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Primary Health Care for All the People

Rajakumar MK. Primary health for all the people. Singapore Family Physician. 1980;6(1):12-4.

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We live in an age when expectations of people are high yet their confidence is low on the experts who will be needed to fulfil these expectations. This is most acutely true of medicine and in recent years, physicians have come under scrutiny and challenge in the face of a demand for better health care. These increased expectations on health have occurred contemporaneously in the developed as well as the developing countries.

At the Thirty First Meeting of the World Assembly, in May 1978, an appeal was addressed to the political leaders of the world to make the target of health for all by year 2000, the social target for the last quarter of the twentieth century. This was proclaimed at the Conference on Primary Health Care held at Alma Ata in September 1978 under the sponsorship of the World Health Organisation (WHO) and the United Children's Fund. This was an inter-governmental conference attended by 134 governments and by representatives of 67 United Nations organisations, specialised agencies and non-governmental organisations in relation with WHO and UNICEF. The Declaration of Alma Ata reads in its fifth part:

“Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of Governments, international organisations and the whole world community in the coming decade should be the attainment by all peoples of the

world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary Health Care is the key to attaining this target as part of development in the spirit of social justice.”

This, you might well say, is the business of all of us gathered here today yet not a single organisation of physicians in Primary Care, general practitioners or family physicians, were present at Alma Ata or contributed to the Declaration. It is a sad and astonishing fact that organisations represented here today were neither invited nor put in anything to a historic Conference that placed Primary Care on the top of the agenda of social objectives.

Part of the reason, no doubt, is that planning and organisation of health care is very largely in the hands of public health physicians and of health administrators who advise the politicians. Notwithstanding that, it would be letting us off too lightly to accept that as the whole reason.

The sad truth is that General Practitioners and Family Physicians have allowed themselves to be overtaken by events, even as they relaxed in the warm glow of the achievements of the past two decades in giving our discipline its rightful place in medicine. Particularly in the developing nations, where the challenge to the physicians is greatest, the general practitioners have prospered in a professional ghetto and lost sight of the necessity of making their skills relevant to the needs of their people.

The impact of the Declaration of Alma Ata promises to be great on the nations of this region for two reasons. For one thing, as still underdeveloped nations, they are in the line of the main thrust of the WHO campaign. For another, being a relatively better off and better organised group of nations, they are better able to receive and implement the ideas of the WHO. It is therefore important to study these ideas closely and critically.

There are three aspects of the Declaration that I should like to examine. Firstly the term Primary Health Care is used loosely and often appears as a synonym for a form of minimal health care activity designed for poor countries as a substitute for good health care; a basic system planned by public health officials and delivered by lay health worker and using traditional healers where necessary. This seems to me to be a retrograde development. It must be admitted that there

are a few nations in the world so poor and so disorganised that very little health care is better than none at all. Nevertheless if not today, then tomorrow, all developing countries can and must aim at delivering modern medical care through trained teams.

This brings me to my second reservation regarding the WHO's Primary Health Care. It appears to give up too easily on the prospects of getting physicians to work in rural areas where they are needed most. It seems to me that rural populations need the best trained and experienced physicians because their health problems are more severe and more complex. At the present time throughout the developed world there are no rewards for the physician in the rural areas, neither financial inducements for private practice nor career advancement in government service. Is it any wonder that bright young doctors quickly recognise that politicians do not wish to be taken seriously when they say that rural health is a top priority but do not provide the funds to make that possible?

Finally, there is the use of traditional medicine. It has become politically popular to push the use of traditional medicines or even urge their incorporation into modern medical practice. I am not saying that there are not therapeutically active agents in traditional medicine. On the contrary, it is likely that research will continue to discover therapeutic activity in various herbal preparations. Traditional medicine is part of the historic heritage of modern medicine. A great deal of the modern pharmacopoeia is still of herbal origins, reflecting the traditional medicines of western and other societies. We owe to herbal medicine a good number of our most important drugs, including morphine, digitalis, ephedrine and atropine. No doubt, more active agents are waiting to be discovered. However, this is quite a different matter from advocating the introduction of unknown, unidentified and untested medications and methods into medical practice. Such a development would open wide the doors to charlatanism and the community would be the worse.

Notwithstanding these reservations, the primary health care objectives of the Declaration of Alma Ata are important developments which have the potential for much good in this region. It is up to each country to make what it will of it. As primary care physicians from this region we can help to determine the shape of the primary health care delivery system and to train a new generation of physicians to deliver this care. We can make primary health care in this region a genuine

contribution to raising the standards of life and not merely a cover for neglect. The organisation of general practitioners in this region can play a vital and decisive role in determining the shape and standards of the new general practice in this region as a vital part of the movement to achieve health for all.

Regrettably, we have done very little. Over the past few years, there have been a series of regional workshops on different aspects of primary health care and there has been no participation by general practitioners. General Practice in our region has become equated with private 'shop-house' practice confined to episodic care of those who pay, irrelevant to the health needs of the community.

I believe then the fault lies with us. General Practitioners in the region have failed to keep up with the advances in primary care and the new concepts that have appeared over the past two decades. There has been neglect of education and a lack of ideas to contribute to solving the health problems of the community. As a result even within the area of our expertise, other specialists have had to do the thinking and propose solutions. The awful standard of primary care in developing nations of this part of the world is a reflection of neglect by the practitioners of primary care. We have failed by default.

We need a strategy to reverse this drift and to rescue primary health care from its deformed existence. There must be many approaches to this task and I give you my own thoughts and a little bit of the directions of my own College. To begin you need an organisation. The College of General Practitioners of Malaysia was founded in 1973. There is a great deal worth discussing on how to set about forming a College but I need not preach to the converted assembled here today.

Then there is the matter of establishing credentials as an educational body. The national medical association is the appropriate body for medical politics, not the College or Academy. The Universities have to be persuaded that we are collaborators and not rivals. The decisive argument is an active and superlative educational programme. My College has an active but not-yet-superlative continuing educational programme. This has been in no small measure a factor in the acceptance of the earnestness of our purpose by the medical profession as a whole in my country. All the organisations participating here today have excellent continuing educational programmes and we all envy the Family Medicine

Programme and the Check Programme of the Royal Australian College of General Practitioners.

The development of vocational training is a milestone. We have put our concepts on training into a report which we have called 'Specialisation in Primary Health Care - Training for the New General Practice in Malaysia'. This report outlines the objectives, content of training and the mode of examination. At the same time, our College has joined a Committee of the Malaysian Medical Council to define the qualifications and experience of those who are entitled to be called 'Specialist'. Significantly one of the categories of specialist under discussion is that of 'Family Physician'.

Finally there is the role of providing expert advice on the future of primary health care in our countries. If general practitioners are the experts in primary health care, then they must provide expertise in that area. We must have expert committees and ensure that our views and advice are sought and used in planning and decision making. We have to be expert and we have to be persuasive.

The developing countries of this region urgently need good systems of primary health care delivery. They have committed themselves to a hospital-oriented system which has shown an infinite capacity to absorb all health funding. Fortunately the developing countries of this region are relatively prosperous and can afford a reasonable investment in health.

The common dilemma of these countries is that they are unable to get doctors to go to the rural areas. As a result some form of compulsory service has been introduced. Young doctors are sent to the rural areas from which they rush back to the cities as soon as their compulsory service is completed.

The problem is a very real one. In developing countries, four-fifths of the population live in the rural areas, but four-fifths of the physicians are in the urban areas. Four-fifths of the morbidity and mortality is in the rural areas, but four-fifths of health funds go into the urban areas. Four-fifths of health problems need primary health care but four-fifths of the health budget goes into hospitals. These proportions are generally true for the developing nations although the percentages may vary from nation to nation and according to the definition of urban and rural.

In Malaysia, my College has addressed itself to these problems. We have argued that primary health care in the rural areas is no less demanding professionally than hospital medicine. It needs well-trained physicians and not inexperienced ones. Primary rural health care must not be considered an exile or punishment but as exciting and challenging work. It must not be a job in which the physician loses out but one in which he gets rewards and recognition.

The creation of teaching Health Centres is an important part of the solution of attracting primary care physicians to the rural areas. These teaching Health Centres must receive the sort of priorities for funds that are now reserved for teaching hospitals.

The teaching Health Centres can fulfil the following functions.

1. Develop new approaches to the delivery of primary health care.
2. Train and motivate a new generation of physicians and other health care workers.

In primary health care delivery, we are in new and unexplored terrain and we need to tryout different approaches. The aim is to develop primary health care teams led by physicians who are expert in their field, can function as a unit and deliver health care of a very high standard.

The expectations of people are high and they will if necessary bypass inferior health providers and trek to the cities for their medical care. These teaching Primary Health Centres must be well equipped centres with skilled staff if they are to win the confidence of the community. From these centres, we can provide the new generation of health care teams who work well because they know they have been well-trained and that their work is recognised and rewarded.

To plan the programme, you need a National Institute of Primary Care. The National Institute can provide the resource backing, help to develop medical record systems and treatment protocols and summarise the experience of the Centres.

Ultimately success or failure depends on the availability of funds. Good Primary Health Care is not cheap but it is the most cost-effective. When politicians promise top priority for rural health, will they pledge the necessary funds to go with their promises? One encouraging development has been the inclusion of health within

the area of interest of the World Bank. If good schemes for Primary Health Care delivery can be proposed, international finances surely can be found. Health is the most precious possession next to life itself and there can be no development without health.

The Primary Health Care movement is an endeavour worthy of international support and one that can bring decisive improvements at the level that touches the lives of great numbers of people.