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POPULATIONS ARE PEOPLE:
CHOICES FOR RURAL HEALTH CARE

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Summary

According to conventional wisdom, in a public service available free to everybody, finite resources face infinite demands. Needs of individuals therefore conflict with needs of communities and nations. For public services to survive, doctors are told to harden their hearts and make agonising choices.

This assumption needs critical evaluation from daily experience of carers in rural-agricultural, rural-industrial, or now mostly post-agricultural and post-industrial settings. Experience reveals real and necessary conflict. Choices have to be made, but they are not those proposed by conventional wisdom.

Rural clinicians must from day to day and hour to hour make tactical decisions. These are products of two forces, pressures from personal wants and pressures from community needs. Rural clinicians know they must keep these decisions within bounds of local custom and consent while also helping to expand local imagination, political skills often lacking in higher authorities. Clinicians are usually paid only to respond to symptoms. Their knowledge of medicine imposes larger responsibilities unpaid but more rewarding because they are more effective – to identify and organize to meet health needs. Whether or not they are paid for it, rural doctors with a critical approach to their work must act simultaneously as GPs, as public health doctors, and as advocates.

Medical care is becoming exponentially more effective. We are therefore easily deceived that curative interventions have become more important than continuing care, that personal clinical medicine can discard its connection with public health, that solidarity must yield to consumer choice, and that continuity has become an obsolete sentimentality. These deceptions are promoted by multinational companies offering care as a traded commodity. They have emerged not from local experience or needs, but from neoliberal governments and parties, the International Monetary Fund, the World Trade Organization, and the World Bank.

Public health services everywhere are now suffering a global pandemic of "reforms", transforming them from public institutions actually providing care into State purchasing agencies providing business opportunities. These will buy care

from any agency apparently offering immediately cost-effective solutions, not for the problems of communities, but for shareholders. They will buy care regardless of motivation, whether for public service, profit, or a more or less inseparable mixture of the two.

The profit motive can drive production faster than is possible when wealth and labour are tied to land or controlled by the State, but this volatile and explosive fuel requires equally powerful cultural structures to hold society together. This is so particularly in rural areas unprofitable for care trade and therefore of little interest to investors. In the past this unifying authority was provided by church and monarchy. We now live in increasingly secular and democratic societies, where village doctors offer more convincing miracles than priests or kings. Developed societies can be ruled only by consent, and health care has acquired a powerful role in maintaining this. If rural doctors, who are close to the people, become community advocates, they will have serious power in their hands.

[slide 1. Heading]

According to conventional wisdom, in a free public service available to everyone, finite resources face infinite demands. Needs of individuals therefore conflict with needs of communities and nations in which they live. For public services to survive, doctors are told to harden their hearts and make agonising choices.

Let's look at this, not from the Olympian heights of the London School of Economics, the Abril Report,[1] or the World Bank, but from our daily experience as providers of care in rural-agricultural, rural-industrial, or now mostly post-agricultural and post-industrial settings, where everybody knows everyone else and it's harder to hide. Of course there is conflict, and choices do have to be made, but they are not those proposed by conventional wisdom.

[slide 2. Pentrediwaith]

From 1961 to 1987 I was responsible for leading primary medical care of about 2000 people, grouped in about 500 households, in a Welsh coal mining village. Glyncorrwg closely resembled villages you can still see today in Asturias. People looked the same; short, strong, and intelligent. In my pocket was a diary, my balance sheet of available time.

[slide 3. Diary 1963]

The hours in this diary set the resource limits within which I had to reconcile the wants of my patients with the needs of our community. Within these limits I had to determine in detail, from day to day and hour to hour, my tactical decisions. These were the products of two forces, pressures from personal wants and pressures

from community needs. Rural clinicians know they must decide within bounds of local custom, imagination and consent, political skills often lacking in higher authorities.

I was paid only to be a GP responding to symptoms, but my knowledge of medicine imposed larger responsibilities, unpaid but more rewarding – to identify health needs, and organise answers to the problems they posed. Whether or not they are paid for all these roles, rural doctors with a critical and serious approach to their work must act simultaneously as GPs, as public health doctors, and as advocates for their patients and communities.

[slide 4. Sad woman]

For example, my decisions about a patient sitting in front of me, close to tears, and about to tell me the true story of her recurrent orbital haematomas; that they were not caused, as she had many times insisted, by bumping into a door or falling downstairs, but by her husband. For five days a week he was a lovely man, but on the sixth day he started a weekend of binge drinking, becoming violent, sexually impotent but verbally and physically brutal, a danger and cause of ill health to everyone – himself, his wife, his children, and his community.

[slide 5. Man and child waiting]

As I listen to her I hear also the hum of other patients in the waiting room. I estimate their number and their mood, and how far I can allow my consultations to lag behind their appointed time. I also consider how painful if is for this woman to reveal long concealed truths not only about her orbital haematomas, but also about her recurrent somatised depression (which once led to a completely irrational cholecystectomy), and her oldest child's frequent absence from school. This is an opportunity no to be missed. Others must wait, because this truth can hugely improve the efficiency with which I use my scarce resources while caring for that family in the future.

[slide 6. Deep South domestic tragedy]

People in our village were accustomed to such intuitive calculations; everyone had to make similar tactical decisions about rival priorities in their own lives. This always formed a large part of their moral agenda and political thought. Their principal problems were not these tactical choices of priority, but strategic questions about who controlled resources, and whose interests they served. That's what being a community means; that its members recognise their interdependence, the necessity of social solidarity in sharing resources according to consensually approved need, and of acting collectively to expand resources available; a consensus strategy.

People in my waiting room, seeing a woman with a black eye go in to see me, expected her consultation to last longer than the average 7 minutes I was able to give each patient when I first measured this in 1965, and perhaps longer even than the average 10 minutes I reached by 1980. This collective judgement of the waiting room usually supported my personal judgement of each individual case. We all recognised that real life was a struggle, where our strongest allies were mostly to be found close to us. Effective allies were less likely to be found among people further away who knew our problems not from personal experience but from reading books. They were least likely to be found among remote experts paid by government or corporate interests, and those who wrote books.

[slide 7. Consumer choice]

Since those days things may have got better, but people often seem to have got worse. Medical care is becoming exponentially more effective; so much so that we are easily deceived that curative interventions have become more important than continuing care, that personal clinical medicine can discard its tenuous connection with public health, that solidarity must yield to consumer choice, and that continuity has become redundant. These deceptions are promoted by ideas of managed care as an industrially produced and traded commodity. They ideas have emerged not from local experience or needs, but from Neo-liberal think-tanks and governments, the International Monetary Fund, the World Trade Organization, and the World Bank.

[slide 8. World Bank loans for health vs WHO spending]

The World Bank's global funding for health care rose from less than half the size of the WHO total budget in 1989, to about 50% more than the WHO budget in 1990, and well over double the WHO budget by 1996.[2]

Public health services everywhere are now suffering a global pandemic of "reforms", transforming them from public institutions actually providing care into State purchasing agencies providing business opportunities. These will buy care from whoever offers most immediately cost-effective solutions, not for the problems of patients, but for the profits of shareholders. They will buy care regardless of whether competing providers operate for-profit, are non-profit voluntary agencies, or are more or less inseparable mixtures of the two.

Apologists for Neoliberal "reforms" claim that these are an inevitable consequence of ideologically neutral technical change. The era of big ideas, they say, has come to an end. First Francis Fukuyama announces the end of history, then Josip Figueras announces the end of big ideas about organization of health care.[3] They believe all countries and all cultures have to converge toward a single final economic solution for optimal production and distribution of man's worldly goods; the final elimination of all alternatives to the single idea first articulated by Adam Smith in 1762, The Invisible Hand of market competition.

[slide 9. Adam Smith]

Adam Smith was a great man, so great that his grandeur survives despite disciples few of whom seem to know anything about him, except his Invisible Hand. Here is what Adam Smith had to say about the State:

> "Civil government … is in reality instituted for the defence of the rich against the poor, or of those who have some property against those who have none at all." [4]

He understood that the profit motive could become a hugely powerful but socially corrosive and potentially explosive fuel to drive production much faster than anything possible when all wealth and labour were tied to land or centrally controlled by the State. He understood that to contain this socially divisive force, society required equally powerful cultural structures to hold it together.

In Adam Smith's time this structure was provided by the Anglican Church and the monarchy. Today Britain has become one of the world's most secular societies, and its monarchy has become a popular entertainment rather than a social authority. Developed economies can be ruled only by consent, and health care has acquired a dominant role in maintaining this. A village doctor now offers more convincing miracles than any priest. Public health care and educational systems now provide most of such evidence as we have, that governments have any concern for the people who elect them. Doctors, nurses, teachers and cultural workers provide most of the brains, eyes and ears for societies which without them, might have only stomachs and genitalia. So all these professionals have serious power in their hands, if they have the imagination to use it.

[slide 10. The Citadel]

Many of you will have read or seen *The Citadel* by AJ Cronin, published in 1936, made into a Hollywood and at least two television films. It's still in print, and translated into most languages. It's a shallow, sentimental story, but it gripped public imagination because it reflected more real experience than most other medical romances.[5]

One of its themes is the relation of clinical medicine to public health. Following an epidemic of typhoid fever in a remote Welsh coalmining village, Cronin's GP hero Dr Manson forces replacement of a leaking sewer by blowing it up. Using sticks of explosive from the mine, he floats these down the sewer in cocoa tins, to explode a few minutes later. The public health doctor who advises the Council is portrayed as a lazy and incompetent bureaucrat. Attributing the event to spontaneous combustion of methane, the Municipality finally agrees to spend money on a new

sewer, thus bringing their community from the era of typhoid and cholera into the 20th century.

There was a real model for Cronin's story. In the early 1920s, while Cronin was gathering brief experience a GP assistant in the South Wales coalfield, Dr Bob Roberts served both as a GP and as Medical Officer of Health for a similar coalmining village about 35 kilometres further East. These two functions were in those days commonly combined. Dr Roberts was both a clinical and a social activist. To both roles he brought assumptions of unaccountability, still common today among enterprising GPs in the NHS, where they still serve as independent contractors, and therefore believe that primary care, though a public service, remains their personal property. Like Manson, Dr Roberts faced recurrent outbreaks of typhoid from a decayed and leaking sewer, which the Council would not repair because it had no money. So Dr Bob persuaded two young miners to blow it up, using precisely the technique described in *The Citadel*.

Cronin made the clinical activist his hero, and demonised the public health doctor as a useless bureaucrat. He presented an essentially social problem – the low priority for safe water, compared with ineffective measures for personal care – as soluble through individual acts of heroism (or terrorism, depending on your point of view) rather than social solidarity. In those days, local Councils in South Wales were so poor they could not afford to immunise children against diphtheria, there was no central plan or funding for immunization, so each year about 3000 children died. Of course central government, then as now, found enough money enough to bomb dissident peasants in Iraq.

[slide 11. Glyncorrwg with river]

Like Dr Manson, in 1966 I found a leaking sewer in my village. The sewage pipe crossed the river upstream from an area dammed each summer by the local children to use as a swimming pool, an illegal act long sanctioned by local custom. A young postgraduate student of microbiology happened to be studying the river Afan further downstream for his PhD thesis, so I asked him to let me see what he found. Meanwhile I drew the attention of the Glyncorrwg Council, of which by then I was an elected member, to the leaking sewer. The Clerk of the Council, a local representative of God on earth of a type familiar to everyone who has worked in rural communities, denied that any leak could exist. The public health doctor advising the Council, as lazy and incompetent as the one in Cronin's novel, said he was shocked that I, a professional man, could condone law-breaking by children swimming in the river.

The Council met again one month later. By then I knew that my microbiology student had found *Salmonella typhi* in his samples. "Do you mean the Salmonella typhi that kills people with typhoid fever?", I asked him. "Well, you know I'm not a doctor, I'm just a biologist. I couldn't really tell you that." He was frightened by his own results, too frightened to support me if I raised the alarm publicly. I took some

coloured photographs of the leaking pipe, and showed them to the director of the Council. “If we get any cases of waterborne infection”, I said, “I shall have to encourage my patients to sue both the Council and its public health adviser.” The pipe was repaired the next day. I kept quiet about the evidence of typhoid bacteria. We never had any cases of waterborne infection from that river, so I shall never know whether my student’s findings were accurate.

Clinical and public health objectives are the same. Laziness and incompetence are enemies wherever we find them; no professional group has a monopoly of these evils. Primary care teams must define their aims and measure their success in terms of public health outcomes, not clinical interventions. Without this their work becomes ineffective clinical tinkering.

There is a fundamental unity between personal and collective needs, between care for persons and care for people, between clinical medicine and public health, essential for professional integrity. The choices entailed in maintaining this unity are those posed by reality, not by the market. In the real world, resources are *not* finite and demands are *not* infinite. We have professional responsibility to make these truths known, understood, and acted upon, as advocates for our patients and their communities. Resourcing of public health services depends on political decisions prioritising different kinds of investment, different ways in which the whole social product may be used and invested to expand real wealth (of which health is an important part), and different ways this can be distributed. Medical care is a continuing social process, not a commodity transaction.

We have aging populations with rising expectations of what medical science can do to maintain health. Medical science is growing even faster than these expectations. These developments require a rising proportion of the whole social product for investment in education and health care. We all know this is more important and deserves higher priority than investment in mobile telephones with video screens, computer war games, 100 synthetic flavours for ice cream, or anything else requiring all the resources of advertising to persuade us we need it. Political parties originally created to pursue progressive social agendas must either return to that path, or give way to new, more imaginative social formations that will fight for real alternatives to the marketplace.

The clinical determinants of public health indices such as mortality rates under 65 increasingly depend on techniques requiring patients to be not passive and transient consumers, but well informed, hard working participants, often for the rest of their lives. Where health workers are grossly under-resourced through virtual disappearance of serious funding for public health, the resources brought by their patients are almost all that they have, and their only means of exerting pressure to obtain greater material resources.

[slide 12. Thinking Negro]

The imagination and intelligence of patients everywhere has always been the most important and valuable resource for prevention, for their own care and the care of their families, friends, and local communities, and for social and political change. This resource is not finite. It can expand without limit in states that encourage solidarity and citizenship, but will certainly diminish in states that encourage consumerism and social division. Health professionals have power either to promote or to discourage local participative democracy, to enlist patients as intelligent co-producers and thoughtful citizens, or to reduce them to consumer status. Programmes like the UK Expert Patient scheme[6] and the Welsh advocacy programme could produce exciting results, if central government returned to a citizenship agenda, as we can hope to see through the Wales Assembly.

Nor are the demands on our material resources necessarily infinite.[7] In classical economic theory, at zero price, demand for a commodity will be limitless. This ignores the many costs to patients entailed in any continuing care process - above all, some loss of independence, and uncertainties entailed in all clinical decisions. Unlike producers of commodities for the market, doctors of integrity want their patients to be sceptical, with realistic understanding of the limitations as well as the possibilities of current medical knowledge. As yet, the European Union has successfully resisted pressure to accept Direct-to-Consumer-Advertising of pharmaceuticals which has sent prescribing costs through the roof in USA and New Zealand.[8] [9] Resistance in Brazil, India, and many other developing countries is impeding the drive of US and European multinational pharmaceutical companies to maximise profits rather than health benefits through so-called intellectual property. We need to remind everyone that virtually all the great discoveries of medical science in the 20th century were given free to the world to meet human needs, not for profit. Jonas Salk gave polio vaccine, Howard Florey gave the penicillin production process, and Waksman gave all royalties from streptomycin for further research. Over half the funding for US pharmaceutical research still comes either from government or public charities.[10] Medical researchers do not need to become dollar billionaires. Why must the world get meaner as it gets richer?

Problems facing health workers serving rural societies are essentially similar throughout the world. Their access to centralised specialist agencies is poor, they are isolated from their colleagues and from recognised centres of innovation, time off call may be scarce or non-existent, their public care systems give even lower priority to rural than to urban funding, and recruitment of staff is difficult or sometimes impossible.

However, they also have some advantages. They are remote from Washington, London, and Madrid. They know personally, and are personally known by, their patients and their communities, continuity is still valued, and so are local institutions. People think more of themselves as citizens helping to build a better collective future for everyone, and are less susceptible to the illusory promises of consumer choice. Results of effective work are visible and measurable, so that though rural practices are seldom recognised as appropriate for innovation or

research, they may in fact achieve more than academic centres lacking roots in any community.[11] [12]

Whatever the dominant ambience, there is no part of any countryside where people struggling to pay their rent or mortgage do not greatly outnumber either new rich refugees from the cities, or old rural aristocracy. We may easily underestimate how precariously governments now hold the public imagination, and how close our communities already are to ideas that could move society to more intelligent priorities.

Writing in 1867, the conservative English journalist Walter Bagehot worried about the Victorian monarchy:

[slide 13. Bagehot]

> "As yet, the few rule by their hold, not over the reason of the multitude, but over their imagination and habits; over their fancies as to distant things they do not know at all, over their customs as to near things which they know very well."[13]

The customs of rural multitudes as to near things they know very well include health services. For their future, they look to the opinions of medical and nursing professionals and their own past experience. In this they show sounder judgement than experts paid to discount every big idea that is not profitable, whose visions of the future depend not on imagination, but sponsored visits to California. Here on the ground, at the point of clinical production, you hold the ultimate power. Use it.

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