Primary Health Care in the 21st century

by Michael Krawinkel

Univ. Prof. Dr. Michael B. Krawinkel
University of Giessen, Germany

When the World Health Assembly decided that primary health care should become a universal approach to achieving health for all in 1978 it foresaw a different course for the history of global health. The systemic approach appeared to promise to meet the needs of people and optimise health. Therefore the Alma Ata Declaration stated:

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

»Primary health care:

1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and Public Health experience;

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunisation against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

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

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

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

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.« [1]

Laid out as such, these seven principles could be interpreted as being optional, especially points three and four, thus undermining the principal idea of the declaration. This lead to the »Selective PHC«-approach in favour of specific interventions which were expected to be more efficient.

A couple of aspects were compromising the universal, national, regional, and local implementation of PHC as a systemic approach:

First, governments realised that giving people the right and power to settle their health promotion, prevention and care issues in village health committees also meant allowing them to develop democratic views on participation in one policy field. Very quickly, e.g. in Ecuador, this political empowerment approach was creating greater demand for democratic participation in other fields. Therefore, autocratic governments were the first to reduce PHC to basic health care, both preventive and curative. Causes of diseases related to poverty, social discrimination and unequal distribution of resources for health care were excluded.

Second, for aid organisations the integrated approach of PHC was a problem: as long as they could act in a paternalistic way they could ask their supporters in rich countries to give money for defined interventions, e.g. vaccinations, breastfeeding promotional campaigns, distribution of oral rehydration salts, condoms, and implementing growth monitoring. A true PHC-approach would have had to follow the principles and to accept the will of the target population to select measures to improve their health situation according to their priorities.

Third, the funding needs for implementing and maintaining PHC-systems were substantially underestimated: PHC was regarded as a cheap approach for those excluded from the benefits of modern health technology. The consequence of this assumption was detrimental for the concept: people felt the gap between low-level health care for them and high-level health care for the more affluent. What started as an appropriate technology for all ended up as discriminating health care.

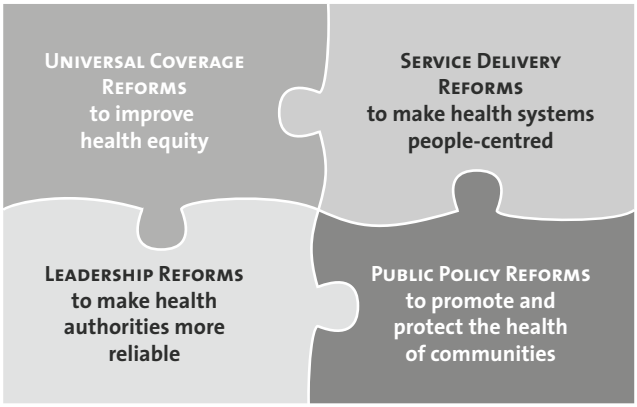
Change seemed likely when the Commission on Macroeconomics and Health of the WHO under its chairman Jeffrey Sachs presented its report in 2001.[2] The report became a background for a new global funding concept: the Global Fund to fight Aids, Tuberculosis and Malaria (GFATM). Since its creation, many countries have obtained substantial amounts of money for improving health services for these three diseases. But the fund is under global observation to ascertain if it really funds an approach enabling health systems to tackle problems or if it just procures drugs from Western drug companies which cannot even be applied and used properly where

they are most needed. Despite huge amounts of money from the fund and other governmental and private funding institutions (e.g. PEPFAR[3], Gates Foundation, Clinton Foundation and others) the relevant MDGs are far from being achieved in 2015 in Africa.

Following the gradual disappearance of the PHC-concept up until 2008, the World Health Organization suddenly re-vitalised the idea: after years of focusing on specific programs, improvements to existing health care systems, e.g. through Integrated Management of Childhood Illnesses, and following the increasing role of private health providers, PHC was put in the middle of the World Health Report 2008[4]. But, as WHO found, like all experts in the field, PHC in the 21st century is different from PHC in 1978. Urbanisation, the HIV-epidemic, smoking and drug abuse, and the nutrition transition require different and appropriate approaches.

Globalisation of health care is associated with new opportunities and challenges. The private sector has developed and now makes a profit by offering attractive and accessible health services. At the same time governmental and other Public Health care systems came under extreme pressure when the World Bank and the International Monetary Fund required – and request up to now – the reduction of existing public institutions in favour of privatisation. Only since 2008 can any move towards strengthening the public sector be observed.

The new PHC focuses again on universal coverage, service delivery, leadership, and public policy (Figure copied from World Health Report 2008). As there are also funding and access problems of health systems in industrialised countries, the new PHC-approach basically aims at improving the access to health of individuals and populations again. It can be expected that the actual implementation will depend primarily on the civil society demanding the right to health and making their political choices depending on policies and achievements in this field. Policy can not be neglected again. Therefore, the global people's health movement and its national chapters and allies must play an important role in complementing the expert concepts of WHO – as well as those of many agencies involved – pushing politicians to make health an issue of public concern and to meet the expectations for equal access to health care.[5]



With the experience of privatisation and globalisation even the health service aspects will not be achieved by immediate improvements of governmental health services or leaving it to the private sector only but by well planned governmental policies and by guiding and supervising the private health care providers. The dangers of a simple free-market-approach to this sensitive field do not need to be explained. Access to and quality of care must be considered as an essential public good in which the private sector can play an important role if it accepts the rules and regulations for this very special market.

The primary health care approach in the 21st century has the potential to meet the millennium development goals – if it is appropriately funded. The targeting of the Global Fund against AIDS, Tuberculosis and Malaria (GFATM) should be revised. It has become more than obvious that the focus on the three diseases may be helpful in obtaining funds – but to efficiently fight the diseases requires qualified staff and sufficiently equipped health infrastructures and systems with long term commitments instead of short-termed drug-based interventions only.

One more recent challenge is the »internal« brain drain adding to the burden of the south-north migration of qualified staff. By hiring qualified staff from governmental health institutions for internationally operating governmental and non-governmental organisations, the public sector is weakened, and although working through the institutions may be less »effective« in the short run it is the only solution in the foreseeable future.

A true PHC-approach today also means sustainably strengthening the health systems of financially resource-poor countries. This is an opportunity and a restriction to international interventions as well as a requirement for good governance in all countries around the world. ■

1) www.who.int/hpr/NPH/docs/declaration_almaata.pdf
2) whqlibdoc.who.int/publications/2001/924154550x.pdf
3) PEPFAR: (US-)President's Emergency Plan For AIDS Relief
4) www.whr_en.pdf
5) www.phmovement.org/cms/

Abstract

Primäre Gesundheitspflege im 21. Jahrhundert

Primary Health Care oder primäre Gesundheitspflege war ursprünglich ein Konzept, um globale Gesundheit für Alle zu erreichen. Der Systemansatz sollte den ungleichen Zugang zu Gesundheit und die Integration von Gesundheitsförderung, Prävention und medizinische Versorgung durch volle Beteiligung der Gemeinschaft sicherstellen.

Aber das Konzept der politischen Befähigung der Bevölkerung verursachte zunehmend die Forderung nach demokratischer Partizipation auf anderen Gebieten; Hilfsorganisationen fanden es leichter, Unterstützung für Impfungen, Stillkampagnen, Verteilung oraler Rehydrationslösung, Kondome und Wachstumsbeobachtung zu leisten. Schließlich wurde der Finanzierungsbedarf für die Einrichtung und den Unterhalt massiv unterschätzt. Ein Konzept, selektive primäre Gesundheitspflege, wurde entwickelt, und die Kommission zu »Volkswirtschaft und Gesundheit« half den globalen Fond für den Kampf gegen Aids, Tuberkulose und Malaria zu begründen.

2008 stellte die WHO die PHC-Idee des Weltgesundheitsberichts ins Zentrum. Neue Herausforderungen sind Urbanisation, HIV, Rauchen und Drogenkonsum sowie die Veränderung der Ernährungsgewohnheiten. Private Anbieter machen Gewinne mit Gesundheitsdienstleistungen, und öffentliche Gesundheitsdienste sind durch die neoliberale Privatisierungswelle geschwächt. Das neue PHC-Konzept zielt erneut auf universellen Zugang, Bereitstellung von Dienstleistungen, politische Führung und Verantwortung. Die Einführung wird wesentlich von der Zivilgesellschaft abhängen, die nach Gesundheit verlangt.

Das globale »People's Health Movement« mag Politiker dazu veranlassen, Gesundheit zu einem Gegenstand öffentlicher Aufmerksamkeit zu machen. Der PHC-Ansatz im 21. Jahrhundert hat das Potential, die MDGs zu erreichen – wenn er angemessen finanziert wird. Der »brain drain« setzt die Institutionen zusätzlich unter Druck. Heute bedeutet ein wirkliches PHC-Konzept, die Gesundheitssysteme von Entwicklungsländern nachhaltig zu verstärken.