

## Tipping the balance towards Primary Health care Network (TTB)

(Future Strategic Directions for Primary Health Care The story so far; Or holding on to Alma Ata essentials)

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*The purpose of this presentation is to give TTB members the opportunity to view our experience in the context of key global developments and possible directions; and to consider how to prepare for an uncertain future.*

In January 2000 the WHO Director General **Brundtland** proposed that WHO should conduct a **global review of the challenges to PHC**. Some of us in TTB were involved in the European regional review that formed part of the exercise. Later the World Health Assembly passed the resolution **WHA. 56.6** that inter alia requested the Director General to convene a meeting to "**examine the lessons of the past 25 years**" and "**identify future strategic directions for PHC**"

The meeting was held Madrid October 2003. A Report with the working title **Future Strategic Directions for PHC** was subsequently drafted. It set out to integrate the outcomes of the Global Review with those of the high level expert meeting in Madrid. That report remains unpublished. However enough has become known of the essence of its findings.

### **DG's message to the Madrid meeting**

Brundtland had retired by the time of the Madrid meeting. Her successor **Lee**, who had spoken in very positive terms about PHC in the period immediately after his election, did not attend the Madrid meeting, but did send it a strong message. The following paragraphs touch on some of the points he made.

He started by recalling that twenty-five years ago the **Declaration of Alma-Ata** challenged the world to embrace the principles of primary health care to overcome the stark health inequalities between and within countries. The goal of health for all could be achieved by strengthening PHC systems.

He drew attention to the **more complex policy-making and operating environment for PHC** that had evolved since Alma Ata. Globalization – the movement of goods, ideas and people across borders - has affected health, just as it had all other aspects of development. There are now many actors, different providers and different ways of funding. Private sector and civil society organizations play an increasingly visible role in services. And all these developments put pressure on governments to update and streamline their national regulatory framework to guide all health sector work.

**The key trend and challenge to the health sector**, that more and more diseases are chronic in nature and need long-term support and care from communities and the health system, needs to be seen against this increasingly complex environment.

A major international event setting a huge challenge to the health sector was the UN meeting in New York September 2000, when 149 heads of state and government agreed a set of **Millennium Development Goals (MDGs)** to be achieved by 2015. Some of these were explicitly health focused but others were also clearly health related.

A significant recent event had been the work of the **WHO Commission on Macroeconomics and Health**, whose report **Macroeconomics and Health** was presented in December 2001. The report showed that investments in health can produce a huge economic and social return. Health is not only an end in itself, but also a means to an end, i.e. sustainable economic development.

He pointed out that **25 years experience of PHC** had seen much diversity in the implementation of PHC. There is no one model for implementation. But we have learnt that PHC has to be adaptable and flexible. to be responsive to local needs. PHC has to keep up with the speed of change and to respond to emerging challenges, which may come as a result of global trends and developments.

He stressed again the importance of holding on to **the principles of primary health care**, of which he specifically identified:

**universal access to care and coverage,  
commitment to health equity and a development strategy oriented to social justice,  
community participation in defining and implementing health agendas, and  
intersectoral approaches to health.**

The overall conclusion that he drew was that for the future we need a renewed combination of **professional dedication political commitment and a shared sense of urgency** ,and we also need to win the minds of those who manage financial resources, convincing them that *investing in health makes economic sense too*.

### **John Bryant's testament**

Significantly as a reaffirmation of basic values, the final speaker at the Madrid meeting was **John Bryant. Bryant** as the then Chair of the Christian Medical Commission ,World Council of Churches, was a key adviser to **Halfdan Mahler** the Director General whose charismatic leadership led to the adoption of health for all as the goal of WHO and the development of PHC as the key means to attaining the goal.

It is clear from Bryant's words that he was very moved by the occasion: "I remember so clearly those days at Alma Ata. In: the early hours of the meeting we realized that we were in involved in a process with global and possibly historical implications", and again, "As we read again the Declaration of Alma Ata, we are immensely impressed with what was said there, and how lasting is the relevance of those words "

His own very varied experience led him to PHC approaches that are , as he put it, strongly community-based, participatory, see PHC as broadly encompassing health promotion and 'public health', and thereby include consideration of the social determinants of health.

He noted that the **20th Anniversary Meeting in Almaty**(the present name of **Alma Ata** ):observed that the **Alma Ata Declaration's insights** were strikingly accurate: the critical place for **human values** equity, fairness, gender sensitivity; the importance of **accurate information** on the nature of problems and the effect of the responses made; and the need for building health system research, especially in relation to the poor(**equity**). He stressed the central value of equity by quoting Mahler's remark at the tenth anniversary meeting in Riga 1988.

**"To improve the health of any society, it is necessary to raise the level of health of its less privileged members. This is an epidemiological truism and a moral obligation, the principle of principles that has crystallized out since WHO was born."**

Bryant went on to suggest that there were some problems that were less apparent (or not fully appreciated ) at Alma Ata-e.g.: limitations of governmental capacities; the importance of social and cultural parameters ,that are often locally unique; and the need for health care reform in virtually every country.

And some problems he felt were not predictable at that time: emerging and re-emerging diseases; advances in information technology; globalization; the emergence of increasingly pluralistic societies; the eruption of armed conflict at local level after the end of the cold war that as threats to peace were threats to human well-being; and call for PHC to address life style issues through both 'society-wide' and 'settings-based' programmes.

None of these points undermined the relevance and need for PHC.

Bryant then produced what was a moment of truth.

**"The history of PHC tells us there have been times when PHC had the absolute commitment and support of WHO as a global movement. History also tells us that there have been times when PHC was quietly placed on the shelf.**

He went on to argue that "The basic reason for raising this issue is that the lives and well being of

numberless persons the world over stand to benefit from the effective further development of PHC.

“A process of having multiple parties involved in contributing to the maturation of PHC at local, national and international levels, could make a major difference. Call them Partners in PHC, and leave more detailed characterization to others. Partners in PHC could contribute to adaptations of PHC to different national settings, to monitoring its effectiveness using diverse measures, to the training of human resources for PHC, to research on various aspects of the design, management and implementation of PHC systems, and more.”

### **MDGs or PHC?**

Everything Bryant said at Madrid was a reaffirmation of his continuing commitment to Mahler’s vision of PHC and HFA. But Lee, who had earlier been a strong advocate of PHC in his message to the opening of the Madrid meeting had stressed the importance of the adoption of the MDGs. Lee even went on to suggest that the MDGs and their related targets are yardsticks to measure our progress towards the overall goal of Health for All. He then attempted to get the best of both worlds by adding **“Or put in another way: the MDGs will not be achieved without a health system driven by PHC”**

So how far are the MDGs and PHC compatible? Enter **Pertti Kekki**, Professor of General Practice and Primary Health Care , University of Helsinki who produced a paper PHC and the MDGs: *issues for discussion*.

Kekki went to the heart of the matter when he noted that the **health MDGs** look like *vertical programmes* and are directed to specific population groups /diseases. This is in clear contrast with the principles of **PHC** which emphasize **access and coverage** for all, and **the coordination and integration of services and programmes**.

With studied understatement, he observed that it may prove difficult to ‘find synergy between the vertical programme approach and the development of PHC infrastructure’. Perhaps even more fundamentally, so he points out,

*MDGs fail to cover the important issues of preventable risks and chronic noncommunicable diseases that are rapidly transforming the required patterns of work in PHC, and setting new requirements for knowledge and skills .*

### **Crucial weaknesses of PHC practice**

But while sceptical of the MDGs as the way ahead for developing PHC, Kekki, following many other commentators, was in no doubt about the problems that bad experiences of PHC development had exposed. Among those identified were: the continuing lack of social participation, absence of teamwork and poor teamwork skills; weak intersectoral action, integration of activities, and coordination of care; and inadequate information systems for measuring performance and making decisions.

Kekki was also critical of what he called a ‘limited quality culture’ and a generally negative attitudes towards or limited use of performance assessment, clinical audit and review, and evidence-based practice.

### **Key challenges for PHC**

At least two major challenges emerge from Kekki’s assessment of where we are today .

The first is **attracting and retaining competent personnel**. This calls for much improved programmes of vocational training and continuous professional development (CPD).

The second challenge is the search for **innovative ways of organizing** PHC. It is highly likely that new ways of working will require profound **changes in attitudes and behaviour** .

These challenges in turn point to the importance of **research in PHC**. But present attitudes o research are *not very positive*, and this only serves to undermine PHC's scientific credibility.

### **Primary Health Care: a framework for future strategic directions**

At Madrid, **Bryant** quoted pertinently from the report **Primary Health Care and Health Sector Reform: 15 Years After Alma** ‘ a critical agenda is to build on two challenges: to adapt the ideas and concepts to each country, and to strengthen country capacities to absorb these products.” He observed that in Madrid, too, ‘we face the need to move on to country level implementation.’

So in light of past experience and the likely future operating environment, what are the concerns that countries and communities should be thinking through? Having assessed past experience as revealed by the global review, the Madrid meeting then developed a number of challenging ideas for facing the future. These are now outlined in the following paragraphs.

**The first steps:**

**clarify what problem needs to be addressed , then decide what needs to be done**

When setting out to improve health systems and health care systems, countries will likely find themselves at one of **three** starting points (although these are not mutually exclusive)

In the **first** case, existing policies and systems are based on PHC principles, but it is evident that they are *not* delivering to their full potential. This is because although a good start has been made, for some reason the **process of implementation is still incomplete**. In such a situation the task is to discover and understand why implementation has failed so far, and then to determine and take appropriate *remedial action* in order to complete implementation

In the **second** case policy makers and the other interested parties are clear in their appreciation of the nature of their future policy environment. They have assessed the health challenges, demographic changes , socio-trends etc, and there is agreement that potentially, applying PHC principles would generate effective responses to the challenges.

The problem is 'how', since one or more aspect or part of present **health system and policies are not geared for the tasks now required**. In this situation effort must be directed toward *clarifying what needs to be strengthened* in order to meet the new challenges that have been identified, *and how this can best be done*.

In the **third** case, the problem is even more obviously political. Here the need is to adapt policies and systems in response to a new political and social paradigm, **without compromising PHC principles** or abandoning *health for all goals*..

There could well be situations where it becomes necessary to recognise that the PHC approach *cannot solve all the community's problems* with health consequences, and an impact on health outcomes. There are limitations to the promotion of a PHC approach. If the new political and social paradigm dictates that *other concerns have primacy in public policy and action*.

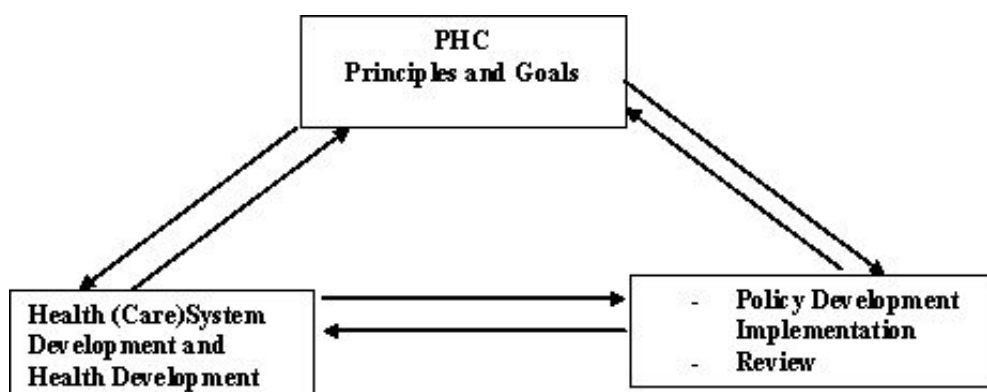
To the greatest extent possible at all levels, PHC principles should still be the cornerstone of health policy, but taking full account of what have become more fundamental concerns. (e.g. if the new political preference is for providing health and social care through competitive market rather than a comprehensive public service framework).

In situations where a new paradigm has to be accommodated, the need is to clarify the part that PHC principles can still play in pursuing broader public policy goals, and to judge how far health systems, priorities, processes, etc. must necessarily be adjusted and what can be protected.

**A common strategic framework**

**Having decided what needs to be done, all health policy makers and system designers , whatever the specifics of the arrangements they are working within, can make use of the simple framework endorsed by the Madrid meeting.**

The framework has **three elements** and the relationships between them are depicted in this diagram.



## Diagram 1.

Our health **goals** need to be shaped by clear **principles** (in our case especially those articulated in the **Declaration of Alma Ata**) in order to establish a proper **sense of direction**, or 'where we want to be'. But they only become *practically* meaningful when they are implemented through realistic **policies and strategies**.

**Implementation** is variously through **health system development** (typically health care services), or health development ( i.e.the range of measures taken in and outside the health sector to protect and promote population health).

Principles,goals, policies and development strategies must be **kept under review**, and as necessary, adapted in response to evidence (e.g.the outcomes that have been achieved and the reported experiences of both receivers and providers of services ).

## PHC principles and goals in a complex world

**The basic conclusion of the global review and the consensus at Madrid was that we still need the Alma Ata principles, but there are also certain other principles which we need to acknowledge and promote.**

Here they are in summary.First, health must be seen as a national and global **resource for social and economic development** Secondly,given the many dimensions of **globalisation**, many health determinants need addressing on an international basis.Thirdlyit needs to understood by all that individuals have **responsibilities** within civil society, for their own and others' health Fourthly Government's leadership responsibility means a responsibility to work with civil society, all sectors, other governments and international agencies tro protect and promote health.

It may be that these 'new 'principles were already implicit ot latent in the Declaration of Alma Ata, but now they need to be made quite explicit.

These new principles will evolve with new political and social paradigms, and they will need to be kept under review. For this reason we can formulate a **final principle**:

*Principles are dynamic.and any debate about the guiding principles which should inform actions will be as important as the actions themselves.*

Clear, but evolving, principles provide a "**PHC lens**" through which decisions, actions and results can be constantly and consistently examined.

## Policy development, implementation and review

The Declaration of Alma Ata makes clear who should be involved in the development of PHC, but has *little or nothing to say on the task and means of implementation*. The Madrid conference took this , and as a step towards repairing this omission, suggested that the following would be critical to successful implementation.

If policy development and implementation were viewed through the "PHC lens" *at all times* , then clear principles and health goals would necessarily inform decision making. It was no no less essential to engage with the widest range of interested parties, both in the formulation and the implementation phases if decisions were to be fully grounded in reality '**Policy development-implementation –review**' must be a continuous dynamic process, not an occasional event. It must be *informed by evidence, including* information from the grass roots.And lastly, always explore rigorously the possible consequences of policy changes in order to avoid,or at least reduce, the chances of undesired unintended effects .

## Health system development

It is axiomatic that a country's social, economic political characteristics should determine how PHC principles are applied. However,there are some concerns which shouls always come in to play. The "PHC lens" should be consistently applied to the **organisation of the health system, especially** when considering choices in the organisation of the subsystem of health care.

To satisfy the conditions derived from PHC principles, the health system must have the capacity to identify and respond to the health needs of all,and particularly those of disadvantaged people. It must have the capacity to deliver evidence based, appropriate and accessible health care to all populations. And it must have the capacity to act on the determinants of health and hence must be organised to facilitate partnership across sectors and different agencies, and with communities

## What now for TTB?

As said at the beginning, the purpose has been to set TTB in the bigger picture. It is evident that our experience mirrors the trends problems and challenges found elsewhere by the global review. Likewise, the ideas emerging about how to secure PHC in the future are quite consistent with our own thinking. There is no reason why TTB should not continue to act as a laboratory for new thinking and mutual inter-professional, inter-organizational, inter-sectoral and inter-national learning, with it's strong commitment to self evaluation and reflective practice , to various forms of research and development activities, and to dialogue with our communities.

**An artist's perception of primary health care?  
Did William Morris anticipate Alma Ata?**

At least I know this:  
a person cannot enjoy the sort of health I am speaking of  
*if* they are **overworked** in any degree;  
*if* they are continually chained to one dull round of mechanical work, with **no hope** at the end of it;  
*if* they live in **continual sordid anxiety** for their livelihood;  
*if* they are **ill housed**;  
*if* they are **deprived** of all enjoyment of the **natural beauty** of the world;  
*if* they have **no amusement to quicken** the flow of their spirits from time to time.  
All these things, which touch more or less on their bodily condition, are born of the claim I make to  
live in good health.  
**William Morris 1884**

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