CHAPTER 1

Meeting people's health needs

In spite of remarkable advances in medical science and technology, over one billion people throughout the world do not have access to basic health services.[1–4] Thus, more than one out of seven persons lives daily with the threat of premature morbidity and mortality from diseases that could be treated or prevented. This immeasurable human suffering overwhelms our comprehension, raises serious humanitarian and ethical issues, and evokes a profound desire for more effective approaches to providing quality health care for the world's population.

The challenges of ensuring consistent access to high-quality health care for the entire population are not limited to low-income countries. Middle- and high-income countries are dealing with unsustainable costs, fueled by aging populations, rapid increases in the prevalence of noncommunicable diseases, and fragmentation, duplication, and maldistribution of health services with consequent lack of access especially in rural and low-income communities. The potent forces propelling medicine toward specialization and reductionism accentuate the corresponding need to complement and integrate more narrowly focused, specialty-oriented endeavors with an approach that concentrates on the whole patient within a comprehensive health care system. Primary health care, strengthened by family medicine provides the necessary framework for achieving this synthesis.[5]

Family medicine also serves to link those concerned with population health and those who are at the forefront of delivering health care to individuals. The convergence of public health and person-centered care expands opportunities to deliver better-quality health care that is more cost-effective, relevant, equitable, and sustainable. Consequently, this approach is likely to address the needs of patients, health care providers, and decision makers, regardless of their country's state of economic development.

This chapter identifies peoples' current and evolving health care needs,

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introduces the role of family physicians in health systems, delineates challenges involved in implementing primary health care and family medicine, and provides country-specific scenarios to clarify and facilitate health policy decisions by national leaders.

1.1 IDENTIFYING PEOPLE'S CURRENT AND EVOLVING HEALTH NEEDS

The health status of individuals and populations is influenced by a variety of biological, social, and economic determinants. Key variables include a country's stage of socioeconomic development, availability and distribution of resources, the number and distribution of physicians and other key health workers, and the epidemiology of diseases.

Stages of economic development, resources, and physician numbers and distribution

There is wide variation among countries in their stages of economic development and available resources. Access and quality are strongly influenced by the amount and distribution of funding that individuals and countries allocate to health services. Average per capita expenditures range from US$25 in low-income countries to US$4692 in high-income countries.[6] Many sub-Saharan African countries lack adequate facilities, diagnostic equipment, drugs, and human resources to care for their populations. While many health professionals are needed for the delivery of health services, the availability of doctors often determines access to life-saving care. Malawi and Ethiopia have doctor-population ratios of 1:50 000.[6] In contrast, many European countries have more than three doctors per 1000 people and a relatively abundant supply of health care facilities.[7] Social and economic factors such as poverty, lack of clean water, poor sanitation, inadequate roads, low levels of education, limited access to information, and political instability further accentuate health disparities.[8,9]

Epidemiology challenges

There are also major discrepancies in disease burdens among countries. For instance, in sub-Saharan countries over 60% of this burden is due to communicable diseases and maternal, perinatal, and nutritional conditions. The leading causes of death in children between 0 and 4 years are diarrhea, respiratory illnesses, and those associated with the perinatal period such as birth asphyxia, premature birth, and low birth weight. Communicable diseases and maternal conditions are the leading causes of death in adults. Trauma, violence, and noncommunicable diseases are also major causes of premature morbidity and mortality.[7] Although more challenging to document, mental illnesses such as

depression, schizophrenia, and alcoholism are also substantial contributors to the disease burden in low- and middle-income countries.[10]

Noncommunicable diseases are the leading causes of death in all regions except Africa.[11] Diabetes, hypertension, cancer, and chronic lung disease predominate in the European countries, with only 5% of mortality ascribed to infectious diseases. A similar spectrum is encountered in the United States where there has been a significant increase in prevalence of diagnosed diabetes in adults over the 15-year period from 1995 to 2010.

In spite of their predominance in high-income countries, noncommunicable diseases disproportionately affect low- and medium-income countries, accounting for nearly 80% of the 36 million noncommunicable disease-related deaths worldwide. Furthermore, the World Health Organization (WHO) projects that noncommunicable disease-related deaths will increase by 17% over the next 10 years, with the greatest increases in the African (27%) and the Eastern Mediterranean (25%) regions.

This dramatic rise is a major concern throughout the world. In addition to their impact on individuals, noncommunicable diseases are closely linked with global social and economic development. Thus, the WHO calls for overall health system strengthening so that both the public and the private sectors have the elements necessary for the management and care of chronic conditions. Elements specified include appropriate policies, trained human resources, adequate access to essential medicines and basic technologies, well-functioning referral mechanisms, and quality standards for primary health care.[12]

1.2 RESPONDING TO PEOPLE'S HEALTH NEEDS

The discrepancy between our capacity to improve health and actual health outcomes has triggered responses from communities and world health leaders regarding the fundamental importance of primary health care.

Primary health care and primary care: universal needs, local solutions

In 1978 the Declaration of Alma-Ata identified primary health care as the most cost-effective way to deliver essential health services.[13]

There has been some confusion since that time about the terms primary health care and primary care. We need to differentiate primary health care, as a strategy to attain health for all, from primary care, as first-contact care. Primary health care as a strategy encompasses high-quality primary care services.

There have been variations and refinements of the concept of primary health care throughout the past 3 decades, with committees and individuals stressing the importance of the following attributes of high-quality primary care services:[5,14–19]

- personal – patients treated with dignity and efficiency
- first contact – provides accessible entry into the health system
- continuous – establishes longitudinal and sustained relationship with patients over time
- comprehensive – addresses all health care needs, common problems, and comorbidities, including physical, psychological, social, and cultural determinants of health and disease
- coordinated with other health professionals
- cost-effective
- high quality
- equitable distribution of health services
- community oriented, including local involvement and partnerships
- accountable.

The unique features of primary care include first contact, longitudinality (continuity), comprehensiveness, and coordination.[18] The way in which these characteristics are organized and incorporated into a systematic approach within successful primary health systems is distinctive and thus provides a template for countries seeking to improve the efficacy of the care they provide to their citizens.

The contribution of family medicine

While a variety of health professionals are essential for the delivery of health services, family doctors are particularly well suited to this function because they are trained to care for individuals of all ages. They also serve as integral, complementary members of the primary health care team, providing supervision for other health workers and ensuring comprehensive, continuous, and coordinated health care for individuals, families, and communities.

Family medicine is a component of primary care and is defined as a specialty of medicine concerned with providing comprehensive care to individuals and families and integrating biomedical, behavioral, and social sciences; it is known as general practice in some countries. Family doctors are medical specialists trained to provide health care services for all individuals regardless of age, sex, or type of health problem. They provide primary and continuing care for entire families within their communities, address physical, psychological and social problems, and coordinate comprehensive health care services with other specialists as needed. Family doctors may also be known as family physicians or general practitioners. They differ from general doctors who may work in the community without further specialist training following medical school.

The scope of each family doctor's training and practice varies according to the contexts of their work, their roles, and the organization and resources of the health systems in each country. A wide spectrum of skills is necessary for family doctors to adapt to the health care needs of their individual countries. In those countries with few medical practitioners, such as in some countries in sub-Saharan Africa, family doctors may be employed in the public sector and serve as the backbone of district hospitals, performing surgical procedures including caesarean sections, managing trauma, and caring for adults and children. In some countries in Europe they may concentrate on ambulatory primary care and serve as the gateway to hospital and specialised services. Increasingly, as members of multidisciplinary primary care teams, around the world their scope of practice is expanding to include public health activities such as teaching and consulting with village health workers and midwives; working with schools, churches, and other groups within the community; and providing care in homes, clinics, and community health centers.[20] Also, the worldwide increase in noncommunicable diseases (NCDs) accentuates the need for well-trained family doctors to manage and care for people with chronic diseases and their associated comorbidities.

The wide range of contexts in which family doctors function is summarized in Box 1.

BOX 1.1 Range of contexts where family doctors may work

- Low- to middle- and high-income countries
- Homes, communities, clinics, and hospitals
- Rural, suburban, and urban environments
- Solo, medium, and large group practices
- Public, nongovernmental, and private health systems

Likewise, their scope of practice, which can be tailored to fit the needs of the populations they serve, is described in Box 2.

BOX 1.2 Scope of practice of family doctors

- Care for patients of all ages, from "womb to tomb"
- Ensure access to comprehensive primary and secondary services
- Manage infectious and chronic diseases
- Provide emergency, acute, and long-term care
- Serve as clinicians, teachers, advocates, and leaders
- Coordinate individual clinical, community, and public health services

The ability of well-trained generalist doctors to adapt to the unique circumstances and specific health care needs within each country is reflected in the rapid growth of the World Organization of Family Doctors (WONCA) from 18 founding member organizations in 1972 to 126 member organizations representing over 130 countries by 2012.[21]

This diversity requires a flexible, yet deliberate, educational approach to ensure that competencies are aligned with local needs. Doctors are best prepared for these multifaceted roles when their training is concentrated on the specific problems and diseases they are likely to encounter in their future practices. Thus, the knowledge base necessary to manage the majority of these recurring events can be mastered. This focus provides the expertise and confidence that is necessary for family doctors to provide quality care to their patients without unrealistic expectations upon themselves or from patients, other providers or decision makers. Subsequent chapters will describe the rationale for considering family medicine as an essential component of primary health care, evidence of its efficacy, and practical consideration of its implementation with examples from various countries.

1.3 MEETING THE CHALLENGES AND CONVINCING THE LEADERSHIP

The health of the population and the social and economic capacity of a nation are interdependent.[1] Therefore, each nation has a fundamental interest in promoting and improving the health of its people. Government authorities, educational institutions, health care organizations, financial systems, and civil society play distinct and complementary roles in the oversight, production, and maintenance of complex health systems. These groups influence the policies, organization, staffing, financing, and delivery of health care services that in turn affect economic as well as individual and population health outcomes. This reciprocal relationship makes it even more important for governments to employ their finite budgets and available resources efficiently as they strive to achieve maximal health outcomes that require the active participation of all sectors of the population.

Primary health care challenges

All countries face formidable challenges as they strive to provide high-quality health care that is cost-effective, relevant, equitable, and sustainable.[5] These challenges, as described in the World Health Report 2008, can be summarized as follows.

- **Inverse care**: people with the most means consume the most care, whereas those with the least means and greatest problems consume the least, often because of a lack of access to affordable, acceptable services.

- **Impoverishing care**: when people lack social protection and health payments are out-of-pocket, health problems may lead to catastrophic expenses.
- **Fragmented care**: excessive specialization and a focus on specific diseases discourage a holistic and continuing approach to health services.
- **Misdirected care**: resources are mostly allocated to curative, acute services, often neglecting primary prevention and health promotion.
- **Unsafe care**: poorly designed systems and unsafe practices lead to high rates of hospital-acquired infections, errors, and adverse effects.

Health policies that address these inequities and ensure adequate resources and incentives are required to support robust primary health systems and human resources for health.

Insights gained from experiences throughout the world indicate that solutions must be specific, based on sound evidence, and sensitive to local contexts. The World Health Report 2008 delineates four interdependent reforms that are necessary for robust primary health systems.[5]

1. **Universal coverage reforms**: to ensure that health systems contribute to equity and end exclusion on the basis of such variables as income and ethnicity; and to invest adequate resources for maintenance of a robust primary health system with universal access.
2. **Public policy reforms**: to integrate public health with primary care and to promote public health policies across sectors; to promote collaboration between family doctors, communities, government and private sectors, and academic institutions to address the evolving health needs of societies; and to ensure the recruitment, training, deployment, and retention of health professionals according to the needs of the population.
3. **Leadership and research reforms**: to promote inclusive, participatory, negotiation-based decision making based on the values of solidarity, social justice, and accountability; to conduct research to assess quality, satisfaction, and outcomes and to revise services based on sound evidence; and to promote global solidarity and shared learning.
4. **Service delivery and educational reforms**: to reorganize health services with teams of health workers delivering people-centered, culturally appropriate, community-based health promotion, preventive services and primary care; and to train family doctors and other health workers to manage the most common problems at the community level and to support and/or refer patients to other specialists as needed.

Family medicine challenges

Family doctors face unique challenges related to their identity, roles, and financial support. When family medicine is a new concept, the public and other health professionals often do not understand or appreciate the unique skills of family doctors. In some cases, family doctors may experience role conflicts with other health professionals. This confusion may be exacerbated by inconsistent standards, policies, and communications within and between health professional groups.

Adequate resources, incentives, and salaries are also required. If family doctors are remunerated at much lower rates than other medical specialists, it will be difficult to recruit and retain sufficient numbers especially in rural areas, in district hospitals, and in areas with high concentrations of people living in poverty. Inadequate preparation and working conditions will promote the migration of health professionals to more attractive working environments and exacerbate the burden of work for those left behind.

Additional challenges include medicine's expanding knowledge base, increasing reliance on expensive technology, and the complexity of managing patients with comorbidities. Flexible models of training and continuing education address these factors through focusing on the needs of the populations to be served and promoting primary health care teams, protocols that maintain high quality and use of low-cost information technology to remain current and communicate with other specialists. The latter will include mastery of such tools as online learning and curricula, telemedicine consulting, and computer population mapping.

Those working in rural areas may also require advanced obstetric, surgical, and trauma skills. Furthermore, they may feel isolated and be concerned about access to educational, cultural, and employment opportunities for family members. These challenges can be addressed in part through the support provided by group practices and the congregation of several practitioners in centrally located community health settings or in district hospitals. Doctors can thus share the workload and have time for recreation and family activities. They can still serve a network of surrounding villages through consultation, teaching, and supervision of other primary health care workers based in those communities.

Convincing the leadership

Exemplary leadership and advocacy by political, community, and medical leaders will be required to steer a wide range of interventions toward meeting these challenges. Successful implementation often involves balancing competing values in a manner that is complementary and mutually reinforcing. For example,

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health systems that ensure equitable access to comprehensive services need to integrate the care of individuals with public health measures. Both components of health care are essential and more effective when working in synergy. Furthermore, quality needs to be balanced with cost-effectiveness in order to provide care at a cost that each society can afford and sustain. The dichotomy between comprehensive, integrated approaches and specialized, reductionist approaches to health care presents additional challenges.

The realignment of health systems to best meet people's needs also involves important societal changes. Flexibility on the part of each stakeholder will be necessary in order to manage competing priorities in the context of finite resources. When addressing these challenges, leaders may achieve consensus among key stakeholders by focusing on shared goals and values such as health promotion, the prevention and alleviation of suffering, and the importance of equity and cost-effectiveness.

The implementation of family medicine will vary according to the circumstances in each country, as reflected by internationally recognized classifications such as per capita income levels, indebtedness, and economies in transition or emergency status. Each category requires a specific, flexible approach to the development of family medicine in each country. Identification of the stage of development of a nation will facilitate understanding of the particular contribution family medicine can make and of the critical decisions that have to be made in order for the discipline to succeed. The following scenarios describe this spectrum of developmental stages within nations.

Amplification

In many low- and middle-income countries family medicine is considered synonymous with primary health care, and components of this discipline are, therefore, practiced by a variety of health professionals, the majority of whom are nonphysicians – that is, medical assistants, nurse practitioners, and community health workers. This workforce, often identified as primary health care workers, provides essential health services to a large proportion of the population, particularly in rural and remote areas. The WHO has described how primary care requires

> teams of health professionals: physicians, nurse practitioners and assistants with specific and sophisticated biomedical and social skills – it is not acceptable that, in low-income countries, primary care would be synonymous with low-tech, nonprofessional care for the rural poor who cannot afford any better.[5]

Because of limitations in numbers and the scarce resources available to these countries, the most effective contributions of family doctors under these circumstances may be to provide training and supervision for primary health care workers throughout a region, to complement care for those patients with complex problems, and to facilitate appropriate referrals. In these situations, decisions need to be made about the roles, responsibilities, distribution, and compensation of family doctors, and how they can strengthen the delivery of primary health care at the community level.

Substitution

In some countries the discipline of family medicine is not yet established or recognised, and therefore does not attract medical school graduates to enter family medicine specialty training. In these cases, medical schools may tailor their basic educational programs to train doctors to address the most relevant health needs, with the assumption that all doctors should be competent in delivering primary care services. Decisions need to be made about whether this approach is an effective substitute for deliberately trained family doctors, and whether establishing formal specialty training would improve outcomes.

Recognition

In many countries the discipline of family medicine is formally recognized and taught as a specialty, but there are few incentives or opportunities for the career advancement of family doctors. In these scenarios, the general public often favors direct access to subspecialists in the belief that they provide the best service. There have been initiatives from many governments and health service organizations to reverse this trend and promote family medicine through appropriate legislation, public education, and professional incentives. Where these initiatives do not already exist, decisions need to be made about whether increased recognition and support for family medicine would improve access, quality, comprehensiveness, or cost-effectiveness of health care.

Reconstruction

Countries may be reconstructing their health systems after major political changes or armed conflicts. In these cases, the introduction of family medicine is an important contribution to health system reforms: supporting decentralization, improving access to health care at the community level, and providing private practice options. However, a multiplicity of interventions and a relative lack of coordination may lead to confusion and uncertainty, with distraction from the goal of efficiency and equity. In these situations, the most important

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contribution of family medicine is as an integral component of a comprehensive, coordinated plan for overall health system improvement.

Productivity

Some countries are using family medicine to improve patient satisfaction and to control rising costs in health service organizations. In such situations, while the privileged have ready access to high-quality care, the health needs of disadvantaged individuals and groups may be neglected. These nations face the challenge of developing universal access to high-quality, cost-effective health care in environments where market forces and individual freedom to choose one's personal physician are publicly recognised virtues. In these cases, decision makers need to consider whether educating the public and training and supporting sufficient numbers of family doctors will enhance the delivery of comprehensive, cost-effective, community-based health services and ultimately contribute to the improvement of population health.

Humanism

In countries with a tradition of social solidarity supported by government policies, primary health care is recognised and nurtured as a fundamental human right. Equal opportunities for personal development, respect for differences, social justice, and enhancement of the public interest underlie the foundations of these societies. Decisions to invest in family medicine may represent tangible contributions to a renaissance of humanistic values, improving the quality of life by building a more socially responsive health system.

Strategies for change

These scenarios are not an exhaustive taxonomy of situations that leaders of family medicine will encounter, nor does any scenario completely describe a specific country. The majority of nations share the features of several scenarios. Health system leaders are more likely to consider investments in family medicine, however, if recommendations are based on careful needs assessments that take into account their country's cultural and societal context, demographic circumstances, epidemiology, stage of development, and available resources.

There is an urgent need to link family medicine, and the implementation of high-quality primary care, with the global movement to achieve universal health care coverage. This approach provides the most efficacious means for guaranteeing first-contact quality health care to all people.

The confidence of health service leaders in making this link may be further enhanced by the following measures.

- **Present the evidence**: factual information and arguments emphasizing the benefits of family medicine are necessary to convince national leaders, and for use by these leaders to convince other concerned parties. When evidence is insufficient for a specific context, it may be necessary to develop pilot projects to gather additional information.
- **Show living examples**: successful family medicine programs, documentation of practical experiences, site visits, and case studies serve to build confidence in the feasibility and impact of family medicine development projects.
- **Develop international collaboration**: partnership arrangements among countries provide opportunities for mutually beneficial international exchanges of information and experts. These exchanges facilitate comparisons and adaptation of projects to fit local needs and enhance visibility, and may generate additional resources.

These strategies will clarify the contributions that family doctors can make to people's health. In so doing they will provide perspectives that help to reconcile health care dilemmas and create synergies throughout the full range of developmental scenarios.

Conclusions

The Universal Declaration of Human Rights states that, "Everyone has the right to a standard of living adequate for the health and well-being of oneself and one's family."[22] Family doctors have the potential to make vital contributions to this laudable goal through the provision of comprehensive primary health care services. The following chapters describe the rationale for considering family medicine as an essential component of health systems, evidence of its efficacy, and practical considerations for its implementation.

Further details about the current state of family medicine in each region of the world are available on the WONCA website (www.globalfamilydoctor.com).[21]

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