

Discourse

Primary Health Care: Then and Now

Helen Glass

The term *primary health care* is now entrenched in our minds and our actions. A *health for all by the year 2000* strategy is being examined to determine what has been achieved and what has not. All countries and most professions, including nursing, are scrutinizing the progress they have made towards achieving PHC. It is my intention, in this discourse, to move from an historical view to present-day concerns as they relate to the achievement of PHC. It will be impossible to do more than mention many of the latter, but I hope to set the stage for the articles that follow in this issue of the Journal.

Historical Perspective

Nursing has been involved in the development of PHC from the beginning. Concerns about the state of basic health care surfaced in 1973 (World Health Organization [WHO], 1973), when alarming states of health and vast gaps in health services for populations in developing countries were identified. An Expert Committee on Community Health Nursing was convened to recommend ways in which nursing might make a real impact on urgent problems throughout the world (WHO, 1974). The Committee made recommendations on: (1) the development of community health nursing services responsive to community needs in order to ensure PHC coverage for all, (2) the reformulation of basic and post-basic nursing education to prepare nurses for community health nursing, and (3) the inclusion of nursing in rational distribution and appropriate utilization in support of nursing personnel.

Helen Glass, OC, BSc(N), MA(N), MEd(N), EdD(N), LLD(Hon.), DSc(Hon.), is Professor Emerita, Faculty of Nursing, University of Manitoba. She is the former Director of the (then) School of Nursing, University of Manitoba, Winnipeg.

Since 1974, there have been a series of closely related events aimed at reducing the pressing needs of society and improving community health as rapidly as possible. The Thirtieth World Health Assembly recognized the important role of nursing and midwifery in PHC by adopting *Resolution 30:48* (WHO, 1977), which asked World Health Organization (WHO) member states to: (1) study the roles and functions of nursing and midwifery personnel in providing PHC, (2) plan for a rational increase in the supply of these personnel in providing PHC, and (3) involve nursing and midwifery personnel in the planning and management of PHC.

In 1978 the adoption of *Resolution 36:11* (WHO, 1978b) confirmed support for these resolutions. There were many other WHO resolutions urging member states to support nursing in this endeavour. The International Council of Nurses (ICN) actively urged nurses to become involved. The ICN prepared and distributed much information to help its members understand the PHC concept, and it encouraged nursing organizations to assume a leadership role. The ICN and the WHO held a conference on leadership in Tokyo (WHO, 1986), which enabled many nurses to not only prepare themselves for leadership, but assist nurses in other countries to do the same. Further, the ICN was instrumental in helping nursing organizations participate in the PHC movement. Canada was particularly involved, assisting several countries that wished to train their nurses in PHC.

The federal health minister's 1974 report (Lalonde, 1974) declared health promotion, prevention, biology, and environment the cornerstones for health in Canada. The report would influence the next round of developments in PHC. The *Alma-Ata Declaration* (WHO, 1978a) marked a dramatic point in programming for community health nationally and internationally. The international conference on PHC that produced the Declaration also produced a universally applicable definition of PHC, described concepts and principles for the development of PHC, and recommended strategies for achieving universal health care — of which PHC was seen as key.

In *Community Nursing: Promoting Canadians' Health*, Rodger and Gallagher (2000) describe the move towards PHC in Canada, indicating the involvement of the Canadian Nurses Association and nurses generally (pp. 40–42). It is a litany of achievements and shows the deep commitment and involvement of nurses in the PHC approach. Yet much remains to be done.

The WHO's activities internationally stimulated the political move to implement PHC in Canada. The release of health minister Jake Epp's

Achieving Health for All (Epp, 1986) moved Canada a step forward in the overall strategy. All provinces responded, and all engaged in developing their own action plan for implementing PHC. For the most part they initiated health-care reform reflecting PHC principles. However, there are many different approaches to health-care reform, some of which have defied the *Canada Health Act* (1985) and in some instances may have strayed from the basic principles of PHC.

The *Ottawa Charter for Health Promotion* (WHO, Health and Welfare Canada, & Canadian Public Health Association, 1986), the WHO's first attempt to expand upon health-promotion principles, was developed in Canada by representatives of 32 countries. Co-sponsored by the WHO, Health and Welfare Canada, and the Canadian Public Health Association, it was the result of a WHO debate on intersectoral action for health, one of the major principles of PHC. Issues addressed were: health promotion, its prerequisites and resources; the advocacy required for people to achieve their full health potential; and mediation between different interests in society for the pursuit for health. The emphasis was on creating supportive environments, strengthening community action, developing personal skills, and reorienting health services. There is much more to be achieved with regard to these important elements, but the *Ottawa Charter* was an impressive beginning.

Evaluation of Progress

The WHO examines its progress every year, and in the process hears from each country as to its success in implementing PHC. The book *Achieving Health for All by the Year 2000: Midway Reports of Country Experiences* (WHO, 1990), and Tarimo and Webster's (1997) report of advances in PHC, determined that the major challenge lay in implementation of the concept. The WHO reported on how each individual country had adapted the PHC approach to its own evolving circumstances. The Canadian study, conducted by Spasoff and Hancock (1990), covered one province only, though it included references to other provinces. Since that time there has been an increased awareness of advances made by other provinces, such as regionalization and various models of PHC. All provinces have established structures to embrace the concept. Refinement of the concept has been evident in the direction taken to implement population health and health determinants. Less headway has been made in community development, environmental protection, or clarity of the roles and functions of various health professions, or, indeed, in enabling communities to grasp the nuances in PHC and all of its interacting elements.

A great number of technical and annual reports offer valuable information on the advancement of PHC and the achievement of health for all. The World Health Report for 1998 (WHO, 1998) and its three predecessors draw a comprehensive map of the issues that dominated world health in the second half of the 20th century. *World Health Report: Bridging the Gap* (WHO, 1995) identifies poverty as a major stumbling block to achieving health for all. *World Health Report: Fighting Disease, Fostering Development* (WHO, 1996) identifies three priorities: fighting diseases, both old and new; addressing antimicrobial resistance; and combating newly emerged diseases. *World Health Report: Conquering Suffering, Enriching Humanity* (WHO, 1997) focuses on the causes of suffering, especially poverty, poor housing, and disabilities, and points out that increased longevity without quality of life is an empty prize. While this report reveals some decrease in disabilities, it notes the persistence of chronic, long-term disabilities, resulting in much suffering, and the need for preventive measures in cancer and in pulmonary, musculoskeletal, and visual disorders. A number of WHO technical reports also address these concerns. In addition, the 1997 report urges improvements in the education of health professionals and university involvement in PHC, especially with regard to evolving perceptions of PHC as countries seek to change their approach and institute PHC community interventions.

On the unfinished agenda, poverty remains the main item. Other important topics are safeguarding health gains already achieved and sharing medical knowledge, expertise, and experience on a global scale. The reports suggest that industrialized countries can play a vital role in helping to resolve global health problems. A third directional move suggested in the reports is enhancing health potential by reducing premature mortality, morbidity, and disabilities at all age levels. Finally, it is pointed out that increased longevity and quality of life, reduced disability, and increased community involvement will require much more research. Further, with regard to achieving health for all by the year 2000, research indicates that although substantial progress has been made worldwide in decreasing disparities between and within countries, the disparities have nonetheless persisted and in many cases increased.

Many differences have been observed in the interpretation of PHC as a concept. Not all countries have grasped the notion that PHC is an approach to health development and that it embodies specific principles and values: universality, accessibility, and coverage according to need; community and individual involvement and self-reliance; and

intersectoral action for health, appropriate technology, and cost effectiveness. While these principles are often cited by those working in PHC, little progress has been made in upholding them. Universality and accessibility truly represent a population health approach that should lead to health development. However, there is still confusion over *how* population health should be approached. There is a need to address the health status of the population in each community as health development occurs, either individually or as a collective. Further, without economic equity there can be little hope of narrowing the gap between the haves and the have nots. This was recently pointed out at the Canadian Conference on Shared Responsibility and Health Impact Assessment: Advancing the Population Health Agenda: "The population health approach has the potential to encompass much of humanity's accumulated knowledge, from biological insights to the lived experience of everyday life, to interplay among political, economic and social forces and their impact on health, well being and quality of life" (Frankish, Veenstra, & Gray, 1999, p. 6). The importance of policy-making, by health professionals and members of the community as well as by governments, was recommended as a means of furthering population health development (Frankish, Vreestra, & Moulton, 1999; Glass & Hicks, 2000).

The second principle, community and individual involvement and self-reliance, requires that a community play an active part in the process of improving its health status. This principle has two aspects: political and social. The political aspect relates to decentralization and an increase in community decision-making power. Governments are involved, but health professionals have the greatest opportunity to assist people in taking responsibility for their health.

The third principle, intersectoral action, deals with determinants of health, some of which relate to social economics, some to environmental forces. There is much to learn about ways of interacting with other sectors of society. Cost effectiveness includes strategies for yielding the greatest benefits for all people. The focus on strengthening preventive services and health promotion derives from this principle. It also requires a shift away from hospitals to community health centres or other models of care, a shift that is taking place in many countries. A good many of the solutions will be linked to the other concerns — that is, much more headway will be achieved once the public accepts the fact that it can largely direct its own health care and then assumes responsibility for doing so.

The 21st Century: Making a Difference

At the outset of this paper I indicated the early involvement of nursing in PHC. There is no doubt that nursing has done its part. It has also been heavily involved in research in many areas of PHC. The nature of nursing research is suited to the study of PHC, with its emphasis on both qualitative and quantitative methods. It serves to identify many elements, especially in qualitative research, that will be helpful in the study of phenomena that arise from this method.

Dr. Gro Harlem Brundtland, the current Director of the WHO, states in the World Health Report for 1999: "The world enters the twenty-first century with hope, but also with uncertainty. Remarkable gains in health, rapid economic growth and unprecedented scientific advances — all legacies of the twentieth century — could lead us to a new era of human progress. But darker legacies bring uncertainty to this vision and demand redoubled commitments" (WHO, 1999, p. vii). Tremendous insights can be gained from perusing the research that WHO has conducted over the years, in every aspect of PHC development. The 1999 World Health Report offers some direction as to what will make a difference. Dr. Brundtland suggests areas that would seem to lend themselves to study: poverty; the rising toll of non-communicable diseases; the quest for a tobacco-free world; the delivery of quality care to children, adolescents, and women; reproductive health. Nurses have been active in some of these areas; other areas, such as community development and intersectoral action, can be expected to engage nurses.

As we enter the increasingly complex world of cyberspace, we can expect to see a greater distribution of research results through the media, schools, interactive video, networking, and various technologies. This will serve to bring much-needed information to the community, thus stimulating residents to seek ways of improving their health. The four Community Nurse Resource Centres established in Manitoba have witnessed many instances of communities taking responsibility for projects they see as needed: establishing the projects; doing research with health professionals to obtain useful data; working intersectorally; and influencing policy development as a result of the findings. I am convinced that great strides will be made by nurses as they explore the intricacies of PHC.

References

- Epp, J. (1986). *Achieving health for all: A framework for health promotion*. Ottawa: Health & Welfare Canada.
- Frankish, J., Veenstra, G., & Gray, D. (1999). Introduction. *Canadian Journal of Public Health*, 90(Suppl 1), 5-6.
- Frankish, J., Veenstra, G., & Moulton, G. (1999). Population health in Canada: Issues and challenges for policy, practice and research. *Canadian Journal of Public Health*, 90(Suppl 1), 71-75.
- Glass, H., & Hicks, S. (2000). Healthy public policy in health system reform. In M. Stewart (Ed.), *Community nursing: Promoting Canadians' health* (2nd ed.) (pp. 156-170). Toronto: Saunders.
- Lalonde, M. (1974). *A new perspective on the health of Canadians: A working paper*. Ottawa: Government of Canada.
- Rodger, G.L., & Gallagher, S.M. (2000). The move toward primary health care in Canada from 1985-2000. In M. Stewart (Ed.), *Community nursing: Promoting Canadians' health* (2nd ed.) (pp. 33-55). Toronto: Saunders.
- Spasoff, P.A., & Hancock, T. (1990). Maintaining progress through health promotion. In E. Tarimo & A. Creese (Eds.), *Achieving health for all by the year 2000: Midway reports of countries' experiences*. Geneva: Division of Health Services, World Health Organization.
- Tarimo, E., & Webster, E.G. (Eds.). (1997). *Primary health care: Concepts and challenges in a changing world — Alma-Ata revisited*. Geneva: Division of Analysis, Research & Assessment, World Health Organization.
- World Health Organization. (1973). *Organizational study on methods of promoting the development of basic health services*. #206. Geneva: Author.
- World Health Organization. (1974). *World Health Assembly Resolution 30:16*. Geneva: Author.
- World Health Organization. (1977). *Thirtieth World Health Assembly Resolution 30:18*. Geneva: Author.
- World Health Organization. (1978a). *Primary health care: Report of the International Conference on Primary Health Care, Alma Ata, USSR*. Geneva: Author.
- World Health Organization. (1978b). *World Health Assembly Resolution 36:11*. Geneva: Author.
- World Health Organization. (1986, April 7). *Why leadership for health for all? Leadership in Nursing for Health for All Conference*. Geneva: Author.
- World Health Organization. (1990). *Achieving health for all by the year 2000: Midway reports of countries' experiences*. Geneva: Author.
- World Health Organization. (1995). *World health report: Bridging the gap*. Geneva: Author.