Primary health care and the role of the University

Primary health care (PHC) is currently the most important health reform underway in the world today. In most countries, governments and services have taken the lead in PHC development as a result of the declaration of Alma Ata.[1]

Since the 1990s, a large amount of evidence has demonstrated the impact of a strong primary health care system on the health of the communities.[2, 3] Improved health status of a community is directly related to a better or more balanced ratio of primary care professionals to specialists and to increased individual access to primary care within a region. As co-morbidities increase as a population ages, access to comprehensive and coordinated primary care becomes an increasingly cost-effective approach. Accessibility to primary care reduces the adverse effects on health of social inequalities.

So why have universities and health sciences centres been so slow to participate up until very recently? The document entitled, *Towards Unity for Health,* offers some suggestions:[4]

1. Universities, particularly, faculties of medicine under the influence of the Flexner report (1910) have maintained an orientation that favors "specialism".
2. Faculty incentives and promotions are usually linked to biomedical research.
3. Faculty members are generally more interested in specialty graduate trainees who can support their inpatient service needs.
4. The growth of primary care faculty members is often perceived as a threat to the resources of established, specialty power bases in the university health centres.
5. The power base of primary care is to be found in the communities, while in university health centres, primary care is often at the margins of power.

Universities must play a very important role in the reform. Universities have to be socially responsible and help improve the well-being of their communities through education and research.

Where and how can universities play a role?

Universities have a role to play in building competencies for delivering programs based on unique training needs of a primary care workforce of tomorrow, which include areas of community health team leadership, community health skills, population health skills, health promotion and disease prevention rather than the traditional competencies of academic faculty. Three stages in developing the university's role are outlined below.

Continuing in-service education. Experience with in-service training in Brazil is similar to the Canadian experience, where family medicine practices had a key role in the continuing education of their colleagues before they were in a position to have sufficient human and financial resources to develop a university department. The in-service education reinforces the knowledge of the generalist, allows for the "recycling" of specialists into generalist roles, and later identifies future role models and sites for residency.

These in-service training programs, over time, identify potential instructors and as the market for PHC is defined, they can aspire to becoming autonomous departments at universities with grounded interdisciplinary programs, based on practice realities. However, a pre-condition to this training is the need to have enough placements for PHC students to apply these new skills so this type of training will be treated seriously. If there is no real market within the system or support for such training, it will only survive as long as energy permits.

The teams of PHC workers, implemented in Brazil, are trained by universities and health systems through financial support provided by the government. Financial support is provided to universities and health services to

facilitate the initial in-service team training. The strategy outlined above, allows for the development of a grounded curriculum based on the professional experiences in the field. This curriculum is then reality-based and responds better to the learner's needs and community needs. Canada has moved to offering residency in Family Medicine as the only route for a physician to practice primary care. This is due to an extensive review by the Canadian Medical Association, where preference was given to grounding the curriculum in community needs and emphasizing the ambulatory nature of Family Medicine.

Graduate and undergraduate multidisciplinary programs. In Canada, the support for the development of a university department of Family Medicine came after the introduction of a universal national health care system. In countries in Latin America, universities have been engaged in training specialists and there are few formal primary care training programs. There is a great need to provide training to practitioners in the health system in primary care. This is a crucial step, because for reform to be realized, a critical mass of trained people already working in the field is needed. A substantial portion of the training experience of learners must take place under the mentorship of primary care role models.

The importance of multidisciplinary teams has been emphasized in many recommendations and is considered an important part of both the policies and actions implemented in health system reform (Alma Ata, 1978; Jakarta, 1996). *Team* is the word most frequently used to discuss collaboration.[5, 6] *Multidisciplinarity* refers to the participation of different disciplines and *interdisciplinary* describes the working process of primary health care teams.[7]

The curriculum for undergraduate students and the number of training positions for postgraduates must reflect a balanced, primary care to specialist ratio, of its graduates consistent with local, regional or national needs.

Research. Research is essential to the development of evidence-based primary health care. Using the knowledge and skills in research at the university level will help build capacity for future academic departments of primary health care as well as ensure a better quality of services offered to the population by building a research agenda in community health outcomes (by geography and by health need in addressing socioeconomic disparities). Research will:

- Promote the status and image of primary care as a valued specialty
- Advocate for universal health care based on evidence
- Enhance primary care as a vital component of the institution's scholarly effort

In summary, the University in partnership with local health services, policymakers professional association and communities are pillars of health reform. University can play a central role for the sustainability and legitimacy of Primary HealthCare as an area of scholarship through training and research and the development primary care department. Actions that have been proposed by Boelen's article, *Towards Unity for Health*, to promote a primary care orientation at university health centres include:[4]

- Increasing the number and visibility of role models in primary care identified during in-service capacity building activities.
- Overcoming the entrenched, urban-oriented, specialty-focused institutional leadership.
- Increasing the support for primary care research and for an evidence-based documentation of the value of primary care to community health.
- Increasing the base of support for innovations in primary care education and service.
- Integration between clinical care and public health or individuals and communities.
- Reducing fragmentation of primary care forces within the institution, separated by different departments (e.g. internal medicine, family medicine, pediatrics), different colleges (e.g. nursing, dentistry medicine, pharmacy), fields (e.g. medicine, public health), or government bureaucracy (e.g. ministries of health, ministries of education).
- Facilitating access by less privileged and rural-based students, including indigenous students, to the university.

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