The primary healthcare (PHC) Declaration of Alma-Ata, the first international action on advocacy of the importance of primary healthcare (PHC) stated PHC as the most important strategy for achieving "Health For All".1 Thirty five years down the road, PHC is still not well established in its true spirit even in many of developed countries.2 With an ever increasing disease burden and rapid globalization, there is a significant stress on all the countries, developed and developing alike. The poorly performing health systems across the globe pose huge challenge on the healthcare providers, urging the imperative need to improve health system, which must respond to the need of the masses in a better way and at a faster pace. There is cumulative international evidence that PHC is the way forwards- "to meet the challenges of a changing world".2 The PHC is the core of the healthcare system and provides care for the individuals and families in the community. It not only caters for acute health problems, but also caters for individuals with ongoing chronic conditions. This aims at health promotion and disease prevention and at the same time provides supportive and rehabilitative care.3 The evidence supports that it is the foundation of healthcare system and results in better health outcomes.4

Emergency Medicine and Family Medicine are the two major entities of the PHC. Both are now recognized specialties at undergraduate and postgraduate level in Pakistan.5-7 The training programs in both the specialties prepare physicians to provide broad-based healthcare. However, history of the two specialties is not very old. College of Physicians and Surgeons Pakistan (CPSP), keeping in view the need of these important disciplines, started postgraduate training i.e. Fellowship of College of Physicians and Surgeons Pakistan (FCPS). The FCPS program in Family Medicine was started in 1993, and since the start has produced 69 FCPS trained Family Physicians. For various reasons, 20 years since start of the program there are only 3 medical institutes with recognized Family Medicine residency programs. Only 6 medical colleges have undergraduate curriculum in Family Medicine. There is parallel MCPS program in Family Medicine with a total of 608 MCPS trained doctors to-date. On the other hand, FCPS in Emergency Medicine was introduced in 2011. The training in Emergency Medicine is in the initial phase and there are only two institutions offering training in Emergency Medicine in Pakistan. The discipline of Emergency Medicine is facing lot of challenges in Pakistan among which lack of trained Emergency Medicine faculty is the important one.

In Pakistan, more than 125,000 medical practitioners have been registered with the Pakistan Medical and Dental Council to-date,8 providing primary healthcare to the community in various capacities. Despite this, there is a huge gap between the health needs of the communities and basic healthcare provision as there is no structured training of these doctors and there is poor coordination and collaboration at various levels of healthcare systems.

Family Medicine and Emergency Medicine are the first-contact services where 90% of person and population healthcare needs are catered for.9 Common illnesses like infections, cerebro-vascular accidents, myocardial infarctions and road traffic injuries present in the acute form to the Emergency Departments (EDs).10 However, these patients may also present to the Family Medicine clinics initially and are subsequently referred to EDs. Similarly, a significant proportion of patients in Family Medicine Clinics require urgent input from EDs. During this process of shuttling between ED and Family Medicine Clinic, patient care is compromised due to lack of coordination and integration of the services at most places. This results in duplication of investigations, treatment, and over and under diagnosis, with huge resource consumptions without fruitful outcomes. Pakistan, like many other countries of South Asia is facing quadruple burden of problems like communicable diseases, non-communicable diseases, mental health problems and accidents / injuries.11 This is an absolute fact that with growing chronic disease burden, the workload of all doctors is increasing, this combined with huge lack of resources in our country, results in major work related stress.12

It seems very logical that with such dire healthcare services and manpower crisis in our country, we should aim for organized and systematic ways of movement of patient from ED to Family Medicine and vice versa and
from these two disciplines to other levels of the healthcare system. The provision of coordinated and collaborative care in these two disciplines can be actualized only by close affiliation and integration between these two domains at many steps. These include structured training of the health personnel not currently in training but providing care in the community. This can be achieved by shared domains in the core curriculum and cross-training; designing and implementing various care pathways for common and important health conditions; developing and reinforcing referral system for transfer of patient from one level to other level of healthcare system. In this way, patients are more likely to receive resource efficient (time, cost and manpower) care for all their health problems. Such systematic approaches at the first-contact care have shown to reduce the cost of ambulatory care by as much as 50%.

Collaboration and integration becomes easier in organizations with established Electronic Health Records and Management Information System (MIS) support. However, where such facilities are not available, patient held health records should be encouraged by all healthcare providers, with adequate information given to patient. This can be used as means of communication at various levels of healthcare system.

To conclude, Family Medicine and Emergency Medicine, by close collaboration to coordinate and integrate healthcare services with each other, can provide resource efficient, good quality healthcare to the majority of patient population. At the same time, systematic approach is likely to lessen the stress and burden on healthcare personnel.

REFERENCES

3. Ontario health services restructuring commission, primary healthcare strategy, advice and recommendations to Hon Elizabeth Witmer. Minister of Health; 1999.