

Letter to Editor: Differences in Public and Private Health Services in a Rural District of Malaysia

Sir,

Aljunid SM and Zwi AB's excellent study¹ of the services provided by the public and private sector in a rural district in Malaysia confirms long held impression about significant differences that exist between these two sectors of the health care delivery system. The findings of this study merit further discussion.

Supporting staff

The supporting staff in the private general practice clinics performed a wider range of function and was nearly always trained on the job. Trained nurses are scarce worldwide. Recruiting of 'untrained' nursing staff is common practice not only among the GP [General Practice] clinics but also in the mushrooming private medical centres. With the booming economy and competition from the service industries, the factories, the supermarkets and etc, it is difficult even to recruit SPM holders to work in the GP clinics. It is therefore daydreaming to aim for trained staff or assistant nurses for the GP clinics. In any case the nature of the job in the GP clinic is not all that complicated [the most difficult being dispensing] and one must not forget the counselling and dispensing advice already provided by the doctors to the patients before they collect their medicines from the supporting staff. We should not therefore be unduly alarmed about the existence of 'untrained' staff in the private sector. The important thing is that there should be an internal mechanism to institute periodic check on the competency of these clinic nurses. Sometime back the MMA or perhaps another body organised a training scheme for this category of staff. I believe it was not well received. A good alternative would be for bodies like the MMA or the Academy of Family Physicians of Malaysia to provide guidelines for in-house training of this category of staff as part of the guidelines for Practice Management.

Range of clinical services

This was generally broader and more flexible in the private clinics especially if the services provided by the midwife cum clinics were included in the public sector for comparison purpose. Furthermore the consultation hours were generally longer in the private services. This, however, in no way implies the superiority of the services provided in the private sector. Both types of health care delivery system have their strengths and weaknesses.

As expected, treatment of malaria was available only in the District Hospital. Malaria is relatively uncommon these days. Treatment may be complicated because of the existence of Falciparum malaria which may be multiple-drug resistant and or fatal. The important thing for the GP and other primary care doctors is early diagnosis and referral.

Management of TB was rather unsatisfactory in that they were all 'referred to the State General Hospital and National TB Centre' for initial in-patient treatment. Except for the small number of drug resistant cases and TB complicated by HIV infection, the majority of the TB cases can be treated in the primary care setting. The important thing is again early diagnosis, and also [in this case] the tracing of defaulters.

Sexually transmitted diseases are quite common. For many reasons, the GP clinics is the ideal setting for treatment of this condition as was revealed in this study. Let us hope that management extends beyond the dispensing of antibiotics. Counselling, treatment of sexual partners and notification should also be emphasised.

A worrisome finding was the absence of services for emergencies such as 'severe haemorrhage, shock and acute asthma' in 5 of the 15 private clinics. Before we pass any adverse judgement, we should define what are medical emergencies and what are the minimal facilities expected of the GP clinics. For example, I think it is reasonable to expect the GP to have a nebuliser for acute Bronchial Asthma, perhaps an IV drip set for Hypovolemia, and Adrenaline for Anaphylaxis. But it may be asking too

much to expect the rural GP to have Oxygen therapy set or even to group together to run an ambulance service. It is also unfair to imply the lack of monetary reward as the reason for the reluctance of GP to provide emergency care. A very important reason is the fear of adverse publicity resulting from deaths taking place in the clinics following treatment of medical emergencies.

As in the case of many urban GP clinics, antenatal care was provided usually for the first and second trimesters. Rather than advising that 'this service is better left to the public/government sector' I feel the GP's role can be improved by encouraging the use of special antenatal cards and by making Specialist Obstetrician service of the District Hospital more easily accessible to the rural GP. A few or may be some rural pregnant mothers may land in the hospital in early labour without any previous checkup. It is important to provide antenatal care to as many of them as possible by enlisting the help of the private sector even if this service is not as comprehensive as that provided by the public sector.

Regarding the GP's role in immunisation, the authors decry about the absence of Immunisation Cards in the GP clinics. This should not be a problem nowadays since babies delivered in the Government hospitals as well as in the private medical centres are already provided with cards where the weights and dates of immunisation can be recorded. The critical comment about the failure of 'cold chain' in vaccine storage in the private sector is important and is easily and must be rectified.

Regarding family planning, while conceding the more convenient and wider range of services available in the private sector, the authors are dismayed by their observation of the lack of a standard protocol [e.g. checking for medical contraindications and performing of Pap smear] and selling of OCP without medical consultation. In interpreting these observations, we should bear in mind:- how difficult it may be to persuade the rural folks to have Pap smears done, how often OCP are sold over the counter in the pharmacies, the prevalence of contraindications to OCP among our rural females of the reproductive age group, and the risk of unplanned and unwanted

pregnancies arising from our refusal to be more liberal in dispensing OCP. Having said this I would still support the idea of having a practice protocol regarding family planning.

Diagnostic services

Blood film examination for malaria parasites and sputum examination for AFB are not easy and are therefore best left to the government sector as was found in this study. Stool examination is also not feasible and as expected was not available in the GP clinics. It is more practical to deworm children on regular basis. Blood glucose and cholesterol estimation were commonly available in the GP clinics reflecting the rising trend of chronic diseases such as diabetes and hypercholesterolemia and the availability of simple, affordable, and reasonably accurate measuring instruments. An interesting omission in this study was finding on facilities for urinalysis and ECG. I believe they were available in most of the private clinics. The authors were rather unhappy about the easy availability of X-Ray and Ultrasonography in the GP clinics in the presence of inadequate training to use these machines. The X-rays performed were usually CXR and plain film of the long bones and the ultrasound scanning was used for gestational dating and placental location and perhaps diagnosis of gallstones and renal calculi. These procedures are actually quite simple and there is no necessity to make a big fuss about training requirements. This research was carried out using 'semi-structured interviews with the participating doctors, followed by observations using a checklist to assess the quality of vaccine storage'. Without outcome data on the use of these machines by the 'untrained' private doctors, it is not fair to make the claim that 'without proper control mechanisms, these machines were probably used to increase profits without necessarily providing any benefits to the patients.' The important thing for the GP is to realise that they should not do examinations beyond their competence, that chemicals and machines can deteriorate over time, and that, in case of doubt, they should refer. And if the expected patient load is low, instead of investing in an expensive X-ray machine or ultrasound scanner, it would be better to refer to one's colleagues nearby or to full time Medical Imaging centres which are increasingly available.

Short hours clinics

As expected, these practices, owned by doctors with more than one clinics, scored low in terms of accessibility, range and quality of services. It may be prudent for practitioners concerned to seriously consider switching to the practice of long hours clinics.

In conclusion, this study is an important contribution to the database of primary care services in this country. It highlights important differences and short comings in both the private and public sectors, indicating a need to 'draw the Ministry of Health, public sector workers and private providers into a dialogue' to provide input on how these services may be improved. I do not agree with the suggestion to 'regulate the private health sector' in a profession which is already over-regulated. This is a descriptive study of a defined area. We should not generalise or extrapolate beyond data. We should not advocate measures which may be unfair to our rural colleagues on the basis of such generalisation.

H W J Hee, General Practitioner,
9 Jalan Tun Ismail, 25000 Kuantan

Reference

- 1 Aljunid SM, Zwi AB. Differences in Public and Private Health Services in a Rural District of Malaysia. *Med J Malaysia* 1996;51 : 426-36.