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Primary health care

The attached document is a paper prepared by WHO headquarters to facilitate discussions during the fifty-eighth session of the Regional Committee for Europe on the strategic and programmatic role of WHO in supporting the renewed commitment of countries to primary health care.

This paper will be discussed under provisional agenda item 7(b), Stewardship/governance of health systems in the European Region: meeting the commitments made at the WHO European Ministerial Conference on Health Systems: "Health Systems, Health and Wealth".

Feedback from the six WHO Regional committees will be taken into account in the production of the document to be presented to the Executive Board at its 124th session in January 2009 and subsequently to the Sixty-second World Health Assembly (WHA62) in May 2009.

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1. This report has been prepared to stimulate discussions during the Regional Committees about the strategic and programmatic role of WHO in supporting the renewed commitment of countries to primary health care. It provides an overview of the concept and aims of primary health care, reviews the new challenges that confront health systems, and considers the capacity of primary health care to respond to these challenges. A final section discusses some of the implementation and operational issues that need to be addressed.

Primary health care: the vision of Alma-Ata

2. Thirty years ago, the Declaration of Alma-Ata articulated primary health care as a set of guiding values for health development, a set of principles for the organization of health services, and a range of approaches for addressing both priority health needs and the fundamental determinants of health.

3. The ambition was bold. It assumed that enlightened policy could raise the level of health within populations, enabling people to lead socially and economically productive lives, and thus driving overall development. To do so, ways needed to be found to rationalize the use of scarce resources and reach vulnerable and marginalized populations with essential health care.

4. The Declaration broadened the medical model of health to include social and economic dimensions, and acknowledged that activities in multiple sectors shaped the prospects for better health. In line with this broad public health approach, primary health care sought population-wide solutions aimed at reducing gaps in health outcomes. Guiding values emphasized equity in access to essential care and fairness in distributing the benefits of medical and scientific progress.

5. At the policy level, this meant that decisions about the use of financial and human resources, and the choice of medicines and other technical interventions, should align with the population's priority health needs. Primary health care placed emphasis on local ownership and community participation. In doing so, it honoured the resilience and ingenuity of the human spirit and made space for solutions created by communities, owned by them, and sustained by them.

6. Above all, primary health care, as articulated in 1978, offered a way to organize the full spectrum of health care, from households to hospitals, with prevention on a par with cure, and with resources invested rationally in the different levels of care.

7. The Declaration of Alma-Ata launched Health for All as a worldwide movement. The architects of this vision could not have foreseen subsequent world events: an oil crisis, a global recession, and the introduction of structural adjustment programmes. As resources for health shrank, selective approaches using packages of interventions gained favour over the intended aim of fundamentally reshaping health services.

8. The emergence of HIV/AIDS, the related resurgence of tuberculosis, and a deterioration of the malaria situation moved the focus of international public health away from broad-based programmes towards the urgent management of high-mortality emergencies. All of these events diminished the place of primary health care in the public health debate.

9. In the past decade, disease trends and stalled progress in reaching international health goals have again revealed the critical importance of health systems and made their strengthening a matter of urgency. In the quest for robust policy guidance, primary health care is again being considered as a way to organize the full spectrum of health services and solve a number of specific problems.

10. Most recently, several high-level international conferences have explored the advantages of primary health care in addressing today's complex health problems. These conferences have elicited renewed commitment to primary health care, often based on extensive country experiences, as a mature approach that has come of age.

11. Considerable evidence has accumulated to support this commitment. Studies show that health systems oriented towards primary health care generate greater user satisfaction, produce better health outcomes, and do so with more efficient use of financial and human resources. Research has convincingly demonstrated the power of community-based and community-directed approaches to achieve striking and sustainable reductions in morbidity and mortality. Equally important, research has further contributed a range of simple yet powerful technologies that help make community-based care first-rate care.

Health challenges in a complex landscape

12. The Millennium Declaration and its Goals gave continuity to the values of social justice and fairness articulated at Alma-Ata. They further affirmed the central place of health on the development agenda as a key driver of social and economic productivity and a route to poverty alleviation.

13. Greater political commitment to health has been accompanied by significant funding from new sources and a proliferation of health initiatives and partnerships. These efforts, though welcome, have proved insufficient to boost progress in the absence of delivery systems that can reach those in greatest need, on an adequate scale, in time. Most evaluations of progress towards individual health-related goals cite weak health systems as the principal obstacle to success.

14. For health systems, commitment to reach the health-related Millennium Development Goals has two main implications. First, delivery systems must do a better job of reaching the poor, who tend to live in remote rural areas and urban shantytowns. Second, schemes for financial protection must be in place to ensure that the costs of health care, especially catastrophic expenses, do not themselves cause poverty.

15. Renewed concern over the capacity of health systems coincides with several alarming trends. Most health systems face a critical shortage of appropriately trained workers. The activities of multiple implementing agencies are often poorly coordinated and poorly aligned with national priorities and capacities, contributing to inefficiency and overburdening administrative systems. Single-disease initiatives, if not well-designed, can draw health workers away from the provision of basic health care. In many countries, health care is increasingly provided by the private sector, which is often poorly regulated.

16. The costs of health care are escalating. The expectations of consumers are rising. Health systems will not automatically gravitate towards greater efficiency or greater equity in access. Unless deliberate steps are taken, steady advances in medical care will continue to benefit a privileged minority, the poor will continue to be excluded from basic essential care, and the gaps in outcomes will grow wider, both within and between countries. A world that is greatly out of balance in matters of health is neither stable nor secure.

17. Health in all regions is increasingly shaped by the same powerful forces. Phenomenal increases in international air travel have made emerging and epidemic-prone diseases a much larger menace. Trade agreements influence the global availability and prices of commodities, including food and pharmaceutical products, often with little regard for the impact on health.

18. Urbanization and demographic aging are global trends. The epidemiological transition has been joined by nutritional and behavioural transitions. Chronic noncommunicable diseases, long considered the companions of affluent societies, now impose their greatest burden on low- and middle-income countries. The requirements of life-long treatment strain already weak systems of care. Growing numbers of the frail elderly further increase the demands on health systems, the health workforce, and social infrastructures.

19. Efforts to address the fundamental determinants of health have become more complex. Chronic diseases, for example, are largely caused by a limited number of lifestyle-related factors, yet these factors lie beyond the direct control of the health sector. Although better health has long depended on the collaboration of multiple sectors, efforts to shape the determinants of health increasingly pit the interests of public health against those of powerful industries with powerful marketing strategies.

20. The world's interdependence means that health increasingly has global consequences as well as global causes, especially when health emergencies require international assistance. Most experts agree that countries with resilient, community-based systems of care will be best able to respond to the shocks caused by global events, such as food crises, climate change, and pandemic diseases.

21. Taken together, these trends suggest some conclusions. Greater attention must be given to prevention, as a component of health policies, but also through health promotion and education aimed at behavioural change within communities. Multisectoral action is essential, also as a contribution to prevention. Consumer demands need to be addressed, as do imbalances in the provision of essential care. Stronger local health systems can reduce the demands on the international community when future disasters occur.

22. Waste and inefficiency need to be addressed. Better incentive schemes are needed to improve performance. The need for incentives also applies to the health workforce. Pending the training and deployment of more health workers, ways need to be found to motivate service in rural areas and to ensure that different conditions are managed at an appropriate level of skills.

23. These trends, and the new demands they place on health systems, have fostered a quest for greater efficiency in health systems and better performance in the delivery of care. They have also fostered a critical appraisal of the appropriateness of a primary health care approach and the advantages it can bring, particularly in terms of incentives for greater efficiency and more equitable performance.

Primary health care: appropriate solutions

24. Against this background, several advantages of a primary health approach are readily apparent. These advantages include the strong emphasis on prevention, the encouragement of collaboration among multiple sectors, and the drive to reach vulnerable and marginalized populations. Additional advantages include an explicit recognition of the power of community participation as a sustainable resource for health, and the emphasis given to technologies that are both appropriate and affordable.

25. In particular, the strong emphasis on prevention, individual responsibility for health, and health-promoting behaviours gains added relevance as a strategy for stemming the rising tide of chronic diseases. It also holds great promise for the long-term prevention and management of HIV/AIDS, including the provision of antiretroviral therapy, the integrated management of HIV/AIDS and tuberculosis, and the control of malaria through use of treated bednets and home-based treatment.

26. A solid body of evidence demonstrates the contribution of a primary health care approach to greater efficiency in the use of resources and better overall performance of health systems. As a way of organizing the health system, primary health care is a gatekeeper that helps keep patients with minor complaints from flooding emergency wards. By ensuring that conditions are managed at an appropriate level of skills, primary health care contributes to the more efficient use of human as well as financial resources.

27. Health systems oriented towards primary health care are well-positioned to seize a number of recent and emerging opportunities. Broad-based schemes, such as microfinancing, are unleashing the power of women to act as agents of change within communities. Research shows that, when women have control over financial resources, investments go towards better nutrition, improved sanitation, mosquito nets, and the education of children.

28. Advances in information technology make it possible to link remote health centres with higher levels of expertise. As suggested by some pilot studies, these advances can also revolutionize the collection and use of data within district health systems, thus addressing the perennial problems of inadequate monitoring and evaluation while supporting better priority setting.

29. The contribution of civil society, especially at the grassroots level, has grown considerably, offering new models of service delivery, often based on the ethic of voluntary service. As a resource, civil society initiatives are especially well-suited to community-based approaches.

30. Evidence of the value of community-based and community-directed approaches to service delivery continues to mount. Apart from their proven ability to reduce morbidity and mortality, these strategies show great promise in terms of cost-effectiveness and enduring community commitment.

31. Research has greatly expanded the range of technical tools suitable for use in households and communities. Some recent examples include drug regimes for the home-based treatment of malaria and childhood pneumonia, kangaroo care for pre-term infants, ready-to-use-therapeutic foods for the home management of severe malnutrition, simplified test kits for malaria, heat-stable drugs for chronic care, and simplified tools for the early detection and management of cervical cancer.

The challenge of implementation

32. Health systems are highly context-specific. No single set of solutions can improve performance in all settings. In 1994, a WHO report on progress towards Health for All concluded that dissemination of practical experiences in overcoming problems was the most important tool for progress. This conclusion remains valid.

33. Nonetheless, implementation of primary health care faces some common challenges in all settings. Regional Committees are invited to explore experiences and opportunities in the areas outlined below and provide guidance on how a revitalized primary health care approach could address these and other challenges.

34. **Support for change**. While primary health care contributes to efficiency, it is neither cheap care nor a cheap way for governments to fulfil their responsibilities in the health sector. Political support is essential. Ideally, such support should be motivated by a desire for equitable population coverage with basic health care and a conviction that better health outcomes translate into better productivity and stability within populations. Public support, expressed by civil society, non-governmental organizations, and other groups, is equally important. Moreover, some evidence suggests that demand-led reforms, in which the pressure for change arises from the citizens themselves, are more likely to endure frequent shifts in political power and priorities.

35. **Financing the health system**. Despite recent increases in external financial assistance for health, more than 75% of all funds for health in an average low-income country continue to come from domestic sources. Total health expenditure, from all sources including external assistance and loans, averaged less than US$ 30 per capita in 43 low-income countries in 2005. This amount is well below what is considered necessary to purchase an essential set of health interventions. Clearly, many developing countries will need to depend on external financial support for health for some years to come.

36. The need to invest in strengthened health systems has recently been recognized by the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance. How can WHO support countries in taking advantage of new funding opportunities to strengthen health systems? In addition, the importance of well-functioning health systems is being addressed in new initiatives, such as the International Health Partnership. How can experiences in pilot countries be translated into lessons for use in multiple countries? What role should WHO play?

37. **Financial protection**. Within existing financial constraints, governments need to devise systems for social protection, whether financed through pooling arrangements, employment schemes, more efficient tax collection, or an increased share of the national budget allocated to health. WHO estimates that, each year, health expenses cause 150 million people to suffer financial catastrophe and push 100 million below the poverty line. Poor households face a double challenge: they experience more illness

and thus need more care, yet they are least able to afford the cost of services, especially when paid for out-of-pocket. What can be done to alleviate this sickness trap?

38. **Intersectoral action**. The Report of the Commission on Social Determinants of Health will provide insight into the wider determinants of health and how they can be addressed through the policies and programmes of various sectors. Many of the fundamental determinants of health lie beyond the direct control of the health sector. At the same time, health ministries frequently have less persuasive power when priorities are set and budgets are fixed than that enjoyed by other sectors. How can other sectors be encouraged to include a health impact assessment when planning their activities? What can be done to raise the prestige of health ministries within government hierarchies?

39. **Extending care to vulnerable populations**. For many health problems targeted by international commitments, high morbidity and mortality persist despite the availability of highly effective and affordable interventions. This situation creates a moral imperative to scale-up access, aiming for universal coverage. At the same time, poor households tend to live in places, such as remote rural areas and urban shantytowns, that are beyond the reach of the formal health system. In response, new models of service delivery for vulnerable and marginalized populations have been created. These include the Basic Development Needs initiative in EMRO and the Faces, Voices and Places initiative in AMRO/PAHO. Monitoring has documented their potential to reach those in greatest need through community-based approaches. How can these models be replicated or expanded to reach the goal of universal coverage?

40. **Integrated services**. The success of the WHO/UNICEF Integrated Management of Childhood Illness (IMCI) initiative, which has been adopted as the child survival strategy in 100 countries, paves the way for the future of integrated approaches. IMCI delivers quality clinical care, in a public health approach, according to the principles of primary health care, and within the constraints of the existing health system. It includes provisions for training, the selection and quality assurance of essential medicines, and the shifting of tasks to the lowest level of safe and acceptable competence. In addition, the related approach, for Integrated Management of Adult Illness, provided the backbone for scaling up coverage with antiretroviral therapy, which is now reaching nearly 3 million people in low- and middle-income countries. How can these and other models be used to make the delivery of integrated services more routine, systematic, and broadly available?

41. **Community participation**. Initiatives that foster community participation and ownership are one of the most important legacies of the Alma-Ata Declaration. Evidence demonstrating the advantages continues to mount. How can diverse experiences be shared among countries and translated into a menu of best-practice options for different settings? Practical advice on ways to empower communities is likewise needed.

42. **Improved health outcomes**. While improvements in efficiency and performance are important, the ultimate objective of health system reform is to reduce gaps in health outcomes and raise the overall status of health within populations. To determine whether specific reforms are indeed contributing to better health outcomes, much more work is needed in the areas of monitoring and evaluation, country comparisons, and the exchange of experiences and lessons learned, especially with innovative approaches. More operational and implementation research is likewise greatly needed. What role can WHO play in generating better knowledge about what works best to improve health outcomes, and why?