Primary Health Care and Primary Care: A Confusion of Philosophies

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The internationally accepted definition of PHC is qualitatively different from that of PC. Both PC, which produces professionally and institutionally driven services, and PHC, which creates community-based and community-driven services, can serve Nursing’s Agenda for Health Care Reform.

In 1978, the term primary health care (PHC) was coined by the World Health Organization (WHO) and the United Nations International Children’s Emergency Fund (UNICEF) in the World Health Assembly, which included 25 member countries and organizations. At that time, member countries expressed outrage at the low life-expectancy averages and the high mortality rates among children of a majority of the world’s population, whose living conditions were standard and impoverished. It was acknowledged that advances in science had helped eradicate many of the major communicable diseases, but it was noted that the most dramatic decreases in morbidity and mortality rates were achieved by simple, local, inexpensive solutions to health problems, such as rehydration programs. Health indicators pointed toward the need to combine economic and social development with health.

As a result of these discussions and deep concern over health care for a majority of the world’s population, the World Health Assembly prompted the formation of a global health strategy called primary health care, and all members of the WHO were invited to act toward attaining health for all by the year 2000. That declaration is commonly known as the Alma-Ata declaration, referring to the geographic location within the Soviet Union where the conference took place.

The adoption of PHC as the means to achieve health for all implied the concurrent acceptance of a new world view of health and a new strategy for the delivery of health care. Health was now viewed as an integral constituent of social and economic relationships, and the responsibility for health was transferred from the physician, as a healer, to a primary health care worker, as a partner.

Internationally nurses have participated in numerous meetings for planning and implementing health care based on the Alma-Ata declaration. Similar collaborative activities have occurred in the United States. However, we believe that the way PHC is currently conceptualized and implemented in the United States is frequently confused with the concept of primary care (PC), as delivered by nurse practitioners, and that PC qualitatively differs from what was proposed at Alma-Ata in 1978. The clari-
Primary health care

Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible through their full participation and at a cost that the community and country can afford.

Primary care

Delivery of a complex set of services, which include the first contact and the maintenance care. It assumes responsibility for referral to distinct services in response to the client needs and cultural values.

The responsibility for health was transferred from the physician, as a healer, to a primary health care worker, as a partner.

Progress toward PHC implementation worldwide was analyzed in 1988 at Riga, Latvia. U.S.S.R. At that time, five subject areas were identified for critical attention and emphasis. (1) strengthening political and social interventions, (2) strengthening the organization and management of health systems. (3) supporting community-based and home-based health activities, (4) facilitating applications of science and technology to PHC, and (5) developing leadership for “Health for All” (Box 1). The WHO Executive Board studied the future effect of nurses within PHC. They concluded that the role of nurses would move from the hospital to everyday life in the community, that nurses would become resources to people, rather than to physicians, and that nurses would become leaders and managers of PHC teams, including supervising nonprofessional community health workers.

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PC, on the other hand, was born in 1965, when Silver and Ford originated the role of the pediatric nurse practitioner as a physician extender on the
health care team. The nurse practitioner literature chronicles the health care crisis in the United States from 1965 to the present, outlining the shortage of primary physicians the unequal distribution of health care personnel. This reduced services available to impoverished and rural populations, and the rising cost of all health care.

The American Nurses Association and the National League for Nursing defined PC as advanced practice based on generalist (BSN) preparation, predicated on the construct of PHC, with concepts of direct contact, comprehensive care, case management, prevention, health, and wellness. Nurse practitioners provide direct client (individual or family) care, but also assume indirect roles, including those of educator, administrator, clinical supervisor, consultant, and researcher.

Current issues for nurse practitioners within PC revolve around the autonomy debate for independent professional practice and labor market competition involving reimbursement practices. Some authors argue that, in the future, the term nurse practitioner would describe only a master’s prepared nurse and encompass critical elements of advanced practice. Reitsminder encouraged nurse practitioners in the United States to support Nursing’s Agenda for Health Care Reform since it is the only plan that addresses the role of the nurse practitioners in the provision of health care.

Both PHC, as defined by WHO, and PC, as manifested in the U.S. health care system, evolved in response to the recognition of health disparities among socioeconomic, ethnic, age, and gender groups. The poorer health of the disadvantaged — whether viewed as individuals, aggregates, or nations — is the basic problem addressed by both approaches. They differ fundamentally, however, in the conceptualization of the underlying sources of the problem and, consequently, in the strategies adopted to bring about a solution. They also differ in their definition of health. The PHC model targets social, political, and economic environments as the key determinants of health for populations, as well as for individuals. Thus intervention at the community level or above, to bring about health-promoting environmental changes for individuals and groups, is integral to the PHC approach. In contrast, PC models identify unequal access to health services as the principal cause of health disparities. Efforts are focused on removing some of the health care access barriers affecting individuals and families, but not communities. Essentially, differences in the conceptualization of the problem of health inequities are evidenced as differences in the level at which disparities in health are addressed, and differences in importance assigned to the provision of medical services in improving health.

Practice

PHC refers to an array of essential services, those without which a healthy life is not possible. These services are to be provided to every citizen, regardless of degree of health risk, and at a reasonable cost. PHC does not necessarily go beyond a guarantee of essential services, but does commit to access, equity, and affordability with particular emphasis on vulnerable populations. PHC services are both curative and restorative, as well as preventive and promotive. PHC involves not only access, availability, and service delivery, but community participation, remediation of the causes of health inequities (e.g., poverty, unemployment), and a subscription to the right of all citizens to health care. Universal distribution of essential services with emphasis on vulnerable (high risk) groups is a principle of PHC that differentiates it from PC. PHC embodies not only principles of PC but also principles of public health and is currently practiced in the United States by public health nurses, school nurses, and other health professionals.

The practice of PC can be contrasted with the practice of PHC. PC refers to first-line medical and health care, controlled by the providers, but often community-based and frequently rendered in community clinics, physician’s offices, or health department facilities. Access may be a hallmark of PC services; however, PC providers do not guarantee essential services to everyone; nor do they necessarily offer services at affordable costs to those without health insurance. They do frequently provide services beyond what is an “essential” level of care through referral and a systematic use of third-party insurers to cover cost. PC services do not focus as much on prevention and promotion as they do on curing and restoring, including the use of advanced technologies.

While discussing each of the five principles of PHC covered below, we will demonstrate the similarities, differences, or absence of the principle in PC practice in the United States (Table 1).

**PRINCIPLES**

**Essentiality**

A hallmark of PHC is the concept of essentialness, or essentiality. PHC is considered to be “essential care.” A
The dictionary definition of essential is "necessary or indispensable." The Alma Ata Declaration specifies which services are considered essential:

**Primary health care** includes, at least, education (about prevailing health problems), promotion of food supply and proper nutrition, adequate supply of safe water, basic sanitation, maternal and child health care, immunization-prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries, promotion of mental health and provision of essential drugs.1

Further, **essential** assumes economic and social development as basic to the attainment of health for all.

In the United States, what is considered essential in one setting or one community may not be considered so in another. Essential services, in the spirit of Alma-Ata, are considered to be those that the populace cannot do without for a healthy life. They extend beyond traditional health care services and involve issues of housing, the environment, and economic, political, and social opportunity. Further, essentiality requires that services be based on practical, scientifically sound, and socially acceptable methods and technology.12

PC, while usually scientifically sound, may be neither practical nor socially acceptable. Within the context of PC, essential refers to clinically delivered physical or mental health services. Several professional organizations have identified a common scope of health care essentiality as comprehensiveness, prevention, diagnosis, a therapeutic focus, health maintenance, and rehabilitation.13-15 Specific services identified as constituting a "package" or a "core" of essential services include "primary health care services" (undefined), "hospital care, emergency treatment, inpatient and outpatient professional services, home care services, prevention services including prenatal, perinatal, infant and wellchild care, school-based disease-prevention programs, screening tests, prescription drug, medical supplies and equipment, laboratory and radiology services, mental health services, substance-abuse treatment and rehabilitation, hospice care, long-term care services of relatively short duration, and restorative services determined to prevent long term institutionalization."13, 15 A presidential campaign paper on health care reform identified health education as an essential component of health care services.16

Further, there is some commonality that certain groups should be targeted for services initially: women and children13,15, the elderly14,15, and the poor.13 The recognition of these populations as deserving of special attention is compatible with the PC principle of emphasis on the most vulnerable.

However, while there is considerable agreement among professional organizations with regard to what constitutes a package of essential health care services, they nonetheless remain within the purview of traditionally delivered health services. There appears to be little consideration given to the larger sociopolitical context within which the health care is delivered and in which health evolves, that is, to the inextricable relationships between health status and levels of poverty, employment, education, quality of life, and general community development. In this sense, the treatises cited must be judiciously considered as to whether or not they meet the spirit of essentiality within PC.

**BOX 2. ESSENTIAL ELEMENTS OF INTERSECTORAL COLLABORATION IN PC**

- National policy supports PC
- Allocation of human and monetary resources
- Decentralized control
- Formal and informal linkages
- Local interpretation of goals
- Local development of plans
  *Local accountability and responsibility
- Cooperation and mutual respect

In sum, the scope of PC and of PHC differs in what is involved in minimum essential care that should be accessible to all populations. In PC there is more focus on privatization, on treatment and restoration of physical health and functioning, on providing referral to secondary and tertiary care, and on limited preventive care. The driving force for PC is ascertaining eligibility for services. On the other hand, PHC is driven by public institutions and by providing services that are initiated by the consumer communities. These services are expected to be available universally to all, with eligibility also defined by the community. The primary focus of PHC is on providing health care services for the majority, with a particular emphasis on preventive health care.

**Community Participation**

The Declaration of Alma-Ata asserted that people, both individually and collectively, had the right and duty to participate in their health care.1 This assertion is radical for the health professional to consider, since most professionals are socialized as, and expected to be, experts advising individuals and communities on what is best for their health. PC lacks community participation as defined and proposed by proponents of PHC. The in planning and implementing community participation in PC is manifested in the definition, the components, and the roles of PHC providers.

Rifkin et al.17 defined community participation as "a social process whereby specific groups with shared needs living in a defined geographic area actively pursue identification of their needs." Community participation implies that there is equity in relationships between health care workers, administrators, and the people, and equity in the provision and accessibility of services and programs.

Meleis18 identified several components that need to exist for community participation to occur. First, a framework for defining communities should be developed and utilized. Definitions
of community include geography, common interests, and vulnerability to a health concern. A second necessary component is the level of members' awareness that they belong to a community. Other necessary components include mechanisms to mobilize the community awareness of community needs, community recognition by the political system, willingness of health professionals to work in partnership with the community, a clear definition of participation, and the development of a "culture of participation."

Participation can be categorized in several ways, as contribution, as organization, and as empowerment. Participation as contribution includes voluntary or other contributions made by people to already existing or planned programs. Participation as organization focuses on the process by which people participate. Finally, participation as empowerment includes the development of skills that enable people to make decisions and take action which they believe is essential for their health.

Rifkin described three approaches to participation: (1) the medical approach, which is aimed at curing disease and is controlled by medical professionals; (2) the health services approach, which mobilizes people to take an active part in the delivery of services; and (3) the community development approach, which requires active involvement of people in decisions to improve health. The first two approaches imply a "top down" approach that is expert driven and typical of PC, and the last is a "bottom up" approach that is community driven and more consistent with PHC.

Even when communities have been defined and identified the questions of Who participates needs to be addressed. Communities are not homogeneous entities, and leaders may only represent a segment of the community. Some groups, particularly women, children, and minorities may be prevented from participating because of oppression. Rifkin described five levels of participation: People may participate as recipients in the program, actively participate in activities of the program, participate in the implementation of the program, monitor and evaluate the program, or participate in the planning of the program. True participation, according to Arnstein, includes partnership, delegated power, and citizen control.

The role of the professional varies from manipulator to team leader to resource. The role of the professional as a resource for the community is most consistent with the principles of PHC. Professionals may be threatened by community involvement because it requires the sharing of knowledge and skills, the professional's source of power. Some authors assert that there must be de- or re-professionalization for true community participation to occur. Community participation cannot simply be viewed as an intervention to improve health care. It is a dynamic process and is supported by the belief system inherent in PHC. If participation is to be sustained, it requires time, energy, and constant dialogue among actors involved. Nurses as community resources are expected to continue to strive toward the development of respect, trust, and common goals with the community. The PC model, with a focus on reimbursement for services, does not provide the conditions necessary for community participation.

Intersectoral collaboration provides the framework within which individuals in the community can work. It is the means by which international, national, regional, and local policies can be translated into local concerns and by which resources can be allocated and programs developed. The community establishes the goals for collaborative effort. These goals direct the process of interpreting policy into a plan of action that addresses the needs of the people in a manner that is congruent with the cultural beliefs of, and is sustainable by, the community.

The essential elements for successful intersectoral collaboration, as listed in Box 2, include national policy that supports PHC through the allocation of resources, decentralized control, local goal-setting, planning and provision of services, mutual accountability, responsibility, cooperation, and respect. Coals for health must be made in the context of the social, political, and economic realities of the community, while being supported by national policy and decentralized control. The community's goals must be translated into local plans that are supported by an equitable allocation of human and monetary resources.

The constellation of sectors involved in a particular community will depend
TABLE 1. DIFFERENCES AND SIMILARITIES BETWEEN PRIMARY CARE AND PRIMARY HEALTH CARE

<table>
<thead>
<tr>
<th>Essentiality</th>
<th>Primary care</th>
<th>Primary health care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community participation</td>
<td>• Tends to be driven by private, for-profit sector</td>
<td>• Tends to be publically driven</td>
</tr>
<tr>
<td></td>
<td>• Primary focus on treatment and restoration</td>
<td>• Minimum level of care is defined by the community</td>
</tr>
<tr>
<td></td>
<td>• Limited preventive care</td>
<td>• Universally available regardless of payment source</td>
</tr>
<tr>
<td></td>
<td>• Provides entry to secondary and tertiary care, dependent on eligibility</td>
<td>• Focus of resources on health care services for the majority/preventive health care</td>
</tr>
<tr>
<td></td>
<td>• Focus on resource allocation on tertiary/high-tech care</td>
<td></td>
</tr>
<tr>
<td>intersectoral collaboration</td>
<td>• Provider directed</td>
<td>• Client directed</td>
</tr>
<tr>
<td></td>
<td>• Community defined as power brokers</td>
<td>• As grassroots effort, client participates as partner,</td>
</tr>
<tr>
<td></td>
<td>• Professional role: experts, providers, authority, team leader</td>
<td>• Professional role: facilitator, consultant, catalyst, resource</td>
</tr>
<tr>
<td>Access</td>
<td>• Limited availability to medically oriented health care services</td>
<td>• Universal availability and eligibility to health care services and resources</td>
</tr>
<tr>
<td></td>
<td>• Access to health care limited by eligibility for third-party reimbursement</td>
<td></td>
</tr>
<tr>
<td>Empowerment</td>
<td>• Focus on individual being able to obtain resources for self-care</td>
<td>• Collective decision making and action</td>
</tr>
<tr>
<td></td>
<td>• Paternalistic patterns of interaction</td>
<td>• Redistribution of power</td>
</tr>
<tr>
<td></td>
<td>• Provider-assisted process</td>
<td>• Collaborative, enabling; a process and outcome</td>
</tr>
</tbody>
</table>

on the community's needs, culture, and level or stage of development, among other factors. Sectors include both private and public health care sectors, governmental and nongovernmental entities, social and economic sectors, politicians, and representatives of the consumers of health care services. Formal and informal linkages between sectors must be developed such that mutual goal setting and program planning, development, and evaluation may occur. These linkages must be able to sustain collaborative efforts through the facilitation of communication, work flow, development of new programs, evaluation of program effectiveness, and monitoring of program congruence with outcomes and community needs.27

Another component of intersectoral collaboration is the mutual and ongoing accountability and responsibility for the services provided, and for the ongoing support and direction of those services. Community needs may change and essential health care services must be responsive to those changing needs. In the case of a rural community, the priority need may be for basic medical services, transportation, and nutrition services. Other needs may resolve around the economic development of the community to sustain the population. With development may come a different array of problems or needs that the existing health care services are not equipped to address. Thus intersectoral collaboration is a dynamic process that evolves with the growth and development of the particular community.

Finally, there must be a spirit of mutual cooperation and respect. The competitiveness that is familiar to business and industry must become secondary to cooperative participation in achieving goals that support the common good. The notion of social justice must supersed individual gain so that those people in a community that are least advantaged receive equal care and service.

barriers to intersectoral collaboration include historical, political technical, cultural, linguistic, environmental, or geographic constraints. These vary with each community and can interfere with the successful implementation of the collaborative process. Furthermore, resource inadequacy or the inequitable distribution of resources can impede collaboration, as
can the effects of complex bureaucracy, which impede well-intended plans and programs. It is essential that barriers be identified and minimized by the community. Dean et al. 35 noted that in the United States the National Health Planning and Resources Development Act of 1974 designated local health agencies to plan for the health care of the residents of specific geographic areas. Studies were conducted and plans made, but the barriers to health care persisted. The effects of bureaucracy, inadequate resources, and resource distribution, social inequities, and overreliance on technology are among the many reasons for the failure of this Development Act to improve health care outcomes.

When the social, economic, and health care problems of a society are treated independently of one another, the programs and plans have a lesser chance of success. In the United States, the collaborative efforts of health care professionals providing primary care are largely confined to the health care sector, and thus are intrasectoral, rather than intersectoral. It is only through intersectoral collaboration that the necessary links to support health within the community are formed. Intersectoral collaboration is enhanced when communities participate in identifying problems, needs, resource requirements, and implementation strategies. The process of collaboration is itself empowering to those who participate. Fundamental to this process is the belief that individuals within their own communities can and will direct their own development, whether economic, health related, or educational and national and regional policies must support that process.

Access
Access to health care is a core element of Nursing’s Agenda for Health Care Reform, 13 a central component of nursing practice, and an arena for nursing action. 39 However, one of the most conflictive issues regarding access to health care is the current meaning, definition, and focus of access to health care. The confusion between the definitions of PHC and PC, as shown in Box 1, is partly responsible for the difficulties in defining and directing access.

Defining access to health care from a PHC perspective implies a focus on the communities to be served, and suggests continual community participation and involvement of individuals and families in defining (1) what are essential health care services and resources, (2) what are culturally and socially accessible health care services, and (3) what are affordable health care services.

The PHC perspective also requires that health care be available where people live and work.

A PHC perspective also requires that health care be available where people live and work. Community settings, therefore, are ideally suited to enhance health protection and promotion. From a PHC perspective, accessible, affordable, and essential health care services, as well as resources, must be defined by the communities served according to their own priorities and needs. This implies a commitment to community participation and involvement in the definition.

On the other hand, from a PC perspective, access to health care suggests entry into a complex arrangement of health care services. The emphasis of access is on the individual’s need for disease prevention and curative services. The PC perspective also includes access to the delivery of services by nurse practitioners. This implies access to nursing services in which nurses are accountable for complex medical services within a given health care institution. From this perspective, health care priorities and needs are determined by health care providers. Furthermore, issues of accessibility, affordability, and appropriateness of health services are defined by providers from a profit perspective, which is essential to compete in the market-driven U.S. health care economy. As stated by Levine, 30 these entities have “failed to provide either universal access or cost control.”

To provide access in the United States within a PHC perspective, a reassessment of access is necessary. Stevens 39 provided a reconceptualization of access congruent with nursing practice and the principles of PHC. Stevens acknowledged that social justice and social equity are essential conditions for health care to be accessible and affordable. Consistent with the philosophy and principles of PHC, the following conditions for access were identified:

1. Cost experiences are to be equal across all groups.
2. The availability of services and resources must be based on the needs and geographical distribution of the population.
3. Health care encounters must be of equal quality and comprehensiveness for all groups.
4. Positively perceived interactions with the system must be experienced by all clients.

This reconceptualization of access is congruent with the principles of access as identified by the Nursing’s Agenda for Health Care Reform and by PHC. 13 Essential health care services ought to be affordable and “as close as possible to where people live and work, and constitute the first element of a continuing health care process.” The clarification of these concepts and their philosophic approaches will enhance the efforts to improve the issues of access to health care in congruence with nursing and PHC.

Empowerment
The acceptance of the Alma-Ata declaration resulted in the emergence of empowerment as a means to achieve world health. Although first identified as a community approach to guide mental health policy, the philosophic
base for empowerment has extended into nursing. Empowerment implied people would be helped to control their own lives. It also conveyed the ideology of persons helping themselves and other people, without the assistance of structured helping systems. The definition of empowerment varies and depends on the characteristics of the people, community, and context where it is used. In comparing PHC and PC perspectives on empowerment, consideration needs to be given to the assumptions and values framing the concept and the activities that will provide empowerment.

The application of empowerment in the health care system begins with a fundamental belief in the capability of people to create healthy environments. Through social, political, and economic advocacy, nurses can acknowledge their partnership with people in a movement for better health. Social advocacy implies cultural sensitivity, respect, and loyalty to the community. Political advocacy includes familiarity with the health care system and understanding the processes that govern resource allocation. It also means a working knowledge of the mechanisms for developing health policies. Professional advocacy implies that nurses work as a group through their nursing associations and conferences.

The implementation of empowerment as a process to achieve the goals of PHC depends on the community’s ability to overcome the challenges posed by social, political, and economic constraints. These challenges include: (1) a lack of congruency between the health care delivery philosophy and PHC, (2) the need to gain acceptance of PHC principles by the dominant political establishment, (3) availability of resources, and (4) the community’s acceptance of PHC principles.

There are barriers to using empowerment as a goal and a strategy which need to be understood in relationship to the basic PHC concepts of accessibility, equity, community participation, and intersectoral cooperation. The first barrier to be overcome in the implementation of empowerment as a process is the values of nursing professionals. Currently, the philosophic underpinnings of nursing come from both medicine and nursing, and some have argued that these are grounded in the values of inequality, competition, and individualism—values contrary to those of PHC. Nurses will need political skills and cultural competency to assist people in identifying their health issues and concerns and the most appropriate strategies to deal with them. Nursing may also need to address their own empowerment as individual professionals before assisting in the empowerment of the client.

A second barrier, and perhaps the most formidable to be overcome in implementing any community strategy, may be the local governing body. The political establishment within the community is a determining factor in the decision to allow for the definition of PHC concepts to prevail. It may be to the advantage of the dominant society or ruling party to keep people in a powerless, dependent position. As a result, a collective consciousness may be threatening to the political establishment.” A third barrier to the success of PHC program implementation is the accessibility and equitable distribution of resources. The political system of the community will ultimately facilitate or constrain accessibility and equity of means necessary to achieve productive goal outcomes.

Empowerment, unlike community participation and intersectoral collaboration, is a PHC principle that is discussed in PC models in the United States. The meaning and expression of empowerment in PC, however, is very different from that described in the PHC literature. Empowerment from a PC perspective is grounded in the ideology of individual responsibility. It is viewed as the process through which individuals become aware of and able to make meaningful choices affecting their health. It is assumed that once empowered, individuals will make appropriate choices that are consistent with the values and beliefs of health care professionals. However, empowered individuals may also make choices that are contrary to medical recommendations: thus so-called noncompliance could be viewed as a manifestation of empowerment and reasoned decision making. This is a problem from a PC perspective.

When personal empowerment is the focus, attention is drawn away from the social, economic, and political structures that constrain individual choices. In contrast to the PC emphasis on personal empowerment, PHC emphasizes collective empowerment, which is the process through which communities become activated toward health issues. It is through the empowerment of groups and communities that health-promoting changes in the environment may be accomplished.

Empowerment can be the catalyst to achieving health for all by the year 2000. In working with the community in a spirit of cooperation, in having the community identify their own problems, objectives, and strategies, barriers may be reconciled or overcome.

**THE ALMA-ATA DECLARATION RESULTED IN THE EMERGENCE OF EMPOWERMENT AS A MEANS TO ACHIEVE WORLD HEALTH.**

**IMPLICATIONS**

PC and PHC share ideals of equity and justice and acknowledge the prevention and promotion aspects of health and well-being; however, there are differences in the goals and the emphasis, as demonstrated in Table 1. Primary care advocates decided that extending the services of physicians with specially trained nurses would significantly reduce inequalities in the system. Primary health care advocates designed an approach to health and health care that would radically change the system.
itself. The role of the nurse practitioner fits well within PHC; however, PHC also covers the larger issues of government involvement to change policy, the community as the basis of care, and collaboration between health professionals and community groups.

Empirical evidence exists to show that in the past 20 years health changes have occurred in under-developed countries as a result of changes in political, economic, and social structures; and these have occurred independent of changes in the health sector. If health is dependent on social, economic, and political structures within a community, the implementation of essentiality, community participation, intersectoral collaboration, access, and empowerment will also be determined by these structures. Primary health care advocates implementing these principles at the structural, as well as individual, level of intervention.

Nursing practice within a PHC framework takes place in hospitals, clinics, and diverse community settings. Hospital nursing is not abandoned in any way, but its emphasis is reduced in favor of simpler services and health-promotion efforts where people live and work. The location of nursing practice will be altered as more nurses respond to community needs for local services. The style of nursing practice will change as nurses work in professional teams with physicians, social workers, and others, at levels of intervention that increasingly target prevention, education, and social change, as well as treatment of disease. Nursing for the future will deliver cost-effective care to an aging and diverse population, emphasizing management of care with a community orientation. Additionally, nurses will find new ways of working with the public and being a public resource.

Implications for nursing education from a PHC perspective include preparing nurses for multiple levels of practice, contingent on the needs of the community. In some regions, non-nurse community health workers have been very successful at basic health education and intervention. Nurses often serve in a supervisory role in this case, and act collaboratively, rather than adversarially, with community and other health workers. At another level, community health/public health nurses need increased clinical preparation in and with communities, rather than in classrooms or hospitals. Some argue that baccalaureate nurses' preparation should include epidemiology, biostatistics, health services administration, and clinical experiences in and with the community. Nurse practitioners' preparation should also include experience with elderly and vulnerable populations, in settings closer to the community than the hospital.

Nurses at all levels need education in public health policy and the use of both personal and group influence to bring about change. For too long nurses have complained about a lack of equity for their patients, while remaining ignorant of ways to change the system. Nurses must be able to analyze the influence of health care policy and the strategies for implementing change at the organizational, community, state, and national levels.

Nursing research should also be directed by principles of PK. Research questions should be proposed around concepts of PHC, such as participation, access, and empowerment. Research should target vulnerable populations, such as women, children, the chronically ill, immigrants, and minorities. Nurses should be asking questions that address not only individuals as clients, but also larger groups at the local community, city, state, and national levels. Those questions must take into account the social, political, and economic environment of the client, as well as client behavior.

Finally, research questions need to consider different health outcomes. It is no longer useful to study whether or not nurse practitioners can do a pap test as effectively as a physician. Proving clinical competency must give way to showing healthy outcomes in response to nursing interventions. If health is a result of economic, social, and political resources and limitations, then changes in these variables can be considered as outcomes of nursing interventions. Health outcomes cannot be measured by disease indicators alone. Nurses, along with medicine, social work, and other health disciplines, can and should measure indicators of quality of life, well-being, and social equity, to name a few.

CONCLUSION

Primary care and primary health care need not be mutually exclusive concepts. There are, undoubtedly, nurses who deliver PC within a PHC philosophy. They strive for universal access and affordability, espouse empowerment of the client, and target those at risk for health problems, particularly preventable health problems. In addition, PHC subscribes to a philosophy that aims to alter major sociopolitical barriers to achieving and maintaining health, such as poverty, unemployment, and racial, ethnic, gender, and religious discrimination.

A key feature of PHC is that public institutions and governments (i.e., schools, public health departments, city councils, state governments) are involved with and committed to the health of the population. Further, the system which delivers PHC is integral to the entire health care system of the country. Consumers must be involved in the planning and delivery of care. These issues are key to the current debate on health care reform. As nurses, we must decide if it is enough to alter current insurance-driven health care
services, or if we must engage in reworking the entire system with PHC principles in mind.

Finally, the intent of this article is to initiate a forum for discussion and to promote debate about some of the fundamental differences and similarities between PC and PHC, as we have outlined. We believe that without such discussion and debate, nurses’ participation in health care reform may perpetuate the definitions and framework that reflect institutional needs, rather than the needs of the people who are to ‘be served:

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