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Have health sector reforms strengthened PHC in developing countries?

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The policy thrust in the health system in many developing countries over the last decade has been on reforming structures. This paper examines such reforms in the light of the principles of primary health care that were adopted at the Alma Ata conference in 1978 and which are re-emerging as underpinning the current WHO global policies. It concludes that many of the reforms at best did not strengthen PHC and at worst ran counter to it.

Keywords: equity; health sector reform; multisectoralism; participation; primary health care; prioritization

Introduction

This paper examines two major policy initiatives that have been at the forefront of health system thinking in developing countries over the last 25 years. It firstly examines the primary health care policies that were set out in the Alma Ata Declaration of 1978 and which were espoused by governments throughout the world. It then looks at the policy focus of the last decade, which has been on health sector reforms. Finally it looks at the effects of the reforms on the original PHC principles which are now re-emerging as the key values on which to build health systems in the twenty-first century.

The Alma Ata Declaration and primary health care

Twenty five years ago, the WHO conference on primary health care held at Alma Ata resulted in a major declaration (WHO/UNICEF 1978) which provided the mainstay of policy thinking in low income countries for the following decade. The declaration, signed by health ministers from throughout the world, was a political statement which was the culmination of technical work drawn from the experience of the previous decade and before. The declaration set out a view of the strategy to achievement of health (at that stage encapsulated as 'Health For All' by 2000, which may be interpreted as a naively optimistic target or as a politically astute slogan). The endorsed strategy was one of primary health care (PHC). Alma Ata and its PHC strategy has remained an important milestone in the development of health policies globally and in particular in developing countries. Indeed one of the failures of the post-declaration activity was the inability to persuade 'developed' countries that it had relevance for their own health systems (Green, 1987). One of the causes of this was the very term 'primary health care' which was narrowly interpreted in some quarters either as referring to the first level of care incorporating a number of key elements (see Table 1) which for many developed countries were seen as existing already.

Elsewhere a broader more principle-focused interpretation was taken. This consisted of five major strands. Underpinning the whole philosophy was an explicit commitment to equity within both health and health care. This was a statement of values and created a political difficulty for governments espousing different political ideologies. Equity was not clearly defined in the declaration and its precise conceptualization and measurement remains the subject of discussion (McCoy *et al.*, 2003). Indeed it can be argued that one of the deficiencies of the declaration was its emphasis on equity within

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Table 1 Primary health care components

Broad themes
• The importance of equity as a component of health
• The need for community participation in decision-making
• An emphasis on health-promotional activities
• The need for a multisectoral approach to health problems
• The need to ensure the adoption and use of appropriate technology
Specific elements
• Education concerning prevailing health problems and the methods of prevention and control
• Promotion of food supply and proper nutrition
• Adequate supply of safe water and basic sanitation
• Maternal and child health care, including family planning
• Immunization against the major infectious diseases
• Prevention and control of locally endemic diseases
• Appropriate treatment of common diseases and injuries
• Provision of essential drugs

Source: Green (1999).

countries at the expense of that between countries.

The second strand was a commitment to participation by communities in decisions about health care. This can be seen to be both an objective in itself and a means to promoting better health. The former stems from a belief that the process of health improvement should fully involve individuals and communities and derives from both community development principles and wider civic democracy. The latter is a more pragmatic rationale that suggests that better health outcomes are likely to be achieved through services whose design and management have been informed by inputs from, and are 'owned by', individuals and communities. As with equity, the concept of participation has been interpreted differently in a number of quarters. Following the Alma Ata Declaration, a number of countries developed community participation initiatives ranging from community health worker schemes through to village health committees. Alternative interpretations were taken by proponents of community-based financing schemes, such as the Bamako Initiative (UNICEF, 1995) who have argued that the process of paying directly for health care is, in itself, a form of participation. Though the declaration said little about formal governance mechanisms as a means of strengthening participation, the subsequent interest in decentralization both in the health sector through deconcentration and more widely through devolution of central government has provided a potential, though often unrealized, opportunity for participation (Collins and Green, 1994).

The PHC philosophy also stresses the importance of preventive and promotive strategies in the pursuit of health. The continuing medical focus of most health systems has tended to mean that this has been interpreted primarily as strengthening the preventive aspects of health care delivery through both medical technologies such as immunization, and educating the public into more health promoting practices. However the PHC philosophy specifically called for a recognition of the multifaceted nature of health determinants and hence attention to strategies in other non-health-service delivery sectors. Multisectoral collaboration (as it was branded – though has subsequently frequently been confused with collaboration with other health care deliverers (more accurately multi-agency)) was often inadequately dealt with by the institution of national level committees with little power to regulate health damaging activities or provide incentives to health promoting activities by other sectors.

The final strand of the PHC philosophy was a call for more appropriate technology in the delivery of health care. This sprung in large degree from the critical resource constraints faced by the health sector in many countries and concerns that expensive medical technology could divert resources from those prevalent health problems that could be dealt with using lower cost technology. One specific example of this was the growth of essential drug lists to counter the overprescription of unnecessarily expensive and brand name drugs. In many respects this predated the subsequent growth in the discipline of health economics and in particular the techniques of cost-effectiveness and its application to technology assessment.

Health sector reform (HSR) policies

The period immediately after the Alma Ata Declaration witnessed significant leadership from

WHO as the main sponsor of the policy. Indeed it can be argued that the early 1980s was the zenith of WHO's global role in the health field, which was to a large degree supplanted by the World Bank in the following decade. Under the leadership of Dr Hafdan Mahler, the WHO Director General, countries were encouraged to put operational flesh on the bones of the PHC policy. One area of policy debate focused on the proposal (Walsh and Warren, 1979) that resource constraints would require a more selective approach focusing on particular diseases.

However, by the late 1980s and into the following decade the earlier optimism had been replaced by a sense of disillusion, particularly in the donor community, about the progress made towards health improvement. Major diseases, which had been seen as on the retreat including malaria and TB, were re-emerging alongside the growing HIV/AIDS pandemic. This failure to achieve health improvements and indeed in some countries to see a reduction in health coincided with wider shifts in the northern (donor) countries to the political right. The Alma Ata Declaration had been developed during an era when the prevailing assumption was that the public sector was the prime agent in the health (and other social) sector. This was now being challenged generally through economic policies of structural adjustment led by the IMF and World Bank which included a general push to reduce the role of, and resources placed in, the public sector accompanied by encouragement to the private sector. Within the health sector, this more general policy manifested itself in 1993 in the World Bank's World Development Report *Investing in Health* (World Bank, 1993; Zwi and Mills, 1995), which had both a general diagnosis of the problems facing the health sector and a more prescriptive set of reforms which to a large degree mirrored those going on in the UK NHS at the time.

There were three key elements of the health sector reforms. First, the reforms sought to increase the funding base of the health sector largely through the introduction of user fees (also rather coyly known as 'community financing' or, worse, 'cost recovery'). This coincided with the New Right philosophy of shifting the balance of responsibility for health from the state to the individual. The early enthusiasm for charges has increasingly been replaced by an awareness of its negative effects particularly in the terms of equity (Gilson *et al.*, 1995) and recent financing policies have focused more on the development of social insurance schemes either at the community or national level.

Second, the reforms attempted to face up directly to the inevitable shortfall between resources and health needs through seeking new explicit ways of setting priorities for the health sector. Two, in particular, gained particular support from international agencies whose financial leverage and technical expertise (particularly the former) meant that their views dominated the reform processes. These were the use of cost-effectiveness tools derived particularly from the newly emerged field of health economics and drawing on the contentious (Barker and Green, 1996; Anand and Hanson, 1997) measure of health, the Disability Adjusted Life Year (DALY), and the development of minimum or essential packages of health care.

Last, the reforms focused on how the constrained resources available to the health sector could be more efficiently used. This third element of the reforms contained a number of different components and was the most controversial. Key components included firstly attempts to introduce a split between purchasing (or as it later became known, commissioning) of health care and provision of health care. It was soon realized, however, that this direct mirroring of the internal market of the UK NHS in developing countries was unworkable largely because of the absence of realistic competition (or even contestability), on which the reform was predicated. A second component was a shift in the roles of the public and private sector with an encouragement to private agencies, including the voluntary sector NGOs (non-government organizations) to provide curative care leaving the public sector to focus on provision of public health services and regulatory responsibilities which had previously been neglected. A third component was decentralization policies in response to concerns over excessive, irresponsive and bureaucratic central control with greater power being given to lower levels of the health sector (through deconcentration) or, where there were wider devolution policies, to local government. A particular aspect of this, that is echoed in recent UK foundation hospital policies, was the granting of greater powers to semi-autonomous hospitals.

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This focus on health sector reform dominated the health policy agenda of many developing countries over the last decade, but increasingly it was recognized that the approach contained a number of flaws. These can be categorized as errors of technical content and of process. As has been indicated in the preceding, a number of specific reform elements were drawn from an ideological belief in the power of the market and were untested. Furthermore their universal prescription failed to take account of the contextual differences between health systems and to recognize the inevitable failure of a single blueprint (Mogedal *et al.*, 1995). At a process level, the reforms were often perceived as being donor driven with little local ownership and thus, even where elements might have been relevant, the package was resisted.

By the end of the 1990s, the balance of global health sector influence had shifted away from the World Bank back to WHO (or perhaps more accurately to an uneasy partnership between them) as reflected in the WHO report of 2000 (WHO, 2000) which focused on health system performance and development (HSD) (a subtle shift away from the health sector reforms (HSR) of the previous decade). Unfortunately this report, which contained a new conceptual framework for understanding the critical elements of a health system (and introduced the health sector to the term of stewardship), is largely remembered for the political (and technical) furore around its attempt to develop league tables for the performance of national health systems (Musgrove, 2003).

The other major system-focused initiative of WHO was the Commission on Macro Economics and Health (WHO, 2001) which, though technically focused, had a critical political objective of shifting health up the agenda of policy-makers in terms of resource allocation. One of its significant and stark conclusions was the analysis that the minimum level of annual per capita resources that a country needed in order to provide basic health care was $34 – a figure which a number of countries were not attaining, particularly when it was recognized that current expenditure particularly favoured the specialist hospital sector. This provided WHO and other donor agencies with ammunition to use in the fight for health sector resources. This drive for resources has been manifest in a number of different areas. First, the links between health and poverty are increasingly being seen as an important, yet previously neglected, policy focus, leading to potential access for international official funding from heavily indebted poor country (HIPC) initiatives related to debt relief measures. Secondly, there are attempts through international public private partnerships to attract funding from a variety of sources to specific targeted health initiatives (Walt and Buse, 2000). The most recent of these is the global fund against AIDS, malaria and TB set up in recognition of the failure referred to earlier to respond to these major killers.

Assessment of effect of HSR and HSD on Health systems and PHC in developing countries

In this last section the relationship between these health reform policies and the aspirations set out in the Alma Ata Declaration and its PHC philosophy is examined.

The above has suggested that international health policy in the last decade has focused on the structure and operation of the health system. Of course, there have been a number of technical policy developments occurring in parallel with this which have not been referred to here given the focus of the paper. However it can be argued that the last decade has seen unprecedented interest in the operation of the health system in the search for a structure to deliver the health outcomes that are clearly desperately needed in many low-income countries. Three indicators of the failure to do this illustrate this strongly and are shown in Table 2.

It was argued earlier that the key value underpinning the PHC approach was that of equity. The gap between the health experiences of low- and high-income countries remains as large as ever, and indeed for the poorest countries is growing (WHO, 2003). Clearly this failure to reduce the gap would be difficult to attribute to a single cause, and in particular health sector reform policies within low-income countries, particularly where the health decline has been affected by the AIDS epidemic as in some sub-Saharan African countries. It can be argued, however, that the overenthusiastic adoption of particular models of reform in the 1990s for

Table 2 Life expectancy and mortality rates, by country development category (1995–2000)

Development category	Population 1999 Millions	Annual average Income US $	Life expectancy at birth (years)	Infant Mortality (deaths before age 1 per 1,000 live births)	Under 5 mortality (deaths before age 5 per 1,000 live births)
Least-developed countries	643	296	51	100	159
Other low-income countries	1777	538	59	80	120
Lower–middle-income countries	2094	1200	70	35	39
Upper–middle income countries	573	4900	71	26	35
High-income countries	891	25730	78	6	6
Sub-Saharan Africa	642	500	51	92	151

Source: WHO (2001).

which there was no clear evidence may have, at a minimum, distracted attention from service delivery issues which affect equity.

Furthermore, aspects of reforms and in particular the growth of the private sector and user charge policies have disadvantaged particular groups in society, and especially the poor and those with less power to access the system (Gilson *et al.*, 1995). The increased interest in social insurance signals a return to collective forms of health financing and the greater potential for equity in terms of contributions. However, the precise design of insurance arrangements is important. For example, use of co-payments is a user charge by any other name; fixed level contributions are inherently more inequitable than income-related contributions; exclusion of dependants implies major inequities; the type of benefit package and the provider mechanisms can lead to inequities between patients by health need or by location and the possibility of opting out by high income earners/low users reduces the cross-subsidization necessary for any genuine equity-focused financing scheme.

In addition to the above general concerns, community-managed insurance schemes carry the potential for intercommunity inequity reflecting differential income levels. Such intercommunity inequity is also possible as a result of decentralization policies (Collins and Green, 1994) where there are either significant differences in the ability of different local areas to raise revenue for health care, or the priority given to health.

There is mixed evidence on the likely effect of health sector reforms on participation in health sector decision-making. In part this depends on the purpose underlying the participation and which form of participation is seen as desirable. It has been argued that user charges provide an incentive for greater individual patient participation and community financing provides a mechanism for community involvement though often only related to the management of a revolving drug fund rather than wider issues. At the wider level, whilst decentralization may suggest opportunities (and indeed a major underpinning motivation) for greater control at the local level, in practice this depends on both the precise form of governance and the incentives/requirements within the system to/on health professionals to open up decision-making. Local decision-making carries the potential for greater control by either health professionals or by local elites (Collins and Green 1994). There are interesting examples of participation in Brazil where community-based forums are used to influence wider priorities. This is at the other end of a spectrum from the technocratic black box approach to prioritization represented by the cost-effectiveness tools which are inherently disempowering of the wider community (Green and Barker, 1988).

The objective of health sector reforms is, of course, to improve the levels of a society's health – primarily through more efficient use of resources. However, one of the dangers of the health sector reform 'movement' has been that there has been greater attention to technical efficiency (maximizing the output from a given set of inputs) rather than allocative efficiency (maximizing the output from the overall sector). Reforms have led to two often competing structural forces in this respect. The essential service

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package is a mechanism whereby centrally determined priorities which should reflect allocative priorities are imposed. However, the strengthening of selective vertical disease-focused structures runs counter to this, particularly given that the funding of such structures is often largely in the hands of different aid organizations, including public private partnerships with no mechanism for arbitrating between different overall priorities (Unger *et al.*, 2003).

As such there is no particular reason to associate health sector reforms with a greater emphasis on preventive health interventions. Closely linked to this is the Alma Ata principle of multisectoralism which was closely associated with an 'upstream' promotive focus on wider determinants of health. Devolutionary decentralization policies provide one possible mechanism by which such promotive strategies may be enhanced – depending on the range of sectors for which local government has responsibility. However, there is little evidence that where this has occurred local government has acted in a more co-ordinated fashion than central government (Green *et al.*, 2002).

It can be argued also that the emphasis on the private sector that was, to varying degrees, an important component of health sector reform, has resulted in a greater focus on curative rather than preventive care, and also may have led to less appropriate technology. In Thailand, for example, the inappropriate growth in CT scanners (given the health needs of the majority of the population), has been associated with the growth in the private sector (Green, 2000). Furthermore, the growth of the private sector has not been accompanied by enhanced regulatory mechanisms to ensure quality. Across most of Asia, for example, increasing numbers of patients with TB seek treatment from private practitioners – yet this treatment is generally of poor quality with very low cure rates, leading to increased TB prevalence of drug-resistant strains (Newell, 2002).

Conclusion

The preceding has provided an overview of the major shifts that have occurred in low–middle income countries since the Alma Ata Declaration, focusing particularly on the health sector reform policies that dominated the agenda in the last decade. During this period the guiding principles of Alma Ata were overshadowed by the restructuring of health systems, with pursuit of efficiency as the key driver. Whilst it would be hard to challenge the diagnosis that provided the platform for the reform movement, it is increasingly recognized that the particular reform prescriptions were not necessarily appropriate and, in some cases, ran counter to the PHC principles. It is positive therefore to note that in the texts of the newly appointed WHO Director General, PHC is re-emerging, albeit blinking, into the light after many years of shadow. The recent WHO report (WHO, 2003) *Shaping the future* encouragingly is based firmly and explicitly on PHC principles. Furthermore, it recognizes the importance of health systems and their appropriate structure and resourcing to redress the massive global health inequalities and in pursuit of the wider millennium development goals.

A number of critical challenges face this re-emerging philosophy. First, it is difficult to turn the reform clock back. Some of the changes that have taken place have had negative effects, which are hard to reverse. In particular, for a number of countries the encouragement of the private sector can be seen to have caused long-standing damage to the public sector. Secondly, the gaps in health experience between the richest and very poorest countries are growing, and attention needs to be given to this aspect of inequity. This is particularly the case given the potential for globalization to exacerbate such inequities in, for example, the siphoning of health professionals between differently resourced health systems. Thirdly, whilst Alma Ata stressed the importance of multisectoralism, pursuit of the broader determinants of health remains elusive, with the focus in the health sector remaining, to a large degree, on health service provision. Lastly, the critical issue of participation in health system decisions and at a broader level, empowerment of the community remains one of the principles requiring considerable further work in all health systems (Florin and Dixon, 2004).

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