



REGIONAL OFFICE FOR THE WESTERN PACIFIC  
BUREAU RÉGIONAL DU PACIFIQUE OCCIDENTAL

REGIONAL COMMITTEE

Thirty-second session  
Seoul  
22-28 September 1981

WPR/RC32/7  
30 July 1981

ORIGINAL: ENGLISH

Provisional agenda item 13

HEALTH SYSTEMS SUPPORT TO PRIMARY HEALTH CARE (PHC)

Health systems support to primary health care was the subject of the Technical Discussions held during the Thirty-fourth World Health Assembly in May 1981. Delegates to the Health Assembly from Member States of the Western Pacific Region contributed to the deliberations of the six groups into which the Technical Discussions were divided.

The attached document, prepared in the Regional Office, is presented to the Regional Committee with a view to encouraging it to discuss and comment on the subject as a whole from a regional point of view and to make whatever recommendations it feels might provide the necessary encouragement to Member States in reorienting the support provided by their health systems to primary health care.

## 1. INTRODUCTION

The International Conference on Primary Health Care, held in Alma-Ata in 1978,<sup>1</sup> considered primary health care to be an integral part of a country's health system, as well as the main focus of overall social and economic development of the community. Health systems support to primary health care must be viewed in the light of this statement, and the impression avoided that primary health care is a special programme. It is, on the contrary, the basis upon which the health system should be developed.

Considered in this way, a number of issues need to be addressed by the health system in its effort to redress the inequalities in the health status within a country that is pursuing the primary health care approach.

## 2. POLITICAL COMMITMENT AND ACTION

In any major national undertaking, political will and action are essential. This is especially the case with primary health care, which focuses unprecedented attention on the needs of the community, with clear implications for the preferential reallocation of resources to the periphery. Political commitment and action are needed not only at the local level, but also, and even more important, at the intermediate and central levels, which, in most countries, control the flow of resources. A prerequisite of such commitment is a favourable attitude on the part of political decision-makers, which, in turn, depends on a proper understanding of primary health care and its implications. It would be useful, therefore, for countries to review the intensity, methods, and scope of their promotional activities, and assess whether the message of primary health care has really been understood by the decision-makers at all levels of government.

## 3. COMPREHENSIVE PLANNING TO SUPPORT PRIMARY HEALTH CARE

All countries carry out the planning function according to established procedures and through organized efforts, namely, managerial processes. Planning at central level must provide the policy framework for primary health care and be able to identify depressed and underserved areas. Planning at intermediate and local levels should involve a careful diagnosis or assessment of community health needs, and determination of what is wanted and feasible at community level. It should also take into account resources that may be available in the community.

---

<sup>1</sup>Alma-Ata 1978, Primary Health Care, WHO, Geneva, 1978 ("Health for All" Series No. 1).

Since primary health care requires planning at different levels, it is necessary for ministers of health to strengthen their planning mechanisms, encouraging the "bottom-up" approach to planning, and extending participation in the planning process to include the community, other components of the health sector, and the agencies of health-related sectors.

#### 4. INTERSECTORAL COORDINATION

The expected prime mover in primary health care is the minister of health. However, he will need the cooperation of health-related sectors. While it is claimed that most countries have very little experience in intersectoral coordination in the area of public health, nevertheless, it is necessary to formulate a plan to secure support in primary health care and not to leave promotional activities to chance or ad hoc arrangements. An analysis of the selected sectors/ministries, and an understanding of their ways and means of operation, including their short, medium, and long-term plans, is necessary. Areas of duplication, or possible conflict, should be identified and resolved. In this respect, the national development or planning authority should provide guidance, and even assume a leading role. In fact, of all the government agencies, it should be the initial target of the ministry's promotional activities.

At the central level, the degree of political commitment should be reflected in support to the ministry of health in achieving intersectoral cooperation and coordination. Mechanisms for coordination at different levels will need to be strengthened or established. The ministry of health will need to strengthen itself as the support of other sectors will depend on its influence and authority. It must at least show to other sectors that it is fully conversant with the health situation, especially at community level, and that its recommendations are based on research and on careful analysis of relevant information.

#### 5. COMMUNITY PARTICIPATION

Community participation is one of the most important and dynamic elements of primary health care. Choice of the most appropriate model for community participation will depend on such factors as the cultural tradition and political system of the country, the educational level of the community, and existing political and administrative structures within the community.

Community participation may be developed on the basis of existing structures. This means that no separate mechanism will be needed for health. Community participation, in this case, means engaging existing political, trade, women's, religious and other organizations in health activities and coordinating their work. Where real community participation is traditionally poor or virtually non-existent, the health system may have to create organizational structures, which could be used initially to mobilize the community to solve concrete health problems which it has itself identified with guidance from within the health system. These structures could eventually be converted into a single structure for overall community development, through which local representatives of other sectors would be active.

An important prerequisite of successful community participation is some degree of decentralization in decision-making. If planning and important decision-making are confined strictly to the higher administrative levels, the local community will lose interest and no feeling of responsibility will be generated. This will be further aggravated if the members of the community see that hospitals and clinics are constructed out of tax funds in areas much better served than their own.

The encouragement of self-reliance and community participation must not in any way be interpreted as diminished responsibility on the part of the government to provide the population with basic health services. Often, broader health-related goals cannot be pursued unless the availability of such services is ensured, especially personal health services and their appropriate support and referral systems.

In preparing to enlist the community in the task of health development, the ministry of health will have to train its health workers to understand, support and guide community participation. It is important that they should learn about community organization and change so as to be better able to foster broad promotive and preventive efforts.

## 6. HEALTH MANPOWER PLANNING AND DEVELOPMENT

Existing health workers will need to be trained in the primary health care approach, with emphasis on community organization and mobilization. They should be conversant with the interests and activities of other sectors so as to be able to work with them effectively.

The curricula of basic and post-basic training courses may have to be reviewed and revised in the light of the needs of the primary health care approach. It is important that training institutions, in conjunction with the ministry of health, should continuously study the changing health needs and conditions of the community, and use the results to ensure the relevance of their courses. Apart from ensuring the relevance of teaching, the ministry of health and the training institutions should formulate realistic health manpower plans to avoid an overproduction of health workers who are not so much in demand and an underproduction of those who are badly needed. Studies to effect better health manpower distribution and improve conditions of employment should also be undertaken. The introduction of new categories of health manpower may have to be considered, including village health workers. Encouragement and training of practitioners of traditional medicine, promotion of self-care, and official recognition and supervision of traditional birth attendants may be necessary. For all these innovations, supporting legislation may have to be introduced.

## 7. FINANCING

Adoption of the primary health care approach will not reduce a government's expenditure on health. On the contrary, it will cost more; but it is expected to yield greater overall return. It will require the improvement or extension of the basic health services provided to the

underprivileged segment of society, as well as referral mechanisms and facilities. It will also require funds immediately for the retraining of existing health staff.

Scarcity of resources is a problem, not only of the health sector but of all other sectors. Each sector will normally try various means to secure a higher budgetary allocation. Mobilization of community resources will be necessary, but the communities most in need, the depressed areas, may have limited financial resources to offer. It would be very discouraging for them to be asked to contribute while hospitals and clinics are being built or expanded in already well-served areas out of the national budget. The ministry of health may therefore have to consider various options, such as:

- (1) to maintain health expenditure in well-served areas at a constant or slightly increased level, and allocate the larger share of the budget increase to the underserved areas.
- (2) to enhance the efficiency and effectiveness of existing resources, such as to assign promotive and preventive tasks to hospitals, and institute more rational procedures for drug and equipment procurement, distribution, and supervision of use.
- (3) to mobilize and coordinate the activities of the other members of the health sector, including other ministries maintaining health facilities or carrying out some form of health activity, in order to plan a joint approach for the underserved communities.
- (4) to carry out studies to reduce the cost of health care.
- (5) to conduct studies on alternative means of financing.
- (6) to prepare suitable proposals for negotiation with external agencies.

#### 8. MANAGEMENT AND SUPPORTIVE SUPERVISION

Apart from the fact that health staff need to develop skills in mobilizing and guiding community participation, those at the district and subdistrict levels should be familiar with the management and supervision of integrated health programme operations. One health official should be identified or designated who will have overall responsibility for health in given areas and under whom all other health staff of the ministry will work, whether they be on a permanent or temporary assignment (i.e. assigned from centrally operated programmes). Simple but clear manuals of operation for basic health units would be most useful. A plan for training in health management should be developed for field staff, especially those in charge of health districts. The necessary reporting system should also be developed.

## 9. FACILITIES, EQUIPMENT AND SUPPLIES

The facilities, equipment and supplies provided to the community will depend on what the health system expects to do at that level.

It will be necessary for countries to review their physical resource requirements to support primary health care and to undertake studies to reformulate those requirements if necessary. Standards developed in one country, while informative, may not be applicable to another. Even within one country, requirements may vary. It cannot be overemphasized that the clinics or centres constructed should be simple and functional, and not beautiful show-pieces.

Simple equipment is needed for village health work. However, in procuring equipment for health facilities of higher capability, consideration should be given to the availability of spare parts, to the amount of energy the equipment will consume, and to the skills needed for its operation and maintenance.

At community level, it may be relatively easy to formulate a list of 20-30 essential drugs which would be made available by the government or by community organizations. At national level, however, obstacles may be expected, arising from a lack of understanding, on the part of medical practitioners and the pharmaceutical industry, of the concept of having an essential drug list.