Primary health care —
what still needs to be done?

The past 12 years have seen a worldwide campaign to promote health
for all through primary health care, yet coverage of the population is still
far from complete. When recently a WHO consultation brought together
a number of public health professionals very experienced in this field,
World Health Forum took the opportunity to ask some of them what
more needs to be done to ensure the success of the programme.

Quite a few people are saying that the
primary health care strategy is not faring
very well. What are your views on this?

Professor Bryant: I think it might be
useful to backtrack a little. You remember
that the concept of health for all through
primary health care was developed at
Alma-Ata in 1978. Then in 1988 there was
a meeting in Riga to assess progress, and the
point was made that a lot had been done in
those 10 years. At the same time it was

agreed that a lot had not been done,
particularly in the poorest countries. So
WHO is now asking itself: is this a policy
we should give strong emphasis to? Does it
really have a place in this world of ours
today? Those who took part in the recent
Geneva meeting had some very strong views
on this. They thought that we now know a
lot about primary care and that this
know-how would carry us towards health for
all. But the question is how to market those
ideas, how to spread them, how to get them
accepted, how to arouse enthusiasm for
them at the periphery, particularly in the
poorest countries. Mind you, it’s one thing
to look at what you would like to do, it’s
another to look at what lies ahead in the
nineties, and this might be a good point to
ask Andrew Creese what he thinks the road
ahead is going to be like in view of the
serious economic deterioration we are
seeing, particularly in Africa.

Mr Creese: It’s difficult to say in any sort
detail. We can say with some clarity,
though, that the road for the industrial
countries is going to be very different from
the one that the poorest countries are on. Over the next 5–10 years the long-term macroeconomic forecasts for the industrial world are of continued growth—at rates below the levels experienced in the last 5 years but nevertheless a positive economic

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growth, faster than the rate of population growth. But in the poorest countries the last decade has seen some substantial reversals in living standards. People in many parts of Africa are now living at levels of income and consumption lower than they were 10 years ago. And the forecasts for the next 10 years for the poorest countries are also, at the most optimistic, of very low positive growth. What this means for primary health care, of course, is that the pressures are going to continue and in some cases to get worse. While the pressures on the health care system continually increase as the population grows or as new diseases appear or as people’s expectations rise, there are at the same time severe constraints on the capacity of governments to pay for that health care.

Marketing of health care

Mention has been made of marketing. It is said that we have to market primary health care. Don’t people want primary health care? Do we have to sell it? How do we get people to ask for it?

Dr Khalid: Primary health care is a new concept, and as with any new product we have to let it be known to people that there is such a thing and that it is an alternative to the traditional way of doing things. Unfortunately, this has not been done adequately. So the people who make decisions and allocate resources—and for that matter the consumers themselves—do not know what our strategies are. As a result, the response is negative. It can even amount to violent rejection because people may think that primary health care is cheap care. Politicians view it differently from health professionals, and those who make decisions on the allocation of resources may suspect that we are trying to compromise on standards, on the level of care and quality.

Some seem to think that the solution is for people to contribute cash. If they get the service they should pay for it. How would that work out in Africa?

Mr Creese: People already do pay. People pay the majority of their health care costs in some of the poorest countries in the world. So there shouldn’t be any misunderstanding about the contribution that people make. At the same time it’s also true that there has been a great deal of innovation and experimentation with methods of raising additional finance for health activities. These include direct payments, even in places where they have been constitutionally ruled out hitherto. Sometimes donations are made in kind at community level, with people constructing a building or donating cash or other goods in exchange for health services. Insurance schemes of one kind or another are being introduced in countries where they did not exist before. These may be simple community-level schemes or more highly organized employer-based schemes. Taxes are being used in some countries—an extra tax on tobacco, for example, the proceeds being used for the health sector.
So all these wrong notions have to be dispelled. The concept has to be marketed, and in that respect we could learn something from the private sector.

Mr Creese: One of the problems of marketing things, of course, is that sales are determined by the distribution of purchasing power whereas primary health care is intended for people who have the least purchasing power. So although we’re exploring a multiplicity of different ways for generating additional resources for health care, the direction in which these resources are pulling is often away from the poorest, away from the people whose health needs are greatest. The continuing challenge is to work out ways of channelling additional resources and possibly of liberating existing resources that are being inefficiently used so that they are available to the poorest people.

Professor Bryant: So in this instance the marketing would be directed at policymakers or politicians who would believe in the issues of social equity and support for the poor. A question I would ask Dr Khalid, who has seen so much of these things, is this: in how many countries would he feel that the leadership, either in the health bureaucracy or in the political arena, sees primary health care as having a particular value for the poor?

Dr Khalid: I think most of the political leaders and top administrators do believe in the value of primary health care. But the people who matter are those dealing with finance, and they have great difficulty in finding the necessary resources.

Are there any identifiable groups of people who are fighting for primary health care? If you take AIDS, for instance, or poliomyelitis or tuberculosis, you have a very vocal group of people who will use every opportunity to fight for the cause, collect money, sell flags in the street, and make sure everyone knows about it. Primary health care, on the other hand, seems to be something very subtle, not a cause that seems to arouse the campaigning spirit in people. Is this one of the problems?

Dr Khalid: Primary health care is a product we’re going to have to sell, so the packaging must be appropriate. Instead of saying “we want to sell primary health care”, we shall have to say “we want to sell equity, we want to look after the poor who are currently denied access”. The right presentation is important if it is going to be attractive.

Professor Bryant: This raises an interesting point. We in the health sector are frequently telling ourselves that health should not be seen in isolation because so many things that happen in other sectors like education or the environment contribute to health. But it occurs to me that in order to market primary care, you may need to connect it with something else that has great value. For instance in some societies the role of women in development is becoming much more highly valued, and health plays a very important part in this.

The concept of primary health care has to be marketed, and in that respect we could learn something from the private sector.

Dr Khalid: Yes, that’s true. In certain areas the health cause is enough in itself; in others we have to jump on the bandwagon. I think we have to be opportunistic.
**Professor Bryant:** Let me ask Mr Creese if there is any way in which we can in a sense sweeten the choice of the politician or the policy-maker. Is there an argument we can use that will really appeal to politicians, so that we can say “it is in your best interest to go this way, Mr Politician”?

**Mr Creese:** I think there are a number of attractive characteristics that primary health care ought to have for the politician. The first, as Dr Khalid mentioned, is that by focusing on those most in need we can consolidate the goodwill of the political system. The second, and I think in the contemporary economic reality the more convincing, is that many of the activities that make up primary health care can save lives and treat or prevent illness at relatively low cost. Therefore part of the case for investment in primary health care on a much larger scale is not necessarily that the total bill is going to be less but that what countries get from their health spending could be much greater. So the combination of cost-effective activities and the capacity to benefit the people in greatest need make this a very compelling argument, both politically and economically.

**Orienting health staff**

**Professor Bryant,** you are teaching young doctors and nurses. Do you manage to get them to believe in primary health care, to convince them that it is going to be their future?

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**Professor Bryant:** Well, at the Aga Khan University in Pakistan, where I work, we are faced with a very complex situation. Medical students in Pakistan have gone through a very competitive educational system. This means that most of them come from rich families that have given them an educational advantage. Only occasionally do we have people coming from poor families. We try to find them and try to support them. None the less, you have for the most part young people whose families and traditions are more in the direction of clinical medicine and specialized medicine. So it would be a bit surprising if they were taken wholeheartedly in the direction of primary health care. But in fact we have been surprised, and pleasantly surprised, to find that a few of them are very attracted to this field and go into it. And quite a number of the others tell us: “I don’t want to be a primary care doctor, but what I’ve learned through working in poor communities is how important it is to the country. So what I would like to do is to be a clinician and to use my clinical experience by working in community settings so that I can have both the excitement of being a doctor with special training and at the same time the social satisfaction of helping the people”. That’s not a bad balance, I think.

**Dr Roesma:** In South-East Asia there are problems with some personnel—doctors in hospitals or universities who have not caught the meaning of primary health care, so that education is still not as oriented to primary health care as it should be. The production of doctors should be such that they can go straight into primary health care. But education is not the only problem. For doctors in remote areas in our region life can be very difficult. If they are in a village in the Himalayas, for example, there is no electricity, no water, no postal services, no magazines. They are totally isolated, and if they are there for three years—well, you
can imagine. This is one of the difficulties we are facing in finding doctors for primary health care.

So what you are saying is that we must have socioeconomic development at the same time. We can't have just health development alone, it must be an integral part of overall development.

Dr Roesma: Exactly. Health cannot stand alone; it has to go together with other development.

Dr Ginawi: Primary health care was built on practical principles, and we should look at health as part of socioeconomic development. Health services alone can never satisfy the hunger of people. They cannot provide shelter for those living in shanty towns. They cannot provide water for those living where there is no water. So health is part of socioeconomic development.

The effect of vertical programmes

Could we now look at another aspect of the situation? It has often been said that while primary health care seems to have a lot of problems, vertical programmes like immunization seem to have a lot of success. How are we to explain this?

Dr Ginawi: Nobody can deny that some of the vertical programmes have been very successful — smallpox eradication, for example. But if you look at the vertical programmes in general, you see that they accomplish only one or two specified tasks, mostly the control of one disease or one group of diseases. At the same time they have a lot of resources — an army of people in different categories specialized in one task or activity. Therefore they can achieve something in a limited period of time.

At the same time, they have created a lot of problems. Most of them are sponsored by a United Nations agency or a bilateral agency or a nongovernmental organization, and they work for four or five years, and then withdraw. They leave the country with a big army of manpower specialized in only one aspect and able to do only one or two tasks. The country is left trying to meet the running costs and has to cut the budget somewhere and give it to the vertical programme just to enable it to exist, and usually primary health care is the victim.

I remember, when I was a provincial medical officer in the Sudan, we had six vertical programmes — smallpox, malaria, schistosomiasis, onchocerciasis, leprosy, and tuberculosis. Each of them had to work vertically and was administered from Khartoum.

I had no say in any of them. Yet Khartoum cannot understand that part of the country better than the person who is right there and has visited every part of it. But such are the vertical programmes.

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How could that situation be improved without taking away the "fire" that these vertical programmes have? They are doing a good job, we have to admit that. How could these programmes become a support for primary health care?
**Dr Ginawi:** In several countries in the Eastern Mediterranean region, we have started to integrate the vertical programmes. You don't want to do away with them because you need the experts—the malariologists, the people knowledgeable in onchocerciasis control, and so on. But the programme can benefit from the community involvement being fostered by the primary health care programme. All activities can be covered in one training course. Instead of paying for all the lectures in the different vertical training courses, we can economize by having one set of lectures covering everything.

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**What we achieve in the health sector is going to depend on overall economic development.**

activity itself can be integrated with other activities. Instead of training microscopists just to look for one parasite, you train them to look for the parasites of other diseases as well and to carry out other simple diagnostic activities.

Of course, you still need central support because the sponsoring agencies have agreements with the Ministry of Health, but in practice you can arrange to have a good measure of local control.

We have started one integrated decentralized primary health care programme in one country containing 13 vertical programmes. We have integrated them into one primary health care programme and have all WHO's financial support in that country to strengthen this approach.

We think that if they work as one programme they will be more cost-effective. When there were so many vertical programmes there was no coordination between them, let alone between them and the primary health care people. So now in this country if any programme manager wants to train his staff, each vertical programme can bring in the kind of training it needs, so that we end up with multipurpose training. The malaria

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**Community participation**

*It is an interesting point that the vertical programmes might benefit from community participation, and this leads us to consider what everyone agrees is a vital element of primary health care. We have to ask ourselves: is enough being done to promote community participation?*

**Dr Roesma:** Extensive health education has been done in the South-East Asia region but in order to bring about community participation, motivation, mobilization and supervision are needed. There is a lot of variation from country to country. Some countries are very advanced, with the community really taking action on health care. But in other countries, community participation is just in the form of manual labour. But that is often how it begins, then you see an increase in various ways until finally there is full participation, even in the planning and decision-making processes. There has been a similar development in intersectoral action. First it is always in the form of committees, and you are never sure if there will be any follow-up. But once the different sectors see that they have a common goal, there is action. They come together and look for policy action.

*But do the health staff understand this? Is there something about the health staff or their training that makes them feel that they should decide rather than the people?*
Dr Roesma: Well, that certainly is a problem, and that’s why we have to try to achieve some reorientation. What is lacking is knowledge in organizing the community. Where formerly we concentrated more on hospitals, there is now a slow reorientation towards the primary health centres and maybe the health posts. But this does not mean that we don’t pay attention to the hospitals. They are still the centres to which people are referred after they have first been to the primary health centre. The hospital staff should do the more sophisticated work, and lay people could take over a lot of the simpler work. Ministries of health in our region give priority to traditional health and self-care practices.

*These ideas have already been expressed at Alma-Ata, and here we are 12 years later, still saying the same things. Why have we not had more success in bringing the people into the primary health care movement? What is wrong?*

Dr Roesma: I don’t think there is really a problem here, because in South-East Asia we have had a good deal of success in primary health care. And in every country in which this has been achieved the community played a fundamental part. Of course, it all starts at the policy level and works its way down to the district level in stages. It does not come straight away.

Professor Bryant: One of the fundamental problems of the world today is that the poor have very few people to speak for them. It takes special people, I think, to reach across the voicelessness. It worked in Dr Khalid’s country because there it was a matter of policy to serve the poor.

Dr Khalid: That was because at one time most of the facilities were in the towns, and the country people – 70% of the population – had nothing. The government in its wisdom realized this at a very early stage in our development, so we went all out for it.

Can we overcome the problems?

Professor Bryant: May I put a question to each of you—are you an optimist or a pessimist? We are faced with a list of very depressing trends. Population growth rate is very high, and the impact of crowding, of increased demands, of fewer resources is going to fall mostly on the poor. Poverty is increasing, and, as Andrew Creese mentioned, for the poor countries it’s going to be more dismal than it is now. There’s ecological deterioration, which hits the poor more than anyone else. We see urbanization—landless people going to the cities and more and more so-called megacities, where the crowding into squatter settlements is very great. And yet here we are, talking about primary health care, which is a strategy for trying to reach the people who are most affected by these things. Dr Khalid, are we looking at disaster in the making, or is it simply going to be a tough decade, which we’ll get through somehow?

The poor have very few people to speak for them. It takes special people to reach across the voicelessness.

Dr Khalid: Well, there’s not the slightest doubt that what we achieve in the health sector is going to depend on overall economic development, and this is something we are only gradually realizing now. In the past the health sector never bothered to look into economics because it was always assumed that the money would
be forthcoming somehow, but nowadays health managers are doing so more and more, and I am very happy to learn that WHO is taking an active interest in this. I remember it being said in the World Health Assembly that the health of the world is often determined not so much by the Health Assembly as by other international forums.

Just by eliminating inefficiency I believe we could improve our productivity by a third.

Having said that, I'm an optimist, and I think if we really re-examine the way we work we'll find a lot of wastage and inefficiency. Just by eliminating inefficiency I believe we could improve our productivity by a third.

Mr Creese: I think it's widely recognized that the medical profession does not have a reputation for spending money wisely. It is recognized both inside and outside the health sector that resources are badly used when the yardstick for assessing the output of the sector is preventable deaths. It is a matter for serious concern. The problem is whether anything substantial can be done to tackle this wastage. It's very hard to give examples of wastage being successfully tackled and the savings put into the provision of better health services. If you're a pessimist, I suppose you decide that wastage is like the law of gravity—something you simply have to live with. If you're an optimist, you regard it as a challenge that has to be constantly tackled. The real source of pessimism is both the knowledge that the economic future for poor countries is bleak and the fear that this reality is going to be unrecognized in terms of the way it influences the allocation of resources within the health sector. But there is also some cause for optimism, if there is going to be a reassessment of spending priorities and an effort to ensure that the system works better to provide services for the people most in need.

Professor Bryant: Can I give you just a little bit of ammunition for your optimistic view? In Karachi, with 8 million people, 40% of them living in deep poverty, we have, with the government, established some small community-based primary health care projects. We have seven of them, each relating to a population of about 10 000 people, and the community is playing a very prominent role in their development. Women health workers reach every household on a monthly basis to see what's happening there. They support mothers in taking care of their children. In this way we have been able to halve the infant mortality rate over a period of one or two years, and the cost is around $2 per person per year. So this is a relatively low-cost way of saving lives and preventing a lot of disability. Now, this is a microsystem, in which you can control the variables, and the question is: are we smart enough, are we good enough managers, and can government and other parties organize themselves well enough to enable these principles to be absorbed into large systems? Nevertheless, what we've done, and what other people have done in similar situations elsewhere, is one of the things that gives us hope that we can in fact carry out primary health care in a fairly cost-effective way.

On that happy note perhaps we should end our discussion. Let us meet again in 1998 and see where we have got to 20 years after Alma-Ata.
From Alma-Ata to the year 2000
Reflections at the midpoint

Has the social goal of health for all, formalized a
decade ago at the historic Alma-Ata Conference,
produced measurable changes in the orientation
of health services and the welfare of humanity?
This book takes a hard look at the complexities
behind the simple slogan, the reasons for the
successes and failures, and the main problems
facing the coming decade. Throughout, an effort
is made to cast the humanitarian potential of this
movement against the realities of a world
political and economic order that rarely gives
priority to health.

Against a background of key statements made
at the Alma-Ata Conference, readers are given a
detailed, critical assessment of what the vision
of health for all has achieved during its first
decade of practical application. While noting
major gains in a number of industrialized and
developing countries, the book concentrates on
the plight of the poorest countries, where health
conditions have either remained the same or
deteriorated. Readers are reminded that the
development process has done little to relieve
the suffering of the world’s most vulnerable
groups, that efforts to improve health now face
a new set of solution-resistant problems, and
that socioeconomic progress will stagnate
unless these problems are quickly and effectively
addressed. To this end, means of securing the
necessary motivation and support are proposed,
followed by ten detailed lines of action.

A critical review of the main tasks to be faced in
the coming years serves as a compelling
reminder that successes and failures will be
measured in terms of human lives and deaths.

Geneva, World Health Organization, 1988,

Achieving health for all
by the year 2000

Midway reports of country experiences
edited by E. Tarimo & A. Creese

This book explores the extent to which the
principles of primary health care, mapped out at
the Alma-Ata Conference in 1978, have had a
real impact on health care in different parts of
the world. While acknowledging the importance
of changes in health policy and the structure of
services, the book makes a special effort to
uncover what has actually happened in the
human setting where both the ambitions of
primary health care and the true measures of
success reside.

Fifteen country reports are authored by public
health experts having first-hand knowledge of
experiences in the country. Written in a spirit of
frank self-assessment, these country profiles
illustrate the diversity of ways in which the
principles of primary health care have been put
to work in rich and poor countries alike. Some
mechanisms are identified by which the impetus
for better health care can move from public
pressure to the political agenda and finally to
legislative action.

A completely different set of challenges emerges
in reports from developing countries, where
priorities remain defined by the need for
essential health care, and obstacles range from
high rates of illiteracy and severe poverty to
terrorist attacks on health posts and the
 persistence of life-threatening traditional
remedies. Under such conditions, documented
improvements in health take on particular
significance as lessons in the use of simple,
inexpensive technologies to stretch resources
and extend health coverage despite highly
unfavourable conditions.

These reports confirm the power of the primary
health care approach to reach people, to achieve
better health, and to make a life-and-death
difference in the world.

Geneva, World Health Organization, 1980,
v + 262 pages, Sw.fr.46.–/US$ 36.80.