

Health care in the freely Associated States in Micronesia: strategies beyond the Compacts

ANGELA A. TOKUDA*
 GEORGE P. CERNADA**
 DAVID K. KURAHARA***

Introduction

As the Compacts of Free Association (Compacts) nears its end in 2001 for the Federated States of Micronesia (FSM) and Republic of the Marshall Islands (RMI), many economic uncertainties lie ahead. In addition, a detailed article by Dr. Angela Diaz in 1995 on the Pacific Basin (including FSM and RMI) indicates the drastic need for health improvements¹⁶. Regardless of the outcome of Compact renegotiations, these states need to begin reassessing and rebuilding current health systems. Accomplishing this is a challenging task, but Micronesians must pull their efforts together at all levels and initiate cost-effective strategies that will utilize indigenous resources and decrease dependency on the United States.

Currently, no reports or documents of contingency health plans exist^{1,2}. General consensus from people representing various national departments within the U.S. and the Freely Associated States (FAS) is that there is a serious need to develop and implement effective, cost-efficient health care systems and programs for FSM and RMI. For this report, key people directly involved in Compact renegotiations and others who are knowledgeable on health and political issues in the FAS were contacted.

... Micronesians must pull their efforts together at all levels and initiate cost-effective strategies that will utilize indigenous resources and decrease dependency on the United States.

*Health Policy & Management student at Harvard School of Public Health. **Professor, Dept of Community Health Studies, University of Massachusetts, Amherst, USA. ***Assistant Professor of Pediatrics, John A Burns School of Medicine, University of Hawaii. Contact: Angela Tokuda, Email: aatokuda@hotmail.com

It is with this framework in response to the near expiration of Compact funding that four strategies are proposed for self-sufficient health planning: 1) public health prevention & intervention; 2) local community empowerment; 3) health care rebuilding & reorganizing; and 4) improving training efforts for health care providers. A general overview of the current status of Compact funding and health care situation in the FAS is first provided which will set the context for future health strategies.

Compact funding in the FAS

The Compacts have generated a tremendous amount of financial dependency on the United States. One of the main goals of the Compacts is to assist the FAS towards becoming economically self-sufficient. However, the rush towards implementing the Compacts left insufficient attention to economic planning. In response to these problems, the U.S. Department of Interior (DOI) contracted with the Asian Development Bank (ADB) to provide economic planning expertise for the FAS^{3,4}.

In general, the U.S. has placed very few limitations on funds and has not held these jurisdictions accountable for how each government handles or spends the money. However, some have felt that the U.S. "hands-off approach" has been a "failure"⁵. Despite specialized help from the ADB, the U.S. Congress has criticized both FSM and RMI for irresponsible spending of nearly \$3 billion worth of Compact aid^{6,26}. Until the General Accounting Office gets answers from these jurisdictions, U.S. Compact negotiator Alan Stayman has indicated that it is "premature to be talking about future aid"⁵.

Despite these uncertainties, the U.S. and FSM and RMI governments are considering to renew Compact funding. Both FSM and RMI have felt that 15 years is not long enough to accomplish economic development and self-sufficiency, as both regions still require much help^{7,8}. Palau's situation remains on the backburner, as their Compact payments will not expire until 2044. Currently, ongoing rounds of negotiations to extend funding for FSM and RMI are being conducted⁹. During this time, both governments will con-

tinue to receive funding until 2001 as sanctioned under Article III, which reads: "the period of negotiations shall extend for not more than two additional years, during which time the provisions of this Compact including Title III (Security & Defense Relations) shall remain in full force and effect"⁸.

Impact of Compacts on Health

The Freely Associated States

Little effort has been made to address the issue of the impact on health care if Compact funds terminate (or significantly decrease) in 2001. According to various sources, there are currently no contingency health plans in either FSM or RMI, and no efforts are being made to establish such a plan^{1,2}. Why are no actions taking place? Perhaps these jurisdictions are heavily relying on Compact renegotiations, in anticipation that the U.S. will extend funding. This outlook has serious consequences. According to sources, if the U.S. does not provide federal funding for health, public health services will cease to exist in these jurisdictions³. Serious planning and strategizing for the continuation of and improvements in health care are needed. Government and health officials in these islands need to collaborate and develop a health plan that will minimize U.S. dependency and maximize use of available resources. Before this can happen, however, current health issues need to be addressed. A detailed report published by the Institute of Medicine in 1998 provides comprehensive information on current health care systems and programs for all jurisdictions in the Pacific Basin⁴. The following is a brief overview of the current health care situation in the FAS.

Public health concerns. Both FSM and RMI currently face problems in poor sanitation and access to sanitation facilities and clean water. In FSM, statistics have indicated that in 1995, only about 34 percent of households had flush toilets; about 18 percent were connected to a public water system; and about 11 percent were connected to a public sewer⁴. During the same year in RMI, less than a quarter of households were connected to a public water system and only about 31 percent of the population had access to safe drinking water⁴. Rapid population growth in these areas has also created health risks, especially in crowded urban centers. RMI is most notable for having one of the world's highest population growth rates. In 1997, the population growth rate was 3.9 percent with birth rates of 7.2 children per family^{4,15}.

The people also face a host of health problems, of which most are preventable. Notable examples are nutrition-related issues, especially vitamin A deficiency and malnutrition. According to reports, FSM has one of the highest rates

of vitamin A deficiency in the world^{4,15}. Malnutrition is considered the leading cause of death for Marshallese children under five, accounting for 17 percent of deaths during 1989^{4,16}. Other problems include obesity and non-communicable diseases such as diabetes and strokes.

Financing health care. Health care services for FSM, RMI, and Palau are almost exclusively financed through Compact funding. Annual amounts for each region are approximately \$7 million for FSM, \$3 million for RMI; and \$2 million for Palau^{3,4,17}. Several federal agencies such as the DOI also provide health-related services to these regions (residents of the FAS do not qualify for Medicaid/Medicare benefits). The two most important funders are the Department of Health & Human Services (DHHS), providing approximately \$13 million in aid for fiscal year 1996⁴, and the Office of Insular Affairs (OIA), providing approximately \$12 million in total between fiscal years 1993-1997¹⁷.

The lack of financial and physical resources for health care in FSM and RMI can be attributed to U.S. dependency and poor planning & priority spending on health care services. Currently, health care services for the people of FSM and RMI are entirely sponsored by their government¹⁷. No private health insurance market exists in these jurisdictions¹⁴. This poses a huge financial problem for the governments as user fee charges for health services remain very low (i.e., RMI charges \$2 per outpatient visit) and collection efforts are not enforced^{14,18}. Furthermore, a lack of expertise in health care administration has resulted in

... the majority of resources are spent on payroll with very little allocated to maintain facilities, buy equipment and supplies, or train staff.

poor health planning. For example, since the RMI government did not establish requirements for an eligibility criteria for enrollment into the program, RMI had a problem of over-enrollment in their 177 Health Care Program sponsored by the U.S. government for families affected by nuclear testing⁸.

Poor health facilities & lack of supplies. According to sources, the majority of resources are spent on payroll with very little allocated to maintain facilities, buy equipment and supplies, or train staff¹¹. Consequently, hospitals and dispensaries on FSM and RMI constantly experience supply, equipment, and drug shortages. In some areas such as Chuuk, facilities have been left abandoned due to the lack of funds to provide equipment and staff⁴. Even when equipment is available, the lack of maintenance and supplies needed to run these sophisticated machines are often neglected^{14,16}. Overall, health facilities on FSM and RMI have remained outdated, are in dire need of repair, and experience frequent power shortages¹⁴.

Lack of skilled health care workers. There is a severe shortage of trained health professionals in the FAS. In 1997, there were only a total of 41 MD's in the FAS¹⁴. Part of this

reason may stem from dependence—yet again—on outside help. According to reports, almost all MD's across the FAS (except Palau and Kosrae) are expatriate workers contracted through programs such as the National Health Service Corps¹⁴. Although nurses (RN, GN, & LPN's) in the FAS represent the largest health professional group, the ratio between nurses to the general population can be as low as 1 to 740 in overcrowded places like RMI¹⁴. Health assistants also outnumber physicians; however, most are only trained in basic first-aid needs¹⁴.

Off-island care. FSM, RMI, and Palau, although not as severe, do not have the financial resources to develop and maintain modern medical care facilities as their neighbors on Guam and Hawai'i. Additionally, the shortages of skilled health workers, medical supplies and equipment in these regions make it difficult for people to seek appropriate treatment. Consequently, medical care for specialized services requires travel to another island or country. Excessive spending for off-island referrals have wasted millions of dollars each year to benefit very few people^{9,14}. For example, according to reports, FSM has been spending several million per year for referrals—more than is invested in all public health programs combined¹³. In RMI, 33 percent of their health budget was spent on off-island care in 1996¹⁴. Additionally, medical facilities that receive these patients, also suffer financial losses due to unpaid debts.

Impact on Guam and Hawai'i

Other locations that play an important role in providing crucial treatment for these people such as tertiary facilities on Guam and Hawai'i, also face tremendous financial and ethical problems due to off-island referrals. The impact of the Compacts in Guam and especially Hawai'i, has produced unexpected outcomes. Since the Compacts went into effect, a noticeable rise in immigration and population rates has occurred in both places and continues to increase¹⁹. Under the Compacts, members of the FAS have privileges to migrate to the U.S. and any of its territories and possessions. Almost immediately, people began to take advantage of this new provision, seeking health care off-island. Consequently, this became a major financial burden for Guam and Hawai'i, which is reflected in their current health economic crises. Two years after the Compacts became effective, the numbers of FSM born residents residing in Guam tripled from 1,700 in 1988 to 4,954 in 1992¹⁹. Guam estimates it spent \$3.7 million between 1989 and 1992 to provide health services to citizens of the FAS¹⁴. In 1999, however, Guam received \$4.6 million of impact aid from the U.S. and continues to receive more funding in 2000²⁰.

Hawai'i faces similar problems on a larger scale. In 1986, when the Compacts went into effect, the FAS migrant population increased by 4,815—almost three-and-a-half times as much as Guam during the same year!¹⁹ Large debts incurred by the state and private entities in Hawai'i from FAS patients continue to cut deep into already financially troubled pockets. Outstanding bills for health services have yet to be paid from the FAS governments, with many lagging behind as much as 2-5 years²⁰. To date, Hawai'i has lost about \$700,000 total in public funds and private institutions have incurred losses totaling approximately \$13.5 million²⁰. Unlike Guam, however, Hawai'i has not received any compensation or financial reimbursement from U.S. Congress.

Strategies for the future

The scarcity of financial, physical and human resources compounded by the current public health crises has led to FSM and RMI's dependency on outside sources, leaving these regions in difficult circumstances for improving health care. Nevertheless, the realization that Compact funding may terminate is an awakening for the FAS that is much needed. In order to prepare for financial changes, efforts to initiate and implement cost-effective health plans must take place. With these current health-related issues in mind, four recommendations are proposed to promote self-sufficiency in improving health care.

Strategy #1: Public health efforts are needed and should be directed towards prevention & intervention.

Public health prevention and intervention strategies are the most effective methods of decreasing health care costs. Establishing clean sanitation & access to safe drinking water, immunizations, health education for preventable diseases, and developing intervention strategies for high risk behaviors, can reduce the number of hospital/clinic visits (e.g., for diarrheal diseases) and decrease costly emergency care for severe, but preventable problems (e.g., drunk driving accidents, drug overdose, infectious diseases). Since approximately 70 percent of the population is under 25 in FSM and RMI, health strategies should emphasize adolescents and young adults¹⁴. In addition, efforts to provide education on family planning, reproductive health, and sexually transmitted diseases and HIV/AIDS, will encourage healthy and safe interactions among young adults. All of these public health initiatives must involve people at the local level in order to accommodate local environments and provide the most culturally appropriate services.

Excessive spending for off-island referrals have wasted millions of dollars each year to benefit very few people. For example, according to reports, FSM has been spending several million per year for referrals — more than is invested in all public health programs combined.

An example of a successful program is the Youth to Youth Health Program (YTYHP) in the RMI^{14,21}. This is a non-governmental organization that combines efforts of youths and families to promote cultural identity and pride with health education and awareness. In response to the high percentage of young people in RMI, the program trains adolescents to serve as peer educators and counselors. It also sponsors youth outreach programs and produces radio shows, brochures, e.g., to promote health and cultural awareness on various topics such as nutrition, family planning, and substance abuse. The program operates on 20 islands within RMI and receives some financial support from their Ministry of Health (MOH).

Strategy #2: Involve people from local communities to promote local empowerment.

Any attempt to improve health care in the FAS needs to involve and provide some measure of control to those who are being affected. Local communities need to have the responsibility to handle their own funds to develop appropriate health care services. One possibility to decentralize government infrastructure is creating local health authorities or boards independent of the government that could keep funds separate from the government's general fund. These health boards or committees would serve as the liaison to the national health departments and oversee all aspects of projects including planning, prioritizing, and implementing health initiatives; monitoring distribution of all funding; performing evaluations to ensure plans are being adequately met, and providing accountability for each region/jurisdiction. Members of this board could include people from the local government, public health personnel, chiefs, and local communities. Other existing organizations that are dedicated to regional-wide efforts such as the Pacific Island Health Officers Association (PIHOA) or the Interagency Working Group For Health, could also serve in a consultative capacity with these local health boards. The main idea is to provide more flexibility and responsibility for individual communities/regions, avoiding long delays and bureaucratic obstacles from the government.

Even unique places such as RMI that perceive the government as maintaining a traditional social structure and a source for providing financial support, can use this foundation to form a stable relationship between the government and communities. In turn, this may offer opportunities for people at the local level to implement changes¹⁵. RMI's MOH has served an important role in providing opportunities for communities to become involved in implementing and managing their own programs. A result of this working

relationship has led to the success of the YTYHP, forming a cooperative relationship with the MOH. Additionally, the MOH has provided some support to this program with funding, office space and supplies²¹.

Strategy #3: Improve health care facilities and services.

Poor planning of federal programs, including health services, have exhausted funding to the point where facilities have been abandoned or have not yet been built. According to sources, no new health programs have been established during the duration of the Compact²². In order to facilitate the FAS towards a self-sufficient path in health care, cost-efficient strategies utilizing local resources are needed. Below are several examples within the FAS that may serve as models:

- a. *Palau.* Perhaps the most economically and structurally developed region in the FAS is Palau¹⁴. The economy, employment, and income levels in Palau have been doing very well, and are forecasted to significantly rise in the future²³. Thus, Palau could serve as a model state for FSM and RMI, providing help in reorganizing health care. Palau's recently built Belau National Hospital is the most medically advanced facility in Micronesia. The Hospital could serve as a hub for satellite dispensaries to other regions across the FAS, linking short-wave radios, telephones, or telecommunications systems to Palau. More medical technology, equipment, and supplies could be invested into the Hospital, establishing Palau as a center for referrals or providing medical supplies and drugs to other dispensaries. These efforts can reduce costly referrals to far away places such as Guam and Hawai'i, saving time on treatment.
- b. *Yap.* Yap has an extensive network of dispensaries throughout the islands which was considered at one time a model of primary health care delivery¹⁴. What is unique about these dispensaries is that a primary care team consisting of a physician, nurse, dentist, and medical assistant from the Yap State Hospital occasionally visits these outer facilities. Perhaps expanding the team to involve other health workers throughout the FAS and establishing a network of traveling teams could provide a cost-efficient method for dispensaries far away from main hospitals where staff shortages remain a problem.

Financial strategies

Limiting off-island referrals. Palau is able to spend more per capita on health care compared to FSM and RMI. Unfortunately, differences in spending are largely due to

Palau could serve as a model state for FSM and RMI, providing help in reorganizing health care. Palau's recently built Belau National Hospital is the most medically advanced facility in Micronesia.

the relatively low population in Palau compared to the more densely populated places such as Chuuk and RMI. Nevertheless, carefully organized and planned health budgets in Palau also help to establish better health care delivery for its inhabitants. For example, Palau limits spending to \$30,000 per patient per year for off-island care¹⁴. Additionally, approximately 75 percent of their patients are referred to countries with less expensive health care than the U.S., e.g., the Philippines or Guam¹⁴.

Privatizing health care. There is general consensus among government and health care officials in the FAS and the U.S. that health care should be privatized to encourage a competitive market. Such efforts are slowly taking place in FSM and RMI, and have already occurred in Palau^{14,18,24}. According to sources, two private clinics have been established in Pohnpei and another one is being planned for Chuuk²⁵. Additionally, sources indicate that FSM's government is considering an expansion of their health insurance plan to non-government employees (either a national or state by state plan) who are willing to purchase their plan²⁵. The ADB could provide financial advice for FSM and RMI on privatizing health insurance. While Palau is currently the only jurisdiction to have a private health insurance market, all of these efforts towards privatization in the FAS are encouraging, as effective management and planning is possible and already happening.

Strategy #4: Improve training efforts for all new and current health care workers.

Severe shortages of skilled health workers in the FAS have been a major problem. Efforts to recruit and retain workers and continue medical education needs to happen. There are various health programs and resources currently available within the FAS that could be expanded or serve as models across the region. Here are some examples that may provide a solution to these issues:

a. **RMI.** Strong U.S. military presence in RMI could provide one alternative for medical training. Health care facilities established and run by the U.S. military (not open to civilians), may serve as training sites for local health workers and professionals. RMI's medical community could consolidate their efforts together with the U.S. military and establish a medical training/apprentice program. New and/or current health workers around the FAS could be sent to the Army Hospital for training.

RMI is currently running a program for recruiting and training native workers¹⁴. Established by the MOH and funded by HRSA, this health care opportunities program trains high school graduates to become health assistants in a special 18-month training program that includes 4 months of formal classes at the MOH and 5 months of work in the Majuro Hospital before being sent out to staff the dispensaries.

b. **Expanding the roles of nurses & health assistants.**

Nurses and health assistants outnumber physicians across the FAS. There are a total of 41 MD's compared to 522 nurses (RN, GN, & LPN's) and 189 health assistants¹⁴. Therefore, more advanced training for nurses and health assistants should be available and focus on primary health care needs. In this manner, more routine cases can be treated by nurses, leaving physicians more time to handle complicated health problems. This alleviates demands on physicians and offers nurses/health assistants a larger role in the community. For example, all dispensaries in RMI are managed by a health assistant¹⁴. Having these assistants is a cost-effective method of providing

basic treatment instead of relying on costly and scarce physicians.

c. **Distance-based learning.** Palau is one area that has already begun to experiment with distance education. One example is Palau's continuing education courses for nurses offered through the University of Guam¹⁴. Other areas such as Pohnpei and RMI are also beginning to invest in telecommunications systems. In fact, Pohnpei is noted to have one of the best telecommunications systems in the Pacific Region¹⁴. Efforts could be made to consolidate technologies of Palau, Pohnpei and RMI to create a telehealth network for the FAS and provide a host of resources including distance-based learning, continuing medical education (CME), or workshops and conferences. Additionally, costly medical procedures or the lack of trained medical specialists usually requiring off-island treatment can be potentially resolved through telemedicine referrals and consultations. Most of these places such as Palau and Pohnpei have already been linked to other medical facilities and personnel on Guam and Hawai'i.

Conclusion

This report has indicated the urgent need for the FAS to start developing contingency health plans in response to Compact renegotiations. To reiterate, the current health

the current health economic and public health crises of the FAS need to be addressed by focusing on four areas: 1) need for public health efforts directed towards prevention & intervention; 2) promoting local empowerment; 3) improving health care facilities and services; and 4) improving training efforts for all new and current health care providers.

economic and public health crises of the FAS need to be addressed by focusing on four areas: 1) need for public health efforts directed towards prevention & intervention; 2) promoting local empowerment; 3) improving health care facilities and services; and 4) improving training efforts for all new and current health care providers. Although substantial work lies ahead, immediate action from governments and local communities must take place. The underlying issue will always concern money, and this problem will never cease to exist. It is time to look beyond Compact funding and put serious efforts into revitalizing health care with available resources. The people of Micronesia have suffered long enough.

Nevertheless, the future for improving health care in the FAS is very promising. It has been indicated in this report how various islands within the FAS have already begun the process of health reform for their people, setting encouraging examples for the future. Building new hospitals and dispensaries, establishing training programs and CME for health workers, and investing in telecommunications systems, are just some of the ways these regions are beginning to utilize local resources effectively and decrease dependency on outside sources. Financial support and local autonomy given to local programs (such as the Youth to Youth in Health Program) by national and state governments have made these programs successful in reaching out to targeted populations with specific health issues. By empowering local communities, encouraging the utilization of indigenous resources (both natural and man-made), promoting public health education and prevention and primary care services, the road to a healthy, self-sufficient path will be one step closer to reality.

References

1. Stayman, AP. [personal communication] February 20, 2000.
2. Lawrence, RS. [personal communication]. February 11, 2000.
3. Stayman, AP. Testimony prepared for the joint hearing on the U.S. interests in the South Pacific and the Freely Associated States, U.S. Committee on International Relations (pp.9-26). Washington, D.C., September 25, 1996.
4. Brazeal, AE. Testimony prepared for the joint hearing on the U.S. interests in the South Pacific and the Freely Associated States, U.S. Committee on International Relations (pp.42-54). Washington, D.C., September 25, 1996.
5. The Island Tribune. *Pacific Islands Renegotiate U.S. Payments*. Federated States of Micronesia, December 27, 1999.
6. Pacific Islands Report. *U.S. General Accounting Office representatives to visit FSM*. [WWW document]. URL <http://www.pidp.ewc.hawaii.edu>, March 15, 2000.
7. Takesy, AR. Testimony prepared for the joint hearing on the Compacts of Free Association with the Marshall Islands, Federated States of Micronesia, & Palau, U.S. Committee on International Relations (pp.33-36). Washington, D.C., October 1, 1998.
8. Muller, P. Testimony prepared for the joint hearing on the Compacts of Free Association with the Marshall Islands, Federated States of Micronesia, & Palau, U.S. Committee on International Relations (pp.59-63). Washington, D.C., October 1, 1998.
9. The Island Tribune. *FSM Urged To Put Increased Compact Cash In Trust Fund To Improve Negotiating Position with the U.S.* Federated States of Micronesia, March 8, 2000.
10. The Island Tribune. *First U.S.-FSM Compact Renewal Negotiating Round Concludes in Honolulu*. Honolulu, HI, November 7, 1999.
11. Stayman, AP [personal communication]. February 17, 2000.
12. Bendure G. & Friary N. *Micronesia, Lonely Planet*. Lonely Planet Publications: Hawthorn, Australia, October 1995.
13. Hezel, FX [personal communication]. February 21, 2000.
14. Institute of Medicine. *Pacific Partnerships for Health: Charting a Course for the 21st Century* (PPH). National Academy Press. Washington, D.C., 1998.
15. Bank of Hawaii. *Republic of Marshall Islands (RMI) Economic and Policy Update*. [WWW document]. URL <http://www.boh.com/econ/pacific/1998/rmi/index.asp>, April 1998.
16. Diaz, A. The health crisis in the U.S. associated Pacific islands moving forward. *Pacific Health Dialog*, 1995; 4(1): 116-29.
17. U.S. Department of the Interior, Office of Insular Affairs. *Report on the State of the Islands*. Washington, D.C.. U.S. Department of the Interior, 1999.
18. FSM Consulate General, Hawai'i. [personal communication]. February 18, 2000.
19. U.S. Department of the Interior, Office of Insular Affairs. *The Status of Micronesian Migrants in 1998*. [WWW document]. URL <http://www.doi.gov/oia/imp99rm.htm>, 1999.
20. State of Hawaii, Office of the Governor. Testimony prepared for the US Department of the Interior annual report to Congress on "The Impact of the Compacts of Free Association on the United States Territories and Commonwealths and on the State of Hawaii." Honolulu, HI, January 14, 2000.
21. Republic of Marshall Islands. *Youth to Youth in Health Program*. [WWW document]. URL <http://www.rmitembassy.org/tytyh.html>, accessed April 2000.
22. Stayman, AP. [personal communication]. April 4, 2000.
23. Bank of Hawaii. *Republic of Palau Economic Report*. [WWW document]. URL <http://www.boh.com/econ/pacific/pal/2000/palau2000.pdf>, February 2000.
24. Hezel, FX [personal communication]. February 23, 2000.
25. Hezel, FX [personal communication]. April 16, 2000.
26. Federated States of Micronesia, Office of the Public Auditor *Capital Improvements Projects Financed by the Compact of Free Association. Fiscal Years 1997 and 1998*. Palikir Government of the Federated States of Micronesia, February 17, 2000.