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Special Article

THE RAJAKUMAR ORATION 2009

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PRIMARY CARE: THE EVIDENCE BEHIND DR RAJAKUMAR'S VISION

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Members of the Academy of Family Physicians of Malaysia, ladies and gentleman, I am extremely honoured to deliver the inaugural Dr Rajakumar Oration to your 2009 convocation.

Dr Rajakumar was a revered leader in Malaysian and International Family Medicine.

The phrases I have encountered with regard to Dr Rajakumar include:

- a passion for life
- deeply devoted to family and friends
- selfless service to patients and society
- commitment to the poor
- leading left wing intellectual
- acted locally and thought globally
- concern for improving the general standard of health care
- a very intelligent man who was well read and a great orator – a leader
- always held onto his ideals
- a man of absolute integrity and honesty
- a caring doctor adored by his patients
- only interested in serving the poor and needy
- he was a family doctor first
- he promoted general practice as a modern discipline at a time when medical schools emphasised specialisation
- he advocated post-graduate training in family medicine
- he proposed university departments of family medicine
- he encouraged research and quality assurance in family medicine
- he championed rural health
- one of the icons of international family medicine... and from whose shoulders we have the privilege to stand and gain a better overview of the vast domain of primary health care

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I can see that Dr Rajakumar must surely be missed as an exceptionally inspiring role model and leader in family practice. I can understand that the grief you feel after his death in November 2008 must still be strong. I very respectfully pass on the heartfelt condolences of the Royal Australian College of General Practitioners.

This morning I wish to speak to you about the world's evolving understanding of just what primary care has to offer. Dr Rajakumar was indeed ahead of his time as he understood the power of primary care long before most others.

Primary care reduces social inequality in health

Dr Rajakumar noted *"Equity is not a marginal philosophical issue but central to human civilisation"*[1] (p. 160).

The 14th of October 2008 was the 30th anniversary of the international signing of the Declaration of Alma-Ata, where the first international call for equity in health care was made under the auspices of the World Health Organisation (WHO). To mark this event the WHO has published a World Health Report, "*Primary Health Care – Now More than Ever*".[2] The report critically assessed the way health care is organised, financed, and delivered in rich and poor countries around the world.

The report found that when countries at the same level of economic development are compared, those in which health care is organised around the tenets of primary care produce better health outcomes for the same resource expenditure.

The evidence for this finding is very strong.[3] Countries around the world are just starting to understand this – even the USA has just stated that primary care will be their designated approach to health care under President Obama's administration. It will be interesting to watch them turn that ship around.

The definition of primary care I use is by Starfield *et al,* i.e. "the provision of integrated, accessible health care services by clinicians who are accountable for addressing the majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community"[3] (p. 458).

Overall the stronger the primary care approach in a country's health system the better the health outcomes.[3]

Thirty years on from the Alma-Ata Declaration

On reading the WHO's report, "*Primary Health Care – Now more than ever*", lessons to learn from the world's experience since the signing of the Declaration of Alma-Ata include[2]

- Primary health care should be the designated approach to health care. Primary care should not be seen as 'the antithesis of the hospital' but instead as the 'coordinator of a comprehensive response at all levels'[2] (p. XV).
- Action is needed, not just rhetoric.
- People with the most means – whose needs for care are often less – consume the most care with public spending benefiting the rich more than the poor.
- Health is limited if health systems are built around hospitals and consultant specialists.
- When health is skewed to consultant specialist care many preventative and protective health care activities are lost.
- Health care is often delivered according to a model that concentrates on diseases, high technology, and consultant specialist care rather than on primary care.
- Health systems built around vertically-orientated disease programs and other priority programs produce poorer outcomes than those built around primary care.
- Unregulated commercialism is toxic to good health outcomes. If health care is treated as a commodity and driven by profitability health care quality and equity is sacrificed.
- Primary care is not cheap but it provides better value for money than its alternative.

The benefits of primary care – the evidence

The evidence for the health benefits of primary care is strong. "Systems that explicitly distribute resources according to population health-needs (rather than demands), that eliminate co-payments, that assume responsibility for the financing of services, and that provide a wide range of services within the primary care sector are more cost effective"[4] (p. 1365).

Let me present to you the evidence of the benefits of primary care. Barbara Starfield and colleagues[3] have pooled data from numerous countries. They have measured the degree of primary care within international health systems and the primary care features influencing health outcomes. They note the four main features of primary care services as "First-contact access for each new need; long-term person- (not disease) focused care; comprehensive care for most health needs; and coordinated care when it must be sought elsewhere"[3] (p. 458).

Primary care is best when these four features are fulfilled along with a family and community orientation as relevant.

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The more primary care physicians per head of population:[3]

- The lower are all causes of mortality including death from heart disease, cancer, stroke, cervical cancer, asthma, emphysema and pneumonia.
- The lower are infant deaths and low birth weight babies.
- The less people self-report poor health even after taking into account age, education, income, smoking status etc.
- The lower the number of acute hospital admissions and teenage pregnancies in General Practitioner serviced areas of socioeconomic deprivation.
- The lower the in-hospital mortality rate.
- The more preventative services are delivered such as screening, immunisation, and counselling about adverse health habits.
- The more adolescents were likely to receive preventative care and less likely to seek emergency department care.
- The less people reported feeling depressed.
- The lower the suicide rate.
- The greater the reduction in health disparities due to race and socioeconomic grouping.
- The better the ante-natal care provided, leading to fewer low birth weight infants.
- The better diabetes care, with lower smoking rates, neuropathy and peripheral vascular disease, with less lower limb amputation in this population.
- The lower the rate of hospitalisations for both acute and chronic conditions.

The characteristics of comprehensiveness (the primary medical practitioner provides the service themselves rather than referring) and family orientation (services are provided to all family members by the same practitioner) were key markers for positive outcomes.

The total costs of care are also lower if provided by primary care physicians even as quality of care is enhanced.
In contrast, the higher the number of consultant specialists per head of population the higher the cost of health care provision and the poorer the health outcomes.[5,6]

Perhaps this point is easier for me to mention amongst my primary care friends.

It is important to note that the evidence of the benefits of primary care rest with the ability of a child or adult to be cared for by the same medical practitioner at each visit – this definition of continuity of care is important to note. Having the same place of care but differing providers of care decreases the health benefit of primary care significantly.[3]

"*If the interest is in patients' health (rather than disease processes or outcomes) as the proper focus of health services, primary care provides superior care, especially for conditions commonly seen in primary care, by focusing not primarily on the condition but on the condition in the context of the patient's other health problems or concerns*."[3] (p. 477).

Preventative health care

In the area of preventative care Starfield *et al*[3] found that higher ratios of primary care physicians lead to:

- Lower smoking rates
- Less obesity
- Higher rates of immunisation
- Higher rates of breast-feeding
- Higher rates of physical activity
- Higher rates of good nutrition
- Better secondary and tertiary prevention such as earlier detection of breast cancer, colon cancer, cervical cancer and melanoma
- All aspects of diabetes management apart from checking for foot ulcers or infection
- Hypertension management which also leads to less hospitalisation for complications due to poorly managed hypertension such as stroke or myocardial infarction
- Management of recent myocardial infarction
- Depressive disorder management

Possible reasons why primary care physicians deliver better health outcomes

Surmising why the health outcomes from receiving care from primary care physicians are superior to that provided by other medical practitioners Starfield *et al*[3] offer the following reasons:

- A focus on the person rather than managing a particular disease; the overall aspects of the patient's health rather than a specific disease.
- Being a first point of contact protects from over-treatment.
- Continuity of care or a relationship over time (the individual uses their primary care physician, over time, as their primary source of care) generates more accurate diagnoses, greater satisfaction with care, better compliance with management plans, and lower emergency and hospitalisation rates.
- Previous knowledge of a patient increases the odds of recognizing psychosocial aspects of care.
- Continuity of care and first point of access leads to greater efficiency in using less consultation time, fewer laboratories or other tests, and fewer prescriptions all leading to cost savings.

- People with no source of primary care delay seeking help for longer, and do not receive timely preventative care.
- Consultant specialists are likely to over-estimate the likelihood of illness in patients they see leading to inappropriate diagnostic and management modalities leading to adverse events and medical errors.[7]

Also noted is that

- At least two years of a relationship and as many as five are generally needed for patients and medical practitioners to get to know each other well enough to provide the best care.[8]
- Choice of practitioner is important to ensuring the relationship is sustainable over time.

The role of professions and colleges

Boerma and Rico[9] note that "Recognition [of general practice by other medical specialties] follows the following steps: firstly, its specific field of knowledge is accepted; secondly, an academic body is established to develop this field of knowledge; thirdly, those who practice produce literature that describes that knowledge; finally, there is external recognition by other medical disciplines, as well as by the state and society as a whole. A strong role of general practice in health care is related to advanced stages of recognition."[9] (p. 62-63).

In Australia we have achieved all steps except adequate external recognition by other medical disciplines, the state and society but I believe the current health care reform agenda on the table in Australia is about to change that. Perhaps Malaysia is in the same situation. The government plans for reform I have noted during this visit to Malaysia bode well.
This brings me to the point that adequate provision of primary care serviced is associated with supportive government policies delivering:

- The provision of universal or near universal financial coverage guaranteed by the publicly accountable body of government.
- The provision of low or no co-payments to receive health services, and
- Payment to General Practitioners commensurate with other specialists

Australia has a way to go to deliver in these key policy areas. I wonder how Malaysia is faring?

In summary

I have offered an over view of the benefits of primary care to the health outcomes of societies, especially those members of our societies in most need. I have also mentioned some of the challenges Family Medicine/General Practice faces such as ensuring the strength of our discipline within our societies. We owe it to Dr Rajakumar to continue the quest to deliver better health outcomes to our societies, especially to those most in need. Dr Rajakumar knew health care equity could be achieved by a primary care-led health system. I truly believe the next decades will deliver his dream to many more countries across the globe. I invite the orators at your convocations of the future to review progress in this endeavour at every 10 year mark – a time-capsule challenge. I join you at your convocation in celebrating our discipline and Dr Rajakumar's vision for the future health care of the societies of our planet.

Thank you once again for inviting me to deliver this oration. It has been a true honour.

REFERENCES

1. *Family Medicine, Healthcare & Society: Essays by Dr MK Rajakumar.* Teng CL, Khoo EM, Ng CJ, editors. Kuala Lumpur: Academy of Family Physicians of Malaysia; 2008
2. WHO. *Primary Health Care - Now More Than Ever.* World Health Organisation; 2008
3. Starfield B, Leiyu S, Macinko J. Contributions of Primary Care to Health Systems and Health. *Milbank Q.* 2005;83(3):457-502
4. Rawaf S, De Maeseneer J, Starfield B. From Alma-Ata to Almaty: a new start for primary health care. *Lancet*. 2008;372(9647): 1365-7
5. Starfield B, Leiyu S, Grover A, Macinko J. The effects of specialist supply on populations' health: assessing the evidence. *Health Affairs (Millwood)*. 2005;Suppl Web Exclusives:W5-97-W5-107
6. Pierard E. Working paper 0901: The effect of physician supply on health status as measured in the NPHS. Journal [serial on the Internet]. 2009
7. Hashem A, Chi MTH, Friedman CP. Medical errors as a result of specialization. *J Biomedical Inform.* 2003;36(1-2):61-9
8. Starfield B. *Primary Care: Balancing Health Needs, Services, and Technology.* New York: Oxford University Press; 1998
9. Boerma W, Rico A. Changing conditions for structural reform in primary care. In: Saltman R, Rico A, Boerma W, editors. Primary care in the driver's seat? Organisational reform in European primary care: Open University Press; 2006:50-67