PRIMARY HEALTH CARE

The basis for health systems strengthening

FREQUENTLY ASKED QUESTIONS

World Health Organization
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Frequently asked questions

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Message from the Regional Director

More than three decades after the Alma-Ata Declaration on Primary Health Care, there is growing realization that the concepts and approaches elaborated in 1978 continue to remain valid. The continuing and sometimes widening gap between the health status of people within and among countries is a matter of concern. With only a short time remaining for the Millennium Development Goal (MDG) deadline of 2015, the need for ensuring universal coverage with cost-effective public health interventions is of paramount importance. Primary health care (PHC) aims to provide quality and comprehensive health care in a cost-effective and equitable manner, and is the foundation for health systems strengthening.

Several opportunities for health systems strengthening are available to countries. These include the health systems strengthening components of the Global Alliance on Vaccines and Immunization (GAVI) and proposals supported by the Global Fund to fight AIDS, Tuberculosis and Malaria and other global health initiatives. Application of PHC principles to these proposals will go a long way in ensuring sustainable and effective health systems strengthening.

On the occasion of the 30th anniversary of the Alma-Ata Declaration in 2008, the WHO Regional Office for South-East Asia (WHO/SEARO) had organized a Regional Conference on Revitalizing Primary Health Care. A booklet entitled *30 Frequently asked questions on primary health care* was produced to mark the occasion, which was well received. Since then, WHO/SEARO has received several requests for reprints. This publication attempts to clarify the concepts of PHC and suggest how it may be applied to health systems strengthening.

This booklet does not claim to be exhaustive but aims to answer some common questions and concerns regarding PHC-based health systems strengthening. It is hoped that students of public health, health planners, programme managers and public health professionals will find this useful. WHO/SEARO will welcome feedback to effect improvements in future editions.

Samlee Plianbangchang

Dr Samlee Plianbangchang
Regional Director

Acronyms and abbreviations

CBHW	community-based health worker
CHV	community health volunteer
GAVI	Global Alliance on Vaccines and Immunization
Global Fund	Global Fund to fight AIDS, Tuberculosis and Malaria
HFA	Health for All
MDG	Millennium Development Goal
PHC	primary health care
PHEIC	public health emergency of international concern
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization

FREQUENTLY ASKED QUESTIONS

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Q1 What is primary health care? How is it different from primary care?

Primary health care (PHC) is an approach to health development. It is a broad and comprehensive concept that places national health development within the overall social and economic development, as embraced in its definition: "*PHC 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 of both 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*".[1]

Primary care refers only to the first level of contact or close-to-client health care.[2] This first level of contact varies from country to country and by geographical area. In rural areas, this contact is usually with the health centre, health subcentre, health post or private practitioner (doctor, nurse or midwife). In urban areas, a majority of the middle- and upper-income group visit a private practitioner, who may be a general practitioner or a specialist, or go directly to a hospital. In many countries, the so-called family doctor serves as the first point of contact. Primary care is an integral component of primary health care.

[1] *Declaration of Alma-Ata*. International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978. Available at: http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf (accessed on 26 June 2010).

[2] Primary care. *Mosby's Medical Dictionary*. Eighth edition. Elsevier, 2009.

Q2 Why is PHC always associated with the Alma-Ata Declaration?

PHC and Health for All (HFA) are part of the Alma-Ata Declaration that marks the commitment of UN Member countries towards achieving a more equitable health status across the world, particularly in developing countries. The Declaration was the result of a joint World Health Organization (WHO)/United Nations Children's Fund (UNICEF) International Conference on Primary Health Care held at Alma-Ata (now called Almaty), the capital city of the Kazakh Soviet Socialist Republic, from 6 to 12 September 1978.[1]

Q3 Do developed countries also adopt PHC for health development?

Yes, they do. A common misperception about PHC is that people think it is meant only for poor developing countries.[3] Others think that it is cheap care for the poor and for those living in rural areas. This perception is totally incorrect and needs to be changed. In fact, PHC is a universal concept for health development, as articulated in its definition.

Q4 The last part of the PHC definition says that it is "a continuing health-care process". What does this mean?

A "continuing health-care process" implies that health care does not stop at the primary level of care or at the first point of contact. If more comprehensive or sophisticated care is needed, the patient will be referred to a higher level of care – either secondary or tertiary. These levels of care are usually hospitals equipped with sophisticated equipment and technologies, and are manned by various specialists

[3] World Health Organization. *Primary health care*. Geneva, WHO, 2010. Available at: http://www.who.int/topics/primary_health_care/en/ (accessed on 26 June 2010).

besides general practitioners. The tertiary-care level is the most sophisticated.

Q5 When we refer to PHC in a particular country, what do we actually mean?

Before answering this question, it is important to know that the PHC concept encompasses three intertwined perspectives or aspects. These are:

a. a package or a set of activities
b. level of care
c. an approach, which has been used interchangeably with the terms *PHC principles*, *PHC pillars* and *PHC strategy*. [4]

- As a package of activities, the contents of the package evolve with changes in the pattern of health problems. In 1978, it was agreed that the package should consist of at least eight elements (*see* Q.16) in which preventive and promotive measures were emphasized without neglecting curative and rehabilitative measures. In other words, the emphasis in PHC is to achieve a balance between public health and medical care.
- The second aspect of PHC is the level of care – *primary*, *secondary* and *tertiary* levels. PHC emphasizes the primary level of care or, as explained earlier, the first level of contact with the health services.

  This emphasis on primary care does not, however, suggest that the higher levels of care are not important. On the contrary, secondary and tertiary care is mandatory to provide the necessary back-up services and supportive supervision so as to achieve a continuum of quality and safe care. It is this link that is frequently missed, leading

[4] WHO. *Primary health care approach.* Cairo, WHO Eastern Mediterranean Regional Office. Available at: http://www.emro.who.int/mei/PHC.htm (accessed on 26 June 2010).

to an erroneous perception that primary care is second grade and of low quality.

- The third aspect of PHC is PHC as an approach. This aspect explains how the PHC concept materialized in practice. First and foremost, PHC adheres to its *social values*, i.e. *equity* and *social justice*. Aiming for equity is the most important value not only for health outcomes and access to health care but also for its applicability to social determinants of health such as education, income or wealth, geography and gender.

Q6 How do we define equity in health?

WHO has operationally defined "equity in health" as "minimizing avoidable disparities in health and its determinants – including but not limited to health care – between groups of people who have different levels of underlying social attributes".[5]

Differences in social attributes are reflected by political, social, economic, geographical, gender, ethnic and age differences. Health or health status is determined *not only by health care*, but also by the *other non-health determinants* mentioned above.[6]

Thus, minimizing the disparities in health between different groups requires special efforts on the part of the health sector to deal with disparities in risk factors, which, in turn, arise from socioeconomic and gender disparities. Hence, achieving equity in health will be easier if there is equity in the other determinants of health as well. Experiences in Europe show that even in relatively affluent nations that emphasize equity

[5] WHO SEARO. *Equity in access to public health*. Report and documentation of the technical discussions held in conjunction with the 37th Meeting of the CCPDM. New Delhi, 31 August 2000. New Delhi, WHO, 2000 (Document No. SEA-HSD-240).

[6] WHO Commission on the Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health*. Geneva, WHO, 2008. Available at: http://whqlibdoc.who.int/hq/2008/WHO_IER_CSDH_08.1_eng.pdf (accessed on 29 July 2010).

in access to health services, there are *significant disparities/gaps/differences* (thus inequity) in health status, such as those reflecting more fundamental social disparities in socioeconomic status, education, and working and living conditions.

WHO's definition of "equity in health" encompasses two different aspects.[5]

- ***Equity in health (health status)*** means the *attainment by all citizens* of the highest possible level of physical, psychological and social well-being.
- ***Equity in health care*** means that health-care resources are allocated according to *need*; health care is provided in *response* to the legitimate expectations of the people; health services are received according to *need* regardless of the prevailing social attributes, and payment for health services is made according to the *ability to pay*.

Q7 How does PHC aim to address inequities in health?

PHC addresses inequity in health by advocating the following approaches:[7]

i) universal coverage,
ii) intersectoral collaboration,
iii) community participation, and
iv) appropriate technology.

Achieving *universal coverage* of health care across socioeconomic groups is the centre stage of the PHC approach. To this end, *intersectoral collaboration* needs to be pursued vigorously in dealing with the risk factors and social

[7] WHO. *Alma Ata and the principles of the PHC approach*. Cairo, WHO Eastern Mediterranean Regional Office. Available at: http://www.emro.who.int/mei/PHCalma.htm (accessed on 26 June 2010).

determinants that affect health, which fall under various domains beyond health.

Good health is an outcome of the interplay of several determinants – social, economic, environmental and political.[6] *Intersectoral collaboration* of the health sector with other sectors such as education, water and sanitation, nutrition, agriculture and industry is necessary to ensure optimal health outcomes for different segments of the population.

Community participation is best achieved through educating and empowering the community in general and women in particular. Education, income generation and gender equality are some pre-requisites for empowerment. Community education and empowerment not only lead to appropriate health behaviour but also enable the community to demand good-quality health care.

Appropriate technology is also crucial for achieving universal access to health care, not only in resource-constrained countries but indeed in all countries. Utilization of appropriate technology will also contribute to improving efficiency in the health system.

Q8 Three decades have passed since the Alma-Ata Declaration. How has the PHC concept evolved since then?

This is a very important issue. While the basic pillars of PHC remain valid, the evolving political, socioeconomic, demographic and epidemiological situation has led to fresh thinking on PHC.

The *World health report* 2008[8] has examined the evolution of the PHC concept over time. The following table summarizes the evolving focus of the PHC concept.

[8] WHO. *World health report 2008. Primary health care: now more than ever*. Geneva, WHO, 2008. Available at: http://www.who.int/whr/2008/whr08_en.pdf (accessed on 27 July 2010.

Early attempts at implementing PHC	Current concerns of PHC reforms
Extended access to a basic package of health interventions and essential drugs for the rural poor	Transformation and regulation of existing health systems, aiming for universal access and social health protection
Concentration on mother and child health	Dealing with the health of everyone in the community
Focus on a small number of selected diseases, primarily infectious and acute	A comprehensive response to people's expectations and needs, spanning the range of risks and illnesses
Improvement of hygiene, water, sanitation and health education at village level	Promotion of healthier lifestyles and mitigation of the health effects of social and environmental hazards
Simple technology for volunteer, non-professional community health workers	Teams of health workers facilitating access to and appropriate use of technology and medicines
Participation as the mobilization of local resources and health-centre management through local health committees	Institutionalized participation of civil society in policy dialogue and accountability mechanisms
Government-funded and delivered services with a centralized top–down management	Pluralistic health systems operating in a globalized context
Management of growing scarcity and downsizing	Guiding the growth of resources for health towards universal coverage
Bilateral aid and technical assistance	Global solidarity and joint learning
Primary care as the antithesis of the hospital	Primary care as coordinator of a comprehensive response at all levels
PHC is cheap and requires only a modest investment	PHC is not cheap: it requires considerable investment, but it provides better value for money

Q9 How can we define "health system"?

A health system consists of all organizations, people and actions whose *primary intent* is to promote, restore or maintain health.[9,10] This includes efforts to influence the determinants of health as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example, a mother caring for a sick child at home; private providers; behaviour change programmes; vector-control campaigns; health insurance organizations; occupational health and safety legislation. It includes intersectoral action by health staff; for example, encouraging the ministry of education to promote female education, a well-known determinant of better health, and the ministry of transport to mandate the use of safety belts to prevent severe injury to the driver and passengers of motor vehicles.

Q10 What is the difference between health system and health care service?

Health systems are much broader than health services. Health services refer to medical and public health services provided by both the government (the health sector) and the private sector.[11] They cover modern and traditional medicine as well as services provided by the community.

[9] World Health Organization. *The world health report 2000 – health systems: improving performance*. Geneva, WHO, 2000. Available at: http://www.who.int/whr/2000/en/index.html ` (accessed on 26 June 2010).

[10] World Bank. Healthy Development. *The World Bank Strategy for HNP Results. What is a health system?* New York, The World Bank, 2007. Available at: http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1154048816360/AnnexLHNPStrategyWhatisaHealthSystemApril242007.pdf (accessed on 26 June 2010).

[11] World Health Organization. *Health services*. Geneva, WHO, 2010. Available at: http://www.who.int/topics/health_services/en/ (accessed on 26 June 2010).

Q11 What is meant by health systems strengthening based on the PHC approach?

The main objective of PHC is to provide a continuum of preventive, promotive, curative and rehabilitative care and not just medical care alone. The PHC approach aims at people-centred care that offers universal coverage, social equity and financial protection.

A health system which is based on PHC is one that aims to provide cost-effective, comprehensive, equitable and quality care to the entire population including the poor, the vulnerable and the marginalized. All measures taken to achieve this constitute health systems strengthening based on the PHC approach.

Q12 Before moving further with the health system, can we revisit the Health for All (HFA) by the year 2000 movement, since like PHC the world is also committed to HFA 2000?

Similar to PHC, misperception also prevails regarding HFA. "Health for All", as articulated in the Alma-Ata Declaration, did not mean that in the year 2000, health professionals will provide health care for everybody.[1, 12] HFA did not mean that in the year 2000 nobody would be sick or disabled. HFA is actually a vision of health development. For this reason, HFA does not need a concrete time line, although the target set by the Alma-Ata Declaration to achieve well-defined targets was the year 2000. The world admits that, till date, HFA has not been achieved, but HFA remains a goal to be aspired for. Strengthening PHC is an approach to HFA.

[12] World Health Organization. *Global strategy for health for all by the year 2000*. Geneva, WHO, 1981. Available at: http://whqlibdoc.who.int/publications/9241800038.pdf (accessed on 26 June 2010).

Q13 How can we define "Health for All"?

Health for All (HFA) is a social goal. HFA aims at providing the highest possible level of health to all people so that they are able to live a socially and economically productive life.

HFA can be defined as: *a stage of health development whereby everyone has access to quality health care or will practise self-care protected by financial security so that no individual or family experiences catastrophic expenditure that may bring about impoverishment.*[1] HFA is a process leading to progressive improvement in the health of the people. It translates into the following:

a. People will be enabled to use better approaches to prevent disease and alleviate unavoidable disease and disability through the life course.

b. Available resources for health will be evenly distributed among the population.

c. Essential health care will be accessible to all individuals and families in an acceptable and affordable way, and with their full involvement.

d. People will realize that they themselves have the power to shape their lives and the lives of their families. They will be free from the avoidable burden of disease, and aware that ill-health is not inevitable.

Q14 What is the connection between HFA and the Millennium Development Goals (MDGs) to be achieved by 2015?

The MDGs were adopted by all United Nations Member States in 2000.[13] The MDGs have become a universal framework for development and a means for *developing countries and their development partners* to work together in pursuit of a shared future for all. The MDGs gave continuity to the values

[13] United Nations General Assembly. *Resolution 55.2. United Nations Millennium Declaration.* 2000. Available at: http://www.un.org/millennium/declaration/ares552e.pdf (accessed on 26 June 2010).

of social justice and fairness articulated at Alma-Ata in 1978. They further affirmed the central place of health on the development agenda, as a key driver of social and economic productivity and a route to poverty alleviation.

We can consider the health MDGs as the *mission or objective* of HFA till 2015. They simultaneously serve as proxy indicators for HFA.

Q15 How optimistic are we of reaching the target of the health-related MDGs by 2015?

The health-related MDGs are largely achievable if countries act now. This will require sound governance, increased public investment, economic growth, enhanced productive capacity, and *strengthening of health systems*. Revitalizing PHC will accelerate progress towards achieving the MDGs.

Q16 There are so many technical terms in the definition of *health system using the PHC approach*. Shall we visit them one by one?

We will start with comprehensive care. Many health experts use the term *comprehensive PHC* instead of comprehensive care.[14] Comprehensive PHC emphasizes that improvement in health-care delivery systems is only one aspect of health-care reforms. Health and health care are regarded as basic human rights that require community participation in decision-making and implementation of PHC activities. It also recognizes that improvements in health have been due to changes in the economy and social and political structures, rather than changes in the health sector alone.[15]

As defined in the Alma-Ata Declaration, comprehensive PHC

[14] Obimbo EM. Primary health care, selective or comprehensive, which way to go? *East African Medical Journal*, 2003, 80:7–10.

[15] Navarro V. A critique of the ideological and political position of the Brandt Report and the Alma Ata Declaration. *International Journal of Health Services*, 1984, 14:159–172.

refers to PHC that comprises a package or set of activities.[1] Please remember that PHC encompasses three intertwined perspectives or aspects (*see* Q. 5). In 1978, the comprehensive package included at least the following:

1) Education on prevailing health problems and methods for preventing and controlling them
2) Promotion of food supply and proper nutrition
3) An adequate supply of safe water and basic sanitation
4) Maternal and child health care, including family planning
5) Immunization against major infectious diseases
6) Prevention and control of locally endemic diseases
7) Appropriate treatment of common diseases and injuries
8) Provision of essential drugs.

It is important to note that the Alma-Ata Declaration emphasized that these eight items are a minimal list. This implies that the items are context specific and may be adjusted to meet a country's specific needs.

Q17 Is there any other type of care other than comprehensive care?

After the Declaration of Alma-Ata, a debate on the possibilities for implementation was opened. Two major schools of thought dominated the debate: those supporting "selective" PHC and those advocating "comprehensive" PHC, which is discussed in the previous question.

A "selective" approach attacks the most severe public health problems facing a locality in order to have the greatest chance to improve health and medical care in less developed

countries.[16] Selective PHC, or the more frequently used term "vertical approach", refers to the implementation of a single disease programme that may have a significant impact on reducing high morbidity and mortality within a short time frame.[16] Some examples are polio eradication, making pregnancy safer, immunization programme, control of HIV/AIDS, tuberculosis and malaria. Of late, however, more and more donor agencies realize that selective PHC cannot be sustained without strengthening the fundamentals of health systems. Funding agencies such as the Global Alliance on Vaccines and Immunization (GAVI) and the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) now promote health systems strengthening.

Q18 The second technical term related to health systems strengthening is *affordable care*. What does this imply?

Affordable care relates to the ability of an individual or a family to pay for health care. The maximum ability to pay has been estimated to not exceed *40% of non-food expenditure* of an individual's or family's income. Expenditure beyond this limit is categorized as *catastrophic expenditure*. In many societies, catastrophic health expenditure is a major cause of impoverishment.[17]

Q19 The third term is *equitable care*. How is it different from equality in care?

First, let us look at the notions of *equity* and *equality* or *inequity* and *inequality*.

Equity is an ethical concept that eludes a precise definition.[18]

[16] Walsh JA, Warren KS. Selective primary health care: an interim strategy for disease control in developing countries. *Social Science and Medicine*, 1980,14:145–163.

[17] Ke Xu et al. Household catastrophic health expenditure: a multicountry analysis. *The Lancet*, 2003,362:111–117.

[18] Braveman P, Gruskin S. Defining equity in health. *Journal of Epidemiology and Community Health*, 2003, 57: 254–258.

Synonyms are *social justice* and *fairness*, which again, could be taken to mean different things by people at different times. Equity usually deals with a predetermined standard or norm, which is considered "just" or "fair".

There are three dimensions of equity:

Focus: Equity in health mainly focuses on the health of the *vulnerable* population in absolute rather than relative terms. A policy or programme aimed at improving the health of the most vulnerable would be seen as being *equitable*.

Inclusion: No one in the community should be left out. In this view, a health policy that does not provide health care to certain population groups, e.g. people living in thinly settled, remote, mountainous, island or desert areas would be *inequitable*.

Narrowing gaps: Equity measurement identifies the relative and absolute gaps in health status. Thus, a policy that improves the *health of the best off* more than anyone else would not be considered equitable.

Equality: Equality does not take into account whether the existing disparity/gap/difference is "fair or just". In practice, *the terms equity and equality are used interchangeably*. [19]

Q20 Another technical term is *quality of care*. How important is this aspect?

Quality is perceived differently by the consumer (patient) and the service or health-care provider. Consumers usually associate quality with non-medical matters such as *responsiveness* of the services (which covers elements such as quality of food, amenities, social acceptability) and behaviour of the provider. The provider considers

[19] Culyer AJ, Wagstaff A. Equity and equality in health and health care. *Journal of Health Economics*, 1993, 12: 431–457.

appropriateness of care (which also includes responsiveness to a legitimate consumer's need), adherence to standard operating procedures, effectiveness and efficiency of care, and patient safety as the main components of quality care.

Q21 The final technical term appearing in the definition of health system is *cost-effectiveness of the interventions*. How does this differ from cost and benefit of interventions?

The term *cost-effectiveness*, to some extent, reflects the efficiency of different health interventions. For example, an immunization programme can prevent 10 deaths among children below the age of five years. A case treatment programme with a similar cost as the immunization programme for the same disease that is preventable through immunization and affecting a similar age group can prevent five deaths. In this case, we say that the immunization programme is more cost-effective than the treatment programme. In a cost–benefit analysis, a comparison is made between the *benefit-to-cost* ratio of two or more interventions. The intervention having the highest benefit-to-cost ratio is preferable. Measuring the efficiency of an intervention is much more tedious than measuring its effectiveness. We can, of course, minimize inefficiency by minimizing *allocative* and *technical inefficiency* (*see* Q. 22).

Many essential health-care packages, including the one proposed by the Commission on Macroeconomics and Health,[20] are based on cost-effectiveness. It must be remembered that other factors besides cost-effectiveness, such as feasibility of implementation and acceptability by the community at large, have to be taken into account in developing such a package.

[20] World Health Organization. *Macroeconomcs and health: investing in health for economic development. Report of the Commission on Macroeconomics and Health*. Geneva, WHO, 2001.

Q22 What is the difference between *allocative inefficiency* and *technical inefficiency*?

Allocative inefficiency occurs when more health funds are allocated towards less cost-effective interventions. For example, allocating an unnecessary amount of funds to medical care as opposed to public health interventions would qualify as allocative inefficiency. Overall, public health interventions (disease prevention and health promotion) are more cost-effective than medical care (treatment of cases and rehabilitation of disabilities).

Technical inefficiency is said to occur when we choose sophisticated technologies that may be unnecessary instead of available and appropriate technology.

Q23 Why is it necessary to attempt health systems strengthening based on PHC?

Health systems strengthening based on PHC seems to be the best way to ensure equity in health outcomes and health system efficiency. It will address the following issues:

- PHC promotes comprehensive care with a focus on public health interventions (health promotion and disease prevention) balanced with medical care (curative and rehabilitative care). Public health interventions are much more cost-effective in reducing the disease burden compared with medical care.
- The focus of PHC on primary care supported by good referral care can result in better equity in access to care and health outcomes.
- PHC promotes greater utilization of community-based resources (such as community based health workers [CBHWs] and community health volunteers [CHVs] who are close to the community). This makes health services more accessible, affordable and acceptable.

- It can prevent high out-of-pocket expenditure by individuals in accessing health services and contribute to minimizing catastrophic expenditures on health.
- PHC empowers the community to actively participate in health-care delivery. This makes health care more responsive to their legitimate needs, more transparent and more accountable.
- PHC forges intersectoral collaboration. It has the potential for attracting greater attention to health through reflection of health issues in other sectoral policies leading to "healthy public policies".

Q24 What are the actions needed for PHC-based health systems strengthening?

a. *Reaffirm high political commitment toward PHC.* Governments should strongly support the concept and implementation of PHC through health systems strengthening as well as health development. Allocation of funds to public health should be prioritized.

b. *Improve health equity through specific actions* in the health sector as well as other sectors that influence health outcomes, i.e. the social determinants of health. Equity or social justice is the most salient feature of PHC. Pro-poor policies in national development in general and in health in particular should be continually promoted.

c. *Foster more effective multisectoral collaboration* for establishment and implementation of a healthy public policy, i.e. policies of other sectors beyond health which promote health. Health impact assessment is one manifestation of a healthy public policy, which should be implemented along with environmental impact assessment. Implementation of a healthy public policy is becoming more important in the light of climate change.

d. *Strengthen the health workforce* including CBHWs and CHVs.

e. *Implement equitable health-care financing* such as tax-based and social health insurance, and various forms of community-based health financing. Out-of-pocket health expenditure has been blamed as one factor that leads to widening health inequity and, at the same time, increases the numbers of the poor.

f. *Promote better transparency and accountability* of health systems through improved leadership and governance (stewardship).

g. *Utilize to their fullest various global health initiatives* (e.g. GAVI and Global Fund) and partnerships in health (International Partnership in Health), which have shown an interest in health systems strengthening.

Q25 One hears the term "public goods" in the context of health systems. What is a public good?

The United Nations Development Programme (UNDP) defines a *global public good* as a public good with benefits that are strongly universal in terms of countries, people and generations.[21] In the area of health, it refers to health issues that need concerted efforts from all countries to prevent spread across the globe. Included in this category are diseases that have the potential to cause a pandemic. A country that mounts a good response to contain a communicable disease will benefit other countries without their having to pay a penny. In dealing with global public goods, the International Health Regulations, 2005 uses the term public health emergency of international concern (PHEIC). [22]

[21] United Nations Development Programme; Kaul I, Grunberg I, Stern MA, eds. *Global public goods: international cooperation in the 21st century.* New York, Oxford University Press, 1999.

[22] Health Organization. *International health regulations, 2005.* Second edition. Geneva, WHO, 2008. Available at: http://www.who.int/ihr/9789241596664/en/index.html (accessed on 26 June 2010).

Public goods are "non-excludable". This means that the benefits of the goods are available to all. Further, public goods are "non-rivalled". This means that consumption of a good by one person does not exclude consumption by others. Health promotion and communicable disease control programmes are examples of public goods.

Q26 Another term used in the context of health systems development is "externality". What does this mean?

The World Bank defines externality as the result of an activity that causes incidental benefits (desirable effects) or damages (costs, pollution) to others with no corresponding compensation provided or paid by those who generate the externality.[23] An example of *positive externality*, i.e. externality that brings benefit to health, is immunization programmes and vector control through house spraying. A household that refuses to immunize its children against a certain disease will still benefit from the immunization carried out in surrounding households. The reason is that transmission of that disease will be reduced resulting in less risk of contracting the disease from the household that refuses immunization. The same is true for a household that refuses spraying with insecticides to prevent malaria.

Negative externalities also affect health outcomes. The best example is smoking. A passive smoker is exposed to negative externality. Another example of negative externality is pollution and the effects of global warming.

Q27 What influence do public goods exert on a health system?

By their very nature, the production and distribution

[23] The World Bank. *Externalities*. Available at: http://www.worldbank.org/depweb/english/beyond/global/glossary.html (accessed on 26 June 2010).

of public goods is by and large the responsibility of the public sector.

Since consumption of public goods is free of charge, the private sector generally is not interested in producing public goods as the profit margins are low or non-existent. Their production will thus depend on the government. Without government intervention, "*market failure*" will occur where we observe the existence of a high demand for a certain product or good.

Q28 Can public–private partnership solve the issue of public goods in health?

To a certain extent the answer is yes. The government needs to focus on financing and delivering services that are public goods in essence, such as public health interventions that rely more on preventive and promotive measures. Since health funds are usually in short supply, the private sector should be motivated to share the burden in producing public goods. In some big cities we observe the provision of immunization services by private health providers, although these are directed at the better-off segment of the population. With certain incentives, the private sector should be willing to expand services to the less well-off rural population.

Q29 The private sector is growing at an unprecedented rate. Can this be used to strengthen health systems based on PHC?

To tap the benefit of this unprecedented growth, the government should strengthen the existing public–private partnerships. Recommended action may include strengthening the health information system including

information related to the private sector. Better information on the private sector can then be utilized to improve policy for better division of services between the government and the private sector. It may also lead to better regulation to achieve a better quality of and safety in health care. Innovative financing can rope in the private sector for improving universal coverage and health equity.

Declaration of Alma-Ata

International Conference on Primary Health Care,
Alma-Ata, USSR, 6–12 September 1978

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

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

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII

Primary health care:

1. reflects and evolves from the economic conditions and socio-cultural 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;

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this

end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX
All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X
An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, nongovernmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries.

The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

WHO DOCUMENTS AND REPORTS RELATED TO PRIMARY HEALTH CARE

In the past four years, the Regional Office for South-East Asia has organized Regional meetings/consultations as well as produced documents to advocate and promote primary health care and its application in health systems strengthening. Additional information on primary health care is available from the following meeting/ consultation reports and documents.

1. World Health Organization Regional Office for South-East Asia. *Strengthening health systems based on primary health care approach.* New Delhi, WHO SEARO, 2007. Pyongyang, Democratic People Republic of Korea, 18–20 April 2007. (SEA-HSD-298). Available at: http://203.90.70.117/PDS_DOCS/B0583.pdf

2. World Health Organization Regional Office for South-East Asia. *The Regional six-point strategy for health systems strengthening based on primary health care approach.* New Delhi, World Health Organization Regional Office for South-East Asia, 2007 (SEA-HSD-305). Available at: http://203.90.70.117/PDS_DOCS/B0684.pdf

3. World Health Organization Regional Office for South-East Asia. *Revisiting community-based health workers and community health volunteers.* New Delhi, WHO SEARO, 2008 (SEA-HSD-309). Chiang Mai, Thailand, 3–5 October 2007. Available at: http://www.searo.who.int/LinkFiles/Publications_HSD-309.pdf

4. World Health Organization Regional Office for South-East Asia. *Strategic directions for strengthening community-based health workers and community health volunteers in the South-East Asia Region.* New Delhi, World Health Organization Regional Office for South-East Asia, 2008 (SEA-HSD-311). Available at: http://www.searo.who.int/LinkFiles/Publications_HSD-311-Regional_Strategy_CBHWs_CHVs.pdf

5. World Health Organization Regional Office for South-East Asia. *Accelerating progress towards achieving maternal and child health Millennium Development Goals (MDGs) 4 and 5 in South-East Asia.* New Delhi, WHO SEARO, 2009 (SEA-CHD-7). Ahmedabad, India, 14–17 October 2008. Available at: http://www.searo.who.int/LinkFiles/FCH_SEA-CHD-7.pdf

6. World Health Organization Regional Office for South-East Asia. *Revitalizing primary health care.* New Delhi, SEARO, 2008 (SEA-HSD-

316). Jakarta, Indonesia, 6–8 August 2008. Available at: http://www.searo.who.int/LinkFiles/Health_System_Strengthening_SEA-HSD-316.pdf

7. World Health Organization Regional Office for South-East Asia. *Self-care in the context of primary health care.* New Delhi, SEARO, 2009 (SEA-HSD-320). Bangkok, Thailand, 7–9 January 2009. Available at: http://www.searo.who.int/LinkFiles/Health_System_Strengthening_SEA-HSD-320.pdf

8. World Health Organization Regional Offices for South-East Asia and the Western Pacific. *The application of sociocultural approaches to accelerate the achievement of MDGs 4 and 5.* New Delhi/Manila, WHO SEARO/WPRO, 2009 (SEA-MCH-256). Bali, Indonesia, 11–13 August 2009.

9. World Health Organization Regional Office for South-East Asia. *Health care reform for the twenty-first century in the South-East Asia Region.* New Delhi, WHO SEARO, 2009 (SEA-HSD-329). Bangkok, Thailand, 20–22 October 2009. Available at: http://www.searo.who.int/LinkFiles/Reports_SEA-HSD-329.pdf

10. World Health Organization Regional Office for South-East Asia. *The use of herbal medicines in primary health care.* New Delhi, WHO SEARO, 2009 (SEA-HSD-322). Yangon, Myanmar, 10–12 March 2009. Available at: http://203.90.70.117/PDS_DOCS/B4260.pdf

11. World Health Organization Regional Office for South-East Asia. *Teaching of public health in medical schools.* New Delhi, WHO SEARO, 2010 (SEA-NUR-465). Bangkok, Thailand, 8–10 December 2009. Available at: http://203.90.70.117/PDS_DOCS/B4507.pdf

12. World Health Organization Regional Office for South-East Asia. Decentralization of health care services. New Delhi, WHO SEARO, (in preparation). Bandung, Indonesia, 6–8 July 2010.

More than three decades after the Alma Ata Declaration on Primary Health Care, the principles elaborated in 1978 – universal access, community participation, intersectoral collaboration and use of appropriate technology – remain valid. Persisting inequities in health status and access to health care remain areas of concern. Health systems strengthening based on PHC is an avenue to ensure equitable, affordable, comprehensive quality care. This document tries to contextualize the PHC concept to current attempts at health systems strengthening in the form of Questions and Answers.

World Health Organization
Regional Office for South-East Asia