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Abstract—Primary health care in the WHO sense was triggered indirectly by the failure of the Malaria Eradication Programme. The response to this failure was an ideological change which considered that health services were not purely a way of delivering health care interventions to people but were something important to individuals and groups in their own right. Key changes of this idea called primary health care were linked to qualities such as power, ownership, equity and dignity. Such an ideological change involves the evolution of new forms to reflect the changes in content and some of these structures still require development.

The advocates of highly selected and specific health interventions plus the managerial processes to implement them have ignored, or put on one side, the ideas which are at the core of what could be described as the primary health care revolution. They are in this sense counter revolutionaries.

Key words—primary health care, selective primary health care, equity

Most of us have difficulties in describing a success. We are aware of the conditional clauses we would have to use to describe a successful person. Few would say it was the richest person, or the one who had the most children, the person with the greatest apparent power, or even the one who states that he had reached the peak of all his aspirations. We all have heard of the unhappy millionaire, the miserable leader, the near vegetable who exists in a cloud cuckoo land of apparent achievement and yet exists in personal and social squalor.

The definition and description of health involves similar problems for very similar reasons. There are so many facets that have to be seen together and there is no objective way of judging whether one mix is better or worse than another. Two individuals can have two very different mixes and each may be the ideal for that particular person. Because of the diversity of acceptable outcomes, the promoters of success (or health) feel forced to concentrate on trying to prevent failures (or disease). Unfortunately, when one follows this line of reasoning one almost inevitably is led to the idea that if we can prevent, abolish, or remove enough aspects of failure, the result will be a success. This is not valid reasoning. Certainly, it must be 'good' to abolish or control diseases but this does not inevitably lead to health or to what people necessarily want.

Philosophic dilemmas such as the above sometimes resurface and become the starting points of new initiatives, and primary health care (PHC) as expressed by WHO could be said to have had its genesis from the implications of failure rather than from any vision of success. It is worth remembering that PHC started in the late 1960s and early 1970s. This was the era dominated by the thinking of people such as René Dubos [1] whose 'Man Adapting' was almost compulsory reading for anyone interested in the biomedical sciences. In the same era WHO and many countries were struggling to face the implications of the failure of malaria eradication as an idea and as a programme and the long knives were out looking for technical, political and administrative scapegoats to blame. The conclusion which was most widely and comfortably drawn from these malaria debates was that while there were technical reasons for the difficulties in malaria eradication the most dominating cause of failure was the lack of a complete continuing health service infrastructure which could reach every household and remain in place. This health care infrastructure did not have to be very sophisticated and the degree of completeness of its coverage and its stability were more important than its level of technical competence.

With such a conclusion, WHO was almost forced to look more deeply into the distribution, form, and roles of 'basic health services' (as such services were then often called). This was done by the Executive Board of WHO proposing, carrying out, and reporting on an Organizational Study on the Methods of Promoting the Development of Basic Health Services [2]. The report was a surprising and unexpected document. An appreciation of the present position [2, p. 106] describes a “major crisis on the point of developing” in the developed as well as in the third world. It states that “there appears to be widespread dissatisfaction of populations about their health services for varying reasons”. A number of causes (of dissatisfaction) are listed and include:

—"a failure to meet the expectations of the populations;
—an inability of the health services to deliver a level of national coverage adequate to meet the stated demands and the changing needs of different societies;
—a wide gap (which is not closing) in health status between countries and between different groups within countries;
—rapidly rising costs without a visible and meaningful improvement in services;
—a feeling of helplessness on the part of the consumer, who feels (rightly or wrongly) that the
health services and the personnel within them are progressing along an uncontrollable path of their own which may be satisfying to the health professions but which is not what is most wanted by the consumer."

A number of reasons for the above were explored further and the report concludes that “they are possibly symptoms of a wide and deep-seated error in the way health services are provided”. When the report describes what should be the content of basic health services, it denies that any collective or world list of health service actions should exist. “Physicians cannot say that persons with this or that condition, for which a health intervention is possible, should be given first priority or that another disease should be left alone to be dealt with later.” Instead it suggests that it is the responsibility of the health sciences to describe possible interventions and their implications and costs, but not to choose.

I have quoted at length extracts from this report for two reasons. Firstly because it turned objectives for a health service upside down by saying that its structure and content should not be dominated by a form required for malaria eradication, or any other disease control measure, but for quite different societal reasons. Secondly, because the debates on this report by the Executive Board of WHO and within the following World Health Assembly led up to the idea of PHC as expressed by WHO.

During these debates it was the representatives of the industrial world who first rose to their feet and stated that the report described their health system problems. This was followed later by similar statements from representatives from the developing world. In the debate on the implications of the report, the examples quoted were not limited to disease states but included occupational hazards, pollution, traffic accidents, and drug addiction as often as malaria, child and maternal mortality or communicable diseases. The issues moved on from the right of every individual to have access to health care towards the realities that the form that the health system took was not just of epidemiological, fiscal or managerial relevance and that both the long and short term objectives, and who should decide, were of fundamental importance. The imminent crisis that was being described and the criticisms of the existing health care scene were not directed towards the present health status of populations or to particular disease states but to the indignity of health and health care being ‘owned’ by special groups and the form and objectives of these systems being imposed on populations on quasi-rational grounds. The report was unexpected and revolutionary because it described health systems as failures because people were dissatisfied with their ideology and form—not because they were unsuited for malaria eradication.

The evolution of a statement consistent with these ideas has been slow and tortuous and is far from being completed. As with any radical shift in ideology, the steps from ideology to applications and methods of implementation present real difficulties. Even a definition seems to start with essential or core qualities rather than a proper statement giving boundaries and direction. The first attempt to describe a revised system, given by WHO the code name of PHC, followed the Joint WHO/UNICEF study of success [3]. This was in a paper presented to the 1975 World Health Assembly [4]. Here PHC was described rather than defined and seven qualities or principles were proposed. These included the design of a PHC system around the life patterns of the population, the need for total health systems to be designed to support the needs of the periphery, the acceptance that many primary causes of ill-health were based on factors such as poverty, deprivation and environmental abuse, the need for active participation (ownership) of health systems by local populations, and equity. These principles were accepted by the Assembly, and led to the meeting in Alma Ata in 1978.

Large, formal international meetings of national representatives have their own peculiar needs. It is difficult for a representative to return home and report on an ideology. What is wanted is a programme. At Alma Ata, almost inevitably the emphasis moved from what is wrong, and why, to what can health services do, and how can success be measured. Lists started to appear of health status problems which needed to be dealt with and they included the expected, including maternal and child mortality, water and sanitation, health education, fertility, and the communicable diseases. It can fairly be said that it would be surprising if such widespread horrors were not on such a list. However, the risk of such an activity is that when you start with any list, the entire reasoning starts to change and the list becomes the objective.

It can be said that ‘selective primary health care’ (SPHC) may possibly have started from the lists of Alma Atas rather than from the Walsh–Warren article in 1979 [6]. There seems little difference in principle between an international forum selecting a group of disease and intervention priorities and saying we will try and implement these throughout the world, from a different group making a different selection based on the cost and effectiveness of interventions and saying do these things first because they work. Both groups are putting forward health status objectives as goals and are either saying use PHC principles to implement our choices (if they are cheaper, more effective or more acceptable) or let us design a different series of delivery systems which could optimize our goals and leave the more general goals to some later date when such luxuries can be afforded.

To the convinced PHC advocate such SPHC proposals are not PHC at all but are the antithesis of it. They are disease control programmes which are ideologically similar to the malaria eradication disaster and are a regression to the very qualities of imposed systems which were described in the Organisational Study. The selected initial lists are expressed as ‘interim’ objectives but even if these items were solved they could then be followed by another list using similar logic, ad infinitum. In no way do they share the objectives of PHC and the apparently preferred vertical programme management structure is very different from the horizontal decentralisation which is an essential component of a PHC form. The choices are those of the technologists and managers (national and international); ‘ownership’ rests with the programmes; mechanisms are designed for the job and not for the system; objectives and outcomes are
short term rather than primary causes or barriers of change; there are built-in assumptions that the problems and outcomes are those of the people and the technology is the preferable one for all societies; and the programmes support the existing resource gathering and distribution patterns and may increase dependency.

Such statements can easily be misinterpreted. The 1960s and 1970s were not only the time of the appearance of PHC but were also the era of smallpox eradication. This success story of modern medicine was selected internationally and was implemented using highly specific methods designed exclusively for the programme. It would be difficult to find anyone now who does not applaud this programme and who is not satisfied with the result. But the main health problems of both the poor and the rich countries do not fall into the same category as smallpox. The health problems of today, when viewed by the professionals or the people, are ones requiring continuing action cohort by cohort, person by person, and day to day. There are few health advances which do not have to be weighed against disadvantages and opportunity costs which are important to individuals and to societies. SPHC and PHC are not similar.

The clash between PHC and SPHC is real even though the points of conflict are not the obvious ones. Both sides in the argument accept that poverty, deprivation, malnutrition, lack of education, the status of women, environmental hazards and a gross maldistribution of resources are among the primary causes of much ill-health and that these things need to be faced directly in their own right. SPHC takes no responsibility for attempting to alter them and PHC may only influence them indirectly or marginally. Similarly, both sides equally accept that many (or most) infant, child, and maternal deaths and some other illnesses and deaths can be directly prevented or influenced by existing interventions which can be cheap and effective. Both sides are aware that these interventions are only being applied to a minority of the world's risk populations.

These agreements may seem to be so all-embracing that the differences must be only marginal. They are not. If the objectives and who decides them as well as the form are opposed, then the similarities rather than the differences are of little account. PHC advocates feel that, even if the list of actions and interventions put forward by SPHC are applied to a total population, the health system may still be classed as a failure. If what results is still an oppression, does the health system still be classed as successful even if some of the illnesses and deaths targeted by SPHC continue to occur? Such statements can be reversed to say that a PHC system can still be classed as successful even if some of the illnesses and deaths can be directly prevented or influenced by existing interventions which can be cheap and effective. Both sides are aware that these interventions are only being applied to a minority of the world's risk populations.

CONCLUSION

There are moments of history when unplanned and apparently irrelevant events present the opportunity to view ourselves in a different way and to change. The events of the 1960s and 1970s not only made visible the magnitude of the health problems facing the majority of the world's people but gave us the opportunity to discuss publicly some of the absurdities of our health systems and the objectives we
were working towards. If health is not definable except in a fluffy way, can never be completely attainable by individuals or groups, and will always involve a play off between risks and aspirations, then why do we continue to act as if disease and death control equals health? There is no objective way of using the scientific method to choose between these issues, to select this rather than that illness for action, to say that the death of a child is somehow worse than that of an adult, or to selectively direct public resources to one set of individuals rather than to another. These are inevitably value judgements. Only society can choose and if a society has rights one of them must be the right to know what the choices are, to have access to those choices in an acceptable way, and to understand the consequences or implications of the decisions.

The continuing evolution of PHC is the nearest thing that we have at present which reflects these rights. It is likely that it will take a long time and many ineffective attempts before it is possible to get it to work properly. The PHC failures may need to be ruthlessly destroyed but the movements towards workable forms have to be protected and encouraged. SPHC is a threat and can be thought of as a counter revolution. Rather than an alternative, it is a form of health service feudalism which can be destructive rather than an alternative. Its attractions to the professionals and to funding agencies and governments looking for short term goals are very apparent. It has to be rejected, but for the right reasons.

No one can justify the mismanagement, logistic incompetence, and conceptual confusion of many so-called PHC systems which make many of the interventions selected by SPHC inaccessible to the people who might very well choose them if they had the opportunity. But if these are corrected in the wrong way, they may result in pathetic substitutes for the real thing if the main objectives and qualities of PHC are forgotten or put on one side.

REFERENCES
4. WHO. Promotion of National Health Services, Paper for WHA A29/9, April, 1975.