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PRIMARY HEALTH CARE: A LOOK AT ITS CURRENT MEANING

INTRODUCTION

Since Alma-Ata (1978) when the concept of PHC was defined and given international recognition, it has become the main thrust and focus for the promotion of world health. While the Alma-Ata definition of PHC developed from a growing accumulation and synthesis of ideas and experience from around the world, it nonetheless marked a significant turning point, the dawn of a new era in health development. The Alma-Ata Declaration represents a global ideal, a new vision about how to achieve world health. But as we gain experience of translating this ideal into reality, it becomes necessary to refine and clarify the PHC concept.

Three years after Alma-Ata it is apparent that much progress has been, and is being made. Experience of implementing PHC is accumulating from many countries with the result that the concept has further developed and begun to take shape and substance. But ideals or visions can be interpreted differently, and it is becoming clear that in the process of implementing PHC a number of confusions have emerged about what is really meant by PHC. Attention has been drawn to the wide disparity in the use of the term by a report of a recent study of PHC (JC23/UNICEF-WHO/81.3). This report states that "despite an internationally agreed definition, the term Primary Health Care is being applied around the world to a variety of realities and even of concepts". While it is expected that the variety of circumstances pertaining in countries would necessitate some differences in interpretation of the concept, differences in definition of the concept itself suggest a need for greater clarification of what we mean by PHC in the light of experiences to date. This paper is an attempt to clear up some of these confusions, and to assess where we have reached in our understanding of the concept since Alma-Ata, and to represent as concrete a summary of PHC, as we now understand it, as is possible in a short general paper.

PHC has come to mean much more than when it was first conceived as an "alternative" approach to health care (Alternative Approaches to Meeting Basic Health Needs in Developing Countries: a joint UNICEF/WHO study). There would seem to be at least two different dimensions or levels of interpretation. PHC can be defined as a general approach or strategy which gives expression to some explicit principles and values. These values, while not confined to PHC, nevertheless provide the ideological basis on which PHC is built. They provide the PHC "philosophy".

Secondly, there is a narrower definition of PHC which refers to a level of health care at the periphery of a health system, and to a set of activities performed at the point of contact between a health system and the community. It is this last definition, that of levels, which has tended to

dominate the way PHC has been defined by countries, where it has frequently become synonymous with community health workers (non-professional community members performing health tasks on a part-time or full-time basis), with "low-cost" community health care programmes or simply health activities that the community does, as distinct from the formal health system of a country. This has given rise to the erroneous view that it is a second-class medicine for the poor. This view of PHC is totally at variance with the Alma-Ata Declaration.

PHC - THE APPROACH

1. The PHC Philosophy

Before considering the approach itself it is necessary to outline briefly the values or principles which provide the ideological basis for the strategy. These are not confined to the field of health but they closely parallel and reflect changing perceptions on the meaning of development and the means of achieving it.

(a) Fundamental to the understanding of PHC is its emphasis on equity and justice. Health as a human condition is a basic right of every individual and not just those who can afford to buy it. The growing inequality in the world gives the lie to any claim to progress in world development terms and is a sharp reminder of the urgent need to give this goal a higher priority than hitherto. PHC is about the equitable satisfaction of health needs, about reducing gaps: gaps between those who have health and those who do not; gaps between high and low child mortality rates in different groups. It is about an equitable and just distribution of resources and the need to reallocate existing skewed distributions in such a way as to meet the health needs of those whose needs are greatest. This applies not merely to health care resources, but also to resources for which an individual must have access to maintain health, such as income, food, land or job, opportunities for education, etc. The concept of PHC is firmly rooted in this fundamental principle, or goal of equity.

(b) Another tenet of the philosophy, related to that of equity, reflects a broader understanding of the concept of health. It recognizes that health is the outcome of a complex set of socio-cultural and economic, as well as physical, or biological, factors. This leads logically to the recognition that health will only be realized in the context of overall development and specifically to a pattern of development which gives high priority to social goals in addition to economic ones.

(c) A third component of the philosophy is that of self-reliance and individual self-realization. People must be given an opportunity to exercise control over their own lives and their environment and take responsibility for their own health. It is not governments, or agencies acting on their behalf, that are responsible for "delivering" health to the people, but rather the achievement of health is a joint responsibility.

(d) Finally, there is a fourth principle embodied in the philosophy of PHC which deserves mention. It is particularly pertinent in the context of WHO, the main international vehicle for the promotion of PHC. This concerns an international solidarity in health. It is rooted in an international concern for equity and for balanced world development and international peace. For those concerned with health promotion the search for a New International Economic Order (NIEO) stems as much from the PHC concept as it does from the development debate. The full implementation of PHC internationally would contribute to an NIEO. But perhaps more importantly, it has to be recognized that successful application of PHC is, to a large extent, dependent on changes taking place in international economic relationships. Thus the realization of the PHC ideal is firmly linked to other international developmental efforts.

2. The Strategy

PHC grew out of the recognition that strategies and technologies for health were based on models developed by industrial countries which were being transferred, mostly without adaptation, to developing countries, in spite of widely differing socio-cultural contexts, patterns of health problems, demographic structures and economic potentials. This has resulted in the major inequalities in health care provision and the other inappropriate and costly services which are observed in most countries. Furthermore, this approach to health care ignored the social and economic origins of ill health. In contrast, some countries, notably China, had developed a radically different approach to solving health problems with significant success.

The PHC strategy which gives expression to the principles outlined above, has three main interrelated components. The one which has been most clearly defined so far involves changes in the health sector. The second is the development of individual and collective responsibility for health or "community involvement" in a broad sense, while the third links health more concretely with overall development strategies. None of these are distinct and separate strategies. As will be clear from the discussion on the health care system, community involvement and intersectoral collaboration are part of the changes as well as being key strategies in their own right covering a broader field. In considering the concept of PHC as an approach or strategy it has to be emphasized that this is a dynamic concept defining a process, a process of change and direction in the means to be used to promote health.

A. The Health Care System

The health care systems of most countries have developed in such a manner as to provide limited coverage to the few, usually urban elite, with a top heavy system emphasizing sophisticated technology, at the expense of meeting the priority needs of the population. The PHC approach aims to

reverse this state of affairs. It redirects the entire system by giving priority to meeting the needs of the majority. Thus total coverage with essential health care which is both relevant to their needs and effective in meeting them, becomes the new priority and main thrust of the whole system.

The following summarizes the characteristics of a health system based on PHC:

(a) Accessibility:

It is accessible to everyone. In practical terms this requires a country definition of what actually constitutes "accessibility" and the type of services to be made accessible, including referral services. How accessible must immunization or child care services be? How accessible must delivery services or referral to a first level hospital be? What is acceptable accessibility to drinking water? Accessibility includes not only physical or geographic accessibility but also economic and cultural access. PHC has most frequently been identified with rural health care, primarily because it is the rural population who tend to have the least geographic access in most countries. However, urban people are just as much in need of PHC. While the more economically advantaged usually live in urban areas where they have both geographic and economic access, so too do the urban poor in many large cities. For a variety of economic and cultural reasons they do not have access to relevant or effective services even though they may live in the vicinity of the national teaching hospital.

(b) Relevance:

It provides relevant services. This is a matter of quality of care. A health system based on PHC provides services which meet priority health needs and which are socially and culturally acceptable as well as effective. PHC does not mean poor quality. The reverse is true. There is a need to explode the myth that effectiveness or high quality is directly correlated with expensive and complex technology. The examples of the effectiveness of oral rehydration therapy in the treatment of diarrhoea or of the superiority of breast feeding illustrate this point. Alternative and innovative technologies will need to be applied in combination with research, monitoring and quality control.

(c) Functional integration:

PHC is fully supported by and functionally integrated with higher technical echelons of the health system. This is discussed more fully below in the context of the definition of PHC relating to levels and activities.

(d) Community involvement:

Communities and representatives of the people are involved as co-partners in the management of health services at all levels. This means communities must have the opportunity, through effective mechanisms, to participate in planning of services, to express their needs and satisfaction, or otherwise, with the services they receive and to participate in choice of technologies to be used, such as home deliveries or institutional, or choice of water pump and method of maintenance. Also, communities may undertake collective health activities such as clean up campaigns, water and sanitation projects, or spraying or other vector control activity. Community members may be trained to carry out simple health care tasks. Contributions in cash or kind (labour, land) may be given for specific projects such as building a clinic or staff house, digging a well or a drainage system. Community involvement has been promoted in some countries as a means of mobilizing additional resources for health care. In less developed countries there may be no alternative for this if coverage and access are to be improved. But the danger here is that the poor are made to pay for their own health care while governments continue to use national health resources in the same inegalitarian way, i.e., for catering to the needs of one segment of the population. Community resources need to be matched by government resources.

Community involvement in the planning and management of health services raises a fundamental contradiction. The rapid expansion of health services by government authorities, so urgently needed by most countries, can stifle the slower, more uneven development of grass roots community involvement. It is necessary to reach a sensitive balance between the development of the national health care system and at the same time support and encourage the communities' own initiatives. Real decentralization of health system management is probably a necessary prerequisite for achieving this balance.

(e) Cost effectiveness:

A system based on PHC is characterized by cost effectiveness. This means that resources will be allocated in such a manner as to achieve the greatest benefit at the lowest cost. Benefit is measured, in this instance, by the extent to which the health problems of the majority are being met, while the methods used to meet them will be those that are inexpensive and effective. For example, anaemic women will not be treated by intravenous therapy in an expensive urban hospital, but with oral iron at home, or, if intravenous therapy is required because home treatment failed, at the local health centre.

This characteristic of a PHC oriented health system incorporates a dynamic concept applicable to all countries, not just the developing ones. It implies a health care system that a country can afford - any country -

because it uses the resources it does have wisely. This is just as important for the developed countries, but has special significance for the less developed countries precisely because they can least afford to waste their money. As countries develop economically so the pattern of health care will change consistent with a changing epidemiological pattern and increased availability of resources.

Cost effective use of resources also implies efficiency. This can mean efficiency in use of health personnel time and skills (delegating simpler tasks to those with least technical training); efficiency in use of transport, i.e. use of alternatives such as public transport, bicycles or motor cycles, where appropriate, particularly important with the rising costs of fuel. Efficient use of one of the most expensive items of a health budget, drugs is another important concern: the selection of a limited number of drugs relevant to the predominant pattern of disease and control of their distribution and use, is one of the most promising areas for making savings in expenditure and improving the efficiency and effectiveness of the whole health system. In many countries severe shortages of cheap effective drugs coexist with oversupply of expensive preparations of doubtful efficacy. Rationalizing the use of resources and improving efficiency is implicit in the meaning of PHC.

(f) Intersectoral collaboration:

The health care system based on PHC has collaborative working relationships with other sectors at all levels. This aspect of PHC is dealt with more broadly below, but it is important to emphasize the need for the health care system itself to articulate with other sectors at the appropriate level. For example, a health centre responsible for a defined population would need to work closely with the agricultural services in identifying nutrition problems and in finding appropriate solutions, or in analysing seasonal interrelationships between agricultural labour demands and disease incidence and supply and distribution problems, or in mitigating and controlling occupational health hazards from resettlement programmes or irrigation schemes. At the community level it may not be appropriate to set up special health structures, if health matters can be dealt with effectively by existing social organizations such as a village development committee. As one moves towards the centre dissaggregation of sectors becomes inevitable and special mechanisms are needed to maintain the links between the health activities and objectives and those of other sectors. Unfortunately this has so far been difficult to achieve in most countries to date: even where formal mechanisms exist they rarely function effectively.

The above characterizes a health system based on PHC: it describes what the ideal looks like. A strategy for achieving this would involve the following kinds of changes:

(i) Redistribution of resources

While the unit costs for PHC are relatively low, the comprehensive coverage envisaged would result in a substantial total cost to the nation. This means that countries committed to PHC will have to ensure that a reasonable proportion of GNP or of national government budget is allocated to the health sector. Also, resources will have to be reallocated within the health sector. If PHC is to be effective at the community level it must be properly supported. At present the greater proportion of health care expenditure goes to the higher technical levels, the urban and specialist hospitals. To implement the PHC strategy, there will have to be a shift in the pattern of resource allocation away from the urban hospitals towards the more peripheral primary care services, and community programmes, particularly to ensuring adequate support for them. Because such a reallocation is politically difficult to achieve, few countries have managed to move very far in this direction, although it is possible to discern some change of direction in some countries. Redistribution of health resources has been referred to as the "litmus test of political commitment" - it is an indication that a country is seriously attempting to "put its money where its mouth is" and not just paying lip service to PHC. One of the difficulties lies in measuring how far the pattern of resource allocation is actually changing, as few countries have an accounting system which shows how money is being spent according to a PHC based classification, i.e., by function. The setting up of such an accounting system is a first step in the process of political commitment to reallocating resources along PHC lines.

(ii) Legislative reforms

In order to mobilize the necessary resources for PHC and reallocate existing resources towards meeting priority health needs implies a degree of collective control over health care expenditure. New health care legislation may be required to control the private sector, in order to ensure a better distribution.

Legislation may also be needed for changes in financing and accounting, and for reforms in medical education (see below), conditions of service, financial incentives and reward systems, to promote an orientation towards PHC amongst health professionals. So long as government conditions of service and/or private practice reward urban and sophisticated curative medicine disproportionately in relation to rural and primary health care, educational reform and appeals to health workers to change their attitudes amount to little more than pious preaching. Legislation on pharmaceutical importation, production and prescriptions may also be required.

(iii) Reorientation of health manpower

The majority of existing health workers do not have skills and attitudes consistent with a PHC orientation. Their training and attitudes result in an emphasis on clinical skills, often merely for the purpose of making enough money to open a practice in the city. In government service rural posts are often perceived as a punishment. Attempts will have to be made to change attitudes and increase motivation through appropriate incentives, applying alternative selection criteria for trainees and their teachers, and by displaying enthusiasm for PHC at the highest levels of the health system.

Secondly, the skills required for PHC at all levels go way beyond technical competence. For example, if health is understood in broader terms, health workers should be able to identify the social and economic factors which are the main contributors to ill health in a given situation or amongst particular groups - say young children of families in specified occupational groups: they should be able to communicate with community leaders and with other sector professionals in the search for solutions. They need skills in management, in community development and in essential epidemiology, and in integrating different programme tasks.

The relationships between health workers both horizontally and vertically also need to be re-thought in the light of PHC objectives. Rational analysis of the tasks to be performed and the resources available may mean developing new categories of manpower and retraining existing ones.

(iv) Improved management and planning methods

A PHC approach, which calls for greater community involvement, intersectoral collaboration, and the application of alternative technologies, will need more flexible approaches and new styles of management. New organizational structures may have to be developed at different levels to ensure effective community participation in management and intersectoral collaboration. Organizational changes may have to be made in existing structures. More effective planning methods will be required to put into effect the principles of PHC. Technical planning functions will need to be more effectively integrated with the political decision-making process, with planning in other developmental sectors, and with the day to day management of PHC implementation. New institutional arrangements may be required for this. Health plans will need to build in specific equity goals at the start of the process, for example in the use of resources on the lines indicated above. Some aspects of decentralization of the management and planning processes will have to take place if the principles of PHC are to be recognized.

(v) The use of appropriate technology

The goal of cost-effectiveness implies harnessing alternative and innovative technologies. For example, there is a need to identify technologies which can be used in different organizational contexts, i.e., by communities and "lay" individuals, with or without some training, rather than by health professionals, or which can be used by other sectors such as agricultural extension workers or school teachers. Research, both basic and applied, will need to play a major role.

The above briefly summarizes some of the essential changes involved in the practical implementation of a PHC strategy. To effect these changes in the health sector will require considerable political steadfastness but countries have already begun in some areas, and PHC must build on the advances that have so far been made.

B. Individual and Collective Responsibility for Health

In addition to changes within the health sector the second major thrust of the PHC strategy is the promotion of individual and collective responsibility for health. Community involvement has already been discussed in relation to changes in the health service system but this is part of a much broader strategy. There are two parts to this concept of community involvement. The first is a political issue. The more governments are democratically controlled and socially accountable to their people, the greater is the potential for real community involvement, in health as in other matters. Decentralization of decision-making allows for political control (in contrast to technical supervision) of action for health. But such political control needs to be combined with an elightened public awareness about health matters. The need for an informed and mobilized public is a complementary and necessary concern in the understanding and interpretation of PHC. It is not just commitment on the part of the political leadership that matters, but widespread public support from the grass roots.

The second aspect of community involvement, which also requires an informed and motivated population, recognizes that if individuals are to realize their potential as self-reliant, mature human beings, they must take personal responsibility for their own and their families' lives. This means adopting changes in behaviour and life styles, and understanding, and as far as possible controlling, their social and biological environment, in partnership with collective organizations and their governments. The political and administrative processes of governments need to be supportive for this.

A major public relations effort is needed to inform and motivate, and to communicate creatively the logic and justice of PHC, especially to those target groups who will benefit most from it. Also if people are to take

responsibilities for their own health they need to have access to information and the tools that they need. Health knowledge and skills will need to be delegated to individuals, and not closely and jealously guarded by health professionals as in the past. Self care and specific preventive measures or promotion of health through changed behaviour and life styles are fundamental to the PHC concept. It will be necessary to develop and make available to people appropriate and inexpensive technologies for this purpose.

C. Other Sectors Contribution to Health

The third component of the PHC strategy, involves making health goals a higher priority in the overall development process. Intersectoral collaboration has been discussed above in relation to the operation of the health services. But more than this is needed. The PHC philosophy gives explicit recognition to the fact that ill health is related to poverty. The PHC strategy must therefore focus attention not so much on poverty itself, as on what has made, and keeps, the poor poor. In particular, it has an important role in identifying those aspects of poverty that are specifically health related. For example, cash income may not be the most important determinant of health. Land and food availability all the year around, existence of social infrastructure, social services such as water, schools and health facilities, which are geographically and economically accessible, the level of literacy: these may be more significant health determinants. The practical application of this tenet of the PHC philosophy involves the steering of overall economic development more consciously and directly towards the maximization of health, and sharpening awareness about the costs and benefits to health and human development from alternative economic development policies and programmes. What would be the net health impact, for example, of a rise in food prices, a new factory, an irrigation project, a social security scheme? Who benefits and who loses in health terms? In terms of choice of interventions -- and choice is important where resources are limited -- the most dramatic health benefits might be achieved, for example, by an adult literacy campaign for women.

This strategy will only be achieved through greater involvement of informed and motivated health professionals in economic development planning and through an enlightened mobilized public. Research is needed to gain a clearer understanding of the complex relationships between socio-economic factors and health, and which can be used to raise the level of public awareness and effect changes.

PHC - THE LEVEL

This narrower definition is the one so far adopted by most countries in practice. This dimension of definition concerns the most peripheral level of health care, the point of contact between the community and the health services system. It has sometimes been erroneously seen as an

"alternative" to basic health services -- rather than as a complementary or more peripheral level. Basic health services tended to stop at the health centre or sub-centre level. PHC extends further into the community, into the very homes (mothers are the most important PHC providers for children). It provides the link between the more formal health system and the community. It is in connection with this definition of PHC that so much confusion has arisen. Where does PHC begin and end? This is a concern with levels of care, with health services and their organization, rather than with PHC as a total approach as discussed above. But even for this dimension of definition -- that of levels of care -- there is need for clarification. The Alma-Ata Declaration states that PHC forms an "integral part of the national health care system <u>of which it is the central function and main focus</u>". The concept of "Health system support for primary health care" which is currently being promoted by WHO and member countries is an attempt to refocus attention on the <u>totality</u> of the health system as a comprehensive interlinked system which effectively meets the priority health needs of the population. This involves meeting needs at the level of community or home as well as ensuring access to higher technical levels, but basing such access on the criteria of need rather than socio-economic or geographic factors.

Another dimension of the definition of PHC associated with levels is that of <u>activities or range of tasks</u> -- the PHC functions. This range of tasks comprises initial and continuing care at the point of entry into the health system, both for individuals and for the community as a whole. The Alma-Ata report outlined eight essential elements to be included in the content of PHC. But these are broad headings, each of which can be broken down into a hierarchy of tasks and activities to be performed <u>at different levels</u> within the total system. Activities in relation to nutrition and water, for example, take place at national level as well as community and district or province level. Are these activities then PHC or "support for PHC"? If PHC is defined broadly as an approach then the activities that reflect the principles of meeting priority health needs at all levels will be included. If PHC is defined in organizational terms then it will be decided by individual countries what activities or tasks will take place at what levels within the health system and the more central level functions if properly planned and integrated will be supportive to PHC. Unfortunately, some countries have begun implementing PHC almost as a separate vertical "programme" with its own organizational structure and have run into serious difficulties with it as a result, because it is unsupported by the rest of the health system.

The question of levels and what is or is not included as PHC may be a pertinent one where countries, in the process of implementing PHC, want to monitor the extent to which resource allocation is being shifted towards PHC, in accordance with stated priorities. For example, are resources for first line hospitals providing essential surgery to be included as PHC together with Health Centres, health posts and community activities? Or are these hospitals to be regarded as secondary level? Is it possible to

separate resources to support PHC from resources for secondary level? The answers to these questions will depend on country specific definitions and models of health care, specifically to what is defined as "essential" care in a particular country, "essential" being what is included in PHC activities for that particular country. Such essential surgery may be provided at a health centre or at a first level or rural hospital in different countries, recognizing that distinctions between these two types of institutions are often indistinct. In general health centres are usually classified as Institutions providing PHC along with the community level activities, while first level hospitals are usually referred to as secondary care.

In conclusion, PHC can be defined as a philosophy, as an approach, as a level of the health care system or even as a set of activities. It is all of these. Understanding what PHC means today, in the light of the experience of trying to implement it, does not mean that new perspectives will not emerge over the next few years. We must be constantly reviewing the concept with the fresh insights gained from experience. But it is the understanding and acceptance of the underlying philosophical principles or values, outlined earlier in this paper, which will determine what PHC really means in countries.

Political will and commitment to PHC on the part of governments first and foremost requires acceptance of these values. Commitment, however, is itself a process and shades or levels of commitment are usually the reality, rather than political commitment existing or not. Furthermore, governments are by no means homogeneous in their shades of commitment and several different shades may exist in countries simultaneously. Some countries already have policies, and are pursuing patterns of development in conformity with these principles. Some political systems are more favourable to PHC precisely because they emphasize these values and are concerned with a broad attack on poverty and inequality and on the socio-economic structures which maintain them. Even for the health sector the pattern of existing health systems and opportunities for change reflect wider socio-political values. It will be easier to effect the kinds of changes discussed above, in countries where the overall development policy gives priority to equity and social justice, than in countries where economic growth is being pursued regardless of the human consequences. It has to be clearly understood at the outset that commitment to PHC is a commitment to a political goal which will have to be fought for against opposition forces and progress is likely to be slow. This is why PHC is a political issue.

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