Renewing Primary Health Care in the Americas

A Position Paper of the Pan American Health Organization/WHO

March 2005
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Acknowledgments:

Special thanks to Maria Magdalena Herrera, Frederico C. Guanais, Lisa Kroin, Lara Friedman, Soledad Urrutia, Juan Feria, Etty Alva, and Elide Zullo.
Executive Summary

For more than a quarter of a century Primary Health Care (PHC) has been recognized as one of the key elements of an effective health system. During this period, experiences in more-developed and less-developed countries alike have demonstrated that PHC can be adapted and interpreted to suit a wide variety of political, social, and cultural contexts. A comprehensive review of the concepts of PHC - both in theory and practice - and a critical look at how this concept can be “renewed” to better reflect the current health and development needs of people around the world, is now in order. This document-which was written to fulfill a mandate established in 2003 by a resolution of the Pan American Health Organization (PAHO)-states the position of PAHO on the proposed renewal of PHC.

By examining concepts and components of PHC and the evidence of its impact, this document distills lessons learned from PHC and health reform experiences over the past quarter-century and proposes a set of key values, principles, and elements essential for building PHC-led health systems. It postulates that such systems will be necessary to tackle the “unfinished health agenda” in the Americas, as well as to consolidate and maintain progress made and rise to the new health and development challenges and commitments of the twenty-first century. The ultimate goal of the renewal of PHC is to obtain sustainable health gains for all. The goal of this paper is to generate ideas and recommendations to enable the renewal of PHC into a concept that can lead the development of health systems for the coming quarter century and beyond. Both are meant to be visionary; the realization of this document's recommendations, and the realization of PHC's potential will be limited only by our commitment and imagination.

Basic Messages:

- Health is a social, economic and political issue and, above all, a fundamental right. Inequality, poverty, exploitation, violence, and injustice are at the root of ill-health and the death of poor and marginalized people. Approaches to improving health must address multiple health determinants in an integrated fashion.

- The region of the Americas has made great progress in improving health and access to health care over the past quarter century, but persistently overburdened health systems and widening inequities threaten to undermine gains already made and endanger future progress towards better health and human development.

- A review of experiences over the past quarter-century shows that PHC has been interpreted and implemented in varying manners in the Americas, incorporating different points of view, being operationalized in different ways, and embracing diversity.

- Today, PHC is considered a regional priority and is widely viewed as a cornerstone of national and regional strategies to achieve equity and equitable gains in health and human development.

- After more than a quarter of a century, it is now time to renew and reinvigorate our approach to PHC, with an emphasis on lessons learned and seeking to update the concept to clarify longstanding disagreements and deal with new and anticipated challenges.
Conclusions and Recommendations:

• A new and reinvigorated approach to PHC can drive the transformation of health systems and promote more equitable health and human development.

• A PHC-led health system is one that is organized and managed around a core set of values, principles, and elements. It is an overarching approach to the improvement of health and equity achieved by orienting all health system structures and functions to focus on achieving the right to health, equity in health, and social solidarity.

• Achievement of equity represents a regional imperative on scientific and moral grounds, and there is evidence that PHC may be one way to enhance equity in health. A renewed approach to PHC will therefore need to place equity concerns at its core.

• PHC renewal must pay increased attention to structural conditions such as access, financial fairness, adequacy of resources, and to the development of systems to assure high quality care.

• Lessons learned from health sector experiences demonstrate that there is no single best practice for reform. To be successful, reforms must be congruent with citizens’ values; contain mechanisms to protect the poor; and strengthen the capacity of national and local actors to plan, administer, regulate, evaluate, and innovate.

• Full realization of a renewal of PHC requires additional focus on the role of human resources. It also requires the development of strategies for managing change and aligning international cooperation with the PHC approach.

• The next step to renewing PHC is to constitute an international coalition of interested parties. The tasks of this coalition will be to frame PHC renewal as a priority, develop the concept of PHC-led health systems so that it represents a feasible and politically appealing policy option, and find ways to capitalize on the current window of opportunity provided by the 25th anniversary of Alma Ata, the need for strengthening health systems, and the accompanying international focus on the importance of attaining the Millennium Development Goals.
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I. Why Renew Primary Health Care?

The World Health Organization has been a champion of primary health care (PHC) since it adopted the approach as central to the achievement of the goal of “Health for All” in 1978. Since that time, the world--and PHC with it--has changed dramatically. Despite changes to the way PHC has been conceptualized and implemented during the past quarter-century, there is an emerging international consensus that PHC remains a valid and appropriate means of promoting health and human development throughout the world.

Because of the need to take stock of more than 25-years of experience with PHC, several international meetings have been held over the past decade to evaluate progress, lessons learned, and future challenges. From these international efforts has emerged a critical mass of individuals and organizations dedicated to renewing and reinvigorating the PHC approach.

The purpose of renewing PHC is to revitalize countries’ capacity to mount a coordinated, effective, and sustainable strategy to tackle existing health problems, prepare for new health challenges, and improve equity. The goal of such an endeavor is to obtain sustainable health gains for all.

Building on this process of reflection, WHO commissioned a series of regional workshops to bring together policymakers, health system managers, PHC professionals, and others to gather their perceptions and experiences working in PHC and their thoughts about what new models of PHC should look like.

In September 2003, during the 44th Directing Council, PAHO/WHO passed Resolution CD44.R6 calling for Member States to adopt a series of recommendations to strengthen Primary Health Care (PHC). It also calls for PAHO/WHO to take PHC principles into account in the activities of all technical cooperation programs, especially those related to the Millennium Development Goals (MDGs); evaluate the different systems based on PHC and identify and disseminate best practices; assist the training of health workers for PHC; support locally defined PHC models that are flexible and adaptable; celebrate the 25th anniversary of Alma Ata; and organize a process for defining future strategic and programmatic orientations in PHC. In response to the above mandates, PAHO/WHO created the "Working Group on PHC" (WG) in May 2003 to advise the organization on future strategic and programmatic orientations in PHC. This document is the principal outcome of the working group process.

The Context for PHC in the Region of the Americas

A thorough examination of primary health care is timely, as the majority of countries in the Americas have undergone dramatic changes over the past three decades. These changes include democratization, economic liberalization, redefinition of the role of the state, and reformation of the health and social services systems, including an increased role for the private sector. Health reforms have had the aim of streamlining healthcare financing, decentralizing authority for planning and implementation, and in recent years have sought to improve the quality of care and enhance equity [7]. These objectives have developed against the backdrop of widespread poverty, increasing inequality, social exclusion, political
instability and environmental deterioration within most countries [8, 9]. In addition, the region is experiencing significant demographic and epidemiologic changes that have shifted the burden of disease, the effects of globalization, which has created interdependence and vulnerability, and the introduction of new forms of political, social, economic, and technologic development. See Table 1.

Primary health care, in its widest sense, should be an essential component of economic and social development objectives [10, 11], but the impact of PHC on the achievement of these objectives has not been well documented, particularly in developing and transitional countries. More than a quarter of a century after the groundbreaking Declaration of Alma Ata, in which the International Conference on Primary Health Care affirmed the fundamental characteristics of PHC and called for “urgent and effective national and international action to develop and implement primary health care throughout the world,” today there is little consensus on the achievements and challenges of the PHC approach in improving population health, let alone socioeconomic development, over time [12]. This document aims to demonstrate that, when the many experiences of successful PHC experiences are taken into account, a renewed and strengthened approach to primary health care emerges as the cornerstone of global and national strategies meant to improve health and equity [11, 13-17].

Box 1: The Latin America Region and the Millennium Development Goals (MDGs)

Progress towards the MDGs shows promise on some fronts but faces serious challenges in others. Among developing regions, the Latin America and the Caribbean (LAC) region had the highest life expectancy, was the only region where girls have a higher literacy rate than boys, and the only one on track to meet the child mortality and drinking water goals.

In spite of the fact that the LAC region has the highest gross national income (GNI) per capita of all developing country regions, it is still not likely to achieve the poverty goal due to its ranking at the top as the most unequal Region of the world.

Given current rates of progress, only about half of the countries in the LAC region are on track to meet the MDGs for underweight prevalence, only 10 percent are on track to meet the under-five mortality goal, and less than 5 percent are on track to meet the maternal mortality goals. The poorest countries in the region (Bolivia, Haiti, Honduras, and Nicaragua), and averages for country indicators in middle income countries mask wide disparities in social conditions by income, ethnicity, gender and geographic location. Child malnutrition, for example, remains a problem both in the lower income countries of the region and in the poor regions of some of the middle-income countries.

Source: [13]

Since Alma Ata, there have been several important advancements in our understanding of and approach to health promotion and disease prevention. In the 1980s and 1990s world summits on children, women, the environment, reproductive health, sustainable development, and human rights helped mobilize national and local governments and non-governmental organizations (NGOs) to take action on major global problems; established international standards and guidelines for national policy development; served as forums where new proposals were debated and consensus sought; and set into motion processes, still in place, whereby governments make commitments and report regularly to the United Nations. In some cases, they set the groundwork for codification of citizens’ rights and governments’ obligations into international treaties and agreements [18]. For example, the Rio Summit
on the environment led to four new international treaties dealing with climate change, biological diversity, desertification, and high-seas fishing, respectively.

In 1986 the Ottawa Charter for Health Promotion launched a new era in health promotion, defining the prerequisites to health—including peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity—and laying the groundwork for mobilizing societies to promote health [19]. This coincided with an increased understanding and articulation of the health sector in the areas of policy, law, and finance [20-22]. New health technologies—from organ transplantation to oral rehydration therapy—have proliferated and become commonplace. Overall, the world has changed dramatically in terms of the ability to collect, analyze, interpret, and transmit data and other information based on the widespread diffusion of new technologies such as computers and the Internet. These changes have promised new hope, but they do not adequately address the full range of health challenges, such as those embodied in the Millennium Development Goals (MDGs). See Box 1. For PHC to be successful in the twenty-first century, it must adapt to meet new circumstances, take advantage of lessons learned, apply new technologies, and develop a strategic approach to improving equity in health.

**KEY MESSAGE:** The region of the Americas has made great progress in the past quarter century, but persistently overburdened health systems and widening inequities threaten gains already made and endanger future progress towards better health and human development.
<table>
<thead>
<tr>
<th>Dimension</th>
<th>1978</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic</td>
<td>Younger population; high fertility; populations becoming primarily urban (although with high levels of rural population)</td>
<td>Aging of population; reduction of fertility; strong patterns of migration; high levels of urbanization</td>
</tr>
<tr>
<td>Epidemiologic</td>
<td>Predominance of infectious diseases, malnutrition, maternal, child and infant health problems</td>
<td>Emerging health issues such as HIV/AIDS and SARS, and the increasingly complex burden of disease from conditions such as stroke, cardiovascular disease, cancer, diabetes, hypertension, hyperlipidemia, mental health problems, violence, drug abuse, injuries and deaths from external causes, and the adoption of unhealthy life styles or risky behaviors.</td>
</tr>
<tr>
<td>Globalization</td>
<td>Limited flow of people, trade, technology and capital</td>
<td>Increased transnational influences in several areas such as the economy, trade, travel, labor, food security, environment, technology, communication and media, and foreign policy.</td>
</tr>
<tr>
<td>Political</td>
<td>Cold war; China’s Cultural Revolution; establishment of a “New international Economic Order” to uplift less-developed countries; dictatorships in many countries of the Americas; post colonial era in the Caribbean</td>
<td>End of Soviet era; democratic processes established in most countries of the Americas; increased community participation and self-determination (although still insufficient); governance and political crises in many countries; formation of regional blocks (e.g. Euro Zone, MERCOSUR, NAFTA)</td>
</tr>
<tr>
<td>Social</td>
<td>Poverty and inequality among vast sectors of the world population; wide gap between developed and developing countries</td>
<td>Lack of significant progress in poverty reduction; social unrest due to political and or economic crises; limited governance; improved levels of education (although with great disparities); rising public expectations; citizens are better informed and demand their rights; women have improved their social status (although gender disparities persist); increased social and domestic violence; significant growth of social movements and organizations.</td>
</tr>
<tr>
<td>Cultural</td>
<td>Less racial, ethnic, and cultural diversity (more segregation)</td>
<td>Increased ethnic and cultural diversity; indigenous populations are better organized and demand their rights; recognition of African descendents and heritage.</td>
</tr>
<tr>
<td>Economic</td>
<td>Limited economic growth; high foreign debt; high inflation</td>
<td>Slow and unstable economic growth; economic and financial crises in many countries; widening income inequalities; high unemployment rates; debt burden unchanged</td>
</tr>
<tr>
<td>Environment</td>
<td>Large unspoiled, unexplored areas</td>
<td>Progressive environmental degradation; loss of bio diversity; contamination</td>
</tr>
<tr>
<td>Information, communications technology</td>
<td>Rudimentary information and communications technology</td>
<td>Explosive expansion of internet and other innovations in communications such as telehealth(^1), electronic health care and electronic medical records.</td>
</tr>
<tr>
<td>Science and technology</td>
<td>Important discoveries in science and technology (although less accessible and advanced than today’s)</td>
<td>Advances in rational drug design(^2); imaging(^3); minimally invasive surgery(^4); genetic mapping and testing(^5); gene therapy(^6); vaccines(^7); artificial blood(^8); regeneration medicine(^9); health engineering(^{10}); nanotechnology.(^{11})</td>
</tr>
<tr>
<td>Institutional context</td>
<td>Poor access to basic social and health services; most health services are government owned and centrally controlled; little private sector participation in the provision of services; poor coordination among economic sectors; weak citizen participation in decision making</td>
<td>Access to basic social and health services improved (although with greater disparities between and within countries); rising health care costs; health reform efforts steered by criteria largely extrinsic to health (e.g. decentralization, civil service reform, reduction of government spending); government role redefined; steering role of governments weakened in performing essential public health functions; greater number of health actors, including the private sector, both for-profit and not-for-profit; NGO’s expansion networks; “Brain drain” of health personnel; improved evidence-base for health interventions; internationalization of health systems.(^{12})</td>
</tr>
<tr>
<td>International development agenda</td>
<td>Little understanding of the links between development and health; fewer actors in the international development arena</td>
<td>Better understanding of the relationships between economic development and health; health has a place on the international development agenda; greater emphasis on collaborative and partnered approaches, accountability and performance assessment; emergence of concept global public health goods; a focus on equity.</td>
</tr>
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</table>

\(^{1}\) The application of information technology and telecommunications for diagnostic and treatment services (also referred to as telemedicine), educational and support services and health information management systems.

\(^{2}\) The use of computers to design drugs that target a specific receptor.

\(^{3}\) The use of new imaging technologies to look at the form and function of organs that were once examined only in surgery.

\(^{4}\) The use of miniaturized devices digitized imaging, and vascular catheters in neuro-surgery, cardiology, and interventional radiology.

\(^{5}\) The identification and testing of genes and genetic interactions that causes disease.

\(^{6}\) The use of site-specific genes to treat a variety of inherited or acquired diseases.

\(^{7}\) The use of vaccines to bolster immune systems, target tumors, or immunize against viruses, and of delivery methods including oral and nasal sprays.

\(^{8}\) The use of recombination hemoglobin to create a blood substitute.

\(^{9}\) The use of stem cells (Human embryonic stem cells capable of differentiating into any somatic tissue), tissue engineering; xenotransplantation (The transplantation of tissues and organs from animals into humans), use of artificial organs, induced repair/regeneration, & the modulation of ageing processes.

\(^{10}\) Physical and engineering sciences will support whole systems engineering, mimicry of natural sensor/effector pathways, image analysis, predictive modeling of biological behavior, and clinical decision support.

\(^{11}\) Research and technology development at the atomic, molecular or macromolecular levels, in the length scale of approximately 1-100 nanometer range, creating and using structures, devices and systems that have novel properties and functions because of their small and/or intermediate size, and the ability to control or manipulate on the atomic scale.

\(^{12}\) Movement of patients and of providers, provision of services by services based in one country to patients in another one.