From I.W.W.

Ian Webster "Health for All" Oration: a global perspective on the contributions of primary care to health equity

This oration honours Professor Ian Webster AO and his lifetime of commitment to primary health care and health equity. Ian is a great medical humanitarian and a role model for us all.

Being invited to deliver the Ian Webster Oration is an honour and also a daunting challenge. Especially in front of Ian himself.

In 2005 the *Sydney Morning Herald* published a wonderful article about Ian headlined "*A friend to those in need*". I was living here in Sydney at the time and I remember sitting in my apartment in Kings Cross, eating my breakfast and reading the article. My dining room window looks out over Woolloomooloo where Ian had been working for 30 years as honorary visiting physician at the Matthew Talbot Hostel for the Homeless. I remember thinking what a wonderful epithet, "*A friend to those in need*".

The article described how Ian was spending, in the journalist's words, "*his golden years healing the poor, trying to reduce suicide rates and improve mental health policy.*"

The journalist wrote, "*while some of his peers may have retired to the golf course, Professor Webster prefers to work at the coalface with under-privileged and highly vulnerable people.*"

My own career has overlapped with Ian's in a number of ways. Through my clinical practice, during my 13 years working as a GP in

Darlinghurst, especially working with people with HIV, I have been involved in the care of some patients treated by Ian. Ian and I share a passion for academic primary care. We share a passion for improving mental health care. And we share a passion for improving the health care provided to vulnerable and marginalized people, with Ian approaching this from a drug and alcohol perspective, while my approach has been from a blood borne virus and STI perspective. There has been lots of overlap, especially when it comes to advocating for the continuation of the successful needle and syringe exchange programs established across this country following the beginning of the HIV epidemic and through support for this state's world leading medically supervised injecting centre in Kings Cross.

I was trying to recall when I first met Ian. I think it might have been in 1989 when I was a new academic general practice registrar at Monash University. That year the Australian Association of Academic General Practice, now called the Australian Association for Academic Primary Care, was due to hold its annual meeting in Perth in conjunction with the annual conference of the Royal Australian College of General Practitioners. But that was the year the Ansett pilots went on strike and domestic air travel around the country quickly ground to a halt so the college conference had to be cancelled.

My boss at Monash University, Neil Carson, was the AAAGP president at the time and he wanted our meeting to continue so he offered to host a two-day general practice research conference in Melbourne and dobbed me in to do all the organising. General practice

researchers came to Melbourne by car, by train, by bus and even by boat, from Tasmania.

I remember looking around the room at the gathered senior leadership of the Australian academic general practice community and feeling in awe of the collective wisdom all brought together in one place. In those days I thought you had to be brilliant to be a professor. Later, when I became a professor, I discovered that wasn't necessarily always true.

Ian was, of course, one of the nine foundation professors of community medicine and general practice appointed in Australia in the mid 1970s as part of the Whitlam Government reforms of Australian health care. Among the nine are other legendary names in Australian general practice like Charles Bridges-Webb, Max Kamien and Neil Carson. Ian took his appointment seriously and went on to sit the fellowship examinations of the Royal Australian College of General Practitioners, becoming a Fellow in 1988. In fact I think Ian might be Australia's most "fellowed" doctor with earned fellowships of the colleges of physicians, general practitioners and medical administrators, and the faculties of rehabilitation medicine, public health medicine and addiction medicine.

As family doctors, we are all indebted to our teachers; our family doctor colleagues who have taught us how to practise medicine in our communities using a combination of, as John Murtagh likes to say, "scientific knowledge and tender loving care". Indeed this is the Latin motto of the RACGP, *cum scientia caritas,* "with scientific

knowledge and tender loving care." Our teachers during our medical training and subsequent careers have influenced the sort of doctors we became.

Our medical schools shape our future doctors, and shape our health systems, and are also shaped by our health systems. Doctors are granted substantial privileges and resources by our society. These privileges imply a corresponding responsibility to participate in improving health systems and training the next generation of doctors to meet the needs of our societies. While our medical schools have the capacity to influence health care systems, they do not always choose to do so. Some medical schools pursue research agendas and technological developments that have limited relevance to the urgent, unmet health care needs of the communities where they are based.

Social accountability involves a commitment by medical schools to direct their education, research and service activities towards the priority health concerns of the community, region or nation that they serve. Such responsibility to society should guide every medical school and permeate the scope of their activities. The four values used to assess progress in our health systems- relevance, quality, equity and cost-effectiveness– are equally important for our medical schools. The University of New South Wales and Flinders University, where I am now dean, and are two Australian universities which have a strong commitment to social accountability, especially in our medical schools.

We share a commitment to health equity, to addressing the urgent health care needs of Aboriginal and Torres Strait Islander people, to addressing the health care needs of people living in rural and remote Australia, and to supporting the health and well being of the people of our near neighbours in the Asia Pacific region.

And it is through academic leaders like Ian that universities like this have seen the light and found ways to make a positive impact, especially towards health equity. Our medical schools are preparing our medical students to work where they are most needed. And we are seeing a greatly heightened interest among our medical students in global health and the contributions we can all make towards health equity and universal health coverage.

I am going to share with you some perspectives on the contributions of primary care, and specifically family medicine, or as we say in Australia, general practice, to health equity. These perspectives are based on my experience over the past 15 months as president of WONCA, the World Organization of Family Doctors.

WONCA was founded in 1972 by 18 colleges and academies of general practice and family medicine from around the world; 18 organisations with members sharing a commitment to improving the quality of life of the peoples of the world through fostering high standards of care in general practice/family medicine, and through respect for universal human rights. Australia is represented in WONCA through both the Royal Australian College of General

Practitioners, the RACGP, and through ACRRM, the Australian College of Rural and Remote Medicine.

Forty-two years later WONCA's mission remains the same and WONCA now has a membership of over half a million family doctors in 131 countries around the world. WONCA's membership includes Ian and all the members of the RACGP and ACRRM here today. The 500,000 family doctors represented by WONCA each year have over 2 billion consultations with our patients. Two billion. That's the scope of our current work and our influence.

But we need to do more. We need to work to ensure that every family doctor, every GP, every primary care doctor, joins us in our commitment to deliver high quality primary care to our patients and communities. And we need to expand our commitment to the education and training of family doctors and quality care and primary care research to the 80 nations of the world where WONCA does not yet have a presence, which includes some nations across Asia and the Pacific Region, especially among the island nations of the Western Pacific. This is one of my personal goals as president and just this week we have welcomed family doctors from Bhutan to the WONCA family.

In the words of our very first WONCA president, Australian Dr Monty Kent Hughes, speaking to the first WONCA world council held in Melbourne in 1972: "the future of our professional discipline will depend on our ability to work together in the service of humanity."

And we have been working together ever since, providing the global voice of family medicine and advocating for the important work GPs, family doctors, do every day in meeting the health care needs of our patients and our communities. We are also the eyes and the ears of global health care observing and listening to our individual patients and our communities and identifying their health care needs. And we are the head and the heart of global medicine – combining our scientific knowledge with tender loving care.

Why do we do this? Because family medicine and primary care is important.

Because the evidence is clear that health systems based on strong primary care, which includes strong family medicine, are the most efficient, equitable and cost-effective.

Because strong primary care is the best way to improve the health of individuals, families and communities.

Because we believe every family should have a family doctor who the members of each family can trust for their medical care and advice.

Because family doctors and the members of our primary care teams are part of the social fabric of our societies and we work together to keep the fabric of health care together.

The family practice team has an important role to play in the life of every family in every community in every nation of the world.

In the words of Professor Ian McWhinney, one of the giants of our profession who passed away recently, "ideally, family doctors should share the same habitat as their patients." This allows us to best understand the social context of our patients' lives.

Ian understands this social context well. Ian was born in rural Victoria, in Kyabram, during the Great Depression and witnessed the all-too-apparent poverty at that time which formed his famed commitment to helping those who find themselves in difficulty.

There is a wonderful quote from Ian in an article from the Penington Institute: "*One of my passions is about injustice and poverty. It's... about wanting to see things done fairly, feeling anger at injustice... and at exploitation of people. I want to stand on the side of the people who have led difficult lives... and who nevertheless demonstrate resilience in the face of those adversities.*"

Ian witnessed the challenges of rural life during his youth. Many of these challenges persist today and we cannot tackle health equity without addressing the health needs of people living in rural areas right around the world.

Last month WONCA released our new Rural Medical Education Guidebook. In one wonderful chapter, Dr Susan Phillips from Canada writes about the challenges of attracting doctors to work in rural areas and attributes this to images of rural doctors. Susan challenges the stereotype of the rural doctor as a "rugged male". Susan did a search of Google images and described her findings.

Susan states, "*The typical picture of the family physician and, the rural doctor in particular is the rugged male.*" I did a Google search and, sure enough, my Google search brought up the same image. Susan goes on, "*Although hardly scientific, a Google search of why doctors choose rural practice unearthed many images of male physicians hiking across fields and forests (often wearing stethoscopes), riding horses, or roasting pigs on a spit. On those rare occasions when women are pictured, they are at work, smiling at children, and wearing those white lab coats most of us abandoned years ago. A recurrent picture is what might be labelled 'The Big Fish', not because the doctor gets to be 'a big fish in a small pond' (a role some might seek) but because the male rural doctor is often holding his catch of the day – a big fish!*"

Susan says that "*such images can deter young female doctors from rural family practice. If learners do not see themselves in their preceptors or work mentors, they will avoid such practice settings. Yet while the icon of the rural physician is stereotypically male and not inviting for women, women are drawn to remote practice with the same frequency as men. ... Perhaps it is the attraction of the rural setting as 'a place to make a difference' rather than 'the big fish' that explains why women doctors might choose a career as a rural family doctors.*"

While our clinics may be different from country to country, what is important is the way we are the same – through our commitment to comprehensive, continuing, coordinated whole person care. Through care that is person-centred, and family and community-oriented.

Through first-contact care, acute care, chronic disease management, prevention and health promotion. And through our understanding of the interplay between population health and the health of individuals in our communities.

This is the wonderful Professor Barbara Starfield who showed through her research comparing health systems in many different countries, that comprehensive care by generalist primary care doctors is not only more cost-effective, but also leads to better health outcomes at a population level than compartmentalized narrow specialist care.

Barbara, through her research, provided us with the evidence of the benefits of primary care in lowering the cost of care, improving access to services, and reducing the inequities in a population's health.

I last met with Barbara a few months before she died in 2011. Barbara was keen to talk about the biggest challenges she saw for family medicine in the future, and what WONCA, and what Michael Kidd as the incoming president, should be doing. This being the great Barbara Starfield, I wrote it all down. Here is Barbara's last message for WONCA:

"*Here are the three challenges I think you should focus on:*
"How do we develop primary care research to address the challenges of care for people with comorbidities?
"How do we truly adopt patient-centredness into family medicine?

"How do we use the information from primary care to improve population health?"

There is enough in that simple statement for a dozen PhDs at the UNSW Centre for Primary Health Care and Equity.
Barbara recognised the failure of guidelines to accommodate comorbidity and multimorbidity and the need to turn our evidence-base upside down.

Barbara recognised that primary care is person-focused, rather than disease-focused and that our health systems need to be reformed to focus on person-centred care and to embrace our greatest allies in family medicine – our patients.

And Barbara recognized the power of the information that we are starting to collect through digital means in primary care and how this can be used to improve population health? We need to build our own evidence base from primary care. And where do we get this evidence from? The answer is right in front of us. It is from our encounters with our patients. In the words of immediate past WONCA president, Rich Roberts, "If we want evidence-based practice, we need practice-based evidence." Research like this is critical to the continuing development of family medicine.

One privilege of being WONCA president is that I am invited to visit family doctors across the world to gain insights into the challenges that our colleagues face in providing the best possible care to the people of their local communities. I want to share with you some of

the lessons I have been learning over the past year about the contributions of primary care to health equity, by sharing with you stories from some of the remarkable family doctors I have met over the past year. I will also share with you images of our colleagues from around the world working in their family medicine clinics. The patients you see in these photos are other family doctor colleagues role-playing, so that there is no breach of patient confidentiality.

This is Dr Yin Shoulong, a rural general practitioner in Tai Shitun Village in China, who hosted my visit to his clinic in March. Tai Shitun Village is in the Mi Yun District, two hours drive north of Beijing and a very different world from the densely populated metropolis to the south.

Dr Yin lives in a typical Chinese rural village house built around a central courtyard with his clinic occupying one side of his home. His patients are from his farming community and many are impoverished and elderly and frail.

Dr Yin has devoted his career to supporting the health and well being of the people of his village and the surrounding district. Recently he has become involved in providing experience in rural medicine to young family medicine trainees on rotation from the prestigious Capital Medical University in Beijing. He is part of the primary care revolution underway across China.

China has embarked on a massive drive to train and recruit up to 400,000 general practitioners in the next seven years in order to

reform the country's health system to meet the current and future needs of the population, especially the 800,000,000 people living in rural areas.

The reforms underway in China will have implications for the rest of the world, and especially for those countries where family medicine is not yet well established. The Chinese Government recognizes that one of the biggest challenges is training the family doctor workforce to meet the needs of both urban and rural China. If the challenges can be met with success, then this should provide lessons that will flow to many other parts of the world facing the same challenge of providing universal health coverage.

One of the founders of WONCA was Dr Prakash Chand Bhatla from India, who once wrote that *"Every national health program should involve general practitioners. Education and motivation of the community has to be done on a personal basis. And who is nearer to the community than the family doctor?"*

Who is nearer to the community than the family doctor? As family doctors we need to be engaged by our governments and international health organisations in the planning and delivery of national and local health programs. Family doctors are part of their local community and have the trust of their local community and can be part of ensuring the successful delivery of health care programs, especially to the most vulnerable members of our populations.

Last week I was in India, on my third visit to South Asia in the past 12 months. Over 25% of the world's population lives in South Asia, many in dire poverty with limited or no access to health care, and I am keen to see WONCA support the developments in this region. India's primary care workforce includes 1.7m doctors but few have had any postgraduate training, few are involved in continuing professional development, and 1/3 of those claiming to be primary care doctors have no medical qualifications at all. Many of these doctors work in private with fee for service arrangements. As we know such fee for service arrangements can be catastrophic for low-income families when a family member becomes seriously unwell and the family utilises all their resources in an attempt to save the life of a loved one.

As a result the image of primary care in some parts of India has not been good and many medical graduates seek therefore to train to become consultant specialists and then subspecialise further, becoming what is called in India a superspecialist. This has skewed health care expenditure away from community-based primary care to high technology tertiary care. It has led to a health care system which breaks the rules of Barbara Starfield and creates huge inequities in health care access and outcomes.

This diversion of health care expenditure means that India is struggling with universal health coverage; the challenge of providing health care to all 1.2 billion people of this vast country, 80% living in rural areas. The national government of India, has recognised at last that health care can only become universal through strengthening of

primary care, and is working with WONCA and our member organisations in India to turn things around. It is a long process but centres of excellence like the Christian Medical College in Vellore are leading the way in providing excellent experience in community-based family medicine for all their medical students, and in providing postgraduate training in family medicine. I hope we will see the specialists in family medicine become recognized as the super superspecialists that they are.

Of course we have another country with a vast population next door to Austalia. Last year I visited Indonesia and this rural family medicine clinic, called a puskesmas, or Primary Health Center, on the island of Timor, about an hour north of the city of Kupang in West Timor. This clinic has serious challenges due to its isolation. The electricity supply is patchy at best and blackouts are frequent. There is no running water. Water for the clinic is drawn from a well. I had never drawn water from a well before and enjoyed the novelty of hauling up buckets of fresh clear water from deep below the earth's surface. I was informed by the locals that the novelty wears off very quickly.

Yet, despite the challenges, the energetic and dedicated family doctor and her team at this clinic deliver primary care services to the members of their local community and also run a birthing centre which has led to a substantial reduction in the rate of infant and maternal mortality in the region.

There are those who say that family medicine has no real role to play

in low and middle-income countries. Well we have blown that theory out of the water. Last year the Director-General of the World Health Organization, Dr Margaret Chan, launched WONCA's new guidebook on the contribution of family medicine to improving health systems. The guidebook includes a chapter from the WHO showcasing the research into the impact family medicine is having in improving health outcomes in many middle income nations including China and Thailand. And there is a chapter outlining the remarkable work that is underway across Africa to strengthen family medicine, especially involving WONCA member organisations within Africa supporting developments in neighbouring nations.

What these developments demonstrate is the need to strengthen the whole health care workforce, including family doctors, community nurses, community health workers, and traditional birthing assistants, and support us working together to deliver appropriate care to all people. People in low income countries still want and deserve access to health care, access to caring clinicians, access to life saving medications.

We also need to embrace the concept of reverse innovation. What can health systems in high-income countries learn from the health systems in lower income countries? It is something that each of who spends time working in another health system in another country learns very quickly.

It is also a lesson that was emphasised by another of our past WONCA presidents, Rajakumar from Malaysia, who once wrote that:

"Experience in different health systems will make us better doctors and better human beings."

But serious health care delivery challenges can occur in any country. In February this year I was invited by the Fukushima Prefecture in Japan to visit communities affected by the 2011 tsunami and the nuclear reactor disaster.
We all remember the tragedy of the March 2011 tsunami that hit the Pacific coastline of Japan following an earthquake, killing thousands of people and destroying coastal towns and villages. And the global fears that followed when the damaged Fukushima nuclear power plant exploded releasing radiation into the atmosphere. The radioactive contamination resulted in over 100,000 people being evacuated from their homes and a 50 kilometre exclusion zone was established around the damaged nuclear plant and the path of the radiation fallout.

I was invited to travel to the affected areas to learn about the role local rural family doctors and their primary care teams are playing in assisting in the recovery of the surviving members of the devastated communities. It was a sobering week.

Three years later, the evidence of the damage caused on that terrible day remains. Many people still live in temporary housing and are prohibited from returning to their abandoned homes. Many people, especially young families, have moved away to other parts of Japan. Many elderly people left behind grieve for their missing families, their lost homes and their lost way of life. 200,000 affected people

are being followed up regularly in special clinics set up to screen for problems related to radiation exposure.

The coastline is desolate, having been cleared of the ruins and debris that was all that remained of coastal cities and rural communities and the surrounding forests destroyed by the tsunami. The villages have gone, the farms have gone, the forests have gone. It is like there has never been anything there. The exception is the exclusion zone around the nuclear reactor where the damage from the tsunami is still visible with damaged buildings, upturned cars and fallen trees. Whole villages that survived the tsunami but were subjected to radioactive fall out are now ghost towns with deserted homes and shops with empty windows and no sign of life.

This visit was a stark reminder of the challenges people face in rebuilding their lives and their communities following catastrophic events. And the huge impact such events have on the physical and mental health of each affected person. But I also had the privilege to visit the family doctors of this region and discuss the roles that family doctors and the members of our teams can play in supporting our communities during and after such devastating events

This is young rural family doctor, Dr Hiroshi Takayanagi, who is based at the Kitakata Centre for Family Medicine in Fukushima Prefecture, which is a teaching practice linked to the Fukushima medical school.

Hiroshi works with his elderly patients to seek to reduce the impact of the forced relocation and social isolation. He has seen many of his patients experience worsening of dementia and development of depression and anxiety. Others have sought to find solace in overuse of alcohol or in poor nutritional choices leading to a rise in liver disease and obesity. Some public health experts in Japan believe the health impacts on many elderly people would have been less if they had been left to live in their own homes, regardless of the nuclear contamination.

It is in times of community peril that family doctors and the members of their primary care teams often rise to the challenge and do so brilliantly. And we do so in Australia as well.

Bruce Chater is one of the leaders of our WONCA working party on rural practice. Bruce and his wife Anne hit the headlines in Australia in 2010 when their hometown of Theodore in rural Queensland was threatened by serious flooding. Bruce and Anne and their family made sure all the people of the town, including the elderly and the frail and their beloved pets, were all evacuated safely before the flood waters arrived. Bruce was the last person to leave before the floodwaters engulfed their town and destroyed their clinic. And Bruce and Anne were the first ones back, setting up a makeshift clinic where Bruce looked after his patients for many months before a new clinic was built. Hiroshi and Bruce and Anne and all their colleagues are true heros of primary care. They demonstrated their care for every single member of their community.

In the words of another great medical humanitarian, *"I don't know what your destiny will be but one thing I know. The only ones among you who will be really happy are those who have sought and found how to serve."* Words from the Nobel Laureate, Dr Albert Schweitzer.

WHO Director General Dr Margaret Chan has become a staunch supporter of family medicine and our potential to ensure global universal health coverage. I was speaking at a meeting in Hong Kong last December with Dr Chan, and she stood up and proclaimed *"I love family medicine"*, which didn't please our colleagues in the audience from other medical specialties.

Dr Chan has recognised the value of family medicine and our contribution to primary health care and to universal health coverage. Dr Chan has also recognised that primary care is not cheap and must not be a "B-team" version of health care delivery. Dr Chan is leading a long overdue refocusing of the WHO at global and regional levels on primary health care and is working with WONCA on the contributions family medicine can make in improving health systems and ensuring universal health coverage.

One of the countries leading the world in innovations in strengthening family medicine to ensure that health care is available to all people is Brazil. Brazil is the global leader in addressing universal health coverage through family health teams of doctors, nurses and community health workers. In November last year, in one of the favelas, or shantytowns, of Rio de Janeiro, I had the

opportunity to visit one of the primary care clinics established to meet the health care needs of the poorest people of that great city.

At this family medicine clinic I met with young family doctor Euclides Colaço and his colleagues. Euclides works with a family medicine resident, two nurses and six community agents, or community health workers, providing comprehensive clinic-based and home-based care as a team to a defined population of 4,500 people.

This visit allowed me to see the renowned "Family Health Team" model of Brazil in action. Euclides and on of the community agents in this family health team showed me a map of the geographic area his team is responsible for. They are expected to know about the health status of every single person living in that area. The community health agents have a key role to play; they go out into the community and visit everybody and bring those in need of assessment and assistance to the clinic, or the community health agents escort the doctor or one of the nurses on a home visit. This is true comprehensive primary care delivered to an entire community. And there are over 33,000 such teams in operation across the entirety of Brazil providing care to 200,000,000 people.

This is universal health coverage in action. Through innovations like these primary care and family medicine have the power to transform our world. To bring health care to the 1 billion people currently without access to any health care at all.

Universal health coverage has been part of the charter of the United Nations since 1948. Universal coverage does not mean meeting the needs of 80% of the population – it means ensuring that health care is available to everybody in the world. With over one billion people with no access to any health care at all, we still have a long way to do.

As family doctors we need to support the focus on the social determinants of health and ensure that those groups of people in our communities most at risk of poor health, the most marginalized, the most vulnerable, are not excluded from access to health care.

Every human being should be treated with dignity and respect. And as health professionals we should be leading by example.

Something Iona Heath, former president of the Royal College of General Practitioners in the United Kingdom and a great advocate for health equity, said a few years ago really struck a chord with me, "*I believe that general practice/family medicine is a force for good throughout the world.*"

Through my work in Australia and around the world, I am impressed with the commitment of family doctors and the members of their primary care teams to human rights issues. I am convinced that family doctors right around the world care about human rights; the basic expectations we all have about how we and our families and all people should be treated.

As family doctors we have social responsibilities. Each of us needs to

I am pleased that during my time so far as WONCA president, our organization has established two new global working parties, one with a focus on health equity, and another with a focus on the health of Indigenous peoples and minority groups, bringing passionate family doctors from around the world together, through the marvels of the digital age, to share experiences and develop global policy which we can use in our advocacy with the WHO and the nations of the world.

One of the major areas of WONCA's recent work has been in mental health. Our work with the WHO is focusing attention in many countries on ways we can better integrate mental health into primary care and family medicine. In the words of Professor Chris Dowrick from Liverpool, one of the leaders of WONCA's mental health working party, *"at a time of global fiscal austerity in many parts of the world ... primary care mental health is being squeezed between a rock and a hard place: on the one hand mental health problems are increasing as a consequence of rising unemployment, poverty and debt; while on the other hand secondary mental health services are being scaled back as a result of government cuts - so primary care is left with an increased burden and reduced specialist support."*

These challenges for our patients also test our own resilience. While we continue to innovate within our practices and within our communities to ensure that our patients receive the highest possible standards of care, it is critical that we also continue to innovate to find ways to support each other as well.