EDITORIAL

Primary Care - Directions We Should Be Taking

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In 1978 at Alma Ata, Malaysia endorsed the World Health Organization's Declaration of Health for All through Primary Health Care. Since then Malaysia has made great strides in meeting its objectives. There is now an expanded scope of services with better facilities in the public community polyclinics. Primary Care departments have been established in the local universities, either independently or as part of community medicine. Medical students now have better exposure to primary care. Postgraduate specialist training (M.Med. in Family Medicine) is offered by three public universities[1].

Are these achievements adequate to meet the nation's goals and its population needs? The provision of quality healthcare is now a national priority with the "Vision of Health"[2]. High quality primary health care depends, among others, also on the availability of well trained primary care physicians[3].

There are now 123 Family Medicine Specialists with 72 more undergoing training[4]. However, using the norm of 1:50,000 population, 555 Family Medicine Specialists are required in the next 4 years[5]. Each university has a capacity to produce 20 candidates per year[4]. In the private sector, about 200 doctors have passed the conjoint examinations conducted by the Academy of Family Physicians of Malaysia (AFPM) and the Royal Australian College of General Practitioners. The fact that this number have passed in spite of the lack of local recognition suggests a desire for further training and a need for a flexible on the job vocational training. The lack of flexibility is one reason for doctors not joining or dropping out of the M.Med. Family Medicine programme.

About half of the 15,000 Malaysian doctors are in the private sector, the majority in primary care[6]. This means that most primary care doctors from both sectors have only a basic medical degree without postgraduate vocational training. With the increasing expectations of our patients, advances in medical knowledge and technology, changing patterns of diseases and the emphasis on evidence based practice and quality healthcare, there is a need to adequately equip doctors to cope with the wide spectrum of problems they are expected to handle in primary care. Current CME activities lack comprehensiveness with few courses covering communication skills, critical appraisal, quality assurance, professional behaviour and practice management. CME talks sponsored by pharmaceutical companies do not meet the needs. A survey on the types of CME, primary care doctors undergo, and the role of pharmaceutical companies would be informative and useful for future planning.

Systematic compulsory vocational training for all primary care doctors, similar to that offered in other countries, is needed for quality healthcare. Private medical colleges and universities together with AFPM can help in training, for example by conducting in-service or part time distance learning courses or a postgraduate certificate or diploma in primary care. However, funding issues have to be resolved.

Singapore has introduced a structured multi-tier training programme from postgraduate diploma to Masters and Fellowship[7]. In Australia, all those who are trained and awarded FRACGP are recognized and given monetary incentives. The lack of recognition of various postgraduate qualifications such as FRACGP and the relative rigidity of M.Med. Family Medicine are holding back the development of the specialty.

Besides training, quality assurance and research activities are important. All doctors need to assess their own performance regularly to see if they meet set standards. However, many primary care doctors in

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Malaysia do not know how to do a medical audit[8]. Audits are now routine in UK general practice and are part of their undergraduate medical training[8,9]. Although there are quality indicators for public primary care, these have yet to be recognised fully in the private sector.

Two primary care articles in this issue found less than optimal management of diabetes mellitus. Mafauzy found that the majority of the diabetic patients in private primary care were not satisfactorily controlled and associated with a high prevalence of complications [10]. Wong found that 48% of the diabetic patients in a public primary care clinic had proteinuria and advocated screening and treatment of proteinuria in diabetics in primary care setting to retard the progress of nephropathy [11]. Wong noted that optimal blood pressure was not achieved in the majority of diabetics with concomitant hypertension. Previous studies also found less than optimal diabetic management in primary care[12,13].

Quality Assurance programmes in primary care are urgently required with provision for training and incentives, for example, a "Quality" certificate for the clinic and benefits in the forthcoming National Health Financing Scheme (NHFS) for those who comply.

This journal issue has four primary care articles indicating the emergence of primary care research in Malaysia [10,11,14,15]. Historically, primary care doctors were leaders in research, for example, Jenner who discovered the etiology of smallpox and Finlay who observed that yellow fever were transmitted by mosquitoes[16]. However, when clinical science research came to the forefront in the 20th century, primary care lost ground.

With the development of primary care as an academic discipline and the establishment of primary care research networks in a number of countries including Malaysia, there is now an increase in primary care research. Primary care research networks facilitate the sharing of ideas, expertise and collaboration amongst primary care doctors and academic primary care[17,18].

Research in primary care contributes to the understanding of the origin and natural history of disease and identify factors that enable health, as well as determinants of seeking and receiving health. The aim is to provide evidence to support the provision of primary care services and to improve the quality and effectiveness (including cost effectiveness) of care[19].

In the remaining 2 articles, Khairani et al found adolescents attending a public primary care clinic failed to consult health professionals about important health problems [14]. Chan and Teng found primary care doctors in Melaka had a positive attitude towards Evidence-Based Medicine (EBM) but few had ever conducted a Medline Internet search [15]. Main barriers for practising EBM were a lack of personal time and Internet access in primary care clinics.

The above barriers are the same for conduct research in primary care. In addition, primary care doctors need training in research methodology and in conducting a proper Medline Internet search. Primary Care research has become a priority for support in countries like UK[19]. Locally, funding remains a problem.

It is also timely that primary care physicians develop expertise in special interests areas to enable them to take the lead in teaching, research and development of management guidelines in primary care.

The unregulated private primary care has been neglected and beset with important problems, beyond the scope of this editorial, for example: private hospitals offering primary care services, laboratories promoting and ordering health screening tests and dispensing rights by primary care doctors versus pharmacists. In addition, primary care doctors await the forthcoming NHFS and the implementation of the Private Healthcare Facilities and Services Act 1998, uncertain of the impact and changes on their primary care practices.

A government backed regulating body, totally committed to high quality primary healthcare for all, is needed to address the above issues and oversee changes, such as legislation for compulsory vocational training, CME and practice audits. Funding for training, research and quality assurance activities needs to be addressed. The division between public and private primary care has to be removed and replaced by a seamless system to help achieve Health for All through quality primary healthcare.

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