

Primary Health Care in Europe

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CONTENTS

	<i>Page</i>
Preface	v
1. Introduction	1
1.1 The setting of PHC and main principles	1
2. Health and the development of health services in the European Region	4
2.1 Changing patterns of living in Europe	4
2.2 The health of Europe	4
2.3 The development of health care in Europe	7
2.4 Primary medical care in Europe today	9
2.5 Summary	9
3. The main problems of PHC in the European Region	10
3.1 Introduction	10
3.2 The relationship between health and society	11
3.3 Operational and technical obstacles to the application of the PHC approach to health care in Europe	12
3.3.1 Accepting the principles of PHC	12
3.3.2 Problems related to the principle that health care should be "needs related" and universally accessible and acceptable	13
3.3.3 Problems related to the principle that community participation is essential in PHC	16
3.3.4 Problems related to the principle that PHC should be effective and efficient	17
3.3.5 Problems related to the principle that PHC should be part of all development and of the wider health care system	18
3.3.6 Problems related to the environmental health component of PHC	19
3.3.7 Problems of training for primary health care	21
3.3.8 Problems of indices of health and the survival of the unfit	21
4. Towards new solutions: some new strategies for PHC in the European Region	22
4.1 Introduction	22
4.2 Regional contributions	22
4.3 The health centre and polyclinic movement: unification of services	24
4.4 The health care team	26
4.5 Health and education	27
4.6 Community participation, the family, and the individual	27
4.7 Some important contributions from research	29
4.8 The importance of PHC: new recognition?	30
4.9 The future	30
Annex I Declaration of Alma-Ata	33
Annex II Other publications of the WHO Regional Office for Europe relating to primary health care	37
Annex III Publications and documents on primary health care distributed at the Alma-Ata Conference by Member States of the WHO European Region	38

PREFACE

The International Conference on Primary Health Care, held in Alma-Ata, USSR in September 1978, issued a Declaration embodying the fundamental principles of primary health care and urging national and international action to translate those principles into practical programmes. Inevitably the Declaration, and indeed the Conference itself, stressed the need for urgent action in those areas of the world in which the population has no access to any permanent form of health care. Europe is clearly not one of those areas; the majority of the Member States of the WHO European Region are industrialized and provide highly organized systems of medical care for their people.

Although the primary health care approach in Europe is different from that envisaged for the developing world, the Declaration of Alma-Ata, the text of which is reproduced as Annex I, p. 33, identifies several principles that apply equally to both developed and developing countries.

- (a) health care should be related to the needs of the population;*
- (b) consumers should participate, individually and collectively, in the planning and implementation of health care;*
- (c) the fullest use must be made of available resources; and*
- (d) primary health care is not an isolated approach but the most local part of a comprehensive health system.*

These principles are not only relevant to the European Region but are actually being put into practice in several countries and analysed in many of the current programmes of the Regional Office. It is timely, therefore, to review the present situation in Europe, the problems that must be overcome in implementing the primary health care approach, and some of the developments that are taking place.

This publication is based largely on my report to the Alma-Ata Conference. I wish to acknowledge the valuable contributions to our thinking on primary health care in the European Region made by my colleagues in the Regional Office, in particular Dr D.K. Sokolov, Director, Development of Comprehensive Health Services, and Dr J. Jirouš, formerly Regional Officer for Development of Community Services. I am also indebted to Professor E.M. Backett, Department of Community Health, University of Nottingham, United Kingdom for stimulating discussions and editorial assistance. The

final reports on meetings arranged by the Regional Office, as well as a number of background documents, have been particularly helpful. I have referred to some of these reports and documents to illustrate certain points; many more, though not quoted, have been sources of inspiration to me in preparing this presentation.

Leo A. Kaprio

1. INTRODUCTION

The contribution of the European Region to the Alma-Ata Conference consists of a review paper comprising three main parts. In the first I describe briefly the changing patterns of life in the Region and the main features of health and illness against which primary health care (PHC) must be seen, and I also briefly outline the development of the complex and highly organized health care and the social and welfare services found in the Region. In the second part I describe the main problems impeding the full development of the PHC approach in the Region. Finally, in a section I have called "Towards new solutions: some new strategies for PHC in the European Region", I indicate some of the developments that are taking us in Europe quite near to achieving some of the goals set for PHC in the rest of the world.

The views expressed here are my own and do not reflect the opinion of Member States or of the Regional Committee, although I would hope that both could agree with much of what I have to say.

1.1 The setting of PHC and main principles

It is necessary first to consider PHC in the setting of a region that is technically and industrially advanced and where medical care is highly organized. As you are aware, in the vocabularies of WHO and UNICEF the term "primary health care" has a special meaning in relation to the developing countries. In the early days of WHO we used to speak of "local health services"; in the 1960s the term used was "basic health services", and now we speak of "primary health care". However, the terms "local health services" and "basic health services" in a way reflected ideas imported into the developing countries either by outside advisers or through the views of "elitist" health leaders in those countries. Primary health care, on the other hand, is intended to develop from the people themselves and, according to Dr Halfdan Mahler, Director-General of the World Health Organization, "should fit the life patterns of the community it serves and should meet community needs and demands". Thus, in the developing world, it is seen as something much more than the primary *medical* care provided in Europe. However, in spite of this fundamental medical emphasis, PHC developments in the European Region at all levels share a number of common or basic principles with PHC in the developing world.

The first and most important of these principles is that there is a close relationship between health needs, the associated tasks, and the various caring roles that are developing in health care.

Fundamental to much of the recent writing on PHC is a relatively simple conceptual model that links the health care needs of a population (descriptions of which are a feature of many recent epidemiological studies) to the health care tasks involved in meeting those needs. These tasks and the related skill constitute the care needed and thus define the educational and organizational objectives involved. It is of great importance that much of the care needed falls within the scope of PHC.

In simple terms, the ideas that form much of the current model for PHC are derived first from a study of the broad spectrum of *health needs* of communities. These needs should define the community response towards health care. The necessary tasks and skills cluster together, some being appropriate to the physician, some to the nurse, others to various categories of medical auxiliaries, and most important, still others to providers of non-medical primary care coming from the community itself – indigenous health practitioners (where they exist), the individual's neighbours and relatives, and even the individual himself or herself. Such care is, of course, at least in theory, universally accessible and acceptable.

The value of such a framework is principally that it provides appropriate and integrated task and role analyses that are at the one time traditional features of medical care (the physician, the nurse, etc.) and also, in medical terms, unconventional (the health attendant, the family, and self-care by the individual). In short (and in conformity with views now current in WHO), a "needs derived" frame for discussion of PHC places more emphasis than other frames of reference on nonmedical care, health education, family and self-care, indigenous health care, and spontaneous community-based movements towards PHC.

Next are those notions deriving from the ideal of community^a participation in health.

Here, the notion of PHC requires that the care given should involve the local community. Care should, if possible, result from community activity, or at least be a part of it in the sense that the local community takes an active, or even sponsoring, role. Locally derived priorities are served and local community resources used, as far as possible. A more subtle and more important feature, mentioned above, is that PHC is not imposed from outside and is always in harmony with the life style and culture of the community. It follows that health is often defined in local, rather than in "imported"

^a It is not always clear what is meant by "community". The local small group of villages concept is often inappropriate in the European Region, where some kind of local authority or regional administration is often substituted. The two concepts are, of course, quite different from the point of view of PHC.

medical, terms. It also follows that the life style and culture are likely to carry a great deal of weight in modifying the health status of the community.

Another shared feature of PHC is the notion that it must use its resources as effectively and as efficiently as possible.

PHC is effective in that it promotes health and prevents and cures disease, and cost-efficient in that it does all this while strictly conserving resources; therefore, the community can afford it. Part of this notion is that PHC is comprehensive, that is, it takes into account the ecosystem in which communities live and recognizes that many interrelated conditions (some of which, like poverty, housing and education, are very complex) have a strong influence on health. This principle also implies that PHC is distributed according to need, that is, PHC aims at the most vulnerable sections of the community, and those most in need, and distributes resources accordingly.

Finally, PHC is not seen as an isolated approach to health care, acting on its own, but as the most local (i.e., community based) part of an integrated and comprehensive health system.

Thus PHC is seen as bringing together primary, secondary, and tertiary levels of care, including prevention, promotion, and diagnostic and curative services, rehabilitation, and after-care. It follows that PHC is seen as making its contribution to general development along with education, agriculture, industry, transport, etc., which also use local resources and which, acting in combination, play a part in promoting health and in enhancing the quality of life.

This brief summary shows that while the basic principles of PHC are most readily applied in the developing countries where needs are greatest and resources least (and where action to control the environment, to disseminate the most elementary and basic knowledge about health, and to promote caring services at the village level are of the utmost importance), they are also relevant to the European Region, but in a different way.

In the European Region the health care situation and the needs, demands, and caring services are, at least in the industrialized areas, completely different from those in the developing world. For the most part services are highly organized, coverage is complete, and PHC is thought of in less general terms but particularly as *medical* care since it is usually organized by medical personnel.^a

Several countries in the European Region are well on the way to reaching the goal of "health for all by the year 2000"^b and their varied experiences

^a A few countries in the Region that have less developed services, however, experience the need for PHC in the way it is formulated for the developing world.

^b See Mahler, H. Health for all by the year 2000. *WHO chronicle*, 29: 457-461 (1975).

in this direction are highly valuable for other countries, which can profit from their mistakes and achievements. For all countries the PHC concept has much to offer, but it must be adapted to European cultural and developmental achievements.

Keeping the major differences between the developed and developing countries in mind, and emphasizing the importance of primary medical care in the European Region, I now consider the background to our present situation and PHC problems in the Region, proposing finally some tentative steps towards the solution of these problems.

2. HEALTH AND THE DEVELOPMENT OF HEALTH SERVICES IN THE EUROPEAN REGION

In order to visualize the nature of PHC in the European Region, and the difficulties met in providing this type of care, we must view it in the light of the life style and the major and characteristic challenges to health experienced there. These health challenges and the changing contributions of the health services, social welfare, and education, as well as the assaults on the individual made by environmental deterioration and industrial development (to mention only some of the factors that influence the human ecosystem and thus the health of European populations) form the, admittedly, crude background to our understanding of the situation.

2.1 Changing patterns of living in Europe

With few exceptions, affluence and generous supplies of energy and food, together with good transport and communications and universal education have brought about the transformation of even the rural areas. Europe now comprises populations where the most arduous and disagreeable tasks are mechanized, where technology has entered the sphere of family life, where families are smaller and geographically scattered, where there is little illiteracy, and where religious and cultural traditions are changing rapidly. As a consequence, there are great differences in the attitudes of the different generations, and in all European countries there are increasing numbers of lonely old people as a result of the greater life expectancy and of its variation in men and women. At the same time, the vast majority of people enjoy economic security, even in old age.

2.2 The health of Europe

Europe is becoming healthier, death rates (which we must use in spite of their being a poor indication of health) are falling, and patterns of need are

changing. The number of deaths from infectious diseases declined sharply during the last decade, and with rising living standards have come increases in deaths from the chronic degenerative diseases and from such external causes as accidents, violence, and suicide. Cardiovascular diseases account for more than 50% of the deaths in one third of our Member States and for more than 40% in another third. Malignant neoplasms cause about 20% of deaths.

Two important trends may be seen. First, there is the change in the contribution of chronic degenerative disease and accidents, etc., to total mortality; here, there is a massive increase that corresponds to the aging of our populations. Second, there are the trends in the age-specific death rates, most, but not all, of which are declining. These trends reveal our successes in controlling infectious and acute disease and our failure to control such conditions as lung cancer and heart disease or the modern "epidemic" of road traffic accidents. Our information on "health" is, as usual, deficient and that on morbidity is less complete than that on mortality. Nevertheless, the available data show that some of the notifiable acute communicable diseases have disappeared although others show only slowly decreasing numbers of cases. Reported cases of typhoid fever, for example, still reach several thousand each year, and cases of diphtheria several hundred. Meanwhile, there is no apparent change in morbidity from infectious diseases due to viruses (upper respiratory infections, influenza, etc.).

While diseases associated with infectious agents form a smaller but continuing problem, pathological conditions determined by a combination of genetic, environmental, and behavioural factors are beginning to dominate the health scene and intrude into family and community life, and are challenging society as well as medical science to find ways of controlling them. Conditions such as allergy and juvenile diabetes are increasingly important.

Socially sensitive mortality rates, such as infant mortality rate, are declining fast in most countries and in some have already reached a steady low level.

A new picture of child health is emerging: the most important health problems of the young are congenital disorders, accidental injury, malignant neoplasms, and mental and social maladjustment (often manifested by alcoholism and drug dependence, and sometimes by suicide). There is relatively little malnutrition in the Region and mortality indices for this are low, but in some countries there are problems of dietary imbalance and overnutrition.

In older persons, particularly in countries where those aged 60 years and over comprise between 15% and 20% of the total population, the chronic degenerative diseases (including mental disorders) are, of course, frequent. Their increasing contribution to total mortality and morbidity dominates the health picture.

Although the countries of the Region differ as much in their respective health situations as in their ways of life, they can be divided very roughly into four main groups.

Group 1 consists of countries with the lowest overall mortality and an infant mortality rate below 20 deaths per 1000 live births. The tuberculosis mortality rate in these countries is less than 5 per 100 000 and deaths from infectious and parasitic diseases are under 10 per 100 000. With a few exceptions, the countries in this group have low reproduction rates. Age- and sex-specific death rates from cardiovascular diseases vary but mostly show an upward trend; this is probably due to a real increase in these diseases. Mortality rates from malignant neoplasms in most of the countries rank high and, with a few exceptions, show a slight upward tendency – mostly due to cancer of the lung and bronchus.

Group 2 consists of countries with an intermediate overall mortality and an infant mortality rate below 30 per 1000 live births. The tuberculosis mortality rate is less than 10 per 100 000 and infectious and parasitic disease mortality rates are 20 per 100 000 or lower. The majority of countries in this group have the lowest reproduction level and rank high in cardiovascular disease mortality. Mortality from malignant neoplasms is relatively high and, as in group 1, shows a tendency to increase.

Group 3 countries have the highest overall mortality and an infant mortality rate ranging from about 30 to over 50 per 1000 live births. The tuberculosis mortality rate is over 20 per 100 000 and the infectious and parasitic disease mortality rates rise to over 35 per 100 000. The level of reproduction varies from relatively low to very high. The same applies to mortality from cardiovascular diseases and malignant neoplasms. However, an upward trend is so far apparent only in mortality from neoplasms.

For all the countries in groups 1, 2, and 3 fairly complete health information is available.

Group 4 comprises the few remaining Member States of the Region; for these less exact information is available, but the health situation is evidently much less favourable. These countries still face a large number of health problems that are characteristic of the developing world and which range from communicable and parasitic diseases through high infant mortality to unsatisfactory sanitary conditions and poor nutrition.

Countries in group 4 (about 10% of the Member States, representing perhaps 8% of the total population of the Region) are at the point in their development where an active PHC approach is likely to be immediately rewarding. The need here is for what might be termed “developing world” PHC. The development of the other three groups of countries is advanced (by any standards) and their PHC needs are different; this is the pattern experienced by the vast majority of the population of the Region, and the problems it gives rise to are the subject of this paper.

To summarize, we can point to the emergence in Europe of chronic degenerative disease and accidents as the major challenges to life, the aging population as the main challenge to caring, and reduced fertility (or at least smaller completed family size) along with child survival, safe childbirth, and

planned families as the main achievements of family health. Extreme poverty is uncommon and, with two or three exceptions, countries of the Region are relatively affluent. The diseases associated with poverty, though still present, are sporadic rather than prevalent in their occurrence.

As regards health, however, there is still some way to go, and epidemiologists are aware of shortfalls in all our crude measures of health. Although disease is less often the result of, for example, infected water supplies or insanitary waste disposal, the data point to new and subtle causes of illness reflecting the presence of new toxic substances in the physical environment coming from industrial activities, the unsatisfactory nature of our psychological environment, stresses associated with urban living, and changing family structure. The patterns of demand for health care are changing also, and these often indicate a less-than-satisfactory quality of life.

2.3 The development of health care in Europe

It is axiomatic that health, particularly those aspects of health that are subtle and not reflected in morbidity and mortality rates, is affected by most of the conditions present in the human ecosystem. One of these is availability of health care. In this section I deal briefly with the response of European society to its health problems, that is, the growth of the health and social services. Most of these services, though often fragmented, are intimately linked with current ideas about welfare, health insurance, and the interaction of health with education, industrialization, and growing affluence.

In European and indeed in all industrialized countries the health services and some aspects of what is now called PHC have grown up over the last hundred years in response to the needs and demands of the community. Health services changed as the demands of society changed. The one did not always follow the other, however, and much of the care provided was ineffective, but PHC in Europe today can only be understood in this historical context.

Towards the end of the nineteenth century the "public health revolution" that was sweeping across Europe caught up with the effects of universal education (in some countries at least), with new and higher standards of living (again, in some countries only), and with new attitudes towards poverty and degradation. The basic principles of the "welfare" movements that grew up in a few countries became widely accepted, and by the turn of the century the early forms of social security and personal preventive medicine (immunizations and nutritional supplements for schoolchildren, for example) gradually helped to promote the idea of health care as a universal need. Later, and only in some countries, this became a universal *right*. Out of the multitude of charities for the sick and needy came the beginnings of the comprehensive health services of today.

Elementary public health systems were founded in several countries and industrial workers were insured against absences from work due to sickness and for medical care costs. Later (and in some cases earlier), this insurance was extended to civil servants, the armed forces, and the police. The part played by the state in these early beginnings of community care was not always clear and *national* health services came, if at all, much later.

By the end of the nineteenth century efforts were already being made in Europe to promote PHC in the form of limited "front-line" preventive, promotive, and medical care services at the community level, although these efforts were by no means always successful. However, health service coverage for populations in the Region has always been broad and the indigenous caring systems, which are still important in other parts of the world, were soon made redundant. In most countries of the Region they were superseded by organized medicine, at first by private insurance systems then gradually by state or state-supported insurance.

Early PHC was provided by midwives, health visitors, and nurses who visited peoples' homes and were in many ways closer to the community than the physicians who followed them. Early experimental health centres,^a though few, had been tried by the early 1920s, and the same ideas were applied in the polyclinics and dispensaries that succeeded these health centres in some countries. In the USSR, where after 1917 a new social system developed, first priority was given to health care for children and workers in industry and agriculture. Later, this system of priorities provided the pattern for delivery of health care in other countries with similar social and health care systems.

Advances in medicine and the provision of new health services, however, seemed always to be followed by newly perceived needs and thus by ever increasing demands for health services in all countries — a phenomenon suggesting that the notion that health care means more health and therefore less demand was wrong. The new demand was rarely for primary health care.

There were other problems too. For example, increased knowledge led to much specialization in medicine and to the largely uncontrolled proliferation and fragmentation of the health services. This in turn led many countries to develop what amounts to *disintegrated* systems of health care dominated entirely by health professionals.

As a consequence, lack of coordination of services, particularly the absence of links between primary and specialist outpatient and inpatient care, gradually became a serious problem. Coverage suffered, and in some cases resources and manpower were wasted. In spite of these problems

^a By this is meant the Anglo-Saxon notion of a place of work for the primary health care team consisting of a physician, a nurse, a midwife, and possibly a social worker.

sophisticated medical services in the Region have, in broad terms at least, been following the apparent demands of the people: babies are now born, and old people are dying, in hospital, and high-technology diagnostic services are provided to satisfy patients and their families that everything possible is being done for their wellbeing. Expectations are high and rising, influenced often by considerations far distant from those of good health care.

2.4 Primary medical care in Europe today

In the final analysis, Europe is characterized by a multitude of different health care systems, but all of these are based on some kind of general practitioner – “primary health care physician” – whose narrow role as “physician of first contact” reflects the status of PHC in the Region.

At present, methods of providing primary medical care differ between those countries where there is a tradition of private practice by physicians and those where medical care is provided as a social service. Primary care is provided in a wide variety of ways, which comprehend different kinds of physician/patient relationship. These range from traditional private medical practice, where the patient pays for services rendered, to complex primary medical services organized and paid for by the state and provided free of charge to the whole population through an easily accessible network of institutions and health professionals. Between these two extremes are the primary medical care services organized by social security institutions, by “mutual” or “friendly” societies, and by public and private social welfare services, all of which provide for selected groups of people, depending on their sources of finance.

The type of service provided is fundamentally important when efforts are made to secure the better utilization of available resources and the more efficient functioning of the total system. Some countries, for example, in attempting to bring about such improvements, have been obliged to concentrate their efforts at the local level; other countries have been able to start improving their health services at the national or regional levels through the introduction of new administrative structures for primary medical care. However, in spite of their differences all European countries aim, at least in principle, to provide health care, and in particular primary health care, of the highest technical quality to the largest possible number of persons in the community. I deal with the constraints preventing the realization of this ideal in the next section.

2.5 Summary

In the European Region over the last 100 years the total health care system, including “front-line” PHC (as it is understood in Europe), has evolved in parallel with social and economic development, reflecting not

only advances in medical science and the (often parochial) outlook of many health professionals but also, especially at the local level, the true wishes of the population.

The growth of front-line care has not always progressed smoothly and evenly in all the countries. Overemphasis on sophisticated hospital-based care for example, has often been detrimental to primary care. Therefore, the new worldwide emphasis on PHC is particularly welcome in the European Region.

3. THE MAIN PROBLEMS OF PHC IN THE EUROPEAN REGION

3.1 Introduction

In this section I list and discuss briefly some of the main obstacles to the realization of the new and broader approach to the organization of health care implicit in the concept of PHC. As I have pointed out, the principles of PHC can be properly applied (i.e., in the way in which they have been newly formulated for the developing, and largely rural, countries) in only a small proportion of countries in the Region. In all the other countries of the Region historical influences, relative affluence, and an abundance of medical care have strongly modified the familiar problems, making them highly distinctive.

The difficulties encountered in applying PHC concepts to the relatively rigid and fixed health care systems of the highly industrialized countries are the well known problems associated with innovation and change. These could well serve as warnings or danger signals to the developing world. Here, it may be said, are some of the difficulties they are likely to encounter, and which foresight might prevent.

First, we must be clear about the relationships between health care, man's environment and human behaviour, and current ideas about health in industrialized societies. I wish to stress particularly the recent advances in our understanding of interactions between the general factors influencing health. These suggest, for example, that the best way to improve health may be through behavioural and environmental improvements combined with the provision of care.

Next, I present a number of examples of technical and operational obstacles impeding the application (and in some cases the acceptance) of PHC ideas in the Region. The list is not exhaustive because each country has its own difficulties (and some examples apply not only to PHC but to all

health care), but I give one or two examples of problems in the application of each of the principles mentioned in my introduction^a and a few more from my own specialized regional experience.

3.2 The relationship between health and society

Several complex notions are involved in this most important relationship. At its most theoretical, modern thinking about the health of populations places increasing weight on the interrelationships between factors rather than on their individual contributions. Health is seen as a function of the whole social system. Thus the contributions made to health by, for example, nutrition, education, the environment (both physical and sociopsychological), and the socioeconomic complex of relative poverty do not depend on the "weighting" that can be attributed to these elements individually but to the degree of interaction, or synergism, between them. The PHC approach recognizes these interrelationships and demands (through the somewhat vague term "integration") that they should be applied for the improvement of health care. With even stronger reason, it sees health and enhancement of the quality of life as just one element contributing to the whole process of development.

Much of the thinking underlying the notion of integration in health care stems from the findings of research on the human ecosystem, particularly that which seeks to quantify the various contributions to health. Thus it is seen that health services as such, though of vital importance to the health of populations (and probably of special importance where there is much illness), may be no more (and sometimes even less) important than, say, the complex of relative poverty and poor education, "unhealthy" behaviour patterns, inappropriate smoking, dietary, and drinking habits, lack of exercise, and perhaps poor housing or a polluted environment.

It follows at the practical level that the minimum demand for the PHC approach is intersectoral collaboration in the management and planning of care. This, in many European countries, conflicts with the logical and historical development of, for example, separate (and often mutually antagonistic) central government ministries and departments. At the regional level fragmentation of the contributory elements to health is often even worse and,

^a These are:

- (1) that health care should be "needs related", universally accessible, and acceptable;
- (2) that community participation is essential;
- (3) that PHC should be effective and efficient; and
- (4) that PHC should form part of all national development and of the wider health care system.

although the interaction of, say, education and health has long been recognized and respected in Europe (and statistical data exist to support the relationship), wholehearted integration (in the schools and community health services, for example), or even collaboration, sometimes present almost insuperable problems. Even the preventive and curative aspects of care are only occasionally to be found working together.

To summarize, therefore, it must be said that modern knowledge of the interaction of factors in sustaining the health of populations demands that fragmentation of these components should be avoided. Coordination is the aim. At the community level collaboration is vital to community health and may be simpler to arrange locally than within large health care systems, the rigidity of which has been confirmed by time and tradition.

3.3 Operational and technical obstacles to the application of the PHC approach to health care in Europe

Beyond the major impediment of the fragmentation of caring services mentioned above there are a number of other barriers to the implementation of the PHC approach in the European Region.

3.3.1 Accepting the principles of PHC

Perhaps the greatest obstacle is PHC itself. As I have said, primary care in Europe is thought of as *medical* care, and the dramatic and important widening of this concept is not easily accepted. Tradition and the weight of medical opinion are both respected in the Region and neither will yield easily to a holistic, interactive interpretation of health. Professionalism and private practice exert their pressures on decisions about who can and who cannot be involved in care, and benevolent paternalism rather than participation characterizes the relationships between providers and consumers of care. There are enough physicians to meet the demand for medical care in Europe, and thus one of the several reasons put forward for diversification of caring roles in the community is invalidated. Teamwork in caring is, however, well accepted and may be the European solution to primary health care.

To advocate caring roles that are "nearer to the people", a much publicized aspect of PHC, is less compelling when the social and educational distances between the people and the physician are small. Criticisms of high technology, excessive specialization, and the primacy of the hospital, which are reasonable and comprehensible features of PHC advocacy in poverty-stricken societies, are less convincing in an affluent society where these developments result from popular demand and are readily afforded. This is particularly true where the hospital-based technologies (renal dialysis or some aspects of intensive care, for example), costly though they are, may actually

be of value. Hip replacement illustrates this point well. At first, both the operation and the prosthesis were a costly use of resources. Two developments followed: the prostheses became better and cheaper and estimates of the quality of life enjoyed by the patient before and after the operation showed a very great improvement in the successful cases.

It is clear that technology, the primacy of the hospital, and excessive specialization can only be reasonably attacked when they start to detract from a more holistic and effective approach to care; when, for example, focusing attention on the hospital causes wastage of human resources, destroys continuity of care, costs more than simpler ways of improving health, and removes preventive medicine, other forms of community development and the consumer from the caring scene. As I shall show later (see p.27), constructive criticism along these lines has begun in the European Region.

3.3.2 Problems related to the principle that health care should be "needs related" and universally accessible and acceptable

(a) Policy, planning, evaluation, change, and innovation in health care

After acceptance of PHC principles the next main obstacle is connected with that part of the PHC approach that leans heavily on the definition of health care needs and analysis of the tasks involved in meeting those needs as the proper starting point for policy and planning. Although this is both a logical and a necessary starting point for the planning of health care in the European Region, it is unlikely to do more than provide a conceptual framework for discussion of PHC. Health care systems are not regularly evaluated, and innovation and change, when they come, are the result of highly specialized political decisions rather than systematic analyses, scientifically based though these may be.

WHO has given much consideration to the quality of care and has in particular sought to promote the use of planning cycles where the efficiency and cost-effectiveness of care are measured repeatedly. These measurements form the basis of innovations that bring health care services closer to the ideal of meeting the health needs of the population.

(b) Research on health service organization and function

Health care research in the European Region is not contributing as much as it could to the effectiveness of care. Biomedical research has higher prestige, better facilities, and more resources, but research on how best to meet the health needs and demands of populations should probably be given higher priority than it has at present.

(c) *Delivery of care by health personnel other than physicians, including self care*

It follows from (a) above, and from the fact that PHC is seen in the European Region as medical care, that health care by personnel other than physicians, and particularly the vital role of the family in its own health care, has been neglected in the Region.^a This is also one, but not the only, reason for so little enthusiasm being shown in the European Region for the self care movement, now widely supported in some other WHO regions, and a major reason for the objections to extending the caring roles of pharmacists, nurses, medical auxiliaries, and the few remaining indigenous health practitioners. The position, importance, and status of the physician in Europe goes a long way to explaining why "health by the people"^b — an essential element in PHC — is almost universally rejected in the European Region.

There are also other reasons. For example, small and isolated communities are less frequent, family size is smaller, and the expensive network of services in most European countries lessens individual and community responsibility for care.

(d) *Curative versus preventive medicine*

The separation of preventive services from curative services and the neglect of the former is an example of imbalance, indicating disregard for the growing challenge of preventive medicine. Specialization in preventive medicine is lacking in prestige and status for the physician; specialization in curative medicine, on the other hand, flourishes and attracts recruits. The effect of these status differences on the application of PHC in the European Region is profound. There is an urgent need for prevention, much of which is within the scope of PHC, but curative care has a dramatic quality, it demands high technology, and is more at home in the hospital than in the polyclinic, dispensary, or health centre. These values are passed on to the consumers who, quite reasonably, become more concerned with curative than with preventive care.

Separation of the curative and preventive aspects of care does not stop here. Medical educational systems, governmental policies, research programmes, and the important voluntary caring agencies (which are numerous in Europe) all reflect the high status of curative care compared with prevention. As a consequence comprehensive care, in the PHC sense, is often lacking.

^a This generalization does not mean that delivery of health care has been totally neglected (see part 4), only that there is sufficient neglect for this to prove an obstacle to the application of PHC.

^b See Newell, K.W., ed. *Health by the people*. Geneva, World Health Organization, 1975.

(e) *The ineffectiveness of some curative medical care*

Widespread recognition of the interacting determinants of health has come from further studies of the human ecosystem, from understanding of the detailed etiology of many pathological conditions, and from analysis of the effects of control programmes. The balance between medical care, socioeconomic conditions, behaviour, culture, and the various aspects of the physical environment are now better understood, and it is becoming more obvious than ever before that in spite of the dramatic effectiveness of some medical care (and of course the right of each individual to receive such care), curative medicine alone cannot sustain the health of whole populations. For this, a total ecological approach is necessary. A large proportion of the adjustments necessary for promoting health are nonmedical in nature and well within the competence of either the community (for example, in housing or environmental control) or the individual and the family; many of these necessary adjustments have little to do with medicine in the strict sense but are concerned with the unequal distribution of wealth, education, communications, etc. As I have said earlier, improved health is more likely to be achieved by an attack using all these resources than through curative medicine alone.

(f) *Distorted technology and priorities*

I have already referred to the question of what is appropriate medical technology. This is a particularly complex question because demand often conflicts with measures of the effectiveness of equipment. Thus the problem has special importance only in the presence of constraints on resources. Waste on inappropriate and costly technology does, of course, occur in the European Region, but this has little adverse effect on health where plenty of human and other resources are available. Where these resources are scarce, high technology almost always claims more than its proper share. Thus it is not the technology but its use that may be wrong in diverting resources from areas where they could be used more effectively. Decisions must, of course, reflect the demand for care and the cost-effectiveness of the care provided. The results of such evaluations are often painful; for example, the effectiveness in terms of unit cost of much modern medical equipment is currently being questioned. Priority analyses based on costs and benefits are now much simpler as new data become available and where resource constraints exist they will show clearly the importance of diverting resources to PHC.

The harnessing of very high technology to the needs of PHC is a new and challenging idea, and there are new tasks of considerable complexity

that will have to be undertaken if the quality and effectiveness of care is to be enhanced. Many of these are applicable at the PHC level.^a

I would like to conclude these brief comments on technical progress by stating that we in the industrialized countries are already used to a rather high level of medical technology; our medical system relies on it, we need it, and we stand to benefit considerably from its results. Clearly, however, we overemploy such technology, frequently using it in the wrong places, generally at unnecessary expense and much too late in the life of an individual — that is, close to the terminal phase. I therefore feel that it is essential to reappraise our regional health services in order to determine where these new technologies should properly be used.

3.3.3 Problems related to the principle that community participation is essential in PHC

(a) Community nonparticipation

A general problem in the European Region is that of community nonparticipation in medical care. In our Region the physician remains supreme in all, or most, fields of health care and the community usually respects this arrangement. However, the relationship is not a participant one, and only in a few countries does the care “spring from the community” in the idealistic sense in which this phrase is used in PHC. More usually, the many different methods of payment, issues of confidentiality, and emphasis on the physician/patient relationship preclude extensive community involvement in medical care. However, it is not clear that this threatens the health of our populations in any significant way.

(b) Underserved populations

A special problem is that of the “underserved” population, where the uptake of available care is lower than it should be and less than might be expected. Need exists but services are not utilized. There are a number of possible explanations for this, some of which highlight the value of the participant PHC approach. It is possible, for example, that if the services nearer to the community were better understood and accepted, or even associated with some community activity or dispensed by an acceptable community leader, the differences would disappear. Among those who underutilize services are the very old, adolescents, and the relatively underprivileged — all of whom are in special need of care.

^a For example, portable electronic preprogrammed aids to effective diagnostic and therapeutic action would alter completely the effectiveness of some caring teams. Other examples are blood pressure measuring equipment for family use and “dipstick” indicators.

(c) *Collaboration between consumers and providers*

The demands made on the community by some of the newer methods of controlling chronic disease, particularly the screening of total populations, has forced health providers to consider how and why populations collaborate in medical care research. Now it is apparent that much more population research is needed, demanding a high level of collaboration, acceptance of common objectives, and mutual understanding. It also involves entirely new relationships because, for example, the population under scrutiny is usually not a population of patients. This, and other developments, will be a testing ground for much of the PHC approach.

3.3.4 *Problems related to the principle that PHC should be effective and efficient*

(a) *The need for evaluation in care*

I have already referred to this and only mention it again because it is a major problem in all of health care and particularly in PHC. It is of the greatest importance to find out whether the care achieves what it sets out to do. Unfortunately, in the European Region it is only in the field of drug evaluation that effectiveness is rigorously and regularly tested.

(b) *Allocation of resources*

One indication of the high status of curative care is that resource allocation in the health field is, more often than not, decided by medical interests, expertise, and pressures rather than by the real distribution of need or demand in the community, which is likely to be a more effective, and perhaps more efficient, basis for allocating resources. A feature of PHC is the congruence of need and resource allocation, based partly on its demonstrable effectiveness and partly on the philosophy of equity. In only a few countries is congruence of need and resources found^a and it seems more likely to occur in countries with decentralized systems than in those where resource allocation is made far from the communities to be served.

(c) *Information systems*

Another serious obstacle to the application of PHC in the European Region is the scarcity of data on the health care needs and demands of our populations. These inadequacies reflect not only the historical trend towards

^a In dispensaries in the USSR and in the resource allocation formulae used in the United Kingdom, for example.

pluralistic systems but also the very recent development of ideas about the uses of such data. In particular, the proper planning of PHC demands high quality information, which should preferably be linked so that the health experience of a population over time may be studied. Such data linkage, which so clearly serves the interests of the population as regards their health, runs contrary to accepted views about confidentiality. Consequently, it has had only limited trials.

(d) Screening for disease

Two kinds of screening are possible: for vulnerability and for existing, usually presymptomatic, disease. The aim should be to identify, within reasonable limits, those who need care now and those who will need care in the future. Screening of all kinds is likely to be a feature of PHC and, since the value of these activities has not yet been fully established, this must be approached as a research project. The mass screening of total populations that has occasionally been tried in the European Region makes little use of our new knowledge about special risk groups, a failure that brings this attempt at preventive medicine into disrepute.

3.3.5 Problems related to the principle that PHC should be part of all development and of the wider health care system

(a) The health centre, the polyclinic, and the team

The notion is growing in Europe of the health centre or polyclinic as the physical centre for PHC. However, "health centre" still suggests narrow curative care and such centres are invariably run by physicians without much help from other health workers or consumers. The notion of a PHC team with differing skills, each appropriate to some of the needs and demands of the population and all working together, is rarely put into effect. The even more unusual notion of a health centre as the centre of community leisure enjoyment, education, and recreation, as well as care (including prevention, rehabilitation, etc.), is very rare indeed.

(b) Separation of health and social care

An entirely artificial division between health care and social care has grown up in some countries of the Region. In at least one of these the distinction has been drawn as a result of the overlapping roles of physicians and social workers, who of course approach the patient differently. If we concede that an important feature of PHC (in this case primary *medical* care) is therapeutic collaboration between social case workers and physicians, then this has only been partially achieved in a few countries of the Region.

The distinction between medical and social need is rapidly becoming an artificial one, especially with the recognition of the care needs of, for example, the very old, the handicapped, and the mentally disturbed.

(c) Separation of PHC from hospital care

In several countries of the Region there is a clear pathway through the medical care system, which starts with primary care – normally a general medical practitioner – and then passes on to hospital specialties, eventually reaching the “super-specialties” of very advanced and complex care. With such an arrangement the referral chain is clear and the place of primary care within the wider system well defined. However, in many countries of the Region the relationship between PHC (in its narrow medical sense) and the hospital is not clear. Functions overlap and the notion of integration is lost.

(d) Payment systems

It is not my intention here to discuss the effects on health care of different methods of payment for services received. However, it is important to note in passing that the ideal of PHC as an integral part of the wider health care system can be effectively ended if health personnel are paid independently of that system. At the same time, much cooperation is possible, and several countries have achieved a high degree of integration in spite of their *laissez-faire* payment systems.

(e) PHC and development priorities

Few countries in the Region see PHC, even its medical aspects, as part of community development. A very large degree of intersectoral collaboration would be necessary and, although that exists to some extent in most countries, the contribution of health to development has rarely been explored.

3.3.6 Problems related to the environmental health component of PHC

(a) Definition and extent of the problems

Among the basic requirements for health are adequate supplies of safe water, provisions for the hygienic disposal of waste, satisfactory housing, and measures to ensure food safety. In industrialized countries there are also other environmental problems to be considered in connexion with PHC, including the effects on health of toxic materials reaching man through air, water, and food, and occupational risks. Although the importance of a healthy environment is generally recognized within the Region, work towards improvements is not always integrated with other aspects of PHC to the

extent desirable. In many countries legal and administrative responsibility for different aspects of environmental protection is divided between different ministries and authorities, often those not immediately responsible for other aspects of health care, and other considerations are sometimes given priority above health aspects. There is a need to develop a holistic approach whereby, for example, the development of water resources or air pollution control programmes are not considered in isolation. Consideration must be given to the total picture of environmental hazards in relation to overall human health.

In most countries within the European Region there is a basic structure of legislation but the implementation is often uneven and unsatisfactory. More attention must be devoted to surveillance and control and also to information exchange and training activities.

In order to ensure community participation it is important that decisions concerning environmental health should be made at the local level. Cooperation must be established with consumer groups and the general public to ensure that activities are understood and accepted before important changes are introduced.

It is important in the industrialized countries to attempt to distinguish between basic health requirements and what may be termed "comfort requirements", which go beyond basic health needs.

(b) *Priority areas*

In most countries within the Region urban populations have generally adequate basic sanitation facilities but there are a number of areas, including backward rural and urban fringe areas, where standards are still unsatisfactory.

Adequate supplies of safe water are not only needed for drinking and for food processing but also for washing and for household hygiene. The *minimum* requirement in urban areas within the European Region may be considered one tap per dwelling with a permanent service. In rural areas a lower standard of service might be acceptable on an interim basis, but it might be regarded as desirable that power-operated pumps be used, since drawing large quantities of water by bucket or hand pump is physically tiring and this discourages people from satisfying all their needs for adequate hygiene. In most parts of the Region the heating of water is also a basic requirement in order to ensure adequate individual hygiene, particularly during the winter months.

The provision of clean and adequate facilities for domestic liquid and solid waste disposal is a fundamental basic sanitation requirement. Within the European Region satisfactory means of waste disposal are available in most urban areas but in some urban fringes and in many rural areas the facilities are still unsatisfactory. In addition, many families in industrialized countries now have summer houses and basic sanitation facilities are often lacking; this becomes more important as the density of such dwellings increases.

Under European climatic conditions adequate housing is important in order to provide a satisfactory level of family hygiene. Minimum requirements include the provision of satisfactory heating during the winter months with adequate lighting and with necessary equipment for toilets, for washing, and for preparing food. Heat and noise insulation is important, but ventilation must also be adequate. If the walls, roof, and floor are of reasonable quality and if there are adequate waste disposal facilities and the property is well maintained the problem of vector control should not be a major one. Despite great improvements in standards of living during the last 30 years within the European Region, a substantial proportion of both urban and rural populations still live in substandard housing from the public health point of view.

Food hygiene forms an integral part of individual, family, and community hygiene and in view of growing problems concerning biological and chemical contamination of food it is important that it is regarded as a component of primary health care.

There is wide disparity in the organization of all these services. Public health authorities are usually responsible for monitoring hygienic conditions at individual and community level, but their efficiency depends on the number, qualifications, and motivation of the environmental health inspectors employed. In many countries the number of properly trained inspectors is still inadequate.

3.3.7 Problems of training for primary health care

The redesigning of part of the training programmes for all health professionals and the radical reappraisal of related programmes for schools, adult education, and the family is urgently needed for the proper understanding and successful application of PHC. Health education of the general population is in disrepute in many countries, but new approaches more closely adapted to PHC are being tried. Physicians are often poor educators, and there is much to be said for the community itself assuming these responsibilities.

3.3.8 Problems of indices of health and the survival of the unfit

I should like to end this section with a word of warning. As we work for the better health of populations we are inclined to use mortality rates — I refer particularly to perinatal mortality rates — as indices of success or failure. Quality of life, a much more vague and difficult measure, could be jeopardized by the undoubted success of our specialized health care. We must be careful lest in reducing perinatal mortality, for example, to a very low level (a recent achievement in at least one European country) we excessively increase disability and handicap. I do not think this is happening, but I would like to see developed new indices for the quality of life, which concerns us all so much.

4. TOWARDS NEW SOLUTIONS: SOME NEW STRATEGIES FOR PHC IN THE EUROPEAN REGION

4.1 Introduction

Only a relatively small fraction of the health problems of the European Region, in both the developing and the industrialized countries, can be solved by curative medicine. The resulting, and inevitable, emphasis placed on PHC — prevention, promotion, health education, rehabilitation, and social measures — requires a more systematic approach to individual behaviour patterns, social conditions, and health in relation to development. Many countries in Europe have already reached the target of full primary medical care coverage for the population. The task now is to convert this *medical* care into the broader, more comprehensive (and ecologically satisfying) *health* care.

In the previous section I listed some of the problems we face in broadening our regional primary medical care approach to embrace the ideas of PHC. In this section I touch on a few features of the largely medical scene that are beginning to show a congruence with these new ideas. Most of these developments are in general practice (or “first-line” medical care in the polyclinic or dispensary) and some are attempted solutions to problems mentioned in section 3. However, in spite of the emphasis given to general practice a few of these developments have a much wider significance; these are both challenging and new.

It seems likely that as the ideas surrounding the PHC approach are adapted and changed in the European Region they are slowly modifying European systems of care. A number of significant steps in this progress can be seen.

4.2 Regional contributions

Reports on Regional Office meetings on the role of the primary physician in health services (1) and on education and training in long-term and geriatric care (2) illustrate the diffusion of ideas. Both meetings emphasized the need for PHC by the community, the individual and, above all, the family. It was also suggested that a permanent first-line service is essential in all medical care systems and that this would have particular responsibilities in the care of the aged, in the prevention of chronic disease and accidents, and in promoting mental health.

The role of the nurse in primary care (3) has properly been considered as vital to the development of the whole PHC concept. The nursing content of PHC is seen as a very broad spectrum of care ranging from generally accepted nursing roles, through many aspects of preventive medicine and screenings, to problems of psychosocial adjustment. The high status of the

nurse in the European Region and her special skills give her a particularly important responsibility in broadening the concept of PHC. Thus, she is a major contributor to health.

The reports of two symposia on the efficiency of medical care (4, 5) and efforts to define parameters of efficiency in PHC (6) illustrate growing preoccupation with the evaluation of care in the European Region.

The use of medical auxiliaries has been studied in one or two demonstration areas, and the effects of regionalization, particularly on the organization of primary services, is under scrutiny in a number of countries including Italy, Malta, Portugal, Turkey, and Yugoslavia.

A more comprehensive approach has been introduced and studied in Gabrovo, Bulgaria (7), where primary care is seen to include early detection of disease through screening of entire registered populations, expansion of dispensary care and, of course, total population coverage through polyclinics. This regionalized system is a demonstration of a holistic approach to care with a satisfying removal of intersectoral boundaries. The "dispensarization" method brings a new appraisal approach to all components of primary health care.

Primary care through health centres is the subject of special studies in France (8) and England. A wide network of outpatient polyclinics ensures primary medical care in the USSR and in other countries that have a similar health service concept (9, 10). In these countries the planning and coordination of intersectoral collaboration and the coordination of community development approaches the PHC model and, in addition, the consumers at various levels are involved. The role of polyclinics and outpatient care establishments in the delivery of community health care in Algeria has recently been described (11).

Active community participation is a major objective in the joint WHO/UNICEF project at Ivanyica, Yugoslavia, (12) while the North Karelia project (13) for the control of cardiovascular disease is unique in that it arose from community recognition of a serious health threat and resulted in joint community action for its control, thus qualifying as one of the most important experiments in PHC in the European Region. Such a programme of primary prevention, health education, social action, and now health legislation is at once comprehensive and fully participant, and arises from the people.

A WHO global programme on the health care of the elderly for which responsibility has been entrusted to the Regional Office for Europe, is giving particular attention to five characteristic elements of PHC:

- (a) a multidisciplinary approach to problems;
- (b) integration of health and social services;
- (c) health education;
- (d) community participation in caring; and
- (e) the role of the family.

Comparable objectives are to be found in the quite different, but equally important, WHO global programme for the prevention of road traffic accidents;^a responsibility for this programme has also been delegated to the Regional Office for Europe.

A large-scale (23-country) study of health service concepts in the European Region was undertaken in 1977 (14). This provided information on the present position of primary care in the Region and also suggested some indicators of future trends. So many countries are exploring the organizational possibilities of PHC that we may learn much from their different approaches to what is basically the same problem.

4.3 The health centre and polyclinic movement: unification of services

Our study of health centres and polyclinics in the European Region showed that ministries and departments of health in all European countries agree on two points.

1. There is a need to strengthen primary care and relieve the hospital of demands that are better, and possibly more economically, satisfied elsewhere.

2. Such strengthening implies that primary care can no longer be adequately provided by the single-handed medical practitioner; supporting staff and facilities must be provided, and their coordination requires some kind of organization.

However, the individual health practitioner is still rather common in many European countries, especially in central Europe, and is supported in his activities by the financial arrangements based on social security. I personally (and clearly the ministries also) feel that this pattern will gradually change towards group-oriented practice, but the specific rights of the individual medical practitioner will continue to be important in such organization and may perhaps be a brake on the development of the broader concepts of primary health care. In spite of this, the major trend is towards what is called in some European countries a "health centre" and in others a "polyclinic". Curative and preventive care is available in both, though neither has yet achieved its full potential (see section 3.3.5 (a)).

^a See, for example, *The epidemiology of road traffic accidents*. Copenhagen, WHO Regional Office for Europe, 1976 (WHO Regional Publications, European Series No. 2).

In general, there are three organizational models for the health centre.

1. A coordinating agency that may or may not provide services to patients.
2. An integrated system of primary care facilities, such as a health centre together with its subcentres.
3. A facility where a variety of primary care services are provided under one roof.

While the third model is perhaps the most common in countries where the organization of primary care is left largely to the initiative of independent providers of care, or where there are no remote areas to be served by satellite facilities, the existence of subcentres functioning under the supervision of a central centre is found where a policy of regionalization of health services exists, and where services have to be extended to outlying areas. Team work and coordination do not necessarily require a common physical base, nor do good premises necessarily produce good team work. A well integrated team can provide first-rate primary care from accommodation that is inconvenient or even unsuitable. However, facilities of some kind and adequate resources *must* be available and properly coordinated for proper functioning of the health centre.

The policy regarding the attachment to health centres or polyclinics of beds for inpatient care varies but, except in remote areas, the practice is uncommon.

In some highly urbanized countries there is a tendency towards consolidation of smaller health centres or polyclinics and for several communities to join in maintaining a common, larger, and better equipped health centre. This trend goes hand in hand with the consolidation of other community services such as schools and churches.

The health centre's (or polyclinic's) degree of dependence or independence varies greatly according to the health system of which it forms a part. In a system with strict regionalization the primary health care centre is a link in the hierarchical organization of the system with accountability upwards, and structured paths of referral and channels of consultation, combined in some situations with a horizontal relationship with the health committee of the local council. The extent and intensity of the last relationship varies with the local community's responsibility for service organization and particularly with the method of financing primary care services within the community's boundaries. Under other systems this relationship will be transferred to a sponsoring agency such as an insurance carrier, a religious body, or a labour union.

So far, I have been describing health centres that are based on a rather "traditional" health services system. Personally, however, I would prefer an

even broader option: I would like to see the social welfare and health services of a community collected together in one place (perhaps called a health centre). The population would know that in such a centre they could discuss their problems, whether relating to a child, an elderly person, or a working adult, and whether the need was for health promotion and prevention, first-aid and primary diagnostic services, or encouragement to try to solve the problems themselves within the family or at their place of work.

I am sure that this type of community service could provide better care for the individual in the community than existing, often fragmented health care and welfare services. At the health centre the individual would meet a counterpart who would listen sympathetically and advise – a kind of “patient advocate”. This person need not necessarily be a physician but might be a psychologist, physiotherapist, occupational therapist, employment counselor, public health nurse, or midwife. However, the two would be able to work together in the care of, for instance, the elderly, the alcoholic, or the handicapped. These are multidisciplinary problems and the individual, through his counterpart, would have access to expert advice, if required.

4.4 The health care team

In the health centre concept, whatever its form, is the notion of a primary care team. In Europe the team includes a physician, who is considered the team leader. There are, however, variations on this theme and some health centre-like organizations combine services to some, but not all, members of the team, and in some cases there is no physician. In some of the more complex health centres the team includes midwives, nurses, social workers, health visitors, records officers, and administrators. These personnel are sometimes provided by the health and social services and sometimes by voluntary agencies.

The health care team, however it is constituted, is considered to play a very important role in PHC and is included in all the new developments in the European Region. It is becoming increasingly obvious, even in the strongly medically oriented services of Europe, that in order to meet the broad objectives of PHC it is necessary to develop a team approach. However, without shared common objectives and clearly defined tasks the team cannot function effectively and tends to resolve itself into a group of individuals uneasily harnessed together. In whatever way the team develops, the practice of primary medicine in a private, individual, “one man” practice seems to be slowly disappearing to make room for group practice using shared premises. I regard this as a wholly good development because it opens the way to the somewhat broader and less exclusively medical care that I have mentioned above.

The caring roles of nonprofessional personnel are increasingly being recognized in the European Region – although we are still only at the

beginning of this trend. Neighbours, pharmacists, associations of persons with similar problems (handicaps, drug dependence, etc.), the family, and the individual will all have increasingly important roles to play. This is recognized in Europe, and a few small studies support the ideas, but the Region has such a wealth of medical skills available that progress in this direction will be slow.

4.5 Health and education

Over the last two decades there has been a great expansion in the coverage and discussion of health problems by the mass media of communication in the European Region. This trend is producing dramatic changes in popular knowledge and understanding of health and disease. Radio and television programmes and newspaper and magazine articles have only been evaluated in a few countries but there is some evidence that they have beneficial results.

Some of these programmes and articles are, quite frankly, highly dramatic and often promote expectations beyond what is possible. Others, however, are soberly concerned with preventive care and with some of the broader aspects of PHC. The good effects of these should not be underestimated, particularly as consumer participation is featured in many of the radio and television programmes.

The role of the health professional in health education in Europe has not been well evaluated but the results are probably poor. Specially trained health educators are being tried in a number of countries and — again belatedly — some medical and nursing schools are teaching their students how to educate. There is new interest in health education in some countries, particularly where statutory provision is made for health educators to work within the health services.

Many medical schools in the Region give special attention to the education of physicians in the medical aspects of PHC. General practice as a subject or as part of community medicine is included in an increasing number of curricula.

4.6 Community participation, the family, and the individual

The extent of community participation in PHC undoubtedly reflects community participation in other major aspects of communal life. Some European populations are more participant than others, but the underlying principle is gaining general acceptance. Medical professionalism is still, of course, the main barrier to full participation, but consumer movements in medical care are seen in several countries.

A recent study made for the Regional Office (15) assesses the nature and scale of the contribution to health being made by the consumer of such care. For the majority of people it appears that self care is the form of consumer involvement most often resorted to. The report suggests that the

self care movements reported from several countries, though not yet strong, must indicate some rejection of medical care and a move towards the notion of health by the people. This is hardly the participant relationship we seek.

The cooperation of the consumer is important and even crucial in the prevention and treatment of disease or disability and in convalescence. It applies to all conditions irrespective of their duration but is of the greatest importance in those that are chronic or acute. The role played by personal relationships and the morale of the patient in the processes of healing, recovery, and rehabilitation are well known.

The reasons and justifications for encouraging consumer responsibility and participation in the different areas and processes of health care are manifold. They include the fostering of good physical and mental health, potential therapeutic benefits, greater effectiveness in the use of resources, and the value of social activities directed to the common good.

The patient or disabled or elderly person should be encouraged towards certain goals or values such as independence, self determination, maintenance or improvement of personal status and self esteem, full access to the opportunities and entitlements of citizenship, and maximum feasible participation in the processes of treatment, support, rehabilitation, and other measures directed towards the alleviation of his condition.

In recent years consumers have become increasingly active in combating environmental pollution, and at the same time have become better informed about the parts played by environmental and behavioural factors in chronic disease. The association between, on the one hand, overnutrition, smoking, excessive drinking, insufficient exercise and stress and, on the other hand, obesity, alcoholism, coronary heart disease, and cancer are well known. Growing numbers of directly affected individuals and their families are engaged in preventive, supportive, and curative activities.

Sophisticated technology is not always necessary in order to meet fundamental sanitation needs. Basic services such as safe water supply, adequate waste disposal systems, food safety, and hygienic housing should be developed and operated by using appropriate local technologies, which may be different in some respects in rural areas from those required in towns and cities. Community participation should be ensured by adequate consultative procedures and by dissemination of information relating to all aspects of personal, family, and community hygiene.

The consumer is increasingly represented on decision-making bodies and thus taking more responsibility in the organization of medical care. Consumers are sometimes elected, but usually they are nominated by representative bodies such as local councils, trade unions, or voluntary organizations. They perform various functions including acting as observers or as guardians or advocates of consumer interests or, less often, sharing in the formulation of policy and running the services.

While this is not exactly the participation envisaged in much of the literature dealing with PHC, it represents the European equivalent of some of those ideas. For this, as well as for other reasons, this development is to be welcomed.

4.7 Some important contributions from research

Apart from the resurgence of interest in consumerism there are a number of other, perhaps less fundamental developments relevant to PHC in the European Region. They will undoubtedly, when taken beyond the research stage, influence the effectiveness of PHC.

(a) *Computer-assisted decision-making.* For both diagnosis and management the equipment is becoming simple and portable. The parallel development of algorithms, check lists, and score sheets, also both diagnostic and managerial, seems likely to be of profound importance in medical care and of even more importance as an aid in nonmedical PHC.

(b) *Total population registration.* I have already referred to the value of total population data to planners and others seeking to improve PHC. A few countries organize their PHC so that total populations are registered. The resulting information is therefore approaching the quality necessary for the systematic planning of health care.

(c) *Data linkage.* Where countries also have a PHC system that ensures continuity of care with linked data for the health of the whole population the effectiveness of PHC is considerably enhanced. A computer terminal linked to a central information bank offers the primary health care team access to diagnostic and therapeutic assistance, enabling them to take part in building up a linked centralized records system, which is a prerequisite for comprehensive care.

(d) *Evaluation by new indices of health.* Evaluation of care requires indices of outcome, and measures of mortality and morbidity have always existed. New and more subjective indices, suitably standardized, are becoming available and offer new opportunities for evaluation in PHC.

(e) *Measuring need.* Measures of the extent of need for PHC can only come from studies of whole populations, but in most countries of the Region such surveys are difficult. In one or two countries, however, very large populations have been studied for elementary morbidity, for long-term needs for care, and for changes in disease patterns. The results of these surveys have important implications for the organization, evaluation, and planning of PHC.

(f) *Screening of populations.* Research on the costs, benefits and effectiveness of presymptomatic screening (an activity seen in some countries as part of PHC) is developing, but although much important research is being performed this has not yet influenced social policy.

(g) *Appropriate technology.* As already mentioned, there is a movement among health professionals, economists, and social administrators seeking to use more appropriate technology in PHC. While activities have related mainly to the developing world, some work is being done in the European Region. Of particular interest, for example, are some simple devices (sphygmomanometers, ECG machines, dipstick testing, peak flow meters, etc.) now being developed. These could markedly improve accuracy in general practice and make accurate techniques available to other health professionals.

(h) *Resource allocation and risk.* Some experimental work and certain policy decisions in the Region support the idea of relating resources to need and risk. Essentially, this is a managerial strategy that seeks to allocate resources (nursing time, health visitor visits, screening, etc.) to those most in need and in proportion to their need.

(i) *New planning and managerial techniques.* A number of planning and managerial techniques developed during the last decade are bringing about a revolution in national health care organization. Of these, the so-called planning or cybernetic cycle, which applies a systems analytical approach to health care, is likely to provide a scientific basis for much PHC development.

4.8 The importance of PHC: new recognition?

In reviewing some of the possible solutions to regional problems in the field of PHC, I have been struck by the growing recognition of the importance of primary medical care and by its gradually widening scope. New health services research groups, the new recognition by the medical schools, the special and extensive education of primary care teams: these are some of the signs. The so-called renaissance in general practice may foreshadow new understanding of PHC in the Region.

4.9 The future

It is possible to group the developments of PHC in the European Region into four main areas of concern; these are the challenges for the future. Management, policy planning, and the organization of care; changes in professional and lay roles in care; and community (especially consumer) participation are the principal areas where we are advancing. The fourth area

comprises a number of special programmes, all of which have important implications for community health. In addition, we must utilize the findings of research teams and promote further research.

In the fields of medicine and epidemiology new research is needed on the prevention of ill health through education, on population screening, on ways of improving the effectiveness of care, and on how best to use resources – human, material, and economic. To do all this we must know more about the outcomes of care, and we need new sensitive measures, which include such real, but difficult, concepts as “quality of life”. Also, we need to conduct more trials of different health care strategies that could be appropriate to different cultures.

We are now on the threshold of a truly quantitative revolution in health care and the new numerical methods must be employed in modelling health care systems, for instance. Then we must study methods and effects of inter-sectoral collaboration in the provision of care and the use of high technology, as well as in the production of more appropriate technology.

At the sociological level we must define relationships between sectors, particularly between health and social welfare. We must learn more about the dynamics of need and demand, and become more sensitive to social and cultural pressures within our communities. We must study the dynamics of the health care team and the changing role of the consumer, and we must discover how to work with the consumer in achieving optimal organization of care. Finally, we must learn much more about the origins of our own attitudes towards the populations we hope to serve.

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Annex I

DECLARATION OF ALMA-ATA^a

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people, particularly between developed and developing countries as well as within countries, is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

^a Reprinted from *Alma-Ata 1978: primary health care*. Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978. Geneva, World Health Organization, 1978.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI

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.

VII

Primary health care:

1. reflects and evolves from the economic conditions and sociocultural 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 the 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.

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

* * *

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, non-governmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

Annex II

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