



REVIEW ARTICLE

Lack of Primary Health Care Services in Developing Countries during Pandemic: An Urgent Reminder!

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Abstract

As the world population is growing and health care resources are in high demand the pressure on medical services is becoming higher. Developing countries are already at a crisis point in health care provision, and time demands a new approach in structuring medical resources. Primary care is the vital pillar for fundamental health care at community level and has been deemed as a cost-effective modality. In the West the primary care physician manages chronic medical conditions in communities and therefore reduces unnecessary hospital admissions. In the West, the primary care system is extremely well organised. Low-income countries must improve teaching, training and funding in primary care. In this article the urgent need for primary care is discussed in developing countries, and ways to minimise costs and improve clinical outcomes at community level.

Keywords

Basic health, Rural health, Resources, Primary care, Low-income

Introduction

Primary health care is the backbone of a country's health system, being the first point of contact for patients and provides clinical management at a local, community level. Primary care is an essential part of health care provision at community level and as the need for health care is increasing it is essential that governments should provide basic health care needs to all its citizens. The WHO [1] and its member states sees universal health coverage as a priority as laid out in the Alma Ata three decades ago and yet primary healthcare remains

inadequate in the developing world, despite the proven benefits in terms of reduction in morbidity and mortality. Primary health care set up is already extremely well established in Western Europe, especially in the United Kingdom but unfortunately that's not the case in commonwealth countries. For instance, Pakistan is the 6th largest country in the world and according to the World Health Organization (WHO) has 0.5 primary care centres per 10,000 population with a life expectancy of 66.5 years.

Discussion

A primary health care doctor commands trust and respect from the population they serve, providing first contact care which saves valuable time and money by preventing the patient from going the local hospital for a condition which can be managed effectively and safely in the community. This model of care has been widely and effectively used in the United Kingdom, Ireland, Australia and New Zealand for decades. Now more countries are following the United Kingdom style of primary care model. For example, Qatar have a government led Primary Care Health Cooperation (PHCC) which has several health centres across the country. The Kingdom of Saudi Arabia is investing more in primary care and the United Arab Emirates have also realized that preventive medicine and primary care is the key to a healthy life and is also financially effective. The fundamental challenges to establishing effective primary care provision are predominantly having a suitably qualified workfor-



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ce; adequate financing; quality assurance; ensuring patient safety [2].

In Pakistan, the provision of quality health care has never been an area of priority for the planners or policy makers [3]. Alongside many other countries, preference has been given to 'vertical healthcare programmes', focusing on specific priorities which has resulted in fragmentation of care [4]. The concept of a Basic Health Unit (BHU) was established, and the idea was to provide essential care to its citizens at community level. There are approximately 5,301 BHUs in the country, each encompassing a catchment population of around 10,000-20,000 people to improve the standards of health services [5]. Unfortunately, due to the lack of political will, mismanagement of health care funding and almost no interest from the health care staff to work in the rural areas made these facilities less effective [6,7]. The lack of schooling, infrastructure, water, electricity in rural areas necessitates health care workers from cities to move to BHUs which are the backbone for the rural communities. Due to these reasons the gap in service provision has been filled by the mushrooming of the private health sector. Most of the health facilities are privately owned and charges vary depending on services but the cost of private treatment in the country is high and not within reach of most of its citizens [8]. The distribution of wealth is significantly unequal meaning only the top 10 percent of the population can access private healthcare, whilst almost a quarter of the population live below the poverty line [9]. The World Health Organization recommends allocating 6 percent of the GDP to the health sector. However, the total expenditure on health is about 2.4 percent of GDP, of which private expenditure constitutes 83.6 percent [10]. Public health expenditure was 0.9 percent of GDP in 2014-15 which is a clear reflection of poor political commitment towards healthcare. Moreover, the expenditure on healthcare provision in Pakistan is the lowest in South Asia [11]. The cost of outpatient visits has increased with a ratio of 2:5 over a decade while the budget has not proportionally increased [12]. Every patient who visits the outpatient clinic bears a cost for the government health facility and if the country's budget is minimal and not being utilized effectively then the standard of services decreases [13]. Because of the increase in health care demand and the chronic lack of resources the dissatisfaction amongst doctors is high especially at the middle grade level [14]. This invariably has an adverse effect on a doctor's performance.

A plethora of evidence was published [15-17] substantiating that a robust primary care system has the capacity to deliver more favourable outcomes for patients at a lower cost which in turn can contribute towards bridging the health inequality gaps between socio-economic groups, not to mention lower utilization of secondary care and emergency services. A study directly comparing the cost effectiveness of the primary healthcare

systems provided in the US, UK and 17 other Western countries, with the UK leading the way in terms of the NHS frontline staff achieving more in terms of clinical outcomes at a reduced cost [18]. The RCGP highlight that 90% of UK healthcare is provided in general practice with on average 30 million consultations taking place each year [19].

In relation to specific health needs, there has been a significant rise in polio [20], HIV [21], mental health conditions in general in Pakistan and neonatal mortality remains amongst the highest in the world [22]. The reasons previously discussed are the major contributory factors for it. It has been shown that effective transition of primary and secondary services requires horizontal integration within a multidisciplinary team, integration of private and public sectors, and ways to support successfully functioning PHC professionals in low- and middle-income countries [23]. The link between primary care and mental health provision is highly significant and it has been reported that this can be achieved in the community [24]. The residents of low-income countries lack access to primary care physicians; therefore, the provision of practice nurses would improve care [25]. In a State in India a project has been successfully implemented to improve primary health care services in order to provide effective and accessible care which will help very low-income families [26].

In a pandemic, a robust primary care structure is fundamental, especially in low-income countries. In India, the mortality with COVID-19 has been high and large studies highlight the value of a comprehensive primary healthcare setup which should also be implemented globally [27,28]. Within the UK, [29] has highlighted on behalf of the Kings Fund that during COVID-19 primary care has demonstrated its' versatility in adapting to the restrictions and adopting novel practices to meet the needs of their patient demographic, principally through the wide use of digital consultations. It was outlined in the NHS long-term plan that every patient had the right to digital primary care services by 2024 and the current crisis has not only accelerated this process but also proved its worth. What has also been seen is enhanced cohesive working within primary care networks through the use of social media and regular remote meetings, ensuring effective local workforce planning. A clear learning point from COVID-19 is to invest in primary care and its related modalities across the world [30].

Conclusion

With an increasing demand on health care facilities and a growing population it is now vital to invest and develop the primary care networks and basic health units in developing countries. Low-income countries must take a serious approach to improve the whole rural health care structure and if needed take advice from well established health systems. This was a stark reminder during recent pandemic that more clinical and admini-

strative investment should go into primary care. Post-graduate medical institutions should expand on primary care physician training. The use of media can't be under emphasised to create awareness and education.

Conflicts of Interest

None.

Funding

None.

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