Comprehensive Versus Selective Primary Health Care: Lessons For Global Health Policy

Meeting people's basic health needs requires addressing the underlying social, economic, and political causes of poor health.

by Lesley Magnussen, John Ehiri, and Pauline Jolly

ABSTRACT: Primary health care was declared the model for global health policy at a 1978 meeting of health ministers and experts from around the world. Primary health care requires a change in socioeconomic status, distribution of resources, a focus on health system development, and emphasis on basic health services. Considered too idealistic and expensive, it was replaced with a disease-focused, selective model. After several years of investment in vertical interventions, preventable diseases remain a major challenge for developing countries. The selective model has not responded adequately to the interrelationship between health and socioeconomic development, and a rethinking of global health policy is urgently needed.

The health care systems of many developing countries emerged from colonial medical services that emphasized costly high-technology, urban-based, curative care.[1] When these countries became independent in the 1950s and 1960s, they inherited health care systems modeled after the systems in industrialized nations.[2] Public health programs of international development agencies during this period were also largely targeted at eradicating specific diseases such as smallpox, yaws, and malaria. Each disease eradication program operated autonomously, with its own administration and budget and very little integration into the larger health system.[3] There were some successes during this period (for example, eradication of smallpox and a decrease in tuberculosis). However, these short-term interventions were not addressing poor populations' overall disease burden.[4] Analysts realized that although one disease might be controlled or eliminated, recipients of that intervention might die of another disease or its complications.[5] The situation worsened into the early 1970s, as populations continued to experience failing health outcomes with rising spending.[6]

Lesley Magnussen is a journalist and a master's degree candidate in the Department of Epidemiology, School of Public Health, at the University of Alabama at Birmingham (UAB). John Ehiri (jehiri@uab.edu) is an assistant professor in the UAB Department of Maternal and Child Health. Pauline Jolly is a professor of epidemiology and international health at UAB.

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Recognizing that narrow targets were not the only option, countries attempted to implement comprehensive approaches to the provision of basic health services. Examples included the creation of the rural health center, staffed by medical and health assistants and supported by the Bhore Commission in India; the implementation of "community-based health programs" in Nicaragua, Costa Rica, Guatemala, Honduras, Mexico, Bangladesh, and the Philippines; and the barefoot doctor program in China.[7] As part of the overall efforts to improve population health, these countries brought a new theme to international health discourse: commitment to social equity in health services. *Social equity* means that although different socioeconomic levels exist, the gaps between those levels are not insurmountable.[8] Examples from these countries contributed to the optimism that inequity could be tackled to improve global health.

■ **Introduction of "health for all."** By the mid-1970s international health agencies and experts began to examine alternative approaches to health improvement in developing countries. The impressive health gains in China as a result of its community-based health programs and similar approaches elsewhere stood in contrast to the poor results of disease-focused programs. Soon this bottom-up approach that emphasized prevention and managed health problems in their social contexts emerged as an attractive alternative to the top-down, high-tech approach and raised optimism about the feasibility of tackling inequity to improve global health. Thus, "health for all" was introduced to global health planners and practitioners by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) at the International Conference on Primary Health Care in Alma Ata, Kazakhstan, in 1978.[9] The declaration was intended to revolutionize and reform previous health policies and plans used in developing countries, and it reaffirmed WHO's definition of health in 1946: "a state of complete physical, mental, and social well being, and not merely the absence of disease or infirmity."[10] The conference declared that health is a fundamental human right and that attainment of the highest possible level of health was an important worldwide social goal.

To achieve the goal of health for all, global health agencies pledged to work toward meeting people's basic health needs through a comprehensive approach called primary health care. Primary health care as envisioned at Alma Ata had strong sociopolitical implications. It explicitly outlined a strategy that would respond more equitably, appropriately, and effectively to basic health needs and also address the underlying social, economic, and political causes of poor health.[11] It was to be underpinned by universal accessibility and coverage on the basis of need, with emphasis on disease prevention and health promotion, community participation, self-reliance, and intersectoral collaboration.[12] It acknowledged that poverty, social unrest and instability, the environment, and lack of basic resources contribute to poor health status. It outlined eight elements that future interventions would use to fulfill the goal of health improvement: education concerning prevailing health problems and methods of preventing and controlling

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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 major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.

■ **Selective primary health care.** One year after the Alma Alta declaration, Julia Walsh and Kenneth Warren presented "selective primary health care" as an "interim" strategy to begin the process of primary health care implementation.[13] They argued that the best way to improve health was to fight disease based on cost-effective medical interventions. Although they acknowledged that the goal set at Alma Ata was "above reproach," they contended that its scope and resource constraints made it unattainable. They proposed that a selective attack on a region's most severe public health problems would maximize improvement of health in developing countries. They identified four factors to guide the selection of target diseases for prevention and treatment: prevalence, morbidity, mortality, and feasibility of control (including efficacy and cost). Thus, rather than the envisioned emphasis on development and sustainability of health systems and infrastructures to improve population health, primary health care implementation in developing countries became focused on four vertical programs: growth monitoring, oral rehydration therapy, breastfeeding, and immunization (GOBI). Family planning, female education, and food supplementation (FFF) were added later. These interventions targeted only women of childbearing age (15–45) and children through age five. This narrow selection of specific conditions for these population groups was designed to improve health statistics, but it abandoned Alma Ata's focus on social equity and health systems development. This transformation from the lofty goals set at Alma Ata to a selective approach sparked more than two decades of exhaustive debate.

Effectiveness Of Comprehensive Primary Health Care

Some global health analysts argue that comprehensive primary health care was an experiment that failed; others contend that it was never truly tested. With only one year between the Alma Ata declaration and the shift toward a selective approach to its implementation, the transformative potential of comprehensive primary health care remained largely unexploited. Nevertheless, there were some important successes, particularly in the 1980s. Mozambique, Cuba, and Nicaragua, for example, expanded their primary health care coverage and greatly improved their population health indices.[14] The keys to these accomplishments were the political will to meet all citizens' basic health needs, active popular participation in the effort to realize this goal, and increased social and economic equity.[15]

Whereas the progress in Mozambique and Nicaragua was short-lived, Cuba has maintained steady progress even after the collapse of, and loss of support from, the Soviet Union and many years of embargo by the United States.[16] Its success has been attributed to its model primary health care system.[17] Under the Cuban constitution, health care is a right of citizens and a responsibility of government. In addition, Cuba's Public Health Law outlines the principles of the National Healthcare System as follows: socialized medicine organized by government; basic services accessible to the whole population and free to all; preventive medicine as the hallmark of the system; public participation in health care; and a comprehensive approach to planned development of the health system. A 1997 report from the American Association for World Health, analyzing the U.S. embargo's effects on health in Cuba, concluded that a humanitarian catastrophe had been averted because the country maintained a high level of budgetary support for a health care system designed to deliver primary and preventive health care to all of its citizens.[18] Cuba's population health indices are on a par with those of developed countries that have several times its budget: Life expectancy is seventy-seven years, and the infant mortality rate is 7.7 per 1,000 live births, which ranks Cuba among the twenty-five countries in the world with the lowest infant mortality rates. As Cesar Chelala observed, Cuba's infant mortality rate for 1997 was half that of Washington, D.C.[19]

Effectiveness Of Selective Primary Health Care

While many factors ultimately affected the implementation of primary health care by national governments and aid agencies, selective primary health care and the resulting programs that were and are supported cannot fulfill the ideals of Alma Ata, including the emphasis on self-reliance, which is essential for communities to promote and sustain their own health.

■ **Shortcomings.** First, the selective approach ignores the broader context of development and the values that are imbued in the equitable development of countries. It does not address health as more than the absence of disease; as a state of well-being, including dignity; and as embodying the ability to be a functioning member of society. In conjunction with the lack of a development context, the selective model does not acknowledge the role of social equity and social justice for the recipients of technologically driven medical interventions. The reality of the model is that vertical programs are centered in urban hospitals and health care facilities. Without the participation of communities, there is no avenue for change.

Second, the donor-driven, technocratic approach to determining priorities for interventions detracts from the grassroots approach that the Alma Ata declaration stated was necessary for health development. Third, the model tends to preserve the status quo of vertical objectives, fighting one disease at a time and not incorporating these efforts into a higher baseline of health status.

Fourth, there is little coordination among these vertical programs, leading to re-

dundancy, overlap, and waste. Finally, the sole emphasis on women and young children, to the neglect of other segments of the population, is an important flaw. The high burden of HIV/AIDS among people ages 20–39 in many developing countries (an indication of infection during adolescence) is not surprising, given the long neglect of this population group in health policy and practice.[20]

■ **Improvements and deficits in global health.** In spite of the above shortcomings, selective primary health care has been lauded as having contributed greatly to improvements in global health. It is said, for example, that eight of every ten children in the world today receive vaccinations against the five major childhood diseases.[21] Globally, between 1980 and 1993 infant mortality fell by 25 percent, while overall life expectancy increased by more than four years, to sixty-five years.

However, whereas the number of children under age five who died from vaccine-preventable diseases decreased by 1.3 million between 1985 and 1993, more than twelve million of these children died within this period nevertheless. Of this figure, vaccine-preventable diseases still accounted for 2.4 million deaths. Moreover, childhood diarrhea and malnutrition remain leading causes of impaired child health in developing countries, contributing greatly to the thirteen million deaths that occur annually among children under age five.[22]

A 2003 United Nations report argues that international assistance aimed at helping poorer countries develop is failing; it calls for a reexamination of current strategies if the world is to meet targets for reducing poverty, hunger, and illness.[23] According to the report, fifty-four countries are poorer now than they were in 1990, and life expectancy has regressed in thirty-four countries, mostly in Africa.

Lessons For Future Global Health Policy

Although disease-specific interventions are important, assuring real change will require attention to environmental, political, and social actions that target the root causes of disease as envisaged at Alma Ata. Alma Ata's comprehensive primary health care was a global recognition of some of the causes of unsatisfactory results in many programs.[24] Studies during the 1970s revealed that lack of overall development was inextricably linked to health and that health discussed in a vacuum would never succeed. However, experimentation with comprehensive and selective approaches to global health policy have also revealed that discussion of health in the context of society, economics, politics, and development put many barriers in the way of success as well.

One of the ideological barriers was the concomitant challenge of social equity and social justice. Alma Ata made it the responsibility of governments and agencies to promote equity and ensure that certain citizens were not unduly suffering for the benefits received by others. Comprehensive primary health care combined many complex features into its definition of health and health care.

■ **Various sectors need to work together.** First, because health does not occur in isolation, the various sectors, including those within a national government and

“Systems characterized by the absence of democracy and by corruption are breeding grounds for inequities in health.”

among aid agencies, need to work together at every level of practice. The ministry of health is not the sole agency charged with production of health; departments of agriculture, housing, sanitation, and education, along with food distribution, are all involved in achieving health.

■ **Interventions must come from needs of the community.** Second, the Alma Ata declaration requires that interventions come from the needs of the community, expressed and subsequently led by community members. Global health problems cannot be solved by distant policymakers and planners.[25] Involvement of individuals and communities mobilizes local resources to deal with health problems.[26] Implied in the concept of participation is decentralized physical location; programs need to be founded and researched in the locality in which they will be applied. The Alma Ata declaration also recognizes that the issue of accessibility to health services and resources has historically been a barrier to effective care and that placing emphasis on curative, tertiary care hospitals located in urban centers often precludes access for a mostly rural population.

■ **Fullest potential difficult to achieve without supporting infrastructure.** These are some of the underpinning principles behind the Alma Ata declaration; unfortunately, key elements are lacking in the selective approach adopted for its implementation. Some developing countries continue to rely on vertical programs, with less emphasis on people’s involvement and development of systems and infrastructures to sustain those programs. For example, although the current initiative on vaccines and immunization designed to help countries incorporate new vaccines into their national health systems surely has benefits for addressing specific communicable diseases, their fullest potential will be difficult to achieve in the absence of effective health systems and supporting infrastructures. Limited assessment of this initiative undertaken in Mozambique, Ghana, Lesotho, and Tanzania revealed that the infrastructural foundation needed for successful implementation and sustainability is inadequate.[27]

Maintaining the cost of expensive new vaccines after donor support ceases also poses a serious challenge to sustainability. As with most vertical programs, analysts have expressed concern that raising poor countries’ awareness of new vaccines and immunization programs without support in implementing such programs could end up creating markets for these vaccines while doing little to tackle major health problems.[28]

Given that disease-focused models continue to be funded and promoted in developing countries, it is apparent that adequate lessons have not been learned from experimentation with selective, vertical approaches; that the notion of self-reliance, community participation, and health systems development proposed at

Alma Ata have diminished in importance; and that inadequate consideration is given to the link between health and socioeconomic development. Global health policy for the twenty-first century should recognize that high-tech and expensive models to address diseases of poverty will not be sustainable where infrastructures needed for operationalization and institutionalization of those technologies scarcely exist.

Revitalizing Alma Ata's Tenets

Although the challenges of addressing the socioeconomic root causes of disease in developing countries may seem insurmountable, analyses of factors that contributed to health improvements in developed countries provide cause for optimism. For example, the appalling health conditions described in the *Report of the Sanitary Commission of Massachusetts* to the Massachusetts state legislature in 1850 were similar to those that prevail in developing countries today.[29] The recommendations embodied the essential elements of comprehensive primary health care—communicable disease control, promotion of child health, housing improvement, sanitation, training of community health workers, public health education, promotion of individual responsibility for one's own health, mobilization of community participation through sanitary associations, and creation of multidisciplinary boards of health to assess needs and plan programs. Recognizing the importance of political commitment, the report called for establishment of a strong public health constituency and addressed inequity by highlighting major differences in life expectancies between U.S. rural and urban areas. Thus, many of the improvements in Americans' health have been attributed to the ensuing political commitment and emphasis on public health and to social and economic interventions.

Similarly, in reviewing factors that contributed to improvements in health in England, Thomas McKeown demonstrated that population health improved more because of investments in "environmental public health," political, economic, and social measures than from specific medical or therapeutic interventions.[30] Decline in deaths from tuberculosis and from respiratory and water- and foodborne diseases had already occurred before any effective immunizations or treatments were available.

■ **Concrete strategies and processes.** Thus, to improve the health status of people in developing countries and to ensure sustainability, a revitalization of the tenets of Alma Ata's primary health care is needed. Of critical importance is the need to establish concrete strategies and processes, with clear targets, to reduce inequities in the allocation of resources for primary health care, and with a focus on both horizontal and vertical equity.[31] The value of this proposal is illustrated by the striking success that has been achieved in social development and health by a few poor countries, notably Sri Lanka, Costa Rica, Cuba, China, and Kerala state in India. Mortality and malnutrition rates are much lower and life expectancy much higher in these countries than in other countries with similar economic characteristics and

indeed some wealthier countries. In this regard, it is important to stress that the nature of the political system, its values, and its processes for participation define the frontiers of opportunity for health equity.[32] Systems characterized by the absence of democracy and by pervasive corruption, violence, and sex discrimination are breeding grounds for inequities in health and in other social spheres.

■ **Social policies.** Health policymakers should be aware that macroeconomic, labor, and social policies have the potential to limit or enhance health opportunities for different groups in the population. International aid agencies and governments in developing countries should be aware that the pursuit of liberal macroeconomic progrowth policies has the tendency to provide better opportunities to those with resources and high levels of education while large segments of the population without these assets are unlikely to benefit and may in fact become casualties of economic transition. Thus, it is the duty of health policymakers to signal when other policies may undermine efforts to promote health equity.[33]

■ **Intersectoral forums.** Countries also need to strengthen their primary health care through the development of intersectoral forums at every level. Human health should be a cross-cutting issue throughout the decision-making process in different sectors and at different levels. Health policy development should involve those sectors, agencies, and social groups that are critical to achieving better health. This can be achieved through advocacy for health objectives as integral to socioeconomic development and through engagement of different sectoral partners and community structures in the consensual process.

■ **Funding commitment.** Developing countries' governments must be committed to funding and budgets for sustaining community involvement in health. This can be achieved through, for example, private-sector involvement and through hosting village, district, or regional people's health assemblies so that the voices and opinions of the people can be represented in the design and implementation of health policies.

■ **Trained health personnel.** Most importantly, to ensure the quality of primary health care, reform of the health sector under primary health care should include coherent human resource development plans at the village, district, state/regional, and national levels and strategies for retention of trained personnel in remote and rural areas. Primary health care systems in developing countries provide interventions that are already known to be effective. This means that achievement of quality in primary health care facilities requires the proper performance of these interventions according to prescribed standards to reduce mortality, morbidity, and disability. However, the most common challenge is that often these interventions are not properly executed.[34] A recent study in southeast Nigeria, for example, revealed that inadequacy in the quality of services provided by community-based primary health care workers is a product of failures in a range of quality measures: structural, process failings, and lack of a protocol for systematic supervision of health workers.[35] Thus, quality improvement in this context is not simply a matter of providing infra-

structural resources but, rather, one of paying attention to improvement in process, especially through training and supervision.

■ **Long-term social interventions.** Finally, although short-term measures do not necessarily undermine the contributions of vertical therapeutic interventions to public health, it is apparent, as this paper has shown, that they are not sufficient to greatly alleviate the overall burden of disease in developing countries unless the socioeconomic, political, and health system factors that underpin health and disease in these countries are challenged. The remedy, as we have argued, lies in a fundamental shift in emphasis from vertical, short-term measures to a revitalization of Alma Ata's primary health care, with emphasis on poverty alleviation, community participation, and the development of health systems and infrastructures to create and sustain health.

NOTES

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