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Future of Family Medicine in Developing Countries

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Ten is an anniversary number and the Tenth World Conference marks the growth of Family Practice to a greater degree than the numerals would suggest. From Montreal in 1964 to Singapore in 1983 marks the universal spread of the concepts of Family Practice. We might well say that Family Practice has come of age. But if that is so, why do we tell it to ourselves so often? Why are our scientific contributions so meagre? Why are we not in the forefront of the plans to bring health for all by the Year 2000?

Two-thirds of the population of the world live in developing countries. By bringing the technology of modern medicine to them, we enable these people to determine their family size, to reduce maternal and infant mortality and to produce a generation which is stronger, fitter and better able to learn, work and function as citizens.

Do we as Family Physicians have anything to offer? If you look at the traditional hospital specialities you will find that the senior physicians, surgeons, obstetricians and other specialists in developing countries were trained in the eminent postgraduate centres of the developed countries but were able to adapt their skills to the problems of their own countries. There is, in other words, a common

body of knowledge and skills in these specialities that have a universal application. Does Family Practice have universal relevance?

I have had this argument before. A few years ago, one of our distinguished colleagues from the US wrote in the *Journal of Family Practice* to ask provocatively whether Family Physicians in the developed world had anything in common with those in the poorer countries. In my answer, which regrettably was not published, I pointed to the spectrum of health care, from urban sophistication to city slums and rural isolation that exists in all countries, to neglected minorities, the poor, the aged and the unemployed. Which nation is free of them? I will repeat it today, that there is much we have to learn from each other and to teach each other wherever we come from.

The emergence of Family Practice is not just a successful organisational effort. It is the success of an idea whose time has come. The ideal family doctor that the community has longed for became scientifically a reality by virtue of the technological advances of the past few decades that have placed effective drugs and new diagnostic equipment within his reach. This is the explanation for the resurgence of primary care that has brought the traditional specialities tumbling out of their institutions into the market place to offer their hospital skills on the basis of age groups, sex, single organs, single diseases or even single operations. Family Practice has evolved, alone and unique, to offer continuing and comprehensive care to the individual as a whole person and to the family as the functioning social unit.

These great advances were anticipated by the use of the term ‘primary physician’ in the Millis Report in the US to mean the principal physician who would have overall charge of a person’s medical care, reuniting the scattered fragments of modern medical care. Primary Care is not only what we Family Physicians do but Primary Care is what can best be done by Family Physicians.

The governments of all our countries put their names in September 1978 to the Declaration of Alma Ata which sets the target of ‘Health for All by the Year 2000’ and identifies Primary Health Care as the strategy whereby to achieve it.

The Declaration describes Primary Health Care as “the first level of contact of individuals, the family and the community with the national health system bringing

health care process - providing promotive, preventive, curative and rehabilitative services sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need.”

No doubt we phrase these things differently but these are objectives that are best addressed by family physicians. Behind these phrases is the great debate on the future direction of health investment in the developing countries of the world. Does Family Practice have some relevance in this debate?

Health expenditure in the developing countries has tended to remain in the groove of the colonial pattern. It consists of heavy investment in building hospitals and training of specialists for these hospitals; responding annually to population growth by mechanical increments in hospital investment. As a result the health budget haemorrhages into hospital building. The population crowds to the largest of these institutions, seeking care for the whole range of symptoms and disabilities; they are responding in the only way they know how. A great many capital cities in the developing world may not have a safe water supply and have appalling standards in primary care but nevertheless will have more than one CT scanner, cobalt bombs, coronary care units and so on, and there are urban elites who will purchase a CT scan for their common headaches. The urban areas of the developing world have elites whose standards of living are in excess even of Western standards. The hospitals are the rest and recuperation centres for the trivially ill amongst the rich whilst the hospital specialists are their primary care doctors. In urban private practice, every internist wants to be a cardiologist, obstetricians taken normal deliveries only, surgeons take out cysts and general practitioners thrive on episodic care of coughs and colds. Perhaps the rich countries can afford this but the rest of us cannot.

To this expensive irrationality, we need to apply the logic of family practice. Acceptance will not come easily. The spread of national colleges and academies into so many developing countries represents the triumph of the concepts of Family Practice in parts of private medicine. This has yet to happen in the centralised decision-making apparatus of governments and they are the principle employers of physicians. Entrenched lobbies of vested interests competing for limited funds command access to political decision makers and to the bureaucracy. It will need more than patient explanation and quiet reasoning to break through, even though the interests of the community as a whole will be served.

Family Practice will serve the interest of the community by its emphasis on continuing care, on prevention, on early diagnosis, on team work and on caring for the whole person and the family unit. This is a prescription of perfection for poor countries but acceptance of these objectives will serve to point us in the right direction.

We must see in the official commitment to Primary Health Care an opportunity for demonstrating the universal relevance of the concepts of Family Practice. We must demonstrate that the Primary Physician trained in Family Practice is the crux to success in Primary Health Care.

The entry of Family Physicians into Primary Health Care will benefit Public Health by creating an influential lobby for a secure water supply, safe disposal of sewerage, control of vectors and a safe environment as well as for anti-poverty programmes. Investment in Family Practice will enable the Primary Health Care programme to counter the awful effects of poverty.

These are realities of health in developing countries and the magnitude of the problem overwhelms the mind. The World Bank reports that the annual increase in income of developed countries exceeds the total incomes of the poor countries. But I believe this will be reversed in many developing countries; the countries in this region for a start.

What can we do? The World Health Organisation is the political centre for international health activities and WONCA is currently awaiting acceptance as a non-governmental affiliate. At the present the WHO gets its advice on primary care from everyone except family physicians. The American Public Health Association played a key role in preparing the Alma Ata Conference. The WHO also collaborates with the International College of Surgeons on a primary health project. We must change this and to change the WHO we must start in our own countries.

Family Physicians in every country must provide the expertise in planning the delivery of primary care. We must provide the research reports and publications that are the resource documents for planners and decision makers. The Colleges and Academies and the University Departments of Family Practice of developed countries, if they share this vision, can help developing countries but we must

push on regardless. Is it possible for Family Physicians the world over to share a vision of service to the world as a community?

If Health for All is not achieved by 2000, it will be because of a failure of the political will to achieve a more fair and just distribution of limited resources within each country. Nevertheless a start would have been made, and the expectation of ordinary people is no small thing. Let it not fail because Family Practice concerned itself not with those who needed us most, but with those who could afford to pay us best.

The target of 'Health for All' creates the occasion for an international pooling of faith and idealism, knowledge and resources, for a truly worthwhile purpose that will transform health care at the point where it touches the life of the great majority of the population of this plan that we share. Do you see a challenge here for Family Physicians?

The establishment of a universal target "Health for All by the Year 2000" provides an unparalleled opportunity for us to demonstrate the centrality of the concepts of Family Practice to the health and welfare of human beings every where. The closing years of the 20th century provide a testing of Family Practice, the chance of a century to provide ourselves.

*"There is a tide in the affairs of men,
Which, taken at the flood,
leads on to fortune:
Omitted, all the voyages of their life
Is found in shallows and in miseries.
On such a full sea are we now afloat,
And we must take the current
when it serves.
Or lose our venture."*

[Shakespeare, *Julius Caesar*: IV, iii, 217]

Let us take heed of the words of a great man who lived and died close to the venue of the next World Conference.