EDITORIAL

The Role of the Health Workers in the Health Care Delivery System of the Country, Sultanate of Oman

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In spite of clear objectives envisioned by international agencies such as the World Health Organisation (WHO), and health planners in both the developing and developed world, the basic health needs of vast majority of the world's population have remained inadequately addressed. In almost all countries the major limiting factors are economic. In the developed world, skyrocketing costs of maintaining existing health care delivery has threatened to undermine present system. In developing countries, additionally, these factors are complicated by lack of experts. While many governments have remained fully committed to United Nation declaration to achieve Health For All by the Year 2,000[1], translating words into deeds and maintaining them is difficult. Current action has concentrated on implementing WHO's scheme which promotes and strengthens community-based care[2].

In most countries, the single most important limiting factor in the delivery of health care is the financial resources. Hence, any attempt to maximise the efficiency of financial management can have enormous consequences. When the cost of treatment is examined; the costliest factors are clinic attendance, hospital admission and, because they increase the incidence of the first two, poor treatment compliance[3].

These economic considerations have particular relevance to the Sultanate of Oman, whose entire health care system has been developed in the last 20 years. This paper, with Oman as a point of reference, examines these economic factors.

Oman: Geography and its people

The Sultanate of Oman is a nation lying on the South-East border of the Arabian Peninsula. It has an area of 312,000 square kilometers with a coastline which extends for 1,700 kilometers. The country has not yet conducted a comprehensive population census, but the population currently is estimated at 1,345,000[4]. This is concentrated in the North and the South, two areas being separated by the intrusion of the Empty Quarter of the Arabian Desert into the Sultanate of Oman. The major part of this distribution occurs in the North. Muscat, the capital, is in the North, strung along the coast, and is a major area of population, with approximately half a million people. The remainder of the population in the North is distributed among the few large towns, rarely with more than 60,000 people, and numerous small villages clustered around them. Because of the mountainous terrain and as yet incomplete network of roads, some of these villages are relatively inaccessible. Farmers and land labourers are found in all regions. Fishermen sail and trade along

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the coastal areas; settled people live in the villages and towns, while nomadic Bedouin roam the desert with their herds.

There is a close connection between the population in Muscat, and the larger towns and rural areas, in that many men work in Muscat, separated from their families, during the week, returning to their villages for the weekend, where their wives and children remain. This system is facilitated by the relatively small size of the Northern part of the country.

In the South, the population estimated to be 160,000 is concentrated in the city of Salalah with a sprinkling of mountain tribes in the hills surrounding it. Once more, there is considerable communication and movement between rural and city areas and many families maintain double residences, one in each area.

Situation in Oman

The above mentioned geographical and demographic features of Oman tend to produce the following constrains in the delivery of health services:

Firstly, the demographic and geographical structure of the country make it likely for the specialist centres of care to be concentrated far from the majority of the people. It should be noted, that research in many parts of the developing world has revealed about 80% of the population dwell in rural areas, where access to specialist care has remained marginal[5].

Secondly, due to the lack of awareness and suitable health education and lack of a close relatively informed and consistent relationship with health care givers, patients mis-use such facilities available to them. They do this by seeking primary care at tertiary centres. Furthermore, these factors encourage individuals to blame the poor results due to the nature of the disease processes, to inadequate or sloppy health care. This undermines the confidence of the population in the health care delivery system, leading decrease in utilisation.

Thirdly, considering the above, its implications are that one gets poor compliance, with all the squandering of resources it entails.

Fourthly, the majority of physicians are expatriates and are likely to remain so for some time. The dysfunction in communication between the patient and doctor resulting from linguistic, educational and cultural incompatibilities are considerable, and act to reinforce the situation delineated.

All these factors can be reduced by the use of local or community based health workers, to work in tandem with local physicians and clinics; and perhaps in addition, with direct links to centralised tertiary services. These workers could carry out some of the functions of physicians and clinics by monitoring the patients at home and in liaison with treatment centres, encouraging compliance with treatment. In the latter task, they would be helped by the long-term and consistent relations they would have built up, by the very nature of their work, with the patients and their families (which could easily have more than one member under treatment); and also with the communities in which these individuals exist. These home-based community health workers could further act as health educators in their respective assigned venues.

It is obvious that suitable trained and educated community health care workers would help to counterbalance the four negative tendencies mentioned above and this reduce the squandering of resources as well as improving the quality of the health care delivery.

Such health workers could be recruited from the ranks of graduates in sociology, psychology and even education, and the latter future posting could include schools. They could receive further training in tertiary centres. This training could include aspects of patient care and management, dispensing drugs and basic health care procedures. A knowledge of some psychiatry and psychology would be essential, as a large part of the

consideration dealt with in this paper stem from relative unsophistication in these matter. Such a cadre has been proposed by the Department of Psychiatry at Sultan Qaboos University and the first batch for training has already been recruited.

Considering the fact that models of health practice in developed countries are going through reassessment in both financial and political terms, the solution to the problems of developing countries may need to be addressed uniquely in order to achieve Health for All. In fact, if these above mentioned considerations are not seriously contemplated, it may emerge that in the absence of such a community of health care system, the quality of health care delivery could never rise above a certain ceiling and that this ceiling could be quite low. It should be noted that the failures in health care, are not simply that of personnel, but may also implicate failures in the social and the economic strategies. Community-based care may represent an important in the light of the present reality.

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