

## A Summary of the 2008 World Health Report “Primary Health Care: Now More Than Ever”



Primary health care was put forward thirty years ago as a set of values, principles and approaches aimed at raising the level of health in deprived populations. In all countries, it offered a way to improve fairness in access to health care and efficiency in the way resources were used. Primary health care embraced a holistic view of health that went well beyond a narrow medical model. It recognized that many root causes of ill health and disease lie beyond the control of the health sector and thus must be tackled through a broad whole-of-society approach. Doing so would meet several objectives: better health, less disease, greater equity, and vast improvements in the performance of health systems.

Today, health systems, even in the most developed countries, are falling short of these objectives. Although remarkable strides have been made to improve health, combat disease and lengthen life spans, people worldwide are dissatisfied with existing health systems. One of the greatest worries is about the cost of health care. This is a realistic concern since 100 million people fall into poverty each year paying for health care. Millions more are unable to access any health care.

The source of the problem is that health systems and health development agendas have evolved into a patchwork of components. This is evident in the excessive specialization in rich countries and donor-driven, single disease-focused programmes in poor ones. A vast proportion of resources are spent on curative services, neglecting prevention and health promotion that could cut 70% of global disease burden. In short, health systems are unfair, disjointed, inefficient and less effective than they could be. Moreover, without substantial reorienting, today's struggling health systems are likely to be overwhelmed by the growing challenges of aging populations, pandemics of chronic diseases, new emerging diseases such as SARS, and the impacts of climate change.

“Rather than improving their response capacity and anticipating new challenges, health systems seem to be drifting from one short-term priority to another, increasingly fragmented and without a clear sense of direction,” says World Health Report 2008 entitled *Primary Health Care – Now More Than Ever*.

With the publication of the report on 14 October, WHO hopes to start a global conversation on the effectiveness of *primary health care* as a way of reorienting national health systems. WHO Director-General, Margaret Chan, wrote in a recent editorial in the journal *The Lancet*: “Above all, primary health care offer(s) a way to organize the full range of health care, from households to hospitals, with prevention equally important as cure, and with resources invested rationally in the different levels of care.”

Actually, WHO hopes to revive the conversation. Primary health care was officially launched in 1978, when WHO member states signed the Alma Ata Declaration. That was 30 years ago. A few countries pursued the ideal. But, says Dr Chan: “The approach was almost immediately misunderstood.”

Primary health care was misconstrued as poor care for poor people. It was also seen as having an exclusive focus on first-level care. Some dismissed it as utopian and others thought it a threat to the medical establishment.

In the World Health Report, WHO proposes that countries make health system and health development decisions guided by four broad, interlinked policy directions. These four represent core primary health care principles.

**Universal coverage:** For fair and efficient systems, all people must have access to health care according to need and regardless of ability to pay. If they do not have access, health inequities produce decades of differences in life expectancies not only between countries but within countries. These

inequities raise risks, especially of disease outbreaks, for all. Providing coverage to all is a financial challenge, but most systems now rely on out-of-pocket payments which is the least fair and effective method. WHO recommends financial pooling and pre-payment, such as insurance schemes. Brazil began working towards universal coverage in 1988 and now reaches 70% of its population.

**People-centred services:** Health systems can be reoriented to better respond to people's needs through delivery points embedded in communities. The Islamic Republic of Iran's 17 000 “health houses” each serve about 1500 people and are responsible for a sharp drop in mortality over the last two decades, with life expectancy increasing to 71 years in 2006 from 63 years in 1990. New Zealand's Primary Health Care Strategy, launched in 2001, has as part of its core strategy an emphasis on prevention and management of chronic diseases. Cuba's “polyclinics” have helped give Cubans one of the longest life expectancies (78 years) of any developing country in the world. Brazil's Family Health Programme provides quality care to families in their homes, at clinics and in hospitals.

**Healthy Public Policies:** Biology alone does not explain many gaps in longevity, such as the 27-year difference in Glasgow's rich and poor neighbourhoods. In fact, much of what impacts health broadly lies outside the influence of the health sector. Ministries of trade, environment, education and others all have their impact on health, and yet little attention is generally paid to decisions in these ministries that have health impacts. WHO believes they should all be part of deliberations and that a “health in all policies” approach needs to be integrated broadly throughout governments. This will require a shift in political calculations since some of the greatest health impacts can be achieved through early childhood development programmes and education of women, but those benefits are unlikely to be seen during a single politician's term or terms in office.

**Leadership:** Existing health systems will not naturally gravitate towards more fair, efficient (those that work better) and effective (those that achieve their goals) models. So, rather than command and control, leadership has to negotiate and steer. All components of society – including those not traditionally involved in health – have to be engaged, including civil society, the private sector, communities and the business sector. Health leaders need to ensure that vulnerable groups have a platform to express their needs and that these pleas are heeded. There is enormous potential to be tapped. In half of the world's countries, health issues are the greatest personal concern for a third of the population. Wise leadership requires knowledge of what works. Yet health systems research is an area that is often severely under funded. In the United States of America, for example, health systems research claims only 0.1% of the nation's health budget expenditure. Yet research is needed to generate the best evidence as a basis for health decision.

By aiming at these four primary health care goals, national health systems can become more coherent, more efficient, more fair and vastly more effective.

Progress is possible, in all countries. Now, more than ever, there are opportunities to start changing health systems towards primary health care in all countries. The challenges are different for countries with different income levels, but there are commonalities. There is more money being spent on health than ever before and more knowledge to address global health challenges, including better medical technology. There is also now recognition that threats and opportunities in health are shared across the world. Aid is important for some countries, but the vast majority of health spending comes from domestic sources. Even today, in Africa, 70% of all resources for health come from domestic funds. Thus most countries have the ability to start moving towards and enjoying the benefits of primary health care.