Whither primary health care in Europe?

FIVE years ago, an international conference on primary health care, called by the World Health Organization (WHO) and UNESCO,[1] achieved what seemed the impossible at the time—an agreement by the representatives of all the participating Governments (including the United Kingdom), to pursue a goal of:

> 'A level of health for all which would permit them to lead a socially and economically productive life.'

The key to attaining this goal was agreed to be primary health care.

Since then, WHO has published a number of booklets about implementing this process in the *Health for all* series.[2] Many conferences have been held on primary health care and its ramifications. The WHO Regional Director for Europe made a clear statement that these policies applied with equal force to Europe as to the developing world.[3] In his report for 1982, he described encouraging developments in 15 European countries.[4]

Time now presses, with much to be done before the target year of AD 2000 and, more immediately, the conference for all European member countries of WHO in Bordeaux in November 1983. At this conference, Government representatives will be asked to state the progress in their countries towards the goal of 'health for all by the year 2000' by the development of primary health care.

What is this primary health care which we are encouraged to develop? WHO describes three main components: promotion of lifestyles conducive to health, reduction of preventable conditions, and provision of adequate health care accessible to all. It is clearly more than traditional general practice, or primary medical care,[5,6] but it shares many of the same goals. The common ground is even firmer when current College initiatives are taken into account, such as: the pursuit of better health by preventive and promotive means; patient liaison and participation; the development of team working; and a concern for the plight of inner cities and disadvantaged citizens who are reluctant to seek medical care. But WHO stresses that it can only offer ideas and suggestions. Each country must define primary health care in terms of its own technical, social and economic context.

The agenda for the Bordeaux conference will be built around the key principles of the Declaration of Alma-Ata,[1] of which the following are highlighted:

1. self-reliance
2. community participation
3. intersectoral collaboration (with social welfare, housing, employment, etc.)
4. integration of health services
5. attention to vulnerable and high-risk groups
6. appropriate technology

This conference will be a good opportunity for those at the Department of Health and Social Security who are responsible for policies for primary health care to take stock of the current situation, to identify future goals, and to work out ways of overcoming obstacles to their achievement.

Many people working in primary health care will be aware of shortcomings in each of the six key areas. They might, however, question that no mention has been made of the principles for which the College has particular concern—for example, clinical standards, performance review, research and education. Nevertheless, few would doubt the wisdom of broadening the horizon of general practice towards the promotion of better health, greater involvement of people in their own care, and an attention to the determinants of health which lie more in the socioeconomic than in the medical field.

Sceptics will say that the Declaration of Alma-Ata is fine in theory, but how is it to be translated into action? A document which helps to point the way has lately been published by the European office of WHO.[7] Recommendations include a firm national policy for developing primary health care, with clear objectives, plans, targets and performance indicators. These terms may frighten general practitioners who are more used to responding to demand than to planning ahead—who are more familiar with a model for problem-solving than for strategic planning. Alas! the hard world in which we operate does not shift resources to primary health care (as recommended by WHO) without clearly costed plans and targets, and some assurance that the transfer will be justified on balancing the gains to primary health care against the losses elsewhere in the system.

Much of the current philosophy of the College is mirrored in the statements from WHO, and we in the

United Kingdom have made much progress in the general direction which they map out. In some areas we are world leaders. But there can be no room for complacency when the Acheson report,[8] the Black report[9] and the Harding-Frost report[10] still await decisive action. Let us hope that the Bordeaux conference is not ignored here, like its predecessor at Alma-Ata, and that there follows an open discussion of national policies for health and for primary health care. General practice could only benefit from this reappraisal.

Financial stringency is a good reason to take stock of plans and priorities for future development; not to inhibit all progress. Did not food shortage in the second World War produce a food policy which resulted in better nutrition? For policies to be effective, they must involve not just the DHSS and the health professions, but the community at all levels—from the Cabinet to the patients in the waiting room.

PETER PRITCHARD
General Practitioner, Oxfordshire

References

1. World Health Organization (1978). Primary health care. Report of a conference. Alma-Ata USSR. 6–12 Sept 1978. WHO/UNESCO. Geneva. Health for all series No 1.
2. World Health Organization. *Health for all* series, Nos 2–8. Geneva: WHO, 1979–82.
3. Kaprio L. *Primary health care in Europe.* EURO reports and studies No 14. Copenhagen: WHO Regional Office for Europe, 1979.
4. Kaprio L. *The work of WHO in the European Region.* Report of the Regional Director. Copenhagen: WHO Regional Office for Europe, 1983.
5. Vuori H. Primary health care in industrialized countries. *J Coll Gen Pract* 1982; **32:** 729-735.
6. Horder J. Alma-Ata Declaration. *Br Med J* 1983; **286:** 191-194.
7. World Health Organization. *Primary health care—from theory to action.* Symposium. EURO reports and studies No 69. Copenhagen: WHO Regional Office for Europe, 1983.
8. London Health Planning Consortium. *Primary health care in Inner London.* Report of a study group (chairman, Professor E. D. Acheson). London: Department of Health and Social Security 1981.
9. Townsend P, Davidson N. *Inequalities in health.* The Black Report. Harmondsworth, Middlesex: Penguin books, 1982. (Originally published by the DHSS London in 1980.)
10. Joint Working Group. *The primary health care team.* (Harding-Frost report). London: DHSS, 1981.

Care of the elderly

IN this issue of the *Journal* three papers—from Northern Ireland,[1] Wales[2] and Scotland[3]—look at different aspects of the health and care of elderly people in the community.

The study from Northern Ireland[1] reports the response to a questionnaire which was sent to all general practitioners, health visitors and district nurses in Northern Ireland. There was a response rate of 60 per cent. The answers revealed a high level of practice attachment among health visitors and district nurses and yet this has not resulted in effective teamwork in the care of the elderly. Although many of the practices had age-sex registers, only a minority of practices systematically reviewed their elderly patients. Several practices had attempted the task but activity had not been sustained. Satisfaction with the standard of care provided by the practice was claimed by half the general practitioners—a greater proportion than that of the health visitors and district nurses, and particularly surprising when almost all studies made over the two decades since Williamson and colleagues[4] have found a high incidence of unmet health needs in old people at home. In the main, the general practitioners were convinced of the benefits of having a district nurse attached to their practice, but a third of them were doubtful about the value of attachment of health visitors. There is much that needs to be done to prove to doctors that the health visitor has an important role in the promotion of health. All three professional groups saw the lack of resources as the major obstacle to proper care of the elderly. More institutional places and more practical help, for example, in the form of bathing attendants and home helps, were advocated. In addition to the inadequacy of resources, many of the respondents had doubts about their own effectiveness and efficiency.

The report from South Wales,[2] in line with other surveys and contrary to popular myth, indicates that families do support and care for their elderly relatives. Indeed, the vast majority of elderly and disabled people in the community are looked after by their families and the contribution of the statutory services, though important, is relatively small. Individual carers of the disabled—usually the spouse or a daughter—often shoulder their burden completely alone. They may become ill themselves and be isolated from the surrounding community. This paper draws attention to this neglected group of people and, like the Northern Ireland paper, recommends practical help for these carers.

Taylor and Ford, in their paper from Aberdeen,[3] do give some hope to general practitioners who may be feeling overwhelmed by the size of the problem of elderly patients. Their analyses of groups of elderly people who have been traditionally regarded as being at high risk have produced useful information: while recognizing that many old people at home do have health problems, these authors have identified as particularly at risk those people who have recently moved house, those recently discharged from hospital, the divorced or separated, and those aged 80 years and over. These groups should be identifiable in all practices, and will reduce the percentage of the practice population requiring assessment from approximately 15 per cent to 5 per