Primary Health Care Now

SETTING THE SCENE

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Primary Health Care today

• Primary Health Care a few years ago:
  – low on international policy and research agendas
  – Alma Ata: “an obscure conference on Primary Health Care” (Science 24/2/2006 311: 1098)
  – 25 years of Alma Ata went almost unnoticed

• 2008: a new momentum for PHC?
  – A year of celebration and statements on the relevance of primary health care for today
Three recent reports
ITM’s involvement in the turmoil of pre-Alma Ata ideas

- P. Mercenier & H. Van Balen: experience in Central Africa and India
- Congo: Kasongo project (1971) ~ field experiment of (what would later be called) a district health system based on PHC
- Belgium: Groupe d’Etude pour une Réforme de la Médecine (GERM) published a pamphlet in 1971: health care organisation should contribute to the global emancipation of human beings
- Later diversification of field experiences in Senegal, Zimbabwe, Thailand, Bolivia, Ecuador, etc…
- PHC: the backbone of research and training on health systems
PHC based on changing ideas and innovative practice

- **Practice**: field experiences all over the world (1960’s)
- **Evolution of ideas**: decreasing faith in science and technology / increasing demands for participation
  - Scientific advancement does not reach those in need: health inequalities
  - Fears of dehumanisation of care, undue medicalisation, iatrogenesis resulting from biomedically inspired views on health
  - Main actors of improved health care: not only experts, also people and communities
The spirit of Alma Ata

Social values underlying AA Declaration:

• Health as a fundamental **human right**
• **Social justice** and **dignity** for all people
• **Participation** as a right and an obligation
• **Self reliance** and **self determination**
• **Social responsibility**
• A spirit of **partnership and service**
• **Solidarity** and **voluntary work**
No rejection of science and medicine
But PHC is more than just medicine

• Scientific evidence necessary to improve health (rationalisation)
• But communities and individuals are entitled to decide whether benefits from health interventions outweigh social costs (participation)
• PHC: tension between rationalisation and participation
• Implications for health services:
  – Health workers need to be suitably trained technically AND socially
  – Partnership relations between health workers and people rather than authoritarian or paternalistic relations
• The health sector alone will not achieve improved health and health equity
• Need for **multisectoral collaboration**
• Need for **political commitment**:  
  – Nationally: central role of the (Welfare) State  
  – Internationally:  
    • Call for a New International Economic Order  
    • Call for world peace and reorienting resources spent on military conflicts to foster social and economic development and equity
What is left?

Some of the spirit of AA seems to have gotten lost

- Increased interest for health systems (health systems research)
- Improved rational decision making: evidence based guidelines, systematic evaluation as part of managerial practice…
- Increased knowledge on social determinants of health: powerlessness makes ill
- BUT
  - The sociopolitical dimension was neglected
  - Qualified workers were often left aside
  - Social justice did not become a priority
The socio-political dimension of PHC was neglected

- Dominantly **technocratic** approaches
- **Selective PHC**: emphasis on effectiveness and efficiency as defined by experts, at the expense of responsiveness to people’s aspirations
- Global Initiatives targeting priority diseases; concern for adverse effects of **verticalism** on health systems and search for positive synergies
- Risks +++ of leaving people out of decision mechanisms:
  - Participation ~ obligation of compliance with expert advice
  - Patients and communities ~ passive recipients of interventions
  - Effectiveness and efficiency as exclusive and ultimate values
Qualified workers were left aside from PHC:

- Other interpretations of AAD emphasised **self reliance** and proposed **community health workers** as **cornerstones** of PHC and **social change agents** contributing to community empowerment.

- Often used to legitimise the **disengagement** of health services from PHC:
  - Low interest of many health professionals for PHC
  - Health services dominantly function along biomedical (rather than PHC) culture
  - CHW ~ extension workers with technical role
What is left?

Equity and social justice did not become a priority

• Instead of economic AND social development, unilateral emphasis on economic development which did not decrease inequalities

• The health gap between rich and poor widened

• Uncontrolled privatisation and commercialisation of individual health care (poor accessibility and quality) and underfinanced public services focusing on disease control and providing only selective care

• Pro-poor policies seldom include social empowerment strategies
Challenges for PHC today

• The *principles* of PHC remain valid
• But *radical changes in contexts*:
  – Demographic and epidemiological transitions
  – Technological innovations
  – Growing costs: financing = major challenge
  – Access to information
  – Diversification of formal / informal providers
  – Changing views on the role of the State
  – Globalisation
  – New (global) actors in international aid
  – …
Need for a new language

- Nostalgia for old words will get us nowhere
- Advocacy for revitalising PHC needs reformulation with **language of present times**:
  - Current terminology: *health systems strengthening, accountability, social protection, universal coverage, etc* ....
  - New terminology?
  - Is “PHC” still adequate, given the variety of interpretations?
- Vocabulary shapes perceptions, visions, attitudes
Need for strategic alliances

• Obstacle to implementation: interests (local, national, international) against redistribution of power and wealth
• PHC: a matter of political commitment
• Need for field research to document PHC in its diversity
• Need for a continuous stakeholder analysis around PHC (at local / national / international level)
• Need for strategic alliances:
  – With (public health) research institutions
  – With social movements based in civil society, including health professionals
• Need for long term strategies
A condition for success

• Acknowledge that health systems
  – Are not « complicated » systems that experts can fix if they get the right technology
  – Rather are « complex » systems, i.e. systems driven by social actors who cannot be controlled like robots

• Experts alone won’t make it
  – An insight 30 years ago
  – An evidence today, supported by social research and complexity theory

Glouberman & Zimmermann 2002): Complicated and complex systems. Discussion paper # 8, Commission on the Future of Health Care in Canada