Primary Health Care

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Thank you madam chairperson.

Distinquished nursing colleagues and friends.

I would like to express my deep appreciation to the organizing committee of this congress for inviting me to be a speaker.

The subjec of my address is very popular one, these days, namely the primary health care.

I propose to exchange ideas with you on primary health care and on role of nurses as primary health care providers at present and for the future in Korea.

Let me first of all refer briefly to the policy base which has led WHO to its commitment to the goal of health for all by the year 2000 through primary health care.

The concept of Health for all by the year 2000 can be traced back from the World Health Organization Constitution which was adopted in 1946.

In the preamble, it says that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

It was only in 1977, almost 30 (thirty) years later that this aim was given full attention.

In that year, the 30th World Health Assembly represented by the highest policy-making authorities from 150 member states of WHO adopted a resolution urging that "the main social target of government and WHO in the coming decades should be the attainment by all citizens of the World by the year 2000 of a level of health that will permit them to lead a socially and economically productive life."

This we now know popularly as "Health for all by the year 2000"

This decision was given further substance in 1978 at the International Conference on Primary Health Care held in Alma-Ata, USSR, which stated that primary healty care is the Key to attaining this target.

In the following year, the World Health Assembly in endorsing the Alma-Ata Declaration launched the gloval strategy for Health for all which was adopted by the thirty fourth World Health Assembly in 1981.

Each region of WHO also prepared its regional strategy for health for all:

Since then all the member states of WHO have prepared and submitted national strategies

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for the achievement of Health for all by the year 2000, member states submitted their first reports on the implementation status of their national strategies in 1983 and it is known that they will be evaluating the initial results of their efforts in the Western Pacfic region in 1985.

Let me remind you all of that ICN as an non-governmental organization endorse the concept of primary health care and accept as a fundamental starting point that health care for the preservation and promotion of health is one of the most basic human rights as declared in the Universal Declaration of Human Right.

In a statement to the primary health care conference in Alma-Ata, sponsored by the World Health Organization and UNICEF, ICN declared its intent to cooperate, at international level, with governmental and non-governmental organization and at national level with its member association in making PHC an effective reality and ICN affirmed the commitment of nurses to effect changes in nursing education, practice and management which are conducive to the implementation of P.H.C.

Our concern with health care including primary health care stems from the realization that health is increasingly recognized as a means and indeed an indispensable component of social and economic development.

The general problem of health care is now becoming a social and political issue in many countries.

We have lived too lony with an assumption that the eradication of certain diseases is the Key to the attainment of health, and that the level of national health could only be up graded in direct proportion to the number of good medical facilities.

In such a climate, hospitals played a central role in the field of Health Care.

Modern medicine has rapidly developed as a biomedical science, and become specialized, segmentalized, and sub-specialized.

Modern medicine deals with organ, tissue and modecule of the sick as a unit not the human as a whole.

Also the training period for personnel has been prolonged in order to learn highly advanced modern medicien, and medical costs has been inflating due to new drugs, expensive facilities and equipment.

The more the technology advanced, the higher the medical care price increased.

This phenomenon make the low-income group less able to afford to medical care, which is contraty to the theme of health care for all.

It is a well known fact that inspite of tremendous increase in health expenditure and high level of sophistication in medical science, the majority of population of world today, does not have benefit of essential health care.

Currently the health status of more than 50% of people, particularly those who live in social peripheries of rural as well as urban of developing countries is reported to be unacceptable.

The existing medical care delivery based upon free marketing system has bean largely

conducive to the development of highly centrally located and technically sophisticated facilities for curative services.

1) and the system has brough to out

(1) waste in health resources

(2) inbalance in health resource between urban and rulal areas.

(3) sky rocketing cost of medical care

and (4) expansion of technical manpower that can function only in the context of fixed institution but are incapable of functioning in communities where their services are very much needed.

The cost explosion in health care has been I guess most responsible for a re-exanination of the relationship between the growing volume of expensive health care, particularly hospital in-patient care and improved health status.

There is growing consensus that additional expenditure on health care, inconvention approach at least in the developed countries, is not bringing about a significant improvement in health.

Furthermore, a pattern of spending that is heavily baised towards technically sophisticated hospital is now seen as inappropriate, ever in the developed countries. In low-income countries, the issue is par more clear cut.

Primary health care is an expression of our will to imbue ourselves with revolutionary concept of health care and the need for equity and justice to enhance popular participation and a fair distribution of resource.

In other words primary health care is a new approach which has been adopted as the means 1) to close gap between the health "have" and "have nots"

2) to achive a more equitable distribution of health resources and

3) to attain a level of health for all citizens of the world that would permit them to lead a socially and economically productive life.

Distinguished colleagues and friend.

Now let me introduce you the Korean situation in primary health care.

Most countries in the world today have one common basic problem: that is "how best improve the health status of their entire populations."

The Republic of Korea is no exception.

Although health conditions have improved considerablly in regent decades, the provision of health care is one of the most important social and political issue in Korea.

The complexity of the issue has become more prominent owing to ever changing needs and rising expectations of the population.

Concern for the health of the people in Korea is of cource nothing new.

What is new is the extent of the awareness that health is one of the important dimensions of national progress and that its improvement require concerted effort in all areas of development.

Even before the year of the Alma-Ata Declaration, a few demonstration projects for primary health care were initiated in Korea.

For example, a teaching community health service for medical and nursing students at Yonsei University, and the government basic health services program through health centers were launched in Korea as early as the 1950's.

However, government as well as health professionals paid little attention to comprehensive primary and community health care until the early 1970's.

In the meantime the Republic of Korea government has tried to implement the policy of dispatching medical doctors to rural areas with a wide range of incentives such as offering special academic credits to medical students fulfilling their internship or residency requirements on rural assignments, revalidating defunct licenses for doctors who would volunteer to work in a remote village or scholarships for students who are willing to serve rural areas.

Korea has been determined to provide all of its provincial communities with a medical doctor to solve rural health problem. Until recently, however, the actual outcome of the government endeavour have been deemed rather slack...something approaching a failure.

Thus, with a square look at the situation, our government decided to launch demonstration project in which nurse rather than medical doctors would assume the chief responsibility of delivering health care to remote or isolated communities, in order to undertake the demonstration project, the Korea Health Development Institute (KHDI) was established in 1976.

The KHDI was to serve as the "think-tank" for the Ministry of Health and Social Affairs in formulation of national health policies.

We have enjoyed two fortunate development in the recent past: One was that the concept of PHC, which was adopted by the KHDI back in 1976 as a pilot health project, has produced encouraging results; the other fortunate development was the Alma-Ata resolution of 1978 that proclaimed the idea of PHC as a viable approach to "Health For All"

In 1978, the Minister of Health attended the Alma-Ata Conference and signed the Primary Health Care constitution.

Since then, the primary health care issue has been strengthened with a high priority.

In order to help put the project on the right track, and expand it on national scale, the Korean government created a special law in 1980, mandating health services for farming and fishing villages in distant regions.

The Korea Institute for Population an Health (KIPH) which is the merger of KHDI and the Korea Institute for Family Planning (KIFP) since July 1, 1981, has been assigned to develop and carry out the nurses (who are called as CHP) training programme for the field deployment of CHPs throughout the country as specified under the Special Law.

The Government has, formulated a plan for the development of PHC based on the newly passed Special Law. The plan specified to train 2000 such CHPs in a period of four years beginning in April 1981, 500 CHPs per year.

With the WHO collaboration, thirty national trainers of CHP training programmes were trained, a competency based curriculum was developed, and eight training institutions in different regions were established.

The national trainers' training course in relation to the implementation of CHP training

programmes has been evaluated for the further development and strengthening of CHP training programme supported by WHO technical collaboration in late 1981.

During the period from April 1981 to the end of 1983, 1300 such CHPs have been trained, from the above-mentioned training programmes financed by the Government, who are now serving at PHC posts in rural areas.

We are expecting to have 1800 CHPs by the end of 1984.

These retrained nurses have performed their duties remarkably well for the past three years.

As prescribed in the special law and its subsequent enforcement ordinance, the goal of their activities is to deploy nursing services in rural communities by inculcating upon their denizens the notion of preventive rather than a mere curative care.

Through this new system, we hope to get remote area residents to become aware of their right to health and help them to maintain and improve their health on their own initiative.

My distinguished colleagues

I would like to spend a few minute to brief on findings of a study on the activities of community health practitioners (CHP's) conducted by the Korea Population and Public Health Research Institute which offers us the following assurance.

First of all, PHC as provided by the CHP's is a health service *of, by* and *for* the residents of a local community.

In the past, health services were available only to the well-to-do.

Others depended on the paternalistic services by medical doctors or other medical care providers very much in the unilateral benefactor to-beneficiary fashion.

Now we are trying to stir up a nationwide movement for all communities to set up their own community health care posts through their own efforts rather than subsidies or grants from the government for initial investment (see table 1)

Secondly, PHC provides health services needed and desired by people.

Traditionally Korea was a male-dominated society (which is still true to a certain extent), This social-cultural factor has created the myth that everybody preferred care by a male doctor instead of a female nurse and that, therfore, services provided by CHP's would accomplish nothing significant.

Since the CHP's actually began to deliver their services, however, we found out that just the opposite was true.

Clients would much rather go to a CHP than a public health doctor who is usually a male. (see table 2 & 3)

As can be seen from table 2 and 3, only 6.3% of the local residents interviewed rated public health doctors as very helpful while 93% of them regarded CHP's as very helpful. The degree for their satisfaction with a CHP's curative care was either "very satisfied" or "satisfied"; and 87% of the respondents indicated satisfaction with a CHP's preventive care.

Thirdly, the CHP post which has been set up for the delivery of PHC functions as a point of entry into a kind of medical health service network.

Through services provided by the CHP post, the popular tendency to purchase over-the-counter medicine for private treatment is being radically cut to the level of 40 to 30 on a scale of 100 The rate of visit by rural community residents to the CHP post as the first place where to obtain health care and or counseling is about 93% (see Table 4)

If this desirable tendency continues, it will be possible to detect a disease in its early stage and prevent the abuse of drugs. Consequently, the financial burden upon the local residents and the nation as a whole will also be lightensd. Should the CHP post fail to function properly, however, more and more people will utilize the pharmacies and private doctors for the initial treatment of their ailments.

Fourth, the services provided by the CHP are not what the pharmacises or the general public think they are.

People confuse PHC with PMC, and they think it is a doctor's job to provide it.

Services provided by the CHP mean a comprehensive health management practice, as difined by the WHO and stipulated in our special law.

The CHP in Korea provides a variety of services and activities including PHC (see Table 5). This is a fortunate development indeed.

A 1982 analysis made by the Korea. Medical Assoc. of the record of services rendered by sub-health centers nationwide shows an average of 5.2 patients receive PHC at a given center per day; meanwhile a CHP post offers the same service to more than 6 persons a day, an activity that accounts for 46.1% of the work performed by a CHP post.

Besides tiagnosis and treatment, of minor ailments a CHP also provides diverse services such as maternal and child health care, family planming, school health servies and so forth.

Tifth, another contribution made by the implementation of PHC program in Korea is the effective use of health manpower at the right place and at the right time. The effectiveness of our PHC program can be measured by client responses and the degree of satisfaction felt by the provider with her work. The quality of service obtains when and where its provider feels happy with her job.

We can see from Table 8 that about 30% of public health doctors working at sub-health centers feel unhappy with their job whereas the percentage of the CHP's who feel likewise is only 2.6%.

Sixth, the PHC prosram enhances the economic efficiency of public health services.

By allocating manpower to places when it is needed, the prosram enhances not only the quality and effectiveness of health work but also the optimal use of financial investment.

Here is a very concrete example. The average per-visit cost of diagnosic and treatment that a patient incurs when he goes to a doctor-oriented health center and a job-health center is calculated at 1,062(or $1.33) and 1,667(or about $2) respectively, whereas a visit to a CHP post incurs only 391(approximately 50 cents). Also, the financial self-sufficiency of a CHP post is 25.4% whereas that of a doctor-oriented health-ecnter is 17.6%.

So it makes a great deal of economic sense for a commvity to have a CHP gost.

Ample evidence is also available elsewhere that points to the excellence of the nurse as

PHC manpower.

In a 1980 43 port submitted to the secretary of Health, Education Z Welfare, the Graduate Medical Education National Committee of the United States said: "The quality of care offered by the nurse in primary health care was not only excellent but it was also readily welcome by the patients, thus enabling many institutions to reduce expenditure." The report also suggested that the quality of public health services in America would be greatly enhanced by fostering more nurses as chief carriers of PHC.

The same is true of Korea. Studies by two of our national institution's, the KIPH and the Korea Development Institute, show that PHC delivered by our CHP's is Qualitatively equal to and economically more efficient than that provided by medical doctors.

My prominent Colleagus and Friends

It is not hard to foresee a growing expectation and demand on services by nurses who are actively involved in the area of PHC as long as they are doing their best.

For the suitability of nurses as PHC providers is now being recognized not only in Korea but also the world over.

First of all, we in Korea expect PHC to be firmly established as the entry point to our national health care system.

This will be the only way for us to achieve effectiveness and economic efficiency of health care system.

If PHC is offered to people as a short-term project, they will only end up finding our health policy incongruent

Secondly, we expect PHC to spread to urban centers where many live in conditions no better than those found in remote villages. The number of urban slum dwellers is likely to grow with high-tech industrialization and modernization. This means that PHC services must be extended to cities and towns so as to ensure the health of the urban poor. The Chun administration has already adopted it as a policy to include in fifth 5-Year Economic Plan provisions for the implementation of PHC aimed at the urban poor.

Thirdly, we expect an increasing need for PHC among the elderly whose number is growing. Structural changes in population are inevitable when the avcrage life span of a country's population grows longer.

Korea's elderly population will grow in number. Their expected growth rate for Year 2000 and 2050 is 6.0% and 16.1% of the nation's total respectively. At present our senior citizens constitutes 3.8% (or 1,456,000 persons) of our entire population. Thus we sense an acute need for ways to provide them with adequate health care and social welfare. This means that we will need the participation of nurses even more than before in a wide range of services so as to enhance the effectiveness and efficiency in answering the health questions of our elderly population. In other words, we foresee a future beyond Year 2000 in which the primary focus of our PHC will shift from the rural community (which is currently our target) to the urban poor, then to child and maternity and eventually to the elderly.

Fourthly, we expect nurses to get involved further in the area of diagonosis, treatment and follow up medical care as more and more diseases tend to become chronic or protracted over a long period of time rather than acute. In fact, the participation of nurses in diagnosis and treatment will grow even more essential for the management of many chronic or long-term ailments. Babara Bates, a reputed physician in America, said in her research works and testimonies that care for an outpatient ought to be followed up by a nurse except for the patient's initial visit.

For a nurse is certainly able to assume such a responsibility and carry it out more effectively. Her studies show that the rate of hospitalization of chronic patients was reduced by 50% when nurses were involved in the management of their care; also, the frequency and length of hospitalization of elderly patients abated substantially when nurses took charge of their care at home or nursing homes with support from doctors.

Fifthly, we project that in the future curative institutions will adopt PHC as their in-house health service. They will have to, because institutional medical care is the most costly of all health services. This heavy yolk must be taken off the shoulders of people and government. People must be allowed a fair and easy access to medical care that they deserve. To this end, we have to seek ways in which institutional medical services can be delivered both economically and effectively.

The slackness of health management that we have today cannot be tolerated any longer. Particular care must be taken with regard to personnel management since this is the costliest area. Here we must apply "the right in the right place" principle. The distance between the outpatient clinic and the nurse's ward is not great. Witness the Kaiser hospitals in the United States where NP's team up with doctors in the outpatient clinic to provide ambulatory care. Soon the NP-doctor teamwork is expected to spread over to private clinies, creating a kind of medical venture in which the NP and the doctor will collaborate as partners.

Dear colleagues and friends

The emergence of new technology and knowledge in the field of health science necessarily alters the functions and roles played by health manpower. The current trends and changing conditions at this point are such that it is rather easy for us to predict the arrival of PHC to maximize the participation of nurses. PHC offers ample opportunities for nursing to develop its full potentials to contribute to health. This is a big challenge. Changes of this kind are not temporary; they are changes accompanying new developments. They are here with us today and they will be there with us tomorrow, coming to us at an ever increasing speed. Why? Because there is nothing around us to reverse the direction of developments and changes that they generate. Thus we are posed with the question of whether to be the master of these changes or their servant. Whether we can adequately meet this challenge depends on our own capabilities.

It is a difficult one because PHC is more than just medicine and nursing, and because HEALTH is considered as part of HUMAN DEVELOPMENT to which nursing should and

can make contribution. This, after all, is the reason for the existence of our profession.

My distinguished member of sigma Teta Tau colleagues, and friends.

I would like to take this opportunity to say a few words before leaving this platform.

I believe that this seminar will be over by tomorrow.

I hope it has been an excellent opportunity for all of us to know each other and to exchange our thoughts and ideas on a wide range of topics.

I believe, your visit certainly gave us a great deal of fresh stimulus and encouragement for the growth of nursing in Korea.

I trust that you have looked around the country quite a bit. I sincerely hope that your discovery of Korea has been an enjoyable one.

Looking ahead somewhat, we will be hosting the ICN congress in 1989 here in Seoul.

We will be hosting the Olympic game in 1988, by 1989 we will have better accommodations for you.

And the ICN congress will be held May or September, avoiding monsoon.

Let us host all of you again in 1989.

Thank you very much for your attention.

Table 1. Ways To Secure Initial Funds for The Establishment of A CHC Post

Ways	Percentage
Investment by Local Residents	54%
Revenues from CHC Post	2%
Other Sources	32%
No Response	12%

Data: KIPH 1982 research on CHP activities

Table 2. Degree of Satisfaction with Services Rendered By CHP's

Degree	Curative Care	Preventive Care
Very Satisfied	63.3%	57.3%
Fairly Satisfied	32.7%	30.0%
In-between	3.3%	9.3%
Hardly Satisfied	—	0.7%
Not Satisfied At All	0.7%	0.7%
No Response	—	2.0%

Data: KIPH 1982

Table 3. Attitude To CHP's & Public Health Doctors

Degree	CHP	PHD
Very Helpful	92.7%	6.3% Very Good
Fairly Helpful	6.0%	45.7% Fairly Good
In-between	1.3%	34.6% So so
Hardly Helpful	—	11.8% Not So Good
Not Helpful At All	—	1.6% Bad

Data: KIPH 1982

Table 4. The First Place of Visit By Rural Community Residents for Health Care & Counseling

Place	Rate of Choice
CHP Post	93.3%
Health Center	—
Sub-health Center	—
Private Doctor	4.7%
Pharmacy	2.0%
Oriental Doctor	—

Table 5. CHP Post Activities By Types

Type of Activity	Cases of Service Per Mo.	%
Diagnosis & Treatment	181.5	46.1
Maternal Health	16.5	4.2
Child Care	54.2	13.8
Family Planning	17.6	4.5
School Health	123.7	31.4
Total	393.5	100.0

Data: KIPH 1982

Table 6. CHP's Rate of Job Satisfaction

Location	Satisfied	Fairly Satisfied	Dissatisfied
CHP Post	22.6%	74.8%	2.6%
Sub-Health Ctr	35.6%	35.4%	30.0%

Data: KIPH 1982
KMA 1983