Hospitals and primary health care

Why should hospitals be involved in primary health care? The answer is in the mounting crisis in health care in the world today. In industrial countries, people overeat, overdrink, smoke cigarettes, and subject themselves to too much stress. Developing countries have problems relating to nutrition and infectious and parasitic diseases: one person in three drinks unsafe water, one in four has an inadequate diet, and there are one billion instances of acute diarrhoea in children under five each year. In some developing countries, 80% of the people have no access to adequate health care, and 75% of the health budget is spent on doctors and hospitals providing curative care for a small minority; one person in two may never see a trained health worker.

The professional and institutional approach has failed to provide effective basic care for the majority. Hospitals should reorient themselves to support the new trends in health care.

Many health workers are trained in sophisticated, expensive and institutional patient care. Too many work in the hospitals and clinics of cities and large towns where pay and conditions are comparatively good and where professional advancement is more easily obtained. In most cases they have too little interest in the health issues of their communities.

Doctors and nurses are too sophisticated and too expensive for many rural areas of developing countries, where 50–80% of the people live. Yet health professionals frequently resist attempts to permit non-professional workers to diagnose and treat. It often appears that their main desire is to make hospitals and clinics better equipped to take care of the minority who go to them.

The primary health care approach is an attempt to extend health care beyond the privileged few, in both the developing and the industrial countries. Diagnosis and the improvement of health for whole communities rather than just for single patients require new management skills and the involvement of the people themselves in their own health care: better diet, proper exercise, simple remedies for common minor ailments, and a general improvement in life-style all play a part. Disciplines outside the organized health care field should make their contribution. It means involving agriculturalists, educators, local government staff, business establishments, legislators, mass communication and marketing experts, and community leaders.

An International Study

In order to help hospitals to reorient themselves to the new trends in health care and to develop the partnership between them and the
communities they serve, an international study was made of the role of hospitals. The aim was to investigate representative examples of the involvement of hospitals in primary health care.

The study placed particular emphasis on developing countries, although some innovative projects in developed countries were included. Special attention was given to health care activities beyond traditional in-patient and out-patient care. How were hospitals responding to unmet health needs in communities? Were there examples of hospitals with successful programmes and partnerships in health care which could be adopted or adapted elsewhere? To answer such questions, a travelling fellowship was created in 1981 by the International Hospital Federation in collaboration with the World Health Organization, with funding from the W. K. Kellogg Foundation.

A first questionnaire was distributed by post to over 800 establishments in 105 countries. More than 400 hospitals responded, and it emerged that they were involved in the following activities in various combinations: health promotion, preventive health care, family planning, health education, curative health care, rehabilitation, integrated hospital and community care, training, administrative support, and research. Over 100 hospitals completed a second questionnaire, which elicited much more detail of their primary health care programmes. The study is based on the replies and subsequent visits to selected hospitals.

A practical outcome of the study has been the preparation of a set of survey documents in English, French, and Spanish for use by national hospital associations. It includes a covering letter outlining the purpose of the project, an introductory letter from the International Hospital Federation, an endorsement letter from the World Health Organization, a sample covering letter for use within the country concerned, an initial questionnaire, an optional second questionnaire on the main features of primary health care work, and a form on which recipients could confirm their intention to participate in the proposed survey.

A number of organizations in various countries have already made use of the survey documents or have stated their intention of doing so. Among those who have conducted their own surveys are the Costa Rican Hospital Association, the Indian Hospital Association, the Voluntary Health Association of India, the Korean Hospital Association, and the Philippine Hospital Association. The American Hospital Association and the University of Washington, St. Louis, MO, have provided information on US hospitals with innovative primary health care involvement.

**Survey Results**

Of the 424 hospitals that completed the first questionnaire, 207 were included in the study (200 replies from one country were analysed at source, and 17 arrived too late). The replies indicated that many primary health care activities were undertaken by hospitals.

**Health promotion**

Health promotion, as well as disease prevention, was concerned with life-style improvement, physical fitness, stress control, dental care, diet, youth counselling, and preparation for marriage and motherhood. The commonest type of health promotion consisted of education in nutrition: 63% of hospitals had in-house programmes, while 48% were supporting community programmes dealing with this subject. The second most frequent type of health promotion was that of dental care. Life-style improvement programmes covered smoking, sleep patterns, drug and alcohol abuse, eating habits, and stress control. Approximately a quarter of the hospitals were involved in this sort of work, both in-house and in the community. A quarter of the hospitals also supported physical fitness programmes, mainly with exercise projects to promote muscle tone, joint flexibility, and cardiovascular integrity.

**Preventive health care**

Immunization was the most frequently reported measure: 69% of the hospitals had in-house programmes, 53% had programmes in the community, and 33% were helping other community projects. A third of the hospitals had safe drinking-water programmes within
the hospital, 32% were sponsoring projects in the community, and 22% were giving help to other projects. Slightly lower proportions were giving some attention to promoting the safe disposal of garbage and human waste. Other programmes in the preventive category concerned the control of disease vectors, supplementary feeding (usually for children under five), nutrition education for mothers and those taking care of children, food production projects, breast examination, and the discouragement of smoking.

Family planning

In the sphere of family planning, education was the most frequently reported activity: 64% of the hospitals had in-house projects, 46% were sponsoring programmes in the community, and 38% were giving aid to other family planning projects in the community. Enlisting the support of community leaders had a place in about a fifth of the programmes. Family planning services were sponsored by 60% of the hospitals; 31% provided services in the community, and 23% were cooperating with other groups in the provision of such services. About 40% of the hospitals provided contraceptives directly, and 25% were doing so through community services as well. Additionally reported were mobile clinics, training programmes for health workers, sex education for adolescents, pregnancy termination facilities, and the training of family planning workers.

Health education

This was tackled with the aid of radio, films, puppet theatre, television, plays, story-telling, songs, posters, teaching cards, cooking demonstrations, comic books, health magazines, and newspapers, and through schools and clubs. Posters were the most widespread means of health education.

Curative care

Within hospitals, the most frequently mentioned areas of curative care were the emergency and accident services, which were followed closely by ambulatory care. In the community the most frequent type of curative care was of the domiciliary kind, provided by various types of community health workers. Hospitals sponsored or participated in certain special projects, including: mobile clinics, teachers' training programmes, projects on sexually transmitted diseases, primary care drop-in clinics, care groups, first aid training, and the provision of village health workers; these projects were rehabilitative as well as curative.

Rehabilitation

Rehabilitation programmes dealt with individuals and communities in all spheres of physical, mental and social activity. Many more intramural than community projects were described. In-patient rehabilitation programmes were reported by just over half of the hospitals, and out-patient programmes were mentioned by 46%. Of the 207 hospitals, 15% had ambulatory projects in the community and 8% gave help to other agencies. There were few home rehabilitation projects employing hospital- or community-based teams. Finally, 22 projects were concerned with leprosy or polio rehabilitation, day care centres, rest homes, alcoholism rehabilitation, nutrition rehabilitation, ophthalmic programmes, and recovery after cardiac incidents.

Integrated hospital and community care

The professional and institutional approach has failed to provide effective basic care for the majority. Hospitals can learn from this failure and reorient themselves to support the new trends in health care.

The most frequent type of integrated hospital and community care involved hospital responsibility for total health care in a designated geographical area; in particular, this was reported from 31% of the nongovernmental hospitals. Seventy-nine hospitals took geographical responsibility for primary health care with overall supervision based in the hospitals. Seventy-one hospitals also participated in primary health care in the community, with overall supervision based outside the hospitals, and 39

WORLD HEALTH FORUM  VOL. 6  1985 225
helped community-based programmes. Integrated care also took the forms of: combined preventive and curative care for specific population groups; comprehensive hospital primary health care for industrial and commercial firms; comprehensive hospital primary health care for insured populations; mobile clinics and services; hospital/community staffing exchange, rotation and secondment; and collaboration with educational, agricultural and other sectors, and with the mass media. Other types of integrated hospital and community health care were mentioned in specific geographical areas. For example, there was an inter-agency health referral council in one Asian country. Domiciliary care and meals-on-wheels were reported in Australia and New Zealand. Support was given to a family life training centre in Africa and to a reforestation project in Latin America. A variety of shared services were described by United States and Canadian respondents.

Training, administration, and research

Training in hospitals most often involved the orientation of health professionals and the preparation of community health workers. In the community, training programmes focused on community volunteers and leaders, as well as on health workers. Over a third of the hospitals were providing administrative support for primary health care programmes, together with laboratory and other services. Research was being undertaken by up to a fifth of the hospitals. Nutrition and health status studies were the most common within hospitals, but personal attitudes that might affect health status, and various epidemiological questions.

The two case studies outlined below give an idea of how integrated primary health care programmes operate.

Dr Carlos Luis Valverde Hospital, San Ramón, Costa Rica

The Dr Carlos Luis Valverde Hospital has 125 beds and serves a rural population of 92,000 people. It pioneered the "hospital without walls" concept. Infant mortality was reduced from 54/1000 in 1971 to 10.1/1000 in 1982 in the area served by the hospital.

The hospital has developed an integrated system of health care in which four cantonal health centres supervise 46 health posts, each of which is responsible for at least two visits a year to each home. The health centres are staffed by medical personnel. Each health post is manned by a paid health aide and voluntary community health workers, and is supervised by a local health committee chosen by the people. Social workers from the hospital help the health centres, while general practitioners and laboratory technicians are sent to the health posts.

The recruitment of health aides from and by the local community is essential to the system. Most of the health aides are women aged 18–30 who have had basic education but hold no professional qualifications. They receive a one-week initial training and periodic in-service training. Being chosen by the community, they appear to be very well accepted by the working teams from the health posts and health centres, which provide the link with the hospital. One of the aides' initial tasks is the collection, by house-to-house survey under professional supervision, of information for the community health map. The map shows every building and gives data on the type of housing, sanitation, social conditions, and mortality and morbidity factors. This information permits the preparation of a programme of priorities for improving health and social welfare, with particular emphasis on the prevention of illness.

Each health post organizes discussions on health matters with the community at least
once a month. Slides, films, health food displays, plays, discussions, and contests are among the attractions of an annual health education week. A popular feature is the “magician of health” — a local person who performs tricks in which there is a health education message.

Every infant death is investigated by a team which interviews the family, neighbours, and local leaders. Medical records are studied and medical personnel interviewed. The findings are summarized and discussed at a meeting of people from the hospital, the community, and interested organizations. Anonymity is preserved so as to avoid unnecessary distress in the family. The socioeconomic background of the community and family, the family’s medical history, the child’s medical condition from the prenatal period to death, and the mother’s and the community’s opinions of the death are discussed. The meeting then considers what can be done to avoid similar occurrences. This process serves to educate both the professionals and the community. The physicians become aware of the importance of socioeconomic factors affecting their patients, and a bond is developed between the health care workers and the people. This gives them a common goal—to control disease and prevent infant deaths.

The experience gained has convinced the leaders of the programme that socioeconomic causes of disease are highly important and that the hospital must be closely attuned to community needs and integrated with other parts of the health system. However, this cannot be effected overnight.

Over several years, the “hospital without walls” programme has generated a number of activities with national repercussions. The treatment of alcoholics as a social problem, with the support of hospitals and communities, and the treatment of psychiatric patients in local hospitals, without obligatory reference to specialized hospitals, led to a significant reduction in hospitalization. Since July 1975, community health workers have been active in the San Ramón area. There are now 800 elected community health workers in the area; in addition, 2500 have been prepared and sent to other parts of the country.

Measures have been taken to increase community health standards by the improvement of living conditions. These include the provision of piped drinking-water to all dwellings; the promotion of house-building; house-to-house promotion of environmental sanitation; electrification and telephone installation; road construction, especially for the most remote communities; the promotion of rural holdings; the promotion of fruit gardens and the distribution of food to needy families; and the provision of employment in a milk cooperative, three coffee cooperatives, a tourism cooperative, a door and window factory, and craft industries.

Silliman University Medical Centre, Dumaguete City, Philippines

The Silliman University Medical Centre provides high-quality medical and hospital care but emphasizes prevention as the least expensive way to maintain and improve health. The centre has 125 beds and serves a province of 700,000 people. Its extension service department supervises two major clinics or “family life centres” outside the city. Each clinic is a base for teams that go out to eight remote villages for health and development activities. In these villages, family clubs have been formed for planning, discussion, education, and community action. Finance for the programme comes largely from international funding agencies, though income from local stores run with the help of village committee members has provided modest amounts of money for paying the village aides.

Village health aides have been trained for volunteer service, and there are also volunteers concerned with food production, nutrition, and sanitation. A profile was drawn up of the type of person who should be selected to be a village health aide. Such a person should be a trusted and respected member of the local community, with leadership qualities demonstrated by participation in community programmes. He or she should have a good knowledge of basic English and the local dialect and the ability to write simple reports. Health aides should be aged over 25; preferably married and
settled down; and, in the case of women, free from the need to give attention to children of their own. Maturity is more important than formal education, and it is necessary for aides to be intelligent, resourceful, and sensitive to the needs of the community.

The village aides are responsible for the promotion of self-reliance as well as for primary health care. Their duties cover: first aid in accidents and emergencies; medication for simple and common ailments; follow-up treatments as prescribed by supervising health workers; referral for more serious conditions; liaison work between development groups and the community; immunization; the supply of contraceptives; the identification and referral of malnourished children; and the promotion of improved sanitation and hygiene. The major ways in which health aides foster self-reliance consist of working for improved food production and encouraging community involvement in various projects.

The training course for village health aides was initially designed to last three months but now continues for 6–10 months on the basis of two days' training per week. Training is practical rather than theoretical and covers: the aims of the extension service department; the role of the aide; human and public relations; community development and communication; the structure and function of the human body; the concept of health and disease causation; the recognition of illness and abnormalities; the treatment of fever and diarrhoea; the treatment of simple wounds; environmental health and sanitation; health education; simple epidemiology and statistics; surveying the community; maternal and child health including family planning; immunization; and relationships with government health personnel.

Formal evaluation takes place every 18–24 months and includes surveys of public opinion. The results are encouraging, although mortality and morbidity data for the villages have not yet been analysed.

Sometimes a community does not see health as a priority; it is important, therefore, in conducting basic surveys, that felt needs be determined, so that it becomes apparent how villages want to be helped. The underlying principle of any community work is self-help; unjustified subsidies do no good. Working through local organizations, or creating them if necessary, is very important. Mothers' clubs were the first target, but parents' clubs also evolved and fathers were thus brought into the picture.

The experience gained in the village health aide programme led to the following conclusions.

- The cheapest way to improve health is through preventive measures such as sanitation, proper nutrition, and immunization.
- Most health services can be given by auxiliary workers supervised by a doctor or nurse; intermittent visits to the community, even by highly trained professionals, are not effective.
- Permanent effects can be achieved through health education of the people and support of community action.
- Trained traditional midwives are available and they meet with ready acceptance; they should receive further training with a view to improving their efficacy and enabling them to help in family planning activities.
- Two health workers should be trained in each village because of the need for mutual psychological support and continuity of services.
- Trainees should be selected by local residents.
- The attitudes of trainees are more important than their academic achievements—even illiterates can be trained to be proficient.
- The aide must be supported by the village served. He or she should only be a part-time health aide and should be partially self-supporting.
Lessons From the Study

Hospital associations reported various ways in which they supported primary health care innovations and activities. Several had conducted surveys of hospital involvement in primary health care, sometimes using postgraduate students to gather information and write reports. One association gave awards to hospitals with outstanding hospital-sponsored primary health care programmes. Another produced a policy on the responsibility of hospitals for health promotion. Other ways in which associations can create increased awareness of the importance of hospital involvement in primary health care are:

— the regular publication in the association’s journal of reports on hospital innovations relating to primary health care;
— the presentation of annual or special awards to outstanding programmes;
— the promotion of visits by the association to hospitals with innovative programmes;
— the holding of special sessions on hospitals and primary health care during association meetings; and

— the promotion of hospital and primary health care weeks nationally.

Individual hospitals can contribute to primary health care in many ways. One may be the creation of a community health department to act as a focus for cooperation with the community. If hospitals specify the populations they serve, it will be easier for them to collaborate with organizations already interested in participating in primary health care activities and with local government workers.

Hospitals can participate in studies to identify and understand community health needs, inform officials and community leaders about pressing health needs and opportunities in the community, train primary health care leaders and workers, and use modern marketing techniques and new approaches in health education to support healthier lifestyles.

Hospitals that reach beyond their walls into the surrounding communities appear to give the best service. Despite the prejudices of some health professionals and of lay people who have become enamoured of advanced technology, primary health care does work.

Primary health care: a victim of scientific snobbery

While disciplines like molecular biology are advancing with great rapidity and ingenuity, the quality of data relating to down-to-earth topics like human nutrition is nothing like so good. We are failing to attract the best brains into this type of work and I fear scientific snobbery must bear a lot of the blame. Scientific prestige does not come often to people who direct their skills towards testing hypotheses mainly related to problems of primary health care.