

# Primary health care, health policies and planning: lessons for the future

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## Introduction

Choices about forms of health care, including primary health care (PHC), are fundamentally political decisions, reflecting global and national power structures and alliances, changing economic conditions, emerging new health problems and health care challenges, and the development of new health technologies. However, these choices also reflect, and are often expressed in terms of, a philosophy or rationale based on ethical theory or political “ideology”, a set of principles that guides decisions. The philosophical perspectives on ethics underlying health issues have variously been identified as utilitarianism, liberalism, neo-liberalism, social egalitarianism and communitarianism (Box 1) [1,2]. As regimes in many developing countries have changed over time, so has the political ideology, resulting in the reinforcement of, indifference to, and sometimes rejection of, the major tenets of PHC.

The major tenets of PHC, as they emerge globally and in the Eastern Mediterranean Region (EMR), prior to and following the Alma Ata Declaration of 1978, support universal access to care, health equity and gender equity, community-based activities to link formal health care systems with the communities, and intersectoral action, which are all needed to tackle what we now

call the “social determinants of health”. As such, they represent to varying degrees principles of egalitarianism and/or communitarianism.

This paper traces the evolution of global and regional policies on PHC and its chequered history, which has been marked by a number of phases when conditions were more, or less, favourable for its development. The paper identifies 3 policy phases: before Alma Ata; Alma Ata – the first 15 years (1978–1993); and the era of health sector reform and the resurgence of PHC (1993–2008). The paper goes on to discuss the regional perspective on PHC and finally closes by recommending a sustainable health system based on PHC.

## Policy development and planning before Alma Ata

### Health systems in developing countries in the fifties and sixties

In developing countries during the 1950s and 1960s conditions gradually emerged that were favourable to systematic health planning, which extended to the local level and was based on a scientific assessment of what worked. This laid the foundation for the Alma Ata Declaration and the significant improvement in maternal and child health in the second half of the 20th century.

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**Box 1 Political ideology underpinning health systems worldwide**

- Utilitarianism – humans act to increase their own well-being (Bentham); policies should be judged by their consequences. The greatest good for the greatest number results in, for example, an EPI target to cover 80% of children, without considering the fate of the other 20%. This perspective is closely related to Kantian liberalism, which holds that all individuals have the capacity to make moral choices about their life; hence the modern usage of neoliberalism which seeks to disengage the State from health and social welfare issues that are more appropriately the domain of individual choice in which health is seen as a commodity, not a right.
- Social egalitarianism – health is seen as a “public good” and the aim is to correct health and social inequalities by promoting a policy which ensures good health on equal terms for the entire population.
- Communitarianism – based on a belief in the kind of society that is desirable, guided by religion or a sociopolitical philosophy such as socialism or Marxism. Health policy focuses on the provision of universal care and disease prevention in an appropriate social framework, as in the former USSR, Cuba and the Islamic Republic of Iran.

Prior to this time, and depending on the country's political situation, social orientation and economic development, health care research and service delivery was fragmented and, in general, did not respond to actual needs. In former colonial countries health systems were developed primarily to protect the colonizers, and to maintain the economic productivity of the indigenous workforce; as such they were poorly adapted to the health problems and needs of the general population [3,4]. In India immediately before and following independence, efforts were made to establish an adequate health service infrastructure. However, these efforts were largely ineffective, especially in rural areas where 80% of the population lived but only 20% of the health budget was allocated. Health planning restricted itself to developing norms and regulations established by various committees [5].

In most of Latin America, where as a result of past colonialism and neocolonialism wide gaps prevailed among

different social classes with respect to rights and privileges, income, education and land-ownership, as many as 5 different health systems co-existed alongside mostly ineffective, understaffed and underfinanced regular government health services [6]. Health services provided by missionaries tended to follow the traditional European pattern: treatment-on-demand in stationary facilities. As conversion was frequently considered more important than the delivery of health care, different denominations often duplicated services in one area, while leaving other areas uncovered [4].

In developing countries overall, health services were fragmented and uncoordinated. Little was known about the health problems of the general population, and even less about the most vulnerable groups. Most countries failed to develop health interventions based on factors acknowledged to have contributed so much to the decline in child mortality in affluent countries in the 19th and early 20th centuries, such as

improved hygiene, housing, nutrition and breastfeeding, and later on immunization and curative programmes.

For the implementation of regional or transnational planning, a number of key prerequisites were missing. Most important among these were: a modern concept of public health; qualified public health professionals; effective communication and exchange of knowledge and experience among health researchers; an epidemiological database of health indicators for the general population, especially for vulnerable groups; and the concept of health services planning and the prioritization of health problems and needs, specifying goals and outcome objectives.

### **The “scientific” basis for health planning and policy formulation**

The period between the mid-1950s and 1970s saw the emergence of modern public health that largely replaced or complemented colonial and missionary health care practices and research in the developing world. Investigations into the overall morbidity and mortality of the general population, especially among preschool children, were carried out. Outstanding were the pioneering surveys on health and nutrition of the Haitian population by the United States Department of Health, Education and Welfare [6] and on causes of child deaths in the Americas [7]. In parallel, an ever increasing number of corroborating and complementary findings were made and published by research institutions and individual researchers the world over, notably the Nutrition Institute of Central America and Panama in Guatemala City in Central America [9–11], ICDDR-B in Bangladesh, [12,13], Narangwal Rural Health Research Centre, Punjab, India (RHRC) and Harvard University in Punjab, India [14,15], other

research groups in Africa [16–18] and elsewhere in the world [19–23]. The nature, precise numbers and causes of child deaths, prevalence and incidence of major morbidity states, such as malnutrition, diarrhoeal disease, acute respiratory infections and tuberculosis, were identified and took their rightful place in the hierarchy of health problems. Inter-relationships between various disease states and their pathological and physiological consequences were researched and clarified [24–30]. Relatively simple yet highly effective intervention methods were devised and successfully tested in both urban and rural populations in various centres [31–34].

By the late 1970s enough evidence had accumulated to support worldwide child and maternal health interventions, first for the most vulnerable groups and later for the entire population. Major infectious diseases could now be controlled: cholera, diphtheria, measles, neonatal tetanus, poliomyelitis, tuberculous meningitis. The devastating disease, smallpox, was eradicated. Preventive as well as curative measures for malnutrition were identified [35]. For the first time selected packages of health interventions could address priority health problems on a worldwide basis [36–38]. At the same time, the causes for and effects of rapid population growth on health, economy and social development were examined and potential solutions advanced [39,40]. The nature and cost of resources needed for these interventions were determined and compared with those available to regular government services [41].

In parallel with these developments and in response to the availability of more evidence for successful interventions, comprehensive health planning in response to the needs of the population now became possible. In the late 1960s, the Pan American

Health Organization (PAHO), in collaboration with the Center for Development Studies of the Central University of Venezuela, developed the PAHO–CENDEZ health planning method to prioritize major health problems in order of their effective response to interventions [42]. At about the same time, some public health universities in the US, notably Johns Hopkins University, started to offer courses on national and sub-national health planning [43]. Senior health professionals from virtually all countries of the globe participated and, on return to their own countries, helped to initiate national and regional health plans. The time was now ripe to rally the world to make use of all that had been learned to create more equitable health services that would result in health for all.

## **Evolution of PHC since Alma Ata – the first 15 years (1978–1993)**

### **The Declaration of Alma Ata and its challengers**

The International Conference in Alma Ata in Kazakhstan in 1978, which was sponsored by the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF), was a landmark in putting PHC on the global public health agenda. Over 3000 delegates, 134 Member States of WHO and 67 international agencies participated in the conference. The major outcome of the conference was the Declaration of Alma Ata (Box 2) that embraced the goal of

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#### **Box 2 Excerpts from the Declaration of Alma Ata**

##### **Article I**

“health...is a fundamental human right and...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”.

##### **Article 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.”

##### **Article 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.”

##### **Article 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.”

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“Health for All by the Year 2000” using the strategy of comprehensive PHC. In addition to the provision of essential health services, it also envisaged tackling underlying social, economic and political causes of poor health [44]. The idea of comprehensive PHC operated at 2 levels: first, as a *level of contact and care within the health system* reconfigured to emphasize the basic health needs of the population; and second, as a *philosophy of health work*, which was part of the overall social and economic development of the community [45]. Other principles of the PHC philosophy included the use of appropriate technology, a critique of medical elitism and the explicit linkage of health and social development that requires intersectoral collaboration and full community involvement [46].

The adoption of the Declaration of Alma Ata created a momentum in many developing countries to initiate changes in service delivery. In order to accommodate the new focus on PHC, many developing countries reorganized their ministries of health, integrating some vertical programmes and strengthening district health systems. WHO itself reconfigured its organizational profile to provide the required technical support to countries and to help them to develop necessary capabilities in planning and management using the concept of “managerial process for national health development” [47].

Within a year of the Declaration of Alma Ata, some international health professionals challenged the comprehensive PHC approach, which gave rise to “selective” PHC. This approach was considered to be more pragmatic, financially palatable and politically less threatening. Rather than trying to strengthen all aspects of the health system and simultaneously transform social and political relations, the proponents of

selective PHC maintained that, at least in the short term, efforts should concentrate on a small number of cost-effective interventions aimed at tackling major causes of mortality and morbidity [48]. The UNICEF-led GOBI initiative – Growth monitoring, Oral rehydration therapy, Breastfeeding and Immunization – was the first example of the selective approach. Later, at least on paper, FFF (Family planning, Female education and Food supplementation) was added to GOBI to make it more “comprehensive”.

Today, it is clear that the selective approach strengthened what are seen in many countries as established vertical programmes. However, selective PHC was characterized by a top down approach, reduced opportunities for response to local needs and local participation. It also ignored the broader concerns of poverty, development and equity in favour of short term, possibly unsustainable, improvements that could be easily measured [49]. As such, it could be seen as undermining integrated PHC.

In response, efforts were made to push the wider PHC agenda. WHO established an Intersectoral Action for Health Unit, supported by the Rockefeller Foundation [50]. In 1986, Canadian agencies and WHO sponsored the adoption of the Ottawa Charter on Health Promotion, which identified 8 key prerequisites for health – peace, shelter, education, food, income, a stable ecosystem, sustainable resources, and social justice and equity [51]. The Rockefeller Foundation supported the “Good Health at Low Cost” initiative to document how some developing countries, such as Cost Rica, Cuba, Sri Lanka and Kerala State in India, had been able to achieve a health status better than expected given their economic resources [52]. According to one analysis, the 5 shared social and political factors that

underpinned the success in these countries were: i) historical commitment to health as a social goal; ii) a social welfare orientation to development; iii) community participation in decision-making processes relative to health; iv) universal coverage of health for all social groups; and v) intersectoral linkages for health [53].

By the mid-1980s, moves to sustain PHC were threatened by a prolonged global economic recession and the associated debt crisis in the developing world that pushed many low- and middle-income countries to the brink of economic collapse. These events provided the context within which powerful industrialized governments and international financial institutions, the World Bank and the International Monetary Fund, could intervene directly in the economies of the numerous developing countries, requiring them to reshape their economies according to neoliberal prescriptions in order to qualify for debt rescheduling and continued aid [54]. The health agenda was affected by the broader economic structural adjustment programmes, which required countries to cut spending on health and to undertake health sector reforms (HSR).

One of the manifestations of the neoliberal approach to health was the levying of charges for primary care, which was formalized in the Bamako Initiative of 1987 [55]. This promoted “community financing”, requiring people in poor communities to pay for their own care, compensating for cuts in social expenditures. WHO, which was faced with challenges to PHC and financially weakened by a funding crisis, sought to mobilize financial support to implement health for all through PHC. In 1988 it advised Member States to allocate at least 5% of their GDP to achieve this goal [56].

### **Influence on national health policies and planning**

The shift from comprehensive to selective PHC has had a major influence on national health policies since the 1980s, with the launch of vertical, unifocal, single purpose disease prevention and control programmes. These currently constitute the major approaches used by national governments to tackle priority public health problems. In many countries, such programmes have been successful and responsible for the control, elimination and eradication of specific diseases. In others, particularly, low-income countries, they have directly contributed to weakening integrated health systems.

The neoliberal doctrine has influenced national health policies in two ways: i) the broader structural adjustment programmes, which imposed cuts on social and health sector spending with negative consequences for health and social welfare; and ii) through the health sector reform agenda, which was in itself an extension of the structural adjustment programmes [2]. The health sector reforms encouraged privatization of health services and decentralization of management, promoted private insurance and advocated or enforced payment for PHC. These cost-cutting measures were undertaken at the expense of equity, and limited the role of government in the provision of health and other social services.

The basic premise of the neoliberal vision is that markets freed from government interference are the best and most efficient allocators of resources in production and distribution and thus the most effective mechanism for achieving the common good, including health. This focus on the free operation of the market undermined



the role of health planning, and exacerbated the decline of the already weak capacity of ministries of health for health planning.

## The era of health sector reform and the resurgence of PHC (1993–2008)

### PHC and health sector reform strategies

The publication of the 1993 World Bank *World Development Report: investing in health* marked the next phase in the seesaw between PHC and HSR [57]. By that time it was clear that the deteriorating macroeconomic situation and the effects of the structural adjustment programmes had undermined the health systems in poor countries and the health status of their populations. The report proposed a three-pronged approach to government policies for improving health: i) foster an environment that enables households to improve health; ii) improve government spending on health; and iii) promote diversity and competition. The report also defined and costed a basic benefit package of essential public health and clinical interventions estimated

at US\$ 12 per capita that governments should ensure reached all the population. The introduction of the concept of disability adjusted life years as a measure of health was intended as a tool to monitor the impact of disease control programmes [49].

This report strengthened the notion of selective PHC and proposed further structural reforms in the health sector, which were contrary to the spirit of comprehensive PHC (Table 1) [58]. By the late 1990s the initial optimism about HSR in developing countries was giving way to concern. In 2000 Berman and Bossert [59] recognized that the more sweeping reforms, such as the establishment of nationwide health insurance systems, were hard to implement and were rarely successful, while the apparently more modest and seemingly less demanding reforms, such as hospital autonomy, also had mixed results. At the same time, some commentators stressed the need to remedy the neglect of equity in HSR [60].

During this period, WHO sent mixed signals about PHC. In its 1998 annual report, WHO reinterpreted and reinvigorated the health for all strategy under the banner of *Health for all in the 21st century*. The revitalization of health for all included a re-

Table 1 **Contrasts between the approaches of primary health care and health sector reform**

Attributes	Primary health care (Declaration of Alma Ata)	Health sector reform
Ideology promoted	Social egalitarianism	Utilitarianism
Overall approach	Comprehensive	Selective – essential package of services
Role of the government	Greater public sector involvement	Restricted role of the government
Focus	Equity and social justice	Efficiency and competition
Champions	Social scientists	Economists
Type of reforms	Programmatic	Structural
Basis	Rights-based	Reform-based

newed effort to promote intersectoral action as a key component of public health strategies [61]. However, the WHO's millennium World Health Report 2000 did not follow up on these messages [62]. Nevertheless, as this report was devoted to improving health systems, it did succeed in bringing WHO back to the centre of the debate on health systems.

The year 2000 also marked the launch of the Millennium Development Goals (MDGs), many of which are health related. To many, the MDGs were seen as a vindication of the comprehensive PHC philosophy. Overall goals are "comprehensive" in that they represent commitments to reduce poverty and hunger, gender inequality, lack of education, lack of access to clean water and environmental degradation. However, the health goals are "selective" in that they target specific health problems [63]. Equity and social justice were not, at first, explicitly addressed in the MDGs. In the same year the growing corpus of human rights laws was strengthened with additions to the landmark 1976 International Covenant on Economic, Social and Cultural Rights, which obligated health policy-makers and practitioners to ensure the right of equitable access to health care and health facilities [64]. This clearly demonstrated the imperative to recognize human rights in the delivery of care and the implementation of public health programmes [65].

In 2005, WHO launched the Global Commission on Social Determinants of Health. The Commission, which will deliver its final report in mid-2008, drew attention to the social determinants of health that are known to be among the most important causes of poor health and inequalities between and within countries. These determinants include gender inequity, unemployment, unsafe workplaces, urban slums, globalization and lack of access to health services [66].

To complement these positive developments in PHC and health equity, WHO has taken upon itself the revival of PHC, making it the subject of the upcoming 2008 World Health Report. WHO is well placed to support PHC as it is among the most decentralized of all United Nations organizations, with 6 regional offices with direct access to Member States. During the PHC-HSR phase, many regional offices remained steadfast to the PHC approach to health systems: among them the Eastern Mediterranean [67], European [68] and Pan American Offices [69].

### **Influence of the PHC-HSR discord on health policy and planning in countries**

There is no question that organized global movements influence global, regional and national policies, especially the swings in health policy between PHC and HSR. For example, in the 1990s many ministries of health, which boasted of directorates, departments or units of PHC became truncated or were replaced by HSR units. In some cases, ministries of health have found ways to work with vertical units, elsewhere the relationship has been marked by disharmony. The relationship has also been complicated by the increasing number of global players since 2000, bringing unprecedented opportunities to access external assistance, primarily directed towards specific diseases rather than integrated PHC [70].

Over the past several years there has been a greater effort, particularly in the Eastern Mediterranean Region, to establish health policy analysis and reform units within ministries of health in order to strengthen health systems based on PHC. The capacity for strategic planning in health in most developing countries has been and remains weak. However, the policy swings between more centralized planning and



greater reliance on free market approaches have created tension and confusion in the minds of health policy-makers in developing countries. Because HSR is in general a macro-reform, which has little to offer in terms of how health services can actually be delivered on the ground, they have distracted attention from service delivery, the district health system based approach and district health planning, which are so critical to effective programme implementation in most poor countries. These reforms also continued to ignore the importance of planning health services according to the health problems and needs of communities, and in harmony with their sociocultural and economic ecosystem. By doing so, service effectiveness and ultimately efficiency will once again be jeopardized as it was in the era of structural adjustment programmes and selective PHC.

### **Eastern Mediterranean Region's commitment to PHC**

Despite the ebb and flow of PHC, the Regional Office for the Eastern Mediterranean (EMRO) has remained steadfast in its commitment to the PHC approach, as seen in the report of the activities of the Regional Office during its first 40 years, 1949–1989, and in the number and nature of resolutions endorsed by its Regional Committee over the past decade [71–77]. This commitment has also been reflected in the community-based initiatives programme, especially in the basic development needs (BDN) component, initiated in Somalia in 1988. During scaling up, BDN has evolved from meeting minimum needs to comprehensive development centred on health, focusing on tackling social determinants of health. This regional initiative is currently supported by WHO in 12 countries of the Region [78].

District Team Problem Solving (DTPS), a district planning and management tool to strengthen the district health system, was developed to identify and solve priority health problems using community resources. The DTPS manual developed for this purpose has been translated into national languages of the Region and training has been provided [79].

At the country level, a number of EMR Member States have taken pioneering steps in PHC. The commitment of Oman to strengthen the *welayat* (governorate) health system, using the DTPS approach, has received global recognition. The PHC programmes based on the training of male and female community health workers, *behvarz*, in the Islamic Republic of Iran and the training of 100 000 lady health workers in Pakistan financed and organized by the government have had a considerable impact on health outcomes in both countries and are considered to be the largest community-based health initiatives in the Region, along with the EMRO community-based initiatives programme [80,81]. Finally, the more recent policy of contracting out PHC services to nongovernmental organizations to provide health services in the war disrupted health system in Afghanistan has shown some encouraging results. What remains to be seen is whether this can be sustained in the long term and whether there is a greater role for the public sector in future [82].

In countries in which PHC became more widely institutionalized, changes in medical education were needed to more closely align curricula with the objectives of PHC. To foster this approach, WHO and PAHO have promoted community-oriented educational institutions for health sciences [83]. The Islamic Republic of Iran underwent a major change in 1985 when all health-related schools and institutions were moved from the Ministry of Higher Education and inte-

grated into the new Ministry of Health and Medical Education [84]. Until today, this is considered to be one of the most important initiatives in the country's commitment to, and the success of, its PHC programmes.

### Lessons for a sustainable PHC strategy in the future

The ups and downs in the short life of PHC since it was formally recognized as a strategy for health for all is not a matter of coincidence and provides several lessons for national health policy-makers, planners and programmers as well as development partners.

- Health for all through PHC as a philosophy and approach has stood the test of time and remains relevant to all Member States, rich or poor. However, *PHC cannot be a "one size fits all" strategy* and has to be adapted to the needs of each country. Among the areas that need to be considered are: the set of health services to be provided, the skill mix required, the mechanisms for monitoring, the cost and financing of these services, and, most important, the non-health determinants to be addressed.
- The MDGs, the growing corpus of human rights instruments, and the re-emphasis on tackling social determinants of health can serve as a sound foundation for the revitalization of the comprehensive PHC approach. There is thus a great need to *align with and build on existing global initiatives*, rather than to launch a new PHC project.
- The evidence generated during the pre-Alma Ata years on priority public health problems provided the scientific basis for formulating health policies and plans and for the interventions that became an integral part of the PHC approach. There can be *no compromise on the need for sound evidence*. However, today evidence is needed on how to make health systems functional and able to tackle the wider health determinants, as well as on disease control.
- Improved efficiency and competition are desirable but *under no circumstance should these override the collective value of equity and social justice* embedded in health for all, which should continue to underpin the development of the health system in any country, rich or poor.
- *Increased involvement of communities* through better governance, effective decentralization and greater responsiveness of health systems is essential. This requires a high level of political commitment, respect for the citizenry, retraining and patience among professionals, and the development of strategies that engage literate and illiterate communities.
- *Reforming ministries to become stewards of health instead of health care* is essential to forward a comprehensive PHC agenda. This entails strengthening ministries of health to engage in a serious dialogue on health with national and international development partners, to lead the effort on intersectoral action for health, and to advocate for greater investment in health for the social and economic development of the country.
- *The role of a vibrant civil society* is essential for the purpose of health advocacy, capacity building, applied research, service delivery, and as a watchdog to ensure that the values of PHC are not compromised in health development.
- During the 1980s and 1990s the promotion of different ideological perspectives by development partners confused and often damaged national health systems. In addition, the recent addition of new

and powerful global health players also poses new challenges. These developments call for *better global health governance through greater harmonization among development partners*. The Paris Declaration for greater aid effectiveness is a step in the right direction. WHO will have to play its catalytic role in better coordination among the players and improving aid effectiveness [85].

- The success of PHC rests heavily on the *strengthening of the public sector, civil society and academic and research institutions and building a critical mass of individual leaders who can guide these institutions in developing coun-*

*tries*. Over-reliance on institutions of industrialized countries would be a recipe for failure.

- *WHO will have to prepare itself to fulfil its ambitious agenda to revitalize PHC*. This means visionary leadership, strengthening its position among global and national partners, providing technical advice based on sound evidence, developing appropriate tools and instruments from policy to community levels and strong capacity in country offices. Most importantly, this time there can be no wavering from the commitment to PHC for at least another 30 years.

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