

Primary health care reforms in Pakistan: A mandatory requirement for successful healthcare delivery

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Abstract

All over the world, family physicians take pride in their work of providing care at the first point of contact; the concept is very well established and refined in the United Kingdom and amongst many other developed countries.

General practitioners in the UK are often known as the gatekeepers to the National Health Service (NHS). This is because of family physicians being the first point of contact for the patients. The majority of patients are managed in primary care, while a few who require further treatment are referred to secondary care for further management. It is known that the access to family physicians has a positive effect on the overall health of the patient.

In this paper, we discuss disease burden, with a brief introduction to current healthcare provision and conclude with suggestions for implementation of family medicine as a speciality in rescuing the ailing healthcare delivery system of Pakistan.

Key words: Family medicine, Family physicians, FCPS Family Medicine, NHS, United Kingdom, General Practitioners. Healthcare in Pakistan

Disease Burden in a Pakistani context

It is known that access to family physicians has a positive effect on the overall health of the patient (1). Pakistan is a country of more than 184 million people, with a male and female life expectancy of 66 and 68 years of age, respectively. It is a country with a high disease burden, resulting in low quality of life. With rising costs, the provision of health care is becoming more challenging in a society facing many challenges in providing healthcare. This scenario is against the background that in 2014, Pakistan spent 2.6% of its GDP on health (2). In the same year, under-five mortality rate was recorded at 81 / 1000 (8.1%) of deaths per live births, a shocking statistic that needs to trigger a major policy reform in health care (3).

The majority of disease burden comes from tuberculosis, HIV and Malaria as well as non-communicable diseases. Diabetes and cardiovascular disease are becoming one of the fastest growing disease burdens in the country. Currently, 38% of its adult population above the age of 11 years smoke, while 11.7% above 25 years of age have high blood sugars and 28.6% suffer with high blood pressure. In 2012 the three major causes of death were Ischemic heart disease 111.4 per thousand (8.4%), Lower respiratory infections 104.5 per thousand (7.8%) and stroke 84.6 per thousand (6.3%). There has been a gradual increase in the number deaths between 2000 and 2012 caused from Ischemic heart disease, stroke, pre-term birth complications and chronic obstructive pulmonary disease. (4)

With current statistics for growth, stunting and malnutrition being comparable to Afghanistan, the government needs to rethink its overall health care delivery in general and primary health care strategy in particular.

A brief comparison of Primary Health Care and Pakistan

Many countries across the world have started taking steps towards improving their primary healthcare by increasing investment and re-structuring of the healthcare provisions.

According to WHO, Pakistan currently has 2.0 Primary health Care Centres / Units per 10,000 of the population (4). Although an improvement on previous numbers, the data should provide evidence that access to a doctor per patient population is ensured. According to a recent survey the United Kingdom, for example with an average sized General Practice, functions at a doctor to patient ratio of between 1:1400 to 1:2200 (5). This is to say that health centres are usually managed as partnerships between general practitioners supported by a team of highly qualified district nurses, practice nurses, ancillary staff and healthcare assistants. Denmark has a far better figure in access to a general practitioner with numbers ranging at 1:1600 (6). Lacking comparison, we can only equate the availability of a doctor to a number of populations. Unfortunately in Pakistan, we not only lack the number of qualified general practitioners but also the supporting staff that helps in the provision of healthcare to the masses.

The provision of primary healthcare services in the western countries is a good example of how Pakistan as a nation can tackle the top three deadliest disease burdens on its list. Looking towards our close neighbours, we notice a shift towards improvement of primary healthcare system. Countries such as Oman, Qatar and Saudi Arabia are good examples.

Ischemic heart disease and stroke are preventable and early diagnosis through effective screening can ensure timely treatment with better outcomes. A system of patient registrations with a local health centre is the key for continuity of care and provision of health promotion. Full use of electronic medical records have shown to have a positive impact on patient care (7, 8). This in turn will reduce the cost of healthcare by promoting prevention and diagnosing conditions much earlier thus reducing the disease burden at a later stage. It is by these means when the centres are managed by qualified family physicians that the health of the nation can change. Patient's contact with a family physician can have a positive effect on the health of the patient. Patients who have regular contact with their family physician tend to do better (9).

Healthcare in Pakistan is provided through a mixed healthcare system. The majority of healthcare provision is through private hospitals with the remaining being provided by government hospitals, armed forces through its social security system and the rest through the employee social security system. At primary healthcare level, care is provided through Basic health units (BHUs), Rural health units (RHUs), and Mother and child Units (MCHUs). Although the level of care at secondary level e.g. in private and many government run hospitals is generally good with

doctors taking up specialisations in different specialities, primary care is generally ignored. For the Primary care services, the workforce is generally drawn from the newly graduated doctors, without adequate training. These include career grade medical officers who have opted to settle in the rural areas, usually close to their place of origin. Some healthcare is provided by doctors in training, these are in the process of completing their specialist training, which is commonly not related to Family Medicine.

In summary 90% of care is provided by doctors who have had no training in Family Medicine. This has a negative impact on the already strained healthcare; the lack of training in a speciality gives rise to poor disease outcome. It is widely known that Pakistan is lagging behind in the provision of healthcare and has failed to meet the WHO targets on providing healthcare in key areas. In 2006 WHO classed it as one of the 57 countries with critical workforce deficiency (11). The lack of appropriate services, poor availability of care, and poor funding are all various reasons for the burden on secondary care hospitals. Around 21% of the population visit secondary care services (11). This increases the financial constraints on the already under funded government hospitals.

Example of Family Physician consultation in the UK

Joe Bloggs is a 45 year old overweight male. He lives in an area classed as four on the Townsend quintile. He has recently lost his job and as a result, he has started smoking heavily due to stress. He attends his general practitioners with a history of cough and recurrent chest infections. His GP examines him, treats his acute infection with some antibiotics and a short course of steroids. His GP notices his frequent attendance for chest infections and orders a chest x-ray and a spirometry. Mr Bloggs returns after the investigations to discuss his results with the GP. He is diagnosed with a mild COPD, his GP discusses this with him, offers him smoking cessation advice and puts him on the practice COPD register, this way he can have regular recalls for the review of his chest symptoms. It is during attendance to one of the COPD clinics in the practice that Mr Bloggs quits smoking with the help of Nicotine patches. His GP who was trained in communication skills while completing his MRCGP also notices the nonverbal cues during the consultation and notices that Mr Bloggs has been overly stressed. He discusses this with Mr Bloggs and on further inquiring, it becomes evident that Mr Bloggs is suffering with moderate depression. He offers a sick note to Mr Bloggs, and discusses the likely treatment options. After shared decision-making, the GP starts Mr Bloggs on an antidepressant and also refers him to the local mental health team for counselling. After attending 6 sessions of CBT, Mr Bloggs returns to see his GP, he is now feeling much better, his COPD is under control and his depression managed he decides to come off the sick leave and look for work.

The previous scenario is a typical example of doctor patient relationship in UK general practice. General Practitioners take great pride in knowing their patients and patients report an increased level of satisfaction from the continuity of care (9, 12). The entire consultation is funded through the universal tax system. GPs are the gate keepers to keeping the costs of unnecessary investigations and treatments under check and work in line with the guidelines from National Institute of Care and health Excellence (NICE).

General Practice Training in the United Kingdom

Family Physicians known as general practitioners in the United Kingdom undergo a training programme lasting 3-4 years after the completion of house jobs. This has to be approved by the Royal College of General Practitioners (RCGP) for doctors to be able to practice as general practitioners. The training programme known as speciality training is based on the RCGP Curriculum (13). The general practice-training curriculum defines the skills, knowledge and qualities required to become an experienced GP. Trainees rotate through a recognised training post in the first two years consisting of hospital rotations in different specialities, including medicine, mental health, accident and emergency, trauma and orthopaedics, psychiatry, paediatrics, obstetrics and gynaecology. The last year of the training programme is generally spent in Family medicine known in the UK as general practice rotation or a GP surgery. The Royal College of General Practitioners have recently recommended that the training programme be extended to a four year rotation with minimum 24 months spent in general practice setting (14). RCGP described it as a "spiral curriculum" which will work by taking a general practitioner from a novice stage to being an expert in the speciality. The candidates after completing their core competencies during their training programme sit a written and clinical skills assessment to gain certificate completion of training in general practice. They are also granted Membership of the Royal College of General Practitioners on completion.

Conclusions

General practitioners have long been the primary care providers. The turn of the century saw a gradual shift towards more specialised care. This led to care being shifted from the primary care to the secondary hospitals. In Britain, for example, the concept of cottage hospitals where general practitioners used to treat patients was gradually abandoned and care was shifted towards more centralised major hospitals. The 1950s saw a resurgence in the importance of family doctors. The college of general practitioners was awarded the royal charter by HRH the duke of Edinburgh in 1972 (15). General practitioners have contributed to the vast majority of health of the country. Most of the western countries have a family medicine programme which effectively runs a modern primary healthcare system. The benefits of such a system are widely known. The current shift towards the same system

as is seen in the west by many Middle Eastern countries is evident by the effectiveness of it achieving better health targets for its population.

Regionally Pakistan lacks a move towards such a system. With currently a handful of training programmes, being offered by a few universities there has been no effort towards the promotion of this speciality. In 2014, the Pakistan medical and dental council released a statement directing all medical colleges in the countries to initiate family medicine as a speciality in the final year exam for its medical students. The college of Physicians and surgeons in Pakistan awards Fellowship in family medicine, but unfortunately due to the lack of training facilities the uptake and future prospects for trainees haven't changed much since its inception. There also hasn't been any change of curriculum at any of the remaining medical colleges in Pakistan towards the implementation of the speciality.

Pakistan needs to reform its healthcare policies from many aspects. The mass training of family physicians as part of many other changes that are required for healthcare targets would improve the outcome of service delivery.

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