Primary Health Care: Past, Present and Future

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Objectives

I. Understand the history of global-public health
II. Know the Millennium Development Goals (MDGs)
III. Review history and milestones in evolution of primary health care (PHC)
IV. Identify key components of PHC
V. Differentiate PHC from primary care
VI. Describe contributions of PHC to achieve the MDGs
VII. Outline facilitators and barriers to effective PHC
VIII. Preview World Health Report 2008; PHC-Now More than Ever
The concept of primary health care emerged in the 20th century as a strategy to provide access to comprehensive, effective health services for populations. Many forces and historic events shaped the evolution of primary health care.
History of Global-Public Health

• Prevention of illness and treatment of disease were integrated in health care for centuries

• Medical sub-specialization focused on disease treatment developed rapidly over the last century due to:
  – Discovery of bacteria and viruses
  – Development of antibiotics and antivirals
  – Techniques to manage severe trauma
  – New technologies and surgical therapies
International Health Organizations

- Pan American Health Organization (PAHO) - 1902
- World Health Organization (WHO) branch of United Nations established in 1948:
  - To promote the highest possible level of health, and the least differences in health status among populations…
  - To establish standards, adopt conventions, promote regulations, monitor health status, track legislation and prevent epidemics
  - To work in partnership with member states, non-governmental organizations (NGOs) and others
  - However, with limited budget, technical assistance and enforcement capacities

The emergence of national and international health organizations provided organizations, personnel and systems to assess the health of populations; describe health disparities within and between nations; and opportunities for discussion and development of universal standards for health care delivery.
INTERNATIONAL HEALTH EFFORTS
The Vertical Program Period
1946-1977

- Selected focus on:
  - Control of major infectious diseases
  - Prevention, treatment or eradication of specific targets
- Remarkable successes:
  - Eradication of smallpox (1977)
  - Reduction of polio, measles, cholera and tetanus
- Significant failures: Malaria, malnutrition
- Limited progress in making basic health care widely available
  - Hospital-based health systems (fragmented and expensive) did not meet the needs of the poor or those in rural areas
DEMOGRAPHIC TRANSITION

• Human population is increasing exponentially
  – 300 million in 0 AD
  – 2.5 billion in 1950
  – 6.7 billion in 2008

• Expected to plateau between 8-10 billion by 2050

• Many people are living longer, leading to changes in the demographic profile, with greater numbers of elderly

• Many countries that are experiencing rapid growth are not able to meet basic human needs for water, food, education and health care

Health systems must respond to the changing needs of societies. During the 20th century, human populations grew exponentially, partly due to improvements in health care delivery. Health systems are challenged to develop services to keep pace with rapid population growth and changes in disease patterns.
EPIDEMIOLOGIC TRANSITION

• Improved control of infectious diseases leads to increased life spans and a greater number of older adults

• Urbanization and changes in behaviors and diet contribute to an increased prevalence of chronic diseases such as hypertension, coronary artery disease, diabetes and cancer

• Many less economically developed countries are faced with the double burden; when persistently high rates of infectious diseases are combined with rapidly rising rates of chronic diseases

• Traumatic injuries, violence and road traffic accidents further strain health systems resulting a triple burden; when there are high rates of trauma, infectious and chronic diseases.

• Populations have experienced epidemiologic transitions at different rates; these transitions have triggered needs for new health services and delivery systems
A SHORT HISTORY

THE DEVELOPMENT OF MODERN HEALTH SERVICES IN LESS ECONOMICALLY DEVELOPED COUNTRIES
DECENTRALIZED HEALTH CARE
PRE-COLONIAL ERA

- Multiplicity of traditions - often intermingled by accidents of history
- Horizontal and decentralized
- Self-sustaining and affordable
- Holistic (spirit and body)
  - Curative and preventive
  - Limited effectiveness
    - Survival of the most fit and the most adapted
    - Practical discoveries, fear and fatalism
HEALTH CARE IN THE COLONIAL ERA

- Traditional systems still predominated
- Science-based “modern” care with strong overtones of western tradition spread slowly
  - Health services faced with Herculean tasks:
    - Lack of infrastructure and capital
    - Low level of education
    - High burden of disease
    - Diversity of language and culture
  - The miracles of penicillin, quinine, etc.
HEALTH SERVICES SHAPED BY COLONIAL POWERS

• Driven by colonial political and economic interests
• Institutions spread out from major centers
• Health care services offered:
  – Mostly curative/minimal preventive
  – Secular – physical orientation
  – Primarily for the ruling and administrative class
  – Paternalistic
  – Limited ‘vertical’ programs aimed at the masses
EXTENSION OF INSTITUTION BASED CARE POST-COLONIAL ERA

- Traditional care still the most extensive, available and affordable
- Science-based “modern” care – adopted as national model and expanded
- Institution based care continues to be the norm:
  - Random patients – come to a centralized institution often with same recurring problems
  - Curative emphasis
  - Highly effective in individual cases
INSTITUTION-BASED HEALTH CARE

• Increasingly specialist and procedure driven
  – Expensive
  – Consumes disproportionate amount of available resources
• As distance from political center increases:
  – Resources for basic services decreases:
    • Discouragement
    • Disillusionment
    • Loss of trained and dedicated personnel
• Commercialization
This figure shows the distribution of the population and health expenditures in Ghana in the 1970s. Most of the population was located in rural areas and could have benefited from primary, preventive and basic curative health services. However, most of the health expenditures were focused on providing secondary or tertiary hospital based curative services that were inaccessible by the majority of the population.
INSTITUTION FOCUSED HEALTH CARE; QUESTIONING THE RESULTS

• Populations close to major centers have access to adequate and increasingly sophisticated care

• Masses at the peripheries left with:
  – Weak and struggling institutions in all domains
  – High burden of diseases with few resources
  – Loss of connections, cultural memory and traditions
  – Devastating wars, interethnic discord and HIV/AIDS
  – Sense of dependency rather than self-sufficiency

• Improved institutions in major centers; yet with overall high mortality rates and low health indices
SOLVING THE DISEQUILIBRIUM

RESOURCES

CENTER < GEOGRAPHY > PERIPHERY
RESPONDING TO HEALTH NEEDS:

THE EVOLUTION OF PRIMARY HEALTH CARE
SOCIAL EQUITY EVOLUTION OF NEW HEALTH CARE MODELS

• Beginning in the 1930’s, international organizations, some governments, and non-governmental organizations (NGOs) sought methods to enhance social equity to:
  • Improve the health of populations
  • Reduce health disparities due to poverty

• Small scale attempts to provide community-based comprehensive care emerged in sites such as China, India, Yugoslavia, Cuba, Costa Rica, Mexico, Venezuela Niger, Nigeria, Tanzania, and in faith-based programs
PRIMARY HEALTH CARE; TURNING THE FOCUS TO MEET COMMUNITY NEEDS

• A number of pilot and longitudinal research programs were established in low income communities to test the cost-effectiveness of different ways of providing PHC and of the relative effectiveness of different components of a PHC ‘package’

• China provided the first broad experiences beginning in the 1930’s; this was expanded into the concept of the “barefoot doctor” on a national scale

• Subsequently the largest experience has been and continues to be on the Indian sub-continent
HISTORY OF PRIMARY HEALTH CARE

- Halfdan Mahler: WHO Director General (1973-88)
- Studied alternative methods to improve health
  - Bottom-up, community based approaches
    - Chinese experience & favorable health outcomes
  - World Health Assembly 1975; prioritized national programs
    - Focused on prevention and local involvement
  - Review led to 1978 WHO conference in Alma Ata, Kazakhstan (former USSR)
    - Defined “health”
    - Defined & prioritized primary health care (PHC)
PRIMARY HEALTH CARE
KEY INTERNATIONAL DECISIONS & MOVEMENTS

• United Nations Declaration of Human Rights - 1968
• Alma Ata Conference – 1978
  – Set goal of Health For All by the Year 2000
• UNICEF – child survival revolution mid-1980’s;
  – Vertical PHC initiatives
• Bamako (Mali) Initiative --1987 – Set goals for PHC in sub-Saharan Africa
  – Decentralized management of services & fees
  – National policies on essential drugs
Health as a Human Right

• “Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.”

• The realization of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programs developed by the World Health Organization (WHO), or the adoption of specific legal instruments. Moreover, the right to health includes certain components which are legally enforceable.”

THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS; 1966
“Health, which is a state of complete physical, mental and social well-being....is a fundamental human right...”

“The attainment of the highest possible level of health is a most important world-wide social goal...”
ALMA ATA DECLARATION

• “The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

• Governments have a responsibility for the health of their people.

• Primary health care is the key to attaining this target as part of development in the spirit of social justice.”
"Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community….It forms an integral part of the country’s health system…and of the social and economic development of the community…bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process."
PRIMARY HEALTH CARE
A LEVEL & PHILOSOPHY OF CARE

- Personal
- First contact
- Continuous
- Comprehensive
- Coordinated
- Community oriented

- Hub of health system
- Equitably distributed
- High quality
- Cost effective
- Acceptable
- Accountable
PRIMARY HEALTH CARE

Recognized *social and biological* determinants of health and called for:

– Social justice and equitable access
– Cultural acceptability
– Economic affordability
– Political support
– Community participation
PRIMARY HEALTH CARE

• Alma-Ata promoted three key ideas:
  – **Appropriate technology**
    • Health technology was out of “social control” (Mahler)
  – **Opposition to medical elitism**
    • Focused on general, grass roots, community approaches
  – **Health as both a means and a goal of development**
    • Required multi-sectoral efforts
    • Health defined as not just an ‘output’ of economic development, but also as an important ‘input’ to development

• *Established goal to provide Health for All by the Year 2000!*
The health compass illustrates importance of balancing interrelated values in primary health care -- Charles Boelen: Towards Unity for Health, WHO 2000

While each of the values of quality, equity, relevance and cost-effectiveness are important for health systems, it is the harmonious integration and balance of these values that allow health systems to be most effective as illustrated by the health compass of interrelated values. Some systems may deliver sophisticated technical care but only to certain segments of the population, siphoning off a substantial proportion of resources while a large percentage of the population lacks access to basic health care. Other systems may deliver essential care such as immunizations at low cost, but fail to cope with common conditions such as hypertension. Progress in promoting any of these values independently may affect the others negatively or positively. The goal of an optimally functioning health system is to achieve equilibrium among these values in order to meet the health needs of a community (Boelen, Towards Unity for Health, WHO 2000).
PRIMARY HEALTH CARE: INFLUENTIAL INTERNATIONAL PROGRAMS

- China – Rural Reconstruction Movement & Rockefeller F. 1930’s
- Pholela Health Centre – S. Africa 1940’s
- Matlab Project – Bangladesh 1960’s
- Danfa Rural Health and Family Planning Project – Ghana 1970’s
- Narangwal Project – India 1967 – 1973
- Hôpital Albert Schweitzer – Haiti 1967
- Jamkhed Comprehensive Rural Health Project – India 1971 - present
- BRAC – Bangladesh 1972
- SEARCH Project – India 1980’s
- Navrongo Initiative – Ghana 1994
PRIMARY HEALTH CARE

KEY LEADERS

• Dr. John Grant - Rockefeller Foundation China 1930’s and ‘Regionalization’, Puerto Rico, 1950s

• Dr. David Morley – Under 5 Clinics, Nigeria, 1960s

• Dr. Maurice King – *Medical Care and the Developing World*, 1972, Uganda

• Dr. John Bryant – *Health and the Developing World*, 1969
PRIMARY HEALTH CARE

KEY LEADERS

• Dr. Carl Taylor – India, Johns Hopkins School of Public Health & Narangwal Project, India
• Dr. James Grant UNICEF 1980 – 1995 World Summit For Children 1990
• Drs Rajanikant & Mabelle Arole – Jamkhed India
• Drs. Abhay & Rani Bang – SEARCH India
• Mohamed Yunis – Grameen Bank Bangladesh – Micro-credit programs
• Fazle Hasan Abed – BRAC (Bangladesh Rural Advance Commission) Bangladesh
Despite the comprehensive vision of PHC, basic health care services remained beyond the grasp of many, especially for rural, poor families. Photo by Cynthia Haq MD 2004, used with permission of family in Kasangati, Uganda.
Dr. Charles Boelen illustrates the common dilemma faced by health professionals who try to bridge the gaps between individual and public health services. In many areas there is poor coordination between preventive and curative health services. Public health services are often inadequate and underfunded; individual clinical services are often available only to those covered by insurance or with other means to pay.
WHAT HAPPENED TO THE ALMA ATA MODEL OF PRIMARY HEALTH CARE?
THE POLITICAL WILL TO CHANGE WAS LACKING

• Few countries tried to implement comprehensive PHC; with few successes, including in…..
  – Costa Rica, Cuba, Kerala State (India), Sri Lanka, China
  – For a short time, Nicaragua, Mozambique
• But for most countries….  
  – Strong, sustained political will was lacking for implementation at local levels
  – Changing political context reinforced conservative attitudes of health professionals that PHC….
    • Promoted non-scientific solutions
    • Demanded too many sacrifices
    • Was second class medicine
INCREASING CRITICISM
ONE YEAR POST ALMA ATA

• Alma-Ata PHC was considered too broad, idealistic, and unrealistic
• Rockefeller Foundation meeting 1979
  – Examined status of health and population programs
  – Expressed concern about decreased interest in population control
• Walsh & Warren; “Selective PHC: An Interim Strategy for Disease Control in Developing Countries” (NEJM, 301, 1979, 967-974)
  – Authors agreed with concepts, yet recommended pursuing selective PHC targets, especially related to mothers and children, due to inadequate funding for comprehensive programs
ADJUSTING THE ALMA ATA IDEALS

THE MOVE TO

SELECTIVE PRIMARY HEALTH CARE
THE SHIFT TO “SELECTIVE PHC” (1978-1990s)

- Most countries shifted to “selective PHC”
  - UNICEF (James Grant) an early ‘adopter’ and promoter
  - Easier to train, deploy and manage staff
  - Quicker to obtain and quantify results
  - Lower program costs
  - Easier to justify and obtain donor funds
  - Measurable outputs, prompt results, technological solutions, easier accountability, and time-limited support
SELECTIVE PRIMARY HEALTH CARE

• Major programs (GOBI)
  – Growth monitoring
  – Oral rehydration therapy (ORH)
  – Breastfeeding
  – Immunization (and Expanded Program of Immunization-EPI)

• Added later (FFF)
  – Family planning
  – Female education
  – Food supplementation

• Resultant casualties
  – Social equity
  – Health systems development
SELECTIVE PRIMARY HEALTH CARE: THE RESULTS

• Some important accomplishments
  – 80% of children vaccinated for 5 common diseases (DPT, polio, measles)
  – 1980-93
    • Infant mortality reduced by 25%
    • Life expectancy increased by at least 4 years
  – 1985-93
    • Children under 5 dying of vaccine preventable diseases reduced by 1.3 M deaths/year
    • Yet these diseases still cause 2.4 M deaths/year
SELECTIVE PHC
THE VERDICT

• Renewed *comprehensive vs. selective PHC* debate
  – Key question: Should *selective* PHC be continued?

• Opposing views….
  – Comprehensive PHC has failed - *vs- PHC was never really tried*
  – Oral rehydration (ORH) is cost-effective - *vs- ORH is a “band aid”, delaying provision of safe water*
  – Comprehensive PHC is too expensive - *vs- Who covers costs after donors stop paying bills?*
SELECTIVE PHC
THE VERDICT

• 2003 UNDP Report* conclusions
  – International assistance is failing its major objectives
  – Assistance strategies need to be reexamined and revised
  – 54 countries are poorer now than in 1990
  – 34 countries have a lower life expectancy (due primarily to HIV/AIDS)


Despite significant progress in some areas, there remains persistent inequitable access to primary health care services particularly for low income and rural populations. Additionally, many health systems are inadequately organized, inadequately funded, and understaffed with insufficient human resources.
SELECTIVE PHC
THE VERDICT

• Selective PHC has multiple shortcomings
  – Low or no community participation
    • Essential to drive change & maximize relevance
  – Donor-driven, technocratic approach
    • Outside experts, emphasis on prompt, measurable results
  – Preserves status quo with little impact on equity
  – Little coordination between vertical programs
  – Until recently, emphasis was primarily on women and children
THE FUTURE OF
PRIMARY HEALTH CARE

LESSONS LEARNED

MOVING FORWARD
LESSONS FROM PHC STUDIES FOR GLOBAL HEALTH POLICY

• Outcomes improve when various sectors work together:
  – Health, housing, agriculture, education, sanitation, food distribution, transportation, etc.

• Interventions are more effective when based on community needs & participation, implying need for…
  – Distribution of services according to population location
  – Network of facilities with functional linkages
  – Decentralized control and local participation
  – Integrated preventive and curative services
LESSONS FROM PHC FOR GLOBAL HEALTH POLICY

• Difficult to achieve full PHC potential without supporting health system infrastructure:
  – Capable and adequate workforce
  – Facilities, supplies, equipment, drugs
  – Sustainable system, not overly dependent on foreign resources and expertise
  – Vertical programs are vulnerable to shifts in external funding priorities

• Impossible to achieve full PHC potential without significant involvement of the community as a partner
REVITALIZING ALMA ATA GOALS

• Must develop concrete strategies and processes:
  – Clear targets, more equitable allocation of resources, balance between horizontal and vertical programs

• Should lobby for more equitable social policies:
  – Labor policies, education (especially of girls)

• Create intersectoral forums and partnerships:
  – Opportunities for different sectors (health, agriculture, education, transportation, energy, etc.) to meet and develop common goals, strategies, programs
REVITALIZING ALMA ATA GOALS

• Obtain sustained funding commitments:
  – Private sector involvement; community participation
• Strengthen the human resources (HR) at all levels:
  – Good HR plans at all levels; better PHC training, supervision, management & remuneration
• Focus on long-term social interventions:
  – Shift from vertical short-term measures to revitalization of PHC goals for poverty alleviation and community participation
• Develop true partnerships with communities
Primary Care (in the industrialized world):

Refers to the entry point into the health system and place for continuity of care for most people, most of the time, provided through access to primary care health professionals. The common concept of primary health care in most industrialized countries is:

“Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.” Source: US Institute of Medicine, 1996

Primary care, as compared to primary health care, is a term more often used in high income countries to refer to the entry point to health services. There is overlap between the functions of primary care and primary health care. In this context, primary care does not usually include comprehensive, community based preventive services or functions such as provision of clean water that are usually provided by sectors outside of the formal health system.
Primary Care and Health Outcomes

- Study by Macinko, Starfield and Shi

- Study assessed primary care in 18 OECD (rich) countries

- It measured essential primary care features:
  - Geographic regulation and access
  - Longitudinality (health system performance over time)
  - Coordination between different facilities
  - Community orientation
Study found that the greater the strength of Primary Care, the less the rates of......

- All cause mortality
- All cause premature mortality
- Cause-specific premature mortality from:
  - Asthma, bronchitis, emphysema
  - Pneumonia
  - Stroke and cardiovascular disease
  - Heart disease
- The study controlled for macro factors (GDP, physicians, % elderly) and micro factors (income, smoking, alcohol, visits)

(Macinko, Starfield and Shi, 2003)
## Primary Health Care vs. Primary Care

<table>
<thead>
<tr>
<th>Primary Health Care</th>
<th>Primary Care</th>
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<tbody>
<tr>
<td>• Promoted by WHO with special focus on low resource countries</td>
<td>• Common concept in industrialized countries</td>
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<tr>
<td>• Level and philosophy of care</td>
<td>• Focuses on level of care</td>
</tr>
<tr>
<td>• Based on principles of social justice and equity</td>
<td>• Is first point of access</td>
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<tr>
<td>• Requires community participation and political support</td>
<td>• Personalized, with continuity of services</td>
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<td></td>
<td>• Provided by health professionals</td>
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<tr>
<td>Approach</td>
<td>Primary Health Care definition or concept</td>
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<td>Selective PHC</td>
<td>Focuses a limited number of high–impact services to address some of the most prevalent health challenges in developing countries. Main services came to be known as GOBI (growth monitoring, oral rehydration techniques, breast-feeding, and immunization) and sometimes included food supplementation, female literacy, and family planning (GOBI–FFF).</td>
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<tr>
<td>Primary care</td>
<td>Refers to the entry point into the health system and the place for continuing health care for most people, most of the time. This is the most common concept of primary health care in Europe and other industrialized countries. Within its most narrow definition, the approach is directly related to the availability of practicing physicians with specialization in general practice or family medicine.</td>
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<td>Alma Ata “comprehensive PHC”</td>
<td>The Alma Ata Declaration defines PHC as “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…It forms an integral part of the country’s health system…and of the social and economic development of the community. It is the first level of contact of individuals, the family and community …bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.”</td>
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<td>Health and Human Rights approach</td>
<td>Stresses understanding health as a human right and the necessity of tackling the broader social and political determinants of health. It differs in its emphasis on the social and policy implications of the Alma Ata declaration more than on the principles themselves. It advocates that the social and political focus of PHC has lagged behind disease–specific aspects and that development policies should be more “inclusive, dynamic, transparent and supported by legislation and financial commitments”, if they are to achieve equitable health improvements.</td>
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Source: categories adapted from

Renewing Primary Health Care in the Americas; PAHO 2007
Prerequisites for a Health Care System that promotes Health for All

- Takes into account micro and macroeconomic factors
- Provides human, physical and financial resources
- Has information to assess and improve health system performance
- Provides for leadership and policies to ensure access, relevance, cost effective and quality services
- Primary health care serves as the hub, coordinated with other levels of the health care system
Global Governance: Toward a Framework Convention on Global Health*

- **Build capacity**: so all countries have enduring and effective health systems
- **Set priorities**: so that international assistance is directed to meeting basic needs
- **Engage stakeholders**: so that a variety of actors can bring their resources and expertise
- **Coordinate activities**: so that programs are harmonized
- **Evaluate and monitor progress**: so that goals are met and promises kept

* Lawrence Gostin, A proposal for a framework convention on global health; *Journal of International Economic Law*; Vol 10; No 4; 2007
UN MILLENNIUM DEVELOPMENT GOALS
MDGs to be achieved by 2015

1: Eradicate extreme poverty & hunger
2: Achieve universal primary education
3: Promote gender equality and empower women
4: Reduce under 5 year mortality rate by 2/3
5: Reduce maternal mortality ratio by 3/4
6: Combat HIV/AIDS, malaria & other diseases
7: Ensure environmental sustainability
8: Develop a global partnership for development
PHC and Millennium Development Goals

Provision of comprehensive PHC would directly address the MDGs in red, and indirectly address all MDGs:

1: Eradicate extreme poverty & hunger
2: Achieve universal primary education
3: Promote gender equality and empower women
4: Reduce child mortality
5: Improve maternal health
6: Combat HIV/AIDS, malaria & other diseases
7: Ensure environmental sustainability
8: Develop a global partnership for development
World Health Report 2008
Primary Health Care: Now More Than Ever
Some key findings.....

• Unequal progress in health outcomes
• The changing nature of health problems
• The rapid pace of change and transformation that is an essential part of today’s globalization
• Vulnerability of the health systems
• See module by Dr. John Bryant for more information on the World Health Report

On the whole, people are healthier, wealthier and live longer today than 30 years ago. However, progress has been uneven. The WHO report 2008, issued on the 30th anniversary of the Declaration of Alma Ata, reviews progress and future challenges to achieve universal PHC.
Reforms needed to change PHC

Figure 1 The PHC reforms necessary to refocus health systems towards health for all

- **UNIVERSAL COVERAGE REFORMS**
  - to improve health equity

- **SERVICE DELIVERY REFORMS**
  - to make health systems people-centred

- **LEADERSHIP REFORMS**
  - to make health authorities more reliable

- **PUBLIC POLICY REFORMS**
  - to promote and protect the health of communities

Word Health Report 2008; page xvi.
Pentagon illustrates importance of collaboration across sectors to provide comprehensive health services. -- Charles Boelen, Towards Unity for Health; WHO 2002
Let us continue to strive for a more equitable world where there are equal opportunities to achieve health for all.
References


Gostin L, A proposal for a framework convention on global health; *Journal of International Economic Law*, Vol 10; No 4; 2007


References (continued)


Walsh & Warren; Selective PHC: An Interim Strategy for Disease Control in Developing Countries *NEJM*, 301, 1979, 967-974


Questions to test your understanding

• Describe key components of PHC as described in the Declaration of Alma Ata
• What are the differences between comprehensive and selective PHC?
• Describe the differences between PHC and primary care.
• How does PHC relate to the Millennium Development Goals?
• What is needed to provide comprehensive PHC for a population?
• What strategies might be used to strengthen PHC in your home site?
Summary

• PHC is a key foundation of effective health systems
• PHC concepts have evolved over many decades and tend to differ between industrialized and developing countries
• Despite evidence documenting the benefits, few countries have achieved universal access to PHC services.
• Comprehensive PHC services would address many of the millennium development goals.
• Provision of PHC requires political will, intersectoral collaboration, sufficient human, physical and financial resources, and community participation.
Credits

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• David Thompson, Professor of Pediatrics, University of Minnesota
• John Bryant, Professor and Chair Emeritus, Aga Khan University
End of module

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