciated than gratuitous ones”.[[6]](#endnote-6) The policy, it was noted, was not well received by the population, however, and in any event the fees charged did not even begin to cover the costs involved in providing this care. As the US reduced its role in the region in subsequent years, and sought to turn over these government services to the local administration, the financial burdens that this placed on local governments, and their inability to shoulder these burdens, were never sufficiently addressed. The people of the islands had by then come to expect a high level of health care, however, with no input or contribution on their part.

This lack of community input manifested itself in several ways, beyond the reluctance to pay for services. Local people were recruited for education and training, and then hired to staff the hospitals and dispensaries, in many instances receiving salaries out of all proportion to what a fellow fisherman could make selling his catch or a farmer his crops. A situation was thus created in which locally-trained people were in essence being paid by the US government, at fairly high salaries, to provide needed services for their own people, while the long-term sustainability of such an arrangement, in a future of locally funded and administered health services, was ignored. In addition, hospitals and aid posts were often built on privately-owned land (rather than on “government” land, which may or may not have been available), and construction often proceeded only after exorbitant sums of money had been paid for the lease of the land. In recent years, dispensaries in the outer islands have been constructed by community members *hired* by the local municipal government with government money. Seemingly at every turn, opportunities have been missed to demonstrate to a community that it should in some way be responsible for its health care, by donating land or by contributing labor to a project, or by being responsible in some way for the support of the health aide assigned there. It would have been better had the community clearly understood that compensation would be realized, not in salaries to build the building or in payments from leasing the land, but rather over the long term, in the health services provided as a result of the community’s contributions.

Government-funded health care in Micronesia has suffered as well, not only from lack of investment by the community, but from a lack of employee investment, evidenced in many departments by poor quality work performance and low productivity. There has been little provided in the way of incentives for employees to do their best, little in the way even of accountability that a task be performed at all. Unfortunately, the norm has been for a government employee in Micronesia to get paid regardless of the quality of the job done, regardless even of regular attendance at work. Hence, pride in one’s work is difficult to discover, and commitment to one’s job or career is an elusive concept. Prior to the introduction of this concept of the salaried government worker, there were undoubtedly within the culture incentives to perform well when the worth of the job to be done was recognized. The worth of providing food for one’s family, for instance, by conscientious fishing and farming, would have easily been recognized in the society of the past, while the “commitment” of the farmer to his task would have been taken for granted. The government employee of the present, however, supports his family via the salary received, and since the money tends to come regardless of the quality of performance, there is little incentive for quality work. Nor is commitment to one’s job a concept much recognized, let alone idealized. Local incentives for quality work certainly exist within the culture, but have not been identified and exploited in designing the civil service system.

Other problems as well have plagued the attempt to graft a civil service system that works in the US onto an island culture. Government workers in Micronesia have great difficulty supervising each other the way that westerners do, as it is almost impossible for someone, short of a village chief, to tell another person what to do. The various ethnic groups within each of the island populations and the hierarchical relationships among them only compound the problem. The vertical funding of government programs out of Washington and San Francisco also exacerbates this compartmentalization and fragmentation among coworkers in the same department, with health workers feeling answerable to someone in California who controls their funding, rather than to their own local supervisors or to the patients they are ultimately hired to serve. The “geriatric” nurse will refuse to help with immunizations because his funding doesn’t provide for that activity, and the midwife refuses to help in the labor room because the MCH program funds only her public health work. Not predisposed to cooperate as a team to begin with, barriers between them are only reinforced by the inflexibility of their funding and reporting requirements.

There is as well within the culture a reluctance to excel or to take the lead: “the nail that stands out is pounded in” is a traditional warning for those trying to be too different. Villages and communities in many jurisdictions have traditionally had two separate lines of authority within them, to prevent any one person or faction from becoming predominant. Much as we decry their effects today, we must realize that these are the customs and the mores that have molded a people to live within the confines of small island societies, where boat rockers are eyed suspiciously as a danger to the harmony vital for the community’s survival, where it is just too risky to trust an upstart taking the lead, even if the direction may turn out to be a good one. Though they may prevent the emergence of leaders or even the taking of initiatives which we see as needed to spearhead necessary reforms in the region, these survival mechanisms have worked for centuries for these communities, and must be taken into account in the search for solutions. It should not be surprising however, that against such a background, our search for the western ideal of individual excellence will often be disappointed.

**Off-island medical referrals**

During the process of setting up the health care system, there was certainly a bit of the can-do attitude that characterizes US initiatives: anything can be accomplished, any problem can be solved, given enough money and skill. And this translated into the practical patient-care arena as well: if a medical problem couldn’t be solved on the island, referral to an off-island facility was a frequently available option, paid for by the US government. At the same time, people in the islands had become accustomed to what was in effect a fairly good level of acute care in the main hospitals, and grew understandably disappointed by a perceived deterioration of services as responsibility for providing them devolved onto the local governments, without the unlimited resources that had been available in the past. The option of referral of the unsolved medical problem persisted into the new era as well (indeed, the Territorial Health Plan for 1980-1985 noted that, under the TT Code, all TTPI residents were eligible for referral[[7]](#endnote-7)), though now within a limited overall health services budget. To meet the persistently high expectations of a community that had come to rely on off-island referral as a ready solution, limited budgets year after year were stretched to cover the costs of these referrals. Ultimately, essential budget items (namely, medicines and supplies) had to be cut from a budget that would not, *could* not stretch, in order to cover the costs of medical referrals (when those costs were covered at all: enormous unpaid debts were accumulated at many off-island institutions). And parallel to the situation in the US, where a significant portion of the health care budget is spent on the last several months of life, many referral cases were, and still are, of terminally ill patients with little hope of long-term survival.

In the current era, off-island referrals continue to devour up to 25% of the health services budget[[8]](#endnote-8) to benefit a tiny minority of patients. A vicious cycle results, whereby referrals reduce available funding for health care on the island, destroying what little remaining confidence the community has in its health care system, which then only increases the clamor for more off-island referrals. The most imaginative solutions to the problem in recent years have been the decision, not to stop or curtail referrals, but rather to find off-island facilities in the Philippines less expensive than those in the US or Hawaii, and the attempt to devise an insurance program that, while on its surface attempts to fund local health care, is really only a thinly-veiled attempt to fund off-island referrals. Another jurisdiction’s solution has been to make the referred patient and family responsible for travel costs and for 3% of the medical bill, which is at least a step in the right direction. How far this is from a true solution becomes apparent when one realizes that 3% of $30,000 is a mere $900, and the remaining $29,100 robs the government of its ability to provide the simplest things like Vitamin K for routine prophylaxis of hemorrhage in its newborns, or oxygen for its patients with pneumonia. A village community would not allow such an inequality to exist in its midst, would not sanction a handful of its members holding the rest of the community hostage to their own interests, no matter how compelling. The fact that government-run health services is the entity being held hostage makes it easier for the entire community to conspire against its own best interests.

**Health care: Centralized vs. Decentralized; Acute vs. preventive**

Just after the war, the islands had a population perhaps one-fourth of current numbers[[9]](#endnote-9), making it only logical that a central hospital provide the bulk of medical care in a given district, with aid posts providing limited care for people on remote atolls. As populations grew within the main island centers, this model persisted, despite its being less and less equal to the task. To be sure, little existed in the way of a model to guide Americans in the establishment of a health care system most appropriate for the islands. (More precisely, no model existed in America.) The attitude of these early years is perhaps best captured in a statement from the Economic Development Plan for Micronesia in 1966:

“. . . communities [of less than 300] are likely to become smaller as the Trust Territory develops, and as the concentration policy takes hold. Improvements in the medical services to these communities should depend on improving the transportation and communication system to give them better access to facilities established in the larger communities.” [[10]](#endnote-10)

Despite this earlier policy, there *was* a move in the direction of decentralization in the 1970s. Dispensaries were constructed under the Hill-Burton Act to serve, not only the outer island atolls, but also scattered outlying communities on the main islands. The move was short-lived, however, and came to a halt in the early 1980s with the dissolution of the TT, as the newly formed state governments found it too difficult to staff and supply both a central hospital and a network of peripheral dispensaries. They opted to concentrate resources in the hospital instead. After all, roads were being paved, improving access to the central hospital, which had been the policy all along anyway. Health services directors were convinced too that hospital-based medical care, specifically the inpatient care of acute illness, is what constitutes genuine medical care. This attitude was no doubt reinforced by a large and influential segment of the physician workforce of that era, namely, the National Health Service Corps physicians assigned to the region who, as American ex-patriates, helped, even if only indirectly, to set the health care agenda. Most if not all of them had been trained in tertiary care hospitals in the US, with little if any training in community health issues or in dispensary health care. And so decentralization withered and died.

It was only in the mid-1980s that Yap state pioneered the move again toward a decentralized health care model. This new move was justified, not by a lack of access to the center as in the 1970s, but rather by the simple desire to provide primary health care to people within their own communities, regardless of whether they could hop a taxi to town for similar services. The emphasis was placed on having the health assistant, or dispensary manager, be the competent provider of a range of services from immunizations to acute care within the confines of the community, supported but not supplanted by the central hospital. In more recent years, this model has gained support, on paper at least, in Five Year Health Plans and Development Plans of the region, and is actually being adopted with varying degrees of success in several of the jurisdictions.

The trend is still tentative, however, and by no means assured or secure. Communities accustomed to hospital care may be difficult to convince that health care depends, not so much on the locale or the physical structure, as on the services available and the competence of the people providing them. Health services administrators and personnel still distrust decentralization as a veiled attempt to establish a parallel system of health care, a duplication of services already available at the hospital, a draw on resources that are fast dwindling and which would be better devoted to improving medical care at the hospital. Indeed, there may be some substance for their concerns, if the dispensaries are allowed to become no more than outpatient departments in the periphery, responding to the communities’ demand for curative services and ignoring what is becoming recognized as the more important function of health services, the prevention of disease.

Bound up with the issue of decentralization of health care is that of acute vs. preventive care. The islands have had the misfortune in certain ways of having as their mentor in health care provision the United States, a nation where arguments about whether a patient is able to obtain a CT scan at a moment’s notice, or might have to wait in line for an elective cholecystectomy, still exercise the citizenry and their representatives in Congress out of all proportion to the real importance of such issues. Similarly have the condition of the hospital and the sophistication of the equipment in it often been the standards by which the quality of health care is measured in Micronesia. A persistently high infant mortality rate is often ascribed to the lack of a neonatal intensive care unit, while the rates of attendance by pregnant women at prenatal clinics, or the rates of infant formula feeding on the island are ignored. The high prevalence of rheumatic heart disease in one jurisdiction has prompted the purchase of a state-of-the-art echocardiography machine (for $150,000), while the high rates of patient noncompliance with monthly preventive penicillin injections remain to this day unaddressed. In short, the fact that much of the premature morbidity and early-age mortality on the islands can be prevented has until recently been overlooked, in favor of diagnosing and curing diseases after they occur. And a vicious cycle results here as well. Emphasis on diagnosis and cure to the exclusion of prevention and health maintenance leaves us more and more patients to diagnose and cure, with fewer resources to diagnose and cure them with.

Certainly, within the US of late, there has been a renewed emphasis on prevention, prompted in part by an astronomical rise in the costs of hospital care. And there is a similar trend in Micronesia today, on teaching people that strokes and heart disease are better prevented than treated after they occur, on convincing mothers that breast feeding is the best way to prevent the baby’s becoming ill, on leading people away from dependency and back to the customs that kept them healthy in the past. The effort is still fledgling, of course, and has its obstacles, not least of which is convincing health care workers of the same messages. And while a hospital-based public health department can certainly manage island-wide preventive care efforts, I have found these efforts to be more effective in small-scale community settings. Engaging communities and individuals directly, on a one-to-one basis, is more likely to be the key to a successful preventive program.

**Training of health care providers**

The ultimate goal of US involvement in the region has been to leave Micronesia some day, with Micronesians in charge. Specifically, in this instance, figuring out how best to train people from the islands to be doctors, nurses, and health aides, and how to prepare them to take over leadership positions within the health care system. The efforts have met with mixed results at best. For one thing, in traditional societies of the past, cures for illness were usually held within families, one clan specializing in the knowledge of herbs for a particular ailment, another clan for another. The knowledge of how and what to use was usually held fast, and not widely shared: if too many people knew the secrets, the cure lost its effectiveness. In addition, knowledge about such things, and about what would be considered the important “professional” functions in the society such as navigation or canoe building, was passed on only by long apprenticeship with the masters of these skills. Classroom teaching of such things was alien, as was the concept that books and such would be consulted for the information needed to solve a problem.

Bringing people out of this milieu and sending them to western institutions for medical training had very limited success at best, as a look at the physician workforce in the early 1980s will show, when less than half of the region’s doctors were local physicians, and most of them were soon to retire.[[11]](#endnote-11) Candidates from Micronesia were at a distinct disadvantage in off-island medical schools, where a firm foundation in the basics gained in elementary and high schools, where even the ability to study, was taken for granted. This foundation was fairly weak in the Micronesian students, and so they returned, failures, after only a year or two away. A pre-medical school remedial education program in Hawaii helped to address the problem, but on scale too small to make a significant impact. The regional nursing schools had better success rates, perhaps because those setting the curriculum and doing the teaching were more familiar with the strengths and weaknesses of the educational infrastructure from which the candidates came.

It is only recently, as a result of the five classes of graduates of the medical school in Pohnpei, that local physicians now constitute upwards of 80% of the physicians in the FSM and Palau (though local physicians are still a minority in the RMI). The program, unlike medical schools abroad which classroom-teach their students for two years before allowing them access to patients, instead imitated the apprenticeship method: students saw patients under close supervision, thus learning hands-on practical skills by doing, from very early on in their first year of study. Even classroom teaching gave way to problem-based learning, where small groups of students helped each other solve medical problems, learning medicine together and teaching each other in the process. On returning to their jurisdictions, the early graduates faced down the initial distrust on the part of patients who’d been accustomed for so long to their doctors being foreigners, and this is no longer the problem it once was.

Instead, current challenges include sustaining the knowledge and skills of the graduates and ultimately reinforcing their commitment to the medical profession, in a milieu that neither recognizes nor fosters this ethic, at least among its health care workers. The ethic probably does exist in some form, however, among the recognized traditional professionals of the society. The professionals of the past, the navigators say, whether they or their fellow islanders realized it or not, were learning new things, and thereby improving their skills, on each and every voyage they undertook for their entire lives. The task now is to convince the newly graduated that each patient is a new voyage, that patient mysteries are solved only by reading about what doctors in the past have written about them in texts and journals, and that one’s entire life is a commitment to this pursuit.

**Budgets**

The end of the Compact of Free Association looms for the FSM and the RMI. The year 2001 is now closer than anyone believed it would actually get. As the Compact, with its gradual step-down of funding over fifteen years, nears its end, budgets are shrinking, and every hospital in Micronesia faces shortages of the most basic medicines and supplies. These shortages, as anyone who has worked in the region can attest, have always existed to some extent, but are now becoming much more acute in year 11 and 12 of the Compact. In March of this year, one of the hospitals in the FSM had no oxygen, no IV medications whatsoever on the pediatric ward, and no thermometers to take temperatures in the outpatient department.

Hospital administrators, faced with limited funding in the past, have always opted to keep the personnel and cut the supplies, since it is just as difficult in Micronesia to fire or lay off employees as it is to supervise them. This leads to a situation where hospital departments are full of people with less and less to do, since there is less and less to do anything with. Inevitably now, however, budget shortfalls are so serious as to affect the employees as well. Pay has been cut by 20% for government workers in most of the FSM. Arbitrarily set at some time in the distant past, with no apparent justification for why an employee should receive this amount instead of that amount, wages have now taken on a life of their own. The government’s inability any more to support its high wage structure, and its decision now to pay workers no more than 80% of what it used to, is met by the employees’ inability now to work more than 4 days a week. By this reasoning, since Compact funding makes up over 50% of the operating budgets of the governments in the FSM, government workers in 2001 will be at work two days a week. A lack of oxygen and thermometers will be the least of the problems to be faced.

Even worse than budget shortfalls, then, is the lack of even the most basic planning in anticipation of these cutbacks. As US funding decreases, for instance, hospital administrators remain reluctant to raise fees charged to patients for inpatient and outpatient services: rates currently charged are not much more than what were charged years ago in the TT era. Nor has there been a concerted effort to identify priorities in terms of medicines and supplies absolutely essential, and those that are of lesser urgency. What ensues is unplanned chaos, and patients bear the brunt. A child, for example, admitted with a serious illness requiring certain medications unavailable at the hospital, is issued instead a prescription for the medicines which the parents must purchase at a local pharmacy (a for-profit enterprise established on the side by a physician working at the hospital), where the medications are often sold at a significant mark-up. And innovative attempts at a solution may actually be illegal. Recently, on the pediatrics ward in one state hospital, the nurses and doctors joined together to address the problem of a lack of medication by buying it themselves at a local pharmacy, providing it at cost to grateful patients on the ward, and using the money collected to purchase a further supply. The perpetrators, if found out, would be subject to arrest, however, since any money collected from patients is always to enter the general fund, and by no means is to be handled in any way by nurses on the ward.

**The path to possible solutions**

The temptation in the past has been to say that the health care needs of the region can be solved by committing to a higher level of funding for the region. This was one of the major recommendations, made by the 1989 study[[12]](#endnote-12), in an attempt to bring the level of health care up to certain minimum standards. Suggestions will surely be made again, that higher levels of funding or extending current funding in some way beyond the end of the Compact, will solve the problems of health care in the region, and make the population healthier and more productive into the 21st century.

The problems, though, apparently have not been solved with a half century of such funding already, funding which far exceeds that available to neighbors in the rest of the Pacific. And so it is indeed open to question whether larger amounts of money, or continued amounts at present levels, will have any greater impact than they’ve had in the past. Immunization rates are low not because of a lack of resources. Children are dying of malnutrition in the region, not because of budget shortfalls. Even the lack of medications and supplies throughout the region are not ultimately due to inadequate funding, despite loud and frequent protestations to the contrary. What is needed is not higher levels of funding from the US, or greater commitment of resources from the US or from other donors over the next decade or two. The top-down funding methods of the past, wherein assistance from the outside was tied to solutions imposed from the outside to problems identified by those coming in from the outside, simply have not worked very well. Indeed, if anything, it has made it more difficult to find the genuine solutions to the problem, which begin in personal and community self-reliance and responsibility.

What is needed rather is something much more difficult to provide than money, difficult even as money is to provide in this era of government cutbacks in the US. What is needed instead is that communities and the people in those communities take responsibility for their own health, for their own illnesses, for their own well-being, indeed for their own societies. What is needed is that those responsible for the health care needs of these communities take responsibility and commit themselves to figuring out the innovative solutions that are necessary. This is not to suggest that funding agencies abandon the region to its own devices . . . completely. What it does mean, however, is that any future assistance for the region must be contingent upon a demonstration that these things are happening first.

With that in mind, and acutely aware of what I’ve just said about solutions imposed from the outside, the following are offered as suggestions for the form I envision solutions taking in the future.

1. Communities should become the center of future health care efforts. Assistance in future would be offered only after the community demonstrates an effort to assist itself, in a concrete proposal to donate land, provide the labor and, over the long term, support the health aide and provide for the purchase of medications and supplies for health care efforts in the community. It is strongly suggested too that, in order to solidify the community’s investment, the assistance be provided as matching funding, so that the community must come up with some financial resources for the center. Obviously, small scale would be emphasized, on the order of an aid post similar to what is currently found in Sokehs Pah and Pohnrakied villages in Pohnpei, or Makiy or Thol villages in Yap, thus demonstrating to the community that quality health care *is* possible in a small-scale setting, needs neither sophisticated equipment nor expensive surroundings, and can be a source of pride for the community itself.

2. Since funding of hospital-based health care has been a drain on resources in the past, somewhat of a bottomless pit, assistance for this should be de-emphasized and curtailed, politically unpopular as this might be in the short term, and difficult as this might be to square with the usual measures of the quality of health care in the region. Decentralization of health care would have the priority.

3. Most assistance for community based health care should be earmarked for prevention of disease, which would include concrete health education activities for sure, but would also include such interventions as immunizations, medications for prenatal patients, dental sealants, etc. Concrete health education activities should involve community groups to a greater extent than at present, with women’s groups and various church groups tapped to be, not only the conduit for prevention messages to the community, but as examples of community responsibility for its own health.

4. Funding for medical referrals should be eliminated from the health care budget. Not only would travel off-island be the responsibility of the patient and family, but so would the payment of any medical bills in their entirety. While this will create a two-tiered system where only the wealthy can afford off-island medical care, the alternative is simply insupportable. This will bring the region into closer line with its neighbors in the Pacific as well.

5. Vertical funding of health care in the region should be eliminated in favor of block grants to the jurisdictions, allowing the use of funding for the most pressing needs as identified by the jurisdictions. As well, funding, if provided, should be given for provisions, equipment, and supplies alone, and not for funding of personnel, which would be the responsibility of the jurisdictions with their own available funds. This would necessarily result in a reduction of current personnel levels, which would not necessarily be a bad thing.

6. Greater accountability for assistance given must be demanded. There must be certain minimum standards (immunization rates, prenatal care visits, well baby visits, follow-up visits of those with chronic disease) expected and documented, with incentives for goals met, and penalties for poor performance.

**Tuberculosis as a model of what not to do**

In the late 1980s, I spent two years in the Golden Triangle of northern Thailand, working in a small border hospital for hilltribes people which was funded by a generous US foundation and staffed by the Thai government. Established several years before I arrived, the hospital had drastically reduced the incidence of malaria in the area. My job was to bring the foundation’s involvement to a close, and convince the Thai government to maintain the same level of services that the foundation had provided which, needless to say, the Thai government had no intention of doing. I realized, as I thought about it, that our intervention in this small area may actually have been a disservice: people in malarious areas develop a natural immunity to the disease which allows many of them to live in a delicate balance with the parasite. Curing the disease soon eliminates this immunity, so that subsequent infections may be deadly, leaving the community open to devastation without the continued high level of services after our involvement. The satisfaction of having saved the lives of a few people pales against the realization that the community lives now in greater danger than if we’d never ridden our steeds upon the scene.

The situation in Micronesia involves tuberculosis, found prevalent in the Pacific following the war, with high PPD positivity even among school children[[13]](#endnote-13). Certainly, the US could, if nothing else, control this disease. Efforts over the years have included long course therapy, short course therapy, long inpatient stays, outpatient treatment, all of which shared one thing in common, inconsistency of treatment and lack of follow-up. The situation at present is a PPD positivity rate in the population that is unchanged from that following the war, while the organism may very well have developed resistance to any conventional methods of treatment. Patients with TB thus become more than ill patients with a communicable disease. They become public health hazards every bit as dangerous as the irradiated atolls of the Marshall Islands, where contact with them could mean certain untreatable illness and eventual death.

In this case, intervention may actually have worsened the situation. With the best of intentions, we attempted to treat a terrible disease in the population. But best intentions did not translate, still do not translate, into concrete actions, so that the intermittent and episodic treatment of TB, intermittent and episodic not because of a lack of resources but because of a lack of commitment, leaves the region with a situation worse than when we started. The lesson: unless we are prepared to address a situation with more than good intentions, we should do nothing.

1. NOTES

   Dorothy E. Richard*, United States Naval Administration of the Trust Territory of the Pacific Islands* (Washington DC: 1957), Vol III, pp. 885-890; pp. 920-948 [↑](#endnote-ref-1)
2. Richard, op cit., p 850 [↑](#endnote-ref-2)
3. Jane Elymore et al., *The 1987/88 National Nutrition Survey of the Federated States of Micronesia* (New Caledonia: 1989), p 4 [↑](#endnote-ref-3)
4. Frank Mahoney, MD, unpublished data from CDC, 1992 [↑](#endnote-ref-4)
5. FSM Office of Planning and Statistics, *Trade Bulletin, No. 7* (September1994), p 67 [↑](#endnote-ref-5)
6. Richard, op cit., pp. 882-883 [↑](#endnote-ref-6)
7. Trust Territory State Health Planning and Development Agency, *Trust Territory of the Pacific Islands Five Year Territorial Comprehensive Health Plan 1980-1985* (Washington: 1980), p 490 [↑](#endnote-ref-7)
8. FSM Office of Planning and Statistics*, Second National Development Plan 1992-1996* (Pohnpei:1991), p 218 [↑](#endnote-ref-8)
9. Navy Department, *Information on the Trust Territory of the Pacific Islands* (Washington: 1948), p 77 [↑](#endnote-ref-9)
10. Robert P. Nathan Associates, Inc., *Economic Development Plan for Micronesia* (Washington: 1966), Part III, p 619 [↑](#endnote-ref-10)
11. University of Hawaii Schools of Medicine, Nursing and Public Health, *An Evaluation of Health Systems in the Pacific Insular Jurisdictions of the U.S.* (Honolulu:1984), p157 [↑](#endnote-ref-11)
12. University of Hawaii School of Public Health, *A Reevaluation of Health Services in US-associated Pacific Island Jurisdictions* (Honolulu:1989), p 5 [↑](#endnote-ref-12)
13. Richard, op cit., p 848 [↑](#endnote-ref-13)