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Primary health care — from theory to action

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INTRODUCTION

The Symposium on Primary Health Care in Europe — from Theory to Action, convened by the WHO Regional Office for Europe, was held in cooperation with the Finnish authorities in Kuopio from 30 November to 3 December 1981. It was attended by 12 temporary advisers from 9 countries, 4 observers from Finland and 3 members of nongovernmental organizations, working in social medicine, the social sciences, nursing teaching and administration, general practice, health administration, and health economics. A list of participants is given in Annex 2.

The Minister of Health and Social Welfare of Finland, Mrs K.-H. Eskelinen, welcoming the participants to Kuopio on behalf of the Government of Finland, expressed her enthusiasm for WHO's goal of attaining health for all by the year 2000, to which the Symposium was intended to make a contribution. On the shift of emphasis towards primary health care (PHC) she felt that the Finnish model was worth studying, since Finland was fortunate enough to possess the will to recognize the responsibilities of society to the individual. Stressing the differences between the health care needs in industrialized countries and those of the developing world, she mentioned the new hazards related to industrial development; the problem of rising costs unmatched by an equivalent return in health terms; and the risks created by man's behaviour, such as his use of alcohol and drugs. A flexible service was needed to meet new challenges, with more emphasis on self-reliance.

Professor O. Hänninen, President of the University of Kuopio, in his address of welcome, noted that the Kuopio medical faculty attached great importance to PHC, and that an important part of medical training took place in health centres. Research at Kuopio concentrated on PHC in such areas as the health needs of the elderly, information systems for primary health care, promotion of fitness, and preventive as well as curative medicine.

Dr M. Murtomaa of the National Board of Health, Helsinki was elected Chairman of the Symposium and Dr P. Pritchard agreed to act as Rapporteur.

The Thirtieth World Health Assembly in 1977 set as a main social target of governments and WHO in the coming decades the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life (WHA30.43). The Declaration adopted by the International Conference on Primary Health Care[a] convened in 1978 by the World Health Organization and UNICEF in Alma-Ata, USSR, clearly identified PHC as the first priority in the future development of the health care system of all countries and as the key to the attainment of "health for all by the year 2000". Even earlier than the Alma-Ata Conference, the World Health Assembly had emphasized the need to develop and implement plans of action in the area of PHC (WHA28.88), and the Executive Board had requested the Director-General to develop a programme of activities in the field of PHC (EB55.R16) and stressed the high priority of PHC as a part of national health services (EB57.R27). The sixty-third session of the Executive Board confirmed these recommendations (EB63.R47).

In the European Region, the twenty-eighth session of the Regional Committee, held in 1978, requested the Regional Director to integrate the recommendations of the Alma-Ata Conference in the European regional programme (EUR/RC28/R12). A year later, the Member States were requested to collaborate actively in the execution of the programmes related to PHC (EUR/RC29/R8). In its thirtieth session, the Regional Committee, in approving the regional strategy for attaining health for all by the year 2000 (EUR/RC30/R8), urged the Member States to bear in mind the Declaration of Alma-Ata. The regional strategy itself relies heavily on PHC in its three main components: promotion of lifestyles conducive to health, reduction of preventable conditions, and provision of adequate health care accessible to all.

In spite of this clear policy mandate, the implementation of the Alma-Ata recommendation has been a slow process in industrialized countries. One of the main reasons is the concept of primary health care itself, its poor definition and a lack of analysis of its implications for industrialized countries. More often than not, the concept is understood too narrowly. It is either considered to be relevant for developing countries only or it is identified with the primary medical services of the industrialized countries. Consequently, the first step in the promotion of PHC should consist in

[a] *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.

translating the principles and recommendations of the Alma-Ata Declaration into a form that corresponds to the situation in the industrialized European Member States.

This Symposium, the first major event in a chain of activities consisting of studies, workshops and working groups and culminating in a conference on primary health care in industrialized countries, brought together representatives of the national health authorities, the scientific community, voluntary organizations and various professional and lay groups interested in the subject, to study the role of PHC in industrialized countries. The Symposium had four main objectives.

1. Analysis of the relevance of the principles of PHC as stated in the Declaration of Alma-Ata.

2. Review of European trends in the implementation of PHC — a mid-term look at the situation.

3. Study of the application of the PHC principles in specific country contexts.

4. Identification of the next steps to be taken in promoting PHC in Europe.

NEW EMPHASIS ON PRIMARY HEALTH CARE

Three common fallacies exist in some industrialized countries: first that primary health care is a new concept, second that it is only relevant to developing countries, and third that primary *medical* care, or general practice, is the same as primary *health* care. It was considered by the Symposium that all these fallacies could be refuted in whole or in part.

Recent developments in industrialized countries have been mostly associated with hospitals and high technology which, though expensive, receive strong popular support and so can be socially justified. This trend, combined with the specialist bias of most medical teaching, has resulted in relative neglect of PHC. Despite the neglect, however, many of the key concepts of PHC had been identified and were being promoted even before the Alma-Ata Conference.

The rising cost of secondary and tertiary care has redirected attention to PHC. The emphasis on curative medicine has not improved people's health to a level which is, or should be, achievable with a balanced health care system. At the same time, specialist care is growing further away from

the needs and aspirations of the public, and this in turn is causing alienation and an increasing resort to "alternative" therapies outside the health care system, as well as interest in "self-help" groups.

There has been a gradual shift of emphasis to PHC, not as a cheap alternative but as being more relevant to people's real health needs in terms of health promotion, prevention of ill health, and an accessible source of treatment when ill. The three components make up the generally agreed definition of primary health care, as distinct from primary medical care or general practice, which are mostly concerned with the third component. At the same time, there has been a rise in awareness by users of services that they as citizens should have more say in the sort of health care provided and the way it is delivered.

These changes in public and professional opinion were set forth in the Declaration of Alma-Ata as a bench-mark against which the evolution of PHC can be measured. They can be summarized under four headings:[a]

(*a*) health care should be related to the needs of the population;

(*b*) consumers should participate, both 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.

Turning the principles of the Declaration of Alma-Ata into action is a central task of both health professionals and health authorities. Particularly in the context of industrialized countries, it is necessary to consider whether the Declaration is still relevant.

ANALYSIS OF THE RELEVANCE OF THE DECLARATION OF ALMA-ATA

The Symposium concluded that the Declaration of Alma-Ata was still highly relevant in Europe. Reservations and comments follow concerning the various sections of the Declaration (also given, for easy reference).

[a] **Kaprio, L.A.** *Primary health care in Europe.* Copenhagen, WHO Regional Office for Europe, 1979 (EURO Reports and Studies, No. 14).

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 worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

It was felt that, as the term "complete" health describes a state rarely attained, and so an unrealistic goal, the word "optimum" was to be preferred. The definition of health, as it stood, could bias people in certain countries against the Declaration.

Intersectoral cooperation was considered a key concept, and the initiative for it was considered to lie in 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.

This section was considered to be particularly relevant to deprived urban communities, to cultural minority groups, and to mobile populations within Europe.

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.

Participants had no reservations about this section.

IV

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

Although generally welcome, this section needed clarification as to the meaning of the words "right" and "duty" and their ethical implications.

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.

Although this section was accepted as relevant, doubt could be expressed as to whether, in the last sentence, PHC was *the* key or *a* key.

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.

It was commented that this section contained a mixture of definitions, both structural and functional, without any reference being made to need. The strategic organization of health care had to be dynamic, and sensitive to changing requirements: geographic, cultural, and economic.

The ideals expressed in sections I–VI of the Declaration were brought together in this section in a form which could lead to the development of strategies. All the seven subsections were thought to have relevance to European countries in varying degrees.

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;

Whereas biomedical research could be considered adequate in Europe, the same could not be said about social and health services research.

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

The "main" problems were interpreted as the common problems, but it was not clear who decided the priorities, users or providers of services. The promotive field was considered to be least well served.

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;

Health education had tended to concentrate on imparting knowledge, rather than influencing behaviour. Other items seemed to be reasonably well covered in European countries. Clarification could be requested on the word "education"; it might be asked whether it referred to the traditional concept or to a more progressive one.

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;

Failure of integration between sectors was seen as being almost universal. Social welfare had been omitted from the sectors listed. The need for a flexible approach should be stressed.

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;

Non-participation was the norm. Community participation was, again, one of the key concepts, but methods needed to be developed. It was felt that the ability of individuals to participate in the primary health care system should have received equal weight in the Declaration.

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;

Experience of referral varied in different countries. Faulty referral processes seemed to be more prevalent when the secondary care services were more influential.

It was not clear what comprehensive health care meant, what its parameters were, and how it could be evaluated.

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.

No mention was made of the health care support provided by the family in conjunction with professionals. The balance between family support, lay care and professional care could have been defined more clearly.

It was also felt that the term "alternative" might be more appropriate than "traditional" when speaking about the health care team in the European context.

It was felt that training for teamwork, both post-basic and "in-team" should be emphasized.

Multidisciplinary education needed to concentrate on changing attitudes, and this might have to be pursued in the face of opposition by entrenched educational interests, some of which were opposed to the development of PHC.

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.

Failure of governments to implement PHC seemed to be the rule. A deadline to be set for formulation of policies could perhaps be suggested.

Specific strategies were required for each country, region and district, and could be initiated at the periphery.

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.

International exchanges of knowledge and experience were desirable. Lack of satisfactory measures of attainment of health was regretted.

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.

This section seemed to be generally acceptable.

PRIMARY HEALTH CARE AT NATIONAL LEVEL: SOME EXAMPLES

The development of PHC in the European Member States illustrates both the different approaches taken and the several factors influencing this development. Presentations were given on the situation in three different Member States, as examples of the different trends. In Finland there had been eight years of structural change, and this was now taking the shape of a more functional adaptation. In Poland an educational change had started the PHC process. Experience in Belgium indicates the strategic value of research in initiating and evaluating change.

Belgium

In Belgium the formal framework of care is a composite of public and private practice forming a policy that is the product of negotiation between differing power groups. In the past, numerous paradoxes have arisen in

which the achievements have not matched up to stated objectives. For example, instead of preventive medicine there was curative medicine; instead of health care there was medical care; instead of an emphasis on home care the stress was on hospital care; and instead of a shift towards PHC, the shift was to secondary and tertiary care.

An inter-university and interdisciplinary research project was set up in 1974 by the Government, in order to inform and prepare social policy. The aims were to clarify the concept of PHC; to determine needs for PHC; and to relate such needs to the actual provision of services. The research showed that there was no commonly accepted definition of PHC, but that the various interest groups defined it from their own individual viewpoints. This reinforced the need for the development of a commonly accepted conceptual framework. The study was unable to demonstrate that the provision of PHC was linked effectively to health needs of the population. Comparisons of the research data with directions suggested for development of PHC in industrialized countries showed discrepancies in: orientation towards self-care; integration between health and other sectors; integration within the health sector; and in community participation. Since the research study's conclusions were published in 1978 they have been followed by a research and development strategy, covering four main areas:

- — relationship of health care to the needs of the population;
- — community participation, and teamwork;
- — effective use of resources in underserved areas; and
- — PHC development as the most local part of a comprehensive health care system.

A preliminary evaluation of the project showed that, although the time perspective was still too short to draw any definitive conclusions, it had made major contributions to the development of an acceptable framework of PHC, to political, professional and lay support for PHC, to the development of organizational models for PHC, and to an increase of research capability within PHC.

Overall the study was a clear demonstration that research is a strategic agent for innovation.

Finland

In Finland the hospital building programme took place over 25 years, so that by 1975 it was almost complete, apart from local community hospitals. One priority was to reduce the previously high infant mortality rate;

this came down to the level of neighbouring countries by 1977. Other health indices were less satisfactory and it seemed that the potential for health improvement had reached its limits. Many of the causes of ill health were related to the lifestyle of the population, so that a deliberate shift of priorities to health promotion and prevention of illness based on primary health care was made by law in 1972. This has brought about a considerable shift of resources (including services, buildings and staff) towards PHC. The major obstacles to change, mostly put up by doctors, were overruled by the political will to pursue a logical programme for health, backed by community participation at all levels. Decentralization of decision-making has been an important part of national policy.

The service is now responding to demographic changes by providing more beds for long-stay care in the PHC sector.

It is clear that the principles enshrined in the Declaration of Alma-Ata are being put into effect. Evaluation will show whether they improve the health of the population.

Poland

In Poland, there is a uniform system of PHC based on regionalization of services, in which a population unit of about 4000–5000 is served by a multidisciplinary team. However, evaluation has shown a considerable shortfall in certain categories of staff, which is now improving. A survey of medical students showed that 90% preferred a career in hospital. By the time they graduated the majority had the same view, and were hostile to the idea of working in PHC. As a result special departments of PHC have been opened in six out of ten medical academies, and in some polyclinics. Though the emphasis is on student education, pilot projects and evaluation are being set up in PHC, together with increased consumer input.

CURRENT TRENDS IN INDUSTRIALIZED COUNTRIES[a]

Interpretations of primary health care

Primary health care has been hailed as "the key to attainment of health for all by the year 2000", or dismissed as "poor care for poor people". Such

[a] This section is based on surveys of the situation in 15 Member States of the European Region presented as background documents to the Symposium by Professor Y. Nuyens and Dr K. Tchamov.

diversity of opinion arises in part from the vague ways PHC is defined: in terms of a philosophy; a strategy; a level of health care; and for a set of activities.

Participants at the Symposium agreed that its philosophy was based on the tenets of social justice, equity and self-reliance. As a strategy it represented planning based on individual and community need, from periphery to centre, embracing the concepts of accessibility, acceptability, affordability and community participation. As a level of care it was closest to the population. In the view of those at the centre of affairs — the apex of the decision-making pyramid — it was, however, the lowest level, and it would remain so unless its philosophy and strategy could be asserted to raise its status. Participants noted that PHC activities included health promotion and prevention of ill health (which received little emphasis in primary medical care), nutrition, basic sanitation, health at work, and first-line medical care.

Precise definitions of PHC must depend on national, political and socioeconomic circumstances, as well as the prevailing health care system, or lack of system. Search for an overall definition applicable in all circumstances had not proved fruitful, yet there were certain common factors which could be used as a yardstick to measure progress in developing PHC in Member States. These were set out in the Declaration of Alma-Ata and they could be considered of permanent relevance to Europe. Each country had to develop its own detailed definition of PHC, but progress in this area had been slow, particularly in countries without a well-organized health care system.

Level of acceptance of PHC in the European Region

In some countries the Declaration of Alma-Ata had been totally ignored, and this could be explained by the prevalence in those countries of the fallacies previously listed, namely that PHC applied only to developing countries, that primary medical care would do instead, and that PHC was a new idea invented at Alma-Ata, promoted by WHO and not needing urgent action. In other countries the concept had been accepted and to a large extent implemented. In most countries, however, the concept had been accepted in theory, but little progress had been made in implementing the Declaration effectively, i.e. to the extent of evaluating not only how the process had been established, but also the outcome achieved in terms of improved health.

Level of implementation of PHC

The difficulty of assessing the level of implementation objectively was felt by Symposium participants to lie in the lack of indicators and measures of

implementation. These were being developed by WHO but were not yet operational. However, examples of good PHC practice could be found in a wide range of activities. The range of PHC was so wide that a classification of categories, or process elements, by which the PHC approach might be put into action was needed as a basis for devising strategies for action and making recommendations (see below).

Obstacles to the implementation of PHC

Unclear definition of PHC has been mentioned as one obstacle, as have the three fallacies referred to above which, although refuted, remain obstacles as long as they are firmly held by people working in politics or health care.

Rigid attitudes based on self-interest were considered by the Symposium participants to be the most frequently quoted obstacle to PHC. In some cases financial interest (e.g. in fee-paying systems) has been to blame, in others the cause is related to the dominance in health care and medical education of the purely medical approach. However, this barrier has been successfully overcome in at least one case, that of Finland, through political will backed by community participation, which may eventually lead to a change in professional attitudes.

Lack of political will in the planning and implementation of PHC is widespread, but the example of some of the case studies (e.g. those cited in the previous section) show different ways in which PHC may be reinforced. It was hoped that the lack of political will could be overcome by the catalytic effect of WHO initiatives, and the acceptance of community participation as a positive influence.

DEVELOPING STRATEGIES FOR PHC PROMOTION

In the course of discussions, seven categories were identified as a useful basis for considering how strategies could be developed by Member States:

1. Intersectoral and intrasectoral collaboration
   (*a*) cooperation between health and other sectors (intersectoral)
   (*b*) cooperation within the health sector (intrasectoral)

2. Community participation
   (*a*) formal
   (*b*) informal

3. Organizational support

4. Health personnel, including education and training

5. Financial support

6. Management, including information

7. Research

These divisions were not hard and fast, and there were some areas of overlap between them. Within each category, a number of questions can be posed (see Annex 1).

Each category can be considered in terms of an appropriate level for action. Thus, a matrix can be drawn with categories listed vertically, and levels listed horizontally. The levels suggested are:

— the World Health Organization and other international bodies

— national governments

— national regions
— national local level } (not considered in the recommendations)

— nongovernmental organizations

— educational institutions

— the research community

Research and education were considered important enough to be included as separate categories and also as levels of action (Table 1).

Intersectoral and intrasectoral collaboration

Intersectoral cooperation between health and other sectors

Some countries had well-developed institutions for intersectoral collaboration and planning, which worked well in nearly all sectors and at all levels. Where these arrangements did not work satisfactorily, health issues tended to suffer, as in many countries health had a low priority. Only strong political will, or strong pressure, would correct the imbalance. Pressure

Table 1. Matrix of categories for development of PHC strategies, and levels for possible action[a]

Categories or process instruments for developing strategies for PHC	Levels for possible action by:						
	Regional Office	National government	Regional government	Local government	Nongovernmental organizations	Educational institutions	Research community
Inter- and intrasectoral cooperation	1.1	2.2 2.3					
Community participation	1.1	2.3			3.3	4.4	
Organizational support	1.1	2.3					5.1
Health personnel, including education and training	1.1	2.3				4.1 4.2 4.3	5.4
Financial support	1.1	2.3 2.5 2.6					
Management, including information	1.1 1.2 1.3 1.4				3.1 3.2 3.4		5.1 5.2
Research	1.1	2.3					5.1

[a] The figures given in the table refer to the recommendations of the Symposium, beginning on p. 19.

could come from a campaign organized peripherally (e.g. to promote road safety for children) or from international organizations such as WHO. One suggestion was the publication of a "league table" of relative health priorities in different countries on certain key issues. For this to carry weight, an acceptable measure of priorities between sectors would be needed. The development of such a measure was considered a suitable area for research.

Legislation might be beneficial in requesting the planners to take into account the probable health consequences of the proposed actions. In the United States new developments had to carry a statement of the impact they would have on the environment. The suggestion was made that a similar statement of the likely impact on health should be added.

Intersectoral cooperation was made much more difficult where health and other administrative boundaries differed. This should be a high priority, particularly in the case of health, social services and housing, so that joint consultation and planning could be made effective.

Collaboration between general practitioners and social workers was sometimes hindered by role conflict, which could be alleviated by structural changes or by educational initiatives.

Intrasectoral cooperation within the health sector

The lack of clearly defined aims for primary health care was considered to be an obstacle which should be overcome in each country. Basic knowledge of the relationship of primary to secondary care was needed.

Information systems in support of PHC tended to relate to existing objectives, and might not be appropriate to new orientations. A major study of information systems for PHC was suggested.

Mainly as a result of faulty information, strategic and operational planning of PHC was inadequate in some countries. There were advantages in looking at this deficiency at the level of an individual health centre and at district level, as well as nationally. The development of overall strategic planning of PHC and secondary and tertiary care could be monitored internationally if suitable indices could be developed.

Community participation

Informal community participation

At the individual level this implies an equal relationship between the person and the health professional, so that individual needs and preferences are taken into account. This can be achieved if a "counselling" style becomes part of the professional's repertoire, rather than the more usual authoritarian style. This skill can be acquired by training. Such an

approach reinforces the autonomy and dignity of the individual and allows him or her a say in the decisions about health.

Community participation in the shape of groups is more complex. It can occur at practice level in "patient participation groups". A number of models of such groups have been described, and though few in number they are gaining in popularity in several countries. Evaluation of their effectiveness is awaited.

Self-help groups with health-related aims are multiplying rapidly in some countries, and can be seen as an attempt by patients to take responsibility for meeting some of their health needs in a more acceptable way. At the same time they might be interpreted as a failure of existing health care systems to meet individual needs. This too was considered to be an area which merited study, and should cover lay as well as family help. Where it can be demonstrated that ill health has social origins, a study of these origins clearly comes within the area of prevention of ill health.

Formal community participation

Countries with little formal organization of PHC are less likely to achieve community participation; conversely countries which already have community participation at all levels as part of their political structure will be nearer to the goal as expressed in the Declaration of Alma-Ata.

Many different structures have been introduced at local or district level, such as health boards with elected members and community health councils. A measure of their effectiveness is the extent to which users of services are brought into the negotiations between authorities and professional providers of services.

Mechanisms for community participation at national level do exist, but the user's voice is likely to be weak. It was suggested that community participation was more likely to be achieved if decisions about services were made as near to the primary health care level as possible. However, central monitoring and support for peripheral community participation might be needed if it was to be effective and uniform in quality.

The aim was to strike a fair balance between the needs and aspirations of the users on the one hand and professionals on the other. A measure of the state of this balance was required.

Organizational support

Primary health care has to be delivered flexibly at local level if it is to respond to local health needs. This presupposes a relatively high degree of local autonomy, which is only likely to be effective with a decentralized administration with authority delegated to the local level for PHC.

Support from secondary and tertiary health care requires an effective referral system with clearly defined procedures, good two-way communication, and no undue delays. Model health care programmes, the subject of a new WHO European programme, will be helpful in defining the proper referral channels and roles of different levels of care. This is another area which merits further study.

There is some evidence from European countries that secondary and tertiary care services are to some extent pursuing their own aims, rather than responding to the needs of patients and of the primary care services. This can only be changed by a move away from professional (chiefly medical) dominance of the health care system and of medical education, and ensuring that secondary care services are more sensitive and responsive, truly supporting PHC.

Health personnel, including their education and training

Training of all health workers varies greatly from country to country, as does the degree to which education and training are related to manpower needs. Specific training appropriate to PHC, particularly for teamwork, is essential but is only slowly developing in certain countries and in certain professional groups. Intercountry collaboration in setting up training programmes and monitoring levels of learning is required.

Financial support

Many countries are experiencing financial stringency over the public services, and in some it falls more heavily on primary health care than on secondary and tertiary care. Participants felt that the trend should be in favour of PHC. Financial provision for PHC needs to be secure and coordinated with that of other sectors, such as care of the elderly and social welfare services. Special financial provision will be needed for both underserved geographical areas and vulnerable groups such as the elderly and mentally handicapped.

The level of funding which PHC receives, and the sector of PHC to which it is directed, are good indicators of the priority accorded. This indicator presupposes an accounting and budgeting system which can provide the requisite information. Linkage would be needed to methods of financial management and control such as cost–benefit and marginal analysis, which do not exist in PHC in most countries.

Management

This category covers planning, evaluation and information systems at national, regional and local levels. Where the emphasis is on central

planning, there is likely to be a neglect of management support for PHC at local level. More delegation of responsibility and local decision-making requires the deployment of management skills at the periphery. The principles of the managerial process for national health development suggested by WHO will be a useful tool to enhance management skills at all levels.

Evaluation has long been a neglected area, and is an essential management tool for which information systems will have to be developed. These will need to be integrated with research at all levels. A clearer delineation and coordination of the way that information systems, evaluation and operational research function would help them to serve each other's needs. Such a coordinated research effort would help to produce indicators of effectiveness in the planning and management systems, hitherto poorly developed.

Research

Research has already been mentioned for its strategic value in initiating and sustaining change. It should pervade each category and each level of PHC as a questioning attitude of mind. However, particularly in the sociomedical field, it cannot function without adequate support and training of research workers in a wide range of disciplines. It is hoped that more will be encouraged to operate in the field of primary health care, working with staff in an "action research" style which will encourage locally-based PHC research. Research into management and financial systems will be needed to produce the necessary methods for developing as well as carrying out PHC policy.

RECOMMENDATIONS

Taking into account existing WHO policies and recommendations to Member States, the participants agreed on the following recommendations.

Regional Office level

It is recommended that the Regional Office:

(1.1) continue to act as a forum, bringing together representatives of governments, nongovernmental organizations and the research community to discuss programmes and strategies on specific issues of primary health care (e.g. intersectoral and intrasectoral cooperation, community participation, organizational support, health personnel and education, financial support, management, and research);

(1.2) by its programmes and publications produce a shift from general policy-thinking to firm time-tabled plans and targets, such plans and targets to be ratified at a European conference of government representatives in 1983;

(1.3) support countries in their efforts to evaluate their progress in implementing PHC by setting up and making available a system of indicators for specific objectives (e.g. team development) and to develop information systems appropriate to the new objectives described;

(1.4) enhance its efforts to distribute information on trends and developments in PHC within the countries, by setting up a central clearing house and information centre (some of the information being in a concise and easily readable form).

Country level

It is recommended that governments:

(2.1) formulate clearly-expressed national policies and strategies for PHC at the highest possible level, involving all the relevant sectors, and from this develop plans of action for PHC at the appropriate level;

(2.2) establish or strengthen multisectoral machinery within the overall national administration to serve as a coordinating nucleus for the necessary planning, programming, and evaluation of PHC, including action planning within given time targets;

(2.3) plan action to cover:

(*a*) intersectoral and intrasectoral cooperation,

(*b*) community participation,

(*c*) organizational support,

(*d*) health personnel (including education),

(*e*) financial support,

(*f*) management support (including information), and

(*g*) research;

(For a check-list of questions see Annex 1)

(2.4) plan action involving local, regional and national levels, with the necessary facilitating machinery between them;

(2.5) increase progressively the resources for PHC within the appropriate sectoral budgets, if necessary by a process of resource reallocation, coupled with cost-containment in other sectors;

(2.6) set aside a proportion of the national budget to support a "national health development network" whose function it would be to coordinate and support the activities of research bodies, educational institutions, information-gathering and innovative agencies, with the aim of providing an input into policy-making bodies, including PHC, at the highest level.

Nongovernmental organization level

It is recommended that nongovernmental organizations:

(3.1) work for greater understanding and positive attitudes towards PHC by promoting information exchange, dialogue and discussion on important issues of PHC within and among nongovernmental organizations as well as with governments;

(3.2) stimulate their members to participate and collaborate consructively in programmes of innovation in PHC, whether developed by themselves or initiated by governments or other agencies;

(3.3) strengthen their efforts to promote full participation by individuals and communities in the planning, implementation and control of PHC programmes, in their capacity as linking machinery between the community, providers of services, and management;

(3.4) extend their interest in underserved groups (e.g. the elderly, migrant workers, the handicapped) by initating programmes, services or actions for and with these groups, within the frame of the PHC approach.

Educational institution level

It is recommended that educational institutions:

(4.1) increase their commitment to the education of professional personnel for roles and functions in PHC which require a consensus between government, professions and educational institutions on a concept of PHC for the future;

(4.2) conceive and redesign training programmes in a more comprehensive way by putting more emphasis on training outside the institution; on health promotion; on health education; on communication skills and teamwork; on the contribution of behavioural sciences to education; and on the mutual understanding of roles;

(4.3) support or undertake model programmes of integrated training for different categories of PHC staff, both at postbasic and continuing education levels;

(4.4) include gradually in their curricula — from kindergarten to university — elements of health education, applied in a participative and experiential manner, and related to individual health beliefs.

Research community level

It is recommended that members of the research community:

(5.1) expand their efforts to develop research on conceptual, organizational, managerial and political aspects of PHC, which would enable the Regional Office to identify a number of centres capable of collaborating on PHC research;

(5.2) help the development of systems for communication with government, so that relevant and usable research knowledge would be available for policy-making in PHC;

(5.3) link their programmes with those of nongovernmental organizations in order to take full advantage of innovative thinking and practices, and to identify and overcome potential constraints;

(5.4) aim to increase the potential for research within PHC, by training staff and researchers, and by developing appropriate research and educational technology.

Annex 1

CHECK-LIST OF QUESTIONS ON PROGRESS IN APPLYING PHC IN SEVEN CATEGORIES[a]

Intersectoral and intrasectoral cooperation

1. What machinery exists at local and more central levels for intersectoral action in health? How well does it function? How could it be improved?

2. How much planning, decision-making and financial control are delegated to the local level? What effect would increased delegation of control have on prospects for intersectoral planning and action at local level?

3. What specific activities are being undertaken jointly with sectors other than health? What sectors are involved? Was planning undertaken locally, or more centrally? How could intersectoral activities be improved?

4. How much integration is there between preventive, curative and rehabilitative services? Does this occur at all levels?

5. How effective is the referral process between primary, secondary and tertiary care in meeting actual health needs? Is two-way communication between levels adequate?

Community participation

1. In what ways are local communities involved in PHC? How widespread is this involvement? What ways have been most effective? What has worked least well?

2. What types of health personnel have been directly involved in promoting community participation? What training have they had for this role? What additional training would be most useful?

3. Which national policies and programmes encourage community participation? Which ones discourage participation? What changes would be most likely to promote participation more effectively?

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[a] See Table 1, p. 15.

4. What administrative or organizational changes have been made to promote community participation? How well have they worked? What additional changes would be helpful?

5. Is participation encouraged at individual as well as local level? Are there training implications for participation at the individual level?

Organizational support

1. What is the current organizational structure of local support for PHC? How is this structure related to the first-line hospital; to other health units and activities; to other sectors? How could it be improved? What organizational changes, if any, have been made to improve support for PHC?

2. To what extent have planning and decision-making for PHC been decentralized?

Health personnel, including education and training

1. Have job descriptions for local health personnel been revised to support PHC? Have staff received any reorientation training for PHC? Have changes been incorporated in basic training programmes?

2. Are any new types of health worker being trained for the community PHC team? What are their functions? How were these functions determined?

3. Where are PHC staff being trained? By whom? What training have those providing the training had for this task? What training manuals and materials are available?

4. To what extent has training for teamwork been developed? Does this include multidisciplinary training, and if so, is this at basic or postbasic level, and in the working team setting?

5. Has adequate provision been made for continuing education of all staff in PHC? Is some of this on a multidisciplinary or small-group basis?

6. Is there a social science element in training of all PHC staff?

Financial support

1. Have funds for PHC increased in absolute terms during the last three years? Have they increased as a percentage of total health expenditure in the same period?

2. What are the funding sources for PHC? What percentage is provided by local communities; government; private sources; international sources? Is present and projected funding sufficient for current PHC plans? If not, where will the additional resources be found?

3. How secure or regular is funding for PHC? Are budgeted funds available at local level?

4. In developed countries, to what extent has the commitment to PHC included active concern for assisting the implementation of PHC in developing countries? How far has this concern been reflected in increases in financial support for PHC activities? What are the future prospects?

Management, including information

1. To what extent have communities been involved in planning PHC? In evaluation? What methods have been used in these processes and how effective have they been? How could they be improved?

2. What is the effectiveness of supervision and monitoring of performance on health workers at all levels? What information is used for performance monitoring? Is it reliable? How can it be improved?

3. Is training for management of PHC adequate and effective at all levels? What additional training needs to be developed specifically for PHC?

4. Is the planning system based on real health needs? Does it operate sensitively and efficiently? Is there adequate strategic and operational planning for PHC?

5. Is there a satisfactory information system to serve the needs of PHC? Is it also accessible and adequate for research purposes?

Research

1. Is the level of research appropriate to support strategic and operational planning? Does such research operate in a coordinated manner between the relevant sectors?

2. Is research taking place into the development and use of "product indicators", whereby the objectives of PHC may be evaluated?

3. Is the input of research into a "national health development network" adequate in quantity and quality to ensure that effective policy-making at the highest national level is possible? (See recommendations 2.6 and 5.2.)

4. Is there enough support for research within PHC, both through the training of appropriate research workers and through encouraging PHC potential for research?

Annex 2

LIST OF PARTICIPANTS

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[a] Participation expenses not paid by WHO.

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