Bull Pan Am Health Organ 15(4), 1981.

PRIMARY HEALTH CARE: A STRATEGY FOR EXTENDING COVERAGE TO THE UNSERVED POPULATION[1, 2]

Fortunato Vargas Tentori[3]

What is known as the "primary health care strategy" must be implemented if health services are to reach all or even most of those presently unserved. This broad strategy requires new approaches and operating procedures, wide ranges of human resources and funding mechanisms, active community participation, cooperation with practitioners of traditional medicine, and application of appropriate technologies that can serve as meaningful components of development.

Introduction

Recognition of the right to health, enshrined in the constitutions of various countries, is expressed universally in the United Nations Declaration of Human Rights and the Constitution of the World Health Organization. A glance at prevailing realities shows that this right is still far from being effectively exercised; but in recent years, for the first time in the history of international public health, the world's governments have responded to these fundamental proclamations by setting as a common goal the achievement of "health for all by the year 2000."

In the past there was no general worldwide agreement about defining a strategy for giving urgent attention to the real needs of marginal populations. Recently, however, all of the 156 WHO member states have agreed that primary health care should be accepted as the tool for accelerating the process by which health services are extended to all. There is also unanimous agreement that the population to receive priority attention should be identified; and there is an emphatic consensus that the present target of this primary health care strategy should be the marginal rural and urban population.

In recent decades, multinational action applied to certain specific fields has yielded unexpected health benefits. The conquest of smallpox provides a good example. Nevertheless, implementing the primary health care strategy is not a matter of taking action in "certain specific fields." For indeed, this strategy does not act on an isolated public health problem or some isolated part of the health system; instead it goes to the very root of the matter, focusing not on health techniques or even the health system, but upon the welfare of mankind. Applying such a broad-based strategy requires different approaches and different operating procedures. It also requires a wide range of human resources and budgetary mechanisms, as well as the application of appropriate technology geared to the political, social, economic, and cultural realities involved that can serve as a meaningful component of development.

All this helps to explain why the principle of "health for health's sake" that once guided programs has given way to the search for "health within the context of development." In like manner, economists and planners who might once have questioned health's essential role in development no longer do so; for they have come to recognize its importance.

---

[1] Also published in Spanish in the *Boletín de la Oficina Sanitaria Panamericana* 90(1):1-9, 1981.

[2] From a paper prepared for the Guillermo Almenara Irigoyen Seminar on the subject "Health for All by the Year 2000." This seminar, conducted in Lima during February 1980, was sponsored by the Social Security Institution of Peru.

[3] Former PAHO Area IV representative, Lima, Peru.

In a similar vein, international financial support provided by the World Bank, the Inter-American Development Bank, and other external lending institutions once went almost entirely to the productive sector. But in recent years that support has been redirected to the fight against poverty, and more attention has been given to social development programs.

At the same time, within the health field, the training of middle-level, auxiliary, and community health personnel that was once given second priority has assumed a predominant role. Moreover, most programs providing such training used to deal mainly with the restoration of health. Today, in contrast, preventive and health promotion activities are increasingly included within a framework of instruction better-attuned to present conditions.

A decade or two ago, marginal rural and urban populations were merely passive subjects of paternalistic development efforts. Today these same populations are assuming key political and social roles. And concurrently, pre-orchestrated community participation in ready-made programs that fail to consider the beneficiaries' suggestions or points of view is giving way increasingly to those beneficiaries' active and aware participation in decisions—and to official acceptance of their participation.

More recently, a clear distinction has emerged between what is known as primary health care and what is called primary patient care. In primary patient care (also known as primary medical care), attention is directed at repairing damage caused by various factors—in other words, upon the same kinds of health-restoration activities considered important in primary health care. But this, of course, is only one important component of primary health care, which deals with all health issues relating to integral development of the individual and the community.

Because the concerns of primary health care are so broad, the interdisciplinary and intersectoral approach is recognized as an essential component of programs for extending coverage. Nevertheless, this approach (vis-a-vis primary health care) has been accepted only recently and is at present being applied only at certain levels of the national and international health structure.

This relates to the fact that the key problem revolving around primary health care at present is how to implement it. Considerable efforts have been devoted to defining and describing the common goal of "universal coverage," but relatively scant attention has been devoted to defining how to achieve it.

Thus, the politician, technical expert, and general administrator should understand that better methods and measures must be applied to reach the desired goal. It is not a matter of imposing what the health system deems unilaterally to be the best for the community on technical and administrative grounds. Rather, it is a matter of imposing on the health system what local, regional, and national communities feel they require to meet their basic needs.

Improving Health Services and Their Coverage

Since the founding of WHO, that organization and its member countries have undertaken numerous joint efforts to improve national health services. By and large, these efforts have been directed at either or both of two closely related goals: improving the quality of existing services and making the services accessible to unserved populations.

Significant progress has been made in improving the quality of existing services—by applying the impressive recent advances of science and technology. However, despite high costs, these improvements have benefited only a minority of the population to a limited degree *(1)*.

Especially encouraging improvements in health service quality have been attained through actions seeking to restore health—actions directed mainly at disease treatment rather than at factors conditioning disease or affecting the level of collective health. Indeed,

one often finds that 80 to 90 per cent of a developing country's health budget is earmarked for attending to disease problems, rather than for any broader-based attack on health problems with an integrated, interdisciplinary, intersectoral approach.

Until recently the second goal, that of extending coverage to marginal populations, was relegated to an increasingly secondary position, most administrative and planning efforts being focused on using available resources within the confines of existing services. This is why three-fourths of the world's population is not now benefiting from the technical and scientific advances of recent times, and why about 139 million rural inhabitants of Latin America and the Caribbean are receiving no services at all.

The Current Problem

The population of Latin America and the Caribbean grew from 284 million inhabitants in 1970 to 379 million by the end of the decade, the urban population including 227 million (60 per cent of the total) and the rural population 152 million (40 per cent). Of this latter rural figure, 30 million were indigenous inhabitants. As of 1980, it was estimated that the population without access to any health service included about 139.5 million rural dwellers and 20 to 30 million inhabitants of poor urban districts *(2)*.

At present, principal obstacles to extending health service coverage to these deprived populations include the following:

- There are no operational mechanisms to facilitate or permit application of policies aimed at achieving community participation and intersectoral coordination.
- The health sector suffers from a multiplicity of institutions, duplication of activities, and a shortage of mechanisms for providing intrasectoral (as well as intersectoral) coordination.
- Cultural barriers exist at various levels, among both beneficiary populations and the institutions charged with delivering health services, and these barriers create resistance to change.
- Human resource training and development is not yet sufficiently related to the health services and is not always responsive to program requirements or real community needs.
- Too little is known about appropriate technologies applicable to primary care and community participation that can be used to extend health service coverage.
- Administrative deficiencies prevent operational needs from being satisfied in the rural zones and urban neighborhoods in need of coverage.
- Financial constraints prevent coverage from being extended with the intensity and speed that the primary care strategy requires.

Overall, the primary health care strategy for speeding up extension of coverage must be based on actions that will make it possible to overcome identified obstacles. At the same time, it must propose alternatives and practical solutions suited to the characteristics of the countries, regions, and communities involved.

The Primary Health Care Strategy

Aware of this serious situation and the importance of health for development, the world's governments have now unanimously assumed the task of ensuring that by the year 2000 all communities and individuals have adequate access to health care and can therefore expect to live socially and economically productive lives. This will require implementation of the primary health care strategy—for the purpose of extending health services with conceptual bases and approaches different from those now in effect.

In the past, the term "primary care" was used in the developed countries to describe actions designed to restore the health of individuals. For this reason, the recent effort to incorporate the new interdisciplinary and intersectoral approach into "primary care" has altered the term's meaning and implications and has made it more difficult to use *(3)*.

Among the accepted meanings of the term "primary" are those of "basic," "fundamental," "elemental," "first time," and "first in importance." Nevertheless, because of the term's apparent simplicity, one also runs the risk of interpreting it as synonymous with

"minimum," or else, because of its connection with extension of coverage, judging it discriminatory—applicable to the type of care directed solely at those with few resources *(4)*.

A thoroughgoing definition of primary health care was placed by the WHO Member States in the Declaration of Alma Ata that emerged from the International Conference on Primary Health Care held at Alma Ata, USSR, in September 1978. So important is an understanding of this term that attaining the goal of "health for all by the year 2000" can be said to depend on its proper interpretation and application.

The Declaration of Alma Ata *(5)* states that "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.

..."Primary health care reflects and evolves from the economic conditions and socioculturral 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.... [It] addresses the main health problems in the community, providing promotional, preventive, curative, and rehabilitative services accordingly."

As this implies, the aim of the primary health care strategy is to imbue individuals and communities with confidence in their ability to solve health problems that are within their grasp, and to create an awareness of their limitations in confronting health problems alone. The strategy also seeks to guide them toward more effective ways of using external resources supplied by public and private agencies to improve their health and general living conditions.

The strategy also recognizes the people who have never received any kind of institutional health care—who for centuries have had to fend for themselves—as the priority target. This does not mean the strategy cannot also be applied to parts of the population already benefiting from health services. Nevertheless, so long as the group that is the priority target is not well-defined within the context of prevailing political, economic, social, and cultural conditions, it will be hard to frame a practical operating concept that will be found equally applicable by those in developing countries with per capita incomes of over US$7,500 and less than US$100 per year *(6);* by the few privileged to consume 900 liters of water per day and the great majority limited to an average of 3.5 *(7);* by the 5 per cent of well-to-do Latin Americans who take in 4,100-4,700 calories per day and the 20 per cent of far poorer compatriots who ingest between, 1,700 and 1,850 *(8);* by highly literate groups and by the illiterates who constitute 73 per cent of the African population, 46 per cent of the Asian, and 27 per cent of the Latin American *(9);* and by mothers who pay roughly US$2,000 for obstetric services as compared to the vast numbers who lack the means to obtain such care *(10)*.

The primary health care strategy seeks to make use of simple, effective, low-cost actions accepted by the community that are designed to prevent disease and to promote and restore health—so as to avoid problems that could produce the kind of deteriorations contributing to underdevelopment. In this vein, the strategy's main thrust is directed against conditions that predetermine, trigger, or cause particular health problems. If action must be taken beyond the primary level because of failure to apply this strategy, it is likely to in-

volve care by costly and elaborate institutional subsystems (such as large hospital complexes)—thereby drawing down resources available for social and economic development *(11)*.

The strategy also seeks to address the most common individual and community health problems wherever those problems originate. Therefore, while it does seek to counteract the effects of disease, it ascribes major importance to dealing with causative factors. That is why besides emphasizing appropriate technology and community participation, the strategy stresses interdisciplinary and intersectoral approaches and ascribes great importance to the traditional folk medicine practiced in the communities involved.

Health System Coordination

In the past the health system's administrative, programming, information, manpower, and other subsystems have operated to support a rigid, centralized, and generally closed organization. Nevertheless, the myriad different factors and situations encountered in applying the primary health care strategy demand that both the health system and its supporting subsystems be flexible. Accordingly, today stress is placed on keeping demand from merely gravitating to the institution promoting and offering the services involved, and on making those services more responsive and better-suited to the populations that need them most. This approach avoids complete reliance on client-facility relationships based on the spontaneous workings of supply and demand for medical and dental consultations, disease treatments, hospitalization, and so forth, replacing those relationships with greater availability and superior community use of interdisciplinary services.

Despite some general knowledge about the health problems of rural and poor urban groups, very little is known about the complex factors conditioning such problems. Therefore, it is imperative that the health services give more attention to preventing these problems at the source, rather than merely treating the diseases that they cause.

Moreover, the type of information usually required for customary health service programming is not available in unserved communities, and so new methods of local information-gathering, programming, and health service organization must be tried. In general, some of the elements that will determine the content and organization of such health programs include the particular problems of the area or region concerned, the multisectoral factors that condition those problems, the resources the community can supply (especially local primary care leaders and volunteers), the prevailing degree of community acceptance, and the prospects for maintenance and continuity that the community can offer the health activities involved.

In general, the following observations about the activities of the administration, information, planning, and programming subsystems should be kept in mind:

- Experience has shown that health programs have tended to foster manipulation rather than community participation. Community support has been used to attain goals pre-established by groups of health technicians for constructing, say, health centers or water supply systems—without participation in the preliminary organizational work by the community involved.
- In general, communities have participated in the execution but not the planning of health programs; in other words, they have had no opportunity to help analyze the problems, express their views, or suggest what would be most desirable. Nor has community input been used to help describe problems and suggest ways they should be solved. Hence, in most cases the affected community has not participated in the decisions relating to a given health project, let alone in the programming and evaluation work.
- When the primary health care strategy is applied, the health system must not be allowed to impose conditions on health program execution. Mutual dialogue, joint decisions, and responsibilities shared by the community and the system should be the principles governing relations between the technical experts and the population served.
- The community may contribute far more to the program than the budgetary estimates suppose.

Considerable amounts can be returned to national treasuries—instead of being used for other activities—because very low figures are used to estimate the public's anticipated contribution to health projects *(11)*.

- Steps should be taken to provide orientation, training, logistical support, supervision, and coordination for practitioners of traditional medicine (including herb doctors, lay midwives, healers, chanters, and so forth), since in many cases they will be the only people available to initiate primary care activities; and so, to a certain extent, the scope and substance of primary health care activities will have to be determined with them in mind.
- Health education addressed to the community must become an established daily activity.
- It is necessary to systematically cooperate and coordinate with people in other sectors—including schoolteachers, social workers, agricultural extension agents, community development workers, and malaria control personnel.

Accelerating Attainment of Universal Coverage

On the basis of these new concepts, the Governments have begun reorienting their activities within the context of their own political, administrative, and legal settings. Their efforts along these lines include the following:

- studies to determine the size, distribution, and characteristics of the unserved population;
- revision of health programs in progress for the purpose of adapting them to the new strategy;
- making an inventory of health programs in other sectors and ones operating in rural or marginal urban areas;
- study and review of necessary health system adjustments in terms of organization, administration, funding, levels of care, referral mechanisms, and so forth;
- studies designed to gain a better understanding of the positive aspects of traditional medicine and the ways it can be coordinated with the institutional health system;
- investigation of practical methods for bringing about conscious and active community participation;
- applied research on the use of appropriate technology, in order to improve the opportunities for its selection and/or adaptation to primary health care needs;
- revision of education and training programs for various categories of health personnel; and
- experimentation with evaluation models to determine the quantitative and qualitative parameters involved in implementing the primary care strategy.

Collaboration afforded by PAHO/WHO will be directed at promoting, supporting, or complementing these kinds of activities.

SUMMARY

Until recently, the goal of extending health service coverage to marginal populations was relegated to a secondary position, most available resources being used within the confines of existing services. That is why three-fourths of the world's population is not now benefiting from modern technical and scientific advances, and why vast numbers lack access to health care.

Aware of this grave problem, the world's governments have unanimously agreed to set a goal specifying that by the year 2000 everyone will have adequate access to health care. Clearly, attaining this goal will require implementation of what is known as the primary health care strategy—a strategy for extending health coverage to all by using concepts and approaches distinct from those now in effect.

Because this strategy is so broad, its application around the world will require new approaches and operating procedures, wide ranges of human resources and funding mechanisms, active community participation, cooperation with practitioners of traditional medicine, and application of appropriate technologies that can serve as meaningful components of development.

Overall, the aim of the primary health care strategy is to imbue individuals and communities with confidence in their ability to solve health problems within their grasp, to guide them toward more effective ways of using resources supplied from the outside, to redirect attention to preventive measures, and to single out those who have never received any formal health care as the priority target.

REFERENCES

(1) World Health Organization. *Modern Management Methods and the Organization of Health Services.* WHO Public Health Papers, No. 55. Geneva, 1974.

(2) Vargas Tentori, F. La atención primaria como estrategia para extender los servicios a la población no atendida. In Instituto Indigenista Interamericano. *Anuario indigenista* (Volume 38, p. 16). Mexico City, 1978.

(3) Vargas Tentori, F. Extensión de la cobertura, atención primaria de salud y participación de la comunidad: definiciones y conceptos operativos. *Bol Of Sanit Panam* 82(5):386-396, 1977.

(4) Alcocer, J. J. Atención primaria de salud. Unpublished reference document prepared for preliminary meetings on primary health care held in Costa Rica, Mexico, and the United States. 1977, p. 6.

(5) International conference on primary health care. *Bull Pan Am Health Organ* 12(4):359-362, 1978.

(6) The Washington Post Parade's Special Intelligence Report. Washington, D.C., 25 July 1976.

(7) The Washington Post. Parade's Special Intelligence Report. Washington, D.C., 10 May 1976.

(8) Economic Commission for Latin America and the Food and Agriculture Organization. Joint Report. In *El Nacional,* Mexico City, 30 March 1976.

(9) Time Magazine. Message to America. *Time.* New York, 11 October 1976, p. 61.

(10) The Washington Post. Parade's Special Intelligence Report. Washington, D.C., 8 August 1976.

(11) Vargas Tentori, F. La atención primaria de salud y la medicina autóctona. Paper presented at the First World Congress on Folk Medicine held in Lima, Peru, on 27 October-2 November 1979.

INTERNATIONAL HOSPITAL CONGRESS MEETS IN SYDNEY, AUSTRALIA

The Twenty-second International Hospital Congress, organized by the International Hospital Federation (IHF) and the Australian Hospital Association was held in Sydney, Australia, on 18-23 October 1981. The IHF—whose members include national health organizations, hospital associations, and individuals from 60 nations—holds international conferences once every two years.

Two multilingual discussion sessions (in English, Spanish, and French) were devoted to each of five subjects at the Sydney meeting, as follows:

- *Hospitals and primary health care.* Emphasis was placed on the hospital's role in promoting and providing primary health care in both developed and developing countries.
- *Assessment of care.* Participants reviewed the progress and problems encountered in developing practical methods for assessing the outcome, quality, and cost-effectiveness of in-hospital care and clinical treatment.
- *Improvement of hospital management.* These discussions related to innovative hospital management ideas and practices.
- *Energy conservation.* One session concerned architectural and engineering considerations, and the other dealt with energy conservation from the viewpoint of hospital managers.
- *Hospitals and disabled persons.* These discussions centered around hospital and staff attitudes; the design of appropriate facilities; physical access problems; and aids, equipment, and information as they relate to the disabled.