

WHY HEALTH IMPROVES: DEFINING THE ISSUES CONCERNING 'COMPREHENSIVE PRIMARY HEALTH CARE' AND 'SELECTIVE PRIMARY HEALTH CARE'

SUSAN B. RIFKIN and GILL WALT

London School of Hygiene and Tropical Medicine, Keppel Street, London WC1 7HT, England

Abstract—What is the impact of technology on improving the life situations of people, especially the poor? How is this impact analyzed in terms of health improvements? These questions are paramount in the minds of health planners as they pursue national policies of primary health care, a policy popularized by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) and accepted by over 150 governments at Alma Ata in 1978. The purpose of this paper is to explore these questions in depth. It begins by giving the background to the debate, then examines the origins of two concepts which have dominated the field, those of 'primary health care' and 'selective primary health care.' On this basis it suggests areas of differences in the two concepts and discusses the policy and practical implications of confusing the two approaches. The paper suggests that the differences are firstly who controls the outcome of technological interventions and the perceived time frame in which plans can be carried out.

Key words—comprehensive PHC, selective PHC, health policy, health interventions

INTRODUCTION

In the post-war era, concern for technological development has dominated not only the economies of the industrial nations but also their relationships among themselves and particularly, with the less developed countries. The transformation of industrial economies by technologies that range from television to nuclear energy plants has led many to believe that with the benefit of that experience, very rapid transformations might take place in the less developed countries without their having to repeat the historical experience that led to the development of the institutional, social and political infrastructures of the industrialized nations.

The concern for transferring technologies became a major issue in the debates which dominated thinking about social and economic development for the less developed countries. Historically, they have focused on the question of *how* new technologies can be introduced, accepted, supported and maintained within countries by cultures which have little scientific tradition and have no roots in Western values. Basically two schools of thinking have emerged. One believes that, once successfully implemented, the technology will transform society so that a new universal (Western type) value system will develop. The other believes that each developing society must evolve in its own way the values and institutions which are a pre-condition for making effective use of technology. In doing this, the technology will itself be transformed to suit the culture and human resources available.

In the 1970s, the development debate shifted from an earlier focus on the ways in which technology could be transferred to the problems of social, cultural and economic constraints which were seen to be inhibiting the effectiveness of these technologies. Under such slogans as 'meeting the basic needs of the

poor' and 'creating an new international economic order,' conceptual and practical concern was expressed, in particular, for the increasing disparities that the technologies were creating within societies. This was apparent in the increasing gap between those who had access to resources and continued to get more resources and those who lacked access and suffered growing deprivation.

The field of health and medical care moved into the centre stage of these debates at this period. There were many reasons for this. Research indicated in both the industrialized countries and especially in the developing countries that technical, curative interventions were expensive and limited in coverage and impact and that preventive measures might improve more lives at a lower cost [1]. The ever rising cost of technical care was made available for mainly the rich, and middle income, urban people leaving those with low incomes living mainly in rural areas without any access to services [2]. Medical personnel were being trained at vast expense only to serve those who paid, not even necessarily in their own country but very likely in a country of the industrial world [3]. As a result, people involved in health care began to examine the cost and effectiveness of the available technologies and to analyze factors which influenced rapid and dramatic health improvements for the majority of the world's population, who were mainly poor, living in the developing world.

This situation led to arguments in the health professions which were taking place in the broader economic and social development field which paralleled the previous two schools of thought. One focused on the efficacy of interventions and the need to transfer existing technologies as quickly as possible. The other, using the evidence cited above, argued that the technologies were only effective when they were themselves an integral part of the development of the society to which they were transferred.

Briefly, the debate might be described as one between those who focus on the programmes by which interventions are introduced and those who focus on the processes through which the intervention might be accepted. In the jargon of the field, this debate has become described as between the supporters of 'primary health care' (also known as 'comprehensive primary health care'), which is concerned with the processes of health development, and those who support 'selective primary health care', which is concentrated on identifying and transferring specific, effective and economical technologies designed to reduce disease.

BACKGROUND

Is there a significant difference between the concepts of 'primary health care' and 'selective primary health care'? Has the time, effort and paper spent on discussing the apparent differences been valuable in terms of planning health programmes? We argue the answer to both these questions is yes because we believe that the assumptions and values on which these concepts are based are fundamentally different. Briefly, we see 'primary health care' as being concerned with a developmental process by which people improve both their lives and life-styles. Good health is a key factor to this process. We see 'selective primary health care' as being concerned with medical interventions aimed at improving the health status of the most individuals at the lowest cost. The critical differences in the two views are about who controls the inputs and outcomes of health improvements and what timeframe is realistic to achieve the expected results. In this paper, we explore the differences in some detail and suggest reasons for these differences. We suggest that the views are irreconcilable. In undertaking this analysis, we hope to clarify issues that are critical to both the definition and more importantly, to plans for improving health.

The idea of 'selective primary health care' was first explored in depth in an article by J. A. Walsh and K. S. Warren entitled 'Selective primary health care: an interim strategy for disease control in developing countries' which first appeared in the *New England Journal of Medicine* [4] and later reprinted in *Social Science & Medicine* [5]. The article suggested that primary health care, as defined by Alma Ata in 1978, was idealistic. The concept needed to be narrowed to allow planning for manageable and cost effective programmes. The authors presented a specific methodology by which the most prevalent diseases in the third world could be identified and attacked at a cost within the range of available financial resources. They suggested that the priority and treatment be allocated to diseases which: had the highest prevalence in the country, had the highest morbidity, or mortality, had the highest risk of mortality and had the possibility of control in terms of effectiveness in method and cost of intervention.

Support for this view was given in articles by Boland and Young [6], who examined the political and economic issues in health care improvements, and by Evans, Hall and Warford [7], who looked at health improvements in the third world as a matter of scarcity and choice.

Others have argued against the Walsh and Warren analysis. In a rejoinder reprinted in *Social Science & Medicine*, Gish [8] suggested that the authors ignored the arguments of the development economists about the role of health care and its relationship to increased production and reverted to the traditional arguments about whether vertical or horizontal health programmes were best. He suggested that the authors were presenting "old wine in new bottles" and were ignoring critical factors such as existing health infrastructures and their impact on disease control and service delivery.

In the same issue, Berman [9] criticized the authors for the inappropriate use of cost-effectiveness analysis and pointed out that their approach well illustrated the problems of using apparently simple costing techniques to very complicated public health problems.

Later, Banerji [10] asked "Can there be a selective primary health care?" and proceeded to question the evidence on disease control programmes that Walsh and Warren presented to support their case. He concluded there were several reasons for concern about the promotion of the selective primary health care (SPHC) approach for third world people which included the fact that the approach: (1) negated the concept of community participation with programmes planned from the 'bottom up'; (2) gave allocations only to people with priority diseases leaving the rest to suffer; (3) reinforced authoritarian attitudes; (4) had a fragile scientific basis; and (5) had a questionable moral and ethical value in which foreign and elite interests overruled those of the majority of the people.

Finally, Unger and Killingsworth [11] put forward an explanation as to why the concept has attracted such a following particularly among the major foreign donor agencies. Their reasons include the fact that SPHC produces recordable results, encourages the private sector to be involved in health service delivery to large populations, appeals to donors because of the 'cost-effective' arguments, promotes use of advanced technologies which benefit multinationals and maintains the financial and institutional *status quo*.

The arguments summarized above are concerned with the delivery of health services and the cost of that delivery. Although those who oppose SPHC recognize that PHC cannot be equated with health service programmes, none sufficiently develop this view. It is our opinion that this aspect is the most critical aspect of the PHC debate and that it must be fully explored.

In this paper, we shall trace the history of the development of PHC and suggest that PHC is not an alternative for health care delivery but a strategy for health development. As such, and in contradistinction to SPHC it emphasizes process and change rather than programmes designed for repetition and replication.

PHC: ORIGINS OF A CONCEPT

It is understandable why the distinction between PHC and health service delivery is not clear. For one reason, there is no clear cut definition of primary

health care, a term in existence before PHC (we shall use capitals when referring to the concept which emerged from the WHO/UNICEF declaration in Alma Ata in 1978). For example, Parker *et al.* found that they needed 92 definitions when trying to assess how different groups viewed primary health care in an American community [12].

For another reason, the concept of PHC emerged from research in the World Health Organization on what was seen to be a rapidly increasing health crisis. This crisis focused on the problems in cost and utilization of existing health services. In a crucial document published in 1973 entitled 'Organizational Study on Methods of Promoting the Development of Basic Health Services' it was noted:

There appears to be widespread dissatisfaction of populations about their health services for varying reasons. Such dissatisfaction occurs in the developed as well as in the third world. The causes can be summarized as a failure to meet the expectations of populations; an inability of the health services to deliver a level of national coverage adequate to meet the stated demands and the changing needs of different societies; a wide gap (which is not closing) in health status between countries, and between different groups within countries; rapidly rising costs without a visible and meaningful improvement in service; and a feeling of helplessness on the part of the consumer, who feels (rightly or wrongly) that the health services and the personnel within them are progressing along an uncontrollable path of their own which may be satisfying to the health professional but which is not what is most wanted by the consumer [13].

Because the roots of the crisis were identified as the problems with health services, it is logical that the solutions might be sought in changes in health service delivery. However, the 1973 document is notable in that it recognized that the crisis would not be resolved by mere reforms in the health delivery system. It rejected a palliative which only looked at administrative changes such as a shift from vertical to horizontal programmes [13, p. 108]. Instead, it was argued that health service delivery needed to be considered as part of the whole social and economic development of a nation and that any improvements in services needed to take account of the whole question of national structures, priorities and goals. In other words, health was too important to be isolated and defined solely within the health sector. These arguments provided the foundation for the Alma Ata declaration on primary health care in 1978.

The document is also notable in that it clearly defines a term of 'primary health care services' as distinct from primary health care [13, p. 113]. In other words, emerging from these discussions is a view that health care is not merely health services but is related to broader environmental and socioeconomic issues.

The decade of the 1970s was a fertile period of discussion and debate about the factors relating to health [14]. The influence of the development debates which focused on the nature of poverty and the need to confront the necessity for structural changes and the interaction of all the UN agencies in attacking these problems brought added dimensions to the thinking of international health planners. One result was the increasingly in-depth examination of the linkages between health, health services and radical health improvements, particularly of the impover-

ished majority in the developing world. It was from this examination that the concept known as primary health care, as articulated at the conference in Alma Ata emerged.

In the late 1970s and continuing today, primary health care has become the basis for WHO's global strategy for health improvements entitled "Health for All by the Year 2000". By this strategy WHO seeks not to make available health services for all but rather "that as a minimum *all* people in *all* countries should have at least such a level of health that they are capable of working productively and of participating actively in the social life of the community in which they live" [15]. The basis of this strategy like that of PHC is not merely health service improvements. It is understanding and improving the range of social, political and economic factors which ultimately influence the improvement of health status.

DEVELOPMENT AND INTERVENTIONS: CONTRADICTIONS AMONG THE PROFESSIONALS

Primary Health Care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part both of the country's health systems of which it is the nucleus and of the overall social and economic development of the community [16].

Selective primary health care is concerned with which medical interventions are most cost-effective to improve the health status of the majority of the people in the less developed countries [4, p. 967].

In reviewing the above definitions, there are several points of difference which have important consequences for planners and for those involved in health care delivery. The following four appear to be the most critical although others could certainly be identified.

1. *The difference in the definition of 'health'*

The World Health Organization has given health the meaning of the "physical, mental and social well being of the individual." This definition is the basis of PHC. The advocates of SPHC, on the other hand, view 'health' as the absence of disease. Their measures for health improvements are the reductions achieved in those diseases which are the most harmful and are the most feasible to control. It might be argued that PHC has broadened the meaning from that of the absence of disease and has focused on a positive state of well being. In addition, it has removed 'health' from the sole responsibility of the medical professional and has highlighted the importance of the environmental and social context. SPCH has confined 'health' to a narrow meaning and has kept that meaning in the control of those trained to deal with disease.

2. *The importance of equity*

Equity is one pillar on which PHC rests. Implied in this concept is the need to address the issues of the root causes of poverty and the existing distribution of resources. "The main criterion for moving toward primary health care in all cases is the increase in

social and economic justice in the use of health resources" [17]. One of the measures of success for achieving PHC is the equitable provision of health care to all people.

This view of a successful health programme contrasts greatly with those of Walsh and Warren in describing SPHC. Their criterion for success for solving health (disease) problems is stated as follows:

In selecting the health problems that should receive the highest priorities for prevention and treatment, four factors should be assessed for each disease: prevalence, morbidity, mortality and feasibility of control (including efficacy and cost) [4, p. 963].

That services should be targeted to the poor and the most in need is not a consideration of their argument. Rather, choices are made and success evaluated on the principle of effective disease control for the least amount of money.

Some advocates of SPHC would argue that SPHC by definition would focus on the poor. However, evidence suggests that particularly among the very poor, the provision of a health service intervention is not enough to dramatically improve health status. Unless sufficient time, effort and money is made available to overcome social and economic problems, people do not use the service provided [18]. It might be concluded therefore that SPHC not only fails to address equity but also consolidates health provision in the hands of the professionals and gives high credence to the importance of medical technology without sufficient recognition of the importance of infrastructure, attitudes and perceptions.

3. The need for a multi-sectoral approach to health problems

PHC recognizes that health is influenced not only by health services but by a multitude of environmental, social and economic factors. These factors include income, education, housing, food production, sanitation and motivation among others. The management of health needs to include not only the management of health services but also the management of agriculture, schooling, irrigation and markets for produce. "Action undertaken outside the health sector can have health effects much greater than those obtained within it" [19]. The conclusion is that health is not merely a disease problem but a development problem. As such, it must be tackled by all those concerned with health influences, not just the health professions, and must make a coordinated effort to attack the roots of the problem. It is not enough to keep responsibility for health in the health ministry alone.

SPHC, by its definition of 'health', focuses on mobilizing health services to attack the most prevalent disease problems. It does not recognize or solicit the help of non-professionals in defining or making decisions about those problems. It centres the solution on medical interventions and the cost-effectiveness of those interventions. Its framework of analysis does not recognize contributions and co-operation by those outside the health profession. It confines the solutions to those with medical knowledge and technology.

4. The importance of community involvement

It might be argued that a basic difference between traditional health care delivery and PHC is that PHC is community based. In the words of the Alma Ata declaration PHC is health care affordable, accessible and acceptable to the community with their full participation [16, p. 34]. A later commentary states that community involvement is core to eventual community self-reliance and self-reliance "sets people free to develop their own destiny. It is the essence of primary health care" [19, p. 9].

To the advocates of SPHC, community involvement is only significant in terms of getting large groups of people to accept the medical interventions the professionals have selected to use. They have no concern with enabling people to determine their own destiny or involving local people in the planning, implementation or evaluation of disease control programmes. They implicitly suggest that the medical professionals are those best equipped to handle health/disease problems and that involvement of the community is not cost/effective. With finance as the major consideration for short quick results, the factors of long term changes in health behaviour, mobilization of community resources and the social justice issues have virtually no platform on which to present their case.

Emerging from these four critical issues are two distinct views about the nature of health and health care. These views may be summarized as one which focuses on process and one which focuses on programmes. The former, PHC, sees health as a dynamic, changing state waxing and waning toward a wide range of life style improvements; as measurable by a variety of indicators which include not only health status but also a number of social and economic factors; as a result of a spectrum of inputs including health services adaptable to each specific local condition, and in summary and most crucially, as a process which, still difficult to define, reflects the existing social, political and economic conditions of individuals and communities at a given time and place. By implication, this approach sees health as the result of the motivation, attitudes and action of individuals and communities who are slowly beginning to define their role and responsibility in health care. The medical professionals cannot either dictate or control their involvement but can only serve as resources for their choices.

The other, SPHC, views health as an ultimate but static state for which all should strive; as measurable by the level of health status of individuals and communities; as the result of medical interventions chosen because of their effectiveness, their efficiency and their relatively low cost; and in summary and most crucially, as a programme which is replicable and repeatable because it rests on science and technology seen to be applicable to all and every situation among all people in all cultures. By implication, this approach sees health as a result of the services provided by professionals to those who suffer ill health and who are beneficiaries and passive recipients of knowledge and care based on 'objective' science and technology and divorced from differences in culture and history of different groups of people.

It follows that the medical professional has the power and the control over interventions which have a predictable impact in a relatively short time, which they perceive as providing life and improvements to those who suffer from disease.

We have described these two approaches as diametrically opposed. This is a description of the two concepts and not of their implementation. In reality demarcation of these two approaches is not so clearly seen. In the next section we shall explore the implications of these conceptual approaches in the reality of health policies and plans.

POLICY AND PRACTICAL IMPLICATIONS

The Alma Ata conference generated a flurry of activities to pursue the goal of PHC. However, the translation of the PHC vision into the reality of projects meant, in many instances, that planners sought to define specific interventions to put PHC into practice. The result was not only the articulation of a concept of SPHC but also the promotion of specific interventions and strategies which it was claimed could radically alter the pattern of poor health particularly among people living in less developed countries. Those who pursued this course adhered to PHC but acted upon their own interpretation of the concept.

Many planners and agencies directed these interventions toward reducing infant mortality rates. An example is UNICEF's promotion of the Child Survival and Development Revolution in which UNICEF has argued that "four relatively simple and inexpensive methods could now enable parents themselves to halve the rate of child deaths and save the lives of up to 20,000 children each day" [20].

There are many reasons why health planners and donor agencies have moved towards more selectivist, interventionist approaches under the PHC umbrella. We referred to some of them above in Ref. [11]. In addition, for many health professionals the concept of PHC demanded action far beyond the remit of their roles in the health sector. By focusing on specific, and particularly preventive interventions, it seemed that they could play a part in promoting PHC, even to the point of involving communities in their own care (by teaching mothers how to make oral rehydration solutions for example). It may be helpful to look at three specific interventions to explore this view further.

Of all preventive techniques, immunization is probably the most attractive. Measles, pertussis, tetanus, poliomyelitis, diphtheria and tuberculosis were together responsible for the death of about four million children in developing countries in 1984 and caused physical or mental handicaps in an additional four million children [21]. Yet vaccines against these diseases are available. They are safe, effective, relatively cheap and easily administered and, in many industrialized countries, played an important role in decreasing the incidence of these diseases. In many developing countries, in spite of the existence of this powerful technological tool, these six vaccine-preventable diseases continue to be responsible for much child mortality and morbidity.

The reasons for this situation are complicated. Achieving a sufficiently high enough coverage of the population at risk is critical to the success of the technology. While campaigns might get rid of measles for a year or two, unless followed up with money and manpower, measles returns. Much more important for successful immunization coverage is the existence of a health infrastructure which can regularly reach the groups at risk. This entails good management and planning but also training, high motivation, incentives and sensitivity to people's perceptions and beliefs. The technology is only half the answer [21].

Furthermore "a child's death is the ultimate consequence of a cumulative series of biological insults rather than the outcome of a single biological event" [22]. In the Kasongo project in Zaire, a high coverage of measles immunizations resulted in a noticeable reduction in measles mortality, but not in overall mortality. About the same number of children died but from other causes [23].

Another technology being widely promoted is that of growth monitoring through the use of growth charts (or road to health cards) on which serial weight for age readings are marked. It has been shown that these charts can help identify and draw attention to children at risk from the synergistic effects of infection and malnutrition; that mothers can safeguard the cards and bring them with the children to the clinics; and that clinic staff can produce aggregate statistics by which to identify regional problems or to indicate problems caused by drought or impending famine by transferring the information to master cards.

However, the potential of growth monitoring is not automatically or universally realized. In a recent evaluation of growth monitoring, Gopalan and Chatterjee [24] conclude that while it is a useful measure which can significantly contribute to the promotion of child health and nutrition, it seldom lives up to its potential. They point out that there are many logistical problems and deficiencies in weighing procedures and the use of growth charts.

"These start with procurement of weighing scales, their transport and servicing. There are also deficiencies in the taking of weights, recording and charting of growth data by health workers. The greatest difficulties appear to be with respect to interpretation of growth data and with the institution of follow-up health action" [24, p. 108].

Others have noted that growth monitoring in MCH programmes can become a ritual, an end in itself [25]. All this suggests that the technique by itself is nothing—it has to be part of a process in which health workers and parents (mothers) understand and acknowledge its usefulness, and feel they can do something about it. It has to be supported by a basic infrastructure. Gopalan and Chatterjee conclude that "Agencies which support growth monitoring operations in developing countries should be equally ready to provide support to facilities for follow-up action. More importantly they should be building up indigenous expertise which will make growth monitoring possible within national resources" [24, p. 109].

Having the knowledge is necessary but not sufficient for action: as is clearly seen in the wide-

spread knowledge about oral rehydration salts (ORS) or oral rehydration therapy (ORT). There is considerable evidence to suggest that in countries where ORS has been promoted people know how to make up a safe salt and sugar solution, or know how to use packaged ORS [20, p. 52]. However, far fewer people use the knowledge they have. People's perceptions about diarrhoea are complicated and these perceptions can dictate whether or not they use the solution [26–28]. Enormous efforts to promote ORS (or to create a demand for it) may be wasteful because it will not be perceived as relevant to all situations.

Moreover, it may not always be technically relevant. While ORS is effective in preventing death from dehydration caused by acute watery episodes of diarrhoea, its role may be limited in other sorts of diarrhoeas. Feachem recently noted that:

"The impact of an ORT programme on overall diarrhoea mortality rates in an area will depend . . . on the proportion of diarrhoea deaths that are caused by acute watery episodes rather than dysenteric or chronic episodes. Where this proportion is high, ORT impact on diarrhoea mortality may be high. Where, as maybe the case in many areas, the proportion is low, the maximum impact of ORT on overall diarrhoea mortality rates can only be modest" [29].

To sum up, these techniques are not "magic bullets" [30] which can be shot into countries to solve specific problems. Nor is their promotion through education and attempted creation of demand for the technology insurance that their use will bring about the expected results of improved health for all people. They depend for their success on a process which takes into account time and effort regarding the change in human perceptions in behaviour, not merely advances in technological development. They depend on attitudes, not only of their beneficiaries, but also of health and other professionals, teachers, administrators and policy makers. They depend on infrastructures and communication. And while few SPHC advocates would argue against this view, the difficulty is that by identifying specific techniques, and strongly promoting them, they divert attention and resources from the process of development to the highlighting of specific programmes with exaggerated and often unpredictable outcomes. Indeed, seeking interventions and 'instant' successes, planners put in danger the long and slow process that leads to sustained improvements in people's lives. They create a climate of short-term expediency instead of long term change.

In other words, we are arguing that in cases like those illustrated above, planners pursued selective interventions believing they were pursuing the goals and values of PHC. However, by taking and promoting simple techniques and focusing on creating a demand among communities for these programmes planners raise expectations which are seldom realized. Policy-makers may support ORS programmes because they give parents more control over the lives and health of their children. But it is at least arguable that high profile donor aided projects deflect attention from the real factors that empower people, and allow them to control their health: the political processes which allow or disallow the channels of dissent, of demand, of participation. It is also at least

arguable that the technologies remain firmly in the control of the professionals: immunizations, and often growth monitoring, take place largely at health service facilities, with minimal community participation in support of these activities. In many parts of the world, ORS is distributed in packages, and is treated as a medicine. Rather than having the packets used to reduce infant dehydration and death, one project in Bangladesh reported that 40% of its ORS packages went to people older than 14 years (and only 3% to children under one) [31].

Reflecting on the above examples, we suggest there may be dangers in a new policy direction which emphasizes selective techniques because it conceptually muddles PHC and SPHC. For instance, by focusing on specific groups (as immunization, growth monitoring and oral rehydration do), it is implicit that other population groups are less important. Yet if a breadwinner (often for an extended family) is chronically ill or dies, the social disruption to the family may be enormous, the loss being felt in the productive sector as well. A child death, however tragic, does not have the same consequences for family or society although we do not want to minimize its negative effects. This is not to plead the case for targeting adults, or even to suggest that targeting is not necessary, but merely to argue that interpreting the concept of PHC to some select medical technologies for specific groups is unlikely to lead to sustained improvements in health for the population.

Furthermore, concentrating on mortality statistics may not only shift the emphasis, as in the Kasongo case, from measles deaths to deaths from other causes but also ignore the quality of life of the survivors. A recent assessment of health programmes concluded "there must be a shift in focus from single interventions directed at communicable diseases in children to a broader concern with multi-purpose intervention, including those directed against the emerging problems of non-communicable disease in adults" [32]. Multi-purpose interventions imply intersectoral action.

Indeed, the main criticism of the focus on selective medical interventions rather than on the PHC process is that they raise false hopes about improving health and neglect the process whereby better health is sustained. Even the original proponents of SPHC seem to be coming round to this view. In May, 1985, the Rockefeller Foundation with Dr Kenneth Warren as the officer in charge, sponsored a conference at Bellagio to review "good health at low cost." Four case studies were presented which included China, Costa Rica, Sri Lanka and Kerala state in India. Cuba was invited but did not participate. All these case studies showed a political commitment to equity and policies and strategies to provide essential services to all. In his summary in the conference proceedings Warren concludes that the improvement in health status in those relatively poor countries had occurred over time, and had to be attributed to a complex mix of social policies guaranteeing adequate nutrition, widespread education and equitable delivery of health services within a political framework which allowed those policies [33]. As Dr Henry Mosley summarized: "Judging by the historical experiences of the case studies this stage may be reached

through a long history of egalitarian principles and democracy (Costa Rica), through agitation by disadvantaged political groups (Kerala) or through social revolution (China). We have also seen that when the commitment to equity is incomplete the mortality declines may stagnate at high levels" [33, p. 429].

However, and most importantly, the explicit lesson from the Bellagio conference was that health improves gradually, with a mixture of policies derived by the countries themselves, from a review of their own priorities and strategies for health. "The focus was on solving problems among the people rather than delivering technologies" [33, p. 430]. There is an implied acceptance of the limitation of technological interventions.

It is the developmental processes that need further exploration and research strengthening capabilities within countries, not injecting techniques into them. Much more work needs to be done at the local level so that it is culturally, historically, ecologically, socially, and economically, relevant, as to what these processes are and how they work: this is where the research effort should be placed rather than in the development of technology.

CONCLUSIONS

Let us return to one of our basic questions—*is there a difference between PHC and SPHC? We have argued there is.*

We believe that those who see health improvements as a result of programmes based on medical and technological interventions have fundamental differences with those who see health as a process dependent on individual knowledge and choice, of which medical intervention is only one and often not the most important, input. We believe the two approaches are different for the following reasons.

Firstly those who accept the former approach believe that those who provide the interventions can control the outcome. Those who accept the latter approach believe that the control of the outcome of medical interventions lies in the hands of those who use or should be able to use the interventions and assume that the means by which this choice is or can be exercised depends on factors over which they have little control. These factors are the social, political and economic conditions of individuals and populations to which medical professionals only contribute but do not define.

Secondly, we see that there is a fundamental difference in views about how long it takes to gain health improvements. Those who accept process expect that radical health improvements will only come after a long period in which changes must occur on both the level of social, economic and political structures and on the level of individual and community perceptions. They recognize these changes are incremental and a result of constant pressure to move organizational structures and people's views, often toward visions rather than clearly defined and measurable goals. The advocates of programmes expect relatively immediate and visible results. They see that technology has the capacity to change the outcomes of health improvements for vast numbers

of people in ways which can be sustained regardless of the society and the people of which it is composed.

We believe that the acceptance of one approach precludes the acceptance of the other because the frameworks by definition are different. While those who follow process do not reject the values of technology and medical intervention and those who follow programmes recognize a process of development, the entry points, the work methods, the expectations and the goals of the two approaches are, we have suggested, not the same. We suggest that the most important issue concerning PHC/SPHC is which approach one accepts. In this paper we clarified the conceptual differences between PHC and SPHC and began to define the practical implications of accepting one or other of these concepts. In conclusion, we would like to note that many of the points we have raised should provide a research agenda for further analysis in this critical area of health care.

Acknowledgements—The authors wish to acknowledge with much thanks the comments and criticisms of the following people: B. Dick, N. R. E. Fendall, H. Hellberg, S. Khanna, P. Mandl, K. Newell, P. Payne, D. Smith and D. Sanders.

REFERENCES

1. Bryant J. *Health and the Developing World*. Cornell University Press, Ithaca, 1969.
2. Abel-Smith B. *Value for Money in Health Services*. Heinemann, London, 1976.
3. Gish O. *Doctors Migration and World Health*. Occasional Papers in Social Administration, 43. Bell, London, 1971.
4. Walsh J. A. and Warren K. S. Selective primary health care: an interim strategy for disease control in developing countries. *New Engl J. Med.* **301**, 18, 1979.
5. Walsh J. A. and Warren K. S. Selective primary health care: an interim strategy for disease control in developing countries. *Soc. Sci. Med.* **14C**, 145, 1980.
6. Boland R. and Young M. The strategy, cost and progress of primary health care. *Bull. Pan. Am. Org.* **16**, 3, 233 1982.
7. Evans J., Hall K. and Warford J. Health care in the developing world: problems of scarcity and choice. *New Engl J. Med.* **305**, 19, 1117, 1981.
8. Gish O. Selective primary health care: old wine in new bottles. *Soc. Sci. Med.* **16**, 1049, 1982.
9. Berman P. Selective primary health care: is efficient sufficient? *Soc. Sci. Med.* **16**, 1054, 1982.
10. Banerji D. Can there be a "Selective primary health care?" Unpublished paper. Consultation on operational issues in the transition from vertical programmes toward integrated primary health care. New Delhi, 4–12 June, 1984.
11. Unger J. P. and Killingsworth J. Selective primary health care: a critical review of methods and results. *Soc. Sci. Med.* **22**, 1001, 1986.
12. Parker A. W., Walsh J. M. and Coon M. A normative approach to the definition of primary health care. *Mil. Mem. Fund Q.* **54**, 415–438, 1976.
13. WHO. *Organizational Study on Methods of Promoting the Development of Basic Health Services*. Official records of the World Health Organization, 206, 1973.
14. Walt G. and Vaughan J. P. *An Introduction to the Primary Health Care Approach*. Ross Publication 13, London School of Hygiene and Tropical Medicine, 1981.
15. WHO. *Global Strategy for Health for All by the Year 2000*. Health For All Series, No. 3, p. 15, 1981.

16. *Primary Health Care*. Health For All Series, No. 1, 1978.
17. Kleczkowski B. M., Elling R. M. and Smith D. *Health System Support for Primary Health Care*, No. 80. W.H.O. Public Health Papers, Geneva, 1984.
18. Banerji D. *Poverty, Class and Health Culture in India*. Prachi Prakashan, New Delhi, 1983.
19. Mahler H. The meaning of 'health for all by the year 2000'. *Wld Hlth Forum* 2, 1, 8, 1981.
20. UNICEF. *The State of the Worlds Children*, p. 3. Oxford University Press, 1985.
21. WHO, as quoted as Dick B. *Issues in Immunization in Developing Countries*, EPC Publication, No. 7. London School of Hygiene and Tropical Medicine, 1985.
22. Mosley H. and Chen L. (Eds). *Child Survival Strategies for Research*, p. 29. Cambridge University Press, Cambridge, 1984.
23. Kasongo project team. Influence of measles vaccination on survival pattern of 7-35 month-old children in Kasongo, Zaire. *Lancet* II, 764, 1981.
24. Gopalan C. and Chaterjee M. *Use of Growth Charts for Monitoring Child Nutrition*. Nutrition Foundation of India, Delhi, 1985.
25. Shears P. and Mkerenga R. Evaluating the impact of mother and child health services at village level: a survey in Tanzania and lessons for elsewhere. *Ann. Trop. Paed.* 5, 55, 1985.
26. Chowdhury A. M. R. Evaluation of a community based oral rehydration programme in rural Bangladesh. Unpublished Ph.D. thesis. London School of Hygiene and Tropical Medicine, 1986.
27. Zoysa I. de, Carson D., Feachem R., Kirkwood B., Lindsey-Smith E. and Loewenson R. Perceptions of childhood diarrhoea and its treatment in rural Zimbabwe. Unpublished paper. London School of Hygiene and Tropical Medicine and Godfrey Huggins School of Medicine, Harare, 1983.
28. Kendall C., Foote D. and Martorell R. Ethnomedicine and oral rehydration therapy: a case study of ethnomedical investigation and program planning. *Soc. Sci. Med.* 19, 3, 253, 1984.
29. Feachem R. Preventing diarrhoea: what are the policy options? *J. Hlth Pol. Plng* 1, 2, 1986.
30. Dubos R. *Mirage of Health*, p. 133. Doubleday, New York, 1959.
31. Stanton B. *et al.* The urban volunteer programme in Dhaka: a community based PHC and research initiative. *Trop. Geogr. Med.* 37, 183, 1985.
32. Prescott N. and Ferranti D. The analysis and assessment of health programs. *Soc. Sci. Med.* 20, 12, 1235, 1985.
33. Halstead S. B., Walsh J. A. and Warren K. D. (Eds). *Good Health at Low Cost*. Proceedings of a Conference sponsored by the Rockefeller Foundation, April 29-May 3, 1985, at Bellagio, Italy.