Primary Health Care and England: The coming of age of Alma Ata?

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Abstract

The Alma Ata Declaration is now 28 years old. This article uses its framework to assess the changes that have occurred in recent years in the English health system. It summarises the health reform changes that have occurred internationally and those in the English health system in two eras, pre- and post-1997 – when the Labour Party came to power. It concludes that linked forces of managerialism and consumerism have had an impact on the health system which has undergone a number of structural changes in recent years. It suggests that the original Alma Ata focus on equity is being modified by the concept of choice. The tensions between central priorities, often reflected in targets, and local accountability and needs are explored. There appears to be a greater interest in seeking genuine health (rather than solely health care) change, with attendant public health and partnership policies, however the gap between policy and practice still needs to be bridged, and questions as to the appropriate locus and leadership for health promotion activities addressed. However there have been numerous institutional changes which carry the danger of distracting from the purpose of achieving health change, and which continue to raise questions as to the appropriateness of a market model for health. Finally the paper argues that the PHC framework of Alma Ata remains a useful framework for assessing health systems, but needs to be tailored to, and prioritised within, a political dynamic.

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1. Introduction

Two years ago, the 25th anniversary of the Alma Ata Declaration passed quietly. Yet for many health systems, especially in low-income countries, Alma Ata with its Primary Health Care (PHC) strategy was influential in setting the health policy agenda during the 1980s. In contrast, in high-income health systems, such as the UK, the Primary Health Care strategy was ignored as irrelevant on the presumption that primary level services were already well-developed. Although referred to as “the cornerstone of health services system in the United Kingdom as well as in many countries” [1] the interpretation of PHC as a focus on services, ignored, as we shall argue, the wider universal principles underpinning Alma Ata [2]

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However by the 1990s the Alma Ata policies were overshadowed by policy fascination with health sector structures and reforms. Indeed in some parts of WHO, its original sponsor, it was even regarded as an historic process with little current relevance. Yet the agenda set by Alma Ata is re-emerging albeit hesitantly in key international policy organisations including WHO [3–6].

This article assesses the current health policies and system in England [7] against the PHC approach. It starts by summarising the key elements of Alma Ata, and analyses the historical shifts that have occurred since then. It then assesses the current health system in England using the PHC principles and concludes by identifying future challenges.

2. The Alma Ata Declaration and subsequent international policy developments

The Alma Ata Declaration was signed in 1978 by health ministers at an international conference organised by WHO and UNICEF [8]. It set out a strategy for attaining Health for All which included two distinct levels of thinking – an operational set of services and a number of principles. The operational set of services at the primary level which ranged from provision of immunisations through to adequate nutrition and water supplies, were seen by more advanced health systems as being already in place. The principles, on which we focus in this article, however, can be argued as universal and equally applicable to developed industrial societies as to low-income rural economies. These principles were:

- attention to equity has to be at the heart of health strategies both for reasons of principle and for sustainability;
- decisions about health care services should be made with the involvement of communities both for reasons of justice and in order to ensure that services are appropriate and acceptable;
- health strategies have to incorporate a preventive approach alongside the more widespread curative focus both on grounds of efficiency and appropriateness of approach;
- the wide determinants of health require health promoting strategies that are intersectoral and much wider than the more traditional narrow medical care focus of many health strategies;
- the inevitable shortfall between resources available for health and the total needs of any population reinforces the need for adoption of appropriate technology in health strategies.

Implicit, particularly in the second of these, was a principle that decisions should be made as locally as possible, i.e. that decentralisation of decision-making was important. This was seen as a response to bureaucratic centralism and as such having the potential to promote greater efficiency, and allow greater identification and response to locally determined needs. This ‘principle’ became more explicit in the late 1980s and 1990s [9].

Alma Ata had a strong influence on policy agendas in developing country health sectors. However implementation of the Primary Health Care principles was more variable [10–12] though its influence can be seen in common policy themes such as the development of community health workers, and the adoption of essential drug lists. However by the beginning of the 1990s there was a sense of disillusion in many low-income health systems and international agencies at the failure to make major inroads into the poor health status of many marginalized groups. Attention focused on the causes of this failure and in particular the health system structures and led to a decade in which a, if not the, key policy focus for many developing countries shifted from PHC to health sector reform [13,14]. This was consistent with a wider focus, in part ideologically driven by New Right thinking, particularly in high-income countries, on reducing, or at least changing, the role of the public sector in the area of welfare. This policy focus was shared, and indeed led by, a number of industrialised health systems – and in particular the UK with the reforms initiated by British Prime Minister Margaret Thatcher [15–17]. The reforms generally contained the following elements:

- introduction of market principles of distinction between the functions of supply and demand leading to a purchaser-provider split;
- enhanced role for the private sector as providers of health care, potentially purchased by public sector commissioning authorities;
• attention to approaches to prioritisation with particular emphasis on economic approaches;
• financing of health care with increased interest in individual financing of health care rather than collective responsibility;
• decentralisation of decision-making powers both to lower administrative levels and to hospital institutions;
• introduction of private sector approaches to management (including the concept of leadership, and greater interest in incentives) in contrast with previous top-down command and control lines of authority.

With the exception of decentralisation the above reform paradigm can be contrasted with that of the Alma Ata PHS principles. For example, financing reforms emphasised the individual rather than community—a key aspect of PHC; efficiency rather than equity were key drivers; and the reforms focused on the role of the health service rather than the wider determinants of health.

The international reform process has, in the last 5 years, shifted away from a formulaic set of common elements to a more organic and context-specific approach. This is reflected in the change in terminology away from health sector reform to health system development. Within the structures themselves, emphasis is placed on issues of governance or, as WHO termed it, stewardship [18] Indeed there has appeared to be, within WHO, a renaissance of the concepts of PHC as symptomised by the call for a return to PHC principles by the new WHO Director-General [3] though the degree of commitment to this has been questioned [6,19].

The last important shift to recognise as part of the policy development process over the last decade, has been the increased interest in evidence-based policy-making exemplified by the focus by WHO at the recent Mexico summit on health systems research and its role in policy-making [20].

Whilst Alma Ata was the dominant policy influence in the 1980s for low-income countries, this was less the case in industrialised countries where PHS was seen as established services. However there were various significant initiatives within Europe and in particular the European Health for All targets [21] and the Healthy City movements [22] which were clearly influenced by

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the PHC philosophy. However, as we have seen, there was far more congruence in the 1990s between low- and high-income country health sector policies with a shared focus on structural reforms.

We consider that the PHC principles provide a robust framework by which to assess health systems and we use this framework to explore the degree to which a PHC revival is occurring in the English health system. We start by a brief outline of the key features of the changes to the English health systems over the last two decades as an important contextual background to the current structures and policies. Box 1 summarises the key dates.

3. Primary Health Care and England – changes since Alma Ata

3.1. History of UK reforms prior to 1997

The Alma Ata Declaration virtually coincided with the election of the centre-right Conservative Government that was to remain in power until 1997. Following an initial laissez-faire health policy during its first term, elements of market reform were increasingly introduced into the UK health sector. These reforms were driven by an ideological belief in the benefits of private over state sector provision, and the power of the market to improve efficiency. They also focused on how to increase the funding base for the health sector and then, more importantly, how the constrained resources available to the health sector could be more efficiently utilised.

Although care remained free at the point of initial access, various user charges were imposed to increase resource generation, most controversially for prescriptions and eye assessments (which still remain for certain groups). Efficiency was focused on, with an underlying belief that increased market competition would produce this, echoing, and indeed, in part leading the global health sector reform movement described earlier. A number of different policy components were included, several proving politically contentious. Key components included firstly the introduction of a split between purchasing (or as it later became known, commissioning) of health care and provision of health care. Provider units were split from the previously integrated local health authorities and established as semi-autonomous hospital and community health service trusts. Services were then purchased from trusts through contracts. A second component was a shift in the roles of the public and private sectors with encouragement to private agencies, including the voluntary sector, to provide a range of services. This was seen most directly in the incentives offered, through tax relief, for older people to take out private health-care insurance [23]. Encouragement (such as increased scope for private practice in the revisions of NHS consultant’s contracts, town and country legislation favouring private sector development, relaxing controls over private hospitals, adjusted taxation and insurance schemes) was given to the placing of contracts with the private sector [24]. A third component was decentralisation policies ostensibly in response to concerns over excessive, irresponsive and bureaucratic central control (it can be argued that decentralisation also provided a convenient means of diffusing political embarrassment with the NHS at the national level) with greater power being given to lower levels in the health sector through deconcentration. The most significant element of this was the establishment of general practice (GP) fund holding in the mid 1990s, in which local groups of primary care physicians were allocated budgets to purchase certain hospital and community services on behalf of their patients.

Wider public health, and particularly efforts to reduce poverty and its consequences on health, received little direct attention by policy makers. Instead, the so-called ‘trickle down’ effect was relied upon to ensure that socially excluded and deprived groups in the population benefited, indirectly, by the wealth creation of others. Similarly, there was little interest in ‘health inequalities’ despite the publication of the Black Report [25]. This report had been commissioned by the previous (Labour) Government in 1977, to assess health inequalities and to make recommen-
dations for action. It, and the subsequent ‘Whitehead Report’ [26,27], demonstrated both that people from lower socio-economic groups were less healthy and more likely to die prematurely than those from more affluent groups, and that the gap was widening. Black made a number of recommendations to tackle inequalities, mainly through progressive tax and benefits, along with special action zones for the most deprived areas and excluded groups. However the new Conservative Government rejected its findings; indeed the report was never formally published. During the 1980s and 1990s, this inequality widened [28–30]. For example, by the early 1990s, death rates were almost three times higher among unskilled groups as they were for professional groups comparing to two-fold difference in early 1970s; in 1999/2001, the difference between areas with the highest and lowest life expectancy at birth was 9.5 years for boys and 6.9 years for girls [31].

The publication of ‘Health of the Nation’, in 1992 [32], was the first attempt by a British Government to set health targets. Whilst these focused on the major disease groups (coronary heart disease, stroke, cancer and accidents) there was at last some recognition of health inequalities, though no target was set and the term ‘variations’ was preferred to ‘inequalities’.

Health promotion also received little attention by policy-makers at this time. One exception to this was the high profile media campaign against HIV/AIDS in 1986/1987. Although controversial at the time, with its emphasis on a mass ‘blanket’ campaign and on promoting changes in personal habit through fear, it is generally regarded now as successful in raising awareness [33,34]. The Health Education Council, the body responsible for setting health education policy and which had led this campaign, came under pressure from the Conservative Government on their approaches to sexual health and community development. This policy difference led the Government to take more direct control of health education policy, by abolishing the council and setting up a new Health Education Authority in early 1987.

The purchaser-provider split resulted in a fragmentation of Health Promotion and Public Health Services. Furthermore, in the context of continual budget restraints, health promotion was also seen by both purchasers and providers as an easy target for cuts. However after the 1993 reforms, which formally established purchasing health authorities, the opportunity arose for purchasing to be based on health gain giving a potentially greater impetus to the science of ‘needs assessment’. This became recognised as a key function for new authorities-based on the utilitarian approach of achieving the greatest gain to meet health needs of a given population [35].

With a growing emphasis on both consumerism and managerialism in health care, health boards of purchasing health authorities recruited lay and business non-executive directors. The first represented a new approach towards local/public representation and the ethos of consumer responsiveness and listening exercises [36] and can be criticised for breaking the earlier link with democratic control through local authority representation. The second indicated a shift from public sector management towards greater private sector management techniques.

3.2. The English health system since 1997

The striking thing about the election of the New Labour Government in 1997 was the initial policy continuity with that of the previous Conservative regime. Whilst the ideological commitment certainly shifted to a greater concern with equity and a reinvigoration of a publicly funded national health service, the mechanism continued to be one of market orientation.

The recent approach to health policy, has been founded upon four central tenets:

- setting of defined standards for the delivery of health services and health improvement, linked to strengthened public accountability through regulatory mechanisms;
- decentralisation of health management and decision-making;
- flexibility of health service delivery through the introduction of new contractual mechanisms;
- choice exercised by patients in the quality, range and location of care given to them.

An initial reaction against what were seen as excesses of the market approach, led to the ending of subsidisation of private health insurance and GP fund-holding and the creation of primary care groups (PCGs). However, the fundamentals of the market approach remained; most notably through the retention of the purchaser/provider split. An initial coolness towards the private sector was replaced however by
a belief that the private sector could drive state sector efficiency gain by attacking the perceived constraints of professional cartels and the introduction of more modern health delivery processes. Decentralisation was most dramatically evidenced by complete devolution of health sector responsibility to the new administrations in Scotland, Wales and Northern Ireland. Since devolved administrations were established in Scotland and Wales, the government has also pursued greater autonomy for the English Regions. Following pilots in devolving economic development policies to Government Offices in these Regions, the Government set out an agenda to devolve various functions from 1999. This included public health with the move of Regional Directors of Public Health to Regional Government Offices in 2002. This provided a new opportunity to tackle the wider determinants of health such as economic regeneration, education and community safety working [37,38].

Under a new health minister, and with media focus on long waiting times and health care quality, the Government launched its NHS Plan in 2000 [39]. This included pledges to boost NHS funding to tackle waiting times, give greater weight to the primary care level through the conversion of Primary Care Groups (PCGs) to Trusts (the latter with greater authority), a plan to tackle health inequalities and ‘codification’ of service and health improvement targets into the Planning and Priorities framework. In England, Primary Care Trusts were established covering populations of around 150,000 people. These now control 75% of total state health care resources, with a broad remit to improve the health of their population, purchase hospital services and provide primary care services. In 2002 former district health authorities were merged to form ‘strategic health authorities’ covering populations of 1.3–4 million and with a performance management function for both primary and hospital care trusts. The Labour Government which was re-elected in 2001 subsequently made a commitment to boost health service expenditure to the European average, and to reform services to meet NHS Plan targets, particularly waiting times for major surgery, and access to services.

In 2003 the Government gave hospitals greater autonomy through the establishment of Foundation Hospital Trusts (FTs). They remain part of the NHS and are subject to NHS inspection and regulation via Monitor (a non-departmental public body established under the Health and Social Care (Community Health and Standards) Act 2003, responsible for authorising, monitoring and regulating NHS Foundation Trusts). However FTs operate outside central control and have accountability to local members who elect a Board of Governors. Some FTs have up to 6000 members – a possibly unexpected level of local interest, although it is still too early to evaluate the effectiveness and genuine representativeness of this type of public involvement. They are funded through a process which links income directly to the amount of activity undertaken within a national tariff system. FTs can access capital markets based on their ability to service debt. This places very direct incentives to maximise business opportunities to improve services. The utility and affordability of additional activity remains a concern at present. One danger of the move to FT status is the shift to private sector accounting standards which potentially exposes historic debt built up in organisations, although in theory this should be dealt with during the FT approvals process.

A significant difference between pre- and post-1997 policy has been an apparent recognition that health improvement requires action on the wider determinants of health. Almost all such determinants are outwith the immediate control of the health sector, and thus there has been emphasis upon multi-sectoral working. An initial exclusive focus on area (community) based initiatives such as Health Action Zones, Surestart, and Structural Regeneration, has given way to local government multi-agency partnerships, called Local Strategic Partnerships, to co-ordinate strategy and implementation. These provided, for the first time since the 1970s, formal structures to work tackle wider determinants of health with an emphasis on community and Local Authority involvement.

The emphasis on efficiency has not mitigated the realisation that the effectiveness of the health sector is critically tied to the overall level of resources invested in it. This has led, since 2000, to substantial planned investment. Between 2002 and 2006 £34 billion, a 43% increase in real terms in health services is planned [40]. However it is clear that, as a result of factors such as changing technology, wage inflation and changes in working practice, this is unlikely to lead to a comparable increase in outputs. Between 1995 and 2003, for example, health inputs grew by 80% at current prices (or between 32 and 39% with pay and price inflation
removed) whilst health output has been estimated to have grown by 28% [41].

There has always been recognition that unless the vast majority of the population remain loyal to the NHS, support will inevitably wane leading to a two-tier service giving greater inequality in access and health outcomes. As such, policy has been geared towards maintaining public confidence and trust in the NHS. This has had effects on the willingness of individuals and corporations to subscribe to private health insurance, leading to price deflation in the private sector and service reorganisation with, for example, BUPA (a leading private sector health provider) selling 9 out of its total 35 hospitals in summer 2005 [42].

4. Assessment of current health system in England

We turn now to assess, against the above background, the current health system using the PHC principles as an evaluative framework.

4.1. Equity

The English healthcare system espouses objectives of equity, usually expressed as equality of access for equal need. The right to access is established in common law and any health organisation denying it would face judicial challenge. The attainment of this objective needs to be assessed by the degree of equity achieved in the distribution of resources, the outputs of health services and outcomes in terms of health improvement.

4.1.1. Distribution of resources

The allocation of financial resources continues to be based on refinement of the Resource Allocation Working Party (RAWP) formula first introduced in 1976 [43]. This is calculated on the basis of population weighted by proxies of health need including demographic profiles, and, despite some criticism [44,45] this formula is generally accepted as equitable [46]. Since 2002, allocations have been made directly to Primary Care Trusts (PCTs). The comparison of present allocation versus ‘ideal’ target allocation gives an indication of the degree of inequity. The policy set for the period 2002–2005 moves all PCTs towards their target allocation, through a combination of a capped increase for over-resourced districts of around 8.5% per annum (still well in excess of inflation) and significantly greater increases of up to 14% for under-resourced districts. The effect of this will be that at the end of the period only four (of 302) PCTs are anticipated to remain more than 10% under target, and eleven PCTs more than 10% over target [47].

Similarly, there has been recognition of the inequity of distribution of human and physical resources. The NHS Plan [39] sets challenging objectives for increasing the number of health care staff. Targets have been set for strategic health authorities in proportion to the base differential from national comparator benchmarks for specific cadres e.g. numbers of community nurses or hospital consultants. The rationale for such targets can, however, be questioned especially as health service modernisation drives skill-mix changes making historically based comparators, focusing on the availability of single professions, difficult to interpret. Specific financial incentives were introduced through ‘golden hellos’ to encourage GPs to take up appointments in more deprived areas. However the effectiveness of these in contributing to greater equity was limited and the scheme was withdrawn in April 2005. This reflects a shift towards addressing resource management issues at local rather than national level, and a realisation that equity of outputs and outcomes are of greater importance than attempted national micro-management of inputs.

Strategic health authorities allocate capital resources to trusts, although the majority of capital in the health service is now controversially raised through private finance initiatives (PFI) with concerns both about privatisation of the NHS and about potential for overextension of recurrent commitments. Allocation of public capital is dependent upon a variety of factors, such as existing building stock, making direct equity analysis complex. The most glaring examples of estates inequity occur within primary care services, in inner city areas. To respond to this, legislation has been enacted to allow the establishment of Local Investment Finance Trusts (LIFT), a public/private partnership focused on producing increased capital resources for community-based services. It remains too early to evaluate the effectiveness of such initiatives, though it has attracted criticism including a concern that this is likely to result in for-profit ownership and leasing of
primary care facilities with potential for misalignment with population health needs [48].

4.1.2. Health care outputs

Any assessment of health system outputs faces a bewildering range of potential measures that reflect the controversy around overall system productivity. In terms of assessment against the equity principle of PHC, we focus on two—attainment of equality of access as measured by the proxy of waiting times and attainment of equal geographical quality of health services—the end of what is called ‘postcode prescribing’.

Waiting lists are the most tangible symptom of inequity within and between the public and private health sectors in England. Eradication of waiting lists has therefore become a policy priority to promote equity and maintain public confidence in a publicly funded health service. The NHS Plan set out annual milestones towards eradication of waits in excess of 3 months for outpatients and 6 months for in-patients by the end of 2005. Substantial progress has been made to reduce waiting lists both in total size and, more importantly, length of waiting time. There has been a reduction from a peak of 1.3 million people on NHS waiting lists in April 1998, to 857,221 in October 2004 [49]. Within this figure there is a significant reduction in those waiting in excess of 6 months falling from 264,000 in March 2000 to 69,638 in October 2004. The waiting time ceiling target has also reduced from a maximum of 18 months to 9 months [50]. Although there have been examples of outliers from the general levels of improvement across the country, these variations have been usually within a few percentage points of overall attainment.

Attention is also now being paid to the, often hidden, issue of waiting times for primary care services. According to the NHS plan, by the year 2004 all patients are expected to have access to GP within 48 hours and a health professional within 24 hours [39]. Whilst at the end of 2001 40% of PCTs were finding it hard to meet these interim targets, particularly the second one [51], by 2003/2004 the majority (79% and 84%, respectively) of general practices were meeting these key targets [52]. The Minister of Health stated that “97% of patients are now able to see a GP within two days” [53]. The Commission for Health Improvement, however, has criticised PCTs as “…technically meeting their target while actually not achieving the underlying goal”; PCTs were not offering any appointments in advance of 48 hours [54], an example of the dangers of the perverse managerial incentives built into such targets. The importance of this is illustrated by the fact that political attention (with particular embarrassment for the Prime Minister who appeared unaware of the issue) was focused on this particular issue in the last election. Policy objectives for the future focus on waiting for diagnostic tests and times from referral to treatment (including any need for diagnostic tests). Whilst this may be desirable in promoting patient care, it does have the effect of further diverting priorities towards acute care provision and away from chronic care such as in learning disability.

Stronger central policy definition and regulation, through for example the development of National Service Frameworks (these are long term strategies for improving specific areas of care, by setting measurable goals and time frames) is aimed at reducing variation in the quality of health service delivery across the country. Although variance still exists [55] there is evidence through the assessments in clinical governance reviews and annual performance assessment ratings by the Healthcare Commission that quality is improving and variance reducing [56].

4.1.3. Health outcome inequalities and equality and diversity policies

The Labour government has given high priority in its policies to reducing the levels of inequity in health experience alongside an objective of improving general health levels. A recent report monitoring progress on inequalities suggests mixed results in terms of achievement against these policies [57]. On the positive side progress is reported on child poverty and housing and in some specific disease areas. However for two key indicators—inequalities by social class in infant mortality and life expectancy have widened. The independent monitoring group also calls attention to need for greater focus on other forms of inequality including by ethnicity. The following explores the details of this.

One important proxy measure of population health is average life expectancy at birth. Throughout the 1980s to the present, there was steady increase in life expectancy [58]. However, significant gaps in life expectancy remain, both geographically and between socio-economic and ethnic groups [59–61]—for example, there is a two-fold difference in infant
mortality by social class [62]. Generally whilst average population health improves, persistent gaps in health experience between the rich and poor remain and in some cases are even widening [63,31]. Health Action Zones were created in 1998–1999 in 26 areas across England particularly challenged by poor health and lower life expectancy – largely in the post-industrial urban areas in the North of England and London. Persistent inequalities were acknowledged in subsequent initiatives such as ‘Programme for Action’ and ‘Spearheads’ and ‘Communities for Health’ launched with the publication of the Public Health White Paper in 2004 [50]. All these initiatives have a common theme-to provide extra resources for community development and cross sector activities, particularly across the Local Government departments such as education, community safety and regeneration, recognising the wider determinant of ill health. However, whilst all these initiatives had been positively received by PCTs and the public health community, the timescales for reversing the trends in life expectancy will require political commitment for many years.

One important and persistent area of health inequality has been for minority ethnic groups. Despite many national and local initiatives, poor health inequalities persist [62]. For example, perinatal mortality within communities with Pakistani and Caribbean origins is almost double the national average [64]. Furthermore, recent widespread criticism of ‘institutional racism’ in some areas of public service, has led the government to launch a new programme to promote diversity and mentorship.

In summary, it can be seen that there is now more apparent interest in inequalities than previously. However, unsurprisingly, the health inequalities are significantly a function of wider forces outside the direct control of the NHS, and raises major challenges for the NHS at different levels in its growing health promotion responsibilities as discussed later.

4.2. Participation and decentralisation

Increasing levels of participation and decentralisation have been central objectives of recent English health policy [65–67]. In addition to the necessity to maintain a balance between strategic and local priorities within partnerships between NHS and local authorities [68], there continues however to be tension between the participation of individuals and patients versus the participation of communities.

4.2.1. Participation

In the early 2000s, UK legislation promoted the participation of patients and community in health [69], with the expectation that this will ultimately improve accountability [70]. Problems remain however in developing effective relationships between NHS and the public to secure accountability [71].

A number of models of participation for community accountability and involvement in planning of health services have been tried. From 1974 to 2003 Community Health Councils (CHCs) which were non-elected bodies had statutory rights to be consulted on changes to the health service. In late 2003 the CHCs were abolished as part of the wider changes in the NHS [72] with the aim to increase public involvement in the NHS via the establishment of alternative means of community involvement such as Overview and Scrutiny Committees and Patients’ Forums. The rationale appeared to be a desire to align patient inputs with specific health care organisations but this can be questioned on the grounds that the public does not necessarily view health care in such organisationally constrained terms.

Another model involves non-executive representation on the boards of healthcare organisations, such as NHS trust boards; however their line of accountability is clear – to the Board chair and through him/her to the Strategic Health Authority. This raises questions as to the accountability of such representatives unless there is a clear link to democratic processes such as local government. As we have seen, FTs include a membership element designed to provide a form of community accountability, but still untested. The role of the public in healthcare inspection processes has been strengthened through, for example, the use of lay assessors in the visits of the Healthcare Commission (a body set up to monitor health care quality and practice) and the annual quality assessment process recently required in all general practices, though their genuine involvement in the process remains to be evaluated.

Increased scrutiny of health services, in particular the effectiveness of their processes for public involvement, is also a function of the recently established Patient Forums which link a group of local residents to their healthcare organisation. An explicit role has also been established for local publicly elected authorities to
question directly the running of district health services. Citizen’s juries, another form of public involvement in health decision-making, have been commented on positively [73,74] and legislation has been enacted which requires healthcare organisations to consult formally with the public on all major changes to service provision [75].

Additional initiatives include analysis of health which includes public perceptions of health and health services. A national patient survey, which can be disaggregated to district level, has been conducted since 2002. This has yielded information on local priorities. More immediate and direct feedback from the public is provided by the Patient Advice and Liaison Service (PALS) established in all healthcare organisations. PALS provides mechanism for the public both to seek advice on using health services, and to register concerns about the delivery of health services. Information from PALS has proved more sensitive and reliable to track the quality of service provision than the more traditional reliance on formal complaints [76].

In 2001 the Modernisation Agency was set up to spear-head dissemination of health improvement methodology across the NHS [77]. The stated objective was to place the patient at the centre of redesign efforts. To enable this, tools such as patient led process mapping and the use of patient questionnaires and histories have been encouraged within the service. These provide opportunities to analyse services from a patient, rather than medical, perspective. Although a number of discreet examples of improvement can be identified, the overall impact is less easy to quantify. Patient surveys indicate a fairly constant level of approval rating for quality of care since they were initiated in 2002 [78,79].

4.2.2. Choice

Choice is a policy theme that places the individual and the decisions they take about the quality, range and location of care available to them at the centre of the healthcare dynamic [80]. This gives increasing importance in policy to individual consumerism as contrasted with the PHC approach to community participation. However, for choice to be genuine, a real set of different and accessible care options needs to be available. Patients can then assess their choices by trading off various known access and quality parameters weighted by their individual values. Participation through choice is seen by policy-makers as an important driver in making services more responsive to individual wishes and preferences.

Choice as a policy initiative has become closely aligned with efforts to diversify provision through encouraging a greater range and plurality (public and private) of providers. As well as promoting choice, the rationale for plurality is also seen as enhancing contestability between health services, which is perceived as encouraging efficiency. The most tangible result of plurality policies has been the introduction of independent sector run treatment centres and an objective to increase significantly the volume of private sector provision contracted by the NHS over the next 3 years [81]. There are however a number of criticisms made of the dangers of such pluralism and the potential for growing privatisation [82,83]. In particular, growing numbers of private providers could change the balance of power in the medium term with concomitant potential for “rapid cost inflation, rising transaction costs in managing the market, and an inability of governments adequately to regulate the private sector” [84].

Increasing choice by driving appropriateness and efficiency is also perceived in some quarters as promoting equity, as summarised by a recent statement from the health minister:

The post-war welfare state was characterised by a belief that services could deliver equality through the provision of the same services to everyone. What became clear is that different people have different needs and that uniformity of provision fails to provide equity of provision for people with different needs. Different provision suited to different needs will encourage equity [85].

There are, however, several potential negative aspects to the focus on choice. Firstly, the ability of patients to exercise genuine choice is adversely affected by levels of deprivation, e.g. access to transport to move to alternative providers. Thus more affluent and articulate groups potentially seize differential benefits. This is exacerbated by the growing ability of certain groups to access information through sources such as the internet, which may provide selective social empowerment. Secondly, an almost inevitable consequence of increased competition is failure of some providers. This may have significant effects on local access in
affected areas. The implications of this have yet to be tested.

It remains too early to judge the success of the ‘choice’ initiative, but it provides a new perspective on, and interpretation of, individual participation driving other aspects of PHC.

In summary, the last few years has seen a number of new initiatives in the area of community and individual participation in decision-making in the NHS with attempts to operationalise the rights of the public to be consulted, with mechanisms to provide greater accountability. This coincides with, or indeed may be driven by, heightened expectations by the public as to their rights within health and health care delivery, which is likely to grow. At the community level, there remain doubts as the representativeness and genuine accountability processes, given the lack of links to a democratic process. At the individual level, participation is being increasingly interpreted as providing alternatives for choice, which raises questions as to the genuine nature of the choices for certain social groups, and a different interpretation to that of the original Alma Ata Declaration which focused on community inputs to decision making rather than individual roles and responsibilities.

4.2.3. Decentralisation

At the core of efforts to promote decentralisation has been the establishment of Primary Care Trusts (PCTs) with the functions of improving health both through public health responsibilities and the provision of health services either directly or through commissioning. Underpinning this was the need to work in partnership with other organisations, notably local authorities and many PCTs are seen to be “...developing partnerships more effectively than any of their NHS predecessors” [86]. It is important to recognise however, that while an overt rationale for decentralisation is a desire to allow central government to focus on key policy levels such as regulation and standardisation, this paradoxically may lead to greater centralisation.

Furthermore, some analysts have argued that the origins of the current decentralisation in the Thatcher reforms were based in a political desire to shift responsibility for the failings of the NHS away from central government.

When first established PCTs were seen as powerful entities in shaping both the future provision of health services and efforts to implement health promoting initiatives, through a strong community basis, and a primary care view on the design of health services. The effectiveness of PCTs in leading commissioning has, however, been increasingly questioned due to the continuing dominance of large hospitals and inadequate capacity of PCTs to successfully perform public health function [87]. Recent policy guidance has given greater emphasis to decentralisation within PCTs [88,89] through the introduction of practice-based commissioning to enable primary care physicians and patients to have a direct influence on service commissioning.

However, since 1997, the scope for genuine self determination of local bodies remains restricted, as a result of the large number of centrally driven targets, and performance management approach. In response to this, financial and target setting systems are being reformed to support local target setting as the next logical stage in supporting local determination. This is seen in two policy areas.

Firstly, greater power and autonomy for local government is being sought [90]. One of the early manifestations of this is ‘Local Area Agreements’ being piloted in 21 local authorities, to release nearly all previously earmarked funding for local determination. Health is one of three ‘blocks, together with ‘children and young people’ and ‘stronger safer communities’. However a central hand remains present with local organisations needing to demonstrate that they can deliver on nationally set targets within budget, before being given greater responsibility – the concept of ‘earned autonomy’.

Secondly, attention is also shifting towards a greater development of locally determined health targets. All PCTs are required to agree a range of targets for local health plans. As long as these comply with a national prioritisation framework and can be seen to be sufficiently challenging, then PCTs have the power to determine them. However, the usefulness of this power is questionable as pursuit of national targets usually consumes all resources available at local level.

In conclusion, there are clear tensions between the desires of national politicians to drive change through centrally imposed targets, and to allow greater freedom at the local level to determine and respond to their own priorities, with the latter clearly being closely related to the conceptualisation and approach to local partic-
ipation discussed in the previous section. What is the balance between accountability upwards to the national level and accountability downwards to the community? As Peckham reminds us, Butler pointed out 10 years ago: “it is still not clear whether the NHS is a central service that is locally managed or a local service operating within central guidelines”[92]. The management of these tensions remains an ongoing political challenge.

4.3. Prevention and health promotion

In recent years has been greater emphasis on prevention and promotion. This can be viewed at different levels – that of general government policy concerning the determinants of health, and the specific activities of the health agencies. In the next section we examine the institutional arrangements for intersectoral activities in pursuit of a public health agenda.

4.3.1. National health promoting policies

Since 1997, the Government has embarked on a more progressive (though still cautious) tax and incomes policies and more socially inclusive policies. There is some evidence that the increasing gap between lower income groups and other groups has halted and in some areas, is narrowing [93]. However data is mixed. The economic and social gap between London/Southern England and the post industrial North (the so called North–South divide) is reported to have widened on a number of economic and social indicators [94–96]. Efforts to address these persistent inequalities have intensified since 2002. For example there is renewed effort to ensure open access to higher education, assistance for public services in areas of high deprivation, economic regeneration policies and access to NHS services through the use of health equity audits which are designed to influence local allocative and service improvement decisions. Audits [97] are expected/designed to identify how fairly services or other resources are distributed in relation to the health needs of different groups and areas, and the priority action to provide services relative to need.

In 2002 and 2004 the government published reports into NHS financing and opportunities for preventing ill health-the Wanless Reports [98,99] which criticised public policy in the area of prevention and accused the NHS for its emphasis on acute care. Interestingly this report originated from the finance ministry in recognition of the high cost of failing to achieve a public health policy. It predicted an exponential year on year increase in the demand for health services and outlined scenarios on how this increase in cost could be prevented or contained. It recommended that only when individuals are fully engaged in their health can there be any opportunity to prevent ill-health. The report was welcomed by the health sector and public health community, although critics point out that the report emphasises individual choice rather than wider community and government action [100,101]. The Government subsequently consulted and published its Public Health White Paper Choosing Health [50]. This attempts to define the role of individuals and communities and government in public health policy in the 21st century and states that its prime objective is to empower individuals to make healthy choices about their lifestyles. The government’s role is seen as creating an environment which will enable disadvantaged people to make healthier choices and to protect those (such as children) who cannot make choices themselves. At the national level there have been various institutions aimed at providing health promotion leadership, of which the most recent, the Health Development Agency, recently merged with the National Institute for Clinical Excellence to become the new National Institute for Health and Clinical Excellence (to continue to be known as NICE). This is intended to reflect the need to advise on good practice in health promotion as well as continuing to assess and issue guidance on clinical procedures and treatments.

The Government’s Public Health White Paper [50] contains proposals to introduce smoke-free public places by 2008. There is, however, a loophole-pubs and bars which do not serve prepared food will be able to allow smoking on their premises. The BMA in a recent study found that 9 of out 10 towns and cities with the highest proportion of ‘non-food’ pubs are in the north of England or the Midlands [102]. This suggests further differences in health status contradicting Government’s policy to reduce health inequalities.

Following the terrorist attacks of 9/11, the government increased investment in public health services to prepare for new threats to the public’s health from...
nuclear, chemical or biological weapons. In England, this was one of the reasons for re-organising the communicable disease control and emergency planning functions, which were fragmented at local and national levels into a Health Protection Agency. Although this investment has been in a narrow field within public health, this increased awareness and investment has had some spin-offs in other areas of public health, particularly in communicable diseases such as STI and HIV/AIDS.

4.3.2. Role of PCTs in prevention
Each PCT is now required to promote the health of its population – a shift from the traditional general practice patient-centred approach. Health promotion’s organisational location within primary care has meant its re-focusing at this level, on health improvement for defined populations. Health promotion services have enjoyed a renaissance with this focus and have engaged in area-based initiatives such as Health Action Zones (HAZs) [103]. However one downside of this has been the loss of a co-ordinated approach in large conurbations where previously functions such as communicable disease control were led from a wider level. Furthermore, the continued political attention to targets such as waiting lists for acute care, inevitably put pressures on PCTs to respond to these, at the cost of attention to wider preventive activities.

One of the implications of the principles of Alma Ata was the need to integrate promotion, prevention, curative and rehabilitative services at the primary care level. To address this integrated approach to prevention National Service Frameworks (NSFs) have been produced for heart disease, cancer, diabetes, older people and child services amongst others. A defined set of proposals now exist to move towards a single holistic approach to health and health care. Whilst certain variations exist, NSFs appear to have been successful in focusing attention and initiating service improvement. Indeed one of the functions of the NSFs is to provide explicit standards to help with equity goals, given as we have seen that in 1990s there were major inequities in provision and use of health services in England [104].

Concern exists however that resultant services, such as smoking cessation, whilst improving overall levels of health still suffer from differential access and effectiveness leading to widening health inequalities.

The above suggests that there has been a greater interest in public health and personal prevention than in previous decades. However, a significant gap between policy and practice continues to exist and to reflect the dominance of acute care thinking in the NHS. There clearly remain areas where public health and preventive policies are less strong than would be desirable, both in terms of national initiatives (such as smoking legislation) and at the local level in terms of co-ordination of activities. This raises in itself questions as to whether the NHS (or any similar health care service) can transform itself into a lead health promoting agency or whether such leadership is more feasible from a different organisational location within government and we turn now to an examination of the relationships between different sectoral actors in health promotion.

4.4. Multisectoralism
The principle of multisectoralism is derived from a desire to promote good health by focusing on the determinants of health, and as such is closely related to the previous section. Here we examine particular mechanisms at different levels for enhancing collaborative work across sectors.

4.4.1. Local partnerships
In 2001 the Government launched a Strategy for Neighbourhood Renewal [105]. Five sectors (health, police, education, business and the voluntary sector) are required to work with local authorities to establish and manage Local Strategic Partnerships (LSPs). All areas are required to establish LSPs, but the Strategy also identified 88 most deprived LA areas ear marked for additional funding to support local work. Nearly all PCTs participate in LSPs-many with specific local health objectives.

Increasing attention is being paid to formal arrangements to link health with directly related areas of public sector provision. The potential to establish Care Trusts fusing health and social care has existed for several years, but this power has only been availed by a limited number of organisations. Much more significant are the implications flowing from the Children’s Act (2004) which require the establishment of Children’s Trusts in all local authority area under a single Director of Children’s Services. Although at a fairly early stage of implementation and with significant potential for
local flexibility it is already clear that health, social and educational services for children will have to become increasingly integrated over the coming years. Knock-on impact into models for adults and older people is likely.

4.4.2. Regional partnerships

Government Offices, alongside Regional Development Agencies (RDAs) and Assemblies act as a key partnership at this level. Nine Government Offices exist in England and through the provision of the White Paper “Your Region Your Choice’ (2002) allow for these organisations to work in partnership on cross-sector planning at a regional level. Through the Regional Directors of Public Health a number have agreed partnership frameworks and plans to tackle health inequalities. Also at Government Office level, other partnerships have developed with the voluntary sector, businesses, education (learning skills councils), the environment (Countryside Agency) sport (Sports Boards), and culture, which have led to incorporation of health improvement objectives into other sector strategies. For example, most regions now have regional housing strategies which require meeting population health needs for new housing development – particularly warm affordable housing in deprived areas. Similarly sporting strategies now incorporate health improvement as a key aim through improving participation in sport and leisure. However as in many areas of government policy implementation at the regional level, there is a lack of robust research on the effectiveness of these partnerships.

4.4.3. National Government Partnerships

During 2004, the Government issued its 3 years Comprehensive Spending Review, which includes spending plans for each department. The Treasury requires each department to make ‘Public Sector Agreements (PSAs) on cross cutting objectives. Public health, for the first time, is a key theme in this review. Each Department is required to establish new partnership arrangements across Whitehall. For example there is obesity PSA, which requires the Departments of Health, Culture, Media and Sport and Education and Science to collaborate to reduce the obesity epidemic (through education, access to leisure and sporting facilities and health promotion). These partnership agreements are new in tackling upstream wider determinants of health at Central Government level; their impact is still to be assessed.

The preceding sections on prevention and multisectoralism have indicated a weakness in the Alma Ata framework. The rationale for a multisectoral approach is, of course, the opportunity for action on the wider social determinants of health, and as such, a major opportunity for health promotion. Assessing the two criteria together, suggests that there has been a significant increase in interest in health promotion in recent years both within the health care system and in other parts of government. Interestingly some of this has been driven by an economic agenda. The impact of this new emphasis and its institutional mechanisms however remains to be evaluated, including the ability of PCTs to take on a genuine broad population-based role and the ability of government to provide sufficient incentives to obtain genuine cross-agency working. Underlying all of this are questions as to the ability and indeed willingness of the NHS, given its history of focus on acute care, to lead on a health (rather than health care) agenda [106]. At the national level, the major thrust towards public health has emanated from Treasury concerns over the economic cost of preventable illness. Furthermore, political considerations have led, to reluctance to “challenge powerful commercial interests that undermine public health” [107]. At the local level, despite a number of important partnership initiatives, the frequent reorganisations of the health service have not helped to allow the emergence of genuine and sustainable partnerships on a health agenda.

4.5. Appropriate technology

Health technology is potentially an all encompassing concept. For the purposes of this paper it is taken to be the set of techniques, drugs, materials, equipment and procedures used by health care professionals in delivering health care to patients and the systems within which such care is delivered. Appropriateness is a more problematic term to define and encompasses criteria such as relevance, safety, cost, usability, feasibility, community and cultural acceptability. Some of these have already been considered elsewhere in this paper. As a highly advanced increasingly post-industrial economy within which many health technologies have been adopted with a well-trained workforce, many aspects of appropriateness appear well met at a general
level. Although not expressed in the direct terminology of appropriateness, concern for maximising the efficiency and effectiveness of healthcare technology has been an important facet of recent health policy. There has been a focus both on individual technologies and their location within healthcare processes.

The Wanless Report [98] highlighted three particular aspects:

- the continuing importance of NICE in examining newer technologies and older technologies and practices which may no longer be appropriate or cost effective;
- extension of National Service Frameworks to other areas of the NHS, to include estimates of the resources – in terms of the staff, equipment and other technologies and subsequent financial needs – necessary for their delivery;
- recognition that a key priority is the need for effective investment in Information and Communication Technology (ICT) with a major programme being required to establish the infrastructure and to ensure that common standards are established.

4.5.1. Healthcare Technology Assessment

The need for effective health care interventions, which provide the maximum benefit appropriate to the resources has led to the development of a National Institute for Health and Clinical Excellence (NICE) which makes recommendations to government and clinicians on the most effective treatments available.

Currently, NICE produces three types of guidance:

- technology appraisals – guidance on the use of new and existing medicines and treatments;
- clinical guidelines – guidance on the appropriate treatment and care of people with specific diseases and conditions;
- interventional procedures – guidance on whether interventional procedures used for diagnosis or treatment are safe enough and work well enough for routine use.

A significant proportion of interventions is assessed as not appropriate for support and therefore should not be made available within the NHS. The recent plans to incorporate the Health Development Agency into NICE will mean that similar approaches will be adopted for public health interventions.

NICE appears to have attained a high level of influence and credibility within the health sector, in determining the health technology assessment and dissemination process and thus its appropriateness within England. Its explicit rulings may also provide a focus for lobbying by interest groups as has been shown recently in public debate over the provision of cancer drugs.

4.5.2. Information and communication technology

The publication of the Wanless report in 2002 led to the production of a new national strategy for ICT [108]. Three main objectives were set to:

- support the patient and the delivery of services designed around the patient, quickly, conveniently and seamlessly;
- support staff through effective electronic communications, better learning and knowledge management, cutting the time to find essential information (notes, test results) and make specialised expertise more accessible;
- improve management and delivery of services by providing good quality data to support NSFs, clinical audit, governance and management information.

Implementation through the National Programme for Information Technology (NPfIT) has focused on:

- greater central control over the specification, procurement, resource management, performance management and delivery of the information and IT agenda;
- development of the infrastructure, including improving broadband capacity, giving central storage (allowing sharing and analysis) of all health information;
- development of key applications which allow effective integration of care around the patient.

Implicit within this was recognition that current ICT had been inadequate in delivering appropriate technology. The previous decentralised approach had led to a multiplicity of systems standards and applications, making effective system communication and integration virtually impossible.

Substantial controversy has surrounded the implementation of the NPfIT over recent years. Major concerns have focused on cost, programme feasibility, confidentiality of records and resistance of professional
groups to adopt new technologies and working practices. Although progress is being made in establishing the core infrastructure, many of the anticipated benefits for staff and patients remain unrealised.

Attention has also focused on improving levels of patient access to healthcare information through both telephone and internet routes. A national telephone access point – NHS Direct – provides advice on handling medical problems based on standardised care algorithms. Efforts to introduce telecare remain at early stage, except in certain vulnerable groups [109] and highly rural locations.

This discussion has focused on two critical aspects of health technology: assessment processes and the importance of ICT in delivering modern integrated healthcare. These suggest that concerns about, and delivery of, appropriate healthcare is an increasingly important aspect of health policy.

5. Conclusions

This article has provided an assessment of the current English health system against the Alma Ata PHC principles. There are two broad areas of conclusion. The first relating to the English health system and the second concerning the PHC principles.

5.1. Assessment of the English health system

Although within the English health system, the perception and understanding of Primary Health Care as a specific strategy has often been limited, the various principles which underpin PHC are in fact largely implicit within health policy. The English system has come some way from its days of excessive secondary care dominance of health services and the internal market of the 1980s, although significant elements of the market still exist.

Clearly health policy has evolved, and is currently located, within a socio-political context that has changed substantially over the past 25 years. Two linked forces: consumerism and market management can be seen to have had a significant impact on the interpretation of PHC within the English healthcare system.

The rising importance of consumerism can be seen to have led directly to increased attention to choice in the type and range of healthcare, based on individu-
a market into the British health delivery system and subsequent reforms have essentially responded in one way or another to this paradigm. Some commentators [111] have argued strongly, that this market philosophy should be rejected; and that this does not need to imply a return to old ‘command and control’ approaches to the NHS. Instead it is argued that a third way is required which addresses the needs for reform without resorting to market principles and drawing on principles of mutualism (idem). We have not addressed this issue directly in this paper, but it is clearly a critical one. Indeed alternative models for structuring the health service will inevitably have implications for the principles of primary care that we have examined, such as participation. The original concept of participation by communities in decisions was intended to be more than the sum of individual participation in their own health care needs. A market approach to health care emphasises the individual as a consumer rather than as a member of a community. Such more communally based participation is not easy to see in the English health system. Whilst, the new roles for Local Government in public health, identified in the Public Health White Paper, may provide an opportunity for more local democratic accountability for health, PCTs and FTs are not, in any sense, democratic and cannot be argued to be representative in any sense of the wider community. This remains a major challenge.

One particular aspect of this relates to the continuing tension between the setting of central policy, as expressed by central targets, and local policies to reflect community needs and interests which is evident within the present system.

One of the major policy shifts that does however seem to be appearing within the English health system is greater attention to the wider determinants of health rather than a narrower healthcare agenda. The critical question is whether these policies can be turned into practice. If this is genuinely implemented and sustained, then this could provide a set of experiences for other countries that struggle to move beyond the narrow and medically dominated interpretation of health policy. Policies to regenerate deprived areas economically and socially will have a direct impact on health. Similarly, health promoting schools and workplaces are likely to provide opportunity for health improvement outside the direct responsibility of traditional health care systems. However there is some evidence that the government may not have the desire to show political leadership in some areas of public health promotion and where necessary challenge commercial or indeed professional interests. Linked to this are questions as to the most appropriate focus for leadership in public health and whether the current structures allow the genuine development of sustainable partnerships for interventions on the wider determinants of health.

Lastly the last 15 years of reform of the English health system has been characterised by a combination of changes in the structure of the system accompanied by a proliferation of institutional responses to policy challenges. As one commentator has suggested this has been a “phenomenon of ‘dynamics without change’” [112]. Indeed, as this article is finalised, a further round of reforms is being prepared for implementation. This is to some degree paradoxical given the political stability which would have suggested the ability to develop a single cohesive approach. There would appear to be a real danger that such the frequent institutional reconfigurations have the danger of masking, and indeed detracting from the underlying objectives and principles of any health system, and in particular those of PHC.

5.2. Primary Health Care as a framework

The dichotomies and tensions within and between AA principles are well illustrated by the experience of the English healthcare system. This illustrates the need to recognise that political value judgements will always be required to prioritise the AA elements giving the implementation of PHC a particular and changing interpretation.

The exercise has not only identified traditional tensions in any health care system (such as equity versus efficiency and central targets versus local autonomy) but interesting new tensions which need further exploration.

For example Alma Ata does not identify the role of government in health improvement and individual choice. Indeed it could be argued that there is a paradox in this paper in that we have focused on the public sector responses to ill-health. However implicit in the interpretations of the PHS principles is the need for state action, and given the endorsement by health ministers, such a focus is regarded as appropriate. The English White Paper attempts to define the boundaries
of government and individual responsibility for a 21st century Western society. It states that individual must take responsibility for making personal healthy choices and that communities and government has a role in creating the right conditions for healthier choices, particularly if those conditions encourage poor healthy lifestyles. This particular boundary may not be acceptable within all societies. However it does provide an example of the sort of policy concerning the role of government that is required.

Indeed, the degree to which a market orientated health care system can support the attainment of PHC objectives presents an interesting challenge to conventional PHC thinking.

Finally, we consider that an exercise such as this is worthwhile is tracking progress and we believe that further mapping by other countries will shed light on useful comparisons.

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References

[7] With UK devolution, the precise health policies and structures for England are different from the rest of the UK and for the sake of clarity we focus here on the former. Where primary care services are discussed, we focus primarily on medical services at the necessary expense of dental and other services.


