National Decision-making for Primary Health Care

A study by the UNICEF/WHO Joint Committee on Health Policy

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NATIONAL DECISION-MAKING FOR PRIMARY HEALTH CARE

The World Health Organization is a specialized agency of the United Nations with primary responsibility for international health matters and public health. Through this organization, which was created in 1948, the health professions of more than 150 countries exchange their knowledge and experience with the aim of making possible 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.

By means of direct technical cooperation with its Member States, and by stimulating such cooperation among them, WHO promotes the development of comprehensive health services, the prevention and control of diseases, the improvement of environmental conditions, the development of health manpower, the coordination and development of biomedical and health services research, and the planning and implementation of health programmes.

These broad fields of endeavour encompass a wide variety of activities, such as developing systems of primary health care that reach the whole population of Member countries; promoting the health of mothers and children; combating malnutrition; controlling malaria and other communicable diseases including tuberculosis and leprosy; having achieved the eradication of smallpox, promoting mass immunization campaigns against a number of other preventable diseases; improving mental health; providing safe water supplies; and training health personnel of all categories.

Progress towards better health throughout the world also demands international cooperation in such matters as establishing international standards for biological substances, pesticides and pharmaceuticals; formulating environmental health criteria; recommending international nonproprietary names for drugs; administering the International Health Regulations; revising the International Classification of Diseases, Injuries, and Causes of Death; and collecting and disseminating health statistical information.

Further information on many aspects of WHO's work is presented in the Organization's publications.

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Chapter 1

Introduction

Background and aims of the study

This report is concerned with the promotion of primary health care (PHC). It is not so much about its technical details as about the problems involved in getting this approach translated into reality, for after the endorsement by all Member States of the 1977 World Health Assembly resolution on health for all by the year 2000, with its central PHC thrust, the real challenges still lay ahead. To implement the approach most countries would have to make radical changes in the organization of their health care system and in other sectors relevant to health. UNICEF and WHO therefore agreed, through their Joint Committee on Health Policy (JCHP), to find out from a number of countries that had committed themselves politically to PHC how the principles were being put into practice. The JCHP decided that the study should be based on the process as it actually occurred in a few selected countries which had embarked on the implementation of primary health care. It should include an analysis of the factors which determined the initial political decisions, a description of the steps which followed in initiating implementation, and the ways in which the policy decision was implemented in action; it should also take account of the problems and difficulties as well as favourable factors encountered.

Primary health care has not been invented "out of the blue". It emerged from a long line of ideas which evolved gradually with the re-evaluation of existing approaches and the assimilation of innovative experiences. Continuity with the past comes in part from the earlier concept of basic health services,[1] which emphasized the "delivery" to all the population of preventive and curative services. It also derives from innovations in the organization of health activities and development on a national scale in countries such as the People's Republic of

[1] The term "basic health services" is used here to describe a network of peripheral health facilities under the direction of a ministry of health, staffed by health personnel employed by the government and providing curative and preventive services.

China, and from more localized health care projects which also incorporated community participation and sometimes emphasized the importance of wider socioeconomic factors for the community's health.[2]

Yet the PHC approach as now advocated by UNICEF and WHO [3] also constitutes a qualitative break with the past, a new way to act for health. Far from PHC being just the addition of yet another layer to the health service—at the bottom, in the communities, using community resources—it implies a reordering of priorities that should permeate all levels and sectors concerned with the promotion of health. Such a reordering has, above all, three main implications.

First, in terms of the *understanding* of health problems, the PHC approach stresses that health promotion involves a set of issues much wider than those which health services have conventionally tried to tackle. Medicine, preventive or curative, cannot hope to attack the causes of ill-health that lie in the economic, social, and political fields. Medicine has no relevance to redistribution of income or wealth or the control over credit; to changing land distribution and land tenure; to improving the chances for productive employment and incomes sufficient to meet basic household needs; or to controlling an economic system that turns out cigarettes and other consumer goods which cause illness and death. To think otherwise means to "medicalize" socioeconomic problems. Therefore, the PHC approach is qualitatively different from that centred on basic health services and is seen to involve political action and the efforts of many sectors other than health.

Second, the PHC approach emphasizes the use of certain *policies* to translate that understanding into practice. The relevant socioeconomic issues must be acted upon by injecting a new political thrust into the health field and by developing intersectoral approaches to planning for health. Then, concomitant with the development of cooperation with other sectors, PHC suggests the need for an integrated approach to health care within the health service itself, the whole of which should come to adopt the priorities of the approach. Finally, it requires a better balance between hitherto predominantly "top-down" planning, organization, and decision-making, on the one hand, and decentralization and active involvement of the mass of the people in health promotion, as well as in the political and economic institutions that affect their lives, on the other.

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[2] DJUKANOVIC, V. & MACH, E. P., ED. *Alternative approaches to meeting basic health needs in developing countries: a joint UNICEF/WHO study*, Geneva, World Health Organization, 1975.

[3] WORLD HEALTH ORGANIZATION/UNICEF. *Primary health care. Report of the International Conference on Primary Health Care, Alm-Ata, USSR, 6-12 September 1978*, Geneva, World Health Organization, 1978 ("Health For All" Series No. 1). The report of the Conference is prefaced by the *Declaration of Alma-Ata.*

Third, there is the question of *implementation* of these policies. For example, in the health sector itself, the structural changes demanded by these policies require that the disproportionate share of health expenditure that has historically been allocated to urban and hospital services needs to be reduced in relative terms, and increased resources should be made available to the eight tasks enumerated in the *Declaration of Alma-Ata*[4] as the minimum core of PHC (health education; food supply and nutrition; water and basic sanitation; maternal and child health, including family planning; immunization; communicable disease control and prevention; basic curative care; essential drugs). Similar principles need to be applied to analagous issues in other sectors.

These three aspects of the PHC approach imply a major social transformation. The aims of this study were to learn more about the process in practice in a few countries, about the scope of change attempted and achieved, and about the problems faced head-on and the issues avoided. It was intended that the insights gained would contribute to the formulation of policies for international cooperation through UNICEF and WHO. It was also hoped that the study would be of use to countries other than those participating directly in it, by giving them a sense of the main issues involved and of different ways of moving forward. A major object, however, was also that the time spent by nationals on preparing the country reports should prove useful to the countries themselves. It should help them evaluate the progress they had made towards PHC, clarify the nature of the problems encountered, and facilitate future policy formulation and especially implementation.

Procedures of the study

A number of factors had to be taken into account in the selection of countries, as a reasonably representative sample of world situations was wanted. The most important requirements were that the countries should have made some progress with the PHC approach; that examples should come from different regions; that countries should represent different degrees of socioeconomic development; and that a variety of sociopolicital systems should be included. Moreover, the government had to agree to the study taking place, and investigators had to be available.

In the event, seven countries were chosen: Burma, Costa Rica, Democratic Yemen, Finland, Mali, Mozambique, and Papua New Guinea. This study is based on their experiences, although the report from Costa Rica is not incorporated as fully as those of the other countries as it was received too late to be taken wholly into account.

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[4] See footnote 3 on preceding page.

Section VII of the Declaration of Alma-Ata states that PHC "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".[5] It would have been particularly inappropriate for a study dealing with decision-making for PHC to have disregarded that injunction simply to achieve greater homogeneity in the national reports. Consequently, the country studies were not undertaken by a group of outsiders, following identical research schedules in all places, but by teams constituted nationally, working with general guidelines previously agreed by representatives of the countries concerned. The guidelines allowed a flexible interpretation at the country level. They were on the whole successful in helping countries to produce broadly comparable reports, which had a good level of national specificity without losing the central theme of the investigation, although the sections dealing with political processes and decision-making could not always be followed closely.

In all countries, the ministry of health assumed the final responsibility for the report, and in a number of countries the majority of team members were officials from that ministry. However, academics from national universities played a significant part, and support was also given in various countries by other ministries and representatives of social and political organizations. The UNICEF/WHO consultants for this study gave local support to most of the national teams during various phases of the research.

The procedure of national teams performing their own research undoubtedly created a deeper understanding within the countries of the issues investigated than would have resulted from a method employing mainly outside researchers. It also placed a considerable strain on the overworked officials involved, who were sometimes already responding to other demands from projects or studies initiated internationally. Even so, in some cases the study provided the opportunity for nationals to acquire valuable experience in research pertinent to PHC implementation; and at times it led to a reassessment of policies and planning mechanisms not subjected previously to much critical analysis.

The guidelines divided the research into sections ("modules"), each concerned with different types of information relevant to the understanding of the PHC process as a whole. A limited amount of information on the country's political, economic and social structure, as well as on its main health problems, had to be presented to provide a background to the study. The historical development of the health sector, particularly

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[5] See footnote 3, page 6.

over the last ten years, required more attention, as did its present operation and its relations with other sectors. Through this module an understanding was to emerge of the meaning given to PHC in the country, as well as of the extent to which it had been implemented in practice. Much emphasis was placed here on the importance of following through changes in resource allocation on the one hand, and on population coverage and access to health care on the other. Finally, there was the central module on the decision-making process, seen as constituting the core of the investigation. This aimed at tracing the interaction of politics and planning during the period concerned. It was meant to deal with the adoption of the broad national policies related to the PHC approach; with the specification of these policies, especially through the technical exercise of planning; with the further political decisions demanded as a result of such specification, in particular with regard to the implementation of changes in resource allocation; and then with the extent of implementation of the more detailed PHC plans and programmes. Decision-making as a process was therefore given a broad interpretation.

All those involved in the study were aware of the delicate nature of the exercise. It is unusual for the political processes and administrative mechanisms of a major policy reorientation to be the subject of reports by governments to international agencies. Issues that arouse controversy, and processes that involve conflicts and disagreements, are not readily discussed publicly within countries, let alone internationally. Given this fact it is remarkable, and a tribute to the national teams, how much has been tackled in the country reports, sometimes explicitly, sometimes more by inference.

As will become clear, the analysis in the following pages of the change towards the PHC approach relates mainly to the country reports, but not exclusively. Acquaintance with situations elsewhere in the world, as well as with the literature on aspects of decision-making processes, has made it possible to broaden the scope of the treatment.

The cases studied: an overview of the participating countries

As has already been noted, the case studies were meant to represent a range of situations where progress has been made in the PHC approach. This creates some difficulty, however, in the exposition of this synthetic report, mainly because of the inclusion of one developed country (Finland) amongst six developing ones. Inevitably, the report must focus on the majority situation of the developing countries; to avoid tedium, the discussion does not constantly repeat this qualification. Nevertheless, the inclusion of a developed country was justified. First, it demonstrates that the PHC approach is not a second-class solution for poor countries,

but is applicable at all levels of socioeconomic development. Second, it points to some "social" areas of the approach which are more advanced in the developing country context and from which some developed countries can learn. Third, the Finnish experience in implementing resource shifts to PHC makes a valuable contribution to this study and is relevant at any developmental level.

Finland, with a gross national product (GNP) per head of US $7500 in 1978, may be most unlike the rest of the countries but the diversity among the others is also great. As regards GNP per head the next country in line is Papua New Guinea, with less than one tenth the figure of Finland (around US $650), while the poorest country studied, Mali, has a *per capita* GNP one-tenth again of Papua New Guinea (about US $70).

From the point of view of population, Costa Rica, Democratic Yemen and Papua New Guinea have around 2–3 million people; Finland has about 5 million; Mali and Mozambique follow with 7 million and 12 million respectively; and Burma is by far the largest with some 33 million. Finland, as expected, differs markedly from the other countries in the social and demographic composition of its population. Whereas in the other six countries the proportion of the population living in rural areas varies from two-thirds (Democratic Yemen) to almost nine-tenths (Papua New Guinea), 60% of Finland's people live in towns. This country has gone fully through the so-called demographic transition: its natural increase in population is no higher than 1.4% per year and the group aged less than 15 years is some 21% of the total. The natural population growth in most of the other countries is nearly double, and the under-15 age group represents 40–50% of the total population, a pattern typical of less developed countries.

The six developing countries of the study are also typical as regards their mortality and morbidity experiences. With the exception of Costa Rica, infant mortality rates (IMR) are high and not known precisely for these countries; overall estimates lie around 150 per 1000 live births for three of them, and around 100 per 1000 for Papua New Guinea. Burma's urban IMR is around 50 per 1000; no figure is available for the 75% of the population living in the rural areas. For Costa Rica the IMR is now under 25 per 1000 live births. Maternal mortality is also high in all the developing countries apart from Costa Rica. Morbidity presents the usual picture, with a predominance of nutritional deficiencies and communicable diseases, affecting particularly young children. The proportion of government expenditure for health care is around 5% for Democratic Yemen, 8–9% for Burma, Mali, and Papua New Guinea, and just over 10% for Mozambique. It is even higher in Costa Rica.

Politically, Costa Rica, Finland, and Papua New Guinea have a multiparty system with parliamentary institutions; all four other countries have one-party systems. Burma, Democratic Yemen, and