Comprehensive primary health care: Current state of knowledge

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Teasdale-Corti Project (1)

- 5 year (2007 – 2011) initiative to develop/strengthen research capacity on comprehensive PHC using triads of new researchers, research users and research mentors
  - University of Ottawa/University of Western Cape and others
  - People’s Health Movement/International People’s Health University
  - Funded by the Global Health Research Initiative, Canada; managed by the International Development Research Centre

- 4 regions
  - India/South Asia
  - Latin America
  - Africa
  - Aboriginal communities (Australia, Canada, Aotearoa/New Zealand)
Teasdale-Corti Project (2)

CPHC seeks intentionally to affect:

- increased equity in access to health care and other services/resources essential to health
- reduced vulnerabilities through changes in community empowerment (capacities)
- reduced exposures to risk through changes in social and environmental determinants of health
- improved participatory mechanisms and opportunities and political capabilities of marginalized population groups reached by comprehensive primary health care initiatives
- increased intersectoral actions on the social determinants of health
- equitable increase in population health outcomes

Teasdale-Corti Project (3)

- Narrative synthesis of existing experiences, discussions to determine new and important research questions
  - Europe
  - North America
  - Australasia
  - Africa
  - India/South Asia
  - Latin America
  (300 + articles presently summarized)
Why is (C)PHC important today?

- Selective PHC criticized for
  - Lack of equity and sustainability
  - Ignoring chronic disease
  - Ignoring that poor have multiple, not single, diseases
  - Little intersectorality

- Health system fatigue
  - Too many donors/reports
  - Fracturing of health workforce
“Any serious effort to reduce health inequities will involve changing the distribution of power within societies and global regions, empowering individuals and groups to represent strongly and effectively their needs and interests and, in so doing, to challenge and change the unfair and steeply graded distribution of social resources (the conditions for health) to which all, as citizens, have claims and rights.”

The World Health Report 2008

**Primary Health Care**

*Now More Than Ever*

Public Policies for the Public’s Health:

“Public policies in the health sector, together with those in other sectors, have a huge potential to secure the health of communities. Unfortunately, this potential is largely untapped [and] there is a need for greater capacity to seize this potential.

A drive for better public policies forms the third pillar supporting the move towards PHC, along with universal coverage and primary care…”
What has PHC accomplished (1)?

- In most *developing countries* where more comprehensive implementation:
  - ↓ IMR, ↓ Under 5 MR
  - ↓ Maternal MR, ↑ LEB
  - ↑ Improved immunization, ↑ Family planning,
  - ↓ Malnutrition

Longitudinal:
- Costa Rica: for every 5 years of PHC, child mortality down by 13%, adult mortality down by 2% - 4%
Role of community mobilization

- Community participation processes effective in improving population health
  - Several controlled and cRCTs in low income settings show substantially greater gains in maternal/child health outcomes when community mobilization efforts are undertaken
  - Mobilization includes delivery of ‘packages’ but, importantly, successful efforts ‘bottom-up’

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- Unlike targeted intervention packages, such processes not easily scaled up:
  - ‘Successes had arisen from the process, not from the setting of performance targets…forward momentum had been generated from within the community’
  - Miriam Were, Kakamega (Kenya) project
What has PHC accomplished (2)?

- In most *developed countries* PHC vs. regular care:
  - Reduced lab tests, lower hospitalization rates, fewer prescriptions, better use of mixed discipline teams, more disease prevention/health promotion
  - ‘Community-oriented’ (publicly provided) PHC with broad discipline mix more comprehensive and cost-effective than with narrow discipline mix or PHC via private providers (family practices)

- Density of PHC providers associated with improved health and with more equitable health care access
What has PHC accomplished (3)?

- **Asia**: PHC projects clustered into three types:
  - those that primarily emphasized community involvement in health services
  - those that saw PHC as including income generation, agriculture and other services
  - those that saw PHC as a politically empowering project for which the services were tools in a process

- **Pakistan**: Comparison of programs for comprehensiveness and sustainability:
  - Institution-led PHC Program
  - Community-led PHC Program
  - Co-partnership Program

- **India**: Two projects exploring the role of ASHAs in comprehensiveness of services and community responsiveness:
  - Preliminary findings:
    - Still medically dominated
    - Inappropriate incentivizes
    - ASHAs organizing for better training/conditions

- **Bangladesh**: Two projects, one comparing models of PHC for comprehensiveness and health equity; another examining impact of a new program on overcoming social exclusion (remote villages)

- **Iran**: Study of behvarz (community health workers) in relation to comprehensiveness of PHC
What has PHC accomplished (4)?

- **Latin America:**
  - Where health systems more integrated, universal and publicly financed, the PHC orientation was more comprehensive (e.g. Cuba, Costa Rica, Brazil, Venezuela, Chile, Bogotá and México City)
  - Where health systems more fragmented, segmented and targeting certain groups only, the PHC orientation was more towards basic care or SPHC (e.g. Bolivia, Colombia, Ecuador, México, and Perú)
  - Studies conducted in Costa Rica, Brazil, Cuba, Chile and Venezuela have demonstrated a positive impact on population health and health services development attributed to comprehensive PHC

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**BRAZIL**
Assess how well the ‘Family Health Program’ rollout of CPHC (health teams of physician, nurse and many community health workers) links marginalized groups to other levels of care

**EL SALVADOR**
Understand the experience of community health that began in 1987 to meet the health needs of the population and obtain findings indicating the lessons and elements that contribute to a revitalization of CPHC

**URUGUAY**
Analyze the role of CPHC in 74 community policlinics to understand the extent to which health care reforms affect the implementation of CPHC

**COLOMBIA**
Analyze current experiences regarding the development of PHC in Bogotá and Santander, focusing on the national and local health policies that limit or enable its development in order to propose strategies for change

**ARGENTINA**
Compare and contrast two PHC programs targeting multiply disadvantaged groups for selective vs. comprehensive approaches
What has PHC accomplished (6)?

Africa:
- The focus of most studies was on:
  - community perceptions and expectations of PHC service delivery
  - role and impact of the work of Community Health Workers in the delivery of services such as community-based DOT, home-based care for people living with HIV, delivering malaria preventative medication for pregnant women
  - the impact of community-based health insurance schemes
  - community involvement in village level health determinants (e.g. water, sanitation)
  - very few evaluative studies, most descriptive of activities rather than outcomes

ETHIOPIA
Two projects. One is assessing the contribution of the Health Service Extension Program in promoting comprehensive primary health care in Tigray region, Ethiopia. Another is assessing the role of CPHC principles and practice in the health sector reform efforts in Jimma Zone, Ethiopia with a focus on village health workers and community participation.

KENYA
Comparing comprehensiveness of PHC in three models of implementation (government, government/NGO partnership, NGO).

SOUTH AFRICA
Examine the role of Community Health Workers in improving access to formal health systems.

DEMOCRATIC REPUBLIC OF CONGO
Evaluating maternal health (Safe Motherhood) program for health outcomes and as a model for health system reconstruction in a post-conflict setting.
What has PHC accomplished (9)?

**Europe:** most emphasis has been on *primary care*
- UK has active PHC networks but most of the PHC principles of Alma-Ata missing in actual health care reform
- Most of the non-medical aspects of PHC advanced as health promotion, ‘health for all’ campaigns, Healthy Cities initiatives
- Community-oriented PHC flexible
  - Some activities on CVD risk, physical activity; others on poverty, mental ill health, social exclusion
  - Multidisciplinary teams and community outreach (community animators) key to comprehensiveness

What has PHC accomplished (10)?

**North America:**
- The impetus for CPHC often originated in lack of, or inequitable access to, primary care services by poor, marginalized or socially excluded groups.
- Many PHC services began as volunteer or activist efforts by socially-minded health workers (doctors, nurses, health promoters).
- Most CPHC activities undertaken by Community Health Centres (CHCs) and public health departments (often in partnership)
**CHCs (CPHC characteristics)**

- Explicit recognition of social determinants of health
- Strong multicultural health orientation
- Strong social network building orientation (social capital, social cohesion)
- Local governance (boards of management)
- Generic community health workers/community developers
- Primary care to health behaviours/targeted programs to population health (organizing, intersectoralism, advocacy)
- Redistributive orientation

**CHCs (CPHC outcomes) (1)**

- Improved equity in access to primary care and a broad range of health and social services
- Compared to other models of care, some studies find CHCs provide:
  - Greater preventive care, particularly for women
  - Lower hospitalization, drug prescribing (savings to health systems)
  - Better management of chronic diseases (following ‘best practice’ guidelines)
  - Some evidence of better chronic disease outcomes
  - More responsive to health needs/issues of disadvantaged populations (vertical equity) (longer appointment times)
CHCs (CPHC outcomes) (2)

- Compared to other models of care, some studies find CHCs provide:
  - Greater continuity, comprehensiveness of care, and user satisfaction
  - Much greater community engagement
    - 2006 study of 17 Canadian CHCs found improved levels of community and individual confidence and trust, more opportunities for participation greater perceived levels of self-control (empowerment)
    - More intersectoral work, more effective referral to other agencies/sectors, less fragmentation of service follow-up
    - Outcomes greater for CHCs with elected community boards than those overseen by regional authorities

When reforms to improved welfare politically stalled

Like most CHCs, South Riverdale began in a struggle to provide CPHC to lower income residents. Its first SDH campaign was to reduce lead exposures due to nearby factories, based on clinical evidence gathered by primary care teams. Its second SDH campaign was to participate in an 18 month province-wide advocacy campaign to force the legislature to approve generous reforms to the welfare system, both in direct rates and in extending non-income benefits.
FIVE INDIGENOUS PROJECTS

Three Australian studies (Congress, Utopia, Victorian Aboriginal Health Service)
Support by the Lowitja Institute
One study in Aotearoa/New Zealand
One study in Canada

CPHC Research Challenges (1)

- Most published studies were ‘slices,’ not wholes
  - Where analytical with outcomes, little information on intervention
  - Where case studies of intervention, little information on outcomes
- Grey literature better than published literature in capturing ‘comprehensiveness’
CPHC Research Challenges (2)

- Few studies allowed for attribution of interventions to population health outcomes
- Most ‘C’ in CPHC was range of medical services and linkage to secondary/tertiary, not community participation or intersectoralism
- Most ‘H’ studies in CPHC were health behaviours not social determinants
- However: > 300 studies and case reports indicating providing some evidence of health-positive CPHC

But what about the politics?
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It’s about commitments to social justice and increased equity in the resources needed for healthy and fulfilling (dignified) lives

Political Context of CPHC (Latin America)

- Neoliberal reforms led to increased donor reliance, SPHC and minimum basket for the poor based on means testing
- Lack of a rights-based approach facilitated roll-backs in funding of public health systems
- Presence of rights/right to health in constitution is aiding the return of CPHC in many countries
- Politicized, empowering participation leads to more equity-enhancing demands
- When participation part of neoliberal programs (voluntary labour) it channels local protest to non-threatening issues
- CPHC more likely when explicit political support, more likely from social democratic than conservative parties
Political Context of CPHC (Canada) (1)

- PHC promoted by left-leaning liberal/social democratic or noblesse oblige conservatives; often began as struggles against medical profession who were opposed to universal health insurance
- CLSCs in Quebec lost their independent boards, now less community responsive and SDH oriented
- CHCs in Canada being ‘challenged’ by Family Health Networks (similar to GP+ in South Australia)

Political Context of CPHC (Canada) (2)

- Concern that ongoing reforms driven by a need to increase access to primary care (‘undersupply’ of general practitioners vs. specialists) in order to constrain rising health care costs, not by commitments to social justice vision of CPHC
- Co-existing policies on social determinants (similar to SA’s Health in All Policies), and support for this in CHCs, some public health departments, continue but increasing emphasis on single-disease lifestyle approaches
The Great Global Irony

As those high income countries with positive experiences of CPHC and universal public health systems are under threat of dismantling these (fragmentation, privatization) those low and middle income countries with decades of experience of fragmented and privatized systems are trying grow CPHC and universal public health systems.

Certain things cannot be achieved, but this is not a reason to give up seeking them.

Mário Quintana, Brazilian poet