ELECTIVE (SSC5c) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

WHAT ARE THE MOST PREVALENT MEDICAL CONDITIONS IN PAKISTAN, AND HOW DO THESE DIFFER FROM THE UK?

There are many medical conditions which are prevalent across the globe, where the distribution of each medical condition is influenced by ethinic variations, age and other comorbidities relevant to the country such as sanitation and avalibility of health care.

In the UK, based on the percentage of deaths caused by illnesses, the following conditions come to mind. Chronic obstructive pulmonary disease (COPD), Ischaemic heart disease, Stroke, cancer and liver disease. All of which have lifestyle factors that have contributed to the rise of other illnesses, hence becoming risk factors for the five conditions listed. The UK, like most western countries has experienced a recent epidemic of increasing obesity, Type 2 diabetes, hyperlipidemia and hypertension. All of which are riskfactors for the above, especially ischaemic heart disease.

Pakistan on the other had, according to the World health organisation has the following medicial conditions which are prevalent. These conditions can be split into: Communicable and Non-communicable. Regarding communicable illnesses, Pakistan is one of three countries where there is still an endemic of Polio, additionally Pakistan has the 6th highest prevalence of Tuberculosis. Regarding non-communicable medical conditions: cardiovascular problems, diabetes, cancer and mental illnesses are on the rise. Pakistan also has a high rate of neonate/infant and maternal mortality, particularly due to illnesses. Where the majority are preventable through vaccination programmes.

So it appears even though the UK and Pakistan are over 6000km away. There seems to be an increasing prevalence of similar conditions i.e. diabetes and cardiovascular disease in both countries.

HOW IS THE HEALTH SERVICE FUNDED AND WHAT SERVICES ARE PROVIDED FREE OF CHARGE TO THE POPULATION OF PAKISTAN, AND HOW DOES THIS DIFFER FROM THE UK AND OTHER AREAS OF SOUTH ASIA ?

Firstly the health service in the UK, the National Health Service (NHS), is provided by the public sector and funded in its entirety by the tax payer, with an annual budget of roughly £115 billion. The NHS was created in 1948 with the aim of diagnosis and treatment of disease, since then although this fundamental principle prevails, the NHS has evolved to include prevention of illness and improving both physical and mental health of the population. The NHS is made up of a number of organisations, which range from providing primary care, secondary care and tertiary care. Health care is provided as free at point of need, with different stipulations applying to foreign nationals. Private health care is also available, but is overshadowed by the abundance of the publically funded service. Due to the move towards prevention of illness, there are various health policy which have been developed by the National institute of clinical excellence (NICE), which are rigorous in their nature and have contributed to the improved health in the UK.

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In contrast the majority of health care in Pakistan is private healthcare; in fact 80% of all health care is private. The public health care where available, was until 2011, led by the ministry of health. In total in 2007-2008, the total spent on public health care was 18 billion Pakistani rupees, which at the current exchange rate is equivalent to £194 million, significantly less than the UK. Additionally only 3 billion Pakistani rupees were actually spent on health, the remainder was spent on development and infrastructure of the heath care.

Whereas in the UK, health care is readily accessible. Health care in Pakistan, varies from location to location. Health care and sanitation is adequate in urban areas, but poor in rural areas. This is also true for other South Asian countries. In most cases, many Pakistanis are priced out of accessing healthcare, which is also seen as contributing to the high mortality rate, from preventable conditions. There is also a shortage of doctors, which is a chronic issue, as majority of doctors who train in Pakistan, migrate to western countries, which has left Pakistan with around 130,000 doctors to serve a population of 170 million people; whereas the UK has roughly 160,000 doctors serving a population of 60 million people. Regarding health policies, this is a key issue the World Health Organisiation, wants improved in Pakistan, in it's recomendations.

BY FOCUSING ON RATES OF DIABETES AND HEART DISEASE IN PAKISTAN, DESCRIBE HOW GLOBAL HEALTH IN PAKISTAN HAS TRIED TO TACKLE AND HIGHLIGHT THESE ISSUES TO THE LOCAL POPULATION, AND WHAT IMPACT HAVE ANY POLICIES, IF PRESENT, HAD?

According to the World Health Organisation, over the course of the last three decades, there have been an increasing number of programs, health interventions and facilities to tackle several of the illnesses prevalent across Pakistan, but the availability is fragmented across different regions of Pakistan. The funding and support for the various interventions that have existed are supported by different levels of government or development partners. But due to lack of communication there is overlapping of the provision of these resources across geographical and thematic areas, which has lead to a duplication and wastage of resources.

Health policies are set at the Federal level, which flows down to the Provincial government and is further delivered to the district government, whom are responsible for the implementation of the policies. The districts do not have any role in the policy making process.

This nature of policy making has lead to two main problems arising. First, the policy process happens at the federal level without involving the provincial and district governments. So does not take into account health problems in the local population of each district. Secondly, the health policies which are formulated are mainly based on the bio medical model, where emphasis is placed on clinical/curative treatment; rather than disease prevention. (Khan 2006 pp. 97-100 and Khan 2009, p. 7).

Hence from the research I've done, I haven't come across any diabetes/ cardiovascular prevention programmes which are national. Although there may be some locally, these haven't deterred the rising levels of both type 2 diabetes and cardiovascular disease across Pakistan. With 25% of people over 40 years having coronary heart disease and 10% of adults suffering from diabetes.

According to the World health organisation's Strategic agenda 2012-2016, the health policies of Pakistan are seen as underdeveloped. And the aim of strengthening Pakistan's health system, involves focusing on the improvement of health policy making and governance, with the aim to increase the

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prevention of non communicable diseases such as cardiovascular disease. But in order for this to happen, there needs to be greater integration between the private and public health systems.

AS THIS IS THE FIRST REAL CHANCE, TO WORK AS A NEARLY QUALIFIED DOCTOR, I WANT TO SEE HOW I COPE WITH THE PRESSURE OF TRYING TO COMMUNICATE WITH PATIENTS IN A LANGUAGE OTHER THAN ENGLISH, AND ALSO LEARN THE MEDICAL PHRASES IN URDU, AS I BELIEVE I WILL NEED TO KNOW THEM EVEN IN THE UK, WHEN TRYING TO COMMUNICATE WITH ELDERLY SOUTH ASIAN PATIENTS.

In terms of my personal development goal of using the local language. I did learn a range of phrases, which I think will benefit me in trying to communicate with South Asain patients later in my career.

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