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Primary health care: a global overview

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Central to the original Alma Ata declaration was the notion of a system, which included the fostering of health through multisectoral collaboration. This aspect often gets referred to as comprehensive health care, in counter distinction to a selective primary health care model, which emerged immediately following the conference, as the former, though laudable in intent, was argued to be unworkable. Indeed from a global perspective, comprehensive primary health care, if noticed at all in the culture of western medicine, was relegated to being of relevance in 'other' places: so-called developing countries. Nevertheless, at the beginning of a new century, in a vastly different world to that of the 1970s, it is the central contention of this paper that it is still possible to assert that the primary health care model is still relevant – in all countries of the world. The work on the 'social determinants of health' increasingly adds weight to the arguments against the irrationality of an overemphasis on medical technical interventions to the neglect of the health-enhancing or health-threatening contexts in which people live out their lives. Consequently it is now becoming possible to think and plan the management of health, not just the management of disease.

Keywords: Alma Ata; primary health care; social determinants of health

Essential to the primary health care approach launched at the Alma Ata conference was the denunciation of the 'gross inequality in the health status of the people' both between and within countries, described in the declaration of the conference as being 'politically, socially and economically unacceptable' (WHO/UNICEF, 1978). A major part of the strategy proposed to remedy this situation was to rely less on medicine and more on a more social development approach to improving health in which health services partnered other significant players, or 'sectors' such as education, agriculture, etc. (Macdonald, 1994).

A quarter of a century later, there is considerable evidence that socio-economic inequalities, again between and within countries, are on the increase and that health inequalities follow suit (UNDP, 1997; Marmot and Wilkinson, 1999; Kawachi, 2000). There is not massive evidence of health services following the exhortation of the other conference, on health promotion, for the 'reorientation' of health services towards a more health and less disease focus (WHO, 1986). One can conclude, in that sense, that the call for primary health care has 'failed', 'not worked' or simply been ignored. We know that the influences working against such radical changes as would be necessary carry great weight. Nevertheless, there can be little dispute that the call for change embedded in the primary health care movement is as real today as it was three decades ago.

No one should suggest that PHC (or any other system or approach for that matter) has a formula to right these wrongs, but the logic behind the PHC approach is increasingly being validated. For example, one of the key elements of the primary health care approach is a community-based focus and community-based mechanisms which deal with local issues and link with systems 'higher up' (Zajac, 2003). The need for such mechanisms and such an approach is increasingly being felt in both 'developing' and 'developed' countries:

- Across a whole continent – Africa – our age is witness to the tragedy of an epidemic of

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unimaginable proportions. At the end of 2002 there were 42 million people living with HIV/AIDS, 29.4 million in sub-Saharan Africa (UNAIDS, 2002). The disappearance of a whole generation, those we can describe in economic terms as 'productive': men and women from 18–45 has meant that top-down health services, often hospital-based, even with the best will in the world, are left standing impotent in the face of the health needs not only of patients but, just as tragically, their children and the older generation left to care for them. Similar tragic scenarios are emerging in other continents.

- In so-called 'developed' countries, we have the phenomenon of an ageing population and a health system often geared to acute rather than chronic care, often missing the needs of this population in a serious way. Today, one of every 10 persons is 60 years old or over, totalling 629 million people worldwide. By 2050, the United Nations projects that one of every five persons will be 60 or older, and that by 2150 this ratio will be one of every three persons. By 2050, the actual number of people over the age of 60 is projected to be almost 2 billion, at which point the population of older persons will outnumber children (0–14 years) (United Nations, 2002). The challenge for society at large and health services in particular is enormous. Again, a hospital-based system which, given the high cost of modern technology and health professionals, consumes the greatest proportion of the health budget is to the detriment of many older people who are in need of another approach to care which is less institution-based. (Of course, ageing is also a phenomenon challenging health systems worldwide and not just in 'developed' countries as is witnessed by the recent WHO initiative of an integrated response to 'rapid population ageing', United Nations Ageing and Life Course Program, undated.)

Again, in all cases, it would be wrong to suggest that a primary health care approach would 'solve' all problems of service delivery, but at least the orientation of the services would have some chance of addressing population need in humane and effective ways. In all countries, the primary health needs of the population would be addressed at the local level where possible, and secondary and tertiary care would inform and back up this front-line service. In addition, great emphasis would be placed on prevention of illness and the maintenance of health. This orientation remains an enormous challenge, as it was in 1978.

One of the contextual factors which helps explain the emergence of primary health care was the critique of that time (1960s–1970s) of the model of development being promoted throughout the world. The idea that modernization was the way to go, along western lines, was behind much of the interaction between developing countries and developed countries and the institutions dominated by these. The problem was that slavish copying of western models, be it in education or health services, to name only two areas, was not delivering: poverty and ill-health increased rather than diminished and the gap between haves and have-nots, within and between nations, was on the increase (Watkins, 1995). This 'globalization' has been the subject of critique (Chen and Berlinguer, 2001; Foran, 2003) and Alma Ata should be seen by the history of medicine in the twentieth century as an important milestone in the challenging of the dominant paradigm of medicine and health care delivery. At that point in time, part of the contradictions of the document of Alma Ata was that the critique of medicine inherent in the approach was seen to apply only to 'developing' countries rather than across the globe (Macdonald, 1994).

This failure to apply the critique and the consequent primary health care approach to 'developed' countries in no way diminishes the truth of its perspective on developing countries: it involved an examination of the failure of health systems to deliver significant change in terms of health outcomes in the countries of the third world. In many of these countries there was evidence of high infant mortality rates and low life expectancy. This was despite many serious attempts to create a health care system to meet the needs of new nations emerging from periods of colonial discrimination (Banerji, 1985). Access to the services of these systems was extremely limited, often to an urban population. The focus was largely on curative institutional care.

In the document of the conference there is at least an implicit questioning of the model of health care used to build these systems and a new

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model is outlined. Some characteristics of this model (which was called 'primary health care') are well known and can be summarized as follows:

- Affordable, accessible (on equity lines), appropriate care for the particular needs of a given population (this would involve the valuing of local cultures, including non-western health care systems) (Wass, 1998);
- Prevention of illness given its due role alongside treatment;
- The role of other sectors which contribute to health to be acknowledged and intersectoral collaboration for health actively pursued;
- People's participation given a genuine role in decision-making (WHO/UNICEF, 1978).

The 'Primary' in the name has ever since given rise to confusion and rather fruitless debate, but there can be no doubt that in its original conception, it included primary medical care, whether through doctors, nurses or community health workers. The term 'primary' has linguistically diverse and even contradictory meanings. In Spanish, in particular, some of these are nearly opposites. Primario can mean 'primitive and uncivilized' or 'principal or first in order or degree'. As a result of the simplistic and biased perceptions of the experiences on which the concept was based, it was easier, more comfortable and safer to accept the former meaning, while the spirit of Alma Ata clearly embraced the latter. The declaration states that primary health care "forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community'. It was never seen as an isolated part of the health care system, nor was it limited to marginal, low-cost treatment for the poor (Tejada de Rivero, 2003). The name also implied referral 'upwards' where necessary: a system of health care turned towards people's needs at the level of the front-line (primary), but with mechanisms of referral in place to secondary and even tertiary levels when necessary. Moreover, in addition to this issue of access of ill people to clinical care, the notion of a system which included the fostering of health – through schools, agriculture, etc., was clearly central to the original idea of Alma Ata and this aspect often gets referred to as an essential component of comprehensive health care. This is in counter-distinction to the selective primary health care model which emerged on the scene immediately following the conference, arguing that the former, though laudable in intent, was unworkable (Walsh and Warren, 1979). The broad health vision of comprehensive primary health care soon became medicalized by many agencies (Macdonald, 1994).

More importantly, perhaps, from a global perspective, has been the indifference with which the primary health care approach has been received by what we can call the western world. As Walton pointed out in the 1980s, in both the UK and in Europe in general, the notions of primary health care were treated with indifference by those responsible for medical education (Walton, 1983; 1985). As mentioned, comprehensive primary health care, if noticed at all in the culture of western medicine, was relegated to being of relevance in 'other' places, so-called developing countries. In some countries (like Australia) today, the approach is accepted by conventional medicine as suitable for Aboriginal health. Aboriginal people themselves, with their more holistic view of human nature and health, on the other hand, have long since embraced the notion of primary health care (see, for example, the Mission Statement of Aboriginal Health Services, like Wuchopperen, Australia: Wuchopperen, 2003).

At the beginning of a new century, in a world vastly different to that of the 1970s, one can still confidently assert that the primary health care model is still relevant in all countries of the world.

Perhaps one will have to see the problems of the health care system in the west get even worse before alternative models are sought after, just as the original Alma Ata declaration emerged from the realization by many that the model was not delivering in so-called developing countries.

Primary health care, then, means a system of medical care and promotion of health focused on the health needs of a given community, a whole care system, dealing with the immediate presenting problem, but seeking to contribute to strategies to prevent the problem more 'upstream'.

In no country of the world should hospitals be filled with older patients with chronic conditions who could be cared for in less medicalized situations and closer to and sometimes in their own homes. Nor should hospitals be filled with children with diarrhoeal disease, even less with

malnutrition: conditions which could and should be dealt with in a primary health care system at the community level. In both scenarios (of childhood diseases and of ageing conditions of ill-health), hospitals and their resources would be used more appropriately for those conditions which cannot be dealt with at the level of the community.

There is, implicitly, in the primary health care vision, a critique of western health care systems. The critique suggests that, left to itself, a typical western-type health care system can easily develop along lines which might mean the improvement of different aspects of medical technology and even medical practice, without necessarily effecting the improvement of health status of communities or even having this as its major preoccupation. Specifically, the mindset inculcated by such a health system allows the perpetuation of the draining of funds into technical medicine to the neglect of the creation of healthy environments. The separation means the perpetuation of the dominance of the 'downstream' approach. There is no doubt that in many countries this is what is happening. Where is the vision of another way? The answer is outlined in the primary health care approach.

It is interesting to ask: why has primary health care never or not yet been accepted in western societies? Even where there has been acknowledgement of the logic of the arguments for a better balance between high-tech institutional care and community-based care and between treatment and prevention and policy statements been made in support of comprehensive primary health care, the reality is often policies and practice based on a dualistic way of thinking and acting, a continuation of the division between treatment and prevention/promotion which has been the hallmark of western health care in the twentieth century. This is despite some token acknowledgement of the need for community care and prevention. It is also of note that the 'three pillars' of the primary health care movement: participation, intersectoral collaboration and the addressing of equity issues (Macdonald, 1994) do appear, increasingly, as preoccupations of concerned commentators on health and critics of health services (see, for example, the excellent work on inequalities in health: Kawachi (2000) and Wilkinson (1996) to name only two), but these preoccupations are rarely welded into an integrated vision, an overarching framework in the way Alma Ata attempted.

The moral arguments of Alma Ata, involving exhortations to address inequalities in health have proved largely ineffectual. In the twenty-first century perhaps the main driver of change will be economic rationalism. As one Canadian commentator, recasting primary health care in the vocabulary of a population health approach, puts it:

> No one with an interest in health care ... can afford to be ignorant of the population health approach. It is the conceptual ground for health reform today ... The latter half of this century has seen an evolution in approaches to health that began with compassion, and was driven on by combined forces of improved understanding, increased health care costs, and decreased dollars (Ah Shene, 1997).

In the west, there is a great deal of interest in ecological perspectives and it is easy to argue that the primary health care approach represents an ecological/population health point of view, in which the main task of health systems is to create healthy environments (Macdonald, 1999). This line of thinking is given great credence by the work done on the 'social determinants of health'. Until relatively recently, the call for more emphasis on prevention and for a more equitable and rational balance in the distribution of the health dollar has been seen as a moral imperative. Indeed it is, there should be a better balance, for example, between treatment and prevention, but especially in the last decade, there has arisen a body of scientific evidence which should be drawn into the debate. The work on the 'social determinants of health' (Kawachi, 2000; Marmot and Wilkinson, 1999; WHO, 1998) increasingly adds weight to the arguments against the irrationality of an overemphasis on medical technical interventions to the neglect of the health-enhancing or health-threatening contexts in which people live out their lives. We have to think and plan the management of health, not just the management of disease.

We have to recommit to primary health care, unashamedly. We need not reject it but need to find new ways of keeping its principles and applying them to the contexts of today.

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