

# A Perspective on Health Care Development in Micronesia

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Having served as Director of Health Services for Kosrae for the past three years, I would like to share my perspective in how we can better focus our efforts to achieve excellence in our health care systems.

My perspective comes from several viewpoints. Firstly, I am an American with 24 years experience as a clinician and health care administrator in the U.S. Navy. Secondly, I lived on Kosrae for six and a half years before becoming Director of Health Services. During that time I interacted with my local family and participated in community activities learning the language and culture. In numerous discussions, I had the chance to hear what the local community thought about their health care system. Thirdly, as the current Director of Health Services for Kosrae, I have had an insider's view over the past two years.

Any developed health care system has several distinct but interdependent parts: **Administrative Services** that include personnel, finance, and miscellaneous other support services, **Clinical Services** that include physicians, dentists, physician assistants and nurse practitioners, **Nursing Services** which include inpatient care for the sick, injured, and for childbirth, **Health Promotion Services** that include various preventive services such as immunizations, family planning, noninfectious diseases, mental health, and curative services in the area of infectious diseases, and **Ancillary Services** that include clinical laboratory, radiology, and pharmacy services.

We in insular health care received a negative report from the U.S. Department Of The Interior's Office of the Inspector General in September of 2008. The report was the result of an inspection tour of almost all the island health care systems supported by U.S. funding. The report was not well received throughout the insular areas for a variety of reasons including the release of the report without first giving the health care officials a chance to answer the report's allegations. The report was negative in tone and was offensive to those working to develop our insular health care systems. The inspectors were from a developed nation (the U.S.) and their biases came through in their report. They were looking for health care systems that mirrored where they were from. Of note, public health was not an issue raised by the report. Was it because we do it well or because they weren't looking for it as a separate organization from the central health care system? Perhaps we should use the report as a tool to help us expand our focus to *all* that is important. While attention to prevention is certainly not wrong, our lack of attention to the rest of our health care systems is a problem.

An area that deserves our attention is the Strategic Development Plan (SDP) for the FSM. It seems a bit dated as it is strong in public health issues but very weak on other areas. It speaks of specific actions in some cases rather than the underlying goals. For instance, if universal access to health care is the goal, we should say so and not say that we want to reduce the number of patient interactions at the hospital. *Where*



we see patients isn't the issue; *that* we see the patients is the issue. If the goals are understood, each healthcare system can address them in the way that best fits the particular community that it serves. If we have a four cylinder engine and only one piston is firing, the engine will not run very well. In a healthcare system, if only one division is functioning, it will not run very well either.

When a developed country approaches an undeveloped country with regards to health the first approach is from a public health perspective. Where no health care infrastructure exists, it only makes sense to immunize the population against diseases that are preventable, identify serious diseases and try to eradicate them, and teach the people how to live a healthier lifestyle involving good nutrition and proper hygiene. While people should want to be healthy, they also want access to treatment should they become sick or injured. At the point of illness or injury, preventive measures don't mean very much. As an organization that is personified by compassion, we should be as motivated to relieve pain and suffering as we are to prevent it. As a health care infrastructure is developed, public health functions should naturally evolve to become seamlessly folded into the new healthcare system. Many functions of what we call "public health" should be institutionalized into mainstream medicine once a sufficient health care infrastructure is in place. There are indications that we have not been pursuing balanced health care systems and are stuck at a point in our evolutionary process. What we should be striving for is a health care system that pays equal attention to *all five* of the above mentioned parts of our health care systems. Our parts should be working together rather than competing with each other. Our facility-based health care depends on effective preventive programs to reduce incidence of disease and its attendant costs. Our preventive programs depend on an effective health care facility that, through prompt, professional, care for the sick and injured will create a trusting relationship between the health care system as a whole and the public it serves. This will, in turn provide credibility for our preventive efforts.

One area that has been chronically missing throughout Micronesia is an emergency response capability. Our ambulances have been simply transportation services with little if any equipment. Another area involves the availability of the basic diagnostic instruments so that our physicians can properly evaluate a patient. Those include stethoscopes, sphygmometers, otoscopes, ophthalmoscopes, etc. Taking a thorough history and performing a basic physical examination will produce a reliable diagnosis in most cases. Clinical laboratory services and radiology are valuable adjuncts to this process but are not an adequate replacement for it.

One particular challenge we face out here in the far reaches of the Pacific is scarce resources. That includes funding, and professional physicians, nurses and technicians. Knowing this, we need to use our scarce resources as efficiently as possible. **Process improvement** will help us to do this.

Process improvement involves the following steps:

- Starts with the "why" of every job.
- Includes customer input and feedback.
- Combines the customer's needs with those of the organization.
- Identifies the most important things to do.
- Transforms the big picture into executable bits.

An example of how we on Kosrae used process improvement involves our outpatient clinic. Historically, patients would crowd the outpatient clinic early every morning and would wait for up to five hours to see



a doctor. We had twelve doctors and only ten offices. The offices were not equipped with the most basic of diagnostic instrumentation. The doctors didn't get much interaction with each other and each felt alone and sometimes overwhelmed with the patient load. Our solution involved tearing down the wall between two of their offices and making a lounge with lockers, TV, computer and bookshelf where the doctors would go while on duty. The other offices were turned into well-equipped examination rooms that are available to anyone who needs one. We put our doctors on two four-hour shifts to cover the outpatient clinic. They see their inpatients either before or after their outpatient shifts. The shared lounge has facilitated better communication among the physicians and has reduced the sense of isolation that they previously felt in their private offices. The result is that our doctors work less hours and the patient waiting time has been reduced to just a few minutes in most cases. An unintended byproduct of this process improvement is that the hospital stays cleaner without the hoards of patients sitting around generating trash every day.

Another example of process improvement involved efficiency in our financial management. We had been purchasing oxygen from the local shipyard at \$125/bottle on the average of three bottles/day. Simple math revealed that we were spending almost \$137,000/year for oxygen. We purchased an oxygen generator for \$100,000 that produces seven bottles/day at a cost of around \$12/bottle. We now have all the oxygen we need at a maximum cost of around \$30,000/year. The savings are used for other essential equipment that we previously could not afford.

An area that we would like to explore is our public health focus. Funding sources have been the driving force in what we pay attention to in public health. This produces money-driven focus rather than need-driven focus. An exercise that we will be doing is to try to forget what we have been doing for a moment and take a fresh look at the needs of our community. We will think about what health care challenges our people face and how we can better meet those needs. Once that is done, we should have a much clearer picture of what we should be doing. I suspect that we will find that our focus may change once we take a realistic assessment of our actual health care situation here. Some areas we might want to eliminate or cut back, while others we might want to enhance or even address some new areas.

The biggest health care challenge our under twenty population faces is dental health. Perhaps we need to increase the resources we are putting toward that area. We also have a much higher rate of rheumatic fever than that of developed countries or even other Pacific island communities. Yet the focus on funding has prevented us from addressing this reality. Do we do only what the funding agencies want us to? Once we know what we really need, we can engage our funding agencies in meaningful communication and request some adjustments in their funding requirements.

One issue that could help us to keep moving is to accept that primary care involves much more than preventive care and that the term "primary care" is not an indicator of importance but of order. It is a patient's first interaction with the health care system. (What is *most important* to a patient depends on where he or she is in the system. A patient who has been diagnosed with cancer, for example, might view the availability of general surgery, secondary care, or chemotherapy, tertiary care, as the most important part of health care at that particular time.) The primary care manager might be a physician, physician's assistant, or nurse practitioner who is the patient's first point of contact with the health care system and manages that patient's health, writes appropriate referrals to specialists as needed, and provides overall management of the patient's health.



**Primary care** includes health promotion, disease prevention, health maintenance, counselling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.)<sup>1</sup>

**Secondary care** is a service provided by medical specialists who generally do not have first contact with patients, for example, cardiologists, urologists, and dermatologists.

**Tertiary care** is specialized consultative care by specialists working in a center that has personnel and facilities for special investigation and treatment, for example, specialist cancer care, neurosurgery, and burns care.

According to the above definitions, almost everything we do here is primary care. We generally refer patients off island for secondary and tertiary care.

**So why the narrow definition we now use?** I believe it is because public health was the first area to be addressed and was identified correctly as primary care. The problem was that people here came to think that primary care was *only* public health. Primary care actually encompasses much more than just public health as is demonstrated in the above definition. So we need to adjust our definition of primary care to include all its parts. Public Health is an important first step as a country begins the journey to development. However, our ultimate goal should be to evolve into a physician centric health care system with the public health functions folded into the new healthcare infrastructure. Our focus should also evolve to one of a balanced healthcare system addressing not only public health but also effective clinical, nursing, administrative, and ancillary components. We should avoid getting stuck on a plateau in our health care developmental process. Our health care engines should be firing on all cylinders.

## References

1. For a more comprehensive definition of primary care, see the American Academy of Family Physicians website at [www.aafp.org](http://www.aafp.org) under Policy & Advocacy.

*“You cannot shake hands with a clenched fist.”*

*Indira Gandhi*

