THE POLITICAL AND ADMINISTRATIVE CONTEXT OF PRIMARY HEALTH CARE IN THE THIRD WORLD*

THOMAS J. BOSSEY and DAVID A. PARKER

Sarah Lawrence College, Bronxville, NY 10708 and Harvard School of Public Health, Boston, MA 02115 and Woodrow Wilson School of Public and International Affairs, Princeton University, Princeton, NJ 08540, U.S.A.

Abstract—Despite increasing knowledge about technical aspects of Primary Health Care (PHC), there has been a yet only limited research into political and administrative influence on the effectiveness of PHC programs. A three-stage model of the policy process is developed as a framework for organizing the relationships between elements of (1) the national political setting and PHC policy formulation; (2) the implementing agency and program administration; and (3) the community setting and service delivery. Drawing upon the literature on PHC and related programs, hypotheses are proposed for each of these stages as a basis for future study and practical application. Possible output indicators are suggested for each stage of the model. Several basic methodological issues must be addressed in the design of empirical research on political-administrative factors, including variable selection, identification of data sources, and choice of analytical approach. It is hoped that this review will encourage more systematic investigation in this area.

Over the past decade, Primary Health Care (PHC) has become increasingly institutionalized in Third World countries. The PHC approach provides essential health services, mainly to dispersed rural populations which often did not have regular access to public or private health care. These new services have generally been designed with the objectives of integrating preventive and curative activities, making use of multiple levels of health workers and promoting local participation in service delivery. Experience over the decade has led to substantial improvements in the technical capability to develop PHC resources and to respond to the health needs of rural populations in the less developed countries (LDCs).

Despite this practical knowledge about PHC, program performance has been varied. Not only the design of PHC efforts, but also the ability to implement them, have been shown to be constrained by characteristics of the particular country or regional location in which they are conducted. A growing literature demonstrates that the context of PHC—the political, administrative, and community settings in which programs are designed and carried out—as well as the different strategies and processes involved in their adoption and implementation, exert important influences on program outcomes. At the extreme, these influences may severely restrict the successful performance of apparently well-designed PHC programs.

There remains considerable scope for improving program performance through a better understanding of the structures and processes which form the context of PHC policy. In an effort to suggest a manner in which these issues can be examined within a systematic and comprehensive framework, the first section of this paper proposes a general analytical model of the policy process for PHC. The second section uses this model to introduce and review the relevant literature on PHC and the third draws from this literature to identify a set of propositions concerning the dynamics of PHC that might serve as hypotheses in further study. The conclusion discusses several important issues of design and methodology for future research in this area.

PRIMARY HEALTH CARE AND THE POLICY PROCESS

Current approaches to PHC have emerged from an increasing awareness of unmet health needs, and the experience of a number of health projects and programs since the mid-1960s [1-3]. Within the comprehensive definition set out by WHO and UNICEF in the 'Declaration of Alma Ata', PHC is identified as having the following principal features:

- It includes promotive, preventive, curative and rehabilitive services, to focus on the main health problems in the community.
- It has at least eight minimum components—health education, nutrition services, water supply and sanitation, maternal and child health care (including family planning), immunization, prevention and control of endemic diseases, treatment of common diseases and injuries and provision of essential drugs;
- It is intersectoral in orientation, involving coordination with activities in related sectors such as nutrition and public works;
- It is based upon local self-reliance and community participation; and
- It makes use of all levels of health workers, including paraprofessionals, and is part of a larger system of referral for specialized care [4].

Implementation of these activities is an ambitious and long-term objective, and one which requires

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considerable alteration of the current health care systems of most developing countries. Furthermore, the extent and intensity of the specific PHC services provided—the 'technical package'—is clearly conditioned by local needs and resources. Thus, within this general PHC model, countries and international agencies have adopted a variety of PHC program designs.

This growing experience with PHC has been subject to a number of assessments in recent years. These include reviews of the effectiveness of PHC-oriented projects in achieving changes in health levels [5]; broader examinations of the potential for expansion of PHC internationally [6–8]; and increasing concern with the financing of PHC [9, 10]. It is beyond the scope of this article to review this technical literature in detail, yet it is clear from these assessments that evidence of the effectiveness of PHC remains rudimentary. On balance, available studies suggest that PHC is likely to have a positive impact on health levels in rural areas; however, it has not been clearly shown that PHC is the most cost-effective means of providing health care to these populations. Pessimistic information suggests that PHC will be effective only if political and administrative conditions allow the development of smoothly running program implementation [11].

In order to better understand the political and administrative dynamics of PHC, we have developed a model of the PHC 'policy process'. This model, taking into account the relation of PHC to its various contexts provides a framework for organizing the literature on PHC, and serves as a basis for the identification and possible testing of hypotheses concerning PHC performance. To fulfill these purposes, the model is designed to meet several minimum conditions: (1) it should be relatively simple, in order to be understandable to a wide range of audiences; (2) it should be operationally meaningful, in order to correspond to identifiable activities and processes, and to allow the development of specific indicators of policy inputs and outputs; and (3) it should be empirically testable, to permit verification and to promote the introduction of feedback for continuing refinement.

The model first makes a fundamental distinction between policy formulation—the broad choice of goals, objectives and means—and implementation—the translation of policy into action programs for the achievement of policy goals. Numerous more complex models have been put forward in the literature, which further categorize policy activities in greater detail [12, 13]. In light of the principles noted above, we follow a classification made by Korten and others, in which the implementation phase is further separated into stages corresponding to 'management' and 'operational' activities, respectively [14]. The resulting three stages of the policy process may be set out as:

(1) **Policy formulation**: the selection of goals to be achieved through intervention; the identification of broad strategies for the pursuit of these goals; and the assignment of budgets and institutional responsibilities for carrying out the chosen strategies.

(2) **Program administration**: the translation of adopted policies into the design of action programs, through the preparation of a detailed plan, the establishment of management procedures and organizational structure and the introduction of pilot activities.

(3) **Service delivery**: The operation of the planned action program at the field level, and the provision of services in target communities to achieve the goals of the policy.

As relatively distinct activities within the policy process, these stages correspond closely to the three principal levels or contexts of PHC: the political arena, the implementing agency (usually the Ministry of Health and the community setting. Specific measures of output are identified at each stage, to permit the assessment of policy performance.

It will be observed that the ultimate technical objective of PHC—the actual improvement of population health status—is not included in this approach. As noted earlier, the linkage between health policies and identifiable changes in health status has yet to be firmly established; the more limited objective at present is to identify factors which affect or constrain the 'smooth-runningness' of PHC services. Through this analysis it will then be possible to suggest conditions under which programs could have significant effects on health status.

It must be emphasized that this model, like any other, is a heuristic device which may assist in our thinking about policy processes. All models pose risks of oversimplifying complex phenomena, and here we will note several limitations on the usefulness of our approach which may make it difficult to apply such an 'ideal' sequence directly to actual cases.

First, as Grindle observes, a policy often evolves over time and during program operations, as objectives are reinterpreted or defined more precisely [15]. Thus, goal-setting cannot be confined to policy formulation, since goals may change over the course of implementation. Such reinterpretation has occurred, for example, in the family planning and nutrition areas, in which many formerly vertical programs have become integrated within a broader maternal and child health care strategy [16].

Second, it has been argued that sequences are not as important as the types of decisions that are being made, such as the distinction between 'political' and 'technical' decisions. In this view, political decisions are those concerned with resource allocation, authority and control relations, and the interface of health services with people, while technical considerations relate to the operational efficiency of particular program designs [17]. In the framework presented here, most technical decisions have been assigned to the 'content' of policy, and discussion is focused instead on the range of political and administrative decisions which are central to the policy process. However, this distinction tends to obscure channels through which technical decisionmaking may influence 'political' dimensions in undetected ways [18].

Third, some analysts advocate the study of political-administrative systems as a whole, rather than attempting separately to examine individual elements of the policy process [19, 20]. This perspec-
tive emphasizes the analytical complexity of the relationships among identified contextual factors. In our model, for example, the predictable resistance of the medical profession exerts influence in all stages of the policy process. Similarly, a 'regime' factor such as the stability of the government may affect health agency decisions as well as community-level politics, and the degree of administrative decentralization conditions both the planning process and the incentives for community participation in PHC. Finally, 'background factors' such as health conditions and the availability of economic resources are likely to influence the other three contexts as well.

In view of these limitations, this model cannot be rigidly applied to all policy settings. As will be seen, however, it is useful for organizing the literature on PHC, and for allowing the systematic development of hypotheses which relate contextual factors to specific PHC outputs.

OVERVIEW OF THE LITERATURE

PHC has become the subject of a wide literature, encompassing published books and articles as well as unpublished reports and other documents. Using the framework that has been introduced, this literature may be broadly divided into three analyses which consider PHC as: (a) a specific policy; (b) a type of program; and (c) an activity carried out in the community.

**PHC as policy**

The 'policy' literature on PHC uses a variety of social science perspectives to examine the question of how PHC is placed on the policy agenda. Some authors have focused on systemic conditions which foster the formulation of new health approaches (e.g., socialist vs capitalist systems), while others have given primary attention to the actors involved in encouraging governments to adopt PHC policies. The focus on systemic factors has emerged from earlier literature on the process of socioeconomic development which sought to distinguish the policy choices of different types of political regimes. In general, no strong relationship was found between regime type and the content of national decisionmaking [21, 22]. Other authors, however, have emphasized that socialist regimes may be particularly conducive to policy innovation, especially in the health sector [23]. Additionally, much of the research on policy actors in PHC has tended to emphasize the contributions of international participants in national policy processes [24].

Studies of population and family planning programs have examined in considerable detail aspects of the formulation of population policy. This literature, which is devoted largely to case materials and broad aggregate analysis, includes a wide range of papers in edited collections [25-27], along with a smaller number of more analytical studies [28]. While not conclusive, the findings of this research suggest that demographic, economic and regime characteristics, as well as interest group activities, set important conditions for policymaking.

A long-standing interest in the formulation of national health policy is reflected in the political science literature, which has focused primarily on developed countries [29-31]. These studies have been supported by a substantial treatment of political issues in the more theoretical literature on comparative health systems [32-34]. As described below, research on health policymaking in LDCs includes many detailed case studies as well as some limited comparative studies. A major contribution in this area is the recent study of national decisionmaking for PHC in seven countries, sponsored by the Joint Committee on Health Policy of UNICEF and WHO [35].

This literature has contributed significantly to an understanding of the health policy process and of the dynamics of PHC policymaking. Overall, however, it is limited by a lack of output measurements related to specific plan provisions and budget allocations and it remains principally descriptive in character.

**PHC as program**

A considerably greater amount of attention has been given to the implementation of PHC, regarding the operation of programs once national policies have been established. Work in this area has emerged from two principal sources—the general field of development administration and evaluations made of health sector programs. These directions of investigation are presently converging in useful ways.

The term 'development administration' refers to a variety of approaches to the study of bureaucratic processes in developing countries, focusing on efforts by national governments and outside organizations to improve administrative performance. Existing institutional structures are viewed as playing a large role in the effectiveness of all types of development activities, including health care [36]. Recently the emphasis of studies in this field has shifted from administrative structures to program dynamics, a trend which has resulted in a large and growing body of research on implementation, on 'how programs work'. The implementation literature has emphasized issues of institutional linkage, timing of activities, aspects of program content, administrative leadership and personnel motivation [37-39].

The implementation of health programs, including PHC efforts, has been addressed systematically in a relatively small number of studies, but there is an increasing application of general administrative and managerial principles to health sector concerns [40, 41]. Much of the research on health program implementation has been based upon evaluations of pilot and demonstration projects conducted over the past decade. Summaries and descriptive analyses of many such projects have been prepared [42, 43]. Detailed studies, especially of large-scale demonstration projects, reflect a broad scope of analytical methods and applications [44-47]. Case materials on programs in related sectors such as nutrition [48, 49] and water supply [50] are also highly relevant to PHC. These and other sources have led to analyses incorporating implementation considerations into health program evaluation [51].

The 'program' literature has thus begun to link design issues with factors of the political and administrative environments in explicit ways. However, as with the literature on policy formulation, available
studies of implementation tend to be largely descriptive and call for considerable refinement in their employment of comparative indicators of implementation effectiveness.

PHC in the community

The 'community-level' literature is concerned with the management and operations of PHC programs at the local site of service delivery. Of particular concern are efforts to promote community participation in program activities and to expand the utilization of paraprofessional workers.

Here again, much of our present knowledge originated from projects to improve the delivery of community-based family planning services. In recent years a large body of useful work has also been directed towards enhancing the management of integrated rural development (IRD) programs, which combine broad sets of activities for the development of agricultural regions [52]. Simultaneous and interrelationships between these undertakings and PHC have made much of this research readily applicable to service delivery under the PHC approach. There is increasing attention to problems in the management of community health programs [53] and much of the program literature described above documents community-level operations in PHC pilot projects.

Local participation in community settings is an integral aspect of PHC. It is seen as a means of generating and maintaining support toward other development activities. A growing body of research focuses on the experience and problems of local participation in rural programs, including those in health [54]. In addition, international agencies have devoted substantial attention to local participation in PHC projects [55, 56].

There is also a large amount of research describing the role of paraprofessionals in the delivery of PHC and related services. This has examined the training, functions, and performance of different categories of local health workers [46, 57]. The use of more highly trained, 'intermediate' levels of health workers has also been explored [58]. In addition, the potential for incorporation and utilization of indigenous medical practitioners has been widely studied from a variety of disciplinary perspectives [59-61].

In general, the 'community' literature is the most comprehensive and best developed of the PHC materials. This emphasis may be appropriate, since the focal point for PHC intervention has historically been the expansion of services at the community level. This literature has been the most successful in addressing the linkages between policies, objectives and operational variables. However, in the other cases, there has been little direct assessment of the relationships between implementation processes and desired outcomes, and there have been relatively few attempts to compare experiences across a large number of nations.

The state of the art

In summary, the PHC literature to date contains useful elements of a general framework for policy analysis, along with scattered examinations of political and administrative influences on health care and other human development projects. There are also several notable examples of comparative analysis of these factors, which point the way for further research. Nevertheless, at least three major problems may be identified in this work:

1. Narrow focus: very little of the PHC research surveyed addresses more than a small part of the 'policy problem'. Studies tend to focus either on issues of technical content or on particular stages of the policy process, with limited regard for how the specific questions they examine are conditioned by the wider political-administrative context or by other stages in the process.

2. Incomplete or description, rather than on generalized analysis: most of the available materials are not only limited in scope, but in their approach to analysis as well. Most studies are descriptive and attention tends not to be paid to conceptual development or to specific measures of PHC effectiveness. Even the evaluation literature is surprisingly weak in this respect. There is thus little potential for the emergence of verifiable generalizations from available published studies.

3. An absence of comprehensive frameworks for analysis: related to these two points is the lack of comprehensive or unified models for the study of PHC programs in different settings. A variety of approaches and relatively limited models are presented in the literature, but few of these are applied to different types of PHC efforts or to more than one stage of the policy process. Our capacity to speak about the relative significance of PHC outcomes across different national settings, as an essential component of PHC policy assessment, thus remains quite limited.

AN INVENTORY OF HYPOTHESES

For the remainder of this paper we build upon the three-stage model introduced earlier, to outline a systematic approach to the examination of the political and administrative context of PHC. Drawing from the existing literature, we suggest a series of hypotheses which may provide an agenda for future research in this area [62].

(A) Policy formulation

During the process of policy formulation a number of factors help to determine whether a given national government will make a commitment to PHC policies. The successful adoption of a national PHC policy may be indicated by several possible measures, including (a) a plan with clearly stated goals and strategies to reach the rural poor through PHC; and (b) an increase in the approved Ministry of Health or other responsible government agency budget for PHC activities.

1. Considering first the ideology and structural characteristics of regimes and elites, PHC appears more likely to be adopted under governments:

   Which are committed to social and economic reforms, particularly in the agrarian sector [63, 64].

   Which are pursuing development strategies that emphasize a mixture of growth and equity objectives, rather than simply economic growth [35, 65].

   Which face very political instability—especially in status quo-oriented regimes, elites are likely to adopt
political and administrative context of PHC

minor reforms such as PHC to promote stability, although conditions of instability are likely to inhibit the implementation of PHC policies [66, 67].

In which there is a greater degree of democracy and in such cases, greater electoral strength on the part of the rural population [68].

The political influence of beneficiaries and providers is an important factor in the competition for scarce national resources. The literature suggests that PHC may be more likely to be adopted.

The greater is the political legitimacy of foreign assistance in the country, and the greater are country needs for assistance [17].

The greater is the convergence of goals for the implementation of PHC among external agencies, and the more effective is the collaboration between these agencies and with the government [24, 80].

The greater is donor agency attention to policy strategies which account for local assumptions of program costs [10, 72].

(B) Program administration

Within the administration of PHC programs, the development of commitment to PHC goals and the improvement of administrative processes are found to have significant implications for the successful delivery of services. Possible outputs or indicators of success at this stage include: (a) increases in the numbers of PHC personnel, health clinics, and other resources; (b) an increase in the population coverage of PHC programs; (c) high rates of expenditure of the PHC budget; and (d) the presence of pilot projects or other initial PHC activities in the field.

(1) First, administrative commitment to PHC is expected to be greater.

The greater is sustained attention to PHC at top levels of government, and the more secure is the tenure of top-level administrators who are committed to PHC [51].

The more consistent are PHC objectives with the other goals of program implementors [15, 46, 77].

The greater is the proportion of non-physicians involved in decisionmaking and implementing responsibilities for PHC [71].

The greater is the commitment of top-level MOH officials to administrative efficiency and to necessary administrative reforms [40, 51].

(2) The administrative capacity of the health agency is a basic factor in its ability to implement PHC programs. Implementation is likely to be more effective.

The higher is the level of planning and management skills within the health agency [19, 37].

The greater is the use of tactical planning methods and program budgeting for PHC [35, 82].

The better developed are the health agency’s systems for management information and program monitoring and evaluation, and the more widely they are utilized at all administrative levels [76, 81].

(3) Procedures for recruitment and training of workers are also central to the implementation of PHC and similar programs. Available evidence indicates that PHC programs will be more successful.

The greater the extent to which recruitment channels account for existing health care workers, traditional practitioners and rural origins [46, 61].

The more training programs are designed to impart basic skills, are conducted at regular intervals at fixed rural sites, and contain clearly defined objectives [57, 85].

The greater is the linkage of medical training and...
practice with PHC activities, and the greater is the promotion of this linkage by national regulations and manpower strategies [58, 71].

The greater is agency capacity for the training of local management [51, 63].

(4) Demonstration projects and other pilot activities have played an important part in the development of knowledge and experience regarding PHC. Their contribution in these areas is likely to be greater.

The greater is the scope and the longer is the duration of relevant projects [43, 46].

The greater is government interest in program outcomes, the stronger is government commitment to large-scale implementation of PHC, and the greater is government participation in the pilot activity operations and financing [72, 84].

The closer is the relation of project designs to policy strategies, the clearer are project goals and objectives, and the stronger are project monitoring and evaluation components [42, 44].

The greater is the replicability of pilot designs, in terms of cost, resource mix, organization and related factors [43, 72, 84].

(5) In addition, aspects of administrative structure—particularly the decentralization and integration of PHC activities—are likely to influence the success of PHC programs. Decentralization of PHC decisionmaking and operations may lead to more effective implementation.

The more consistent are patterns of decentralization among the political system, the health ministries, and PHC implementing units [29, 81].

The less fragmented are political and administrative responsibility and authority [41, 68, 85].

The integration of PHC with other activities, both within the health sector and with other, related sectors may improve program effectiveness.

The more the activities of an integrated approach to PHC are assigned to a single agency or authority [35, 45, 68].

The lower is the administrative level of the functions to be coordinated, given the presence of adequate administrative capacities [35, 38, 43].

The better defined are the functions to be coordinated, and the more consistent they are with the capacity of implementing organizations and staff [45, 86].

(C) Service delivery

During the delivery of PHC services, various characteristics of local communities are seen to influence the effectiveness of program operation. Among the indicators of successful PHC service delivery are: (a) high rates of utilization of PHC services by the target population; and (b) the presence of community support for PHC activities.

(1) Community-level political characteristics determine in large measure the extent to which PHC program efforts are able to reach their intended beneficiaries, and to promote and make use of local participation in PHC activities. Programs are likely to be more effective in these respects.

The more equitable is the distribution of economic and political resources at the local level, and the more open and representative are local governmental structures [54, 87].

The greater is the social, ethnic, and political homogeneity of the population in the community, and the stronger are cultural values favoring communal activity and cooperation [17, 34, 44].

The lower are the ideological, social and cultural barriers between the government and the PHC, target group, and the greater is national political support for community participation [54, 64].

The more available are avenues for community participation through existing local organizations [35, 55, 57].

The greater is the presence of other government programs in rural areas, and the more successful has been their experience with community involvement [15, 56].

(2) Existing health services, including both traditional and modern modes of care, are seen to influence the demand for PHC and the range of necessary PHC services. PHC appears to be more effective.

The lower is the supply and utilization of traditional medical practitioners, and the less rigid are belief systems surrounding traditional practice [35, 46, 61].

The less exposed are local populations to modern medicine, and the lower is the supply of private physicians in rural areas [87, 88].

The lower is the cost of PHC services although it is argued that they should not be free, relative to the costs of other available health care [47, 57].

The stronger is the country's health care referral network and the greater is population access to higher-level facilities [58, 73].

(3) Finally, the resource requirements of PHC programs in relation to the availability of resources within the health agency and in the community, help to shape the program strategies that are followed. PHC programs are expected to be more effective:

The better is the physical accessibility of the target population to services, and the lower are program requirements for transport [45, 63].

The more reliable are lines of supply for drugs and equipment to community sites, and the greater is the capacity of the health agency to manage PHC activities locally [7, 46].

The greater are the physical, financial and human resources at the community level [6, 55].

Where there are few resources in the health agency and greater resources in the community, programs will be more effective when built around local participation and contributions [35, 40].

Where local resources are weak relative to agency capacity, PHC will be more successful when supported by local resource development over the long term, with less reliance on local contributions for recurrent budgetary support [35, 40].

These hypotheses offer a basis for empirical research on the political and administrative dynamics of PHC. However, although they have been identified in the literature, few have been subject to rigorous empirical testing. It is hoped that this selection will encourage the more explicit application of analytical methods in this important area.
RESEARCH ISSUES

The testing of hypotheses such as those proposed above clearly raises a number of methodological concerns. Problems associated with such investigations have been addressed in the literature of comparative policy research generally [89, 90], as well as in that focusing on empirical analysis in the health sector [91, 92]. For the types of research that we have discussed, three major issues stand out: (1) the interpretation of relationships between policy variables in the model, (2) the collection of data for identified indicators, and (3) the selection of cases and analytical methods to be used.

(1) The model that has been introduced points to two broad classes of relationships which bear on PHC effectiveness. Initially there are contextual linkages, between political factors and policy adoption, between administrative factors and program administration and between community-level factors and the delivery of services. The second type of relationship is sequential; between the processes or stages of policy formulation, administration and service delivery. Based on an examination of these latter dynamics we may arrive at a better understanding of how one stage may condition the activities that take place in the others.

(2) Data availability is a predominant and often neglected concern in the design of health policy research. Variables may be identified so as to allow the relatively direct collection of relevant data, but necessary information is typically not accessible for many specific countries or time periods. Such limitations will require the selective adoption of indicators and the identification of alternative measures for which data can be obtained [93]. Depending on the needs of particular studies, different types of sources of data may be considered.

Aggregate Statistics. of broad country characteristics,

General Country Descriptions, providing more detailed national background

Planning Documents, from national agencies, particularly the health ministry and from international organizations;

Budget Materials, relating to expenditure for health care and PHC programs;

Program Reports, regularly collected on PHC activities;

Evaluation Studies, and other formal analyses of PHC programs;

Secondary Analysis, based on academic research, consultant missions and other primary sources; and

Interviews and Surveys, and other primary materials, chiefly collected onsite.

It is likely that any given research effort will call for the exploration of a variety of these categories.

(3) There are three distinct methodological approaches to the cross-national study of health policies, including those for PHC, which differ according to their level of analysis, the nature of the findings that are generated and their requirements for data. The first and most broad of these is aggregate statistical analysis across a relatively large sample of countries. Aggregate methods for cross-national research of social and political hypotheses have been used in the social science literature for some time. Although most studies in this field have tended to focus on limited macro-level topics, significant aggregate studies on socio-economic development processes have been conducted on more micro-level issues [90]. Aggregate research on comparative administration and development assistance programs is not so well advanced, due chiefly to a lack of consensus about the scope and objectives of study [12, 17] and to the unavailability or complete data corresponding to the research frameworks that have been proposed. Reliance on broad social and political indicators usually does not allow sufficient precision to provide consistently meaningful findings about individual country health systems, although some studies have incorporated such variables along with process indicators to yield certain significant results [69, 78]. Aggregate analysis also faces inherent statistical problems related to multiple causation and conditionality of outcomes, which restrict the applicability of standard regression techniques.

A second approach to analysis is the comparison of two or more country cases, using points of relative similarity and difference as a basis for explaining differences in process or performance. Most of this research has focused on Western Europe and the United States, although some attention has been given to empirical comparisons between developing countries. Among these latter studies are, for example, discussions of the transferability of health service models from one setting to another [17], paired country examinations [51] and broader analyses of PHC policymaking across multiple countries [35, 68]. Comparative studies require relatively more detailed information than do aggregate analysis. In addition, the available literature has not resolved issues concerning the reliability of conclusions reached by different types of comparisons: debate continues over the relative usefulness of ‘contrasting’ as opposed to ‘similar’ case studies for the drawing of cross-national generalizations [97]. On the one hand, comparisons of widely diverse countries may fail to yield meaningful findings about the actual dynamics of health system performance. On the other hand, the comparison of logically grouped, similar countries limits the potential for widely generalizable results.

The third and most common approach to the examination of health systems is that of single case studies. Case studies are particularly vulnerable to limitations on their generalizability; indeed, the findings of such analyses are often extended by their authors with little supporting argument. Yet, as Eckstein observes, a properly designed case study may serve a number of useful purposes, especially through the testing of micro-level hypotheses in ‘crucial’ settings [98]. Their chief advantage lies in the potential for providing a rich and detailed analysis of complex interrelationships. They may in fact be the most appropriate approach for the types of research discussed here, especially for the examination of administrative and community-level hypotheses.

This survey of political and administrative issues has focused systematically on the different contexts in which policies for Primary Health Care are formulated and implemented. Through a review of the
literature on HPH, we have attempted to organize the major strands of empirical knowledge in this area within a general model, and to make use of this model to develop hypotheses for future study and practical application. We have found that few of the hypothesis-based relationships are strongly supported by available findings. Most of the relationships proposed are likely to be influenced by a wide range of contextual factors, which must be identified and taken into account by analysts. Considerable further research is needed to explore and more fully document the complexities of the health policy process, we have set out a possible agenda for that task.

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