

# The Medical Nemesis of Primary Health Care Implementation: Evidence From Ghana

Nana Nimo Appiah-Agyekum<sup>1</sup>, Emmanuel Kojo Sakyi<sup>1</sup>,  
Esinam Afi Kayi<sup>2</sup>, Desmond Dzidzornu Otoo<sup>1</sup>  
and Josephine Appiah-Agyekum<sup>3</sup>

<sup>1</sup>Department of Public Administration and Health Services Management, University of Ghana Business School, University of Ghana, Legon, Ghana. <sup>2</sup>Department of Adult Education and Human Resource Studies, School of Continuing and Distance Education, University of Ghana, Legon, Ghana. <sup>3</sup>Department of Management, University of Huddersfield, Huddersfield, UK.

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**ABSTRACT:** Primary Health Care (PHC), based on the Alma Ata declaration, calls for the movement of responsibility, resources, and control away from medical systems and curative measures toward health promotion. However, PHC implementation in practice appears to be heavily influenced by medical systems with its own attendant effects on the attainment of PHC goals. This study therefore examines the extent and effects of medical systems influence on PHC implementation in Ghana. The study uses the thematic framework approach to qualitative data analysis to analyze data collected from PHC managers through interviews. Ethical clearance for the study was obtained from the Noguchi Memorial Institute for Medical Research. Findings suggest that PHC in practice is tied to the apron-strings of medical systems. While this has catalyzed successes in disease control programs and other medicine-based interventions, it has swayed PHC from its intended shift toward health promotion. Community ownership, participation, and empowerment in PHC is therefore lost in the maze of medical systems which reserves power over PHC decision making and implementation to medical professionals while focusing attention on treatment and curative services. Ultimately, PHC has gradually metamorphosed into mini-clinics instead of the revolutionary community-driven promotive services espoused by Alma Ata with concomitant effects on the attainment of Universal Health Coverage. Further, findings show how gradually, the primary in PHC is being used as a descriptor of the first or basic level of hospital-based care instead of a first point of addressing existing health problems using preventive, promotive, and other community driven approaches. Without a reorientation of health systems, significant efforts and resources are channeled toward empowering health workers instead of local communities with significant effects on the long term sustainability of health efforts and the attainment of UHC. The study recommends further studies toward practical means of reducing the influence of medical systems.

**KEYWORDS:** Implementation, primary health care, medical systems, Ghana, PHC managers, universal health coverage, healthcare, Alma Ata

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**CORRESPONDING AUTHOR:** Nana Nimo Appiah-Agyekum, Department of Public Administration and Health Services Management, University of Ghana Business School, P. O. Box LG 78, Legon, Accra 233, Ghana. Email: nnappiah-agyekum@ug.edu.gh

## Background

Primary Health Care (PHC) and primary care are terms that are increasingly interchanged.<sup>1</sup> This is fueled partly by the limited knowledge on PHC and partly by the reference to the first level of medical care as the “primary” healthcare. While this is a global occurrence, it is more common in Europe, Australia, North America and other western societies who had little interest in the PHC declaration.<sup>2</sup> Similarly, less developed and developing countries that invested significantly in the medical components of PHC as part of the selective PHC have also over the years presented their efforts at decentralizing medical care as PHC.<sup>3</sup>

In these countries, PHC is often used to describe basic medical healthcare, healthcare at the periphery, or some extension programs at the margins of health services.<sup>4,5</sup> This may have enforced the erroneous equation of PHC in developing countries with primary medical care or simple curative services with the addition, perhaps, of a prevention program represented by an immunization service or a water and sanitation program aimed at communities or families.<sup>6</sup> Subsequently, Yordy and Vanselow<sup>7</sup> see PHC in this light as the provision of

integrated, accessible healthcare by clinicians accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the family and community context.

However, PHC means more than basic medical care, a component or addition to existing healthcare services. It is a reorientation of health services toward the basic health needs of individuals, communities, and countries, with significant effects on the planning and provision of health services.<sup>8</sup> PHC presented by Alma Ata radically challenges the existing ways of thinking and practice from resource allocation to the attitudes of health personnel. This is not to say however that primary care services have nothing to do with PHC. In fact, while primary care is distinct from PHC, the provision of essential primary care is an integral component of an inclusive PHC strategy.<sup>9,10</sup>

In practice, Keleher<sup>1</sup> further argues that the equation of PHC with primary care is counter-productive because it disguises the transformative potential of PHC strategies that can make fundamental changes necessary to improve health. Secondly, it projects a meaning of PHC that is incompatible



with the comprehensive notions of PHC. This apparent confusion of concepts has led to a situation where primary care practitioners, projects, and interventions are provided with funds and support by both governments and NGOs designated as PHC funding.<sup>6,11</sup> Consequently, though purporting to enhance the principles and tenets of PHC, these primary care interventions rather divert attention and resources toward the provision and expansion of basic medical care.

The concomitant effects of the above include a narrowing of the PHC agenda which is symptomatic of a conservative environment that supports existing medical systems while rejecting attention to the socio-economic determinants of health. Further, the underlying objective of PHC as a system response to reducing health inequities and ameliorating the effects of disadvantage is lost to primary care reforms which seem to have little to do with addressing health inequities and more to do with medical systems.<sup>12,13</sup> Consequently, Rifkin<sup>14</sup> concludes that PHC implementation in general has medical connotations which may increase the role and dominance of medical systems instead of furthering the health promotion agenda especially when PHC is equated to primary care.

Even though Alma Ata's PHC has gained grounds in Ghana and the developing world, it is still significantly challenged by the lack of clarity on the role played by medical approaches and systems as a result of its constant confusion with primary care.<sup>15</sup> Apart from confounding stakeholders, these challenges have lasting effects on the direction and scope of PHC implementation.<sup>16</sup> Whereas relatively little studies are available on this subject, even fewer studies have focused on how medical professionals and activities influence PHC policy implementation and other bottom-end activities.<sup>6</sup> A paucity of studies also exist on medical systems and their roles in PHC implementation using evidence from frontline implementers in resource constrained environments. Yet these are essential in directing attention to the role of PHC in the attainment of the SDGs. This study therefore addresses the gaps identified above by providing first hand evidence from middle and top level implementers in Ghana with wide applicability to other developing countries.

## Methods

This study forms part of a wider study on PHC in Ghana that was approached from an interpretivist view. The choice of interpretivism was influenced by the significant degree of relativism that have characterized implementation studies in different contexts.<sup>17,18</sup> The study also adopted a qualitative case study approach because it facilitates, among other things, deeper meanings into implementation failures, stakeholders, processes, bottlenecks, and reform initiatives.<sup>19</sup> Hamel et al<sup>20</sup> also recommend qualitative case study approaches for investigations into the underlying reasons, processes, stakeholders, and outcomes of policy implementation.

The study methods and subsequent instruments for the study were designed sequentially in line with the PHC implementation assessment tools by Bhuyan et al<sup>21</sup> and El

Bindari-Hammad and Smith.<sup>22</sup> Based on these tools, the instrument for this study were designed to assess the meanings associated with PHC by implementers, PHC management and implementation decision making, resources for implementation and the general orientation of PHC and its managers. Emphasis was also placed on key personnel managing the implementation of PHC in Ghana at the national, regional, and district levels in line with McPake's<sup>23</sup> findings. From this group, Yin's<sup>24</sup> analytical sampling concept was used to guide the selection of prospective key informants based on their depth of experiences, level of management and role in PHC implementation.

A 2-stage sampling procedure was used to traverse the field-work limitations of gaining access and interacting with the PHC managers from the national level as well as across the 16 regions and 216 metropolitan, municipal, and district assemblies in Ghana. The sampling involved the use of convenience sampling to select the primary contacts and secondly using snowballing to involve other respondents recommended by the primary contacts and secondary contacts respectively. Drawing strength from Bhuyan et al,<sup>21</sup> these processes allowed the study to use the lines of reporting and flow of command to remedy some of the key challenges of carrying out PHC studies involving top level personnel. Similar approaches have been recommended by Patton<sup>25</sup> and Berg and Lune<sup>26</sup> to overcome the challenges of gaining access to top-level bureaucrats and limitations emanating from administrative red-tapes.

Using the approach described above, national level officers were enlisted who then helped recruit regional level officers. They, in turn, helped recruit district level officers. Saturation was reached by the 18th respondent and confirmed by the 19th respondent. A summary table depicting the sample and their respective levels of operation is presented in Table 1.

Semi-structured interviews, focusing on PHC implementation in Ghana, were therefore used as the main data collection instrument based on their ease of administration and proven efficacy from El Bindari-Hammad and Smith.<sup>22</sup> The interview guide designed and used in the study was flexible to help elicit responses that reflect authentic experiences of respondents. Interviews lasting between 60 and 142 minutes were conducted at the convenience of respondents and also recorded.

Ethical clearance for the study was provided by the Noguchi Memorial Institute for Medical Research with certificate numbers NMIMR-IRB 087/12-13, NMIMR-IRB CPN 087/12-13 revd. 2014. The study was also reviewed by the Ghana Health Service (GHS) which then granted permission to involve its personnel, facilities, and programs.

Data collection was done over a 6 month period and the recorded data was transcribed and subsequently signed-off by respondents. Analysis was then done using the processes of thematic framework approach espoused by Pope et al.<sup>27</sup> This involved immersion, developing thematic frameworks, indexing, charting, and then mapping and interpretation. The discussion of the analyzed data was then done within the context of relevant literature and reflexivity.

**Table 1.** Study respondents.

LEVEL	DESIGNATION	NUMBER
National	Deputy Director General, GHS	1
	Director, Health Promotion division	1
Regional	Regional Director of GHS	3
	Deputy Regional Director of GHS	3
	Regional Health Research Officer of GHS	3
District	Metropolitan/Municipal/District Director of Health	8
Total		19

Trustworthiness was ensured through the study by applying the 5-fold criteria presented by Lincoln and Guba (1985, 1994). Along these line, emphasis was placed on ensuring that the methods used in the study were credible, dependable, conformable, transferable, and authentic.

### Key Findings

Generally, findings covered the meanings associated with PHC by implementers, PHC management and implementation decision making, resources for implementation and the general orientation of PHC and its managers in line with the assessment tools used for the study.

#### *Nature and scope of PHC implementation*

Specifically, respondents shared varied opinions about the meaning, scope, and contents of PHC based on their implementation experiences. However, these views enforced the dominance of medicine in Ghana's PHC and were constructed around medical professionals, facilities, and services. Additionally, their views appeared to equate PHC in Ghana to CHPS which focuses on selected medical components of PHC.

*"PHC in practice is an extension of medical care across geographical areas through CHPS" (R1, District level)*

Findings also suggest that respondents viewed PHC as the basic level of the existing medical care structure from which referrals were made to hospitals. Additionally, respondents described care provided in PHC centers as a watered-down version of hospital care for rural areas and poor persons. In this sense, the dominant view among respondents was that PHC was a mini medical center with basic equipment and low skilled medical staff for underdeveloped or resource constrained communities.

*"PHC is designed to be the basic care provision hub for poor communities and rural areas so that those there too can get some medical attention for their problems" (R9, District level)*

Another point of consensus among respondents was the medical nature of PHC outreach initiatives. In their view, PHC used community outreach as a means of extending medical care to local communities rather than fostering empowerment and participation. Inherently, PHC appeared to be built around medical systems and involved a defined bouquet of medical services being supplied to local people. Consequently, respondents believed that PHC and how it was provided was dominated, controlled, and determined by medical personnel at the local level in a way that increased the dependency of local people on medical systems and heightened their powerlessness in their health decisions and actions.

*"PHC simply provides an avenue to make care available to communities which are far or have no hospitals. We give the nurses and other PHC workers motorbikes so they can reach out to these communities to give them care. . . We decide at the district or regional levels the priority areas for the year and the community nurses administer them" (R3, District level)*

#### *PHC management and decision making*

Further, respondents acknowledged that PHC management and decision making appeared to be dominated by clinicians who also controlled its implementation. In truth, all but 2 of the respondents had clinical background and still operated as medical professionals with respondents suggesting that almost all persons managing PHC were nurses, doctors, or pharmacists. Importantly, respondents argued that PHC was owned by the GHS and operated as an extension of its medical services, headed by a medical superintendent or a senior clinical officer with practice experience.

*"All of us are employed by the GHS based on our professional backgrounds in medicine, pharmacy or nursing. . . Obviously, you will require some medical knowledge to manage the kind of interventions we offer under CHPS" (R7, Regional level)*

Closely associated with the above is the firm belief of respondents that PHC implementation and associated resources could not be managed by non-medical personnel or lay community members who did not understand health nor had any training on clinical care. Respondents also emphasized that PHC interventions were owned by the Ghana Health Service and not local communities. Consequently, they were responsible to and accounted to their superior officers either at the regional and national levels and not local communities.

*"We are employed and posted here by the GHS so they tell us what to do and how we do it. . . but why should we leave this to local communities who are not don't understand healthcare" (R12, District level)*

#### *Health promotion and disease prevention*

Generally, respondents emphasized the importance of medicine to PHC and further linked successes of immunization and other components of PHC to activities of medical professions.

They however agreed that ideally, PHC was supposed to de-emphasize medicine and promote healthy living and preventive efforts. Yet, because of its situation in the already existing medical structure, PHC in practice in Ghana focused more on curative care than promotive care.

*“On paper, PHC works through health promotion but in practice, PHC here is about treating people and addressing the common diseases and sicknesses they suffer” (R17, Regional level)*

A central argument made by respondents was that PHC in Ghana was built on a continuous support for disease control programs and for the treatment of common diseases than for non-medical components like health promotion. Though poor supervision of local level implementers and community apathy were identified as factors, the main issue garnered from respondents views were the focus of central government and donor community funding on medical equipment, infrastructure, personnel, and supplies than on empowering local communities or encouraging preventive and promotive health.

*“The government and its development partners focus on disease control programmes and empowering medical institutions than on empowering the local communities and people” (R15, National level)*

#### *Control over health resources*

Findings also show that Health Promotion (HP) was seen, operationalized and managed by medical personnel in hospitals or as part of educational components attached to vertical programs. In particular, CHPS was a commonly cited example of how community-based health promotion activities had gradually been turned into mini clinics under the control of Community Health Nurses (CHNs).

*“Even CHPS has now turned into a mini clinic. There is no proper health promotion activity apart from the occasional outreach programmes and the health education talks they give at the OPDs on the CHPS compound” (R19, District level)*

A recurrent theme was the high levels of importance, conditions of service, and career progression of medical personnel relative to other professions engaged in PHC in Ghana. Consequently, findings indicate high levels of attrition of Community Health Officers (CHOs) and other non-medical PHC staff to medical ranks as well as a slow career progression and low levels of assigned responsibility, lack of motivation and a sense of inferiority among non-medical PHC personnel.

*“even study leave is granted to CHOs only if they are going to pursue a programme in midwifery or nursing. . . nurses are paid better and more respected than the CHOs and other health promotion staff (R11, Regional level)”*

#### **Discussion**

PHC as a policy recognizes the wider context of health beyond the limited scope of selected medical interventions

implemented on a piece-meal basis.<sup>28</sup> Nevertheless, a significant section of implementers interviewed saw PHC as a linear extension of medical care found in cities to other deprived parts of country. Odugbemi<sup>29</sup> confirms this occurrence in the SSA context where governments and health partners have for decades focused on extending the scope medical infrastructure and personnel rather than expanding the scope of PHC services to include HP activities. Apart from making medical themes and initiatives dominant in PHC, this creates an erroneous impression of PHC being synonymous with the extension of hospital care. In Ghana's case for instance, this was reflected in the equation of PHC with the CHPS strategy designed to bridge the geographical barriers to accessing facility-based healthcare services. Similar findings were made in Australia,<sup>30</sup> Canada,<sup>31</sup> Asia,<sup>32</sup> and Latin America<sup>33</sup> thereby suggesting the global prevalence of this phenomenon.

Also, reference to PHC as the first level of medical care rather than a broad HP concept by study respondents appears to reinforce the medical undertone on how PHC is approached. Now common in developing countries, such meanings are traced to healthcare in developed countries where primary literally means first level of medical care<sup>2,34</sup> in contrast to Alma Ata's PHC which is a distinct approach to healthcare. Within this frame, PHC stakeholders appear to inadvertently place PHC and hospital care at different, often competing poles of the medical care provision chain by misrepresenting it as basic medical care. Perceptions of PHC as the lowest healthcare center offering basic or routine care and from which “patients” are referred upwards to hospitals appear not be limited to this study's context alone but are dominant in SSA generally.<sup>12,35</sup> Similarly, constant reference to PHC as a functional triage center for identifying, screening, and referring reported cases in this study appear consistent with Alzaied and Alshammari,<sup>36</sup> Chokshi et al<sup>37</sup> and El-Jardali et al<sup>38</sup> thereby confirming this a global phenomenon that further increases the medicalization of PHC.

Additionally, the “basic” nature of services, equipment, expertise, and experience of available staff at PHC centers also creates an impression of inferiority in comparison to hospitals with far-reaching implications on the perceived quality of PHC services. Similar findings associating PHC with basic healthcare provided by lower cadre health personnel with relatively little training, experience, and resources were made by Puoane et al<sup>39</sup> and Tanner and Harpham<sup>40</sup>; and also linked to poor utilization of PHC services in developing countries.<sup>41,42</sup> In truth, the widely held “pro-poor clinic” notion of PHC services also appear to diminish the appeal of PHC services generally with wider implications on utilization and acceptance of PHC services. This is especially true in urban and high-income areas where PHC activities are not patronized because it is erroneously perceived as an inferior medical service rather than its true intended health promotion goals.

Several reasons have been provided for why medical-oriented notions like those presented above are very common

even among PHC personnel. While Keleher<sup>1</sup> attributes this to the dominance of medical personnel in PHC interventions, Macdonald<sup>6</sup> on the contrary believes it is a vivid reflection of the curative nature of PHC services widely practiced in developing countries. Importantly, these meanings of PHC and their subsequent translation into policy and practice have been criticized as being tangential to Alma Ata's paradigm shift from curative care toward HP.<sup>43,44</sup> As findings from this study shows, medical-oriented conceptualizations of PHC have contributed to the medicalization of HP initiatives, restricted PHC's focus on community empowerment and participation and further deepened the dependence of local people on curative services. Significantly, medical conceptions of PHC have gradually shifted its implementation approaches from Alma Ata's demand-led health services based on peculiar health needs and demands of individual local communities to supply-led care determined and controlled by healthcare professionals in healthcare facilities.<sup>13,45</sup> Consequently, health services are not structured around the needs of local people in a manner that is consistent with their socio-economic and cultural practices through their participation. Rather and as is common in other developing countries,<sup>35</sup> PHC in Ghana based on respondents' views is conceptualized, owned and operated by government health agencies and medical professionals who design and supply a defined SPHC package to all residents in the country. In relation, findings by implication suggests that SPHC may well be a counter-productive strategy toward the Alma Ata's recommendation of a de-medicalized health service built on community participation and HP. Respondents' perceptions that SPHC entrenches the role of medicine, medical professionals, and medical systems in determining the population health confirms Macdonald<sup>6</sup> that SPHC places health in the hands of a few qualified personnel in a way that disempowers the ordinary people by making them reliant on health professionals and services for basic decisions and actions affecting their health.

Generally, findings recognized the dominant role of clinicians in the PHC policy cycle even though their influence was stronger in formulation and implementation than in legitimization and review stages. Similar results were presented by Couzos and Murray<sup>46</sup> who link the dominance of clinicians to the tasking of the existing medical structures and systems in developing countries to implement PHC after Alma Ata. McManus<sup>47</sup> concurs that the role of clinicians in formulating and implementing PHC policies influences the support for medically-oriented components of PHC and the subsequent adoption and use of hospitals and other health-center based approaches to PHC instead of tackling the socio-economic determinants of health. In relation, findings supports Awoonor-Williams et al<sup>48</sup> that PHC in Ghana has been built around interventions that could be measured, compared, and costed using objective epidemiological rates and indices like mortality, morbidity, disability, incidence and prevalence rates, exposure

rates, and case fatality rates. Consequently, medical components of PHC which can be assessed through these means overflow with attention and support at the expense of HP initiatives that are difficult to assess through these means.

In what Macdonald<sup>6</sup> calls the radical revolution against medicine, PHC seeks in principle to move control over health resources and decisions from medical facilities and professionals into the local communities and ordinary people. In practice however, medical facilities and personnel have continued to dominate healthcare systems. Especially in developing countries still fighting vaccine preventable diseases, infectious diseases, injuries and NTDs, medicine, and its related professions have proved invaluable.<sup>49</sup> Similarly, the eradication of polio, guinea worm, and the fight against childhood killer diseases in Ghana were linked to disease control programs and other medicine-based interventions by respondents. Consequently, it is evident that PHC in practice does not replace medical intervention but rather seeks to minimize the role of medicine in health by restricting people's reliance on medical systems, tackling conditions that make them dependent on medicine and further empowering them to take responsibility and control of their health. This appeared to be the crux of the CHPS initiative which dominated discussions on PHC with respondents. However, respondents' perspectives suggest that CHPS and other PHC initiatives have not diminished the role of medicine in health. Rather, left under the control and management of medical professionals and the medically-oriented GHS, findings show how curative care has gained roots and grown to overshadow public health and HP approaches in CHPS. Generally, stakeholder perceptions in the study shows how CHPS is run by medical professionals, through medical systems using medical approaches and interventions. In relation, Logie et al<sup>50</sup> believe that medical interventions in PHC usually have more support and commitment from central government and donors and are therefore more successful than non-medical ones. This was similar to Ghana's case based on respondents' views even though health education appeared to also get significant support in times of disasters, epidemics or public health emergencies. Under the influence of medicine, findings further show stakeholder perspectives that PHC interventions that were treatable through medical interventions and systems were more visible and supported than those that were not.

Central governments, health ministries and key partners are blamed for furthering the medicalization of primary care in their acceptance and support for disease treatment and control rather than their prevention and HP.<sup>51-53</sup> Although same was supported by findings, illiteracy, poor social infrastructure, negative socio-cultural practices, and general apathy from local people were identified as other contributing factors. In Ghana specifically, respondents' views suggest that central government funding is restricted to physical infrastructure, machines and equipment for hospitals, and remuneration of medical staff at the expense of HP activities. Policies and practices are also

geared toward building the capacity of GHS to provide PHC services rather than empowering local communities to take control of their health. Meanwhile, external stakeholders have also concentrated on disease control programs, provision of medicines, vaccines and hospital equipment, and training medical specialists.<sup>54</sup>

As in Logie et al,<sup>50</sup> key PHC stakeholders were also faulted by respondents for leaving control and implementation of PHC to medical personnel especially at the local levels. Using the street level bureaucracy concept, Kosar<sup>55</sup> explains how lower level implementers have infinite power to exert their values, interests, and expectations in the translation, determination, and implementation of policy actions and directives. As clearly exemplified by the staffing of CHPS compounds with clinicians instead of public health staff, findings show the increased opportunity and tendency of medical street-level bureaucrats to further consolidate the dominance of curative care in PHC. The case is exacerbated when in the absence of effective supervision of lower officers by superiors, street level bureaucrats take for granted the essence of participation from grassroots stakeholders and policy beneficiaries.<sup>56,57</sup> In these circumstances, lower level personnel have unrestricted discretionary authority and political latitude to stifle bottom-up inputs to policy decisions and actions in favor of directives received from the top levels. In this study for instance, local communities were seen as beneficiary stakeholders with little capacity, opportunity and control over PHC initiatives. In relation, respondents also generally believed that CHOs and other PHC staff at the local levels operated under the directives and served the interests of the GHS rather than local communities.

Even at higher levels and in urban centers, Roshi and Burazeri<sup>58</sup> report that HP activities in developing countries are often concentrated in hospitals and are administered by doctors, nurses, and other medical professionals rather than in communities. Findings showed a similar pervasiveness of the control of medical professionals at the national, regional, and district levels of PHC decision-making and implementation with all top level staff being experienced doctors, nurses, or pharmacists. By tasking them with the design and implementation, PHC stakeholders appear to arm medical professionals with an infinite power to restrict participation of other professions, restrict the scope of PHC interventions and further usurp the role of public health officers in PHC. Rooted in the principles of self-preservation, enhancing professional sanctity, and the ability to restrict control and regulation from other professions, Dingwall and Lewis<sup>59</sup> and Harris et al<sup>60</sup> associate domineering tendencies of medical professions in PHC with the sociology of their professions. Respondents' views in this respect show that CHPS which started as a community-based HP system had gradually metamorphosed into mini-clinics under the control of medical professionals. Additionally, CHOs who are supposed to do outreach, health education and home visits have gradually been turned into

clinical nurses administering facility-based care. Similar experiences have been shared by Wireko and Béland,<sup>61</sup> Plewes and Kinsella<sup>62</sup> and Christopher et al<sup>63</sup> in other sub-saharan African countries.

Importantly, respondents linked the dominance and control of medical professionals with the meanings given to key concepts in PHC, and how these concepts were implemented. Similarly, Weare<sup>64</sup> notes how in practice, the influence of medical professionals results in the confusion of HP with health education or knowledge transfer. Consequently, HP activities in PHC focus on providing specific information in order to reduce risk instead of building healthy public policy, empowerment, and reorienting health.<sup>65</sup> Findings support the above and show several instances where referenced HP activities were simply routine health education talks given in OPDs in hospitals, or during epidemics. Kok<sup>66</sup> in this regard, explains that most HP programs in developing countries are unsuccessful because of the overconcentration on knowledge transmission rather than behavior change. Further, knowledge and education on health conditions, though essential do not automatically translate into improved health.<sup>67</sup> Within PHC specifically, Zweigenthal et al<sup>68</sup> stresses that knowledge and awareness do not necessarily translate into positive behaviors and actions.

Findings also show how under the influence of medicine, the activities, conditions of service, and progression of medical personnel were supported and promoted than those of other professionals. Similar to Macdonald,<sup>6</sup> PHC in Ghana appears to be caught in a vicious cycle of medicalization where medical personnel exert their influence on PHC in a way that prioritizes medical interventions, excludes other professionals, and assign core PHC responsibility to medical staff. These in turn increase the numbers, control, dominance, and relevance of medical personnel in PHC policy formulation and implementation which they use to further their interests and exert more influence. As findings confirm from Macdonald<sup>6</sup> and Kruk et al,<sup>69</sup> medical personnel in PHC were considered core staff and paid better, recognized, and given allowances, incentives, and better opportunities for career development and training relative to non-medical PHC personnel. Within HP, Bunton and Macdonald<sup>70</sup> also examine how the dominance of medicine limits the commitment, increases dissatisfaction and heightens attrition of other professionals and disciplines. This was confirmed by findings of high levels of attrition of CHOs to medical ranks, lack of motivation, and a sense of inferiority among non-medical PHC personnel.

## Conclusion

Upon reflection, findings appear to support Logie et al<sup>50</sup> that the western approaches and scientific methods may have made medicine-based approaches more acceptable to external stakeholders of PHC therefore attracting their support. Additionally, the selective PHC evidenced by disease control programs, described by Newell<sup>71</sup> as the counter revolution to PHC, that

dwelt on tackling particular medically-based and vaccine preventable conditions through existing health personnel and systems may also account for how medicine had maintained its hold on PHC in Ghana and other developing countries. These notwithstanding, the major reason based on findings was that Ghana did not make the radical shift prescribed by PHC. Instead of creating a new health service and system or significantly modifying its health system to make them more attuned to the Alma Ata declaration and Ottawa charter, these initiatives were handed over to the existing medical systems to implement thereby giving them limitless opportunity to exert their control and dominance over HP and PHC.

The medicalization of PHC, though a practical limitation to the attainment of Alma Ata's broad PHC goals of universal health care has made significant inroads toward addressing some of the major causes of mortality, morbidity and disability in Ghana and other developing countries. By focusing attention and gathering support for selected components of PHC, albeit medical ones, the medical systems allows countries to use their existing and established structures, protocols, and personnel to expand care, increase access and eradicate some of the deadliest curable conditions known to man. It also allows for the equitable distribution, control and evaluation of community health initiatives through the uniform deployment of skilled medical personnel controlled from the top. While these may infringe upon the principle of community determination and control of health outcomes, it nonetheless provides a practical means of catalyzing the attainment of the health-related SDGs especially considering the high levels of apathy, low levels of literacy and non-existent social and economic infrastructure for community controlled health initiatives. For similar reasons, community empowerment in this case may also not be practicable in many local areas which are subsistent agrarian in nature and deeply fighting vaccine preventable and treatable conditions in poverty-stricken settings. Most importantly, it has perennially been acknowledged that Alma Ata's PHC is political, utopian, resource dense and very complex relative to the existing medical systems to a point which puts it far beyond the reach of many economies struggling to provide basic amenities.

### **Implications for Research, Practice, and/or Society**

The above notwithstanding, Alma Ata's PHC offers more long term solutions to attaining the SDGs and other national health goals than the existing medical systems. While medical systems may offer significant benefits, these often are short term, unsustainable, increase dependency, and very expensive in the long run. By moving attention and focus from the resource exhausting medical systems and personnel toward the preventive and promotive principles of Alma Ata's PHC, countries may reduce their healthcare expenditure, increase citizen responsiveness to health and further encourage local solutions to local health problems. In Ghana for instance where close to 90% of healthcare expenditure is

incurred on paying emoluments of health personnel, significant savings may be accrued from increasing lay involvement in health decisions. In addition to these and other economic reasons, PHC brings to life the age old saying that prevention is better and indeed cheaper than cure. This is especially true when considered that investments in health promotion and preventive health practices will ensure to a large extent that people do not get ill in the first place and further help them avoid behavior and practices that will make them susceptible to treatable or curable conditions. PHC in its right practice also encourages appropriate and indigenous technology and health practices which often use easy to find materials in local communities, existing social and cultural structures and involve local stakeholder who are more available, acceptable and easier to economically maintain than the medical systems.

Of course some level of medical support may be required to support Alma Ata's PHC and this was rightly acknowledged in the PHC declaration. However, the stranglehold of medicine on PHC is gradually eroding gains made in community health, health promotion and prevention by increasing the reliance on individuals on medicines, hospitals and medical professionals while disempowering them, and reducing their willingness, readiness and ability to take control of decisions that affect their health or make healthy life choices. As evidence from this study shows, communities are gradually becoming spectators and powerless pawns at the mercy of health authorities who now make decisions on what, when, how and in what means health will be provided to communities. This is strongly against the spirit and letter of PHC and epitomizes the very reasons for the Alma Ata Summit.

The PHC discourse must in essence move away from increasing utilization of healthcare services to rather increasing people's ability to make healthy life choices through health public policy and other key tenets proposed by Alma Ata's call for a reoriented health service. Cognizance must also be given to the fact that, in spite of its numerous benefits, facility-based care and the medical systems which offer them remains a part of PHC and not the other way round. Until PHC is reoriented to reduce medical influences and exigencies, medical systems remain counterproductive to PHC and at best, a short term antidote to a perennial desire for improved health outcomes in line with the SDGs.

### **Author Contributions**

Nana Nimo Appiah-Agyekum was responsible for conceptualization, Formal analysis, Methodology, Writing – original draft, Writing – review & editing

Emmanuel Kojo Sakyi was responsible for Formal analysis, Methodology, Supervision, Writing – review & editing

Esinam Afi Kayi was responsible for Project administration, Supervision, Writing – review & editing

Desmond Dzidzornu Otoo was responsible for Formal analysis, Methodology, Writing – review & editing

Josephine Appiah-Agyekum was responsible for managing team Resources, Supervision, Writing – review & editing

## Supplemental Material

Supplemental material for this article is available online.

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