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Debates

PRIMARY HEALTH CARE OR SELECTIVE HEALTH STRATEGIES

Carol Barker and Meredith Turshen

The Public Health Research and Training Unit at the Institute of Tropical Medicine, Antwerp, Belgium, recently hosted a meeting of invited medical/health professionals and social scientists, all working in the field of health planning and policy in developing countries.

Those who attended were mainly academics whose research and consultancy activities have brought them face to face with the current approach to health strategies in the developing world, as propagated by international organisations, and bilateral aid agencies. This approach, described here as the selective approach, has been proposed by its academic apologists as an interim strategy: a temporary alternative to primary health care for all. It involves deciding only to provide limited (and normally only preventive health care) interventions, rather than to provide an integrated system of care.

The conference decided that a campaign against this approach should be launched, on the grounds that selective care will not improve health, particularly not in the countries normally targeted, where the roots of ill-health lie in poverty.

This piece describes and reflects upon the issues involved in this debate, attempts to put it in the perspective of the crisis, and asks what are the likely outcomes of a campaign.

Primary Health Care

Health services in African countries have their historical origins in, on the one hand, colonial curative services geared mainly towards the administration and those related directly to it, missionary services which were largely curative, and on the other, public health programmes mainly aimed at containment of native disease. To services which, even by the end of the Second World War, were rudimentary as compared to total populations, the technical 'revolution' in biomedical sciences of the early 1950s opened up a whole new promise of mass disease control. Just as, during this period, notions of economic development were technocratic, so were notions of health care development. There was a proliferation of vertical

programmes for disease control — malaria, yaws, tuberculosis and so on, with the notion that each disease could be attacked in turn and eliminated or at least strictly controlled.

By the 1970s, it was becoming apparent that this approach contained severe limitations and inefficiencies. At the same time, the development debate had shifted from a technocratic preoccupation with investment in large-scale production as the key to everything, to one which focused on the nature of poverty. As the 'trickle-down' approach was demonstrated not to work, so the notion of equity as an important component of development, began to creep in. Notions of integrated development, in which economic development is but one means and one goal alongside other means/goals such as education, housing and health, produced the 'basic needs' approach. As the approach to development began to predominate not only among liberal academics but among international agencies, it was readily adopted among health planners and policy makers, beginning to see for themselves the need for an integrated service.

Thus, a notion of primary health care (PHC) developed which included the understanding that health, and the possibility of its improvement, is related to a whole range of social, political and economic factors. Health here is a positive concept, related to socio-economic development. The influence of the basic needs approach in the PHC concept, is to be seen in the emphasis on inter-sectoral collaboration and community participation.

Another basic tenet of the PHC approach is that of equity; whatever resources are available for health care must be distributed with regard to equity across geographical regions and social groups. PHC emphasises the need to use the most appropriate technologies for different levels of health care, and emphasises in the manpower field, the use of non-physician health practitioners. Above all, the PHC approach represents a concept of integrated health services. It is not, therefore, concerned mainly with care at the primary level. It is concerned with development and extension of a country's existing health care infrastructure such that care at the primary level (the level of first consultation, and the most accessible) be available to all. But in the PHC approach, it is essential that referral from the primary level to the secondary and higher levels of health care (the hospitals and specialist facilities) is built into the system and works in practice.

At the Alma-Ata Conference in 1978, convened by WHO and UNICEF, enthusiasm for the community-based health service model had formed into a considerable international consensus favouring the strategy of Primary Health Care as the most appropriate means of reaching the goal of 'Health for All by the Year 2000'.

The Selective Approach

Just as PHC concepts were first being implemented by Alma-Ata signatories, Walsh and Warren presented the selective primary health care (SPHC) approach to a joint Ford and Rockefeller Foundation symposium of Health Services in Bellagio, Italy. As an alternative to PHC, selective primary health care would institute health care directed at preventing or treating the few diseases that are responsible for the greatest mortality and morbidity in less-developed areas and for which interventions of proved efficacy exist.

Walsh and Warren assert that PHC as defined at Alma Ata is too expensive to implement, and that even reduced to its most basic form, would be beyond the

pockets of poor countries. They argue that the selection of a limited number (usually 5-10) of health interventions should be established by prioritizing diseases of importance on the basis of prevalence, mortality, morbidity data, and on the feasibility of control. SPHC health services should concentrate on a minimum number of severe problems that affect large numbers of people and ignore interventions of low, questionable, or unmeasured efficacy.

In their methodology, diseases which have a high rate of mortality are given a higher priority than diseases which produce disability. A medium or low priority is given to a disease which lacks an inexpensive control measure. Thus, diarrhoeal diseases which have a high mortality rate would be given a higher priority than leprosy. Examples of problems that would be ignored temporarily because they are difficult to control are tuberculosis, pneumonia, trypanosomiasis and helminthic infections. The cost-effectiveness of medical interventions is analysed on the basis of deaths averted.

After these factors have been studied, a few diseases are targeted for prevention in the population. Walsh and Warren conclude that a selective approach should be targeted at children of 0-3 years and women of child bearing age, provided by fixed or mobile units, and that immediate large-scale treatment of other prevalent diseases should not be undertaken. They designate this strategy as an interim strategy, to which new elements can be added as resources increase and/or innovations improve the chances of controlling a disease.

Boland and Young have supported the argument for a selective approach, by attempting to cost comprehensive primary health care and concluding that it is too expensive. They also argue from the viewpoint of political cost, postulating that the governments which have achieved the most success in PHC, appear to exercise a strong degree of political control over their societies (Cuba, China and Tanzania being quoted as examples). They assert that it is necessary for poor countries to 'trade some measure of individual freedom for improved individual health'. If strong political control and governmental will are lacking, they conclude that countries will be unable to implement primary health care, and should go for a more selective approach.

This selective PHC (SPHC) approach has been favourably received by the World Bank and UNICEF, USAID and the Ford and Rockefeller Foundations. WHO, on the other hand, has warned against it. In academic circles, a major controversy is underway. Some of the major problems with the SPHC approach are summarised here.

Before examining these, it is worth mentioning that various of the authors mentioned below have criticised the scientific basis of the evidence assembled by Walsh and Warren. In summary, the most important of these are: (a) that the cost comparisons on which they argue for the effectiveness of the selective approach are spurious, being based on non-comparable data from a variety of sources; (b) that their attempts to assess the number of deaths averted as a result of different health systems and interventions are methodologically unfounded.

Oscar Gish in his response to Walsh and Warren, pointed out their failure to address the nature of the wider development process, and their failure to understand that within the basic needs approach, '... the improvement of people's health need no longer primarily result from growth; nor need it wait upon that growth, but rather can be accomplished within the framework of existing resource constraints'. Gish

might have added to this that within the thinking of basic needs, it is not merely a question that health need not wait on growth, it is also a tenet of the whole approach that growth itself can only be achieved by a concerted effort to simultaneously improve both production and the basic needs — health, education, water supply, housing and so on. To say that health cannot be 'afforded' is a rejection of the basic needs approach. Gish argued furthermore that these authors ignore the extent to which a health care infrastructure already exists in most countries, already capable of supporting an integrated programme of basic health services. He also points out that, even when within an integrated service there is the need to consider a strategy for a particular health/disease problem, this must take account of not only the technical medical considerations but also of the cultural, social, economic, political, administrative and managerial environments in which they exist. Unger and Killingsworth reinforce and add to this last point by arguing that proponents of SPHC have tended to assess the potential of existing health care structures for controlling diseases by looking only at the current situation, without considering the available room for improvement with, say, improved management training and reallocation of resources. On the other hand, SPHC systems are judged on the potential efficiency of new technologies used with maximum effectiveness — the resulting comparison being, therefore, value-laden.

As these authors point out, the selective approach is also value-laden in that the implication is clearly that selective PHC will merely fill in the blanks left by the private sector, creating a two-tier service, and a weakening both of preventive care and service integration.

Walsh and Warren base their arguments on the assumption that a reduction in mortality rates for a few specific diseases will result in a reduction in the overall mortality rate of a population; this is the old public health approach for the 1950s. However, many others are now arguing that in areas dominated by poverty and malnutrition, selective disease interventions are useless. Thus, suppose a successful measles vaccination campaign reduces the number of child deaths due to measles, Walsh and Warren assume this means a reduction in total child deaths. But in a community where children are so weak and malnourished that measles is a life-threatening infection, what chance does a child stand? It is saved from measles to die of malnutrition itself, or of some other infection. In conditions of poverty, reduction of mortality due to any one disease will simply shift the mortality to other diseases and conditions; lives will not be saved.

It is of course always necessary in planning, to set priorities for the use of scarce resources; as Nyerere once said, 'To plan is to choose'. The problem with SPHC is that the medical view of priority-setting starts from the angle of diseases. On the basis of the argument set out above, this makes little sense. SPHC protagonists fail to see that the planner's priorities for health care need to be set across a completely different range of categories — in training manpower, in planning buildings, in evaluation of alternative technologies. The cost and effectiveness of a health care infrastructure does not depend crucially on local morbidity patterns; the shape and style of the infrastructure itself are vastly more important.

Yet another problem about SPHC, as Unger and Killingsworth point out, is that the selective approach with its emphasis on diseases causing high mortality, has the effect of concentrating efforts on diseases affecting infants and young children. The effect is to set priorities which do not even attempt to do much for adult health problems. Such an approach represents a top-down value judgement made on the

part of health planners. Third World communities themselves, where adult manpower is indispensable for survival, might be expected to contest a health care system emphasising the goal of reduction of child mortality to the exclusion of other goals.

The top-down and anti-democratic nature of the selective approach are also pointed out by Banerji who merits quoting at length:

The approach of primary health care is based on a philosophy of health services development which is qualitatively different from the suggested selective approach. PHC attempts to rectify a historic error which has crept into health services of all the countries of the world. The PHC approach is based on people, rather than on a predetermined technological system, as has usually been the case in the past. It emphasises socialisation of health services....

....The advocates of the selective approach seem to be so impressed with the revolutionary changes that have occurred in China and Cuba that they do not appear to have paid adequate attention to democratic forces which have impelled the political leadership in many other Third World countries to bring about many radical changes in its health system, including commitment to entrust 'people's health in people's hands'.... The differences in the degree of democratisation of the masses rather than the degree of political control can be a much more convincing explanation of differences in the development of health systems in different countries in the world. The solution lies in promotion of democratisation, rather than obtaining political control from above or from outside the countries.

The Politics of the Debate

Despite the impressive array of criticisms that have been mounted against the selective approach to health care, most of the important international agencies are presently favouring that approach in financing aid projects to the health sector. The most visible and notable example is that of UNICEF, who co-sponsored with WHO the Alma-Ata Conference, and yet whose own activities since then have been increasingly selective, reduced to the promotion of single activities/techniques such as oral rehydration in isolation. From the point of view of analysing the shift in approach, however, it is more important to focus on the policies of the World Bank and the IMF.

Taking the case of Sub-Saharan Africa, the effects of global recession in the 1980s have been such that most governments have been left with little alternative than to borrow from either the World Bank or the IMF. African countries, which in the period 1970/78 accounted for only 3% of total IMF credit committed, in 1979/80 accounted for 30% of the total. Both agencies have, since 1981, adopted a distinctly more monetarist approach to global instability. Whereas up to this time, the IMF had greatly expanded cheap financing to third world countries, the emphasis since 1981 has been to reduce access to low or non-conditional financing, and to move from three-year to one-year loans to which are attached substantial packages of conditions. These conditions are aimed rather superficially at 'stabilisation programmes' and 'adjustment programmes', implying the IMF's role to be to help borrowers return rapidly from an emergency situation to some norm. The IMF no longer sees itself as the source of significant concessional assistance to facilitate real structural adjustment in the economies of low income countries. The Fund is committed, as Harris points out, to promoting a market-orientated international economy working towards control via pricing.

While IMF conditionality operates at the level of the macro-economy, it is complemented by World Bank conditionality, the main focus being on allowing

world prices to determine shifts within the national economy. The various conditions which accompany a World Bank structural adjustment loan, penetrate to all micro-levels of the economy: 'domestic policy issues are at the heart of the crisis' (World Bank). The main features of World Bank policy as it has affected Sub-Saharan Africa are set out in the Berg Report, published in 1981.

The Berg Report blames economic crisis in Africa upon the slow growth of export volume, reinforced by inappropriate policies regarding exchange rates, pricing and taxation and confounded by the restriction of the private sector, and the overdevelopment of a state sector beyond its own management capacities. The Report's prescriptions signal the shedding by the World Bank, of any pretence at a basic needs strategy, biased as it is towards private enterprise over state involvement, a shift in income distribution from labour to capital, and growth before equity.

The over-expansion of the state is described not only in terms of growth in administrative expenditure, but also as the provision, without user charges, of extensive education, health and water supply facilities. In addressing its analysis to health services, the Berg Report produces a fascinating piece of reasoning — health services are enjoyed by only a minority in African countries, and this is the inevitable outcome of governments following the world wide practice of expanding free services. 'It is clear then that the only hope...is through greater emphasis on charging' (Berg p.43).

As possible approaches to health care financing, donors are asked to consider the use of loans rather than grants, or of village revolving funds, to PHC projects, and to encourage private sector involvement. Donors should help foster experiments in decentralised, self-financed projects, and projects emphasising user charges and cost recovery, including insurance schemes.

Thus as the basic needs agenda is dropped, the goal of primary health care is dropped for 'PHC projects' and the private sector. Aspects of health care picked out for special attention in the Berg Report include immunisation (especially measles), treatment of vector-borne diseases (diseases such as malaria, schistosomiasis and onchocerciasis, which are transmitted to humans via an insect or other living carrier, and for which vaccines have not yet been developed), oral rehydration therapy and clean (rather than adequate) water supply. Since poor export growth and low *per capita* income growth are blamed on excessive population growth, family planning becomes of major importance.

So there we have it. The selectivist's viewpoint fits perfectly into international policy-making within a monetarist's framework. Those who regard this as an over-estimation of the importance of the Bank, must be reminded that the Bank is increasingly active in the field of donor coordination, aid cartels coordinating bilateral donors, with a trend towards both bilateral and multilateral aid flows being predicated upon World Bank conditionality.

Time, however, marches on. While the selective approach may still be finding favour with the international agencies in the context described above, those concerned with planning and policy in the health field are forming opposition to selectivism; hence the Antwerp conference. Indeed, according to Walt and Rifkin, even the original proponents of the selective approach are doing an about-turn. At a recent conference in Bellagio sponsored by the Rockefeller Foundation, and described by Walt and Rifkin, 'The focus was on solving problems among the people

rather than delivering technologies' and improvement in health status was 'attributed to a complex mix of social policies including nutrition, widespread education, and equitable distribution of health services within a political framework which allowed these policies'.

Are we, then, likely to see a head-on clash between the international agencies on the one hand, and on the other, the social science and health professionals who are often, as consultants, researchers and agency representatives, responsible for the implementation of aid-financed projects? Not necessarily. This conclusion would only carry force among those who see only two possible health care approaches — primary health care, the 'right' way to go, and selective care, the 'wrong' way. Certainly as we have argued above, the selective approach is simply wrong, at all sorts of levels. The roots of its 'wrongness', however, lie in the technocratic approach to a complex and political problem, and selectivity is not the only possible depoliticised and technocratic approach.

We would argue that many proponents of comprehensive primary health care, in fact routinely reduce PHC itself to a depoliticised and technocratic strategy. To caricature some of the ways in which this is possible, there are those:

- who think PHC is equivalent to provision of a basic health service, being really the sum of a list of technical measures which might add up to a second-rate service provision in areas inhabited by the poor, but which leave ignored, and therefore intact, the curative services available to a privileged few.
- who while seeing the need for an integrated health service, choose to ignore the consideration that good health is probably more contingent on overall development than upon the health sector, and choose to ignore PHC's emphasis on community participation, with its underlying threat of mass struggle.
- those who look to traditional medicine or intermediate technologies as ways of letting the state off the hook, by providing a shabby alternative to the equitable redistribution of health care resources.
- those who enthusiastically propound community participation and self-help alone as the path to PHC, thereby necessarily failing to address the question of the role of the state, and by implication failing to recognise the issue of equity.

There are variations on all of these themes. The common denominator is their failure to understand the class nature of health status and health care. As Banerji has observed (see above), the PHC approach emphasises socialisation of health services, and involves building services which start from below, with support from above; the development of health systems is a function of the degree of democratisation of the masses.

These, then, are the important poles in the debate. The creation of a pressure group against the selectivists might very well prove, in its own terms, a success. We might well see the international agencies changing their rhetoric and espousing any of the partial approaches to PHC described above, to the joy of liberal professionals in the health field. Let us remember that the resulting strategies on the road to health for all, are likely to remain with fatal flaws.

Bibliographic Note

For the original definition of PHC, see World Health Organisation, Declaration of Alma Ata (Report on the International Conference on Primary Health Care, Alma Ata, USSR, September 6-12, 1978), Geneva, World Health Organisation, 1978.

For the first exposition of the notion of selective primary health care, see Walsh, Julia A. & Warren, Kenneth S., 1979, 'Selective Primary Health Care — An Interim Strategy for Disease Control in Developing Countries, *New England Journal of Medicine*', Vol. 301, no. 18, pp.967-974. The kind of methods which Walsh and Warren proposed, however, are in many ways like a simple version of the earlier PAHO-CENDES planning methodology: Pan American Health Organisation, *Problems of concept and method*. Prepared at the centre for development studies (CENDES) of the Central University of Venezuela. PAHO scientific publication no. 111, April 1965. Several hundred Latin American health planners were trained in this approach, until, in the mid-1970s, it was generally agreed to be impracticable.

Walsh and Warren's evidence for what a selective approach can achieve and the credibility of selective strategies rests on such fieldwork as that done in Haiti:

Berggren, Warren L., Ewbank, P.M.D.C., and Berggren, G.C., 'Reduction of Mortality in Rural Haiti Through a Primary-Health-Care Program', *New England Journal of Medicine*, 304, 1324-1330, 1981, — a methodological minefield, as is well-explained in Unger, J.P., and Killingsworth, J.R., 'Selective Primary Health Care: Methods and Results', forthcoming in *Social Science and Medicine*.

That comprehensive primary health care is too expensive is argued by Boland, R. and Young, M., 'The Strategy, Cost and Progress of Primary Health Care', *Bulletin of PAHO*, 16 (13): 233-241. This viewpoint is challenged by Oscar Gish in a paper 'Selective Primary Health Care: Old Wine in New Bottles' which is one of a series of contributions to the SPHC debate published together: 'Comments', *Social Science and Medicine*, 16, pp. 1049-1063, 1982.

The proceedings of the 1985 Bellagio conference are published as: Scott B., Halstead, Julia A., Walsh, and Kenneth S Warren, *Good Health at Low Cost* Conference Report, Rockefeller Foundation, 1985.

Other recent contributions to the debate (both anti-SPHC) are: Debabar Benerji, 'Can There be a Selective Primary Health Care?', World Health Organisation SHS/Document No. 4., From the Consultation on Operational Issues in the Transition from Vertical Programmes toward Integrated Primary Health Care, New Delhi, 4-12 June 1984; (A short but more accessible paper by Benerji is 'Primary Health Care: Selective or Comprehensive?', *World Health Forum*, 5, 312-315, 1984.) (Susan B. Rifkin and Gill Walt, "Why Health Improves; Defining the Issues concerning 'Comprehensive Primary Health Care' and 'Selective Primary Health Care', *Social Science and Medicine*, forthcoming, 1986.

On the Berg Report and the World Bank in Africa, see the reviews by Jane Guyer and Gavin Williams, published under the joint heading 'The World Bank's Prescriptions for Rural Africa', *Review of African Political Economy*, No. 27/28, 1984, pp. 186-196, and John Loxley, 'The Berg Report and the Model of Accumulation in Sub-Saharan Africa', same issue, pp. 197-204; John Loxley, "IMF and World Bank Conditionality and Sub-Saharan Africa", paper presented at the Review of African Political Economy Conference, University of Keele, September 1984.

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THE COLONIAL ROOTS OF THE FAMINE IN KARAMOJA: A REJOINDER

Mahmood Mandani

ROAPE no. 33 carried a critique by Beverly Gartrell ('Searching for "The Roots of Famine": The Case of Karamoja') of an earlier article by myself ('Karamoja: Colonial Roots of Famine') in ROAPE No. 25. In what follows, I shall refer to the former as