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General Practitioners: Allies or Enemies of Primary Health Care

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ABSTRACT. In this paper the thesis is advanced that the general practitioners can either be a powerful ally or a major roadblock in the development of primary health care in the spirit of the Alma-Ata Declaration. The role they will play depends on their interpretation of, and attitudes towards, the concept. In the first part of the paper, four common interpretations of primary health care (primary health care as a set of activities; as a level of care; as a strategy; and as a philosophy) are described. The second part identifies common misconceptions – traps into which the general practitioners may fall when taking their stand on primary health care. In the third part, a blueprint for transforming the current systems of primary medical care systems into primary health care systems is outlined. The final section suggests some concrete actions to be taken by the general practitioners in implementing this blueprint.

KEY WORDS: Primary health care. General practice. Organization of health care.

INTRODUCTION

The main theme of this paper is: the general practitioner can either be a powerful ally or a major roadblock in the development of primary health care. Which role they play depends on their interpretation of, and attitudes towards, the concept. I will try to prove this claim by reviewing how primary health care has been defined and interpreted and by pointing out the traps into which general practitioners may fall and have fallen. I shall then suggest a scenario for transforming primary medical care into primary health care. Finally, I shall outline the role of the general pratitioners in this scenario.

INTERPRETATIONS OF PRIMARY HEALTH CARE

According to the Declaration of Alma-Ata primary health care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the community.

This definition suggests desirable characteristics of the health care system but it is not very useful when one tries to identify, in a given country, that part of the health care system, which could be called primary health care. Consequently, the definition needs to be made more concrete.

Four more concrete interpretation have been suggested:

Primary care can be interpreted:

1. As a set of activities.
2. As a level of care.
3. As a strategy of organizing health care.
4. As a philosophy permeating the entire health care system.

1. Primary health care as a set of activities

This is the most down-to-earth interpretation. The Alma-Ata Declaration is also quite explicit and helpful; it states that primary health care involves at least: – health education; – food supply and proper nutrition; – safe water and basic sanitation; – maternal and child health care; – immunization; – prevention and control of endemic diseases; – basic treatment of health problems; and – provision of essential drugs.

According to this interpretation, one could say that a country practises primary health care if its health care system includes these eight basic elements. The advantages of this interpretation are its simplicity and concreteness. Its major disadvantage is that is easily gives rise to a claim that primary health care is irrelevant for the industrialized countries. Another disadvantage is that the minimum services can be organized without any attention given to the principles, implicit and explicit, in the three other interpretations of primary health care.

2. Primary health care as a level of care

This too appears to be a concrete interpretation of primary care. It is that part of the care system which

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the population contacts first when it has health problems. In many countries the situation seems to be quite clear – the first contact level primarily comprises general practitioners, possibly also public health nurses, home health visitors and other similar categories of health personnel. The first contact services can, however, be organized completely disregarding the strategic or philosophical implications of the two remaining interpretations.

3. Primary health care as a strategy

This interpretation means that before one can speak of primary health care in a given country, one has to prove that the health care system has been organized taking certain strategic principles into account. The services have to be: – accessible; – relevant to the need of the population; – functionally integrated; – based on community participation; – cost-effective; and – characterized by intersectoral collaboration.

In addition, the health professionals have to work in teams. A new distribution of resources between primary, secondary and tertiary health care may be needed as well as a reorientation of health personnel both in their numbers, training, activities and attitudes towards primary health care. This reorientation, in turn, may require legislative reforms enabling or facilitating a new division of labour and delegation of tasks.

4. Primary health care as a philosophy

Because of its ostensible vagueness, this interpretation can easily be brushed aside as something lofty but theoretical and impractical. This is, however, the most important interpretation of primary health care. A country can claim to have primary health care in the most profound sense of the word only if its health care system is characterized by: – social justice and equity; – self-responsibility; – international solidarity; and – acceptance of a broad concept of health.

"Right to health" is a principle embodied in the legislation of many countries and cherished by the people. Few countries have, however, fully implemented it. There are great variations in health and the provision of health care between countries, regions and social groups. The reasons of the variation are often socially unacceptable. It has also been increasingly questioned whether all the modern technology is beneficial, let alone cost-effective. Primary health care has been suggested as an alternative that can be offered and distributed in a socially acceptable way.

The concept of international solidarity recognizes the duty of the developed countries to assist the developing countries in achieving social equity. One effective form of help is to demonstrate clearly that the industrialized countries too believe in primary health care and accept it as a solution for their health problems.

The concept of self-responsibility is one of the cornerstones of primary health care. With the increasing recognition of the role of human behavior in the pathogenesis, it has been suggested that an individual can – and should – do much more for his own health.

TRAPS FOR GENERAL PRACTITIONERS

The physicians are sometimes considered amongst the biggest obstacles to the development of primary health care. Although both specialists and general practitioners share the blame, their arguments concerning primary health care differ.

"Poor care for poor people" is typically a *specialist's view.* He may accept that primary health can be needed in the rural areas of the developing countries. But even there, the goal is "modern" specialized medicine, based on high technology and practiced in hospitals. Some general practitioners may share the view of primary care as second rate medicine but usually they do not dismiss the concept outright. On the contrary, they may sincerely count themselves among the true defenders of primary health care. How can it then be claimed that they are roadblocks? It depends on how they interpret the concept, what they emphasize and what they omit.

This becomes obvious if one looks again at the four interpretations.

1. Primary health care as a set of activities

This interpretation does not usually present any difficulties. The general practitioners tend to agree that all the activities suggested in the Alma-Ata Declaration are relevant. They may, however, feel that they are a thing of the past; there are no longer any problems related to the provision of these minimum services in the industrialized countries. Those who think this way, should not consider "proper nutrition" in terms of marasmus and kwashiorkor but in terms of nutritional fads, imbalance and overnutrition. In the context of "immunization" one should remember, for

instance, the recent epidemic of whooping cough in the United Kingdom and think of what it tells about the level of immuization of the population. We may safely drink tab water but what about safe swimming at some of the most popular beaches? One could go on but these examples probably suffice to demonstrate that there still is room for improvement even in industrialized countries when primary health care is interpreted as a minimum set of activities.

A limited notion of primary health care as a set of activities coupled with the view that these services are adequate in the industrialized countries clearly harms any further development of primary health care. It seems that many general practitioners have fallen into this trap.

2. Primary health care as a level of care

This interpretation is particularly dear to many general practitioners. Understandably so – by definition, a general practitioner is a soldier of the front line. Consequently, it is very tempting to equate his own activities with the new concept and to assume that all the fuss about primary health care is intended to buttress his professional position.

Although the general practitioners unquestionably are key providers of primary care services, their responsibility lies primarily in the area of medical care. By trying to monopolize primary care they perpetuate one of the main fallacies concerning primary care – that primary *medical* care equals primary *health* care. This position raises several questions. Studies in many countries have shown that perhaps up to 80–90 per cent of all health problems never result in a contact with the official health care system. They are being taken care of by the lay health care system, by the people themselves, their friends and relatives as well as by alternative health "professionals". Are the general practitioners willing to accept the lay care system as a part of the primary care system? Are they willing to grant an independent role to other health professionals such as nurses, public health nurses, home health visitors, health educators, nutritionists, etc. in the promotion of health and prevention and treatment of diseases or, do they consider the other professionals only as handmaidens of physicians? Should the answers to such questions be negative, we cannot have true primary health care, no matter how effective and comprehensive the primary medical care system may be.

3. Primary health care as a strategy

Perhaps most of the traps are related to this interpretation. In many countries, the general practitioners are fiercely proud of their independent role and private nature of their work. The result is a lack of functional integration between primary, secondary and tertiary services. In such a "non-system" the channels of communication and referral remain obscure; duplication of services is common; mistrust may colour the relations between health professionals; waste of resources is almost inevitable; and intersectoral collaboration remains an illusion.

Independent general practitioners who are not a part of an organized system may also find it difficult to accept team work. They may experience other health professionals either as rivals to be fought against or as servants to be taken advantage of. Restrictive licensing laws may be the desired goal. New legislation which would enable redistribution of labour between the existing groups of health personnel, delegation of tasks and emergence of new health professionals can be actively lobbied against. Community participation can be conceived as a threat, an unwarranted and undesirable interference by the lay people in professional matters. Cost-effectiveness and use of appropriate technology may be sacrificed on the altar of profit maximizing. Decisions concerning what services to produce may be dictated more by self-interest and professional pride than by the needs of the population to be served.

4. Primary health care as a philosophy

In this area, very few charges can be made against the general practitioners. On the contrary, they have often been in the forefront to defend social justice and equity. They are in a much better position than their specialist colleagues to accept a broad concept of health and grasp its significance in the practice of medicine. They may, however, be guilty of adopting a paternal attitude towards their patients thereby undermining the notion of self-responsibility; and in some cases the quest for financial gains may suppress the quest for equity.

FROM PRIMARY MEDICAL TO PRIMARY HEALTH CARE;

A blueprint for change

Most of the industrialized countries have a more or less well developed primary medical care system but

Table I. From primary MEDICAL to primary HEALTH care

From	*To*
FOCUS	
ILLNESS	HEALTH
CURE	PREVENTION AND CARE
CONTENTS	
TREATMENT	HEALTH PROMOTION
EPISODIC CARE	CONTINUOUS CARE
SPECIFIC PROBLEMS	COMPREHENSIVE CARE
ORGANIZATION	
SPECIALISTS	GENERAL PRACTITIONERS
PHYSICIANS	OTHER PERSONNEL GROUPS
SINGLE-HANDED PRACTICE	TEAM
RESPONSIBILITY	
HEALTH SECTOR ALONE	INTERSECTORAL COLLABORATION
PROFESSIONAL DOMINANCE	COMMUNITY PARTICIPATION
PASSIVE RECEPTION	SELF-RESPONSIBILITY

very few, if any, have a primary health care system in the widest and most profound sense of the word. To transform these systems into primary health care systems, changes related to the focus, content, organization and responsibility of health care are needed (Table I).

The relative importance of the necessary changes depends on the situation in a given country.

GENERAL PRACTITIONERS AS PROMOTERS OF PRIMARY HEALTH CARE

One might wish the blueprint to be more concrete. It is, however, probably concrete enough. If one is willing to take a critical look at the health care system of his country, he will easily realize what actions are needed. Some changes and actions particularly relevant for the general practitioners can, however, be singled out.

The most important thing is to recognize that primary health care is a broad concept; it is a set of activities, a level of care, a strategy and a philosophy. It should not be limited to only one of these interpretations and it cannot be monopolized by any one group of health professionals. The general practitioners need to accept the idea of including their work in a national *system* with at least a modicum of national health planning – however much they cherish the idea of private practice. They have to accept the idea that within that system, the services form a hierarchy with a pre-established division of labour and referral and communication channels between the different levels.

From the point of primary health care as approved in Alma-Ata by the leading health authorities of over 130 countries and advocated by World Health Organization, the time of benevolant but paternalistic single-handed practitioners is a thing of the past. Health centres staffed by teams of health professionals working as equals are the locus where a scientific and professional standard of services can be maintained. Such a mode of operation will ensure cost-effective services, the use of appropriate technology and collaboration with other concerned societal sectors, such as education, housing and social services. The planning and management of such centres should be assisted by community representatives to assure social acceptability and relevance to the needs of the population. Ideally, community participation should be extended from mere patient participation groups providing advice to locally elected bodies exercising decision-making power.

The best way of paying for professional services is a hotly debated issue and the final word has not yet been said. In any case, collaboration between different categories of personnel is difficult if they are being remunerated differently. Consequently, one is tempted to suggest salary for all as the most judicious and equitable remuneration mechanism.

The education of the general practitioners has to

face squarely the new challenges. The minimum requirement is that all medical students are exposed to work in primary care already during undergraduate education. Ideally, general practice, family medicine, primary health care or whatever name is chosen should be made a medical speciality. The undergraduate training should prepare the future physicians to work in teams and to accept the other team members as equals. In primary health care, it is difficult to overemphasize the role of a public health or community nurse.

The establishment of departments of general practice in the universities and the foundation of national associations or colleges of general practice will help to achieve and maintain professional standards. Research on general practice will be necessary to create a knowledge basis upon which to build educational programmes and professional standards. Research is also an essential ingredient of professional self-image and self-esteem.

It is clear that this recipe is not very palatable with a great number of general practitioners; in fact some of the suggestions are an anathema for them. The overwhelming majority of all general practitioners in some countries e.g. Finland and Sweden have, however, found them fully compatible with their individual, intellectual and professional needs and expectations. The promotion of primary health care in the spirit of the Alma-Ata Declaration is also the best way to promote general practice and general practitioners as a socially responsible and valuable component of the overall health care system.

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