Introduction of Family Practice Approach in Pakistan

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WHO Eastern Mediterranean Regional Committee in its 63rd session endorsed a resolution during which they urged member states to incorporate the family practice approach into Primary Health Care (PHC) services as a strategy for achieving the universal health coverage. It was agreed that the member countries will strengthen the capacity of their academic family medicine departments and aim to reach the target of three family physicians per 10,000 populations by 2030. They will adopt the WHO framework for quality improvements at the PHC facilities and will also implement essential health coverage.[1] Pakistan being a member state is also committed and has incorporated family practice approach to their National Health Vision 2016-2025 strategy and provincial health policies.

Around the world Family medicine is considered as the backbone of the health care system. The approach of a Family physician is holistic and patients' centred. This ensures ongoing continuity of care in a cost-effective way, which is essential for the success and sustainability of any healthcare system.[2,3] Family practice approach helps to improve the health indicators and provides care which is accessible and affordable to the entire community. [2-5]

Experience of integration of family medicine practice into health system in various low and middle income countries have shown a remarkable improvement in equity of health services and access to quality health care services delivered through family practitioners.[3] Egypt is amongst one of the few countries of Eastern Mediterranean region that has adopted family medicine approach for strengthening its primary health care. As part of its health reforms, approximately half of the primary health care units (2078 in units) have been upgraded to family health units and rigorous family medicine training has been provided to health care workers working at the PHC units[4-6].

Iran is another Eastern Mediterranean country that has shown significant improvement in its health indicators through implementation and strengthening of its primary health care (Behvraz program). Family practice has successfully been integrated into the PHC which was achieved in a phased manner. The family practice model was first initiated in the rural settings and in urban areas with population below 20,000. This was followed by expanding family medicine practice to larger suburban and urban communities. The training program for family practice in Iran was extensive and spanned over 6 years.[6] In 2015 an MPH program in family practice was initiated with distant learning. The length of time for this course has further been reduced for 12 months for general practitioners working at PHC units. Besides this the family physicians also have a continuing medical education programme in Iran.[6] Sudan, and Lebanon offers a 06-month diploma in family medicine in collaboration with WHO.[1]

In Pakistan, Family medicine is not an established speciality, and the concept of a trained generalist is missing. The general practitioners called medical officers (MOs) are mostly non-specialists with limited or no training in primary care. Primarily, the curricula of medical schools are hospital rather than community-based, therefore, the graduates have very little exposure and skills to work in PHC facilities. The non-availability of trained family physicians is a major barrier in achieving the targets of Universal Health Coverage (UHC) in developing countries including Pakistan.[7]

Amongst the 11530 PHC facilities in the country, only few are run by certified Family Physicians[8] and the rest either by doctors with no formal training in family medicine or medical technicians. There is no defined catchment population per PHC facility and neither family registration or recording of the medical history in family folders. Availability of Essential Health Service Packages is patchy and varies between health care facilities depending on its location, which creates inequity in access to the services. The current health system and policies in Pakistan focus more on curative services and hence emphasises is on

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secondary and tertiary care.[9] The disease burden is very high, and people have minimal trust in primary health care facilities and therefore a big hindrance in the utilization at PHC level.

Patients present with multiple complex comorbidities, so a non–family physician specialist approach is not appropriate.[2,3] There is a dire need for an organized training for the primary care doctors in family medicine. The purpose should be to improve the medical care of the community through improving and updating the knowledge and skills of the primary care workforce. There are currently around 186980 registered MBBS doctors10 amongst which half may be doing general practice but without any formal training a progress is seen in the development of family medicine as a speciality. The reasons for this underdevelopment are poor or no postgraduate training programs in family medicine, inadequate and non-existent job opportunities, low monetary incentives leading to an out flux of new graduates towards secondary or tertiary care.[11] The lack of exposure to family medicine in undergraduate years has made it a speciality of low ranking amongst medical students in Pakistan.[7] This has led to a disparity between healthcare providers and a poor understanding of the importance of family medicine amongst the health professionals.[12]

The faculty of public health, Khyber Medical University in collaboration with Ministry of Health and WHO has started a move in 2017 to work for the introduction and implementation of family practice approach in Pakistan. It was decided to adopt a multi-directional response/ approach. Therefore, 12 districts from all over Pakistan were selected to pilot the family practice approach, including Swabi, Haripur, Bannu and Khyber agency from KP province. At the same time the KMU and Aga khan University were asked to prepare the essential documents for family practice approach including, family folders, assessment of health facilities, public private partnership, essential health services packages, catchment population and referral system. It was felt that fellowship and membership cannot fill the gap of more than 66000 required family physicians and therefore, one-year on job diploma should be developed.

To cater for the need of family medicine work force, KMU took the lead and established a family medicine department within the faculty of public health and employed trained GPs from UK and Gulf. One-year diploma training programme was started in collaboration with the WHO collaborative centre of the American university of Beirut which runs a 6 moths and only online course. We at KMU developed a one-year blended program of six contact sessions, 7-9 days each and clinical rotations in close collaboration with WHO and Department of Health, Khyber Pakhtunkhwa. The first batch of 42 rained family physicians will be graduated in September, 2019. We have received a tremendous response and the untrained general physicians/MOs are successfully trained to specialized general practitioners. It is the need of the day that other medical universities should come up and start similar diploma program in their catchment areas.

To attract more trainees, family medicine needs to be introduced and developed at both undergraduate and postgraduate levels.[11,12] The main challenge is the shortage of trained and certified Family Medicine faculty in the country. Concrete steps will be required to expedite the initiation of Family Medicine postgraduate training programs to overcome this shortage. At the undergraduate level, PMDC should incorporate family medicine as part of the curriculum and develop family medicine departments in the medical colleges. This will expose students to family medicine in their early undergraduate years and encourage them to choose family medicine as a career. The graduating doctors will be more likely to select Family Medicine as their speciality of choice for postgraduate training.

The PMDC needs to implement some guidelines and should make compulsory family medicine training for those who are planning to start general practice. This also needs support and recognition by other specialities and instead of considering as a threat they should be considered a support for reducing the workload on already overburden secondary and tertiary care. A public-private partnership, linkages with insurance programs, defining catchment population and introduction of referral system should be considered for implementing family practice approach. Lack of awareness amongst population and health care professionals requires the need to encourage them to receive better holistic care in primary care by the family physician.

In summary, there is sufficient evidence that the implementation of family practice approach can be a one solution to many public health issues. However, we realise that it will not happen overnight but we are finally on track towards its implementation. Close collaboration and partnerships is required among the key stake holders; Ministry/Department of Health, WHO, Medical Universities, Community and private organizations.

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