Why Does Primary Health Care Matter in the Twenty-First Century?

David Bishai

The World’s First Global Health Crisis

For the citizens of medieval Caffa on the Crimean Peninsula, 1346 was a very bad year. Generations of Genoese and Venetian traders had managed to prosper in this Italian enclave, trading the bounty of central Asia through the Black Sea and into the Mediterranean. However, 1346 brought siege at the hands of the Mongol Army. The great Mongol khan, Jani Beg, smelled fortune beyond the walls of Caffa and wanted in. The siege was dragging on, so the warriors turned to terror. A rain of bloated black corpses of fallen Mongol comrades was catapulted over the walls and into the city (Wheelis 2002).

Unbeknownst to all, another invader was launching conquest under Jani Beg’s feet. Plague bacteria (Yersinia pestis) had overgrown and blocked the guts of the fleas living on the rats and men in the Mongol camp. Desperate constipated fleas began a cycle of frenzied biting and vomiting into the wounds they inflicted on both rats and men. The army of the Golden Horde was melting away, and the khan could tell the siege would have to end. Black plague overtook Caffa and devastated Europe, carried by rats and fleas and men in Genoese ships. The world population fell from 440 million to 350 million by 1400 (US Census Bureau 2013).

Black plague was the first documented global health catastrophe.* There were no global conferences, no blue-ribbon scientific committees. Collective

*The human genome bears a record of a genetic bottleneck around twenty thousand years ago, suggesting that the world’s Homo sapiens population was reduced to about one hundred people in Africa. This near-miss extinction would have been a global health event, too.
action in the face of the oncoming plague was futile given the world’s state of knowledge. The hopelessness is crystalized in Giovanni Boccaccio’s *The Decameron*, set in Florence in 1348. In this frame story, the principals agree that death will find them no matter what, so the best thing to do with a lethal pandemic is to hole up in a villa telling one another tall tales.

Much has changed in global health. Now, there are things that can be done. There has been success, and there has been variation in success. There are good practices and bad practices to learn from. There are nonfiction stories to tell about what cities, districts, states, and countries do in health policy and implementation of programs. These stories are a matter of life and death.

This book examines the lessons that countries drew from the Alma-Ata Conference of 1978, the first global conference to focus on primary health care. This conference articulated a vision of comprehensive primary health care (PHC) that still matters deeply for the health of populations in every community in the world. Comprehensive PHC encompasses both whole population activities and services that reach one person at a time. Whole populations need PHC to improve the safety of air, food, water, roads, homes, and workplaces. Individuals need services to deliver health care at a primary medical care visit or when they open their door to a community health worker. The Alma-Ata Declaration described how comprehensive PHC could be established as a multi-stakeholder partnership among citizens, their government, civil society, and the private sector.

Many retrospective discussions of the conference take a wistful tone, depicting it as a moment of unfounded optimism as though the principles announced in the Alma-Ata Declaration were only aspirational and not practical. It is true that the full agenda set out by conference delegates in 1978 never became mainstream practice by a majority of the world’s health systems. However, some health systems did succeed in making the principles of the Alma-Ata Declaration a reality. Moreover, many of the countries where this happened—Bangladesh, Cuba, Nepal, Ghana, and others flagged in chapter 2—turned out to make better than average progress in gaining life expectancy given their economic growth. How they did that matters, and these details are the main point of this book.

Reading a success story can inspire only if there is a sense that the success was neither inevitable nor impossibly accidental. The success stories related in this book occurred in countries that faced substantial obstacles to better health, including wars, revolutions, challenging topography, and poverty. Success was never inevitable. Each success story carries many contextual differ-
ences, but the common theme is that they adhered more or less to the principles of comprehensive PHC. This chapter introduces a theme that will recur throughout the book: that the principles of comprehensive PHC announced in the Alma-Ata Declaration remain relevant everywhere and that every community can open a pathway to similar success.

The World’s First Global Health Conference: A Miraculous Consensus

From September 6 to September 12, 1978, delegates from 134 countries and representatives from 67 nongovernmental organizations, agencies, and United Nations (UN) organizations gathered in the city of Alma-Ata at the invitation of the USSR under the aegis of the World Health Organization (WHO) and United Nations International Children’s Emergency Fund (UNICEF). The purpose of the conference was to exchange experience about something called primary health care. The delegates gathered to define PHC, to promote it, and to learn how governments, NGOs, and UN agencies could cooperate and support PHC. The Alma-Ata Conference led to an important consensus about what could be done to make populations healthy (Newell 1975; Litsios 2002).

Getting 134 countries to agree on anything during the height of the Cold War was a miracle. A large part of the miracle was allowing the term primary health care, or PHC, to remain loosely defined. Some thought PHC was a code word for social justice, while others thought it referred to the organization of clinical services (Litsios 2008). Planners used a working definition of PHC as the combination of basic health services plus community participation plus intersectoral engagement, and that definition offered something for everyone.

Parallel camps on either side of the Cold War spent the early 1970s with convergent dissatisfaction about the vertical approach to single diseases that dominated US agencies and the WHO since the 1950s. A big push from the United States to eradicate malaria had failed, and leading Western voices in global health had to concede as much (Litsios 2002). A 1973 WHO report saw the failure to eradicate malaria as symptomatic of “widespread dissatisfaction of populations about their health services.” Failures included a lack of citizen inclusion, a feeling of helplessness on the part of citizens, and widening health disparities (Newell 1988). Physician groups began dominating health budgets in low-income countries to construct expensive hospitals and to pay for drugs that served the more well-off and not the poor. In the words of Jack Bryant, writing in 1969: “Large numbers of the world’s people,
perhaps more than half, have no access to health care at all, and for many of the rest, the care they receive does not answer the problems they have. . . . The most serious needs cannot be met by teams with spray guns and vaccinating syringes” (Bryant 1969, ix–x). The Christian Medical Commission helped feed both UNICEF and WHO case studies of successful bottom-up approaches from China, Cuba, Tanzania, Bangladesh, Iran, and the Jamkhed project in India. American public health leaders Ruth and Victor Sidel described amazing progress by the barefoot doctors of China (Newell 1975). Carl Taylor described community participatory approaches in India (Cueto 2004). These success stories were disseminated and influential throughout UNICEF, the WHO, and regional offices (Djukanovic and Mach 1975; Newell 1975). Soviet representatives of the WHO saw an opening to make political gains inside the UN in the wake of Western failure and campaigned to sponsor an international conference hosted on Soviet soil to discuss the concept of PHC. It could not have escaped the Soviets’ notice that many of the best practices promoted by the WHO, UNICEF, and Western scholars were from either Communist-orbit or nonaligned countries.

Given years of planning and skillful diplomacy by the WHO, the Alma-Ata Conference managed to avoid explicit political confrontation between Western and Soviet ideology. However, Chinese–Soviet tensions in the 1970s led to China not attending the conference (Cueto 2004). US Senator Ted Kennedy gave a keynote address. Leonid Brezhnev sent welcoming remarks read by a member of the Presidium of the Supreme Soviet. But overt Cold War politics did not get in the way of consensus. The text of the Alma-Ata Declaration had been previewed by delegates and was adopted by acclamation on September 12, 1978. Dr. Marcella Davies of Sierra Leone came to the podium to read the text aloud to the hall of three thousand in one of the most uplifting and sublime moments of unity of the twentieth century.

Prior to the Alma-Ata Conference of 1978, there had been countless international scientific conferences for extensive international sharing of biomedical and public health knowledge. The Alma-Ata Conference was different because it focused on the application of that knowledge into collective human action. The conference was not about one disease or one disease determinant. What was global at the Alma-Ata Conference was a recognition of an approach to tackling the root causes of ill health that could be universalized, in any place, at any time.

The conference brought together medical scientists, heads of national health ministries, and policymakers. Most remarkably, the participants achieved consensus around seven simple principles in the declaration that dis-
till truths about what makes people healthy and that delegates acclaimed to be relevant everywhere and for all health threats.

Like most historical documents, it used words from its era that have shifted in their meaning. At the time, the term primary health care meant different things to different parties, but most understood the emphasis on primary as referring to the first thing to do about the health of people. Today, because primary care doctor has gotten such wide usage, a modern reader might mistakenly think that the emphasis on the words primary health care is about care and expect that the term represents what individual care professionals provide in their clinics when caring for the sick. The Alma-Ata Declaration is anything but a manifesto about the primacy of the clinic. The Alma-Ata Declaration is partly about care, but it is mostly about primary. It is also first about health—promoting, supporting, and empowering communities to improve health—rather than treating disease. To try to avoid the pitfalls about where to put emphasis in the terminology, throughout the book we refer to the topic of the declaration as “PHC.” The most actionable and specific definition of PHC is contained in Article VII of the 1978 declaration.

The Alma-Ata Declaration defines PHC as having seven principles (figure I.1). The first principle notes that PHC evolves from economic and sociocultural and political circumstances so that its research base includes social science and biomedicine. Second, PHC must address the health concerns of a time and place, emphasize creating conditions that prevent disease, and address curative and rehabilitative services. Third, PHC must do things for whole populations at a time, such as community health education, safe water, a safe food supply, sanitation, and so on. Fourth, this population response is bigger than the health sector and must include agriculture, housing, public works, and communications, and all these relevant sectors need to coordinate. Fifth, communities and individuals must take part in planning, organizing, and controlling PHC so that they draw in both the nation’s and their own resources in making their places healthier. Sixth, PHC must be inclusive and comprehensive, giving priority to those most in need. Seventh, PHC must include multiple cadres of health workers—physicians, nurses, midwives, community health workers, and traditional practitioners—who work as a team and respond to the expressed needs of their community.

Reading the Alma-Ata principles makes it clear that in 1978, there was a lot of attention on the social determination of disease. For some biomedical specialists, invoking social determinants is the cue to exit the stage. If it cannot be fixed with a drug or surgery, it is anathema to some members of the
medical community. However, for the participants at Alma-Ata, the announcement that disease was socially determined was the opening curtain. The preparatory studies commissioned by the WHO and UNICEF on health progress in countries such as China, Cuba, Jamkhed in India, and Central Java in Indonesia had shown dramatic transformation in social determinants of disease that did not rely on the slow march of economic growth (Djukanovic and Mach 1975; Newell 1975). Participants announced with confidence that coordinated actions by groups of people could address social determinants and recruit community members in cooperation to make their communities healthier. To paraphrase Carl Taylor, the Alma-Ata Declaration did not offer a global solution to all health problems, but it offered a global approach to finding local solutions (Taylor and Taylor-Ide 2002). These local approaches are complementary and foundational to successful implementation of the big vertical approaches that seem to dominate global health.

Figure I.1. The seven principles of primary health care listed in Article VII of the Alma-Ata Declaration.

6 Achieving Health for All
today. Attention to PHC bridges the chasm between global paradigms, policies, and politics, and their realization in a place.

Diverging Pathways since 1978

There are parallel and diverging histories of what happened after the Alma-Ata Conference. Like most events of the Cold War, versions vary between Westerners and the Global South. Figure I.2 shows a timeline of key events since the Alma-Ata Conference.

The Western Aid Agency Version of Global Health since Alma-Ata

In the West, the dominant narrative is that economic constraints derailed the PHC agenda (see chapter 1 for details). For those who chose to interpret PHC as a project of constructing networks of health care delivery facilities to offer “primary clinical care,” the PHC agenda would put massive demands on limited public sector funds. Many of the poorest countries, especially in Africa, went through the 1980s with badly managed budget deficits that were countered and compounded by structural adjustment policies of the World Bank and the International Monetary Fund (Lawn et al. 2008). The landmark paper by Julia Walsh and Kenneth Warren (1979) outlines a purportedly more economical approach of selective health interventions that emphasized a small set of high-impact packages such as oral rehydration, vaccination, and promotion of breastfeeding. The Ford and Rockefeller Foundations sponsored
a conference in Bellagio, Italy, in April 1979, where the Walsh and Warren approach was the centerpiece of discussions attended by Robert McNamara of the World Bank; James Grant, who went on to direct UNICEF; and John Gillian of USAID (Rockefeller Foundation 1979). These leaders of Western aid agencies rallied around a selective interventions agenda. In the autumn of 1982, Grant and UNICEF launched the Child Survival Revolution to promote GOBI-FFF, which stood for growth monitoring, oral rehydration, breastfeeding promotion, immunizations, family planning, female education, and food supplements. UNICEF raised funds from both the World Bank and the Rockefeller Foundation (Packard 2017). The selective interventions era entered a continuing heyday that was reaffirmed in 1993 with the publication of the World Bank’s *World Development Report: Investing in Health*. The report introduced economic methods to rationalize investments in selective interventions on the grounds of dollars spent per health outcome gained.

A generation of Western-trained health economists was then put to work buttressing an approach to global health policy-making that emphasized the primacy of discrete, specific, and tangible interventions as the pathway to achieving good health at a low cost. The work of health policy has devolved into rational selection of a portfolio of the most cost-effective interventions to minimize the burden of disease within a given health sector budget. Persisting today, many textbooks and curricula in global health treat the topic of global health as a cavalcade of interventions. Students of global health often build careers around specializing in a disease area or in an intervention area. Advocates press for more priority and funds for their specific disease silo. It is still challenging for public health students and professionals to learn practical skills in population health promotion, community organizing, convening, and building coalitions and partnerships, even though this is what a career in PHC would require.

The Alma-Ata Declaration’s version of PHC put the emphasis on community capability to plan and respond to local disease burden. Needing to include the community was the key lesson learned (and apparently forgotten) in the wake of the failure of malaria eradication (Newell 1988). In contrast, the selective interventionists put the emphasis on interventions and belatedly recognized that interventions occur in the context of health systems and with influence from a wide array of social factors. Cries for “greater health system strengthening” emanated from all corners whenever the interventionists ran into bottlenecks from a lack of coordination or community buy-in. The WHO’s Alliance for Health Policy and Systems Research was founded in 1997 and has been instrumental in developing a professional society called
Health Systems Global to coordinate scholarship on health systems. Many of the participants in this community still see health systems strength as a means to an end—the end being delivering the list of interventions. Chapter 4 offers details on how the Global Polio Eradication Initiative has realized the necessity of stronger health systems to achieve its single goal. Chapter 5 shows how PHC aligns well with the realization of Sustainable Development Goals (SDGs). Few continue the rallying cry of the Alma-Ata Declaration’s vision that communities that had good PHC would be resilient solvers of whatever health issues came their way and that they would initiate solutions to their problems that address root causes far beyond the scope of typical interventions.

The foreign aid to support interventions has not necessarily been bad or harmful. These interventions have saved millions of lives, and it is hard to make the case that the alternative course of history might have been Western investments in PHC and the strength of multisectoral, community-engaged, bottom-up health systems. Western aid agencies have embraced three-to-five-year project cycles and the need to measure activities for external accountability. Distributing health commodities such as bed nets, HIV drugs, vaccines, and family planning supplies is eminently countable, unlike improving multisectoral community engagement. Because of their remit, aid agencies might not be well configured to be the doers or enablers of PHC.

Although Western aid agencies might be forgiven for not taking on a direct role in PHC themselves, their interventionist work plan has constrained the way much of the world thinks and speaks about global health. Westerners make an outsize contribution to international scholarship, writing, speaking, and thinking about global health. Graduate students who come for advanced training in global health in Western institutions receive the Western interventionist paradigm and transmit it back to institutions of higher learning in Africa, Asia, and Latin America. The domination of discourse has kept much more of the spotlight on selective interventions as opposed to PHC.

Ultimately, the design of the Millennium Development Goals (MDGs) cemented the primacy of the Western focus on interventions and achieved a new global consensus around a restrictive definition of development that was measured as outcomes and not as capabilities to achieve outcomes (Pritchett and Kenny 2013). The MDGs included two health goals to lower under-5 mortality and maternal mortality that interlocked well with a mechanistic focus on siloed interventions (UN Millennium Project 2005). At the Millennium Summit in 2000, all 191 UN member nations pledged toward eight
goals including goals to reduce under-five mortality by two-thirds and to reduce the maternal mortality ratio by 75%. A group of epidemiologists produced a model called the Lives Saved Tool (LiST), designed to predict how many children’s lives would be saved by investing in each of more than a dozen interventions (Fox et al. 2011). As the pendulum swung to the extreme of mechanistic global health policy-making, a preventable child death was no longer seen as the outcome of social conditions but as the absence of specific interventions (Black et al. 2003; Jones, Steketee, et al. 2003). It did not matter who financed them or organized them, or how the interventions were implemented—success toward MDGs could occur if the interventions marched forward. Critics noted how the MDG paradigm was self-serving for the industry of foreign assistance (Easterly 2009; Donini 2012). An NGO could point out how a low-income country’s health statistics were not on track to reach the MDGs and justify an allotment of foreign aid to parachute in an intervention whose costs were duly estimated (Bryce et al. 2005).

Views on Global Health from the Global South

Annual health spending in 2015 amounted to $9 trillion, of which $833 billion was spent by low- and middle-income countries (Bishai and Cardona 2017) (figure I.3). Despite their domination of discourse about health spending in low- and middle-income countries, Western donors only contributed $46 billion, which is less than 6% of spending. In contrast, citizens’ out-of-pocket and tax-based spending represents most health spending in low- and middle-income countries.

In the wake of the Alma-Ata Conference of 1978, several countries stuck to, or returned to, the original seven principles of PHC. Countries like Sri Lanka, Nepal, Vietnam, Bangladesh, Ethiopia, and Cuba are now some of the leading success stories in achieving good health at a low cost. They embraced and implemented selective interventions, too. The two approaches need not be in conflict. Good PHC makes interventions work better and helps sustain them.

In bringing these success stories to light, this book decidedly focuses on whole country stories. This is not meant to say that PHC is solely the job of national ministries of health or that national scale is always desirable and practical. PHC can involve both the national and subnational levels. However, national-level health policymakers can set up incentives, institutions, and career pathways that make subnational units much more likely to get PHC to succeed. The opposite has occurred in many countries not featured
in this book. In most countries, ministries of health divide into administrative units based on the interventions they will carry out. The districts divide themselves as well. It is typical to see divisions for immunizations, TB, HIV, maternal and child health, noncommunicable disease control, laboratories, and the like, with limited ability, incentive, or interest in collaborating and operating as a system. Moreover, many countries experience a “patchwork” array of NGOs, government programs, other externally funded initiatives, and community-led activities that are uncoordinated and create chaos, inefficiency, and subpar outcomes. An emerging best practice (described in chapter 3) to align actors and activities is the creation of crosscutting units of public health practice quality. These units help all the vertical programs attune to how their work can improve the conduct of community-engaged, multisectoral, population-level PHC both at the national and subnational levels.

Inside any community, the pressing suffering of those already sick will force policy concern to get them cures and clinical care. The world will not make progress by reducing our attention to taking care of sick people or reducing our international collaborations for standard interventions in global health. Instead, we need to add back more emphasis on the PHC practices

*Figure I.3. Aggregate health spending. High-income countries are those with a gross domestic product (GDP) per capita > 12,000 $US, and low-middle-income countries are those with a GDP per capita < 12,000 $US. Source: Bishai 2017*
outlined in the 1978 Alma-Ata Declaration and reemphasized in the 2018 Astana Declaration. What can we learn from countries who built their health systems around comprehensive PHC? What do they know about getting people to make it their job to ask if the community's whole health system is working? We must rediscover and recommit to the best practices that have served these countries in making their communities take ownership of their health. For Western donors, PHC has been the ugly stepchild and never the darling of any external donor with a three-year project cycle. However, for countries, community participation in understanding root contributors to ill health and ways to address their priorities using all available resources across all relevant sectors is the best pathway to make sustained progress.

The Continuing Relevance of PHC

There are five factors that ensure the continuing relevance of PHC.

1. The long-term trend is for less and less reliance on foreign aid for health. As we saw in figure I.3, foreign assistance is miniscule in comparison to domestic spending for health. Over time, flows of development aid will be decreasing and not increasing. Economic growth is enabling middle-income countries to graduate out of needing aid. The agencies responsible for targeted interventions like GAVI, the Vaccine Alliance, have explicit criteria for countries to graduate off assistance and to develop exit strategies where financing for the interventions is maintained. With the decline of Western spending on global health will come the replacement of Western domination of the global health paradigm by voices from the Global South.

2. The epidemiological transition to noncommunicable disease makes PHC more relevant. While it is tempting to think of a selective interventions approach to noncommunicable diseases (NCDs), this approach cannot scale. The risk factors for conditions such as car crash injuries, cancer, heart disease, diabetes, violence, obesity, and so forth do not lend themselves to the distribution of commodities. Approaches to address these risk factors cross sectors and include transportation, food, law enforcement, housing, and social order. Sustaining solutions needs long-term political battles to legislate new regulations and new efforts in enforcement. It requires new ways of cooperating with neighbors to sustain norms of healthier behavior. This is the strength of PHC approaches.

3. The threat of global pandemics makes PHC essential. Among the many lessons learned from the recent outbreaks of the Ebola and Zika viruses was the weaknesses of local-level public health operations. These weaknesses in-
cluded not only delayed detection of the outbreaks but a lack of community trust in the public health officials who labored to enact control measures among the susceptible population. In countries that undertake PHC, there is a commitment to build ongoing relationships between public health professionals and the community. Building trust takes time. The investment pays off by improving outbreak detection and speeding up the enactment of control measures.

4. The upward trend in universal health coverage requires PHC. As people’s incomes grow, the proportion of people covered by health insurance grows. This happens because workers get jobs in the formal sector, where it is easier to offer health insurance. It also occurs because economic growth leads to more ability to demand and pay the taxes or premiums needed for health insurance. Governments will predictably undertake more insurance regulation, and they will offer more governmental health insurance. The growth of health insurance can lead to the inclusion of community concerns in the types of covered services. The interests of insurers become aligned with the methods of PHC in making communities more engaged in population-level health promotion and prevention.

5. PHC is aligned with SDGs. In 2015, the UN General Assembly agreed on a new set of seventeen global goals to replace the MDGs. These seventeen goals are inherently more multisectoral, and their achievement requires communities that are committed to social justice and have their own capability to achieve it. These new goals range from a commitment to “no poverty” to a commitment to creating “sustainable communities” to a goal to commit to use “partnerships for the goals.” The bottom-up pathways to achieving these goals make PHC more relevant than ever. (See chapter 5 for more.)

Summary

This book is divided into two parts. Part I discusses the legacy of Alma-Ata and offers both a narrative history (chapter 1) and a quantitative examination of global health trends (chapter 2). Practical tools to implement PHC are covered in chapters 3 and 6 using supervisory coaching to help health workers practice public health or engage community members as partners. The relevance of PHC to prevailing priorities in vertical disease control is the topic of chapter 4, and the relevance of PHC to the SDGs is covered in chapter 5.

Part II has assembled country case studies of PHC implementation at the national level since the Alma-Ata Declaration of 1978. Each chapter takes a national perspective to describe how PHC was integrated into the health
system. Each country faced slightly different political and cultural constraints, and each took a slightly different path. It turned out that many of the countries that adopted PHC did so in the shadow of civil war. Examples are Bangladesh, Nepal, Sri Lanka, and Vietnam. Obviously, there is no law of history that declares that the victors of a civil war will focus on health and basic needs, but our cases show that this is not exceptional.

The roots of the PHC approach described in 1978 appealed to both Western and Communist bloc countries because of dismay about the slow pace of progress in malaria eradication in the 1950s and 1960s. The PHC approach offered a bit of something for everyone, but comprehensive PHC insisted on a population-level, community-controlled, multisectoral approach as well as evidence-based, basic health care carried out by doctors, nurses, community health workers, and others.

At the Astana Conference of 2018, there was a widespread recognition that ongoing trends will make PHC more relevant than ever. The SDGs, the future scaling down of foreign aid, and the transition to more and more non-communicable health problems and pandemics requiring multisectoral efforts to address social causes are important reasons to pay attention to success stories in PHC.

This book can help readers get ready for the future by learning lessons from the success stories of countries that have made the most progress in attaining health for all.

REFERENCES


This page intentionally left blank