

# Primary health care is still on the agenda, but...

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**P**rimarily health care (PHC) is still high on the international health agenda, but it has lost much of its prestige. Some already consider PHC to be an old-fashioned strategy that is doomed: 20 years after its launching, it still doesn't bring health for all.

The WHO *World health report 2000* (WHR) clearly expressed the "at least partial failure" of so-called PHC programmes. The main criticism is about "too little attention given to people's demand for health care, which is greatly influenced by perceived quality and responsiveness, and instead concentrating almost exclusively on their presumed needs." The major innovation brought by PHC, i.e. community participation—the involvement of individuals and the community in health (care) decision-making—was thus restricted to its financial component.

The WHR however brought a renewed interest for the values underlying PHC, even if—and perhaps because—worn-out words such as "financial equity" and

"attention to felt needs" have been replaced by "fairness in financial contribution" and by "responsiveness", respectively. Although the debate about this report is not closed, it is not the aim of this paper to add to that polemic.

## Threats to primary health care-based health systems

In our opinion, the real threat<sup>1</sup> against PHC is, first, the again increasingly important role of prioritizing in international health policy and, second, the fragmentation of aid programmes.

## Setting top priorities

AIDS, malaria and tuberculosis are certainly the major killers in most developing countries. This being the case, it only makes sense to try to obtain significant global advances by focusing on cost-effective control programmes for these diseases—programmes that often are implemented under a project format. But this priority-setting, which is allegedly based on actual needs, tends to be done at international level with

quite limited input from recipient countries, certainly from those in which AIDS is not highly prevalent.

Believing it possible to control such complex poverty-related health problems without improving health systems seems naïve regarding the lessons learnt from our 20th century history: "sustainable primary care must be the first ambition of any global fund for health" (1). Furthermore,



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even if a project-oriented approach would prove to be more efficient, it may be in contradiction with the WHR, which stresses that health policy decision-making should be more responsive to people's demands.

## Fragmentation

The interventions of the major actors in health have become dispersed and fragmented. First, there has been a huge increase in the number of partner organizations working in the field of health. These include the international agencies, but also many smaller-scale national or local NGOs and organizations. They all share an increasing market-driven orientation, leading to "economically sound" interventional logic's obtaining the upper hand.

Second, bilateral cooperation agencies and private philanthropic funds (for instance, the Bill & Melinda Gates Foundation) are increasingly influencing the agenda and policy of international health by the sheer size of their contributions and the specific conditions concerning the use of these funds ("earmarking"). But the social accountability of these donors can be questioned, with regard to both



<sup>1</sup> The Big Six as defined in the General Programme of Work of WHO in the 1950s: malaria, tuberculosis, STDs, maternal and child health, environmental sanitation and nutrition.

their home communities in the North and the end-users in the South.

Thirdly, the management approach of international agencies has contributed to misdirected efforts. Programme managers in these agencies are evaluated on their capacity to implement a programme (meaning sometimes “capacity to spend the budget”, whatever the content).

But implementing a programme aimed at increasing the wealth of a population does not mean that this is a felt need, or that it is a need identified by local health personnel. Therefore, health workers and the population do not feel really concerned by the outcome of such donor-driven programmes.

Also, agencies exert a perverse influence, as they cause a local brain drain by diverting health workers from their assigned roles. In some cases, health personnel spend up to 50% of their time attending seminars and workshops, stimulated by incentives (2).

All this contributes to a vicious circle that undermines attempts to build a public service that lives up to the legitimate demand for quality care and this, with the tacit consent of all the actors (health workers, policy-makers and donors) (3).

Fourthly, verticalization, in an effort to maximize effect for money, and the measurement trap—whereby preferably quantifiable goals are pursued for results in the shortest time possible—contributes to designing fragmented interventions.

#### Unity: the next frontier

These four elements play a large part in the lack of a systematic view of the problems, which is essential for a “good” PHC approach. Competition, not cooperation, is at the heart of international health these days. Sector-wide approaches (SWAPs) have been attempted in several countries to overcome the fragmentation in health sector

interventions. Unfortunately, this attempt showed how limited such approaches are unless essential ingredients—among which “a country-led strategy around which donors can coalesce” is crucial—are missing (4). More than ever, we need to summon up our strength to insert integrated primary health care systems as the cornerstone of a world strategy to achieve Health Care for All. ■

#### References

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## Making communities real partners

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#### Rationale for partnerships in health

Health care delivery in Nigeria, as in several other developing countries, has been subject to stresses such as inadequate funding and improper management of resources that have adversely affected the quality of service and consumer satisfaction.

In the mid 1970s it was discovered—through hindsight and evaluation of past failed programmes—that community involvement had been obviously absent or lacking in most failed programmes. Most programmes were not sustained after the exit of the initiator because the recipients perceived the programmes to be alien and not their responsibility; they therefore made no effort to see that they were maintained. This led to waning of the effects of programmes such that the pro-

grammes never maintained their initial impact—if there was any impact (1).

It is thus of critical importance that health workers work in partnership with community members. Individuals and families must assume responsibility for their own health and welfare and that of others in the community



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