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Achieving Equity through a Primary Care-led Health System

Plenary Lecture. WONCA Asia Pacific Regional Conference. 6 November 2003, Beijing, China

I am happy to have an opportunity to speak to the leaders of General Practice in this vast region. I am glad to be back in Beijing at this time, but I will have more to say about this.

May I begin on a personal note? When I came in the 80's, as WONCA President, it was to advise on training of a new type of general practitioner for China, instead of the hospital-based specialist care for all complaints, and traditional medicine for the rural people. I found myself interacting with some very dedicated and intelligent people, who clearly knew what needed to be done, but nevertheless wanted my report to add weight to their views on the future.

Over a few more visits, the beginnings of a department of General Practice emerged at the Capital Medical University. A small hospital and a clinic tested out the new approaches, and I was most impressed by their enthusiasm. I helped to organise the first international conference of general practice to be held in China. I met with provincial health leaders who wished to have the same model for their provinces, but we had scant resources even for our Beijing program.

China at that time was reputed to have one of the most equitable health systems in the world. All this had changed when I came back in the early 90's. This was the decade of a global infection that exalted greed into a virtue, and made money as the ultimate measure of personal and institutional success. Medical staff was under pressure to sell services to pay for their salaries, and for the maintenance of their clinics and hospitals. To survive, the small hospital I had previously

visited now used electronic gadgets and doubtful procedures to attract patients, whilst the clinic sold herbs and royal jelly; they still could not make ends meet. I can tell you I was heart broken, and felt I could be of little help to my Chinese friends, and declined further invitations to visit.

When I last came to Beijing, earlier this year, it was as a guest at a Harvard University alumni reunion. At that meeting, William Hsiao of Harvard Medical School spoke on the health services in China, describing it as one of the most inequitable in the world. I was greatly saddened, as his remarks confirmed my worst fears.

Now, once more, there is cause for hope. The winds of change are blowing through this great country. China has become the most rapidly growing economy in the world, and can, at last, afford to spend more on health. There is growing concern about equity, and the neglected health of rural people.

This conference is, therefore, most timely. I hope that our discussions will in some little way be helpful to their health planners, and strengthen the hands of our colleagues in primary care. I am especially pleased to speak under the auspices of WONCA which has grown so much since our humble beginnings.

The Meaning of Equity

All history is the struggle to build a fairer and more just society. Whatever our spiritual heritages, a common theme is to ‘treat others as you would wish to be treated’.

Equity is not a marginal philosophical issue, but central to human civilisation. Medicine is a moral enterprise, and the traditions of our profession are especially strong in our ethical commitment to treat all human beings equally, always placing first their interests in providing care to them. In health, the costs of an inequitable health system come in the shape of more illness, shorter lives, and failure to fully develop human potential. Neglect of any section of a people is reflected in poorer health for all. The SARS epidemic is a reminder that infectious diseases do not distinguish between rich and poor, nor does it respect borders.

A Global Crisis

All countries face some sort of crisis in funding health because of rapidly rising costs brought about by raised expectations of patients and their families, the high cost of new medical technologies, and inefficiencies in health delivery. Generally, I would say that United Kingdom, Canada, and Europe, have adopted the most civilised approaches in managing their health problems. Developing countries, tragically, have drifted into an inefficient and inequitable, commercialised and profit-driven, urban hospital-based system that seeks to market episodic primary, secondary and tertiary care. The focus is on profitable procedures, in a brutal competition for market share. This urban sector drains resources and personnel from the public sector so that the majority of citizens who cannot afford high costs receive very poor quality of health care from a run-down public sector. The rural people, who are still the majority of the population in developing countries, are very badly neglected.

Why Primary Care-led Health Care

Primary care-led means that the demand for care is driven by the needs and preferences of the local community. This enables health workers to share responsibility for outcomes with the leadership of that community. An organised, rational approach to problems can be designed to meet the specific needs of each community, beginning with public health measures. The experience and skills of a health team becomes available to a community. We must emphasise cost effectiveness, not merely cheapness.

Delivering Primary Health Care

Before you can deliver good care, you need enthusiastic, well trained and competent staff who have access to the necessary equipment and medicines. Health education, promotion of health, the prevention of disease, early diagnosis and treatment to prevent or delay complications, and continuity of care for chronic disease, becomes the responsibility of the health district. This health team of the health district has to be capable of providing care of quality for all health problems till the point when a few will require tertiary hospital intervention.

Primary care needs a defined population so that there can be accountability for the outcomes of the care that is provided. A health district of the appropriate size is the unit for planning, investment, and accountability. The health centres together with the community hospital constitute the functional unit of delivery of care. Each patient and family sees the doctor and nurse, working together, as the personal unit directly responsible for their care.

Making Friends, and Influencing People

The forces for inequity in any society are in the short term more influential than the voices for equity. As doctors, we need to patiently explain, educate, and win support for a transformation. Nurses in primary care are obvious allies. Public health doctors are that part of the medical profession that have always led in their commitment to Primary Health Care, and they can make the most expert case for a primary care led health system. Some have been co-opted into the present system, but many, especially teachers of Public Health, have remained loyal to the preventive values and approaches of their discipline. Public Health has lacked allies in clinical medicine, so we need each other. There are also eminent academic researchers, like Barbara Starfield of Johns Hopkins School of Medicine, who have been unflagging voices for primary care and equity.

Strategies

We need small beginnings before we can achieve policy changes that will initiate a transformation in values and investment policies in health. I propose that the budget allocations for health up to district level be separated for primary care from tertiary institutional care, and this be made publicly known. Only then can legislators and the community quantify the existing disparities, and measure progress that will be made in the future. The efficiencies of each sector are apparent and can be measured.

Tertiary care has to develop in response to the ‘push’ of primary care for services that it needs, not to invent and drive demand. The rewards for primary care, and for working in rural areas, must be greatly improved to raise the income as well as the morale of medical staff in primary care.

A Transformation

We are thinking in terms of a transformation of the health services of our countries. It is a struggle for the soul of Medicine. This is a task for the long haul, so we need patience and stamina to win people over. Our immediate responsibility is to enhance the competencies and revise the values and attitudes, of doctors, nurses, and others involved in providing health care. In training, we can help each other between countries, by sharing training resources. What I should like to see are programs in China, as well as in other developing countries, to test out primary-care led approaches to the delivery of health care. I am confident that our friends in other countries, with special expertise and resources, will rally around to help in seminal experiments to achieve equity in health in the poorer counties of the world.

I speak on a subject that is close to my heart. I pray that that my enthusiasm will be infectious to this distinguished audience.