

Primary Health Care: Not the best of beginnings?¹

When I learned of the revived interest in primary health care, I had no choice but to push aside the other ideas that I had for this seminar in order to concentrate exclusively on what I think I've learned about the subject from my recent writing assignment. I do this with pleasure, for if there is any subject about which I feel obsessive it is that of PHC.

From the title of my seminar it's obvious that I have some misgivings about the way PHC was launched by WHO.

Putting it briefly, it was ahistorical, confusing, and didn't respond to what the Governing Bodies wanted.

But before going into that, let me provide some background for those of you who are not familiar with the history that led to the holding of the International Conference on PHC at Alma Ata in September 1978. I should add that my presentation today is totally separate from my official history work, mostly because much of what I want to say is both personal and speculative.

PHC was presented to the WHO governing bodies in January 1975 in a paper entitled "Promotion of National Health Services." I had the privilege of being in charge of the team that prepared that paper, at the same time that I was made Programme Area Leader of a new unit of PHC in the Division of Strengthening of Health Services, whose director was Dr Kenneth Newell.

The paper to the Board argued that, and I quote, "a series of major national efforts to develop primary health care services at the community level is seen as the only way in which the health services can develop rapidly and effectively." This development was to be guided by 7 principles which stressed the need: (1) for PHC to be shaped "around the life patterns of the population"; (2) for the local population to be involved; (3) for "maximum reliance on available community resources" while remaining within cost limitations; (4) for an "integrated approach of preventive, curative and promotive services for both the community and the individual"; (5) for all interventions to be undertaken "at the most peripheral practicable level of the health services by the worker most simply trained for this activity"; (6) for other echelons of services to be designed in support of the needs of the peripheral level; and (7) for PHC services to be "fully integrated with the services of the other sectors involved in community development."

¹ Presented by Socrates Litsios at WHO on 19 February 2007

At this point, the history of PHC became a bit complicated due to the insistence of the Soviet Union, transmitted by its delegate Dr Venediktov, that an international conference be held to review national experiences. As we learned rather quickly, an international conference is no small affair. The nearest experience that WHO had that was of any relevance was that of the World Health Assembly. But this was clearly several orders of magnitude greater in difficulty, not only because of the severe logistical demands that were made by the Conference being organized in the Soviet Union, but more importantly because of the complex nature of the subject, beginning with what exactly was meant by PHC.

There were wide ranging opinions on the subject. Among my colleagues, we had no doubt that PHC's starting point is people. It was no accident that one of the documentary pillars of PHC was *Health by the People* published in early 1975 and edited by Newell. It is also of note that at one point I recorded Dr Mahler as saying: "he could imagine that PHC might best thrive where there were no organized health services." I don't think he meant that to be taken literally. Instead, it was a challenge to get us to think in terms of what people can do for themselves and what improvements to health can be obtained by action outside the health sector. Nevertheless, statements of this kind added to the confusion surrounding what WHO meant by PHC, a point I will get back to later. But first I want to say something about how WHO ignored the historical roots of PHC, which in and of itself may have added to the confusion.

The historical roots of PHC can be found in Social Medicine, a discipline that emerged in Europe during the 19th century. One of its leading 20th century advocates was Dr Andrija Stampar, who, in fact, was deeply involved in the establishment of WHO to such a degree that he is often indicated to be the Father of WHO.

Stampar and other advocates of social medicine managed to have its essential principles spelled out in a report produced in a conference on Rural Reconstruction and Hygiene organized by the League of Nations in 1937 in Bandoeng, Indonesia.

In his oral history given in July 1975, in other words the same year that WHO introduced primary health care, Dr Van Zile Hyde, a high ranking American public health specialist and President of the World Federation of Medical Education at the time of Alma-Ata, describes how he had recently read a document to some people in leadership positions in international health who were talking about community health and asked them how they liked it and if it seemed to cover what they had in mind. They all agreed that it did, and at least one of them thought that it was something that he had written and was testing on them. He then told them how it was excerpts from the report of the 1937 League of

Nations conference.

Somewhere in 1977 I ran across the report of the League Conference just in time to incorporate it in a paper that I wrote for Dr Mahler's signature entitled the *Promotion of PHC in Member Countries of WHO*. In it I contrasted the outcomes of the conference in Bandoeng with the principles of PHC as developed by WHO, and then went on to ask how come WHO had resurrected ideas that had been put forward decades earlier. I used the paper to expand on many of Mahler's most well-known criticisms of existing health systems: the delivery of medical care at the expense of health care, the lack of relevance of medical education to the priority needs of people, the imposition of high-cost technology at the expense of appropriate technology, to name just a few.

There was another day, probably around the same time, when a colleague came to me with a page from a report and asked me where I thought it had come from, just like Van Zile Hyde's experiment. The subject was Provisions for Popular Participation in Health Work. The language was a bit dated but the essential ideas were in the spirit of PHC. The page turned out to be from the 1st Expert Committee that dealt with the Public Health Administration in 1951.² Stampar was a member of that Committee, as was Karl Evang, another prominent member of the social medicine community at the time. It was this committee that gave birth to what was called Basic Health Services.

Despite the model for the basic health services that the Expert Committee developed in the 1950s, WHO's major efforts over the next two decades were in assisting Member States to develop mass campaigns, with malaria eradication leading the way. Only when that eradication campaign began to seriously falter in the 1960s did the leadership of WHO begin to give more careful attention to the problem of how to develop basic health services. This was how Dr Pierre Dorolle, Deputy Director-General, outlined the problem in 1964 for a Study Group that met to discuss the integration of mass campaigns against specific diseases into the General health services.³

The question before the Group, he said, was creating an increasingly acute dilemma, particularly for developing countries. This was due to the fact that while there is a need to control or eradicate major communicable diseases, the general health services are at a somewhat embryonic stage and their development would almost certainly be rather slow.

He continued: There seemed to be general agreement on the need for integration of health activities with the ultimate aim of providing one health programme for the community, intimately related to its

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social and economic development.

The secretariat for this meeting was a joint one involving the malaria eradication programme and the division of public health services.

Members of the group were unanimous in their opinion that mass campaigns can and should be used as an instrument for the development of the general health services.

However, there was a great lack of information regarding many aspects of the relationship of mass campaigns and the general health services. To meet this deficiency they called for field and operational research. The last line in their report reads: This is a challenging opportunity for WHO to stimulate and sponsor useful operational research.

Between 1964, when this Study Group met, and 1971, there were no really significant policy advances in the area of basic health services, as far as I have been able to determine. Matters began to change in January 1971 when the Executive board decided to focus their organizational study on the Methods of promoting the development of basic health services. The WHO Secretariat had not recommended this subject to the Board. It arose out of their discussion, with Dr Venediktov being its principle advocate. Newell, who joined WHO in 1967 as Director of a Research division, was made Director of the newly established division of Strengthening of Health Services in April 1972, at which point he inherited the responsibility of being the secretary to the working group that the Board established to carry out its study.

Before Newell took on that responsibility the Secretariat had prepared a background paper on the subject for the Board's discussion in January 1972.⁴ I have not, unfortunately, been able to determine who wrote this report. Venediktov asked for the name of the consultant who had written it, but no name was given in public.

The paper presented a substantive analysis of the problems facing the basic health services, including that of the need to integrate the mass campaigns into such services. It sketched the policy basis for such services as they had evolved from the early 1950s. The longest section was dedicated to ways and means of promoting the development of the basic health services. The paper was low-key in its presentation, concentrating on technical problems facing public health administrators responsible for extending the coverage of national health services.

The Board's study group met during 1972 and produced their report for its January 1973 session.

4 EB49/WP/6

Whether the change in content and style can be attributed solely to Newell's influence is not totally clear, but everything was different about this report. The picture painted there was an alarming one. Its key conclusion was that the basic health services approach had failed, and that a "major crisis" was "on the point of development" which must be faced at once. The crisis was reflected in the "widespread dissatisfaction of populations" for reasons that included "a feeling of helplessness on the part of the consumer, who feels (rightly or wrongly) that the health services and the personnel within them are progressing along an uncontrolled path of their own which may be satisfying to the health professional but which is not what is wanted by the consumer."⁵

Mahler, in his first Annual Report of WHO, prepared in early 1974, continued in this dramatic fashion when he indicated that "a turning-point in the life of the Organization" may have been reached, which stemmed from the "unequivocal admission" that "the most signal failure of WHO as well as of Member States has undoubtedly been their inability to promote the development of basic health services and to improve their coverage and utilization." As there were few models to "demonstrate that primary health care can come out of the villages at a reasonable cost and in a manner that is technically and socially acceptable," he indicated that it was "an urgent task for WHO to seek a number of innovator countries that will be willing and able to set up such systems of primary health care and demonstrate their effectiveness."

Five major principles dominated the report of the Board's Organizational Study. The first was that while the problem of developing 'health services' (the notion of basic having been dropped) is essentially a national affair, it should be possible to structure responsibilities to give "greater emphasis to consumer preferences." Secondly, "outputs" should be seen in terms of "the final return to the individual in health status and in service." Thirdly, to overcome the current fragmentary nature of the health services, they "must be taken as a whole, public and private; national and international; curative and preventive; peripheral, intermediate and central." Fourthly, the performance of the health services should be judged by health status, operational factors (e.g. coverage and utilization), accepted technology, cost and consumer approval. Lastly, believing it improbable that an international model or 'standard' will be developed, "each country will have to possess the national ability to consider its own position (problems and resources), assess the alternatives available to it, decide upon its resource allocation and priorities, and implement its own decisions."

5 Off. Rec. 206, Annex 11.

Dr Ammundsen from Denmark, the Board member who had chaired the Organizational Study, introduced the subject to the Assembly in 1973. She underlined the fact that the study was “no more than a beginning. An immense task lay ahead; not only to assess the real situation, particularly so far as concerned the primary health services at the peripheral level, but also to try to coordinate under a common plan the often scattered and disparate health facilities and resources that might be funded by the State, by local authorities, by private persons or institutions, and by bilateral or multilateral assistance. A holistic approach was essential if great disasters later in the century were to be averted.”⁶ The resolution adopted by the Assembly in 1973 invited the attention of Member States to the findings, conclusions and recommendations of the study, and outlined a series of recommendations for the Director-General to carry out, beginning with concentrating upon specific programmes that would assist countries in developing their health care systems for their entire populations, special emphasis to be placed on meeting the needs of those populations which have clearly insufficient health services. It also requested him to report to the Board “on the steps to be taken for the implementation of the conclusions and recommendations of the study and their impact on future programmes of the Organization.” But no date was fixed for such a report to be prepared.

For all intents and purposes the subject was closed for the time being.

At this point I need to go back in time to pick up another major thread initiated by the social medicine community. And again I turn to Stampar, a fervent advocate for a broad developmental approach to improving the health of the rural poor.

In a background paper that he prepared in 1954 for a technical discussion of the Assembly on the subject of rural health, he reminded his readers how the experts at the League of Nations by the end of the 1930s, “felt more and more strongly that the questions of rural hygiene should be examined in their natural setting because any real amelioration of the standard of health in the rural environment must depend, in the first place, upon the improvement of living conditions generally.” However, in the ensuing two decades, he noted, the situation of the rural population had gotten “increasingly worse.” Paradoxically, this could partly be blamed on the rapidly increasing rural population brought about by dramatic reduction of disease. He described the situation in the following terms: The rural population is enjoying the first fruits of social medicine. This cannot stop at the first step. The responsibility of social medicine is to carry on and improve their lives. It cannot let die from hunger people whose lives have

6 Off Rec. 210 p447

been saved from disease.⁷

I've mentioned the publication *Health by the People* which was published in early 1975 and edited by Newell. That publication arose out of an initiative that dated back to 1972 when the UNICEF/WHO Joint Committee on Health Policy also chose to evaluate the basic health services. In addition to *Health by the People*, there was another important publication: *Alternative Approaches to Meeting Basic Health Needs of Populations in Developing Countries*, which also was published in early 1975. Both books highlighted developments in various countries including China, Cuba, Tanzania, and Venezuela, along with one community-based project in India. But in *Health by the People*, Newell extended his analysis by including two other community-based projects, one in Indonesia, the other in Guatemala.

All three community-based projects undertook activities of which Štampar would have whole-heartily approved. One project featured goat and chicken farming to increase the income available to the poorest members of the community. In another project, the community was aided in finding funds for introducing tractors, where farmers had lost their cows, and for installing deep tube-wells. In the third project, community health promoters were trained as community catalysts, working in areas other than curative medicine, such as literacy programs, family planning, the organization of men's and women's clubs, agricultural extension, the introduction of new fertilizers, new crops and better seeds, chicken projects, and improving animal husbandry.

While Newell, in his comments at the end of *Health by the People*, expressed excitement at what had been demonstrated in all the projects written up, he was particularly enthusiastic about what had been achieved related to community development. He contrasted issues such as improving productivity of resources to enable people to eat and be educated, and the sense of community responsibility, pride and dignity obtained by such action with the more traditional public health activities of malaria control and the provision of water supplies. The challenge for people in the health field, he concluded, was to accept these wider developmental goals as legitimate ones for them to pursue, even going so far as to admit that “without them there must be failure.”

The 1937 League of Nations report had expressed a similar sentiment when it concluded that if the problem of land reform is neglected, programmes of rural reconstruction not only will be greatly retarded, “but will not be able to rest on a permanent basis.”

At the end of 1976, shortly before he left WHO, Newell wrote in a background paper for discussion

7 Štampar, A. Background to Rural Health. A7/Technical Discussions/1; 1 March 1954.

with the Director-General and the Regional Directors that primary health care was a “code word describing a health related response to the international and national cry for social equality and justice with equal emphasis upon the developing world and the underserved groups of many countries.” Furthermore, he indicated, primary health care was “not only a health concern because it is improbable that any organizational health service response by itself will be sufficient to significantly alter the poverty syndrome to the vast mass of rural populations.”

This conveniently brings me to my second problem that I see in this history, namely the confusion surrounding what exactly PHC was supposed to mean, a confusion that I suspect some of you might be suffering at this moment.

You will have noticed that the term primary health care was used on several occasion in earlier discussions. Mahler spoke of few models that demonstrated how primary health care could come out of the villages and the urgency with which WHO should seek a number of innovator countries willing and able to set up systems of primary health care and demonstrate their effectiveness. Dr Ammundsen had talked of the need to assess the state of primary healths services at the peripheral level, calling for a holistic approach to the problem, but without clarifying just how holistic her view was. Did it go as far as Newell's, who wrote of agricultural development, literacy campaigns, the organization of men's and women's clubs and the like?

The ahistorical nature of the publications surrounding the introduction of the PHC approach left unanswered a number of questions that had been the subject of earlier debates. The basic health services model had failed, but no explanation was given for their failure. Was it the model that Stampar and Evang had proposed in the 1950s that was at fault, or was it the inability of Member States to carry out what had been proposed some 20 years earlier? And how innocent was WHO in all of this history? After all, its emphasis on the mass campaigns had pushed aside the basic health services.

The outstanding problem of how to integrate the various vertical components that hitherto had been the pillar of WHO's programmes was no longer being addressed. Did this mean that it was no longer an important issue? As an aside, one could argue that the quick emergence of selective PHC in the 1980s was not only due to external forces imposing that regressive vision on WHO but to the fact that WHO had not focussed on the question of integration once it started moving towards the concept of PHC.

The Executive Board had altered the focus of attention from the basic health services to the national health services, and in the process down-played the importance of integrating the vertical programs, and then Newell went further with his insistence that all factors contributing and effecting health had to

be kept in focus as well.

All these factors and unanswered questions must have confused many, especially the large number of senior WHO public health specialists in the organization whose career had been dedicated to strengthening national health services by the traditional means of improving human health resources skills especially at intermediate and local levels, and who had struggled in various ways with the problem of integrating diverse programs into one national program.

Looking back on this time, I see that four major visions were competing with each other at the same time for attention under the banner of PHC. Two were holistic at the national level, one, the more holistic of the two, encompassed issues such as agrarian reform and anti-poverty strategies, while the other brought together all health facilities and resources funded from all sources, including private, bilateral and multilateral assistance. The other two visions were also holistic in nature, but applied at the community level. One focused on the health services and involvement of the community; the other on empowering people and communities for broad developmental purposes. Depending on who was presenting PHC, and in what context, one of these main visions was concentrated on, sometimes two, almost never all four. It is not surprising that many were honestly confused about what PHC was all about.

This brings me to my third problem concerning how WHO chose to introduce PHC in 1975, namely that it did not respond to what the Assembly had asked of the Organization.

It was not WHO's wish to make yet another report to the governing bodies in 1975. The Board had concluded its study in 1973 and the Assembly had indicated that WHO should get on with the job of promoting national health services. But Dr Venediktov forced the issue when he proposed to the 1974 Assembly that an international conference should be held on the subject, and that the Director-General should report to the January 1975 Board upon the "steps which could be undertaken by WHO to further the implementation of this and related resolutions ..., and which could result in more effective coordination between WHO's activities and national health programmes."

His proposal for an International Conference was not acted on, but the need for WHO to report again was.

The resolution that was adopted in 1974 could have been taken at face value. WHO could have chosen to concentrate in its presentation to the Board in 1975 on its own activities.

The timing, however, was an awkward one. Newell and many of his staff were deeply involved in the

preparation of the Alternatives Approaches volume and Health by the People. As a result the paper that did go to the Board in January 1975 was put together very quickly. It is possible that Mahler and his immediate advisors did not have more than several days to review its contents. What might have resulted from a more careful review of the subject is worth considering, I think. Like all good chess games that were played in the past, looking for better moves can be both challenging and informative. The paper could have taken into account Mahler's vision for WHO. Mahler, who had become Director-General in 1973, had a different agenda in mind, not that he didn't fully support PHC. On the contrary, it was his more radical statements, as I've already illustrated, that encouraged us to pursue the direction that Newell had hinted at in his concluding section of Health by the People, which was more oriented to community development than to the strengthening of the health services, which was Newell's mandate as Director of SHS, another source of confusion, no doubt.

Mahler was trying to redress the way WHO developed its program. He was unhappy with the fact that the typical WHO involvement in a country took the form of literally dozens and dozens of projects that had little to do with each other, many, if not most, having been developed by headquarters staff. He was committed to try to convince countries to move towards more holistic visions of their problems and solutions, and introduced country health programming as the methodology to bring that about. He sought to make health an obligatory component in all country programmes managed by the United Nations, as I described in my first seminar last year. He sought to get countries to use WHO to coordinate inputs from the international level that aimed to improve health. He envisioned a highly decentralized WHO better positioned to help countries coordinate the use of their own resources and those of the international community.

Both Health by the People and the Alternative Approaches volume were in press at the time the Board met in January 1975. These demonstrated the capacity of WHO to evaluate experiences in different political contexts. In effect, the conclusions reached in both of these publications represented a statement of the PHC principles. The paper to the Board could have presented these principles in the form of what the Organization had learned from its review of experiences, while indicating its intentions to continue in-depth analyses of these and other situations, working with innovator countries as Mahler had called for earlier, all to be undertaken within the context of Mahler's overall strategy for strengthening WHO's coordinating role at country level.

This approach would have brought together the two types of analytic capacity that WHO possessed, one strong at working with issues related to people and communities, the other strong at working

within the framework of national health systems.

At some point in the late 1960s I heard Mahler put forward the idea that only when change from below was consistent with the change that was coming from above, would health systems begin to 'swing', one of Mahler's favorite terms for describing something good. It sounded good to me, which is no doubt why I remembered it, even though I wasn't quite sure what it meant at the time.

The change from below would emerge from community involvement in health services and empowerment in development, while that from above would stem from any number of possible reforms as introduced by country health programming, intersectoral coordination, regionalization, health services and manpower planning, to name just a few.

The paper that could have been written in January 1975 would have described WHO's capacity to cooperate in both types of activities, i.e. from below and above, and most importantly, it would have portrayed WHO's commitment to ensuring that its top-down approach was sympathetic to the principles that were driving those promoting bottom-up change, something that in fact was not evident at the time, a point important to keep in mind, and one which I've addressed on other occasions over the past year.

So what does all of this history and speculation have to do with the situation that WHO faces today?

To begin with, the problem of what PHC means still exists. If you look at the WHO web site and go to PHC, the first definition that you see is a traditional, medical one: Care which provides integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

I would not recommend, however, that WHO open up the Pandora's box of redefining PHC. Instead, the Declaration of Alma-Ata should be taken as the starting point. Perhaps the Governing Bodies can be asked to endorse its basic principles with the idea that WHO bring the subject up-to-date with references to post Alma-Ata developments of direct relevance to the future of PHC.

Even if such an endorsement is obtained, I suspect that vested, conservative forces will oppose it. I have no idea what that opposition looks like today. When Dr Mahler presented his ideas at a meeting in Bellagio in June 1977, David Bell, who summarized the meeting, portrayed the opposing forces as “massed phalanxes of the world's medical professions – in industrial and developing countries alike –

who will oppose that idea with all their power and prestige.”⁸

Assuming that there remains strong opposition to the underlying principles of PHC, WHO must build the strongest working relationships possible with those organizations that are fully sympathetic with PHC, especially civil society groups dedicated to people's participation and empowerment.

In the 1970s there was an extraordinary relationship built up between WHO and the NGO community committed to PHC. Also important was the working relationship between WHO and UNICEF.

However, I must add some caveats. With respect to the NGOs, I have the feeling that WHO was too nonchalant about their involvement. Rather than have taken their support for granted, we should have worked more closely with them to solidify their involvement in WHO's programs.

Similarly, with regard to UNICEF, there were continuous strains between the two Organizations, beginning with an attitude on the part of many WHO staff that UNICEF was a supply agency and nothing else. There was resentment in certain circles of WHO when UNICEF decided to hire its own medical advisors. Perhaps WHO had taken too seriously its Constitutional mandate as being THE coordinator in the field of international health.

If there are forces against PHC outside the Organization, you can rest assured that they exist inside as well. They were present in the 1970s and WHO lost many staff members sympathetic to primary health care because their immediate working situation was not favorable to PHC, despite that fact that the Organization was promoting its principles.

One way that was found at HQ for involving all staff who were interested in supporting PHC was the creation of working groups that discussed various aspects of the subject. These groups lasted for a good while during 1976 and 1977 but suffered the problem of not involving regional staff. In fact, the whole exercise proved counter-productive when the Regional Offices rightly asked how come HQ had so much free time for its staff to volunteer to work in such groups. Today, one could well imagine through the use of blogs and other means, inviting all interested WHO staff to contribute their ideas and suggestions.

In the final analysis, however, it is what happens in countries that will determine whether this historical cycle of PHC will fare any better than its predecessors. Here I only have several observations to make. To begin with, WHO needs to ensure that all of its country-based activities and programs are operating in full sympathy with PHC notions. This was not the case in the 1970s.

8 Working Papers: Rockefeller Foundation Bellagio IV Population Conference November 1977

The vertical programs largely continued to function as before, indifferent to and sometimes hostile to the notion of PHC. But more importantly, the planning tools developed by the Organization were largely insensitive to the needs of PHC. For example, the systems analysts then present, including myself, had not found the way to incorporate the social orientation of PHC into their methodologies. Newell seems to have recognized this. In his first draft for the background paper for Alma-Ata, written in early 1977, he labeled what the systems analysts and modelers had to offer as the “hope of the 1960s,” something which he claimed was “no longer with us.” For “we had misunderstood the nature of the question we were asking and the capabilities of the sciences we were looking to for assistance.” Mahler, too, often castigated us systems types.

It was not only the systems analysts that failed to support what Mahler called the social revolution in health. The social dimension of health, as currently being looked at by the Commission on the Social Determinants of Health, was largely ignored by the majority of programs, and not actively supported by the Organization when such support was critically needed. Introducing the social into the work of WHO cannot be simply mandated; it must be worked on diligently, something that did not happen in the 1970s.

Socially-sensitive health systems research is still needed in all four aspects of PHC that I've described. As I explored in my last seminar, such research stagnated in the 1970s, precisely when WHO should have been leading the way.

In each country where WHO is cooperating to promote PHC and PHC-related ideas, there should be a historical arm, which also was absent in the 1970s. In this regard, it might prove useful for historical reviews to take place in all Member States. Such reviews could explore the degree to which each country has or has not engaged in the past the four visions of PHC. In fact, this might be the way for WHO to begin building its future. Such a program would no doubt uncover many valuable experiences that have not as yet been documented or have been forgotten with the passage of time.

In any case, what is most important, as I've already indicated, is that all WHO programs should be working in harmony with the basic principles of PHC, as enunciated at Alma-Ata.

No doubt there are other conclusions to be drawn from this history, but I will stop here. It's been a pleasure to be given this opportunity to resurrect a bit of the past.