Human Resources

Education for primary health care: accommodating the new realities
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The didactic, authoritarian model in which learners are lectured by teachers cannot meet the needs of people intending to work in health systems where equity, self-reliance, community participation and intersectoral collaboration are the watchwords. The author discusses how the education of health professionals for roles in primary health care should be conducted.

Most health care providers have to deal with immediate, acute or emergency situations: their expertise is developed in response to problems that are already present. The implications of a change in focus, involving attempts to prevent problems from arising, are considerable.

Re-focusing

Serious questions about the nature of health care services began to be raised in the 1970s (1, 2), and a realization emerged that medicine would have to take a much broader view than previously of the factors influencing health. The need for change was formally expressed in 1978 at Alma-Ata, where the world community decided to adopt primary health care as the main vehicle for progress in the health field (3).

As countries pursued this line in practice they began to commit themselves to targets and to seek ways of measuring improvement. This concern with outcomes has led to a new perspective on the allocation of resources. Whereas formerly the degree of activity of a health service was the benchmark for assessing its effectiveness, the present criterion is the incidence and/or prevalence of specific conditions. Health systems have responded by changing budgetary allocations and procedures, and the consequences for the training of health professionals are now demanding attention.

Obstacles

The most conspicuous obstacle to change is the reward system. In the conventional Western clinical model the cure or alleviation of patients’ conditions can be seen to result directly from the skill and knowledge of health professionals, who thus derive great
personal satisfaction from their work and from the appreciation expressed by their clients. In primary health care, however, this kind of reward is diminished, because the link between the efforts of professionals and the health of the people they serve is less obvious. Furthermore, few training institutions examine students on their competence in exposing the determinants of disease or indicating preventive actions; by and large, students receive good grades if they demonstrate expertise in curative care.

Most health professionals providing clinical care consider that working alone is easier and faster than collaborating with others in a team, where interpersonal and interdisciplin ary tensions may arise. Conventional clinical care encourages both specialization and hierarchical relationships between disciplines. However, working alone does not permit the determinants of health to be properly addressed. There is even a need to involve people from sectors outside the health system. In the past the skills of advocacy, mediation and negotiation have not been seen as important for health professionals, yet they are now clearly essential in the interests of intersectoral collaboration.

Confusion can arise when epidemiological arguments for prevention are compared with clinical research methods aimed at treatment-orientated care. Statistical risk is difficult to relate to individual risk, and it is not easy to make prevention a sufficiently real concept for individuals. For instance, a reduction in the risk of contracting a disease from one in fifty to one in a hundred would be highly significant to an epidemiologist but not to any given individual in a population, whose chance of not succumbing would be large in either case. It should be borne in mind that “the determinants of incidence are not necessarily the same as the causes of cases” (4); in other words, what is true for a community as a whole is not directly reflected in what is true for individuals who are part of it. This is why it is so hard to convince people to opt for disease prevention and health promotion.

Health professionals need, but often lack, an understanding of people’s lifestyles and living conditions – that is to say, the vast range of social, cultural, economic, political and ecological factors that influence the health of the individual. In conventional clinical care there has been a tendency to ignore the contexts of people’s lives. Prevention would be impossible on such a basis. The view that objectivity counts above all else ought to give way to a recognition of the importance of personal values; only if this happens is a better appreciation of what affects people’s health likely to be gained.

Solutions

Experience gained in the evaluation of planned change in education for health professionals at the WHO Regional Training Centre for Health Development in the University of New South Wales makes it possible to put forward the following recommendations.

- The development of health professionals should be integrated with that of the systems in which they operate. In this way the professionals can be given enhanced opportunities to apply their new knowledge, attitudes and approaches, and can be persuaded not to revert to former practices. It is vital that human resources, management systems and policies undergo

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planned, interdependent change. Policy-making bodies, training institutions and professional associations should coordinate their efforts.

- The cornerstones of primary health care are self-reliance, equity, community participation and intersectoral collaboration, and these should be reflected in the classroom. The conventional assumption that the teacher should totally control the learning situation cannot be sustained; experiential learning methods, on the other hand, alter the relationship between teacher and learner in accordance with the new realities. Students should be encouraged to start by examining the experiences of their own lives, and should then be provided with opportunities for discovery and reflection. At the latter stage the introduction of generalizations, theories and conceptual abstractions can take place. Finally, the students should be allowed to develop plans for converting their learning into action, and, if appropriate, to implement the plans.

- Education for health professionals should move slowly from the familiar to the new. The basic principles of conventional clinical care are distinct from those of primary health care, and the impression can easily be obtained that a rapid and ruthless transformation is being demanded. The threat to the established system and the people operating it may seem excessive. However, the two approaches can be regarded as occupying positions at opposite ends of a continuum, small movements along which can eventually lead to major changes. A gradual inclusion of new techniques in an established pattern is less threatening to conventional health professionals than is their sudden introduction to unaccustomed activities, such as the lending of support to social movements, even though the principles of empowerment may be operating equally strongly in the two cases.

- Changes in the reward system should be effected. It is not possible to specify how to do this, since the requirements vary according to circumstances. In some instances,

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changes in extrinsic rewards like status and income can have a motivating influence; in others, personal satisfaction and other intrinsic factors may be significant. Role modelling can be highly effective. Whatever approach is adopted, it can be expected to work only if people see their new behaviour as more valuable to themselves than what they did before.

For most diseases, intervention through control of their origins is less costly, more humane and more effective than curative measures, and it is therefore desirable to train people accordingly. Of course, this in no way diminishes the need for training for conventional clinical roles.

References