Defining Primary Care

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Primary Care Course
(Based on Cape Town, South Africa, 2007;
and Barcelona, Spain, 2009)
This presentation explains why primary health care and primary care are a worldwide imperative and how they can be conceptualized and measured to provide accountability for achievement in different areas and countries.
Revolutions in Medicine, 1900s

Ascendance of single disease and chronic illness focus

Diagnostic challenges/more technology

Single cause (? gene) – magic bullet

All fostered an INDIVIDUAL ORIENTATION in health services.
Revolution in Medicine, 2000s

Multiple interacting influences on illness/health
Disparities in health (inequity)
Illness as morbidity burden, not as disease
Risk factors as diseases
Health as an impossibility (a healthy person is someone without enough tests)

All require a POPULATION ORIENTATION.
This chart shows the relationship between the wealth of 177 countries and their child survival to age 5. The size of the circle represents the population of the country. Child survival to age 5 improves with increasing gross domestic product (GDP) per capita. However, at any given level of GDP per capita, there are large variations in child survival. This indicates that countries differ in important ways in their approaches to maximizing the health of their people. Other evidence shows that one of these ways concerns their policy towards organizing and developing equitable health systems.

This graph shows the well-known relationship between country wealth (as expressed by GDP per capita) and life expectancy. Although not previously stressed, it shows considerable variation in life expectancy at any given GDP. For example, Poland and South Africa have approximately similar wealth but life expectancy is, on average, 7-8 years greater in Poland. Variability is noted all along the curve, even at its asymptotic end, as some countries at the wealthy end of the curve experience lower life expectancy than less wealthy countries. These include, particularly, Switzerland and the US. Other wealthy countries fall below the curve; these include Germany, Taiwan, and Singapore. Thus, wealth alone does not assure health. The graph also shows a new phenomenon: an apparent decline in life expectancy above a certain level of country wealth. Some very wealthy countries (US, Switzerland) are recently experiencing lower life expectancy than some less wealthy countries, and some others (Germany, Singapore, Taiwan) are below the curve. That is, they have lower life expectancy than expected despite their wealth. These five countries are all countries whose health systems are more specialty oriented than primary care oriented, suggesting the likelihood that there is excessive and unnecessary specialty and technology use leading to inappropriate care and perhaps even an increasing rate of adverse effects from excessive intervention.

This slide shows the well-known direct relationship between the density of health professionals and one aspect of the health of populations: health professional supply. As this slide shows, the relationship holds only on average, and there is considerable variation, with some countries having many health workers but still relatively high child mortality under age 5. There is even one country with few health workers that has a child mortality the same as the United States and Cuba. Clearly, it is not the number of health professionals that influences child mortality; rather, it must be how those health professionals are organized and what they do that is the influence.

At the beginning of the 21st century, data from industrialized countries such as those in this graph show that under-5 mortality is not related to the ratio of total health workers to population. As there is considerable variation in under-5 mortality even in these industrialized countries, it is evident that it is not the total number of health workers but, rather, the way in which they are organized and what they do (and, undoubtedly, other aspects of social policy) that make a difference to health outcomes.
Increasing recognition that there are systematic differences in health across different population subgroups, i.e., inequity in health, has led to an expanded view of influences on health. In this view, health is viewed as both an average of individuals in the population and the way in which health is distributed in the population. In populations, community and policy contexts have a major role in influencing more proximal influences on health in communities and on individuals in communities.

These societal influences operate differently in the various subgroups of the population. It is these factors, rather than those at the community and individual level, that primarily influence distribution of health within the population rather than average of levels of health such as those that are commonly in use in health statistics.

Political contexts determine the nature of policies, which, in turn, influence the characteristics of communities: environmental; levels of income and their distribution, e.g., income inequality; power and status relationships; behavioral and cultural characteristics; and health system characteristics. Because they are all influenced by the political context, they potentiate or interact with each other and more directly (through unknown individual characteristics and exposures) influence both health levels as well as distributions of health in individuals, both of which also are affected by demographic characteristics and historical health disadvantage i.e., the tendency of good or poor health to persist for long periods of time in defined geographic areas.1

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There are only a handful but increasing number of studies concerning the influences of such characteristics on various health needs.²

A focus on influences on the health of populations does not assume a particular pattern of risks among individuals in that population. In this diagram, the individual risk factors are less salient than community and policy characteristics in a political context. Conventionally the province of public health, interventions at these levels have emphasized the extent to which societal factors can be modified to prevent the occurrence of ill health. Thus, prevention is a major thrust of public health efforts. Less common is consideration of the extent to which characteristics of these levels contribute to worsening of health where it has already been compromised.

In the most recent 20 years, the salience of such activities has become more visible as, for example, the role of health policy in facilitating or interfering with the practices of pharmaceutical companies in marketing retroviral medications for HIV/AIDS. In this sense, the “determinants of disease” and their progression are societal (rather than social), and they operate primarily to alter rates of discomfort, disability, and death rather than occurrence (incidence) of ill health.

The other important characteristic of a focus on populations is that it explicitly requires consideration of distributions in the population, i.e., equity in health, as well as average levels of ill health.


This diagram was proposed by the WHO Commission on the Social Determinants of Health. As such, it focuses on pathways through which inequity in health (“distribution of health and wellbeing”) is achieved. The diagram does not specifically distinguish macro political and economic forces from the policies they engender, nor does it show an impact of individual and community factors (except for the health system) on distribution of health. Its major emphasis appears to be in the reverse direction: that unequal distribution of health influences individual and social phenomena.
The Commission on Social Determinants of Health

Chapter 9: Universal health care recommendations for national governments

(Action area 1: build health-care systems based on principles of equity, disease, prevention, and health promotion)

9.1 with civil society and donors, build health care services on the principle of universal coverage of quality services, focusing on Primary Health Care

(Action area 2: ensure that the health-care system financing is equitable)

9.2 ensure public sector leadership in health-care system financing, focusing on tax-based financing, ensuring universal coverage regardless of ability to pay, and minimizing out-of-pocket payments

(Action area 3: build and strengthen the health workforce and add capacities to act on the social determinants of health)

9.3 with donors, increase investment in medical and health personnel, balancing health worker density in rural and urban areas

9.4 with international agencies and donors, address the health human resources brain drain focusing on investment in increased health human resources and training, and bilateral agreements to regulate gains and losses

Commission on Social Determinants of Health, Health Systems Knowledge Network

1. The evidence base of the report
2. The health system as a social determinant of health and health equity, and equity problems of health systems
3. Strengthen health systems to address health equity: revitalize intersectoral action; promote social empowerment; strengthen the redistributive role of health care; revitalize Primary Health Care
4. Initiating and sustaining health system transformation: national processes to institutionalize change; international support for transformation

Commission on Social Determinants of Health, Health Systems Knowledge Network

“Overall, experience suggests that redistributive health care systems share five common features”.

1. Universal coverage
2. Public funding plays a central role
3. No or very low fees are charged
4. Comprehensive services
5. Private sector complements the public sector if there is effective contracting


1. The challenges of a changing world
2. Advancing and sustaining universal coverage
3. Primary Care: Putting people first
4. Public Policies for the public's health
5. Leadership and effective government
6. The way forward

Based on the October 2008 World Health Report entitled Primary Health Care: Now More than Ever, the World health Assembly affirmed the value of primary health care. In nine resolutions, it urged all countries to accept its principles and values and to promote the organization of health services around the functions of primary health care systems and clinical primary care.
4. to promote active participation ...empowering communities, especially women, in the processes of developing and implementing policy and improving health and health care, in order to support the renewal of primary health care

5. to train and retain adequate numbers of health workers, with appropriate skill mix, including primary health care nurses, midwives, allied health professionals, and family physicians ... in order to respond effectively to people’s health needs

6. to encourage that vertical programs (be) ... integrated and implemented in the context of integrated primary health care
7. to improve access to appropriate medicines, health products, and technologies, all of which are required to support primary health care
8. to develop and strengthen health information and surveillance systems, relating to primary health care ... to facilitate evidence-based policies and program and their evaluation
9. to strengthen health ministries, enabling them to provide inclusive, transparent and accountable leadership of the health sector and to facilitate multisectoral action as part of primary health care ...
A framework based on structure, process, and outcome is helpful in describing and measuring the components of health services systems.
Are there differences in structure, process, and outcomes that can explain variability in health even across areas with similar wealth and resources?
This figure specifies the important components of health services systems according to their type (structure, process, and outcome in the terminology of Donabedian (1966). In the diagram, structural components of health services systems are designated as Capacity and include the characteristics that enable medical practices to provide services. The process components are designated as Performance and include the categories of action engaged in by practitioners as well as the actions of patients and populations that enable them to receive services that are recommended. All characteristics of health systems and their interactions with communities and civil society should be represented by this diagram. (The diagram applies to ambulatory care as well as to care in institutions; hospitalization is represented as a management strategy under the control of providers.) Costs can be superimposed on each of the components of the system.

Primary care is a major component of health services systems.
Primary Health Care and Primary Care

Primary health care is a system-wide approach to designing health services based on primary care.

Primary care is the representation, on the clinical level, of primary health care.
The framework of structure, process, and outcome is useful in defining primary care so that it can be measured and evaluated.
Primary care has four main functions: first contact (the place where care is first sought for a new or newly recurring health problem or health need); longitudinally (person-focused care over time); comprehensiveness (providing for all common health needs without referral); and coordination (integrating all aspects of care when people have to go elsewhere for uncommon or unusually serious health conditions). Each of these four essential functions can be described and assessed by using several of the elements of health systems, as described in this chart.
In addition to the elements important for primary care, this diagram highlights other features that are important to primary health care. That is, they concern elements of health systems that are necessary for designing practices for primary care: personnel, facilities and management, financing, and governance. Decisions about the number and distribution of personnel and facilities are critical in achieving equity in the distribution of resources for primary care. Financing considerations are important in controlling financial access to care, including low or no copayments for primary care services. Little is known about the specific ways in which governance particularly facilitates the achievement of primary care characteristics, but it clearly is important as studies have shown that the political characteristics of governments are related to health levels in different countries.

The diagram also highlights the elements of “outcome” that are appropriate for evaluating the contributions of health services interventions. They range from changes in life expectancy to changes in activity or disability, symptoms resulting from health services interventions, disease rates and severity, achievement of life goals, satisfaction with one’s health, and resilience and vulnerability to influence on illness.
Measurement of Primary Care

- Primary care shares attributes with other levels of care.
- Measurement of *primary care* should address its unique functions.
- Measurement requires knowledge of systems characteristics AND behaviors.

This slide shows how the feature of first contact is made operational by considering the extent to which the facility is accessible (“accessibility”) and the extent to which it is achieved in practices through use of services, when needed, to the primary care facility or practitioner. The first element is a structural feature (“capacity”) of the practice, and the second is the extent to which expected performance (“process”) is achieved.
This slide shows that the primary care feature of person-focus over time ("longitudinality") is achieved when a practice defines its population as the one for which it is responsible (the structural or capacity feature) and that population seeks care there consistently over time. Generally, it requires 2-5 years of a relationship over time for the benefits of longitudinality to be achieved optimally.
Annotation: This diagram selects the structural and performance characteristics that are most essential in providing comprehensive care in primary care settings. The primary care facility should have or have immediate access to a broad enough range of services to meet most health needs of the population served. It should also recognize those situations arising in the practice that require the application of the particular service when appropriate.


This diagram shows that coordination is composed of two elements: a structural characteristic denoting the capacity of a facility or practice to facilitate information transfer from one time or place to another and a behavioral (performance) feature that indicates that problems generated at one time or place are recognized at another time or place.
This diagram shows how just seven elements are used to describe and measure the four essential functions of primary care. Each function entails the achievement of a particular structural element that the practitioner or practice must have in place in order for there to be appropriate performance. Three aspects of performance are important to the achievement of the function. For two of the functions (comprehensiveness and coordination), that element is the recognition of patients’ problems. For a service to be comprehensive, the totality of a patient’s health problems must be recognized in order for appropriate actions to be taken. For coordination, the practitioner or facility needs to recognize which problems require integration into the totality of care provided to the patient in order to achieve effective and safe care.