

The Roles of Primary Physician in Achieving the MDGs

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Introduction^{1–3}

Attaining good health is one of the basic fundamental rights of every human being (WHO, 1948) and is also considered as human investment for national development program (Sachs, 2001). Health is defined as a state of complete physical, mental and social well-being; not merely the absent of disease and infirmity (WHO, 1948).

There are many factors that influence a good health. According to Blum (1974) these factors can be differentiated into 4 main health determinants (**Fig. 1**), namely:

1. Human behavior: daily habits and/or life style of the people that are related to health
2. Environment: the physical and non-physical surrounding conditions that interact and influence the health of the people
3. Health services: particularly referred to the accessibility, affordability and quality of healthcare services that are available in the community
4. Heredity: the quantity and quality of genes that are owned by an individual

To attain a good health, the above-mentioned health determinants should be directed to have a positive impact on health. This can be achieved through the provision of systematic, planned and continuous health efforts throughout nation-wide. It is also know as the national health development program (**Fig. 2**).

Each country has its own national health development program, which objectives and targets may varies. However in 2001, the UN member states adopted the common objectives

and targets of the health development program in order to assist the impoverished nations. It is hoped that with the common objectives, those countries can be more aggressive in enacting the programs. These common objectives are internationally known as Millennium Development Goals (MDGs).

What are the MDGs and what are the roles of the Primary Physician in achieving the MDGs?

Millennium Development Goals^{4–6}

The Millennium Development Goals (MDGs) is a UN framework for achieving a better quality of life for human being. It is done by improving the social and economic conditions of the community. MDGs have eight goals and 21 targets with series of measurable indicators for each target. Each UN member country has made a commitment to achieve these goals by the year 2015.

MDGs were developed from the eight chapters that are found in the UN Millennium Declaration. The declaration was signed in September 2000 and the adoptions began in the following year with 192 UN member states and 23 international organizations came on-board.

MDGs were basically synthesized into a single package from some of the most important international commitments to improve the quality of life of human being. These have previously been agreed and adopted separately through many international conferences and summits. These agreed and adopted international commitments are:

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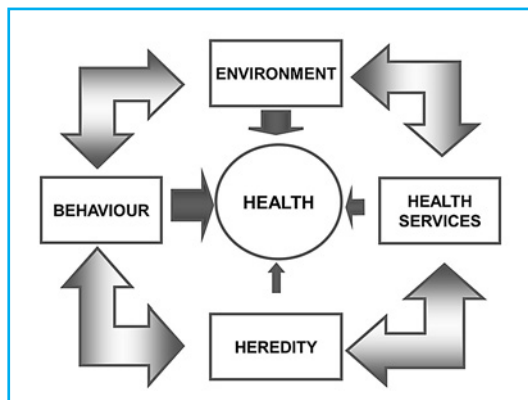


Fig. 1 Four main health determinants

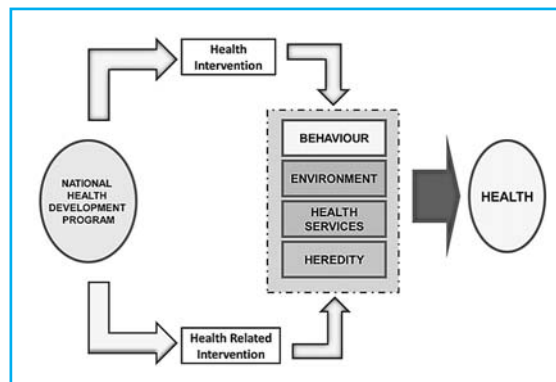


Fig. 2 National Health Development Program

1. Eradicate extreme poverty and hunger (goal 1)
2. Achieve universal primary education (goal 2)
3. Promote gender equality and empower women (goal 3)
4. Reduce child mortality (goal 4)
5. Improve maternal health (goal 5)
6. Combat HIV/AIDS, malaria and other diseases (goal 6)
7. Ensure environmental sustainability (goal 7)
8. Develop a Global Partnership for Development (goal 8)

From the 8 goals of MDGs, 3 of them are directly related as an objective of enhancing the health status of the community. These 3 goals are (1) reduction of infant mortality, (2) improvement of maternal health and (3) to combat HIV/AIDS, malaria, and other diseases. Meanwhile, there are goals that are very closely connected as prerequisites in achieving the objectives of the healthcare service, which are (1) eradication of extreme poverty and hunger, (2) achievement of universal primary education, and (3) promotion of gender equity and empowerment of women. Furthermore, the remaining 2 goals are strongly related as necessary conditions to guarantee the continuous and sustainable implementations of any health policy. Those two remaining goals are (1) environmental sustainability, and (2) global partnership for development.

Unfortunately, progress towards the goals, particularly those that are directly related to enhance the health status of the community have been uneven. There are countries that have achieved these goals, while some others are no way near to realize any of the goals. In Asia-Pacific region, we can see the progress by categorizing them into sub regions:

rizing them into sub regions:

1. **Sub region South and South-West Asia.** This is the poorest performing sub region. Six out of the 10 countries are off-tracks for more than one-third of the indicators. The slow progress is largely because 4 countries in this region can be categorized under the least developed countries. Moreover, 3 countries in this sub region are landlocked, and 1 country is a small island that is still in developing state.
2. **Sub region North and Central Asia.** This region has a high proportion of landlocked developing countries, such as Tajikistan, Uzbekistan, Kazakhstan and Armenia. Number of people who are suffering from malnutritions are increasing, Education standards have also slipped and the virtual collapse of the social sector in some countries resulted in a general deterioration of health indicators.
3. **Sub region Pacific.** The majority of these countries are small island developing states. Less than half of these countries have data for the majority of indicators. None of them offer any information on poverty or hunger, and only few countries have data on education or gender. Papua New Guinea is the few countries that has more information than the rest. Unfortunately, the data indicate that on most indicators Papua New Guinea is off-track. In general, many Pacific countries have problems with water supplies and sanitations.
4. **Sub region South-East Asia.** This sub region has some of the more prosperous countries in the region. As such, it is no surprise that the success in the MDGs largely happens in this sub region. Singapore is recognized as the

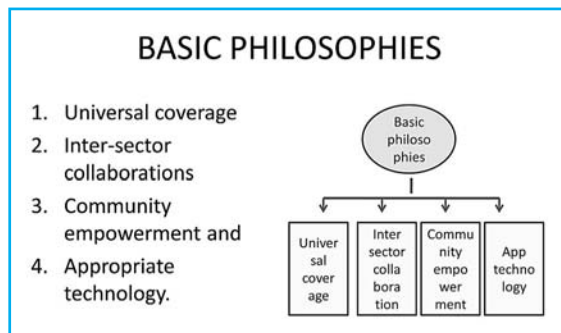


Fig. 3 Basic philosophies of primary healthcare

most successful country in MGDs implementations. Conversely, Timor-Leste, as a newly-established country in the region is the least successful country. Timor-Leste and Myanmar have high infant mortality rates, while Lao People's Democratic Republic, Indonesia, the Philippines and Vietnam still have the unacceptably high rates of maternal mortality. Furthermore, this sub region also has severe environmental problems: forest coverage is disappearing and carbon dioxide emissions per head are rising rapidly.

5. **Sub region East and North-East Asia.** China is already on-track or has already achieved three-quarters of the indicators. Mongolia, however, has struggled with most of the MDGs. As for the Democratic People's Republic of Korea, it is difficult to assess their progress since data are missing on almost half of the indicators.

The deadline to achieve the objectives in MDGs is approaching, yet the trends in healthcare do not look very promising. Many experts doubt that the health-related portion in MDGs can be achieved, unless the values, principles, and approaches of Primary Health Care are implemented. Decades of experience show that Primary Health Care is still the best route to universal access, the best way to ensure sustainable improvements in health outcomes, and the best guarantee that access to care will be fair. To help meet the current challenges, a renewed commitment in Primary Health Care internationally and nationally is crucial.

Primary Health Care⁷⁻⁹

Primary Health Care (PHC) is defined as the first level of contact of individuals, family and com-

munity with the national health system, bringing healthcare as close as possible to where the people live and work. This also constitutes the first element of a continuing health care process. PHC is also defined as the essential care based on practical, scientifically sound and socially acceptable methods and technologies that are made universally accessible to individuals and families. Typically, this is implemented in the community through their full participations at a cost that community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. The concept of PHC was successfully formulated at the International Conference on PHC, organized by WHO and UNICEF in Alma-Ata, the capital city of the Kazakh Soviet Socialist Republic, from 6 September–12 September 1978. This concept is then recognized as the key to solve the many health problems.

PHC forms an integral part for both the country's health system, of which it is the central function and main focus; and the overall social and economic development of the community. The successful implementation of PHC depends on, among other things, a strong commitment from the government, active participations from the community, and the involvement and good cooperation of all stakeholders.

The basic philosophies of PHC can be grouped into 4 main principles (**Fig. 3**): (1) universal coverage, (2) inter-sectoral collaborations, (3) community empowerment and (4) appropriate technology. These four basic principles of PHC are implemented through the provisions of eight basic health services, which are:

1. Education concerning the prevailing health problems and the methods of preventing and controlling them
2. Promotion of food supplies and proper nutrition
3. An adequate supply of safe water and basic sanitation
4. Maternal and child healthcare, including family planning
5. Immunization against the major infectious diseases
6. Prevention and control of locally endemic diseases
7. Appropriate treatment of common diseases and injuries
8. Provision of essential drugs

Along with these basic principles, the implementation of each PHC activity is followed several characteristics, which include:

1. Address the main health problems in the community
2. Provide comprehensive healthcare with good referral system
3. Rely on health workers that include the professionals, community workers and traditional practitioners
4. Involve all related sectors and aspects of national and community development
5. Require and promote maximum self reliance and participation from the both community and individual
6. Use local, national and other available resources

The implementations of the eight basic health services depend on specific health problems encountered and the ability to solve the health problems. Consequently, they will be different from country to country. Fortunately, PHC always covers them both; the medical as well as the public health services. In most developing countries, the lack of resources enforce the provision of medical services to be conducted integratedly with public health services. This is done through the establishment the Community Health Center at the community level.

In contrast, some developed countries separate the provision of medical services from the public health services. In those countries, the provision of medical services is hundred percent under the responsibility of the health infrastructures, whereas the provision of public health services can be delegated to many other sectors including public work (environmental and house sanitation), educational institution (health promotion), and private enterprises (foods and nutrition).

Nevertheless, although the ways to organize and implement PHC in the developed countries may be different from the developing countries, they all still badly need the availability of quality and dedicated primary health workforces. These primary health workers include: the primary physicians to guarantee the successful implementation of PHC.

Primary Physician¹⁰⁻¹⁴

Primary physician is a physician who is respon-

sible to provide primary (health) care at the front line level directly to the community. Primary physician is also known as the general practitioner, family physician or the public health doctor. In the developed countries, the practice of primary physician can be seen as the practice of general practitioner or family physicians. On the other hand, the practice of primary physician in the developing countries is usually conducted by the public health doctors who are working at the Community Health Center established at the village level.

The practices of primary physician have several characteristics, which are:

1. Committed to the person rather than to a particular body of knowledge, group of diseases or special techniques
2. Seeks to understand the context of the illness
3. Attaches the importance to the subjective aspects of medicine
4. Sees every contact with the patient as an opportunity to prevention or health education
5. Views the practice as a population at risk
6. Sees him/herself as part of community-wide network of supportive and health care agencies
7. Share the same habitat as his/her patients
8. Sees patients in the office, in their homes, and in the hospital
9. Function as a manager of resources

Many evidences have shown that the practices of primary physician have several advantages, which include the effectiveness and the efficiency of the healthcare services. Since a primary physician is more committed to a person, understand the context of the illness, and considered the subjective aspect of medicine; the provision of healthcare services will be more effective. Furthermore, since the primary physician prioritizes the prevention measurements, view his practice as a population at risk, and functions as a resources manager of his clients; the provision of health care services will be more efficient.

Roles of Primary Physician

The primary physician is a physician who is working closely with the community. Therefore, if the placement of primary physicians can be done equally in the community, they can be very meaningful to increase the *accessibility* of the healthcare services. Based on the experiences from many countries, one of the serious problems

encountered by MDGs is low coverage of health-care services. This can be solved through the placements of various types of primary health workforce, which include the primary physicians equally-spread in the community.

Concerns toward achieving MDGs is also due to the poor *quality* of the available healthcare services in the community. This resulted to the healthcare services that are unable to encounter the main causes and risk factors of the health problems, particularly diseases that are found in the community. There are many factors influencing the poor quality of healthcare services, which include the low knowledge and skills of the health personnels who are working in the community.

Placing the primary physicians at the front line level can solve the poor quality of healthcare services. The better educated primary physicians will have better knowledge and skills in compare

to other health professionals. Furthermore, this will have a positive impact to the quality of health services on top of the specific and favorable characteristics owned by the primary health care services, such as (1) the comprehensiveness, integrated and continuity of the health care services, (2) the adequate response to the health needs and demands of the community, and (3) the clients based services.

Primary physician also has a significant role to provide *affordable* healthcare services. This factor alone is one of the many important causes that contribute to the unsuccessful implementation of MDGs. In the practice of healthcare services, the primary physician will act as a gate keeper, apply the appropriate technologies, and endorse the promotion and prevention services. All of them will result to the affordable health care services.

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