PRIMARY HEALTH CARE: THE KEY TO HEALTH FOR ALL

A. Piel
Secretary of the International Conference on Primary Health Care, U.S.A.

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Summary

In 1977, the Health Assembly of the World Health Organization (WHO) resolved that the main social target of governments and WHO in the coming decades should be "the attainment by all citizens of the world by the year 2000 of a level of health that would permit them to live a socially and economically productive life". This aspirational target or goal of "Health for All" (HFA) was above all an equity principle, calling for "an acceptable level of health for all". The question then, as it is now, was: Is HFA possible? Is it operationally attainable? How is it to be done? The proposed answer was "Primary Health Care" (PHC). In 1978, a major International Conference on Primary Health Care, jointly sponsored by WHO and the United Nations Children's Fund (UNICEF), took place at Alma-Ata. The Conference reaffirmed that "health is a fundamental human right" and declared that "Primary Health Care is the key to attaining this target as a part of development in the spirit of social justice". This article explores how Primary Health Care came to be, what it is and is not, how it works and relates to broader issues of development, whether it remains valid, and where it may go in the new millenium.

1. Background: Emergence of a Right to Health

In the aftermath of two devastating World Wars, followed by an era of reconstruction and ideological confrontation throughout most of second half of the 20th century, there has gradually emerged, at least in officially expressed international public opinion, a sense or conviction that there exists a human right to access to a basic level of health,

education and opportunity for all. This goes beyond the earlier recognized civil rights of vote and free speech or freedom from torture and enslavement. The expression of a "Right to Health" does not mean that such a right has been universally accepted and acted upon in all constituencies. Freedom "from" enslavement is one thing, but a right "to" health raises a whole set controversial issues, such as who provides what, or gets what, and at whose expense. The United Nations Charter and the Universal Declaration of Human Rights (1948) approached the right to health gingerly, in terms of "medical care and necessary social services". The 1946 Constitution of the World Health Organization (which entered into force in 1948 and has now been accepted by almost 200 Member States) affirms that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being", that health is "essential for peace and of value to all", and that "unequal development... is a common danger". Most governments can ascribe to a "right to health", at least if the questions of who decides or does what and who pays for it can be side-stepped. The operational nature of Primary Health Care is such that these questions have to be met head-on, but in ways that can be applicable in different cultures, countries and communities, and at different stages of development. If the "Right to Health" and "Health for All" present the challenge, Primary Health Care provides a significant share of the solution.

2. Experience: Emergence of a Set of Principles

Over several decades, experiences in an ever-increasing number of countries and communities around the world have shown that an acceptable, even enviable, level of health for all can be and has been attained, without undue reliance on State budgets or external aid, even in poor and otherwise underdeveloped areas. In none of these cases has the experience been totally successful and country-wide. Nevertheless, these experiences have come from every manner of political, cultural, social and economic system: Capitalist, Communist, Socialist, Totalitarian, Monarchist, Theocratic, or Lay Republic, developed and under developed. There appears to be no single universal model, but success stories have tended to pose the same recurring fundamental characteristics or principles for success. First, and perhaps primordially, in these examples the determination, promotion and provision of health in its fullest sense, came mainly from the people and communities themselves "bottom-up" and not so much from prescriptive external providers and donors, or central powers and budgets "top-down", important as such assistance may be. Second, the successful approaches targeted specific health improvement opportunities but also addressed a wider range of factors related to health: education, housing, food and water, environment, as well as occupational and social involvement, and not just sectoral health or medical services. Third, the actions taken aimed at more equitable and ultimately universal coverage according to need, beginning with more basic minimum needs, and using selective interventions that make a difference. Fourth, the health services provided were not just curative or rehabilitative, but also educational, promotive and preventive, aimed at the underlying determinants of health. Finally, the services provided and technologies used were effective, acceptable, manageable and affordable - in short, appropriate and sustainable. Such successes early on suggested that a new strategic and operational approach to health development, based on common principles, was in the offing - well before a name for it had been invented or agreed upon.

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3. Authorship and Choice of a Name

Many are they who have worked on PHC, its conceptualization, expression and realization. Still more carry PHC forward today. The 134 Member States and 67 United Nations organizations, specialized agencies and non-governmental organizations that attended the International Conference on Primary Health Care at Alma-Ata in 1978 worked hard to hammer out and agree on enduring language to describe PHC. To them great credit is due. Particular recognition must be given to the passionate advocacy of HFA/PHC by Dr. Halfdan Mahler, then Director - General of WHO (1973 - 1988). But in truth, no single person, group, agency or organization "invented" PHC. Rather, PHC invented itself. The international health community had the vision to seize upon it, albeit not without controversy and differences in perspective. Even the choice of a name, needed to promote the concept, did not come easily. Finally, the term "Primary Health Care" emerged as the "least worst" of the options considered. The term PHC, even now, is something of a misnomer, suggesting things that PHC in fact is not. In the PHC context, the word "Primary" does not mean only first, or principal, or basic, or peripheral. The word "Health" does not mean only health in the sectoral sense, and it certainly is not synonymous with "medical" or with "extension of health services". The word "Care" does not mean only curative and rehabilitative care, but also prevention, promotion and a wide range of other actions to foster healthy living in a healthy environment. Contrary to what its name might imply, PHC is not "delivered" to people; it is generated by them and from them. It is of them. PHC is, in short, true democracy in health development, with the accent on equity. PHC is driven by history, not invented. Nameless, it would still exist. So, what's in a name? A rose by any other name would smell as sweet.

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4. A Short, Formal Definition of PHC

One inescapable task of the International Conference on Primary Health Care was to capture and express the essence of PHC in a reasonably succinct way, emphasizing the elements of participation, acceptability, access, affordability and sustainability. PHC was conceived as the main entry way to the development of a total health system:

> Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It 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 is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

5. Attributes and Content of PHC

Much debate took place at Alma-Ata on what the main attributes or characteristics of PHC were, and on what should be the minimum content. There were understandable

tensions between proponents of "comprehensive" and "selective" PHC, and between advocates of "health services" focus and wider developmental purposes. The compromise solution was often to say two things at once. There was also the usual drafting dilemma between saying too little and saying too much. For example, should Mental Health be singled out for emphasis in the content of PHC, or subsumed within "prevailing health problems" and "endemic" or "common diseases"? The eventual Declaration of Alma-Ata was both an explanation of what PHC is and an exhortation to what PHC ought to be. The International Conference declared that Primary Health Care:

1. reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
3. includes at least: education concerning prevailing health problems and methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
5. requires and promotes maximum community and individual self-reliance and participation in the planning organization, operation and control of Primary Health Care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
6. should be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

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Biographical Sketch

A. Piel - The author is a U.S. citizen, who was educated at Princeton University (AB 1958), Harvard Law School (DJ 1963), and M.I.T. Sloan School of Management (1971). He joined the World Health Organization (WHO) in 1972, and worked in administration and in technical support to planning and implementation of Primary Health Care in a number of countries in Africa, South East Asia, the Eastern Mediterranean and the Western Pacific. Dr. Piel served as Secretary to the International Conference on Primary Health Care in Alma-Ata in 1978.He was also Secretary of the WHO Headquarters Programme Committee. From 1985 to 1988, he was Director of Support Programme at the WHO Regional Office in Alexandria, Egypt, serving the twenty-three countries of the Eastern Mediterranean Region. From 1988 to 1990 he was Director of Programme Development at the WHO headquarters in Geneva, Switzerland. He served as WHO Legal Counsel from 1991 to 1993, and Director of Cabinet of the Director-General from 1993 to 1996.

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