

Commentary: Primary Health Care Delivery Services in the World

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Abstract

This extract examines the primary health care delivery services in countries of the world as well as sustainable methods to curbing the alienating factors which limits the substantial health care delivery services provided around the world. While some countries have had their health care systems run smoothly, other countries still dwell in the hermit's shell waiting for possible solutions to be offered on a plate of clay. This extracts also examines some studies carried out on this particular area of concentration to further buttress the need for role players in the development and growth of the health care delivery systems in the world.

Keywords: Primary health care; Service delivery; Global public; Unmet needs; Health care delivery

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Introduction

Primary healthcare (PHC) refers to "essential health care", which creates smooth and readily available ways for the easy accessibility of the general public to health care anywhere around the world. This can only be fully utilized through the active but not exclusive participation of the general public to quickly put together while intensively maintaining the development and growth as well as independence of the community health care services [1]. In other words, according to Barbra [2] and the Public Health Agency of Canada [3], PHC is an advance towards sustainable health care delivery services beyond the traditional and conventional health care system which most of the times focuses on producing and implementing prolonged health care delivery policies.

Literature Review

Cueto's study [4], noted that PHCs included all areas consciously or otherwise plays a functionary role in health as well as providing access to other health services which could include; the health environment as a statute of health propagandas, healthy lifestyle attitudes portrayed by these exceptional health care providers. Consequently, joining White [5], I believe that the PHCs and public health measures, when they both flock together in raven pairs (collaborate), may be considered as the underpinning forte (solid foundation) for universal health systems. Andersen pointed out [6], that equity in access to health care is best considered in the context of whether people in need of medical care receive it or not. In other words, access to health care is thoroughly and

methodically examined and evaluated based on the tethering teeth that ground the cola (affected personalities), or the one who wears the coat actually remembers where it had itch at some point in time (victims of health care accessibilities); meaning only those who ideally feel the brunt of the services would be in the best position to dispense the essential information to better uplift the services to be proffered. Some of the limitations that have been expressed regarding this model whereas as indicated in Sibley's and Glazier's [7] study as well as Allin's et al. later study [8] related the lack of information supplied as well as those on the snail road of processing for the non-users to the fact that this entire scope like adequacy, quality and appropriateness of the received care were not included. In the European literature, by Pappa et al. [9], demonstrated that unmet needs as a determinant of access to healthcare is limited, while previous studies have shown that unmet needs may worsen health status and quality of life [10] increase the risk of mortality, or be related to symptoms of mental and psychosomatic nature according to Westin et al. [11]. Furthermore, it was found that the factors that put people at risk of having unmet needs were youth (stubborn and mostly ignorant) and old age (weary, stubborn and hard to deal with as well), female gender (insecurity issues in some cases), lack of insurance coverage, high educational level (the know-it-all attitudes exhibited by individuals with ample knowledge of the PHC services; rather than presenting a diplomatic case they roll into unhealthy debates with health care delivery staffs), low income or unemployment, and poor health care standing/facilities

[7,12,13], implying an inequitable access to health care based on the prevalent poor socio-economic status, as well as inequalities in health care delivery services [14]. These stated factors are also common in the African continent [15-18]. The successes as well as the consistent failures of the UK policies when trying to reduce health inequalities were critically examined [19,20] as well as in Scotland [21] citing wider milieu of the socio-economic class as a major factor of health care challenges in these countries of the world.

In Greece, access to health services has been investigated based on the conventional need-adjusted utilization model [22,23] and the use of unmet health care needs, as an indicator of equitable access to health services, has been studied in the context of two European surveys [24,25].

In the Asian continent, the PHCs are faced with a lot of challenges which may include low financial input, poor or inadequate infrastructural facilities as well as widened socio-economical gap in the continent's health centres [26,27].

This ideal model of healthcare was adopted in the declaration of the International Conference on Primary Health Care held in Alma Ata, Kazakhstan in 1978 (known as the "Alma Ata Declaration"), and became a core concept of the World Health Organization's goal of Health for all while currently setting up an officially inaugurated centre for excellence in primary health care in Almaty, Kazakhstan, on 11 February 2015 [28]. The Alma-Ata Conference mobilized a "Primary Health Care movement" of professionals and institutions, governments and civil society organizations, researchers and grassroots organizations that undertook to tackle the "politically, socially and economically unacceptable" health inequalities in all countries. There were many factors that inspired PHC; a prominent example is the Barefoot doctors of China [4,29,30].

The PHC has a long way to go from where it is currently bench warming. Though there have been policies put in place to relieve the stress and problems faced in the health care centres in the different countries of the world, they appear to be snailishly implemented or sluggishly observable. Judging from public opinion and complains, the primary health care trainings had not been really felt in the community as initiations of these health

care programs will bring about an improvement in the health care delivery services as well as improve the rate of tackling diseases conditions in the community.

The Health Policies in the past, delegated PHC to the governments at the local levels of the world and these governments are undeniably short on follow up resources. The PHCs under a single roof policy (culmination/amalgamation of all the health care delivery centres under on single body per country) should be considered, adopted and implemented in countries of the world that have not started doing so, because this rechargeable policy provides the maximum opportunities for individual countries of the world, thus curbing the decrease of human resources, as well as bringing about candid and beneficial investments to better improve the quality of the delivery services of the PHCs. I believe that if the PHCs under this single roof policy were to be uniformly applied by all world heads of government and the fiscal legroom for health is improved at the continental and sub continental levels, then, the delivery of PHCs on the supply side will certainly improve. However, all the efforts that been invested in the PHCs over the last several years have to be sustained to further improve the existing developments of PHCs around the world.

At the moment, there are substantial private investments in healthcare in all over the world by health organizations, targeting the sea-shore grains of billions of dollars into improving PHC delivery services.

Conclusion

Conclusively, I believe in the Universal spirit of indigenous nations of the world to attain the best of everything especially in the health care systems. Today, there are lots of world players contributing their quota to the growth and development of health care delivery services in the world, judging by these unanimous contributions by the calibres of individuals of this generation, problems as well as challenges of PHC delivery services would be a thing of the past. Much needs to be done and much can be done surely. Man may be limited by growth stages, but man's economy never ceases to grow, hence the need for more improvements and more studies in the providing sustainable means to providing health care delivery services for the global public.

References

- 1 World Health Organization (1978) Declaration of Alma-Ata. Adopted at the International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978.
- 2 Barbara S (2011) "Politics, primary healthcare and health." *J Epidemiol Community Health* 65:653–655.
- 3 <https://www.canada.ca/en/health-canada/services/primary-health-care/about-primary-health-care.html> -Accessed 22nd April 2017.
- 4 Cueto M (2004) "The ORIGINS of Primary Health Care and SELECTIVE Primary Health Care". *Am J Public Health* 22. 94: 1864–1874.
- 5 White F (2015) Primary health care and public health: foundations of universal health systems. *Med Princ Pract* 24:103-116.
- 6 Andersen R (1978) Health status indices and access to medical care. *Am J Public Health* 66: 458-463.
- 7 Sibley L, Glazier R (2009) Reasons for self-reported unmet needs in Canada: A population-based provincial comparison. *Healthc Policy* 5: 87-101.
- 8 Allin S, Grignon M, Le Grand J (2010) Subjective unmet needs and utilization of health care services in Canada: What are the equity implications? *Soc Sci Med* 70: 465–472.
- 9 Pappa E, Kontodimopoulos N, Papadopoulos A, Tountas Y, Niakas D (2013) Investigating unmet health needs in primary health care services in a representative sample of the Greek population. *Int J Environ Res Public Health* 10: 2017-2027.
- 10 McCarberg BH, Nicholson BD, Todd KH, Palmer T, Penles L (2008) The impact of pain on quality of life and the unmet needs of pain management: results from pain sufferers and physicians participating in an Internet survey. *Am J Ther* 15: 312-320.
- 11 Westin M, Ahs A, Brand Persson K, Westerling R (2004) A large proportion of Swedish citizens refrain from seeking medical care—lack of confidence in the medical services a plausible explanation? *Health Policy* 68: 333-344
- 12 Wiltshire JC, Person SD, Kiefe CI, Allison JJ (2009) Disentangling the influence of socio-economic status on differences between African American and white women in unmet medical needs. *Am J Public Health* 99: 1659-1665.
- 13 Ash A, Burell G, Westerling R (2012) Care or not care—that is the question: Predictors of healthcare utilization in relation to employment status. *Int J Behav Med* 19: 29-38.
- 14 DHSS (1980) *The Black Report; Inequalities in Health*. London: Retrieved 05 May, 2017. Also accessed from <http://www.sochealth.co.uk/national-health-service/public-health-and-wellbeing/poverty-and-inequality/the-black-report-1980/>
- 15 Chinua A (2006) Community oriented primary care and transformation of Africa's healthcare system: issues, challenges and opportunities. *African Renaissance* 3: 181-192.
- 16 Kaseje D (2006) Health care in Africa: Challenges, Opportunities and an emerging model for improvement. Presented at The Woodrow Wilson International Center for Scholars. Retrieved May, 09, 2017 from <https://www.wilsoncenter.org/sites/default/files/Kaseje2.pdf>
- 17 WHO (2008) Report on the Review of Primary Health Care in the African Region. Retrieved May 9, 2017 accessed from http://www.afro.who.int/index.php?option=com_docman&task=doc_download&gid=3806
- 18 Maillacheruvu P, McDuff E (2014) South Africa's return to primary care: the struggles and strides of the primary health care system. *Journal of Global Health*. Retrieved May 9, 2017. <http://www.ghjournal.org/south-africas-return-to-primary-care-the-struggles-and-strides-of-the-primary-health-care-system/>
- 19 Bamba C (2016) Health Divides – Where you live can kill you. *Socialist Health Association*. Accessed from <https://www.sochealth.co.uk/2016/12/30/health-divides-live-can-kill/> 09 May, 2017.
- 20 Scott-Samuel A (2016) Causes of Health inequalities. *Socialist Health Association*. Accessed from <https://www.sochealth.co.uk/2016/06/02/neoliberal-governments-health-inequalities-fantasy-paradigm/> -Accessed May 9, 2017.
- 21 Katherine S (2012) Health inequalities in Scotland and England: the translation of ideas between research and policy In Martin Rathfelder. *Socialist Health Association*. Accessed from <https://www.sochealth.co.uk/2012/10/10/health-inequalities-in-scotland-and-england-the-translation-of-ideas-between-research-and-policy/> -Accessed May 9, 2017.
- 22 Tountas Y, Oikonomou N, Pallikarona G, Dimitrakakh C, Souliotis K, Mariolis A, et al. (2011) Sociodemographic and socioeconomic determinants of health services utilization in Greece: The Hellas Health I study. *Health Serv. Manage Res* 24: 8-18.
- 23 Lahana E, Pappa E, Niakas D (2011) Do place of residence and ethnicity affect health services utilization? Evidence from Greece. *Int J Equity Health* 10: 16.
- 24 Mielck A, Kiess R, von dem Knesebeck O, Stirbu I, Kunst AE (2009) Association between forgone care and household income among the elderly in five Western European countries—analyses based on survey data from the SHARE-study. *BMC Health Serv Res* 9: 52.
- 25 Koolman X (2006) Unmet needs for health care in Europe. Comparative EU Statistics on income and living conditions: issues and challenges. In proceedings of the EU-SILC Conference, Helsinki, Finland, 6–8 November 2006; pp: 183–191
- 26 Lee M, Lee M, Wu YT, Chiu T (2010) [Taiwan] Strengthening of primary health care in Asia and Oceania Region. *JMAJ* 53: 6
- 27 van Weel C, Kassai R, Qidwai W, Kumar R, Bala K, et al. (2016) Primary healthcare policy implementation in South Asia. *BMJ Global Health* 1: e000057.
- 28 WHO (2015) WHO opens office on primary health care in Kazakhstan. Accessed from <http://www.euro.who.int/en/countries/kazakhstan/news/news/2015/02/who-opens-office-on-primary-health-care-in-kazakhstan> -Accessed May 9, 2017
- 29 Bulletin of the World Health Organization (October 2008a). "Consensus during the cold war: back to Alma-Ata". World Health Organization.
- 30 Bulletin of the World Health Organization (December 2008b). "China's village doctors take great strides". World Health Organization.