Course Name	**: Primary health care**
Course Code	**: APBPH 1103**
Course level	**: level 1**
Course Credit	**: 4 CU**
Contact Hours	**: 60 Hrs**

Introduction

Primary Health Care, or PHC refers to "essential health care" that is based on scientifically sound and socially acceptable methods and technology. This makes universal health care accessible to all individuals and families in a community. It is through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. In other words, PHC is an approach to health beyond the traditional health care system that focuses on health equity-producing social policy. PHC includes all areas that play a role in health, such as access to health services, environment and lifestyle. Thus, primary healthcare and public health measures, taken together, may be considered as the cornerstones of universal health systems. The World Health Organization, or WHO, elaborates on the goals of PHC as defined by three major categories, "empowering people and communities, multisectoral policy and action; and primary care and essential public health functions as the core of integrated health services." Based on these definitions, PHC can not only help an individual after being diagnosed with a disease or disorder, but actively prevent such issues by understanding the individual as a whole.

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*. 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.

Goals and principles

A primary health care worker in Saudi Arabia, 2008

The ultimate goal of primary healthcare is the attainment of better health services for all. It is for this reason that the World Health Organization (WHO), has identified five key elements to achieving this goal:

- reducing exclusion and social disparities in health (universal coverage reforms);
- organizing health services around people's needs and expectations (service delivery reforms);
- integrating health into all sectors (public policy reforms);
- pursuing collaborative models of policy dialogue (leadership reforms); and
- increasing stakeholder participation.

Behind these elements lies a series of basic principles identified in the Alma Ata Declaration that should be formulated in national policies in order to launch and sustain PHC as part of a comprehensive health system and in coordination with other sectors:

- Equitable distribution of health care – according to this principle, primary care and other services to meet the main health problems in a community must be provided equally to all individuals irrespective of their gender, age, caste, color, urban/rural location and social class.
- Community participation – in order to make the fullest use of local, national and other available resources. Community participation was considered sustainable due to its grass roots nature and emphasis on self-sufficiency, as opposed to targeted (or vertical) approaches dependent on international development assistance.
- Health human resources development – comprehensive healthcare relies on an adequate number and distribution of trained physicians, nurses, allied health professions, community health workers and others working as a health team and supported at the local and referral levels.
- Use of appropriate technology – medical technology should be provided that is accessible, affordable, feasible and culturally acceptable to the community. Examples of appropriate technology include refrigerators for cold vaccine storage. Less appropriate examples of medical technology could include, in many settings, body scanners or heart-lung machines, which benefit only a small minority concentrated in urban areas. They are generally not accessible to the poor, but draw a large share of resources.
- Multi-sectional approach – recognition that health cannot be improved by intervention within just the formal health sector; other sectors are equally important in promoting the health and self-reliance of communities. These sectors include, at least: agriculture (e.g. food security); education; communication (e.g. concerning prevailing health problems and the methods of preventing and controlling them); housing; public works (e.g. ensuring an adequate supply of safe water and basic sanitation); rural development; industry; community organizations (including Panchayats or local governments, voluntary organizations, etc.).

In sum, PHC recognizes that healthcare is not a short-lived intervention, but an ongoing process of improving people's lives and alleviating the underlying socioeconomic conditions that contribute to poor health. The principles link health, development, and advocating political interventions rather than passive acceptance of economic conditions.

Approaches

The hospital ship USNS *Mercy* (T-AH-19) in Manado, Indonesia, during Pacific Partnership 2012.

The primary health care approach has seen significant gains in health where applied even when adverse economic and political conditions prevail.

Although the declaration made at the Alma-Ata conference deemed to be convincing and plausible in specifying goals to PHC and achieving more effective strategies, it generated numerous criticisms and reactions worldwide. Many argued the declaration did not have clear targets, was too broad, and was not attainable because of the costs and aid needed. As a result, PHC approaches have evolved in different contexts to account for disparities in resources and local priority health problems; this is alternatively called the Selective Primary Health Care (SPHC) approach.

Selective Primary Health Care

After the year 1978 Alma Ata Conference, the Rockefeller Foundation held a conference in 1979 at its Bellagio conference center in Italy to address several concerns. Here, the idea of Selective Primary Health Care was introduced as a strategy to complement comprehensive PHC. It was based on a paper by Julia Walsh and Kenneth S. Warren entitled “Selective Primary Health Care, an Interim Strategy for Disease Control in Developing Countries”. This new framework advocated a more economically feasible approach to PHC by only targeting specific areas of health, and choosing the most effective treatment plan in terms of cost and effectiveness. One of the foremost examples of SPHC is "GOBI" (growth monitoring, oral rehydration, breastfeeding, and immunization), focusing on combating the main diseases in developing nations.

GOBI and GOBI-FFF

GOBI is a strategy consisting of (and an acronym for) four low-cost, high impact, knowledge mediated measures introduced as key to halving child mortality by James P. Grant at UNICEF in 1983. The measure are:

- Growth monitoring: the monitoring of how much infants grow within a period, with the goal to understand needs for better early nutrition.
- Oral rehydration therapy: to combat dehydration associated with diarrhea.
- Breastfeeding
- Immunization

Three additional measure were introduced to the strategy later (though food supplementation had been used by UNICEF since it#'s inception in 1946), leading to the acronym GOBI-FFF.

- Family planning (birth spacing)
- Female education
- Food supplementation: for example, iron and folic acid fortification/supplementation to prevent deficiencies in pregnant women.

These strategies focus on severe population health problems in certain developing countries, where a few diseases are responsible for high rates of infant and child mortality. Health care planning is used to see which diseases require most attention and, subsequently, which intervention can be most effectively applied as part of primary care in a least-cost method. The targets and effects of selective PHC are specific and measurable. The approach aims to prevent most health and nutrition problems before they begin:

PHC and population aging

Given global demographic trends, with the numbers of people age 60 and over expected to double by 2025, PHC approaches have taken into account the need for countries to address the consequences of population ageing. In particular, in the future the majority of older people will be living in developing countries that are often the least prepared to confront the challenges of rapidly ageing societies, including high risk of having at least one chronic non-communicable disease, such as diabetes and osteoporosis. According to WHO, dealing with this increasing burden requires health promotion and disease prevention intervention at the community level as well as disease management strategies within health care systems.

PHC and mental health

Some jurisdictions apply PHC principles in planning and managing their healthcare services for the detection, diagnosis and treatment of common mental health conditions at local clinics, and organizing the referral of more complicated mental health problems to more appropriate levels of mental health care. The Ministerial Conference, which took place in Alma Ata, made the decision that measures should be taken to support mental health in regard to primary health care. However, there was no such documentation of this event in the Alma Ata Declaration. These discrepancies caused an inability for proper funding and although was worthy of being a part of the declaration, changing it would call for another conference.

Individuals with severe mental health disorders are found to live much shorter lives than those without, anywhere from ten to twenty-five-year reduction in life expectancy when compared to those without . Cardiovascular diseases in particular are one of the leading deaths with individuals already suffering from severe mental health disorders. General health services such as PHC is one approach to integrating an improved access to such health services that could help treat already existing mental health disorders as

well as prevent other disorders that could arise simultaneously as the pre-existing condition.

Background and controversies

Barefoot Doctors

The "Barefoot Doctors" of China were an important inspiration for PHC because they illustrated the effectiveness of having a healthcare professional at the community level with community ties. Barefoot Doctors were a diverse array of village health workers who lived in rural areas and received basic healthcare training. They stressed rural rather than urban healthcare, and preventive rather than curative services. They also provided a combination of western and traditional medicines. The Barefoot Doctors had close community ties, were relatively low-cost, and perhaps most importantly they encouraged self-reliance through advocating prevention and hygiene practices. The program experienced a massive expansion of rural medical services in China, with the number of Barefoot Doctors increasing dramatically between the early 1960s and the Cultural Revolution (1964-1976).

Criticisms

Although many countries were keen on the idea of primary healthcare after the Alma Ata conference, the Declaration itself was criticized for being too "idealistic" and "having an unrealistic time table".[4] More specific approaches to prevent and control diseases - based on evidence of prevalence, morbidity, mortality and feasibility of control (cost-effectiveness) - were subsequently proposed. The best known model was the Selective PHC approach (described above). Selective PHC favoured short-term goals and targeted health investment, but it did not address the social causes of disease. As such, the SPHC approach has been criticized as not following Alma Ata's core principle of everyone's entitlement to healthcare and health system development.[4]

In Africa, the PHC system has been extended into isolated rural areas through construction of health posts and centers that offer basic maternal-child health, immunization, nutrition, first aid, and referral services.[17] Implementation of PHC is said to be affected after the introduction of structural adjustment programs by the World Bank.

Emergency health care

An **emergency** is a situation that poses an immediate risk to health, life, property, or environment. Most emergencies require urgent intervention to prevent a worsening of the situation, although in some situations, mitigation may not be possible and agencies may only be able to offer palliative care for the aftermath.

While some emergencies are self-evident (such as a natural disaster that threatens many lives), many smaller incidents require that an observer (or affected party) decide whether it qualifies as an emergency. The precise definition of an emergency, the agencies involved and the procedures used, vary by jurisdiction, and this is usually set by the government, whose agencies (emergency services) are responsible for emergency planning and management.

Defining an emergency

An incident, to be an emergency, conforms to one or more of the following: if it:

- Poses an immediate threat to life, health, property, or environment
- Has already caused loss of life, health detriments, property damage, or environmental damage
- has a high probability of escalating to cause immediate danger to life, health, property, or environment

In the United States, most states mandate that a notice be printed in each telephone book that requires that someone must relinquish use of a phone line, if a person requests the use of a telephone line (such as a party line) to report an emergency. State statutes typically define an *emergency* as, "...a condition where life, health, or property is in jeopardy, and the prompt summoning of aid is essential."[2]

Whilst most emergency services agree on protecting human health, life and property, the environmental impacts are not considered sufficiently important by some agencies. This also extends to areas such as animal welfare, where some emergency organizations cover this element through the "property" definition, where animals owned by a person are threatened (although this does not cover wild animals). This means that some agencies do not mount an "emergency" response where it endangers wild animals or environment, though others respond to such incidents (such as oil spills at sea that threaten marine life). The attitude of the agencies involved is likely to reflect the predominant opinion of the government of the area.

Types of emergency

Dangers to life

Many emergencies cause an immediate danger to the life of people involved. This can range from emergencies affecting a single person,

such as the entire range of medical emergencies including heart attacks, strokes, cardiac arrest and trauma, to incidents that affect large numbers of people such as natural disasters including tornadoes, hurricanes, floods, earthquakes, mudslides and outbreaks of diseases such as cholera, Ebola, and malaria.

Most agencies consider these the highest priority emergency, which follows the general school of thought that nothing is more important than human life.

Dangers to health

Some emergencies are not necessarily immediately threatening to life, but might have serious implications for the continued health and well-being of a person or persons (though a health emergency can subsequently escalate to life-threatening).

The causes of a health emergency are often very similar to the causes of an emergency threatening to life, which includes medical emergencies and natural disasters, although the *range* of incidents that can be categorized here is far greater than those that cause a danger to life (such as broken limbs, which do not usually cause death, but immediate intervention is required if the person is to recover properly). Many life emergencies, such as cardiac arrest, are also health emergencies.

Dangers to the environment

Some emergencies do not immediately endanger life, health or property, but do affect the natural environment and creatures living within it. Not all agencies consider this a genuine emergency, but it can have far-reaching effects on animals and the long term condition of the land. Examples would include forest fires and marine oil spills.

Systems of classifying emergencies

Agencies across the world have different systems for classifying incidents, but all of them serve to help them allocate finite resource, by prioritising between different emergencies.

The first stage of any classification is likely to define whether the incident qualifies as an emergency, and consequently if it warrants an emergency response. Some agencies may still respond to non-emergency calls, depending on their remit and availability of resource. An example of this would be a fire department responding to help retrieve a cat from a tree,

where no life, health or property is immediately at risk.

Following this, many agencies assign a sub-classification to the emergency, prioritising incidents that have the most potential for risk to life, health or property (in that order). For instance, many ambulance services use a system called the Advanced Medical Priority Dispatch System (AMPDS) or a similar solution. The AMPDS categorises all calls to the ambulance service using it as either 'A' category (immediately life-threatening), 'B' Category (immediately health threatening) or 'C' category (non-emergency call that still requires a response). Some services have a fourth category, where they believe that no response is required after clinical questions are asked.

Another system for prioritizing medical calls is known as Emergency Medical Dispatch (EMD). Jurisdictions that use EMD typically assign a code of "alpha" (low priority), "bravo" (medium priority), "charlie" (requiring advanced life support), delta (high priority, requiring advanced life support) or "echo" (maximum possible priority, e.g., witnessed cardiac arrests) to each inbound request for service; these codes are then used to determine the appropriate level of response.

Other systems (especially as regards major incidents) use objective measures to direct resource. Two such systems are SAD CHALET and ETHANE,[11] which are both mnemonics to help emergency services staff classify incidents, and direct resource Each of these acronyms helps ascertain the number of casualties (usually including the number of dead and number of non-injured people involved), how the incident has occurred, and what emergency services are required.

Agencies involved in dealing with emergencies

Most developed countries have a number of emergency services operating within them, whose purpose is to provide assistance in dealing with any emergency. They are often government operated, paid for from tax revenue as a public service, but in some cases, they may be private companies, responding to emergencies in return for payment, or they may be voluntary organisations, providing the assistance from funds raised from donations.

Most developed countries operate three core emergency services]:

- **Police –** handle mainly crime-related emergencies.
- **Fire –** handle fire-related emergencies and usually possess

secondary rescue duties.
- **Medical –** handle medical-related emergencies.

There may also be a number of specialized emergency services, which may be a part of one of the core agencies, or may be separate entities who assist the main agencies. This can include services, such as bomb disposal, search and rescue, and hazardous material operations.

The Military and the Amateur Radio Emergency Service (ARES) or Radio Amateur Civil Emergency Service (RACES) help in large emergencies such as a disaster or major civil unrest.

Summoning emergency services

Most countries have an emergency telephone number, also known as the universal emergency number, which can be used to summon the emergency services to any incident. This number varies from country to country (and in some cases by region within a country), but in most cases, they are in a short number format, such as 911 (United States and many parts of Canada), 999 (United Kingdom), 112 (Europe) and 000 (Australia).

The majority of mobile phones also dial the emergency services, even if the phone keyboard is locked, or if the phone has an expired or missing SIM card, although the provision of this service varies by country and network.

Civil emergency services

In addition to those services provided specifically for emergencies, there may be a number of agencies who provide an emergency service as an incidental part of their normal 'day job' provision. This can include public utility workers, such as in provision of electricity or gas, who may be required to respond quickly, as both utilities have a large potential to cause danger to life, health and property if there is an infrastructure failure

Domestic emergency services

Generally perceived as pay per use emergency services, domestic emergency services are small, medium or large businesses who tend to emergencies within the boundaries of licensing or capabilities. These tend to consist of emergencies where health or property is perceived to be at risk but may not qualify for official emergency response. Domestic

emergency services are in principal similar to civil emergency services where public or private utility workers will perform corrective repairs to essential services and avail their service at all times; however, these are at a cost for the service. An example would be an emergency plumber

Emergency action principles (EAP)

Emergency action principles are key 'rules' that guide the actions of rescuers and potential rescuers. Because of the inherent nature of emergencies, no two are likely to be the same, so emergency action principles help to guide rescuers at incidents, by sticking to some basic tenets.

The adherence to (and contents of) the principles by would-be rescuers varies widely based on the training the people involved in emergency have received, the support available from emergency services (and the time it takes to arrive) and the emergency itself.

Key emergency principle]

The key principle taught in almost all systems is that the rescuer, be they a lay person or a professional, should assess the situation for danger.

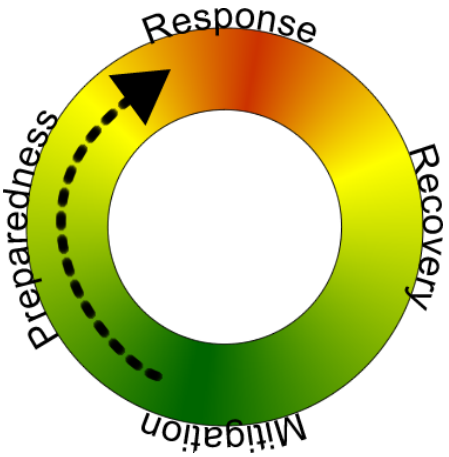
The reason that an assessment for danger is given such high priority is that it is core to emergency management that rescuers do not become secondary victims of any incident, as this creates a further emergency that must be dealt with.

A typical assessment for danger would involve observation of the surroundings, starting with the cause of the accident (e.g. a falling object) and expanding outwards to include any situational hazards (e.g. fast moving traffic) and history or secondary information given by witnesses, bystanders or the emergency services (e.g. an attacker still waiting nearby).

Once a primary danger assessment has been complete, this should not end the system of checking for danger, but should inform all other parts of the process.

If at any time the risk from any hazard poses a significant danger (as a factor of likelihood and seriousness) to the rescuer, they should consider whether they should approach the scene (or leave the scene if appropriate).

Managing an emergency



A graphic representation of the four phases in emergency management.

There are many emergency services protocols that apply in an emergency, which usually start with planning before an emergency occurs. One commonly used system for demonstrating the phases is shown here on the right.

The planning phase starts at **preparedness**, where the agencies decide how to respond to a given incident or set of circumstances. This should ideally include lines of command and control, and division of activities between agencies. This avoids potentially negative situations such as three separate agencies all starting an official emergency shelter for victims of a disaster.

Following an emergency occurring, the agencies then move to a **response** phase, where they execute their plans, and may end up improvising some areas of their response (due to gaps in the planning phase, which are inevitable due to the individual nature of most incidents).

Agencies may then be involved in **recovery** following the incident, where they assist in the clear up from the incident, or help the people involved overcome their mental trauma.

The final phase in the circle is **mitigation**, which involves taking steps to ensure no re-occurrence is possible, or putting additional plans in place to ensure less damage is done. This should feed back into the preparedness stage, with updated plans in place to deal with future emergencies, thus completing the circle.

State of emergency

In the event of a major incident, such as civil unrest or a major disaster, many governments maintain the right to declare a state of emergency, which gives them extensive powers over the daily lives of their citizens, and may include temporary curtailment on certain civil rights, including the right to trial. For instance to discourage looting of an evacuated area, a shoot on sight policy, however unlikely to occur, may be publicized.

Health promotion

Health promotion is, as stated in the 1986 World Health Organization (WHO) Ottawa Charter for Health Promotion, "the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being".

Scope

The WHO's 2005 Bangkok Charter for Health Promotion in a Globalized World defines health promotion as "the process of enabling people to increase control over their health and its determinants, and thereby improve their health".

Health promotion involves public policy that addresses health determinants such as income, housing, food security, employment, and quality working conditions. More recent work has used the term Health in All Policies to refer to the actions that incorporate health into all public policies. Health promotion is aligned with health equity and can be a focus of non-governmental organizations (NGOs) dedicated to social justice or human rights. Health literacy can be developed in schools, while aspects of health promotion such as breastfeeding promotion can depend on laws and rules of public spaces. One of the Ottawa Charter Health Promotion Action items is infusing prevention into all sectors of society, to that end, it is seen in preventive healthcare rather than a treatment and curative care focused medical model.

There is a tendency among some public health officials, governments, and the medical industrial complex to reduce health promotion to just developing personal skill also known as health education and social marketing focused on changing behavioral risk factors.

History

This first publication of health promotion is from the 1974 Lalonde report from the Government of Canada, which contained a health promotion strategy "aimed at informing, influencing and assisting both individuals and organizations so that they will accept more responsibility and be more active in matters affecting mental and physical health". Another predecessor of the definition was the 1979 *Healthy People* report of the Surgeon General of the United States, which noted that health promotion "seeks the development of community and individual measures which can help... [people] to develop lifestyles that can maintain and enhance the state of well-being".

At least two publications led to a "broad empowerment/environmental" definition of health promotion in the mid-1980s:

- In year 1984 the WHO Regional Office for Europe defined health promotion as "the process of enabling people to increase control over, and to improve, their health". In addition to methods to change lifestyles, the WHO Regional Office advocated "legislation, fiscal measures, organisational change, community development and spontaneous local activities against health hazards" as health promotion methods.
- In 1986, Jake Epp, Canadian Minister of National Health and Welfare, released *Achieving health for all: a framework for health promotion* which also came to be known as the "Epp report". This report defined the three "mechanisms" of health promotion as "self-care"; "mutual aid, or the actions people take to help each other cope"; and "healthy environments".
- 1st International Conference on Health Promotion, Ottawa, 1986, which resulted in the "Ottawa Charter for Health Promotion". According to the Ottawa Charter, health promotion:
    - "is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being"
    - "aims at making... [political, economic, social, cultural, environmental, behavioural and biological factors] favourable through advocacy for health"
    - "focuses on achieving equity in health"

- "demands coordinated action by all concerned: by governments, by health and other social organizations."

The "American" definition of health promotion, first promulgated by the *American Journal of Health Promotion* in the late 1980s, focuses more on the delivery of services with a bio-behavioral approach rather than environmental support using a settings approach. Later the power on the environment over behavior was incorporated.

The WHO, in collaboration with other organizations, has subsequently co-sponsored international conferences including the 2015 Okanagan Charter on Health Promotion Universities and Colleges.

In November 2019, researchers reported, based on an international study of 27 countries, that caring for families is the main motivator for people worldwide.

Workplace Setting

The process of health promotion works in all settings and sectors where people live, work, play and love. A common setting is the workplace. The focus of health on the work site is that of prevention and the intervention that reduces the health risks of the employee. The U.S. Public Health Service recently issued a report titled "Physical Activity and Health: A Report of the Surgeon General" which provides a comprehensive review of the available scientific evidence about the relationship between physical activity and an individual's health status. The report shows that over 60% of Americans are not regularly active and that 25% are not active at all. There is very strong evidence linking physical activity to numerous health improvements. Health promotion can be performed in various locations. Among the settings that have received special attention are the community, health care facilities, schools, and worksites. Worksite health promotion, also known by terms such as "workplace health promotion," has been defined as "the combined efforts of employers, employees and society to improve the health and well-being of people at work". WHO states that the workplace "has been established as one of the priority settings for health promotion into the 21st century" because it influences "physical, mental, economic and social well-being" and "offers an ideal setting and infrastructure to support the promotion of health of a large audience".

Worksite health promotion programs (also called "workplace health promotion programs," "worksite wellness programs," or "workplace

wellness programs") include exercise, nutrition, smoking cessation and stress management.

According to the Centers for Disease Control and Prevention (CDC), "Regular physical activity is one of the most effective disease prevention behaviors." Physical activity programs reduce feelings of anxiety and depression, reduce obesity (especially when combined with an improved diet), reduce risk of chronic diseases including cardiovascular disease, high blood pressure, and type 2 diabetes; and finally improve stamina, strength, and energy.

Reviews and meta-analyses published between 2005 and 2008 that examined the scientific literature on worksite health promotion programs include the following:

- A review of 13 studies published through January 2004 showed "strong evidence... for an effect on dietary intake, inconclusive evidence for an effect on physical activity, and no evidence for an effect on health risk indicators".
- In the most recent of a series of updates to a review of "comprehensive health promotion and disease management programs at the worksite," Pelletier (2005) noted "positive clinical and cost outcomes" but also found declines in the number of relevant studies and their quality.
- A "meta-evaluation" of 56 studies published 1982–2005 found that worksite health promotion produced on average a decrease of 26.8% in sick leave absenteeism, a decrease of 26.1% in health costs, a decrease of 32% in workers' compensation costs and disability management claims costs, and a cost-benefit ratio of 5.81.
- A meta-analysis of 46 studies published in 1970–2005 found moderate, statistically significant effects of work health promotion, especially exercise, on "work ability" and "overall well-being"; furthermore, "sickness absences seem to be reduced by activities promoting healthy lifestyle".
- A meta-analysis of 22 studies published 1997–2007 determined that workplace health promotion interventions led to "small" reductions in depression and anxiety.
- A review of 119 studies suggested that successful work site health-promotion programs have attributes such as: assessing employees' health needs and tailoring programs to meet those needs; attaining high participation rates; promoting self care; targeting several health issues simultaneously; and offering different types

of activities (e.g., group sessions as well as printed materials).

Primary care ethics

Primary care ethics is the study of the everyday decisions that primary care clinicians make, such as: how long to spend with a particular patient, how to reconcile their own values and those of their patients, when and where to refer or investigate, how to respect confidentiality when dealing with patients, relatives and third parties. All these decisions involve values as well as facts and are therefore ethical issues. These issues may also involve other workers in primary healthcare, such as receptionists and managers.

Primary care ethics is not a discipline; it is a notional field of study which is simultaneously an aspect of primary health care and applied ethics. De Zulueta argues that primary care ethics has 'a definitive place on the 'bioethics map', represented by a substantial body of empirical research, literary texts and critical discourse (2, 9, 10). The substantial body of research referred to by De Zulueta (9) has a tendency to be issue-specific, such as to do with rationing(11), confidentiality, medical reports, or relationships with relatives.

Much of the literature on primary care ethics concerns primary care physicians. The term primary care physician is synonymous with family practitioner, or general practitioner; meaning a medically qualified clinician who is the first point of access to health care, with general responsibilities which may but do not necessarily include child health or obstetrics and gynaecology. Other primary care clinicians; nurses, physiotherapists, midwives, and in some situations pharmacists may face similar issues, and some (confidentially, prioritisation of patients) may also involve administrative staff. In some healthcare systems primary care specialists may also encounter many of these issues.

The place of primary care ethics in bioethics

Although the ethical decisions made in primary care are often as less dramatic than those in high-tech medicine (1), their cumulative effect may be profound (2), because of the vast number of health care encounters which take place in primary care, (approximately 400.3 million in England in 2008 alone (3, 4)). Each of these involves ethical judgements, occasionally difficult, often straightforward; often deliberate but more often unconscious. Also, since primary care is often the first step in the patient journey, small decisions made then may make big differences later on. Most of the bioethical literature however deals with tertiary medicine, and much less attention is

paid to the daily concerns of primary care physicians and members of the primary care team (5).

In countries with well developed primary health care, patients often stay with the same practice for many years, allowing practices to gather a large amount of information and to develop personal relationships over time. Patients often see the same clinician for a variety of problems, at once or at different times. Whole families may see the same doctors and nurses, who may also be their friends and neighbours. These factors affect moral decisions in primary care, and raise ethical dilemmas which might not occur often in secondary and tertiary medical care (6, 7). Moreover, the transfer into the community of services previously provided in hospital (such as specialist chronic disease management and mental health) may lead to the ethical dilemmas arising which were previously only encountered in secondary care (8).

Spicer and Bowman argue that the 'tertiary' level ethical problems that dominate so much of the debate about healthcare ethics, such as genetics, cloning, organ donation and research, are experienced entirely differently in primary care. Moreover, what might be argued to be core moral principles, such as autonomy and justice, may be reinterpreted when viewed through the lens of primary care (13). Toon, by contrast argues such re-interpretations are not exclusive to general practice and primary care. Doctors in other specialities (such as psychiatry, rheumatology, HIV medicine, where specialists take primary responsibility for a patient's health care over a considerable period) may perform what he terms the interpretative function, but when then do so they are acting as generalists and practising generalism (14). The extension of this argument is that it is not just good primary care physicians who are aware of the ethics of the everyday, but good clinicians (15).

What are the values of primary care?

According to Toon (16), doctors in primary care are charged with three tasks:

1. To deliver the best possible, evidence based medical care to patients who have physical or mental illnesses that can be understood and treated or cured within a biomedical framework

2. Insofar as it lies within their power, to help prevent avoidable illness and death in their patients

3. To help those who are or who believe themselves to be ill to cope with their illnesses, real or feared, to the best of their ability and so to achieve their maximum potential as human beings.

The first two tasks largely involve understanding the patient as a biopsychosocial system that the doctor is seeking to influence, whilst the third involves seeing the patient as a fellow human being in need. Reconciling these tasks is not easy.

Gatekeeping

In many health-care systems patients can only see specialists by referral from doctors in primary care, a system which restricts access to secondary care and is often called "primary care gatekeeping". Although historically in some countries this developed as a mutually beneficial arrangement between specialists and primary care doctors, rather than from a desire to improve patient care, it is widely recognised that it benefits both individual patients and the health care system. Individual patients benefit from having a personal doctor who can integrate their health care and view their problems together rather than in isolation, and who can protect them from over-investigation and over-treatment -which Toon characterises as the 'furor therapeuticus' of specialist medicine (16). Patients as a whole benefit because the system ensures that expensive secondary care resources are spent on those who have the greatest need.

Some people however are concerned that gatekeeping can damage the doctor-patient relationship, since the doctor cannot act solely in the interests of the individual patient (17). Others have questioned whether this is ever possible, even without gatekeeping. Much depends on the system within which gatekeeping operates, and how great the pressures are on the primary care doctor not to refer, and how strong the incentives, personal, professional and financial are for or against referral. All are agreed that "positive gatekeeping" in which doctors are rewarded for encouraging patients to have unnecessary or dubious procedures, as exists in many private systems, is unethical, and that avoiding unnecessary treatment (therapeutic parsimony) is desirable. Heath has pointed out that the primary care doctor has influence over two other "gates" between illness and health, and between self care and professional care (18).

Certification and confidentiality

It is traditional in many countries that primary care doctors issue certificates to allow patients to be absent from work for reasons of sickness. In some countries such certificates are required even for one day's absence from work, and this can form a considerable part of the primary care doctor's workload. In other countries these certificates are only needed for longer periods of illness. In either case this can function can pose ethical problems for doctors as they try to reconcile a duty to do the best for the patient, a duty not to lie to employers, and the need to maintain the doctor patient relationship for professional and/or financial reasons.

Many people want information on patients' health, and are prepared to pay for it. Insurance companies, employers, social agencies such as the police and the courts and

many other bodies have interests in the health status of individuals. The primary care physician is often best placed to provide this information, but doing so can pose ethical problems, particularly in respect of confidentiality. Although patients may sign a consent form to allow information to be released, this consent is not always free, since the patient is often in a position where it would be difficult to refuse, and/or it is not informed, in that patients are often given forms to consent to the release of medical records without what this means being properly explained to them. Doctors can face a conflict of interest in this situation, since they can benefit financially from the fees paid for the release of such information. This poses a difficult ethical conflict as the doctor tries to "serve two masters"; the patient who has a right to confidentiality and the employer or other agency that is paying for the information. Confidentiality has been identified as a key concern to general practitioners in the UK and has been described as one way in which they display their commitment to patient-centeredness (19).

Access and use of time

As the first point of contact with health services, primary care doctors have particular responsibilities with respect to access. Patients typically and understandably want to see the doctor of their choice at the time and place of their choosing, without waiting, and for the length of time they feel they require; however it is rarely possible for all these conditions to be met. The decisions that doctors make about how best to reconcile these conflicting demands by appointment arrangements, arrangements for emergency consultation etc. have a strong ethical as well as practical component.

So too do decisions doctors make about the allocation of their time and resources between different problems and different patients. The three aspects of general practice are mentioned above but even within these doctors make choices that are ethical. One doctor may give priority to the care of patients with diabetes, another to women's health, and a third to psychological problems and so on.

In some countries it is common place for doctors to strike – in others this is seen as unethical. This again depends on the values that doctors espouse, and in this case in particular on doctors' understanding of the nature of the doctor patient relationship.

The doctor, the patient and the family

A characteristic feature of primary care is that doctors' often care for several patients who are related to each other. They also often care for a number of individuals and families who live and/or work in close proximity, and whose lives are intimately related to each other. Particularly though not exclusively in rural areas, the same applies to the doctor and to his staff. This can be a considerable strength of general practice, since doctors gain a fuller understanding of the social context in which their patients live and become ill. It can also pose ethical problems, however particularly in

conflicts between duties to different individuals – family members, employers and employees, and even between friends, when the illness of one affects the life or health of another. Confidentiality can also be a problem, as patients may not understand or accept that information given to the doctor by one family member may not be divulged to others.

Respect for confidentiality, and maintaining confidence amongst patients that confidentiality is respected can be difficult not just for doctors but also for other members of their staff in such situations.

Analysing ethical issues in primary care

As in other aspects of applied ethics, different approaches may be used to understand these problems; they may be seen in terms of the rights and duties involved in medical practice, or how to maximise the good through the work clinicians do, or in terms of the virtues needed to flourish as a clinician or a patient. Deciding which moral framework to apply brings primary care ethics into contact with meta-ethics and epistemology. There is increasing interest in the empirical study of primary care ethics, often using qualitative research methods, which raises important metaethical and methodological questions about the relationship between facts and values.

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