Conference Report

Primary health care: is it poor care for poor people?

SUE BURKHART

Primary health care is a concept that was invented by the World Health Organisation; it applies only to "developing" countries and not to industrialised ones; and it is the same thing as primary medical care—what general practitioners provide in Britain. This is not true, according to Dr Hannu Vuori, WHO's regional officer for primary health care in Europe. To an audience of 100 health professionals and administrators (200 had to be turned away for lack of space) at the King's Fund recently, Dr Vuori explained the Alma Ata Declaration, which invoked complete mental, social, and physical health for all by the year 2000 (see Dr John Horder's article on page 191). The world declaration was signed back in 1978 by all the European members of WHO, including Britain, and since then the signatories will be asked to report on what policies they have to improve primary health care as the first step in achieving this enormous goal. The declaration has received little publicity in Britain, so this conference was organised to look at the possibilities and problems of making health for all come true in Britain by 2000.

Refuting the three fallacies above, Dr Vuori said that "primary health care" had meant different things in different countries. Some thought that they had invented it, while others were organising one week courses to prepare their doctors for it, and still others had never heard of it before Alma Ata. Demolishing the widely held belief that primary health care was meant only for developing countries, he cited two goals of Alma Ata: safe water everywhere and widespread vaccination against disease. Granted, tap water is generally safe throughout Europe, but would you swim in some of Europe's rivers? As for vaccination, the record in Britain for whooping cough spoke for itself. And, regarding the third fallacy, he said that in primary health care the shift was to community participation in health, getting away from the general practitioner or specialist as the first contact, as happens in most countries in Europe now providing primary medical care.

Health care systems should be based in the community, be acceptable to the community, and provide the services that people thought that they needed and wanted. The results of one survey had shown that 75% of health problems never reached the medical services—thus they were under "lay care"—20% went to primary medical care, and 5% without to hospital and specialists. Encouraging people to take more responsibility for their own health was a vital element. Attitudes had to change and the emphasis had to shift from thinking about illness to thinking about health (table 1). After Dr Vuori had put Alma Ata in a European context a general practitioner, a nurse/health visitor, and a voluntary worker commented. All of them brought out some practical problems that must be faced before Britain could begin to change.

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SUE BURKHART, staff editor

Shifting the emphasis:	To health
From:	health prevention and care
Illness	health promotion
Treatment	community workers
Epidemiology, treatment	community workers
Specialists	other social workers, health visitors, etc.
Physicians	community workers
Specific problem	comprehensive care
Single-handed doctor	collaboration among all sectors—housing, education, etc.
Health sector alone	community participation
Clinical decision making	self-reliance
Passive reception by patients	lay care
Professional domination	

Britain's answer

Dr David Hannu practices in a health centre in Glasgow, where the old terraced houses had been replaced with high rise flats and a health centre built. He said that the results of a survey of 1444 patients registered with the health centre had shown that half of them were not living at the address given on the records. He also said that in Glasgow the average family moved every four years. How could he define the "community" around Woodside Health Centre? Was it meant to be collective or individuals? He had also found that people who had to walk or ride a bus for more than 20 minutes to the health centre consulted less often than those who lived closer or came in cars, and so did people who lived above the fourth floor in tower blocks consult less often than tenants below. Twenty eight per cent of patients with physical symptoms had never consulted, but 11% had—with trivia. This was the tip of the iceberg. To get where WHO wanted us to we must find out where we were now.

Shirley Goodwin, honorary secretary of the Health Visitors Association, spoke with refreshing frankness from a nurse's point of view. Primary health care was meant to focus on the community, but nurses were trained in and for hospitals and chose to go into nursing to care for sick and helpless people. Would they accept nursing for health? As for primary health care teams, it was well known that teams did not always work well together, and furthermore the Health Visitors Association supported the independence of their members. To make teams work better she thought that health professionals should be brought together during training, when they could learn from each other. A big disincentive to teamwork was the discrepancy in the status and remuneration between doctors and nurses. As for nurses promoting self care, again a change in attitude was needed to come to terms with working with lay people. They were amateurs and nurses were professionals who had knowledge to spread. It would be difficult to swallow that "not only is the patient not mine, but the responsibility for the patient's care is not mine either."

Heleen Rosenthal works for the London Voluntary Services Council in City and Hackney. She reported an increase in community participation in health, citing projects like the group

of mentally handicapped adults that met to discuss nutrition, sex, and dental care; antenatal groups, some of which turned into postnatal groups; and a continuing debate about childbirth between East End women and obstetricians. But Alma Ata was not that local authority community workers were tackling health as well as social problems, and they also acted as advocates for ethnic groups, interpreting their needs as well as their language for health workers.

What can be done in Britain?

After the King's Fund's superb lunch the conference had been meant to draw up suggestions for Government policies and reallocation of resources to improve primary health care in Britain to implement Alma Ata. By the end of the afternoon, however, there was a lot of confusion and the number of concrete suggestions could be counted on the fingers of one hand. Family practitioner committees now opened their meetings to the public, the community health councils, and the press. They would also help GPs to set up age-sex registers and trace patients for research projects. The Government was encouraging family practitioner committees to meet and plan with the new district health authorities, and new legislation would make them accountable only to the Secretary of State. And the Department of Health and Social Security was doing a lot of work to answer the Acheson report on primary health care in inner London and would report "soon."

To consider again the main tenets of Alma Ata: that the first

Acne and oral contraceptive

The progestogen component of an oral contraceptive may be androgenic and overcome the oestrogen component in a combination pill, making the pill androgen dominant. Norgestrel is such a progestogen, which even in combination with ethinyl oestradiol is unsuitable for women with acne. Many practitioners seem unaware that pills with norgestrel may be androgenic, and acne is not mentioned as a possible side effect.

In a recent study of 67 women attending University College Hospital for acne 26 were taking oral contraceptive pills and 17 of these were taking combination pills with norgestrel (Eugon 30, Microgynon 30, Ovranette) and one taking norgestrel only (Neogest). Acne had first appeared in a third of these women while they were taking the pills, and two-fifths had acne before taking the pill reported an improvement in the condition of their skin. All three women taking Minovlar (1 mg norgestrel/acetate, 50 µg ethinyl oestradiol) reported improvement in their skin condition. Although norgestrel and norgestrel/acetate (or its acetate) are both derivatives of 19-Nor testosterone, norgestrel apparently lowers concentrations of sex hormone binding globulin, whereas norgestrel/acetate does not. We previously reported that just over half of women with severe acne (not on oral contraceptives) had concentrations of sex hormone binding globulin below the normal range and two-fifths had raised free testosterone concentrations. Minovlar raises concentrations of sex hormone binding globulin, thus reducing free testosterone; and it also lowers the rate of sebaceous excretion.¹ If a lower dose of oestrogen is preferred, Brevinor or Ovynorm (0.5 mg norgestrel/acetate, 35 µg ethinyl oestradiol) or Loestrin 20 (1 mg norgestrel/acetate, 20 µg ethinyl oestradiol) also raise concentrations of sex hormone binding globulin appreciably.²

A particularly well-suited combination, provided there are no other contraindications, for treating acne in women is an androgenic and progestogen cyproterone acetate (Androcur)—cyproterone acetate combined with ethinyl oestradiol. A trial in 1975³ claimed benefit in 95% of women with acne, and in a more recent study a reversed sequential regimen of 50-200 µg cyproterone/acetate from day 5 to 14 of the cycle and 50 µg ethinyl oestradiol from day 5 until day 25 of the cycle (Three-fifths of women with acne had improvement). This combination will suppress gonadotropin secretion, thereby reducing ovarian androgen secretion and increase production of sex hormone

contact between the patient and the Health Service should be through "primary health care"—that is, through all health and professional workers and the people in the community—and that a state of health should be emphasised rather than a state of illness, the conference brought out the difficulty of defining and focusing in Britain now. Was a community a neighbourhood or a catchment area for a GP's surgery or a health centre? How do we find out what people want when a lot of people do not even go to their GPs let alone know that community health councils and family practitioner committees exist to help them? Except for the recent surge of interest in prevention, can health professionals be taught to deal with health and not illness? As Professor Brian Abel-Smith, chairman of the conference, pointed out the GP's contract has not changed fundamentally since 1911—and it certainly did not require him or her to go and seek patients.

The objective of the conference was to look at what had been achieved in primary health care in Britain in light of the principles of the Alma Ata Declaration. Though the system of general medical services was well established in Britain compared with other European countries, priority was given to the secondary services: resources were allocated to hospitals and technology and the emphasis was on illness, not health. Many at the conference thought that we needed to know much more about what was being done in the "community" before any plans were made. The chairman ended the conference with a suitably cautious statement: "If we are at least, in the long run, to have a better change, then we have achieved something." Certainly the barriers are there.

binding globulin, thus reducing free testosterone. In addition, the androgenic blocks androgen receptor sites in the skin and presumably in the sebaceous glands, thus providing benefit to women with acne.

An oral contraceptive preparation containing 2 mg cyproterone acetate and 50 µg ethinyl oestradiol (Diane) is currently being assessed and the results seem promising. We hope that this preparation will soon become available for the treatment of patients with acne or hirsutism, or both, who also require contraception.—D. M. LAWRENCE, M. KATZ, G. C. LACHLIN, Department of Obstetrics and Gynaecology, University College Medical School, London WC1, and M. STAW, Department of Dermatology, St Thomas's Hospital, London SE1.

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FELINE OBSTETRICS

There are two female cats, mother and daughter, dwelling in the laboratory of a scalpel and first rate emulsion, in the west end of town. They are by no means kindly disposed towards each other; rather the contrary, excepting on particular occasions, which are their respective periods of parturition. So as seen as one exhibits parturient inquietude, the other endeavours to cheer her by all the kind attention she can perform towards her mamma, or daughter, as the case may be; and when labour actually takes place, they both repair to a box, which serves them for a bed, and placing their backs against opposite sides, make a concourse of paws and claws against the abdomen of her patient, and continues the operation of kneading and rubbing her until a kitten is passing the *os externum*. Then she changes her mode of attention, and assists in bringing forth the young one, in a manner which instants informs her is most calculated to alleviate the pangs of birth. (General Miscellany. *London Medical Repository and Review* 1827; 8: 577.)

Practice Research

Intrauterine contraceptive device clinic in a group practice

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Little information has been published about what family planning services are provided in general practice.¹ This report covers the 10 years from 1 January 1972 to 31 December 1981, during which we ran a clinic in our practice for the insertion of intrauterine contraceptive devices and follow-up according to guidelines set up by the Family Planning Association. A total of 375 intrauterine devices were inserted, which gave 10 295 months of effective use. There were 17 intrauterine pregnancies, two ectopic pregnancies, one perforation, and six cases of pelvic inflammatory disease.

The practice had 11 900 patients on the list, of whom only 960 were aged over 65 years. A large proportion of patients were in families, mainly in social classes II-IV. I began with one session a month for insertions and a second session for check ups, which I combined with a well woman clinic in which cervical smears were taken. When another doctor joined our group practice in 1978 we doubled these sessions. The practice was already holding antenatal and postnatal clinics. One of our midwives helped in the intrauterine device clinic. She completed the short Family Planning Association training course for nurses. When she retired in 1977 two of our allocated health visitor assistants did the work after training with the Family Planning Association.

Patients and methods

Before an intrauterine device was inserted each patient was seen by appointment to give her the opportunity to ask questions, express her fears, and examine the device. Failure rates and possible complications were discussed. We did not encourage nulliparous women to have an intrauterine device because of the known, though small, risk of pelvic inflammatory disease. There were only two nulliparas in this series. I also discouraged women who described their menses as long or "heavy," or both. Women were referred by partners and also by our midwives, who had discussed birth control with patients who had just had a baby. It was impossible to do all insertions at or just after menstruation, but the possibility of interim fertilisation was discussed with patients who took suitable precautions while awaiting insertion. If there was any doubt about whether a woman had conceived—for example, a lactating woman who had not yet menstruated after having a baby—a Gravindex was done one week before the insertion date. Thus, a calm atmosphere was achieved at the clinic because patients knew what to expect and the surroundings were familiar. Some women were nevertheless tense. By asking the woman to wash with a light internal cervical on to take a deep breath and exhale slowly when the intrauterine device was in the cervical canal, the on often relaxed suddenly, allowing me to slip the device in to the uterus. About 15 minutes after insertion patients were ready for a cup of tea in the waiting area.

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I told patients to telephone me any morning during surgery hours if they had problems (very few did), and to report for treatment if they developed lower abdominal pains, particularly after delayed menstruation, or an excessive or unpleasant vaginal discharge. Appointments were made for follow-up at six to eight weeks, after one year, and every year thereafter. Poor attenders for follow-up received reminder letters, occasionally a phone call, and in a few cases a visit from me. They were encouraged to contact either me or another partner if they thought anything was going wrong.

Results

Several different types of intrauterine devices were inserted (table 1). Although the number of Saf-T-Coils inserted was small (29) there were seven serious mishaps, including one acute salpingitis in a woman aged 39 (on date of insertion) after the coil had been in place for 46 months and six intrauterine pregnancies. Two of these progressed to incomplete septate abortion: one in a woman aged 24 (on date of insertion) after 33 months of use, the other in a woman aged 39 (on date of insertion) after 46 months of use (tables II and III). There may have been some personal, albeit unconscious, bias in the selection of women for the Saf-T-Coil, but we decided that the number of mishaps was unacceptably high and no longer use it. Of the 17 women with intrauterine pregnancies three delivered live

TABLE 1—Details of use of various intrauterine contraceptive devices

	Total No.	No. of (C and D)	No. of CuTs	No. of Saf-T-Coils (1972C)
Intrauterine devices	375	258	86	29
Total No. of effective	10 295	8032	1416	747
Average No. of months	27.45	31.52	16.09	25.75
No. of women who left with IUD in place	327			
No. of women continuing use	144			

*There were 316 first insertions and 49 relays.
†Duration of effective use was taken as last date of attendance recorded with device in place.

TABLE 2—Details of mishaps with various intrauterine contraceptive devices

Mishaps	Loops	CuTs	Saf-T-Coils	Total	Per 100 women years*
All pregnancies	10	3	6	19	2.214
Intrauterine pregnancies	9	1	0	10	1.135
Septate pregnancies	1	0	0	1	0.113
Perforation	5	0	1	6	0.699
Discharge	1	0	0	1	0.113
Expulsion	12	3	0	15	1.748
Chronic discharge or cervicitis, or both	4	1	1	6	0.699

*Part Index Formula.
†Acute salpingitis, 2° grade inflammation.

TABLE 3—Details of intrauterine devices in place for 5 to 8 years

	No. of women	Total No. of effective	Average No. of months of use	Average age of women (years)	Mishaps
All Loops, Saf-T-Coils, and CuTs	4031	71 29	32.32	26.16	2 pelvic inflammatory diseases (low grade), 10 intrauterine pregnancies (both in Loops)

babies, including one set of twins. Six pregnancies were terminated. In two early unconfirmed, but probable, pregnancies that threatened abortion the intrauterine devices were removed, and both women stopped bleeding and reverted to normal menstruation. Of the remaining six, all had incomplete abortions and the retained products were evacuated. The two septate abortions mentioned above are included in these six.

Ectopic pregnancies. 2.—One was in a girl aged 22 with CuT in place for seven months; the other was in a woman aged 36 with a Loop after 23 months, who had had an attack of salpingitis some years before the intrauterine device was fitted. A third woman with CuT was diagnosed as having a possible ectopic pregnancy and underwent laparoscopy, but nothing abnormal was found and after dilatation and curettage she was refitted with another CuT.

Expulsions. 15.—Only one of these 15 women became pregnant; aged 24, and delivered a normal baby at term. She had previously expelled a Saf-T-Coil after one month. Five expulsions occurred within two months, but four were after 20 months. Seven of these women were referred.

Pelvic inflammatory disease.—The diagnosis rests ultimately on clinical judgment, which is fallible and therefore difficult, as pointed out by Snowdon,² and it is likely that low grade inflammation sometimes escapes detection. One 38-year-old woman had peritubal adhesions at laparoscopy for sterilisation after impaction of a Loop, which was removed by dilatation and curettage after 71 months of use. She had not complained of any symptoms suggesting pelvic inflammatory disease but had recent intermittent and prolonged bleeding. I had attempted removal unsuccessfully. The second woman with low grade pelvic inflammatory disease showed a messy cervix with slight elevation pain on moving it with the examining finger. This was treated with oral metronidazole and vaginal clorotrimazole pessaries. The intrauterine device was not removed. The four women with acute salpingitis were treated by removing the intrauterine device under antibiotic cover. Two other women were suspected of having pelvic inflammatory disease but at operation they had ruptured ovarian cysts.

Perforation.—The patient, aged 29, para 3, was fitted with a Loop seven months after her third baby was born. She was on the progestogen-only pill and was still breast feeding. The uterus was not

recovered, there was no history of previous surgery of the uterus, and no difficulty in inserting the Loop. Nevertheless, the tails could not be seen nor brought down three months later. X-ray film showed that the Loop was located posteriorly in the midline and the Gravindex was positive. Her pregnancy was terminated, the intrauterine device was removed, and her tubes ligated.

Fetomaternal blood at insertion.—Three patients felt faint, and in one the pulse rate fell to 48 for two or three minutes. A fourth patient suffered a brief episode of hyperventilation tetany.

Discussion

Our results compare not unfavourably with much larger surveys. "It has been estimated that 15 000 000 women worldwide use the intrauterine contraceptive device." The Family Planning Association has done splendid pioneering work and essential work continues in its clinics, but I suggest that the ideal environment for insertion of intrauterine devices and follow-up is in general practice. Some complications may arise during their use, and a few potentially serious ones need to be seen by a doctor quickly and treated immediately. Such care can easily be provided in a group general practice with all overall care of patients. This service can be usefully combined with a well woman clinic in which intrauterine devices are checked and cervical smears taken.

I thank Dr Jenny Bolt for permission to include data on 72 insertions. I also thank my partners Drs R Brown, R C W Hughes, G D Withers, and C Sellack for encouragement, help, and advice; nurses Betty Jones, Christine Harris, and Angela Edgcombe for their work, good humour, and tact during clinics; and our receptionists and secretaries who found records for me, helped me to chase recalcitrant non-attenders, and also made 375 cups of tea.

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Diary of Urban Marks: 1880-1949

On entering St Mary's on 1 May 1899 I went straight to Dr Ridewood, the professor of biology, who agreed to give me extra tuition in that branch of science. I was a student of the University of Cambridge and physics lectures on account of my past record. I devoted 10 weeks working eight hours daily and sometimes more at biology, and it was during this period that I obtained a second class pass in the Preliminary Scientific Examination in July 1899.

It was while studying biology that I discovered a peculiarity

into a biscuit tin with a piece of cotton wool soaked in chloroform. Both of these procedures gave me cold shivers down the spine. The convulsions of the dog and the hideous cries of the rabbit physically sickened me and made me vomit. I was of course laughed at, but it was no joke to me. The animals were killed for me and once dead I experienced no nausea. But even today I cannot pick up a live bird. To do so would cause me to faint. Yet I would have no hesitation in doing anything to the human body alive or dead.

When I reported the result of the examination to Mr Went [former headmaster] he was frankly amazed and offered me a glass of water. It was a very hot day. Beyond that he had nothing to say.