

## The promise of primary health care

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Twenty-seven years after it was embraced at Alma-Ata (now Almaty, Kazakhstan), primary health care and its call for “health for all” still holds a promise (1). Study of the history of medicine suggests its worldwide appeal. Primary health care is the latest expression of a belief that can be traced to the 19th-century pathologist Rudolf Virchow: the solution to major human disease problems resides not only in the best science available but also in brave political proposals for social justice and the improvement of the life of the poor (2, 3). From this perspective, health is not only a by-product of social changes but an instrument to promote such changes — and health workers are in the vanguard. History does not follow a linear path of progress, however: setbacks, resistance, negotiations and compromise have existed in the history, design and practice of primary health care programmes.

Based on reflections by Socrates Litsios (W4) and my own research on the history of primary health care (W5), I suggest four themes for reconsideration: its meaning, funding, and implementation, and the culture created by restricted top-down versions of the philosophy. First, primary health care has had several meanings that undermined its power as a health paradigm. In its more radical version, the complete reform of public health structures and the promotion of major social changes were envisaged, with primary care as the new centre of health systems. In contrast, according to an instrumental interpretation, it was merely an entry point, a temporary relief or an extension of services to underserved areas (W6). The latter interpretation could not avoid being perceived as second-class care, “poor” medicine for poor people.

Second, funding for primary health care has usually been insufficient and inconsistent (7). In the past few

decades it has been difficult to establish an effective financial system with clear indicators that ensures sustained support of community participation and intersectoral collaboration, to mention just two important but controversial project tasks (W8).

Third, implementation encountered resistance from health personnel. Many physicians in less developed countries were linked to specialized urban hospitals and traditional medical schools; they knew much about treatment but little about prevention. Many of them hoped that their expertise would facilitate upward social mobility (W9). Unless health professionals and their systems of training are closely committed, a health programme can be undermined from within.

Fourth, restricted primary health care interventions reinforced a culture of survival in developing countries, where many people believe that public health is an emergency response embodying vaccines, drugs, ephemeral training of lay personnel, or the creation of a health post. Health work is perceived as a low-value, short-lived activity from outside the community. As a result, a culture of survival among the poor sustains the privileges of power among politicians. The poor continue to struggle to obtain access to fragmented programmes and foreign aid in order to relieve pain, delay death and protect loved ones, while the elite’s control of limited resources becomes a source of power in an environment of scarcity. The combination of the culture of survival and the privileges of power reinforces inequity, dependency and passivity, all of which are incompatible with primary health care. It will take imaginative decision-making to transform the public health implications of the culture of survival and recreate a true primary health care system.

In order to renew the promise of Alma-Ata, it is crucial to tackle these

four issues and to increase the awareness of the political contexts in which the strategy might flourish. The persistence of neoliberalism, the transition from an “international” to a “global” framework, and the coexistence of the most terrible expression of human history (war) and one of the most idealistic (the Millennium Development Goals) mark a complex political context, in which one actor should play a crucial role: the local health worker. As a recent report underscored, dramatic changes have occurred recently in the growth, job insecurity and self-assertion of local health workers (10). There have never been so many health workers in developing countries with experience in providing community-oriented care. Many believe in change from below and have a vested interest in the integral improvement of health systems. The old fear of losing professional privileges is no longer a concern because these are evaporating. Mobilizing, empowering and strengthening these human resources in developing countries are crucial to pursuing the promise of primary health care. ■

### References

(References prefixed “W” appear in the web version only, available from [www.who.int/bulletin](http://www.who.int/bulletin))

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