Comprehensive Primary Health Care: Lessons from the Teasdale-Corti Project and Canada’s Community Health Centers

Ronald Labonté, Canada Research Chair, Globalization and Health Equity
University of Ottawa
4 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
- People’s Health Movement/International People’s Health University

4 regions, 20 projects, 15 countries

- India/South Asia, Latin America, Africa, Aboriginal communities (Australia, Canada, Aotearoa/New Zealand)

Funding: Canadian Global Health Research Initiative, IDRC, Alliance for Health Policy and Systems Research, Lowitja Institute, CORDAID
CPHC seeks intentionally to

- increase equity in access to health care and other services/resources essential to health
- reduce vulnerabilities through changes in community empowerment (capacities)
- reduce exposures to risk through changes in social and environmental determinants of health
- improve participatory mechanisms and opportunities and political capabilities of marginalized population groups reached by comprehensive primary health care initiatives
- increase intersectoral actions on the social determinants of health
EQUITY IN ACCESS TO HEALTH SERVICES
Strengths

- CHWs increase immunization, family planning and access to safe birthing for women (Ethiopia, India, DR Congo)
- Communities fully implementing community health program (with community participation) show better immunization, safe water access (Kenya)
- Behvarz CHW program increases coverage of health care through rural areas (Iran)
- Municipal CPHC policy improves access and health outcomes for children (Bogota)
Weaknesses

- User fees continue to be a barrier for the poor (DR Congo)
- Poor state of facilities dissuade use (Ethiopia)
- Distance to facilities a barrier for rural poor (Kenya)
- Central planning can lead to inappropriate resources at local level (Bangladesh)
- Chronic public underfunding increases push to private care (Uruguay)
IMPROVED COMMUNITY EMPOWERMENT
Strengths

- Women CHWs create space for village women to share confidence in reproductive health (Ethiopia)
- Women’s solidarity groups work with traditional male leaders to challenge disempowering traditions (DR Congo)
- Residents in ‘better-performing’ health district report frequent health meetings, improved health knowledge and high levels of satisfaction with the community meetings run by the facilities (Bangladesh)
- Maori CHWs assist Maori community members to challenge prejudice and racism (Aotearoa/New Zealand)
Weaknesses

- Top-down implementation, less attention to social determinants of health, selective implementation by less socially minded managers (South Africa)
- Lack of functioning community committees (India, Bogota)
- Community members have little mechanism by which to voice their health needs and concerns (Bangladesh)
- Patriarchal structures can hinder women’s health empowerment (DR Congo)
- Effective community groups can take several years to nurture (India)
IMPROVED DETERMINANTS OF HEALTH
Strengths

- Villages with health extension workers had 7-fold greater rates of latrine vs. open field use than the rural average (Ethiopia)
- Women’s empowerment groups effective in improving social support and assistance in health care and local food security (India)
- Community health programs facilitate income-generating activities (Ethiopia, Kenya)
- Safe Motherhood program reduces social class stigmas (DR Congo)
Weaknesses

- Few projects show actions on health determinants beyond the local (proximate) level
- Water and sanitation dominate
- When CHWs are paid by specific activities (e.g. immunization, prenatal visits) emphasis on social determinants diminishes
- When community governance is weak emphasis on social determinants diminishes
IMPROVED PARTICIPATION & POLITICAL CAPABILITIES
Strengths

- Village health committees organize dialogue days, identify issues, communicate directly to management levels, management obliged to respond (Kenya)
- Of three models studies (top-down, bottom-up, partnership) the partnership model more comprehensive with empowered community decision-making (Pakistan)
- Victoria Aboriginal Health Service (VAHS) advocates for social services, housing and employment benefits to ensure Aboriginal entitlement rights are respected (Australia)
Weaknesses

- Little recognition of role community participation can play in health improvement (South Africa)

- Participation often passive or restricted to volunteer labour at health post/center and not in program decision-making (Bangladesh, Ethiopia)

- Participation undermined by neoliberal economic policies and a legacy of patronizing health workers (Argentina)

- Participation structures can be dominated by local elites (Colombia)
INCREASED INTERSECTORAL ACTIONS
Strengths

- CHWs become ‘go to persons’ for organizing work across other sectors (education, agriculture) (Ethiopia)
- *Behvarz* involved in environment, sanitary and food safety programs and bring intersectoral issues to higher governance levels (Iran)
- Community members created a multi-level governance system to address conditions which were negatively affecting their health (El Salvador)
- Community governance improves intersectoral action (Australia)
Weaknesses

- Few good instances of intersectoral action
- Fragmentation in government services impedes intersectoral action
- CHW income based on specific activities acts as disincentive to intersectoral action
- Burnout of health workers with too many other tasks as well
OH, CANADA?
2013 CANADIAN COMMUNITY HEALTH CENTRES ORGANIZATIONAL SURVEY
SNAPSHOT: Community Health Centres across Canada, by province and territory

2,987,000*
Canadians receive their primary care at a CHC

1,973,000*
Canadians access health promotion, outreach and community health programs at a CHC

*extrapolated from data received in the 2013 Canadian Community Health Centres Organizational Survey from 213 CHCs
Survey of 213 CHCs

- Most developed in 1980s and 1990s
- New ones still being opened in 2000s, and post-2010 but at a slower rate
- 60% serve rural populations
- Almost half have an (global) budget > $15 million
- Most have multiple funding sources
- Most are only single site
- Not all are community governed, notably in Quebec where they are part of provincial health service
Governance of CHCs (n = 213)

- 40% Regional Health Authority or Ministry of Health governed CHC
- 60% Community-governed CHC (NFP Corporation or Cooperative)
Threats

- Obamacare
- Austerity agenda
- Retreat from progressive taxation
- Increasing privatization, public/private partnerships
- Loss of trust in politics and the role of the state
- 21st century trade and investment treaties empowering corporations over states
- Climate change
- Unsustainable global economic model
Opportunities

- Rhetoric of universal health coverage?
- Evidence of superiority of single-payer systems
- Post 2015 global development goals emphasizing sustainability
- Growing chorus of opposition to austerity (for health, human rights and even economic reasons) and support for global systems of taxation
- Growing political and media disgust with continuing wealth inequalities
Activism matters!

Wherever there is community governance, comprehensiveness increases, action on social determinants improves, and often health outcomes are better.

People’s Health Movement and other global progressive movements’ voices are being heard.
State retrenchment began much earlier (Canada):

Decline in marginal tax rates
70% (1970) to 43% (1988) to 29% (2010)

Decline in corporate tax rates
49% (2004) to 27% (2010)

Decline in government spending
as % of GDP, and offsets of market income inequalities

Foregone federal revenue since 2006 due to tax cuts: $220 billion

Estimated annual revenue loss to tax havens: $110 billion
As in Canada, so also in Australia:

Decline in marginal tax rates
62% (1988) to 45% (2008)

Decline in corporate tax rates
49% (1988) to 30% (2010)

Decline in government taxes as % of GDP
3rd lowest of all OECD countries, 
~22%

Marginal increase in social spending
4th lowest of all OECD countries

Net spending as % of GDP falling since 2010
A simple matter of taxation?

- If Canada taxed at an EU 15 average of 40% of GDP, we would raise an additional $156 billion in revenue annually.
- If Canada spent socially at an EU 15 average of 30%, we would be spending $208 billion more annually.

Canadian Finance Minister Flaherty 2013: “What I worry about is those that suggest that austerity should be abandoned...that's the road to ruin”
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Canadian Prime Minister Harper 2009: “There’s two schools in economics. One is that there are some good taxes and the other is that no taxes are good taxes. I’m in the latter category.”
A simple matter of taxation?

- US study: raising marginal rate from 35% to 68% would have no impact on factors driving economic growth, but would **reduce poverty, inequality and stimulate growth through public spending**
Estimated Fiscal Multipliers
15 EU Countries, 1995-2010

Source: Reeves et al 2013 Globalization and Health