

EDITORIAL

Clinical Medicine or Community Health Care?

"There is much evidence that . . . expenditure would have been better directed towards more public health services designed to prevent rather than to cure disease. Regarding the provision of personal services it seems that these would be more efficiently provided by more diffuse community services than by hospitals. For example, the capital costs of a single teaching hospital in Africa may exceed the entire annual recurrent health budget of the country in which it is situated. In principle such hospitals should function not only as a teaching base but as the peak of a medical care referral system. They do not do so in many parts of Africa."

Office of Health Economics. Medical Care in Developing Countries, London, 1972 p. 25.

Following the Alma Ata Conference on Primary Health Care¹ the pendulum has swung away from concern for centres of excellence in the practise of clinical medicine and towards the most effective deployment of resources for the whole community – including its poorest and most rural members. For instance, it is now policy for both the Commonwealth Secretariat of the UK and the Swedish International Development Agency to support projects which relate to rural health care and, in the latter case specifically, not to provide better hospital services in urban population centres.

A thoughtful paper² presented at the Bellagio Study and Conference Centre in April 1979 criticises comprehensive health care programmes, as were proposed at the Alma Ata Conference, on the basis of their unrealistic costing: even basic health care programmes will not reach the World's poor by 2000.

So in order to identify the most cost-effective strategies the commonest infectious diseases of the tropics are considered individually and compared. No consideration is given to non-infective disease. The reason for this neglect can be traced to the writer's preoccupation with prevalences. But a disease for which effective and cheap control is available should not be ignored just because it affects relatively few people.

And although at the end of the article more research is strongly advocated we read "once diseases are selected for prevention and treatment (on the basis of prevalence, loss of life years and effective-

ness and cheapness of control), the next step is to devise intervention programs of reasonable cost and predictability". However, the selection should not be the initial step, once and for all, but should – like the fact-finding, i.e. research, upon which it properly depends – be on-going.

The case for centres of excellence providing medical education comparable to that in places such as UK has been argued³ recently by Professor G.C. Cook late of University of Zambia, Medical School . . . and partially refuted by a leading article⁴ in a later issue of the journal in which it was published.

Nevertheless there is no sense in developing primary care without that backup which existing hospitals can provide. Secondary and tertiary care refer to services provided when referral is made . . . from a generalist to a specialist (e.g. general practitioner to general physician or surgeon) and, for Tertiary Care, from specialist to specialist (general physician or surgeon to, say, cardiac physician or surgeon).

The generalist need not be medically qualified but should be specially trained. Essentially referral constitutes a screening process maintained by appropriate consultation: and implies that the primary stage can – and should – be extended to include the whole community. Community Diagnosis, a phrase used⁵ by Professor Maurice King also late of University of Zambia, presupposes we secure adequate data on prevalence and incidence from suitably-chosen sample areas. This is where the new plan⁶ for country-wide health care in Zambia could integrate the expertise of epidemiologists on the one hand and of clinicians on the other.

Else the danger is that this country will see resources devoted to public health measures which require, but lack, continuous professional medical input whilst clinicians are left frustrated and depleted of essential support.

By tradition doctors are encouraged to develop their own special field of interest be it a specific disease, specific hazard, specific mode of treatment. The time has now come when we can give our specific interests the widest possible application. The plans for health care in Zambia offer us such an opportunity.

One way in which the opportunity could be seized, as proposed in a discussion document⁷ circulated at the University of Zambia, School of Medicine, is to make each projected contribution to health care into a distinct minutely planned program to be offered to the communities up and down the land. The benefit to those communities accepting one project (termed an "operation") is to be measured by comparison against those communities choosing other projects, measured that is on a rigorous controlled-study basis.

The proponents have claimed that building research into the scheme from the outset would stimulate participation in the field and help attract participation in funds and in expertise from outside. Whether the suggestion is a useful one is too early to assess but some such concept is needed which can bring clinical medicine back into the forefront of humanitarian advance.

Someone, has said "patriotism is not enough". Similarly clinical concern is not enough. We rightly identify with the best interest of our individual patients. But to push this at the expense of potential patients of the same type in the country at large, or even world at large, is surely less than the highest ideal.

Such a new area of endeavour will deserve a new title . . . expressing what is wanted to put the pendulum into a point of equilibrium between two

earlier extremes. It might perhaps be "Community Medical Care".

REFERENCES

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2. *Cook G.C. Training of doctors and delivery of health care in developing countries Lancet 1979, 2: 297-9.*
3. *Leading article. Medical education: enemy of the good? Lancet 1979 2: 1000-1.*
4. *Walsh J.A., Warren K.S. Selective primary health care. An interim strategy for disease control in developing countries New Eng J Med 1979, 301: 967-74.*
5. *King M.R. Medical care for Developing Countries, Oxford University Press, 1966.*
6. *The Planning Unit. Health by the people Proposals for achieving health for all in Zambia. Lusaka: Government of the Republic of Zambia Ministry of Health, 1980.*
7. *Annex Content of Health Care to ref. 6 and available on request from the Dean's Office, University of Zambia School of Medicine, P.O. Box 50110, Lusaka.*