IS PRIMARY HEALTH CARE THE NEW PRIORITY? YES, BUT....

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ELEMENTS OF CHANGE

It is probably more dangerous to read history forwards than it is to read it backwards, but there can be little doubt that, when health historians come to chronicle innovation in medical care achieved in the seventies, they will put great emphasis on what we have come to call by the umbrella title of “primary health care” (PHC) or “community care”.

In a variety of planning instruments in many countries of the world, we can see reflected a recognition of the fact that, in the past, health care has been regressively distributed, with the result that the great majority of mankind are allowed to suffer diseases, disabilities and deprivations which the world community as a whole has the skill and resources to relieve. In order to focus more clearly the later and more contentious parts of this paper, it may be worth sketching out 5 areas in which the “centre of gravity” seems to be moving rapidly and which, taken together, constitute the elements of the new health strategy.

The most obvious element is the wider use of paraprofessional personnel as “frontline workers” who can better bridge the cultural gap between the healer and the healed. Less highly trained, this category of worker can nevertheless deal with the major treatable diseases in his/her locality, administer first aid and carry out simple (but often very effective) measures of preventive medicine. Recruited in greater numbers than more highly trained workers could possibly be, these paraprofessionals supply a greater “cover” of the population with primary care: secondary care is assured (in theory) by a referral service to more sophisticated units.

A second element is the relative downgrading of curative services and a relative upgrading of preventive services. Although there is a growing awareness of the interdependence of prevention and cure, (both technical interdependence in terms of acceptability), preventive medicine is decreasingly the slumland of the medical townscape. Partly as cause and partly as effect, health planners can now accept that much wider issues than the narrowly medical impinge upon preventive services. That brings us to the third element.

This is the gradual metamorphosis of traditional vertical programmes, centring on one disease or cluster of diseases, with a central directorate and a programme-specific field staff, to a much more integrated approach. This integration is beginning to transcend medical boundaries, so that we have seen in the last 5 years a double jump from highly specific vertical programmes within
the ministry of health to, first, integrated programmes with prime emphasis on prevention rather than detection and cure; and then a second jump to integrating the specifically medical service with programmes from the ministries of agriculture, public works, housing and transport, into programmes of genuinely (rather than cosmetically) integrated rural development.

That raises a fourth element; the shift of the spatial focus of health care from the densely settled urban areas, which offer all the benefits of cost-effectiveness, to the less densely settled and usually much less prosperous rural areas where the objective need may be greater but the costs of programme implementation are very high. I put it in these rather formal economic and technocratic terms because I think it is important to emphasize that the urban bias of health services had a logic (if a perverted logic) of its own. It did not result only from a wicked oligarchic plot to hog the largest share of the medical cake, (which is a picture that some more incautious left-wing critics tend to imply), but from an uncritical application of (basically Western) economizing algorithms to a situation of extreme resource scarcity. If medical facilities of all sorts are in desperately short supply, it is neither wicked nor foolish to deploy them where they are most likely to be used. That resources take the “wrong” form is a quite separate argument – though obviously a very important one – which historically came on to the agenda much later. The dethronement of cost-effectiveness and efficiency represents a remarkable “political” change, the more remarkable because it does not seem to fit any preconceived notion of the ideological commitment of governments.

The last element is in some ways analogous to the preceding ones. As there has been a political decision to jettison cost-effectiveness criteria in the health programme overall, (though such criteria may still be used at a high disaggregated or micro level), so there has been an increasing readiness to take back on board at least parts of “traditional” healing systems. There is little evidence of Western technology being jettisoned, (which is probably right); but there is quite a lot of evidence of a more serious approach to the daunting task of fusing Western technology with both traditional technology and traditional delivery systems.

Here, then, are 5 elements of change. To change the metaphor, we can think of each of them as a spectrum along which individual countries move at different paces and in response to various stimuli. There is no reason why progress along one spectrum should be at the same speed as progress along another spectrum. For instance, a country may go much faster in its switch from a curative bias to a preventive bias than it goes in its switch from a purely Western medical technology to a Western-cum-traditional technology. At this moment, then, we see a very wide range of practice. The one uniform feature is that there does seem to be in very many countries movement (or preparation for movement) along one or more of the spectra. Put the other way, I personally know of no significant evidence that any country is moving in the reverse direction, except perhaps as a temporary adjustment to acknowledged failure in a hitherto unexplored band of the spectrum. The almost universal experience of this progression (or readiness to progress) along the spectra is reflected in the deliberations of the World Health Organization and particularly in the main thrust of its programmes as agreed at the last Assembly.
THE NEED TO REDEFINE THE GOALS OF HEALTH CARE

The ball seems to be rolling then. And if the CMC played a part in giving it the initial kick, I hope it seems neither ungracious nor ingratiating to use this platform to ask 3 fairly difficult questions about the terrain in which the ball is now rolling. To stick with this metaphor a moment longer, I think we have all seen the goal fairly clearly from a distance and, (as is most effective on the football field), we have kept our eyes on the ball rather than on the goal. But, as the ball begins to travel towards the goal-mouth, it becomes increasingly appropriate to focus more precisely upon the goal. To anticipate the argument rather crudely, I am going to suggest that the goal is not quite what we thought it was; or, conversely, that if it was what we thought it was, then the ball is not going in the right direction. This, of course, is very embarrassing for us all. It implies that we have mis-specified the goal and, therefore, that we have a great deal more definitional work and strategy planning to do, just when we thought we were through with all that. Further, it raises the difficult and potentially contentious suggestion that some of us who hitherto have been playing on the same side with increasingly sophisticated teamwork may, in fact, find (because of our ideological colours) that we are kicking towards 2 very different goals: goals which do not coincide as closely as appeared when viewed from a distance. Again, back to the tedious business of defining the objective, but this time more acutely aware of the wider philosophical/ideological/political ramifications of that process.

Let me focus the issue by putting a straight question:

**Has the new emphasis of the democratization of health care become no more than a new form of professional domination?**

I do not seek to answer that question dogmatically. But I do want to suggest 5 areas of evidence which make the question worth asking; and perhaps make it worth asking with the expectation that the answer will be yes.

(a) The first area of evidence that I think is crucially important is the increasing evidence that comes from rural sociological and economic studies (practically worldwide) that the priority accorded to health care by villagers is under most conditions rather low. I say, “under most conditions”, because clearly there are occasions – e.g., a measles epidemic – when the morbidity and mortality rates rise so much above those that are commonly accepted as the norm that health care is temporarily shifted up the scale of priorities. But it is almost certainly shifted down again once the immediate crisis is past.

Although I do not pretend to have made a very scientific study of this, my hunch, based on a reading of a fair wedge of empirical work mostly in Asia and Africa, is that the priority accorded to health care varies directly with the “level of development” of the community, the higher the general level of income (as a proportion of the average wage in the modern sector); the greater exposure to mass media; the greater the aggregate urban experience of the community; the more
sophisticated the lifestyle of the community. The higher the priority is accorded to health care in both preventive and curative aspects.

Now, this means that communities that have traditionally been most poorly served are those that accord health care a rather low priority in the demands on community resources. Typically, education, easier access to a reliable (and clean, though this is seldom made explicit) water supply and better marketing opportunities are usually accorded a far higher priority than health care.

This suggests that in delivering health care either unisectorally or multisectorally to these less developed areas, we are responding to criteria and judgements of need that may be entirely defensible in some sense, but which certainly is not felt need. This may already go some way towards explaining why many of these programmes have proved so difficult to implement. I do not want to pursue that line of argument here although, as we shall see, it is not entirely irrelevant to later points. The immediately relevant issue that needs emphasis is this: a community adjusts culturally and possibly physiologically to a certain pattern of disease. To be responsive and responsible, our health planning has to take account of that process of adjustment. If it fails to do so, not only is it unlikely to be practically successful but, at a much deeper level, it stands in danger of threatening the cultural values and, therefore, the cultural and social stability of the community whose health in its deepest sense it is seeking to improve. What is this but professional domination, the imposition of a set of values which have their origin in a professional caste but which are not shared by those on whom they are imposed?

(b) Let me now pass to a second area of evidence. When villagers are asked what kind of health care they need or desire, (2 very different concepts which are notoriously difficult to keep separate in the field), they typically make the “wrong” choices. They say they want hospitals or larger clinics. They say they want a doctor in the village. They certainly show much more enthusiasm for Western curative medicine than for preventive medicine. In fact, they reflect their socio-medical conditioning almost embarrassingly well. Like ministries of health anywhere in the world, they show great reluctance to make the “hard” choices in the distribution of resources. If they see that sometimes a choice has to be made between saving one life or preventing 100 cases of gastroenteritis, they are unlikely to take it as self-evident that resources should be put into preventing 100 cases of gastroenteritis. Hierarchical social structures and status-based ascriptions of value may conflict head on with an egalitarian value system, possibly derived from a Judaeo-Christian origin. Which value system is to predominate? The local system (with its possibly very regressive distribution of resources) or the “professional” (with an attempt at an egalitarian distribution)? The basic PHC philosophy commits us to the latter; and therefore, the neglect and possible destruction of the former.

(c) If the balance of the empirical evidence is that our own ideology of health care is, in fact, not widely shared at the grassroots, there is also evidence that it is not widely shared by those
most immediately concerned with its implementation. By this I do not mean the opposition from
the medical profession. This was always to be expected; and if the conversion of (at least
elements of) the profession has in fact been both quicker and less traumatic than we might
reasonably have expected, that is not necessarily a case for jubilation. More worrying has been
the evidence that frontline troops very quickly learn to aspire to become generals. With the
wisdom of hindsight, it was perhaps naive to expect that we could fashion a new breed of
frontline health workers who would be content to be just that for the rest of their days.
Particularly was this the case if they were to be expected to earn their living by continuing their
original occupations as farmers for much of their time, practising their semi-skill in health care
on a part-time (and to some extent voluntary) basis. But even full-time, “adequately” paid
frontline health workers are not usually latter-day St Francis of Assisi. Though they may identify
with their patients in their natural habitat, the very process of the acquisition of the skill that by
definition those patients do not have; the acquisition of status within the community; and contact
with a much higher status group outside the local community together give them both
inducement and appetite for differentiating themselves further from their patients.

I use this sociological jargon in order to avoid seeming to pass judgement or to be wise after the
event. Merely by reducing the skill level of the frontline workers and to some extent reducing
their obvious identification with a largely alien “health service”, one does not thereby give them
the exceedingly high levels of altruism and selflessness required to remain in the job and on the
job with no prospect of career or financial advancement.

Looking at the experiments that have been going on over the past 5–7 years, then, we find that
one of the recurring problems in implementation is that of motivating and “making stick” the
frontline workers. I am told that, even in China, it is becoming more common practice for the
various types of frontline workers to become increasingly professionalized and highly (or at any
rate less rudimentarily) trained: a possibly gloomy analogue to the experience in Ceylon with the
assistant medical practitioners.

In what sense is this evidence of professional domination? It suggests that power in the
profession is still in the hands of the higher echelons of the fully trained. It is not usually in the
hands of the local community. Only in those (very few) countries in which there has been a
determined and sustained effort to transfer power to the local community is there an adequate
counterweight to the centripetal force of the profession. To put it crudely, the PHC strategy alone
is by no means an adequate attack on the structure of power within the profession.

(d) If neither the patients nor the medical workers have shown much enthusiasm for at least
elements of our ideology, it is perhaps inevitable that an increasingly serious problem is that of
the quality of care.

I realize that at this point I can be badly misunderstood, and indeed be transferred along the
spectrum from medicine red to medicine blue, in Maurice King’s now famous phrase. That is not
my intention at all. I am not appealing at all for the maintenance of inappropriate standards. But I am concerned that we all fully appreciate that reason why actual and potential patients sometimes like new models of health care no more than the old is because they associate them with a low quality of care, in both technical and human or personal terms. It is not fanciful to suggest that one reason why health care is given a low priority, particularly in rural areas, (and why unrealistic demands for “hospitals” are made when issues of health care are raised), is precisely because anything less is perceived as almost inevitably a medical shambles.

It may or may not be true that this is a short-run inevitability, analogous to the almost universal experience of declining educational standards during periods of extremely rapid growth in enrollment. But when diagnostic accuracy declines to (or perhaps remains at) less than 20%, it is debatable whether the cultural intrusion of Western or neo-Western standards and forms of medical care are worth the candle.

Are we absolutely certain that, seen in its widest social context, (which I think most of us would agree is much wider than the purely medico-scientific), low-quality care is to be preferred to the traditional systems of care that it seeks (either actively or passively) to displace?

Let me be clear at this point. I am not arguing that we must wait until a “high” quality of care can be guaranteed and distributed equitably before we invest any resources at all in PHC. I am arguing rather than we at least need to ask whether an equivalent amount of resources invested in traditional types of health care – e.g., in upgrading “village midwives” or extending the range of a herbalist’s stock of remedies by the inclusion of non-local or even imported remedies – would not have a greater impact on the level of morbidity and mortality than a (highly inefficient) “scientific” health care system. Obviously, much depends on how effectively the traditional sector could be mobilized for preventive work. My suggestion is that the probability that it could be no less effective than the “modern” sector is sufficiently high to make more vigorous investigation worthwhile. But, hardly surprisingly, the modern sector has consistently resisted such investigation.

(e) The fifth issue can be raised rather more briefly. One of the major forces behind the PHC emphasis has been the observation that many common diseases are widespread or even nearly universal in populations largely untouched by “modern” medicine. But we have recently acquired evidence that communities adjust to these levels of disease, or at least some of them, culturally, socially and, to a small number, physically. Certainly, a team with which I worked in Zambia was unable to find any compelling evidence of the impact of parasitic diseases on agricultural effort or school performance. Interestingly, an American team under Weisbrod has recently produced directly corroborative evidence from St. Lucia. Let me emphasize again that neither study is wholly satisfactory methodologically. The complexity of the issues, the difficulties of field work, the interrelations amongst the many variables that have to be observed or controlled make detection unusually difficult. But it is surely beginning to look as though “health need” is, to put it at its lowest, a much more subtle concept than either health economists
or medical sociologists have in the past generally believed. As Joyce Leeson has argued, “health need” cannot be defined purely in clinical terms; it has to take account of cultural and social variables: variables which health planners have not begun to identify, much less seriously respond to. Hitherto, the epidemiologist has been king; it is time he was dethroned. Let him now take his place in a Council of Equals in which seats will also be allocated to anthropologists, sociologists, and representatives of the sick and the healthy.

But if “health need” is so subtle a concept, what guarantees have we that the PHC strategy responds to this subtlety? In theory, the guarantee is that the local community is closely involved in the definition of health need and in the priorities of the provision of health care. But all depends on the form in which the dialogue is cast. If the choice before the community is the disposition of uneamarked resources, (that is, resources that are not ostensibly linked to “health” or “agriculture” or “water”), there is a fragile chance that this subtlety will be protected. But “community involvement in decision making” can easily become a charade in which the decisions are compressed into so narrow a focus that we have again to recognize patterns of domination (e.g., “Do you want the clinic here or there? Ten beds or twelve? Which do you want to tackle first – malaria or hookworm? ...”).

We have here, then, 5 areas of evidence that I suggest we need to ponder rather carefully. To recap briefly, these are:

1. Local communities tend to give health care low priority.
2. They tend to make the “wrong” choices when given the opportunity to express their own preferences in terms of delivery systems: at an interpersonal level, they do not necessarily accept medical equality.
3. Community-based health strategies have proved extremely difficult to implement, partly (but only partly) because frontline workers are rapidly professionalized.
4. New health strategies may deliver health care to more people, but tend to deliver an extremely low quality of health care to the majority of those people.
5. We have probably overestimated the effects of disease on a community, and underestimated its cultural and possibly physical adaptability to a given burden of disease.

I have argued that each of these could provide evidence, (which I have deliberately not rehearsed in detail), that PHC strategy alone does not deliver us from the kind of professional domination we all associate with hospital-based curative services. This is not, not to say that PHC is a blind alley, or wrong or a mistake. Please let us be clear about that. It is to say that an overly naive espousal of PHC strategy, without a readiness to face deeper issues, is likely to result in bitter disappointment. For, to anticipate a moment, PHC strategy depends upon fallen humanity (both as healer and would-be-healed) and therefore upon fallen institutions. It, like everything else, is cast in an environment of original sin. This is a theme to which we must return. For the present let us limit the discussion to one central point.
The CMC and its many friends have been wholly justified in declaring war on the medical ideology of the middle sixties. The question I am asking is whether, in producing a substitute ideology, we are not in danger of doing the same violence to people and to communities, (though perhaps for higher motives), as did the people and institutions with which we have been struggling. Is there not a danger that the new set of ideas becomes as dominating, as dehumanized, as ultimately demonic as the old set of ideas? If we really seek to respond to the situation as it is, to respect the whole personality of the community and individuals within it, might we not come out with a very different set of assumptions, strategies and tactics; and might not those assumptions, strategies and tactics have very little, at least overtly, to do with what we have traditionally regarded as health care?

This takes me on to a new point, and a second hard question. The question can be put like this:

**Is community health care as readily institutionalized as any other social service?**

Precisely because the PHC emphasis has already become widely accepted, (if not yet widely implemented), there is surely a danger that it will suffer from a hardening of the administrative arteries and a blunting of sensitivity that will change it from a potential asset to a certain liability.

If one looks at the literature on community services in general, (and person-directed community services in the United States and the United Kingdom in particular), one is impressed by the ease with which an institution subverts the end for which it was created as a means into a means by which its own end can be justified. Within the last 6 years, many studies have revealed how, in our own Western countries, services that were established to deal with “the hard cases” have become extremely adept at developing administrative rules whereby the really hard cases are excluded, with the result that the service becomes available to the less hard, the more easily managed, the more administratively safe.

I see no reason to assume that this tendency is confined to one particular culture or one particular kind of organization. It seems to me to stem much more from the nature of fallen humanity and, when put together with the 5 bits of evidence I adduced for the first question, it does seem to me to suggest that even PHC stands in great danger of developing an institutionalized hierarchy of beneficiaries which will systematically exclude those who stand in the greatest need of health care, and in whose name the original moral impetus of PHC was generated.

This administrative distortion I see as an internal threat: it is paralleled and indeed aggravated by an external threat. That threat is the tendency for governments to see the provision of health care as part of the process by which the government itself is legitimized. To some extent, this is true of all social services; and to some extent, it is a proper and healthful response of government to popular pressure. The danger arises because different social groups are capable of threatening governments to different degrees. Different social groups can therefore demand different levels of tribute; and health care is one form that tribute can take. Put at its crudest, this tends to suggest that once PHC develops its own institutional momentum and its own administrative rigidities, we
may well find that it is subject to the same distributional biases as was the curative, hospital-based, “undemocratic” structure of health care. Whenever and wherever there are resources to be distributed, they will be distributed in response to political pressures. The changing of the health package (in its widest sense) does not much affect that basic fact of political life.

Taken together, then, the internal and the external pressures on the community health care strategy will at the very least much moderate the effectiveness of that strategy in reaching the poorest and the most powerless.

So far, I have asked questions about:

(a) the extent to which PHC has become a new form of professional domination, and
(b) the extent to which it has been, is being and will be institutionalized in a way that prevents it from effectively reaching those who need it most.

If these are valid questions, we have to ask:

What then? What can be done?

What, particularly, can be the reaction of the CMC or its successors? Part of the answer is already clear. In discussing both of the basic questions I have tried to ask, I suggested that what one is up against is human beings as they are. Because one is up against people as they are, one is also up against institutions as they are, mirrors and magnifying glasses of humanity’s moral and cultural ambiguities. Both as dispensers and recipients of health care, individuals-in-community are severely limited in their ability to give or receive health. The fundamental problem that faces us, therefore, is to enlarge that ability.

CONCLUSIONS

The process by which that is done can be ascribed a variety of different labels according to ideological or ethical positions. It can be called conscientization. It can be called liberation. It can be called cultural revolution. Or it can be called salvation. I’m not suggesting that these are either the same or even roughly equivalent; I am suggesting that we are all looking for ways in which the delivery of health care does not become subverted into the protection of a profession; and for ways in which the receiving of health care does not become distorted into a process by which my neighbour is robbed.

Here I think we glimpse something that the CMC has always emphasized, even if sometimes obliquely, namely, that health and salvation are mutually interdependent in every human society, irrespective of culture, political allegiance or level of gross national product (GNP). That interdependence is worked out, not only at the individual level, but also at the macro or social level. The personality of professional and patient is determined by what a passing generation of theologians called the state of grace, and the social milieu in which the personality is formed and
lived. Thus, salvation does not, cannot and must never be allowed to have a purely personal reference. Salvation is a social process as well as an individual liberation.

The question remains: in operational terms, how can we make real this dawning perception that, in all our societies, rich quite as much as (perhaps even more than) poor, the processes of being healthy and making others healthy have to them a dimension completely ignored by traditional thinking. This is a dimension that acknowledges that the people (both healer and healed) and the institutions are in continuous need of liberation, renewal and “at-one-ment”: a need that the biblical tradition calls salvation, but which could often be equally well translated as wholesomeness, or healthfulness? In developed and underdeveloped countries, how do we bring healing and wholeness, not only to the sick, but to those who purport to cure the sick? When we do that, what are the implications for the relationship between the practitioner and the patient, the curer and the cured? This will doubtlessly need much further investigation, but one implication is clear. That relationship ceases to be a relationship between the sick and the healthy. It becomes rather a relationship between 2 people or groups both of which know that they are less than whole and both of which are seeking to find a greater degree of wholeness.

I know that some of what I have said is contentious and may spark challenge and even fundamental disagreement. So be it. But at the risk of seeming to confound confusion, let me make one final comment. If what I have said is even roughly right, there is clearly a limit to the extent to which the CMC, the Christian Medical Commission, can collaborate with agencies which deny to the concept of health the element of transcendental wholeness as expressed in the last paragraph. It is possible that some of these agencies will see that the physician is as much in need of healing as the sick. The real question will be: where will the agencies look for the spiritual resources for the healing of the physician? The Christian answer is (more or less) clear. Can we devise experiments which show those resources in action? Or perhaps they are already at hand?