Chapter 1
Thinking Geographically About Primary Health Care
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The overriding goal of the geographies of health and health care is to ‘construct accounts of why place matters’ to these fields (Mohan 2000, 330). Scholarship in this vibrant area of the discipline of human geography has had a significant impact on numerous areas of health and health care inquiry more broadly, including our conceptualization of the social determinants of health and also issues related to the organization and delivery of health care. However, as Gesler and Kearns (2002, 139) point out: ‘[u]ntil the mid-1990s, geographical analysis of health care … was often undertaken by examining patterns of service utilization. Furthermore, the sites of service provision were viewed as locations rather than as contributors to, and constituents of, health care landscapes.’ More recently there has been a flourishing of innovative research undertaken by geographers and others that offers unique insights into how we conceptualize the geographies of health care in a much broader sense (see Chapter 2), some of which specifically connects to primary health care (PHC). In this book we showcase this work through interrogating the landscapes that inform the very nature and principles of PHC and ultimately shape how this care is both delivered and received.

In this chapter we provide an important background for the book and also an overview of what’s to come in the remaining chapters. We first engage in considering the very nature of PHC. In doing so we begin with the 1978 Declaration of Alma-Ata and continue up to the present time where PHC reform and renewal are happening. We then move to introduce the geographies of PHC. It is observed that while geographers have a long-standing interest in this topic, few studies explicitly or fundamentally engage PHC as a concept. Through focusing on access, equity, and community/participation – central elements of the PHC approach – we frame this area of health geography inquiry. In the final section we provide an overview of the book and summaries of the contributed chapters.

What is Primary Health Care?

In attempting to understand what PHC is, one must start with the Declaration of Alma-Ata set out by the World Health Organization (WHO) in 1978. This Declaration is the outcome of a week-long conference hosted by the WHO in
Alma-Ata, USSR focused specifically on PHC. Over 3,000 delegates representing international bodies, such as the United Nations Children’s Fund (UNICEF), and national governments attended the conference (Cueto 2004). PHC was viewed as a way to achieve ‘health for all’ which was a significant goal of the WHO at the time (Pappas and Moss 2001). We must note, however, that using the Declaration as a starting point does not mean that the kind of care central to the principles of PHC outlined within it was not delivered or envisioned prior to this point (see also Cueto 2004; WHO-SEA 2006). Rather, the Declaration marks the point at which PHC was formalized as a form of care and also defined at a global scale. The Declaration is detailed in Table 1.1.

Both the Declaration and the conference in Alma-Ata remain important moments in the development of PHC as an approach to care provision. Werner (1995) points out that the Declaration is a ‘landmark’ because it identifies health and access to health care as basic human rights. Further, its emphasis on community and community members is what set the PHC approach apart from other health service delivery models (Litsios 2004). Cueto (2004) has identified three important ideas shared in the Declaration which have been widely cited: (1) use of appropriate technology; (2) opposition to medical elitism; and (3) health as a tool for social development. These ideas and others central to the Declaration were built into the WHO’s vision of PHC for specific reasons. At the time of the conference in Alma-Ata there was an increasing desire not to transplant Western models of care to lesser developed nations, an emergence of the determinants of health approach, and an increased recognition of the effectiveness of grassroots and/or local approaches to health care (Cueto 2004; Werner 1995). Successful examples of this community-based approach to care in China, Tanzania, Sudan, and Venezuela in the 1960s and 70s created a general enthusiasm within the WHO about PHC. For example, the ‘barefoot doctor movement’ in China at the time is often cited as providing a significant impetus to the formalization of PHC. These factors led PHC to be viewed as a way forward in achieving ‘health for all’ and overcoming health disparities within and between nations at the time through the provision of equitable and accessible care (i.e., medical treatment, preventative care, health promotion, some forms of social care) in, by, and for communities.

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1 The WHO’s goal of achieving health for all remains. At the time of the conference in Alma-Ata it was declared that this goal would be reached by the end of the twentieth century. By the early 1990s it became clear that this would not be the case. By 1995 the WHO had declared this to be a twenty-first century goal (Pappas and Moss 2001).
Table 1.1 The Declaration of Alma-Ata

I. The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II. The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III. Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV. The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V. Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI. Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII. Primary health care:
   a. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
   b. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
   c. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
Table 1.1 continued

d. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

e. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

f. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

g. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII. All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country’s resources and to use available external resources rationally.

IX. All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X. An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world’s resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

Early versions of this Declaration were shared throughout the WHO and its respective regional offices for up to a year before the conference in Alma-Ata happened. Tejada de Rivero (2003), the former Deputy Director-General of the WHO, notes that the Declaration went through no less than 18 drafts and circulation at six regional WHO meetings prior to the conference. This resulted in much of the final wording of the Declaration looking nothing like what it was originally drafted to convey (Litsios 2002). As Tejada de Rivero (2003, n.p.) recounted: ‘The draft that was officially presented [at the conference] contained a few changes that, in hindsight, contributed to the later distortion of the original concepts. Many delegations and individual delegates fought to include details that had more to do with medical specialties than with health.’ Further to this, the conference was proposed in 1974 (Litsios 2002), giving some national representatives and WHO employees up to four years to digest the PHC concept and prepare their responses. These details are quite significant because immediately after the Alma-Ata conference critiques of the WHO’s vision of PHC were circulated, many of which had taken shape in advance of any formal release of the Declaration.

The Alma-Ata Declaration was immediately criticized as being too broad in scope, thereby making the WHO’s vision of PHC difficult to implement. An outcome of this was that there was a selective interpretation and implementation of the principles of PHC that were set out by the WHO (Cueto 2004; Haines et al. 2007). This has come to be known as ‘selective PHC’ and typically involves a ‘package of low-cost technical interventions to tackle the main disease problems of poor countries’ (Cueto 2004, 1868). Selective PHC often involves temporally and spatially limited initiatives to counter specific health issues, often characterized by GOBI-style initiatives. GOBI is an acronym for a set of four specific interventions (growth monitoring, oral rehydration, breast feeding, and immunization) that were championed by UNICEF and others – and to a certain extent continue to be – as a useful model of selective PHC (Wisner 1988). Such interventions can be funded by external aid organizations and implemented in nations with little or no existing health care infrastructure. While these interventions may assist in a limited way with achieving ‘health for all’, they do not hold true to the basic tenants of PHC put forth in the WHO’s Declaration including that care is delivered by, for, and in communities. Criticisms of selective PHC are numerous and point out that it focuses only on basic health services (Cueto 2004), that it takes control and power away from developing nations in particular and places it with international funding bodies (Hall and Taylor 2003) and non-governmental organizations (Litsios 2002), and that this approach does not adequately recognize the importance of factoring local contexts (e.g., political involvement, cultural norms) into health care initiatives (Walsh 1988). That UNICEF championed a selective interpretation of and approach to PHC has been particularly criticized given that it was a signatory to the (non-binding) Alma-Ata Declaration and a sponsor of the conference. Though, it has been argued that (Taylor and Jolly 1988, 972):
The concept of ‘selective primary health care’ [SPHC] was built into the original definition of PHC in the background document for the Alma-Ata conference. This is important to underline, since this point has often been misinterpreted, especially by proponents of SPHC arguing that CPHC [comprehensive PHC] ignored the need for explicit priorities.

The subsequent undertaking of selective PHC initiatives following the Alma-Ata Declaration has been cited as a major failure of the WHO’s vision of PHC and its ability to put it into action. There are, however, numerous other lasting critiques and challenges to implementing PHC. Cueto (2004) points out that some medical professionals were (and are) resistant to the PHC approach because of concerns over loss of prestige and power through increasing the involvement of non-professionals in delivering care in the community. At the same time, Haines et al. (2007) point out that the increased reliance on volunteer labour by community members makes PHC difficult to sustain. While the focus of the Declaration is very much on the community and traditional practices, Wakai (1995) notes that it places traditional medicine secondary to Western hi-tech medicine, despite its predominance in much of the developing world, provision of first contact care, and clear potential to connect people to orthodox medicine. Furthermore, Tejada de Rivero (2003) contends that misunderstandings resulting from both the Declaration and conference at Alma-Ata have significantly challenged the implementation of the WHO’s vision of PHC. Among these misunderstandings were the questionable word choices made when translating the Declaration into other languages and the oversimplification of reported successes in developing nations. Other cited obstacles to implementing PHC include (Hall and Taylor 2003; Wakai 1995):

1. the structural adjustment programs in place in some developing nations;
2. the World Bank takeover of health care policy making in many developing nations;
3. civil wars, natural disasters, and major health crises (e.g., HIV) that constrained health care development in sub-Saharan nations in particular;
4. a lack of long-term political commitment to PHC; and
5. difficulties finding funding to back comprehensive PHC initiatives in developing nations.

These obstacles often justified, if not necessitated, the selective implementation of PHC in developing nations.

While response to the Declaration and specifically the PHC approach in developing nations was very much to implement selective models of care, developed nations had a much different reaction. That said, it is important to note that developed nations very much pushed for the selective implementation of PHC in developing nations in order to maintain a certain degree of power and control over how health care monies were spent in these places (Hall and Taylor 2003; Werner 1995). In countries such as Canada, New Zealand, and the United Kingdom
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(UK) – those which are focused on the most in this book – health care systems were already in place prior to the Declaration being made. These governments and their health care decision-makers struggled with what it meant to offer PHC. Numerous interpretations of PHC were made in response to the WHO’s definition, and continue to this day due to differences in national health care systems (Haines et al. 2007). In general, a shift in the focus of care away from the hospital and into the community was and is viewed as in keeping with the PHC approach. PHC is often interpreted to mean care that is universal, comprehensive, affordable, and delivered equitably (Hall and Taylor 2003). A focus on ‘first-contact care’ was viewed to be at the core of PHC by nations with existing health care systems. More specifically, putting in place or ensuring equitable and affordable first-contact care delivered via existing primary (medical) care systems was where the PHC approach resonated most strongly and sensibly for developed nations (Haines et al. 2007).

Primary care systems are certainly implicated in the model of PHC promoted by the WHO. Primary care systems facilitate the provision of first-contact, comprehensive, and coordinated medical care (Cardarelli and Chiapa 2007) and are characterized by organization, funding, and delivery (Hutchison et al. 2001). These systems are reliant on family doctors or general practitioners (GPs) for medical care provision along with nurses and some allied health professionals. Primary care serves as the entry point to the formal health care system in many nations and is where core medical and preventative care are delivered (Schoen et al. 2004). From this brief overview of primary care systems they can be understood to be where first-contact medical care is delivered from in nations that have health care systems that are organized by primary, secondary, and tertiary care levels. A position statement from the Canadian Nurses Association helps to differentiate primary care from PHC (CNA 2005, 1):

PHC includes basic medical and curative care at the first level (commonly referred to as primary care). PHC is also relevant to secondary and tertiary care. The PHC approach focuses on promoting health and preventing illness. The PHC approach means being attentive to and addressing the many factors in the social, economic and physical environments that affect health – from diet, income and schooling, to relationships, housing, workplaces, culture and environmental quality. In addition, the PHC approach places citizens and patients on an equal footing with health care professionals with respect to decision-making about health issues.

Because of a shared focus on first-contact care it is easy to understand why many nations with existing primary care systems have applied the principles of PHC most easily to this level of care. However, this interpretation of PHC embraces only a limited conceptualization of the vision laid out at Alma-Ata. Specifically, the application of the PHC approach to primary care systems tends only to reference principle VI of the Declaration and often misses out on an integrated understanding of community participation, among other key concepts. Because
of this, a primary care system alone cannot fully effectuate PHC given its focus specifically on treatment and diagnosis.

Confusion regarding the similarities and differences between primary care and PHC and conflation of one with the other is a long-standing issue. Green (1987), for example, critically examined the uptake of the principles of the Declaration within the National Health Service (NHS) of the UK within the years following the conference at Alma-Ata. He found a general lack of awareness about PHC within the NHS and attributes this to three main factors: (1) confusion regarding the difference between PHC and primary (medical) care, in that much research framed as PHC is in fact about primary care; (2) the view that PHC is a policy strategy for developing countries and not applicable in developed nations; and (3) defensiveness within the NHS due to a slowing of resources and reorganization. These factors clearly serve as significant barriers and provide a clear illustration about both the way in which a developed nation and its health care system may interpret the Declaration and its principles and also the problem of a general inability to differentiate primary care from PHC.

In order to overcome the challenges of interpreting and applying the very broad model of PHC envisioned by the WHO in the Declaration, or of too narrowly applying it to primary care alone or in a selective fashion, many governments, health councils, health professional bodies, and the like have created their own working definitions of PHC. These definitions often reference the Declaration, and most often principle VI. Such definitions frame PHC in numerous ways, including as a paradigm (Cueto 2005), a policy (WHO-EM 2003), a philosophy (WHO-SEA 2006), an approach (CNA 2005), a model, or even a system of care. Each of these framings has a different meaning and ultimately different implications for the actualization of PHC. In order to avoid discussing this in the abstract in Table 1.2 we have summarized a range of framings (or even frameworks) for PHC in a single national context by using the case of Canada. From this table it is possible to understand the range of ways in which PHC is both interpreted and applied in specific contexts. To further exemplify this issue, in Table 1.3 we have summarized a limited number of definitions of PHC across provincial/territorial jurisdictions within Canada. In looking at this table it can be seen that some provinces/territories more closely align their definitions of PHC with the primary care system while others, most notably the Northwest Territories, reference the spirit and principles of the WHO’s Declaration. These Canadian examples serve to illustrate the lack of international or even national consensus regarding how to define, interpret, and apply PHC both within and beyond health care systems.
Table 1.2 Multiple framings of primary health care in Canada

<table>
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<tr>
<th>Framing</th>
<th>Example</th>
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<tr>
<td>A system</td>
<td>PHC is ‘community-based health professionals and programs that are the first point of contact with the health care system’ (Health Council of Canada 2008, 6).</td>
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<tr>
<td>A set of qualities</td>
<td>Responsive, comprehensive, continuity, interpersonal communication, and technical effectiveness (Broemeling et al. 2006).</td>
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<tr>
<td>A range of services</td>
<td>Emphasizing health promotion, chronic illness management, and integration of services within a continuum of care (Health Council of Canada 2008). Also includes basic emergency care, referrals, primary mental health care, palliative care, healthy child development, primary maternity care, and rehabilitation services (Health Canada 2006).</td>
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<tr>
<td>An approach</td>
<td>PHC ‘refers to an approach to health and a spectrum of services beyond the traditional health care system. It includes all services that play a part in health, such as income, housing, education, and environment. Primary care is the element within primary health care that focuses on health care services, including health promotion, illness and injury prevention, and the diagnosis and treatment of illness and injury’ (Health Canada 2006, n.p.).</td>
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<tr>
<td>A sector</td>
<td>‘The PHC sector contributes to health system equity directly through its responsibility for distribution of care within this sector, and indirectly through control over prescriptions, referrals and hospital admissions’ (Watson et al. 2005, 103).</td>
</tr>
<tr>
<td>A set of system components</td>
<td>Specific components of PHC are: (1) improved continuity and coordination; (2) early detection and action; (3) better information on needs and outcomes; and (4) incentives to support the adoption of new health care approaches (Health Council of Canada 2005).</td>
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<tr>
<td>A group of providers</td>
<td>Physicians, dieticians, home care workers, nurses, occupational therapists, physiotherapists, pharmacists, social workers, and other health care providers (Watson et al. 2005).</td>
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Source: The author.
Table 1.3 Primary health care across selected Canadian provinces and territories

<table>
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<th>Province/Territory</th>
<th>Definition</th>
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<tr>
<td>British Columbia</td>
<td>The first and most frequent point of contact with the health care system. Whether it is a visit to the family doctor or from a home care worker, a trip to the pharmacist, mental health counsellor or school nurse, PHC is where new health problems are addressed, and where patients and providers work together to manage ongoing problems. The goal of PHC is to keep people healthier, longer, by preventing serious illness and injury through education and timely treatment of short-term or episodic problems. It also works to help patients manage chronic health illnesses appropriately, so they don’t develop unnecessarily into medical crises.</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>First contact with the health system by patients. Is provided by clinicians who are responsible for addressing a wide array of health care needs and developing a long-term relationship with their patients. Changes to delivery of PHC will result in better, faster access to services, in the community and throughout the health system.</td>
</tr>
<tr>
<td>Northwest Territories</td>
<td>The term ‘primary health care’ is used interchangeably with the term ‘primary community care’ to reflect the health and social services environment. It is the first level of care and usually is the first point of contact clients have with the health and social services system - that is, in partnership with the client, services are mobilized and coordinated in response to client needs to promote wellness, prevent trauma and illness, build capacity, provide support and care for community health and social issues and manage ongoing problems to sustain functional independent at an optimal level.</td>
</tr>
<tr>
<td>Ontario</td>
<td>The foundation of the health care system with a sustainable, long-term relationship between the inter-disciplinary health care teams and patient. It refers to the first level of care and the initial point of contact that a patient has with the health system.</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>It is a philosophy and an approach to health care based on the principles of accessibility, public participation, health promotion, illness prevention, appropriate technology and inter-sectoral collaboration.</td>
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Challenges, criticisms, and difficulties with framing and defining PHC aside, interest in this form of care continues since its formalization in the Declaration. Although by the early 1990s emphasis had moved away from PHC in favour of other models of health care and achieving health for all (Haines et al. 2007), there has been a renewed interest in PHC since the early 2000s (Litsios 2004) including by the WHO (Haines et al. 2007). During the 1990s the health sector reform approach was popularized as a model for health care delivery in developing nations and was championed by the World Bank (Hall and Taylor 2003). Interestingly, the
current renewed interest in PHC within developed nations in particular – including Canada, the UK, and New Zealand (Haggerty et al. 2007) – centres on reform and restructuring. In some instances PHC is being looked to as a model for providing restructured care. This is perhaps most evident in Canada where PHC is viewed as the foundation of the health care system and over one billion dollars have been spent since 2000 on reforming health care, and primary care in particular, by transitioning to a ‘renewed’ PHC system (Health Council of Canada 2005, 2008). Reforms specific to renewing PHC at the national and provincial/territorial scales have been explicated and are consistently cited as: (1) creating after-hours access to care; (2) implementing team-based care; (3) using new technology to enhance care (e.g., electronic medical records); and (4) changing physician payment models (Glazier 2008). This Canadian example illustrates one specific way in which PHC is gaining the attention of governments and health care systems now exactly 30 years after the conference in Alma-Ata was held.

Beyond a concept or idea, PHC is now not only a structural feature of health care systems worldwide, it is also generally understood and desired by the public the world over. Both of these factors mean that it is a fairly permanent feature of health and social care systems. In effect, to remove PHC and its approach to and philosophy of care from these systems would require policy and attitudinal shifts so fundamental that they are almost unimaginable. This can be said for few other post-World War II concepts in health care. Because of this importance, PHC has not only drawn the attention of policy-makers and health care administrators but also of researchers from a range of disciplines. Most obviously, health professional disciplines such as family medicine (e.g., Greenhalgh 2007) and nursing (e.g., Ross and Mackenzie 1996), to name just two, have engaged in research on PHC from its inception and have chronicled both its development and practice. Health service researchers from a number of disciplines have also been active in researching PHC. This work is featured prominently in journals such as the Scandinavian Journal of Primary Health Care and Primary Health Care Research & Development in addition to broader and discipline-specific health, health care, and social care publications. An explicit or implicit interest in PHC also exists within a number of other disciplines including those of the social sciences. This ranges from sociologists’ long-standing interest in specific health professional groups (e.g., Armstrong et al. 1993) to other scholars’ examinations of the political will to adopt comprehensive PHC (e.g., Werner and Sanders 1997). Further, as we show in this next section, geographers too have an interest in understanding and examining PHC.

Introducing the Geographies of Primary Health Care

Given what we have just discussed above, and how broadly PHC can be understood and interpreted, it is not surprising that geographers have had a long-standing interest in researching this form of care. However, with few exceptions, this work is more
implicitly about PHC than explicitly. One of these exceptions is a collection of papers published in 2001 by the journal *Health and Social Care in the Community* edited by Tony Gatrell (2001) entitled ‘Geographies of Primary Health-Care.’ The collection showcases six articles focused on PHC in the UK context that most broadly get at issues of the organization and delivery of primary care and/or of uptake of and access to services. Gatrell acknowledges that the collection does not reflect the full range of PHC research within and beyond geography but contends that it does centre on a concern with ‘place’ as it relates to PHC at scales from the national through to the local. While the collection is primarily focused on what we have discussed above as primary care, it does provide an initial formalization of the ‘geographies of primary PHC’ as an area of inquiry within the sub-discipline of health geography.

As noted above, there is little geographic inquiry explicitly situated within investigating PHC. For example, a search through the archives of *Health & Place*, the flagship journal of health geography, reveals only a very limited number of articles published within the last 13 years that reference PHC in their titles or abstracts. There are, however, numerous articles that are relevant to PHC through a focus on primary care systems, on specific professional groups implicated in the provision of such care such as GPs, or even through their consideration of issues central to the principles of PHC. Because of this we believe the best way to explicate what we already know about the geographies of PHC is to introduce some of the concepts central to PHC that health geographers in particular have been most actively involved in investigating. In reviewing the principles of the Alma-Ata Declaration, we suggest that the concepts or topics of community/participation, access, and equity are those that health geographers have had long-standing interest in with regard to health and social care and their systems and services.

Ensuring equitable access to care is something that is enshrined in the Declaration signed at the conference in Alma-Ata. Haggerty et al. (2007, 304) contend that equity in PCH can be thought of as the ‘extent to which access to health care and quality services are provided on the basis of health needs, without systematic differences on the basis of individual or social characteristics.’

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2 The contribution by Bailey and Pain (2001) serves as an exception. In this article the researchers examine the socio-cultural context of breastfeeding decision-making by women with a focus on health promotion strategies. They conclude by considering implications for policies that extend beyond health care. Such a study, while relevant to primary medical care, is clearly (though not explicitly in its framing) engaging in the type of PHC envisioned by the WHO at Alma-Ata.

3 In searching the *Health & Place* archives in late March, 2008 we found only ten articles that fit this criterion (i.e., referencing PHC in either the title or abstract). This is not intended to be thought of as a systematic or thorough review of the health geography literature. We instead use this point to assist in demonstrating the lack of explicit framing of health geography research as PHC-related.
definition is focused specifically on health care and so can usefully be extended to include social care more broadly along with certain development strategies in order to be more in keeping with a fuller understanding of PHC. Doing so allows for a broadened understanding of equity more along the lines of ‘the fair and just distribution of resources’ (Bowen 2001, 27). Attentiveness to issues of equity in relation to care involves investigating whether individuals experience difficulty in obtaining needed care, receive a lower standard of care, experience differences in interactions with care professionals, receive care that does not recognize their needs, or are generally less satisfied with the care received (Bowen 2001) due to social location, intersecting axes of difference, or other factors. Health geographers have a clear interest in equity as it relates to many issues including access to and receipt of the kinds of health and social care central to a PHC approach, particularly across space or between groups within a particular place (see, for example, Curtis 2004, and Chapter 2).

Equity as it relates to health outcomes is also central to the PHC approach. This relationship is demonstrated clearly in Broemeling et al.’s (2006) results-based logic model for PHC. In this model they identify various factors that both shape and are shaped by this form of care. Some of these factors are (Broemeling et al. 2006, 10):

- PHC inputs
  - Fiscal resources
  - Material resources
  - Health human resources
  - Policy
  - Governance structures and decision-making
- PHC ultimate outcomes
  - Sustainable health care system
  - Improved/maintained functioning, resilience, and health
  - Improved level and distribution of population health and wellness

The last factor under ‘PHC ultimate outcomes’ relates to a more equitable distribution of health and health outcomes. This listing serves as an important reminder that research focused on equity as it relates to PHC, including that by health geographers, need not focus exclusively on the distribution of health care resources across space and within place but also can consider the distribution of health, wellness, or even illness as it relates to the kinds of care provided using a PHC approach or within primary care systems.

Our above discussion of equity references notions of access. Access is certainly a topic of great interest to health geographers and other PHC researchers (see, for example: Feldman 2006; Field and Briggs 2001; Parker and Campbell 1998; Perry and Gesler 2000; Tsoka 2004; Wellstood et al. 2006). Wong et al. (2008) recently conducted focus groups with Canadians regarding PHC priorities, and spatio-temporal accessibility (i.e., timeliness and proximity) was among the six
dimensions of care that were identified to be of most concern; this is but one example of the fact that access is also a topic of both interest and concern to health care consumers. As is demonstrated throughout the various chapters of this book, there are many ways of thinking about access in relation to PHC (Bowen 2001). While considering ‘geographic access’ to care (i.e., one’s proximity to a location such as a clinic) is clearly overtly geographic, health geographers’ interest in access extends far beyond this. Access can be further conceived of in relation to culture, economic status and resources, language, and with regard to PHC specifically we can understand that certain care professionals serve as gatekeepers to people’s access to secondary and tertiary care. Barriers experienced by individuals can (in part or whole) make care inaccessible, which can include: (1) availability of services; (2) one’s ability to pay for care; (3) needs-based barriers (e.g., language, awareness, physical accessibility); and (4) inequitable treatment (Bowen 2001). Issues of access as they relate to PHC extend well beyond an individual’s ability to get to and/or use a particular form of care; access is also an important consideration with regard to communities’ abilities to be involved in decision-making (i.e., access to power), nations’ and systems’ abilities to get the money and material goods needed in order to initiate and continue care delivery (i.e., access to resources), and even services’ abilities to attract and retain qualified personnel in order to meet health human resources needs (i.e., access to workers).

In looking at the non-binding Declaration signed at the Alma-Ata conference, the centrality of ‘community’ in relation to PHC is clear, in addition to the way it is linked to participation. Haggerty et al. (2007) identify four community-oriented dimensions of PHC provision through primary care systems: (1) client/community participation; (2) equity; (3) intersectoral team practice; and (4) population orientation. This first dimension in particular is illustrative of the connection between community and participation in PHC. The second dimension references our points made above, which is that a community’s access to certain forms of power exemplifies a more equitable distribution of control over decision-making. Interest in issues of community/participation more broadly can be seen in the work of human geographers, including health geographers specifically. The roles of communities in hosting sites of care, in care delivery, in building capacity, in bringing about change, in responding to need(s), and in creating their own local cultures of care are all relevant to health geographers’ inquiry regarding PHC and primary care systems. The participation of community members in each of these, whether as formal paid workers or individual citizens, is also of relevance to geographers and non-geographers alike. Examples of such work include Charlesworth’s (2001) investigation of the development of partnerships within UK primary care provision including between government sectors and community-based voluntary providers, Janes’ (2004) critique of community participation in PHC using the case of health care reform in Mongolia whereby she places emphasis on how local and global are connected through health care policy, and Prentice’s (2006) quantitative analysis of the impacts of neighbourhood on primary care provision using the case of Los Angeles, California where it is argued that local
health norms and care availability are significant variables within communities that shape individual uptake of primary care.

**Book Overview**

Our purpose in bringing this edited collection together is to compile significant contributions that inform how we can think geographically about health care and specifically PHC. As noted above, a goal is to showcase this work through interrogating the landscapes that inform the very principles of PHC and ultimately shape how this care is both delivered and received (we revisit this in Chapter 15). In the chapter that follows we provide an overview of key developments in the geographies of health care and the current state of research on this topic within health geography. The main part of the book is divided into three main sections, discussed below. Importantly, considerable overlap exists between these sections in terms of what the chapters present, thereby demonstrating how these themes (i.e., practice and delivery, people, and places and settings) interrelate. Following this, a final chapter draws together important themes of the collection and puts forward an agenda for continued research in the geographies of PHC. It should be noted that no single framing or definition of PHC is used throughout the chapters and so there is (useful) diversity in how the authors approach and understand such care.

**Practice and Delivery**

In this section of the book the authors focus explicitly on core geographic concepts as they relate to the practice and delivery of PHC. By practice we are not referring here to clinical practice but rather the practices through which care gets developed and delivered. Neil Hanlon considers the concepts of access and utilization as they relate to PHC in Chapter 3. He argues that we need to consider PHC more broadly, rather than primary care specifically, in order to more accurately understand access and utilization as doing so allows us to better account for equity in service distribution and use. The chapter concludes by calling for a ‘multidimensional perspective’ on access and utilization by health geographers and others. Nadine Schuurman’s chapter follows (Chapter 4) and serves as an interesting response in that she focuses on specific dimensions related to PHC access. In it she provides a case example regarding access to specific PHC services (i.e., rural maternity and trauma care) in the Canadian province of British Columbia. She contends that dimensions such as population density, physical distance, and socio-economic status must be accounted for when considering access to PHC. In doing so she uses GIS techniques to identify ways to overcome distance and lessen rural vulnerability in the case example.

Janine Wiles and Mark Rosenberg contribute Chapter 5. In it they examine the geographic concept of scale as it relates to PHC. They start by providing a
very useful overview of scale in human geography. They then move to consider the relationship between PHC and scale. To further evidence this relationship they provide examples of scalar concepts embedded in the Alma-Ata Declaration and also Canadian PHC. They conclude by highlighting the implications of scale and how it is conceived and enacted for PHC provision. The chapter that follows (Chapter 6) is authored by Leah Gold and provides a local-scale investigation of the roll-out of a new PHC initiative in Perú. Using an ethnographic approach that includes interviews with health care providers/administrators, she questions whether the initiative is more reflective of selective PHC although it is being touted as a comprehensive approach. She places significant scrutiny on how community involvement is conceived of and enacted in this initiative, arguing that rural peasants are mostly excluded from participating in decision-making and often times from even receiving care.

People

Issues of geography, space, and place are central to how PHC is lived out and experienced both by those who give and receive such care. In this section of the book the focus is on specific provider groups, though through discussing these groups the implications for PHC consumers and others (e.g., community members) are clear. Two chapters focus mostly on GPs and the care they deliver through primary care systems somewhat informed by a PHC approach. Gina Agarwal examines geographic aspects of GPs’ practice in Chapter 7. Her discussion is organized around the *Four Principles of Family Medicine* and makes note of how both community and environment are important to practice. Interestingly, in the conclusion she moves to reflect on the spatiality of her own practice as a GP as it relates to the discussion she presents. Ross Barnett and Pauline Barnett also consider GPs and their practice in Chapter 9. Specifically, they examine the reinvention of primary care in New Zealand, including changes to how care is organized and the implications for GPs. They place their discussion of New Zealand in an international context by comparing elements of primary care reform or reinvention across three nations.

The other two contributions to this section of the book focus on different provider groups and are united in their perspective that biomedical dominance within the health care system must be overcome in order to more fully effectuate PHC. Jennifer Lapum and colleagues focus on nursing practice in Chapter 8. In doing so, they critically reflect on the ‘place’ of nursing in PHC. Considering PHC as both a philosophy and practice, they contend that nurses’ roles in such care have gone unnoticed and under-recognized for many reasons. They conclude by calling for an increased recognition of nurses’ roles in PHC and also for nurses to play a more central role in PHC decision-making, including at the international scale. Daniel Hollenberg and Ivy Bourgeault focus on the practice of complementary/alternative and traditional medicine (CAM/TM) in Chapter 10. They start by contextualizing PHC through a discussion of the Alma-Ata Declaration and explain
the role for CAM/TM in PHC. Through a case example of a specific integrative health care setting (i.e., where CAM/TM and biomedicine are provided in the same clinic), they argue that integrative health care provides new spaces for the provision of CAM/TM and ultimately PHC.

**Places and Settings**

Examining the space of care provision and larger settings that inform the practice and delivery of PHC are topics central to the development of a geographic perspective on PHC. In the final major section of the book the focus is on notions of place and the settings in which care is delivered. The first two chapters turn to the community clinic as a care site. Valorie Crooks and Gina Agarwal consider the role of the clinic environment in care provision and present an original case example based on interviews conducted with women experiencing clinical depression in order to do so in Chapter 11. They draw on issues such as the purposes of the multiple micro-spaces within the clinic, internal design and layout, and people’s different ‘readings’ of the clinic space to support their contention that the environment matters with regard to how care is both delivered and received. They conclude by considering the implications of their discussion for implementing the kinds of PHC envisioned in the Alma-Ata Declaration. Robin Kearns and Pat Neuwelt contextualize their consideration of the clinic with a more nuanced understanding of the role this place plays within the community in Chapter 12. Drawing on their work in New Zealand, they focus on the role of community participation in the clinic and how the very nature of this place can assist with distinguishing between primary care participant and consumer. They further consider how to best actualize community participation in the New Zealand context and conclude by calling for health geographers to place increased focus on how local clinics can and do enact community participation.

The last two contributed chapters closely examine the roles of and need for PHC in different care settings. In Chapter 13 Nicole Yantzi and Mark Skinner turn to the home as a site of PHC giving and receiving. They draw on their own existing research to illustrate the many roles that providers in the home play, including that they often initiate first-contact care and enhance continuity of care. Their contention is that the roles of these providers are undervalued but yet are essential to the continuum of PHC provision. In concluding their chapter they call for greater attention to be paid to those who provide care in the home and their needs. David Conradson and Graham Moon, in Chapter 14, also focus on an under-recognized group related to PHC provision: consumers living ‘on the street’ (e.g., homeless individuals, rough sleepers). They frame this group as being difficult to reach but also in need of care and use two case examples to illustrate whether and how NHS-funded Walk-in Clinics and voluntary organizations are able to meet their needs. Their chapter gets at issues of equity of access in PHC provision and they conclude by suggesting that mobile care provision may be the best way forward in terms of meeting the needs of this group.
Acknowledgements

We are thankful to all those who have contributed chapters to this book. Without their efforts we could never have undertaken this project. We are also appreciative of Ashgate and the series editors for their support in seeing this project through to completion. Finally, we must acknowledge the assistance of Melissa Giesbrecht who worked with us on reviewing several of the chapters for formatting.

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