

Primary Health Care at forty: reflections from South-East Asia

Poonam Khetrpal Singh; Andrew Cassels; Phyllida Travis



REGIONAL OFFICE FOR

**World Health
Organization**

South-East Asia

Primary Health Care at forty: reflections from South-East Asia

Poonam Khetrpal Singh; Andrew Cassels; Phyllida Travis



REGIONAL OFFICE FOR

**World Health
Organization**
South-East Asia

Primary Health Care at forty: reflections from South-East Asia

ISBN: 978 92 9022 688 8

© World Health Organization 2018

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: "This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition".

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization..

Suggested citation. Primary Health Care at forty: reflections from South-East Asia. New Delhi: World Health Organization, Regional Office for South-East Asia; 2018. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at <http://apps.who.int/iris>.

Sales, rights and licensing. To purchase WHO publications, see <http://apps.who.int/bookorders>. To submit requests for commercial use and queries on rights and licensing, see <http://www.who.int/about/licensing>.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.

Contents

1.	Introduction	1
2.	Primary health care in South-East Asia	2
3.	Looking forward	9
4.	References	14



Introduction

The Alma Ata Declaration on Primary Health Care (PHC) set out a global agenda that called for Health for All by the turn of the Millennium.¹ Forty years later, what can be said about its impact, and how can “recommitting” to PHC in 2018 help advance the cause of better health in the WHO Region of South-East Asia? Looking ahead, how should we see the role of PHC in the context of the 2030 Sustainable Development Agenda, the achievement of the Sustainable Development Goals (SDGs), and the desire to ‘leave no-one behind’?

PHC continues to be an influential concept. This paper argues that to understand the past and define an agenda for the future, it is helpful to distinguish between the technical and political legacies of Primary Health Care.

Even at the time of Alma Ata, from a purely *technical* perspective PHC was not that new. The focus on frontline services reinforced what was already happening in many parts of the world – including South-East Asia. What *was* new in 1978 was that WHO – a specialized technical agency of the UN – set out a compelling *political* agenda unanimously endorsed by Member States. Agreeing that:

- Health should be seen as a right for all, not just a privilege for the few
- Ensuring equitable access was a prime responsibility of all states; and that
- The causes of ill-health go beyond the biomedical and have many social and other determinants



Primary health care in South-East Asia

Not starting from scratch

PHC did not come out of the blue. The experience of countries of the Region, with Sri Lanka and the state of Kerala, India most often cited,² but also Indonesia³ and Thailand,⁴ helped shape the concept. The Declaration however codified a package of eight essential components of primary health care, for the first time.

In other parts of the world, notably in Europe, PHC helped increase the technical focus on frontline services but also gave political momentum to the idea that primary care should be the driver of overall health policy and systems development, with well-resourced frontline services acting as a gateway to more specialized care. This idea has taken much longer to take root in South-East Asia - particularly in those countries where funds were scarce, where the interests of hospital clinicians remained dominant, and where Ministries of Health had limited capacity to bring about system-wide change.

In most countries in South-East Asia the Alma Ata Declaration came at a time when tiered systems of health care, combining preventive and curative care were *already* being established⁵. PHC in its technical sense increased the emphasis on outreach, maternal and child health (MCH), community health workers and village committees, but involved no major changes in direction. This combination of primary level and outreach services (mainly for women and children) then quickly became synonymous with Primary Health Care.

Both the technical and political dimensions of PHC have been sustained over the years through successive regional commitments and resolutions, as well as in national health policies and strategies. The case that significant gains in health can be achieved in low-resource settings was convincingly made in the publication *Good health at low cost* in 1985, and has been made many times since then. However, the reality in many countries – even those with rapidly growing economies - was that, even twenty years after Alma Ata, publicly-funded frontline services were seriously under-resourced, in absolute terms and in comparison to the hospital sector.

The Millennium Development Goals

PHC was not the only influence shaping health systems in the Region. By the late 1990s the support of the international development community for the achievement of the Millennium Development Goals (MDGs) started to be felt across the region. The MDG era brought many benefits, not least an influx of resources for communicable diseases and maternal and child health, reinforcing with donor funding what was understood as Primary Health Care in many countries. The downside was the selective nature of the MDGs, which ignored other causes of ill health and promoted approaches to management and financing that constrained the development of more integrated health systems.

Interestingly, documents show that WHO support for community-based programmes for noncommunicable diseases (NCDs) also began around this time⁶, but these never became a recognized part of the PHC agenda. The unswerving focus on the 'traditional' MCH and communicable disease



agenda, and the patterns of staffing and service delivery that it encouraged, arguably remain as an obstacle to the development of effective NCD services to this day.

Financial crisis

The Alma Ata Declaration said little about how PHC was to be financed. For many poor people, the choice when ill was to forego treatment or finance it through debt or disinvestment. While most governments maintained that the state should, could and would both fund and provide PHC services, especially for the rural poor, the reality was that most people had to pay private retailers for medicines on top of under-the-counter fees in public facilities for treatment. It was not until the mid-1990s that the scale and negative impact of direct out-of-pocket payments for health care began to be more widely recognized⁷. In countries of the Region with growing economies and a rising middle-class, household savings became more common, and provided a cushion for meeting health care costs.

The 1997 Asian financial crisis affected the incomes of both governments and households. Access to basic health care became a prominent political issue in the countries most affected – particularly Thailand and Indonesia. The crisis also proved to be an opportunity for significant reform. Social safety nets were introduced, followed by work on new forms of social health insurance designed to cover the whole population. This period thus marks the beginning of more explicit recognition of pluralist financing and provision in many South-East Asia countries.

BOX 1: Thailand's response to the 1997 financial crisis: the 30 BAHT scheme^{8 9}

From the 1970s onwards, Thailand progressively strengthened its health service delivery system of health centres connected to a district hospital, and a health workforce involving major roles for nurses. In parallel a range of financial protection schemes were introduced, which covered different segments of the population. At the beginning of the financial crisis in 1997, around 30% of the population was still uninsured. The crisis created a demand and opportunity for change. In 2001, a newly elected government fulfilled a campaign promise and introduced the Universal Health Coverage Scheme, also known as the 30 Baht Scheme, which filled the gap left by other public health insurance schemes. It was introduced in 6 provinces in 2001; one year later it had been rolled out nationwide.

In countries less affected by the 1997 crisis health was not such a hot topic electorally. As a result there were fewer changes to the organization and financing of health care. Primary level and community-based care for women and children continued to be the prime focus of government-funded PHC efforts – as in many other parts of world – with many good results.

Experience with community health workers is longstanding and widespread in many South-East Asian countries. By contrast, another key tenet of PHC, intersectoral collaboration, has always proved more difficult and too often has been regarded as an add-on to the provision of curative and preventive services. In reality, the full engagement of other sectors requires fundamental changes in the way that government departments are run and in the way that institutional incentives are designed. This is sometimes easier to do at a local level, and it is interesting that examples found are mostly local. These include the Alert Villages programme, established in Indonesia in 2006, to help villages develop capacities to prevent manage their own health problems even during disasters, the Healthy Villagili island programme in the Maldives, and the National Health Development Network in Sri Lanka.¹⁴



Box 2: Increasing access through community-based or outreach health workers

- *Female Community Health Volunteers* were introduced in Nepal in 1988, with a focus on maternal and child health, and have continued nation-wide. They are judged to have contributed significantly to improvements in maternal and child health outcomes.¹⁰
 - *Community Clinics* designed to improve access in hard-to-reach rural areas began in Bangladesh in the 1990s and now number over 13,000. They provide services for maternal and child health and communicable diseases. NCD screening is now also part of their mandate, but this is in its early days.¹¹
 - *Household doctor system*: a different approach was introduced in Democratic People's Republic of Korea, introduced in 1998. Household doctors are responsible for comprehensive health care for 130 households, using both modern and traditional medicine, and involving outreach as well as facility based care. The model continues today.¹²
 - *ASHAs*: Accredited Social Health Activists were introduced in 2005 as part of India's National Rural Health Mission, with roles as health activists and community level health care providers, especially for maternal and child health. Over 850,000 exist. In some parts of the country, their role has been extended to HIV, malaria and TB care, and most recently noncommunicable diseases and palliative care. Key lessons are that they can be very effective, but they do need continuing institutional support and mentoring, and there is a growing need to regularize incentives.¹³
-

With the increased focus today on issues such as noncommunicable diseases, anti-microbial resistance and health security etc. there is greater awareness that these are problems of overall system governance and require political rather than purely technical strategies.

The 'revitalization' of Primary Health Care

Discussions about revitalizing PHC started with the 30th anniversary of Alma Ata and offer a preview of current discussions. The theme of the 2008 World Health Report was *Primary Health Care: Now More than Ever*.¹⁵ This argued that PHC was just as important thirty years after Alma Ata, because its values and principles for the equitable development of health systems (and health) were still relevant. It argued – from a political perspective - that translation of values of PHC into tangible reforms had been uneven, and that while there had been major improvements in health, the gains were very unequal, between countries and within countries. From a more technical perspective, it pointed out that the nature of health problems was changing faster than had been anticipated with the rise of NCDs, ageing populations and urbanization. It also noted the growth in unregulated 'commercialization' of health, and argued that the PHC movement needed to be more responsive to social change and rising expectations, and to tackle fragmentation. All these points were relevant to the South-East Asia Region then and remain so today.



Box 3: Demographic, social and other transitions in the South-East Asia Region^{16 17 18}

- From 2000 to 2015, the number of people over 60 years old rose from 111 to 186 million, with a further rise to 312 million expected by 2030 – around 12% of the population. By 2020, the number of people aged over 60 years will outnumber children under 5 years.
 - From 2000 to 2015, noncommunicable diseases rose from around 40% to 60% of overall burden of disease.
 - From 2000 to 2018, the share of the SEA Region's population living in cities rose from 32 to 41%.
 - From 2000 to 2016, mobile phone users rose from under 3% to 75% of the population in the Region.
-

In South-East Asia, a regional consultation on Revitalizing Primary Health Care in 2008 highlighted misperceptions and proposed a new definition of Health For All that is extremely close to the definition of UHC being widely used today (Box 4).

Box 4: Key messages from the WHO SEARO Expert Group on Revitalizing PHC, 2008¹⁹

Misperceptions of PHC

- Only for the poor
- Cheap and low quality care
- Aimed at developing countries only
- Only for rural areas; deals with primary care only

Proposed new definition of Health For All: A stage of health development whereby everyone has access to quality health care or practices self-care protected by financial security so that no individual or family is experiencing catastrophic expenditure that may bring about impoverishment.

Conference recommendations were codified in a WHO SEARO resolution that same year²⁰. A subsequent Regional consultation on Innovations in Primary Health Care in 2010 synthesized experience with 'new' approaches to PHC from within the Region. Despite the emphasis on innovation, in 2010 discussions about PHC in the Region were still focused largely on community services and community health workers. There were however two discernable additions. First, there was an explicit recognition of the need to develop equitable health financing strategies. Second, a recognition about the need for linking primary level services with other parts of the health system, articulated in a call for more attention to functioning referral systems. This was not the first time referral systems had been highlighted: there had been research projects in Bangladesh, Bhutan and India in 1980's on ways to improve referral systems, but these had made little lasting impact²¹. Some examples of innovations in the last ten years are given in Box 5.



Box 5: Innovations in health financing, medicines, new technologies over the last ten years

- Demand side financing to improve maternal health coverage was introduced in Bangladesh in 2007. In 2013, it was judged to have been associated with improvements in the utilization of maternal and neonatal health services, and reductions in inequity, but there had not been improvements in quality.²²
- A maternal and child health voucher scheme was introduced in Myanmar in 2010 to address high maternal and infant mortality rates. Three years later the pilot was judged promising, with attention needed on ways to take it to a larger scale.²³
- The State Government of Rajasthan, India introduced the Mukhymantri Nishulk Dava Yogana scheme in 2011, to improve the availability of essential medicines, by increasing public spending; establishing a state medical services corporation, and making procurement and supply chain management more efficient. Availability is judged to have improved.²⁴
- Use of new technologies²⁵: in Nepal, new information technologies are being used in a variety of projects. Mobiles are used to communicate with Female Community Health Volunteers; training sessions are provided remotely; Facebook is used by health workers to seek advice; health information is sent by SMS to individuals.²⁶

In a parallel development in 2010, the WHO Regional Committee for South-East Asia requested that a Regional Strategy on universal health coverage (UHC) be developed. This strategy positioned primary health care oriented health systems as the 'underpinning concept' for UHC, and was endorsed in 2012.

Box 6: Regional Strategy for Universal Health Coverage, 2012 ²⁷

- Strategic direction 1: Placing primary health care oriented health system strengthening in the context of UHC
- Strategic direction 2: Improving equity in financial coverage
- Strategic direction 3: Improving equity and efficiency in service coverage
- Strategic direction 4: Strengthening national institutions and capacities for universal health coverage

Evolving frontline service delivery models

Most recently, some new frontline service delivery models, with more emphasis on integrated care, and adapting to changing needs, have begun to emerge. Two examples, which reflect different local situations, are provided by Timor Leste and Thailand.

After independence, Timor Leste introduced a programme of integrated community health services called SICsa, implemented by community health volunteers in partnership with staff from community health centres and health posts. In 2015, this evolved into Saude na Familia, and has now



been rolled out country-wide. The emphasis on outreach to households for health promotion and disease prevention activities remains, but clinical care services are gradually expanding. The Cuban Medical Brigade has been a cornerstone of this approach, though a gradually increasing number of health workers are being locally trained.²⁸

Thailand has progressively refined its frontline services delivery model over the last 30 years. Today it is based on networks of PHC units and health centres - public and private, and an associated district hospital, which cover around 10,000 people. These networks, or 'Contracting Units for Primary Care', must include at least one doctor, two nurses and 8 paramedical staff. They are financed by capitation payments. The numbers of public health centres with doctors is slowly increasing.²⁹

Current situation: improved overall health; persistent inequities

Overall, health indicators have continued to improve. Since 2000, maternal and under-5 mortality rates have declined faster in the South-East Asia Region than in any other WHO Region, but neonatal mortality is declining more slowly. Infectious diseases have also declined, though their share of the disease burden remains higher than in other WHO Regions, and health security threats from outbreaks keep the spotlight on the need for early detection and response. All countries in the Region face a growing burden of noncommunicable diseases. All these challenges require well-functioning and responsive health systems with well-functioning primary health care, able to meet old and new needs.

Access to selected essential preventive and curative health services is progressively increasing (Fig 1). Overall, the Regional average for the UHC essential health services index is 64% in 2018 compared with 44% in 2010. However, there are fewer examples of narrowing inequalities since the start of the Millennium using the conventional stratifiers of income, education and geographical location³⁰.

Fig.1: Changes in essential health services coverage in Member States of the SEA Region, 2010 to 2018³¹

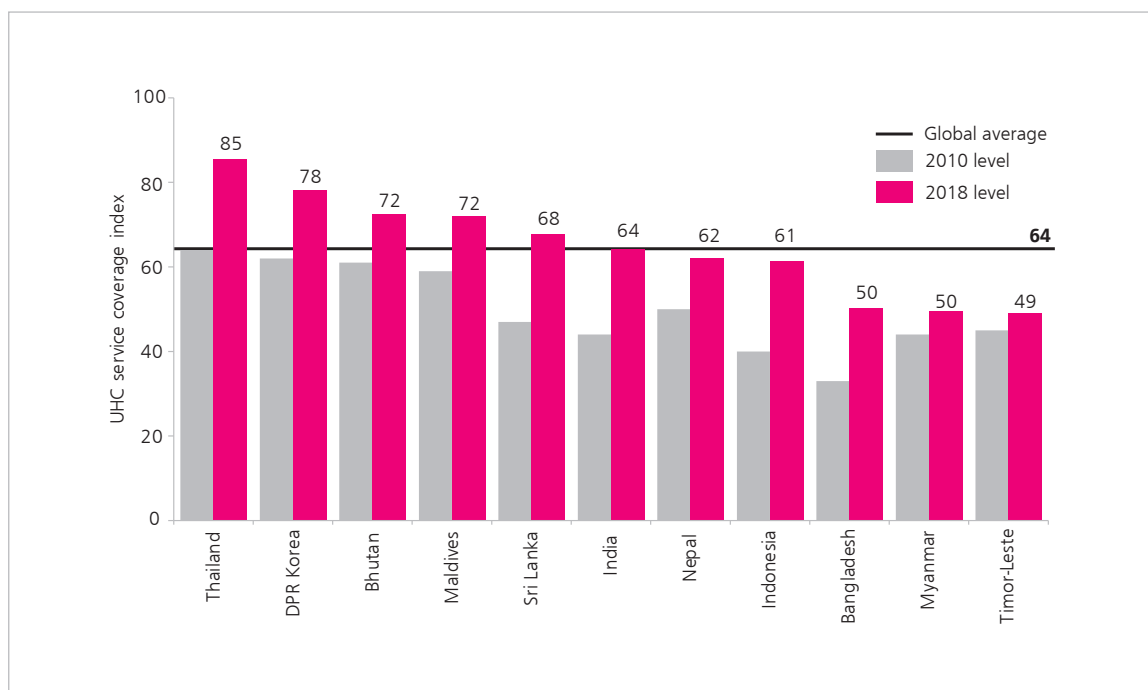
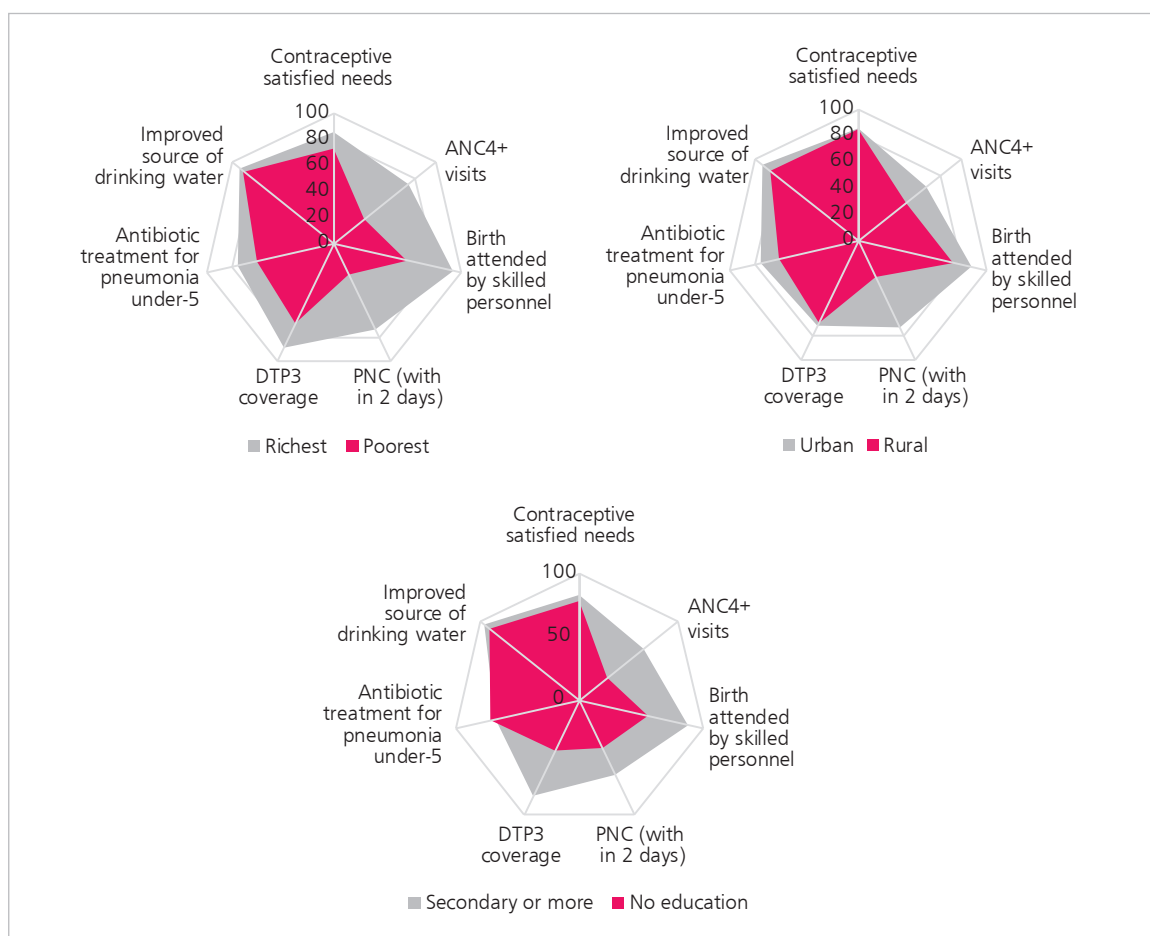


Fig.2: Inequalities in coverage of essential health services by income group, urban versus rural households, and level of education across the South-East Asia Region³²



Since the start of the SDG era, there is renewed attention being paid to national equity analysis – for example in Myanmar and Indonesia,^{33 34} and also a growing awareness of a need to look at a greater range of vulnerable groups such as migrants, mobile populations or the urban poor.

Box 7: Measurement of health inequalities in Indonesia³⁵

The *'State of Health Inequality: Indonesia'* report published in 2017 aims to support evidence-based policy development. It is comprehensive: it covers 11 health topics, using data from 53 health indicators, disaggregated by eight dimensions of inequality - economic status, education, occupation, employment status, age, sex, place of residence and subnational region. Findings were derived from analysis of disaggregated data estimates and summary measures of health inequality. Health inequalities were observed, to varying extents, for the eight dimensions of inequality. These analyses have revealed additional insights into the strengths and weaknesses of the health sector in Indonesia.

The bottom line is that after 40 years of commitment to PHC and more equitable health care, many are still being left behind. While there has been progress, the latest estimates suggest that in the SEA Region, over 800 million people still do not have full coverage of essential health services, and at least 65 million people are pushed into extreme poverty by paying for health care.

Looking forward

As we approach the 40th anniversary of Alma Ata the world's attention turns to Universal Health Coverage. The UHC agenda requires that we take a fresh look at both the technical and political legacies of PHC. The key lesson going forward, however, is that recommitment to Primary Health Care must go beyond general principles and translate into a coherent agenda for action if countries in the Region are to make real progress on 'leaving no-one behind'

Revisiting the technical legacy of PHC

Given their increasingly complex arrangements for providing and financing health services and their rapidly changing epidemiological and demographic circumstances, the *technical* legacy of PHC (i.e. publicly-financed frontline services with a focus on MCH) in the countries of South-East Asia has long been due for an overhaul and update. UHC moves the agenda on in at least five significant ways.

- First, UHC is based on the achievement of health system *outcomes* (universal access to needed services, without financial hardship) rather than fixed programmatic or institutional prescriptions. How these outcomes are achieved is a matter of national preference, acknowledging there are some well-established principles to guide progress to more inclusive outcomes. For example, prepayment for health care is the surest way to advance both access and protection from financial hardship, but countries will choose, based on their own history and circumstances, whether to favour tax-based financing health or mandatory social health insurance, or some admixture of the two. Similarly, countries will have different approaches to the role of the public and private sectors in the provision of different types of service provision.
- Second, while the development of effective frontline services remains a priority in almost all countries in the Region, primary level care can no longer be seen in isolation, given the wider UHC objectives of ensuring access to *all* needed services (which includes hospital care) and protection from financial ruin. Under-utilized frontline services and overcrowded hospitals are common across the region. UHC requires taking a fresh look at approaches to gate-keeping and referral, the role and status of general practitioners, and ways in which hospitals can support the role of frontline facilities and their staff.
- Third, frontline services need to respond both to new demographic and epidemiological challenges and to changes in the relationship between service clients and service providers. Frontline health care has to move beyond episodic care for women and children provided largely by nurse midwives. Continuity of high-quality care requires new approaches to management as NCDs and the multiple pathologies of ageing populations start to dominate the primary care case load.^{36 37} These cannot just be seen as additional tasks for existing under-trained and under-resourced frontline nursing staff. These developments also have implications for the ways primary care and public health staff are trained. Community engagement can also take on a new lease of life under UHC. From a technical perspective, community involvement in behaviour change communication is a vital part of health promotion and prevention. Politically, community and local government representatives



are increasingly well informed on health issues and have the potential to be key allies in building healthy communities.

- Fourth, a significant proportion of all ambulatory care in countries across the region – particularly for NCDs – is provided by private practitioners financed by out-of-pocket payments. The boundary between the public and private sector in many countries is blurred and fluid. Doctors and nurses from the public sector operate their own private facilities out of hours, often referring patients from government facilities to their own private practice, diagnostic facility or pharmacy. New approaches are required which address a dual challenge: protecting patients from financial exploitation and poor quality care on one hand, while harnessing the extensive assets of the private sector (particularly in areas such as diagnostics and lab services) for public health gains.
- Finally, primary level services are not just the frontline in preventing and treating disease, they are also the frontline in terms of protection against the threat of outbreaks and epidemics. Identifying and responding to potential emergencies is central to the idea of a resilient health system. In several countries such epidemiological services have been developed as part of the legacy of immunization campaigns, particularly polio. Indeed, many surveillance programmes continue to be dependent on financing from the polio programme. The challenge for the future is thus to ensure both that surveillance and response are seen as essential element of primary care, and that they are financed from sustainable (ideally domestic) resources.

Box 8: New approaches to financing, organization and management of primary health care in the South-East Asia Region

- *Health financing reforms* in Indonesia since 2014 include contracting with primary health care providers.³⁸
 - *Contracting private and public providers*: the primary care cluster approach in Thailand;³⁹ contracting of public and private providers by BPJS in Indonesia^{40, 41}; different forms of partnership with NGOs in Bangladesh.⁴²
 - *Gate-keeping and referral*: different approaches to gate-keeping are being tried in Indonesia as part of the BPJS reforms;⁴³ Bhutan has a nationwide triage and ambulance tracking system to facilitate timely referral in emergencies, using new information technology.⁴⁴
 - *Continuing, more integrated care*: Thailand's approach to elderly care emphasizes holistic care, and health worker training has been adapted to reflect this; there are plans to introduce family practitioners in primary care in Sri Lanka,^{45, 46} and the Maldives.⁴⁷ Continuing more integrated care is a goal of the new Health and Wellness Centre reforms in India.^{48, 49}
 - *Quality of care*: Bangladesh has introduced quality improvement committees at all levels of care, with a facility performance scoring system.^{50, 51}
 - *Embedding outbreak detection and response in primary care, including communities*: Nepal has created Rapid Response Teams that include staff from health posts; several countries use national NGOs such as Red Cross and Red Crescent for emergency preparedness and response at grassroots level.^{52, 53}
-



Redefining the political agenda of PHC

PHC has always been a political agenda. It is often overlooked, for example, that the Alma Ata Declaration (Paragraph III) argued for economic and social development “based on a New International Economic Order” that addressed health inequities within and between countries. While the 2030 Sustainable Development Agenda says little about the means (economic or otherwise) by which they can be achieved, the overall goals remain similar: “to end poverty and hunger everywhere; to combat inequalities within and among countries....”. This is not just a technical agenda.

Global health is becoming increasingly politicized. This has advantages when G20 leaders pay close attention to health systems, health security and the threat of anti-microbial resistance, but has downsides when the same leaders remain silent about the corporate and commercial interests that drive NCDs or which sustain artificially high prices for medical technologies. Equally, with political divergence comes increasing volatility in development financing and the risk of health issues being held hostage by partisan political interests. The world of 2018 is very different from that of 1978, a renewed declaration may not advocate a new world order, but it should at least reflect the shifts in geo-political power – notably the prominent role of countries across Asia - that will shape global health governance going forward*.

At a more practical and immediate level, there are a number of essentially political issues associated with universality. At the time of Alma Ata, the main concerns were to improve access for the poor in rural areas. Today the picture is far more complex.

UHC can be “the single most powerful concept that public health has to offer”,⁵⁴ but *only* if it stimulates governments and their partners to go beyond their long-standing commitments in national health and development policies and strategies, to tackle the real obstacles to universal access with financial protection. For WHO this means working not only with traditional partners such as UNICEF, but many others across the UN system and more broadly within the development community.

Universality means everyone: not just citizens – a highly contentious issue in a Region where ethnic and religious minorities, migrants and other marginalized groups face discrimination. Universality requires that services are equally available and accessible as a right, irrespective of gender and sexual orientation. Necessary services means access to affordable and safe medicines, to adequate pain relief and palliative care, and, as family structures change, to long-term care for the elderly. Financial protection is not just about insurance, but has to tackle high levels of corruption in the provision of all forms of health care, in access to medical education and health sector employment, and in the procurement of essential medicines and equipment. This list can be extended, but the fundamental point is that tackling inequity requires specificity and detail in defining issues and political support and persistence to implement effective solutions.

* See for example the suggestion that a renewed PHC declaration should offer the opportunity to “stand against neoliberalism and to insist on the strengthening of the left hand of the state” (www.thelancet.com Vol 391, June 23rd).



Box 9: Moving the PHC and public health agenda forward as part of UHC: transitions needed

- From institutional prescriptions, to a focus on health system outcomes: universal access to needed care without financial hardship.
- From primary level care in isolation, to addressing frontline and hospital services together, and harnessing new technologies.
- From episodic, low quality frontline services, to continuity of high quality care.
- From familiar to fresh approaches to community engagement, given more informed populations.
- From partial and ambivalent to more systematic and managed engagement of private providers.
- From routine primary care, to primary care also capable of outbreak surveillance and response.
- From political commitment to equity, to practical implementation of effective solutions for all.

The health agenda: beyond UHC

UHC moves the agenda on from PHC, but falls short of being the overarching organizing principle for a comprehensive future health agenda, because it is concerned primarily with health care services. It is common to hear that health security and UHC are “two sides of the same coin” and that security depends to a great extent on a well-functioning and resilient health system. This is true, but it is equally true that real health security and protection from the devastating effects of uncontrolled outbreaks needs the inputs of many other sectors, particularly when international spread threatens. Similarly, there is much that good quality health care can do to reduce risk factors for noncommunicable diseases, to combat antimicrobial resistance, to address the many social and political challenges posed by rapidly ageing populations, and to mitigate the health impacts of climate change. But while what can be done through the health sector may be necessary, it is a very long way from being sufficient.

Obviously this argument is not new. The need for action across governments and societies was recognized in the Alma Ata Declaration.

“Primary Health Care involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordination of all those sectors;”

Framing an agenda for the future clearly has to go further than just listing all the possible sectors that could impact on health and “recommitting” to a similar set of generalities. The political agenda started by Alma Ata has moved on. That better health requires sound political choices in many different policy arenas is now self-evident and – in the same way that the strongly politicized UHC agenda highlighted above requires detail and specificity – so too with the health governance agenda.



In all the countries of the Region political leaders have made commitments to improving health through strengthening health security and combating social, political, commercial and environmental causes of ill health. The actions that are needed to get to grips with NCD risk factors, road safety, AMR, climate change, environmental pollution, unsafe cities and many other issues - involve multiple groups of stakeholders across government, the private sector and civil society. National action is often constrained by external pressures with their origins in regional or global politics and trade. In every country political bandwidth is limited and sustained opposition from vested interests is guaranteed.

The key point therefore is that this wide range of issues is not amenable to the technical logic of multi-sector actions plans alone. To learn from the political legacy of PHC (and the successes achieved by the fight against tobacco), requires that health professionals step out from their technical comfort zone and start to see future challenges through a more political lens – and adapt their approach to working with political leaders accordingly.

Conclusions

- In the Region of South-East Asia the technical legacy of Primary Health Care - in the form of primary-level services primarily focused on episodic ambulatory care and preventive activities for women and children - needs a fundamental overhaul. Critically, frontline services still need to be seen as a priority if countries are to adequately address new demographic and epidemiological challenges – most particularly NCDs and the health needs of ageing populations. The key lesson from the past is that it is a mistake to see frontline services in isolation – either from the broader health system of which they are a part, or from issues such as human resources, financing and access to medicines which are integral to their effectiveness. The legacy of donor-financed programme structures – often reinforced by UN agencies – may remain as an obstacle to effective service development, even as donor funding declines.
- Universal Health Coverage inherits the political mantle of PHC. It maintains PHC's focus on equitable access, with equity further reinforced by adding financial protection to the agenda. UHC is explicitly relevant to countries at all levels of development and thus avoids the charge previously levelled at PHC of being about low cost health care for poor countries. The challenge for the future is to recognize clearly and specifically the many difficult and politically-sensitive issues involved in securing genuinely universal access and financial protection. Allowing “universal health coverage” to uncritically be presented as synonymous with whatever a government is currently providing does not meet this criterion. Securing rights and overcoming exclusion - and measuring the results of interventions - are integral to UHC. Leaving no-one behind needs to be seen as a real departure from business as usual.
- In today's world in South-East Asia neither PHC or UHC adequately capture the entirety of the health agenda. While UHC covers many aspects of health care it is still commonly seen as being concerned with how the traditional health sector operates. Similarly, while PHC originally noted the importance of intersectoral action, like UHC it is still primarily seen as being about frontline services. A recommitment to PHC might conceivably rekindle the spirit of the original declaration, but something more specific is needed to capture a more actionable agenda. The new agenda needs to cover at least four intersecting components: UHC and the health sector; health security in the face of emergencies; political action to combat the determinants of ill health; and a sustained focus on equity, rights, and the use of science, evidence and research. Health as part of the Sustainable Development Goals provides both the required legitimacy and the breadth of vision to cover all four components.



References

- 1 Declaration of Alma-Ata. International conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. Geneva: World Health Organization; 1978. (http://www.who.int/publications/almaata_declaration_en.pdf , accessed 23 August 2018).
- 2 Halstead SB, Walsh JA, Warren KS, eds. Good health at low cost. Rockefeller Foundation; 1985.
- 3 A healthier South-East Asia: 70 years of WHO in the Region. New Delhi. World Health Organization, Regional Office for South-East Asia; 2018.
- 4 Nityarumphong S. Evolution of PHC in Thailand: what policies worked. Health Policy and Planning. 1990 Jan;5(3):246.
- 5 Roemer MI. National health systems of the world. 2 vol set. New York: Oxford University Press; 1991.
- 6 A Healthier South-East Asia: 70 years of WHO in the Region. New Delhi. World Health Organization, Regional Office for South-East Asia; 2018
- 7 Roemer MI. National health systems of the world. 2 vol set. New York: Oxford University Press; 1991.
- 8 Hughes D, Leethongdee S. Universal coverage in the land of smiles: lessons from Thailand's 30 Baht health reforms. Health Aff (Millwood). 2007 Jul-Aug;26(4):999-1008.
- 9 Tangcharoensathien V, Witthayapipopsakul W, Panichkriangkrai W, Patcharanarumol W, Mills A. Health systems development in Thailand: a solid platform for successful implementation of universal health coverage. Lancet. 2018 Mar 24;391(10126):1205-1223.
- 10 Engel J, Glennie J, Adhikari SR, Bhattarai SW, Prasai DP, Samuels F. Nepal's Story: understanding improvements in maternal health. Overseas Development Institute; 2013.
- 11 Ahmed SM, Alam BB, Anwar I, Begum T, Huque R, Khan AMJ, et al. Bangladesh health system review. Manila: WHO Regional Office for the Western Pacific; 2015.
- 12 Glimpses of innovations in primary health care in South-East Asia. New Delhi: World Health Organization, Regional Office for South-East Asia; 2010.
- 13 Report of the SEARO Technical Consultation on Strengthening Community-Based Health Care Services. New Delhi: World Health Organization, Regional Office for South-East Asia; 2015.
- 14 Regional Consultation on Innovations in Primary Health Care Chiang Mai, Thailand, 17-19 August 2010. New Delhi: World Health Organization, Regional Office for South-East Asia; 2011.
- 15 The world health report 2008 - primary health care: now more than ever. Geneva: World Health Organization; 2008.
- 16 Health, the SDGs and the role of universal health coverage: next steps in the South-East Asia Region to reach those being left behind. Regional consultation background paper. New Delhi: World Health Organization, Regional Office for South-East Asia; 2016.
- 17 World population Prospects, 2017 revision. New York: United Nations, Department of Economic and Social Affairs, Population Division; 2017. (<https://esa.un.org/unpd/wpp/Publications/>, accessed 23 August 2018).
- 18 International Telecommunications Union. (<https://www.itu.int/en/Pages/default.aspx>, accessed 23 August 2018).
- 19 Regional conference on revitalizing primary health care, Jakarta, Indonesia, 6-8 August 2008. New Delhi: World Health Organization, Regional Office for South-East Asia; 2008. (SEA-HSD-316; http://apps.searo.who.int/pds_docs/B4201.pdf, accessed 23 August 2018).
- 20 Revitalizing primary health care. New Delhi: World Health Organization, Regional Office for South-East Asia; 2008. (SEA/RC61/R3; <http://apps.who.int/iris/handle/10665/128720>, accessed 23 August 2018).
- 21 A Healthier South-East Asia: 70 years of WHO in the Region. New Delhi. World Health Organization, Regional Office for South-East Asia; 2018
- 22 Program evaluation for demand side financing maternal health voucher scheme in Bangladesh: Final report. 2013.
- 23 Pilasant S, Kulpeng W, Werayingyong P, Tritasavit N, Yamabhai I, Teerawattananon Y, et al. Maternal and child health voucher scheme in Myanmar: a review of early stage implementation. BMC Health Serv Res. 2016 Oct 21;16(1):600.
- 24 Universal access to medicines in India: a baseline evaluation of the Rajasthan free medicines scheme. New Delhi: Word Health Organization, Country Office for India; 2014.



- 25 Braun R, Catalani C, Wimbush J, Israelski D. Community health workers and mobile technology: a systematic review of the literature. *PLoS One*. 2013 Jun 12;8(6):e65772.
- 26 National e-Health Strategy 2017. Kathmandu: Nepal Ministry of Health and Population; 2017.
- 27 Regional strategy for Universal Health Care. New Delhi: World Health Organization, Regional Office for South-East Asia; 2012. (SEA/RC65/R6; <http://apps.who.int/iris/bitstream/handle/10665/128332/SEA-RC65-R6.pdf?sequence=1>, accessed 23 August 2018).
- 28 Saude na Familia: part of comprehensive primary healthcare package – success stories from the field. Dili: Ministry of Health, Timor-Leste. (<http://www.searo.who.int/timorleste/saude-na-familia-timor-leste.pdf?ua=1>, accessed 23 August 2018).
- 29 The Kingdom of Thailand health system review. Manila: World Health Organization, Regional Office for the Western Pacific, Asia Pacific Observatory; 2015.
- 30 Monitoring universal health coverage and the health-related Sustainable Development Goals in the South-East Asia Region: 2018 update. World Health Organization Regional Office for South-East Asia; 2018.
- 31 Monitoring universal health coverage and the health-related Sustainable Development Goals in the South-East Asia Region: 2018 update. World Health Organization Regional Office for South-East Asia; 2018.
- 32 Monitoring universal health coverage and the health-related Sustainable Development Goals in the South-East Asia Region: 2018 update. World Health Organization Regional Office for South-East Asia; 2018.
- 33 Han SM, Rahman MM, Rahman MS, Swe KT, Palmer M, Sakamoto H, et al. Progress towards universal health coverage in Myanmar: a national and subnational assessment. *Lancet Glob Health*. 2018 Sep;6(9):e989-e997.
- 34 State of health inequality: Indonesia. Geneva: World Health Organization; 2017.
- 35 State of health inequality: Indonesia. Geneva: World Health Organization; 2017.
- 36 Health, the SDGs and the role of universal health coverage: next steps in the South-East Asia region, to reach those being left behind. Regional Consultation Background Paper. New Delhi: World Health Organization, Regional Office for South-East Asia; 2016.
- 37 South-East Asia regional forum to accelerate NCDs prevention and control in the context of the SDGs, Bangkok, Thailand, 9-11 October 2017: Summary. New Delhi: World Health Organization, Regional Office for South-East Asia; 2017.
- 38 The Republic of Indonesia health system review: health systems in transition. New Delhi: World Health Organization, Regional Office for South-East Asia, Asia Pacific Observatory; 2017.
- 39 Tangcharoensathien V, Witthayapipopsakul W, Panichkriangkrai W, Patcharanarumol W, Mills A. Health systems development in Thailand. *Lancet*. 2018 Mar 24;391(10126):1205-1223.
- 40 JLN/GIZ Case Studies on Payment Innovation for Primary Health Care. 2017 (<http://www.jointlearningnetwork.org/resources/jln-giz-case-studies-on-payment-innovation-for-primary-health-care>, accessed 10 September 2018).
- 41 Primary Health Care Systems (PRIMASYS) Case study from Indonesia. Geneva: Alliance of Health Policy and Systems Research, World Health organization; 2017.
- 42 El Arifeen S, Christou A, Reichenbach L, Osman FA, Azad K, Islam KS, et al. Community-based approaches and partnerships: innovations in health-service delivery in Bangladesh. *Lancet*. 2013 Dec 14;382(9909):2012-26.
- 43 Ekawati FM, Claramita M, Hort K, Furler J, Licqurish S, Gunn J. Patients' experience of using primary care services in the context of Indonesian universal health coverage reforms. *Asia Pac Fam Med*. 2017 Mar 21;16:4.
- 44 The Kingdom of Bhutan health system review: health systems in transition. New Delhi: World Health Organization Regional Office for South-East Asia, Asia Pacific Observatory; 2017.
- 45 Reorganizing primary health care in Sri Lanka: preserving our progress, preparing our future. Primary Healthcare Strengthening Project, Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka; 2018.
- 46 Policy on healthcare delivery for universal health coverage 2018. Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka; 2018.
- 47 Health Master Plan 2016-2025. Male: Ministry of health, Republic of Maldives; 2014.
- 48 India's mega health reforms: treatment for half a billion. *Lancet*. 2018 Aug 25;392(10148):614.
- 49 Ayushman Bharat Comprehensive Primary Health care through Health and Wellness Centers Operational Guidelines 2018 Ministry of Health and Family Welfare, Government of India.
- 50 Improving quality of care in the public health system in Bangladesh: building on new evidence and current policy levers. New Delhi: World Health Organization, Regional Office for South-East Asia, Asia Pacific Observatory; 2017 (SEA/APO/001; <http://apps.who.int/iris/bitstream/handle/10665/258711/SEA-APO-001.pdf?sequence=1>, accessed 10 September 2018).



- 51 Health system strengthening initiative technical brief. Dhaka: World Health Organization, Country Office for Bangladesh; 2017 (http://103.247.238.81/webportal/files/HSSTechnicalBrief_2017.pdf , accessed 10 September 2018).
- 52 Personal communication, Regional Emergency Director. New Delhi: WHO Regional Office for South-East Asia.
- 53 Community resilience in disasters: how the primary health care approach makes a difference in recent emergencies in the WHO South-East Asia Region. New Delhi: World Health Organization, Regional Office for South-East Asia; 2010.
- 54 Holmes D. Profile Margaret Chan: committed to universal health coverage. Lancet. 2012 Sep 8;380(9845):879.



