V. Primary Health Care, Paramedicals and the Law: A Brief Critique

In the realm of primary health care* the expressed needs are for diagnosis, treatment and midwifery. If primary health care is restricted to preventive medicine, however important it is, the community will not be satisfied. Their need is for relief of pain and treatment of illness. No community will come to someone for health care if all they offer is preventive care, however crucial that is for real improvement in the quality of life. For them preventive care alone is a non-solution. The real inducement of any respectable primary health care programme is that it offers curative medicine. Legislation and regulations must enable the paramedical cadres to do this.

A. Of the World and of the Law

The present state of the art is that most primary health care is, to put it in legal terms, de facto and not de jure. That is, paramedicals are providing primary health care (including diagnosis and treatment) as a matter of fact because the demand for the care is so great. At first glance there often is very little legal authorization for such practice. What care is extended is provided outside the law, sometimes on the fringes. For example, in Assam an illiterate refugee acts as a "nurse" to the individuals in a small refugee village. She diagnoses and treats. Frequently, her treatments take the form of drugs. She knows, for example, that the treatment for diarrhoea is one white tablet from the round green bottle taken four times a day. Her knowledge is no more sophisticated than that. As long as the drugs which come to her from the dispensary are consistently the same colour and shape and are placed in the same coloured or shaped bottles, she can function reasonably well. Legality matters little to her or to her patients; what they want is the care.

On the other hand, the law is often relevant to those who work within the legal limits of their jobs. Just as often it inhibits their ability to deliver appropriate and timely health care. The following example underscores the types of problems which need to be overcome.

> Mrs Suchin is now in labour and planning to deliver her seventh child at home, as she has done in the past. Of her six previous children four are still living, two having died in infancy from strange illnesses for which she did not know how to provide care. She is 34 years of age, has lived in the same village in Southeast Asia all of her life. As with her previous pregnancies, her elderly aunt will deliver the baby, although she did go to the government midwife for a checkup two months ago. The labour and delivery are easy, Mrs Suchin being a

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* We are constrained to remind the readers that what we are focusing on is a narrower reading of primary health care which includes just medical care

> good patient in labour. The baby is delivered and is apparently a healthy male infant. The placenta, however, does not come easily and the aunt becomes concerned. Mrs Suchin begins to bleed heavily; the government midwife is called. When she arrives, 45 minutes later, Mrs Suchin is pale and still bleeding. The midwife attempts to massage the uterus, but she has no appropriate medications with her because she is not allowed to give medications by injection . She then attempts to remove the placenta manually, but it tears and only part of it is removed. Mrs Suchin continues to bleed heavily and an attempt is made to move her the 40 miles to the nearest health centre with a physician. However, in transit, Mrs Suchin does from blood loss. An injection of Pitocin or ergotrate might well have saved her life. But in Mrs Suchin's country only doctors are supposed to give such medications.(76) (emphasis added).

As Rosenfield has said, "The problems relating to the delivery of health care were markedly exacerbated when the Western delivery system was adopted directly into predominantly rural societies where there were very few physicians".(77) To this Jelliffe has added:

> The health services of the Third World countries have tended to be ill-adapted imports from Europe and North America, with emphasis placed on costly curative institutionalized medicine, largely in urban centres and hospitals, manned by highly (and expensively) trained credential-oriented cadres of orthodox health staff, particularly physicians, attempting similar functions and duties of colleagues in developed countries.(78)

B. Where Primary Health Care and the Law Cross

Along similar lines one of the frequent criticisms of health care legislation is that it is not only sadly out of date, but that it is largely premised on the existence of a health care system which can only be maintained in the richer nations. To a large degree these criticisms are justified. Many of the former colonies have looked to the UK for model legislation. In earlier years, UK health care legislation spread to the India Office and then to other colonies. If indeed these laws were inappropriate in their new settings, once independence was achieved few attempts were made to modify these laws. Whereas new cadres of health workers have had to be developed or the roles which existing cadres take have been greatly expanded, legislation has, in the main, not shifted to accommodate these. This has left many health workers without legislative protection, witness the unprotected medical assistants and rural medical aides of Tanzania. In other countries appropriate legislation has been developed. The medical assistant in particular has been given special protection in several Commonwealth jurisdictions, the most recent ones being Fiji (1978) and the Gilbert Islands (1978). Yet the same gnawing question remains: if it is true, as many assert, that the health care delivery models taken over from the Western world were completely out of context in relation to primary health care, what of the legislative systems which were transplanted to support those models? No one is advocating here that the whole system be overturned, though such a radical approach may have its advantages. What is needed is a concerted effort to re-shape laws and regulations in a way

which facilitates primary health care.

Three brief examples will suffice. At present medical as well as legal standards limit the provision of curative services, including the prescription of drugs and the undertaking of various technical procedures, such as surgery, to a doctor.

1. Prescription and Distribution of Drugs

As noted earlier, one of the statutorily protected functions of a medical practitioner is to "prescribe" medications for the treatment of diseases and disorders. This authority is buttressed by the regulations which arise out of Pharmacy and Poisons Acts.(78a) While it is entirely possible that paramedicals will only need to deal with non-prescription medicines in pursuit of their role in primary health care, this is unlikely to be the case. One of the things they will have to be authorized to do is to handle, prescribe and distribute prescription drugs. In combination then the types of laws mentioned effectively undercut the potential role of non-doctors.

To inject a note of realism here some generalizations are necessary. First, many of the drugs which would be of common usage in primary health care programmes are subject to prescription. Second, though this is so, drugs in many developing countries can be purchased without prescription. This is most often the case only in metropolitan areas where there are pharmacies. In rural areas drugs cannot be as readily obtained, and, where they are most often are acquired through the health services. The health service may adhere vigorously to the doctor's prescription requirement and effectively limit the supply. Where this is so some thought will have to be given to training and authorizing non-doctors to prescribe and administer prescription drugs. This has been done in many countries. By taking an example from the field of family planning some of the possibilities may be seen. In most countries oral contraceptives were subject, initially, to the doctor's prescription requirement. Several readjustments have been made in this position. Three new approaches have been taken.

1. No prescription required for oral contraceptives: Antigua, Bangladesh, Grenada, Hong Kong, Jamaica, Papua/New Guinea.

2. Prescription for oral contraceptives required but either from trained paramedicals, such as nurses and midwives, or from other government authorized personnel, such as special family planning fieldworkers: Malaysia and Sri Lanka.

3. Initial doctor's prescription or subsequent doctor-screening for oral contraceptives required but pills provided on a continuous basis by a non-doctor dispenser on request: Fiji, Barbados and India.(79)

It is recognized that the experience with the Pill may not be applicable to all other medicines. But it does highlight the possibilities. Sometimes these new arrangements can be made without having to change any other piece of legislation. In those instances the change is brought about either under

the Pharmacy and Poisons Act itself (shifting drugs to the non-prescription schedule or to one which may be handled by non-doctors) or within the context of the Public Health Act (the Ministry of Health exercises its powers to authorize paramedicals to handle certain drugs). On occasion, however, provisions must be made for this change in various statutes. The recent Medical Assistants Act in Fiji contains an exemption which could well be adapted for use in legislation pertaining to other paramedicals. Section 7 says

> Notwithstanding the provisions of the Pharmacy and Poisons Act, but subject to any limitations or restrictions which may be imposed by the Permanent Secretary, a medical assistant may issue prescriptions and dispense any medicine or drug.

Advances of this sort will undoubtedly mean that, as in Zambia, different phamacopeias will have to be developed according to the staffing of the health centres. For example, different types of drugs may be available where a doctor is available than where a nurse or auxiliary is the person in charge. But this may tend to perpetuate the status quo unless nurses and auxiliaries are given authority to handle an increased number of drugs essential for primary health care.

2. Injections, Immunizations and Vaccinations

Similar problems arise over questions of who should be able to inject, immunize and vaccinate. These are all essential elements of any primary health care programme. In many Commonwealth countries paramedicals already provide the bulk of these services, though they must usually do so on the instructions of a doctor. In the primary health care context it is reasonable to expect paramedicals to be the purveyors of these services. Perhaps the distinction between preventive and curative treatment is useful here. Certainly on the preventive side, immunizations and vaccinations are tasks which a paramedical can be trained to handle without the necessity of a doctor peering over his shoulder. These could be provided as a matter of course. On the curative side, to the extent that paramedicals are trained to make simple diagnoses, they would also be capable of prescribing and administering antibiotic injections, including penicillin. But in order to assume these functions special authorization may be needed.(79a).

3. Surgery

Surgery is another of the statutorily protected functions of a doctor. For this reason surgery would usually be considered beyond the scope of primary health care practice. At present, apart from cleaning wounds and minor suturing, paramedicals would not normally engage in surgery. They may obviously, however, assist a doctor in surgery. But experience has shown that they can be trained and utilized to do various surgical procedures, some of them thought to be quite major. In Bangladesh even illiterate village girls have been trained to do minilaparotomies (female sterilization) (80) and other paramedicals are currently utilized for performing menstrual regulation,(81) a procedure which is akin to early abortion. In Africa cataract extractions are done by

paramedicals. Elsewhere, some paramedicals do Caesarian sections. In order to do these sorts of procedures special legal protection will have to be extended to paramedicals.

We have seen that two somewhat contradictory themes run through any discussion of the law, paramedicals and primary health care. Many paramedicals are filling doctor-like roles in the primary health care. Many are restrained because of the technicalities of the law. On one hand, one may ask what the law has to do with the first theme. It seems largely irrelevant. On the other, the technical requirements often impede a greater utilization of paramedicals. But this is largely a problem for the high level policy makers. At the grass-roots level the paramedical may not be worried about the niceties of the law. There is a happy medium between the two which combines legal protection for the paramedical with the assurance that he is appropriately trained to render the services he does. The latter implies that laws and regulations serve a greater function than merely providing legal protection. They do. They facilitate training, supervision, enumeration of tasks which may be performed by paramedicals, not to mention how these work to the benefit of the recipients of care. Just exactly how this may be achieved is our next subject.