



## Shifting Focus of Primary Health Care in the Context of Health Systems Reform in Resource Poor Settings

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### Abstract

**Purpose:** To review the concepts of Primary Health Care (PHC) and provide evidence for a shift in its focus and implementation in the resource poor setting.

**Sources of data:** Desk and internet based review of relevant articles and official documents.

**Data extraction:** Search themes were 'concepts and models of PHC', contextual issues in PHC and health care reforms aimed at achieving the universally accepted core social values of health care delivery.

**Results:** Four main concepts and approaches to PHC include selective PHC, primary care; Alma-Ata comprehensive PHC and health and human rights approach. The concept of PHC in resource poor settings is oversimplified and restrictive. This is in contrast with the situation in well-resourced contexts where primary care concept is practiced. The World Health Organisation recommends a shift in focus of PHC through four sets of reforms in the health system, universal coverage reforms, service delivery reforms, public policy reforms and leadership reforms. This shift should bridge the gap between citizens' expectations and performance of the health care system.

**Conclusion:** Inability of health services to deliver levels of national coverage that meet stated demands and changing needs has been a source of worry. The health systems need to respond better and faster to the challenges of a changing world.

**Keywords:** Primary care; Primary health care; Universal coverage; Health reforms; Social protection

### Introduction

The Alma-Ata conference, held about thirty years ago resulted in a paradigm shift in the thinking about health and this eventually led to the mobilization of the "PHC movement" of professionals, institutions, governments, civil society organizations, researchers and grassroots organizations [1]. The movement aimed at resolving the "politically, socially and economically unacceptable" health inequalities in all countries. The Alma-Ata declaration focused on a set of values to be pursued such as social justice and the right to better health for all, participation and solidarity [2,3]. Health systems development has been devoid of equity and social justice and has failed to get the best health outcomes for citizens' money. Currently, three trends have characterized the health system; focusing disproportionately on a narrow offer of specialized curative care; using a command-and-control approach to disease control with focus on short term results and fragmenting service delivery; a laissez-faire approach to governance, which has allowed unregulated commercialization of health to flourish [1].

Globally, there has been a noticeable rise in social expectation among the citizens on health care, and attempts are being made to ensure that "their voice and choice decisively influence the way in which health services are designed and operated"[4-6]. In a recent PHC review by the Pan American Health Organisation, this perspective became clearer as the "right to the highest attainable level of health", "maximizing equity and solidarity" while being guided by "responsiveness to people's needs" [7]. The health systems should respond to the challenges of a changing world and growing expectations for better performance if the goal of health for all would ever be achieved.

The five common shortcomings of the health care system, especially in resource poor settings include the following; first, *Inverse care*, public spending on health services tend to benefit the rich more than the poor [8] in high- and low income countries alike [9-10].

The rich people, whose needs for health care are often less, consume the most care, whereas those at lower socio-economic level with the greatest health problems consume the least [11]. Secondly, *impoverishing care*, where health expenses are paid out-of-pocket by people who do not have social protection, which may lead to impoverishment [12]. Thirdly, *fragmented and fragmenting care*, which is a feature of excessive specialization by health-care providers and narrow focus of many disease control programmes, which discourage a holistic approach to health care and need for continuity of care [13]. Health services for the poor are often highly fragmented and severely under-resourced [14,15]. Fourthly, *unsafe care*, results from poor system design leading to lower safety and hygiene standards, high rates of hospital-acquired infections, and medication errors [16]. Finally, *misdirected care, in which more resources are being allocated to curative services, neglecting the primary prevention and health promotion which contribute up to 70% of the disease burden in communities* [17].

There is need therefore for a thorough understanding of the PHC concepts and models in order to understand the basis for paradigm shift.

The concept of PHC has undergone tremendous over simplification in resource poor settings, e.g. sub Saharan Africa [1]. In well-resourced contexts, however, primary care is described in the context of physicians

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in family medicine or general practice specialty. This concept contrasts sharply with the restrictive and poorly conceptualized primary care recipes used in resource poor settings.

The purpose of this paper is to review the concepts of PHC and to provide evidence for a shift in its focus and implementation in resource poor settings. In addition, the paper examines the contextual issues in PHC as well as the recommended health care reforms for adoption in resource poor settings.

## Methods

Literature search of Medline using Ovid and Pubmed for all papers focusing on concepts in primary health care in developing and developed countries' settings which were published since 1970 was carried out. The first search theme used was concepts and models of PHC with sub-theme as - essential criteria of PHC. The second search theme was contextual issues in PHC with a sub-theme of types of health facilities, and changing role of doctors, assessment of quality of care, and medical education. The third theme was health care reforms aimed at achieving the universally accepted core social values of health care delivery. Studies concerning primary care concepts of individual diseases were excluded, and searches were limited to concepts on which nations organised and evaluated their health care systems. Abstracts were reviewed individually to identify potentially relevant papers, while the full papers were reviewed to select those included in this paper. Subsequently, references to these papers were searched by hand to identify additional publications. Other sources used were libraries and some official government documents and reports.

Three reviews papers, two reports and 32 descriptive papers on conceptual and contextual issues as well as health care reforms were found and represent the work by the author. No quantitative data was included in this survey.

## Results and Discussion

In order to achieve the PHC value of health for all, the health system must "put people at the centre of health care" [19]. Currently, the dominant paradigm is curative medicine, while the PHC paradigm assumes that a diversified health care team should use modern technology and resources to anticipate and promote well being [20].

### Concepts and models of PHC

Two papers saw PHC strategy as an innovative idea that provoked contradictory views and wide differences in interpretation [21]. They reported that the deviations of conceptual content and practice of PHC lead to the concept of selective PHC that is practiced in resource poor countries [21]. Others insist that the divergent views are a product of the ambitious and somewhat vague descriptions of PHC as contained in the Alma-Ata declaration [22]. This argument tended to portray the differences in the conceptualization of PHC as being inherent in the descriptions.

Fourteen papers were reviewed on conceptual theoretical paradigm of PHC as being implemented globally. Four main models of PHC have been described, which include the selective PHC, Primary care concept, comprehensive PHC and health and human rights concept [23]. The first model was described as selective PHC concept which focuses on a limited number of high-impact services to address some of the most prevalent health challenges in developing countries [24]. The main services include GOBI (growth monitoring, oral rehydration techniques, breastfeeding, and immunization) or where food

supplementation, female literacy, and family planning are included GOBI-FFF. This concept emphasized specific set of health service activities directed towards the poor. Most resource poor countries including Nigeria hold this concept of PHC.

The second model is the primary care concept which refers to the entry point into the health system that provide continuing health care for most people, most of the time. This concept and approach to PHC is common in Europe and other industrialized countries. The approach depends on the availability of practicing physicians in general practice or family medicine specialty. It represents a level of care in a health care system [25-27].

A third concept encountered during the search was Alma-Ata 'comprehensive PHC' concept, which defines PHC as the first level of care that is integrated and comprehensive. It includes elements of community participation, inter-sectoral collaboration and reliance on a variety of health workers and traditional practitioners. This concept includes several principles: the need to address wider health determinants; universal accessibility and coverage on the basis of need; community and individual involvement and self reliance; inter sectoral action for health; and appropriate technology and cost effectiveness in relation to available resources [28-31].

Finally, the fourth concept identified was the health and human right concept, which views health as a human right with the need to tackle the broader social and political determinants of health [32]. It advocates that the social and political focus of PHC should be emphasized more than disease-specific aspects [33]. Some papers noted that, although all countries agree on the principles underlying PHC, they differ greatly in their approach to implementation and management of PHC [34-35]. They found that in the resource poor countries, oversimplification of the PHC message by the PHC movement resulted in the adoption of the one-size-fit all recipes, which is ill adapted to different contexts and problems [28]. Consequently, national and global health authorities have tended to see PHC not as a reform strategy but as a health care delivery programme among many, providing poor care for poor people [1]. It has been argued that a shift in PHC focus will provide a sense of direction to the health system, and nations are required to apply a set of specific and context sensitive reforms that respond to challenges of today, while preparing for those of tomorrow [36].

The essential criteria of PHC include accessibility, equity, social justice and protection, improved first contact with the health care system, decentralization of the existing health system, without neglecting the quality of care on higher-level medical services [21].

### Historical context in PHC

Nine papers dwelt on the historical context in which PHC is being introduced. It was observed that many developing countries inherited colonial infrastructures with imbedded values, perceptions, expectations, administration, which may require radical change [34]. Hospitals constitute a very important element of the health care system and they present many challenges to policy makers undertaking reform of health care systems. Hospitals account for about 50% of overall health care expenditure in most countries, dominating the rest of the health care system and being viewed by the public as the main manifestation of the health care system [37]. In South Africa communities are first classified as "developed" or "developing" areas. These communities require different methods of PHC provision depending on their level of development. It is argued that because problems, priorities and resources are not the same in both communities they can not have

same health service [38]. The day hospital and large comprehensive health centres are gaining support as ideal facilities for delivering PHC, especially in urban areas [39]. In South Africa, first-contact primary care is delivered by nurses in small clinics and larger community health centres (CHC) [40]. In China, the government decided to develop a PHC system rather than to promote a system of specialized health care for a small segment of the population [41]. Also, the government established a universal, compulsory financial system for health care [42].

Two articles reviewed concluded that there is need for the doctors' roles to change in line with the principles of primary health care with the implication of expanding service coverage to rural communities. The authors stated that doctors should not only be competent clinicians but also good managers of health promotive and preventive programmes, effective hospital administrators, competent trainers and qualified researchers. The doctor should be able to perform three functions in the PHC system, i.e. consultation, supervision, and training [43]. Adequate knowledge and appropriate skills in supporting PHC at the community level are a prerequisite of a district doctor.

The challenges in resource poor settings are that graduates of traditional medical schools are not adequately equipped for the emerging new roles for doctors in rural hospitals. There is need for reorientation of the existing health system to be able to achieve this. The critical factor in this process of change is the development of appropriate attitudes at all levels of health services. This change involves long established medical institutions which hold firmly to old traditions and values.

Urgent issues for consideration by those involved in the preparation of the curriculum of medical education is the role of the physician in a PHC system and how medical schools can best prepare their prospective graduates for this role in a developing country [44].

Two articles were reviewed on quality of care, both treated quality as relationship issues. This is referred to as patient centeredness [45]. Trust, mindfulness, heedfulness, respectful interaction, diversity, social/task relatedness, and rich/lean communication were identified as important in practice improvement [46]. These were considered to be the core features of patient centeredness. The organisation for economic cooperation and development OECD member countries are more detailed when they make reference to quality of care and they expand the features to include the following dimensions; acceptability, accessibility, appropriateness, capacity, competence or capability, continuity, effectiveness or improved health or clinical focus, efficiency, equity, patient centeredness, or patient focus, or responsiveness, safety, sustainability and timeliness [47-48]. Four papers were reviewed on the adequacy of the medical education of doctors. The authors agreed that the traditional system of medical education did not prepare doctors adequately in developing countries for their expected leadership role in meeting the health needs for their communities through primary health care [49-50]. This is in spite of the acknowledgement and adoption of the Alma-Ata declaration by majority of the countries of the world as a strategy for achieving health for all [51]. Changes in medical education must accompany changes in structure, content and organisation of health services so that health professionals will not find it difficult to function as team leaders in the health care system. There is need for a reorientation of physician training toward primary health care, increasing the quality of existing health services, and ensuring more efficient management of resources [52].

## Health care reforms

Five papers were reviewed on health care reforms in developing countries. One of the papers showed that in Ghana, health care reforms involved changing to a 3-tier health system made up of level A, the community level; level B, the local council subareas; and level C, the district [53]. In Cameroon, obstacles to primary health care include low priority in the country's budget and over-all policy [54]. It has been argued that the goal of equality of health status may not be appropriate in many developing country situations. Instead it has been suggested that a stepwise approach based on progressive redistribution of medical services and resources may be more appropriate as goal [55]. In Thailand, health care system incorporates the private and public sectors. The government regulates health care, protects its interests while providing a climate for competition. Consequently, the private sector has developed and implemented some concepts in health care, neighbourhood-based ambulatory care and home care [56]. In one of the 36 states in Nigeria, Enugu state, the district health system (DHS) was introduced as a structural means of integrating primary and secondary health care services with a functional referral system in the State. Consequently, the health reform law of 2005 assigned the functions of providing policy development, structural reforms, creating integrating structures, decentralization of control, universal access to health care for all citizens, effective referral system (these are assumed and not emphasized in the developed countries' concept of health system) among levels of health care [57]. The law provides for the strengthening of the health system by emphasizing integrated monitoring, supervision and support by levels of component structures of the DHS. The public private providers were to be involved in the DHS.

## Recommended conceptual shift by world health organisation

The review of the World Health Report 2008, on the current concerns on PHC showed a remarkable shift in paradigm [2]. The focus is shifting from access to a basic health package interventions and essential drugs for the rural poor to total transformation and regulation of existing health systems for universal access and social health protection. The focus on maternal and child health is shifting to the all inclusive concept of dealing with the health of everyone in the community. The focus on caring for small number of selected diseases, especially infectious and acute illnesses has shifted to a comprehensive response to people's expectations and needs, and covering all risks and illnesses [2]. The focus on improvement of hygiene, water, sanitation and health education at village level is shifting to the promotion of healthier lifestyles and mitigation of the health effects of social and environmental hazards. Simple technology for volunteer, non-professional community health workers shifts to teams of health workers facilitating access to and appropriate use of technology and medicines. There is need for a shift from the participation as the mobilization of local resources and health-centre management through local health committees to the institutionalized participation of civil society in policy dialogue and accountability mechanisms. Government-funded and delivered services with a centralized top-down management should be replaced with pluralistic health systems operating in a globalized context. The focus on management of growing scarcity and downsizing should shift to guiding the growth of resources for health towards universal coverage. The focus on bilateral aid and technical assistance should shift to global solidarity and joint learning, while that of primary care as the antithesis of the hospital shift to Primary care as coordinator of a comprehensive response at all levels. Finally, the

concept of PHC being cheap and requiring only a modest investment should be dropped in favour of PHC not being cheap and requiring considerable investment, but it provides better value for money than its alternatives.

### Recommended health care reforms by WHO

The review of WHO's recommended reforms revealed four sets of reforms [2].

The four sets of reforms necessary to refocus the health system to achieve the objective of health for all (HFA) include universal coverage, service delivery, public policy and leadership reforms. Universal coverage reforms deals with equity, social justice and the end of exclusion in the health system, primarily by moving towards universal access and social health protection. Service delivery reforms is a component of health system reforms, which reorganizes health services as primary care, focusing on people's needs and expectations, so as to make them more socially relevant and more responsive to the changing world while producing better outcomes. Public policy reforms deals with policy making reforms and aims at securing healthier communities, by integrating public health actions with primary care and by pursuing healthy public policies across sectors. Leadership reforms replace disproportionate reliance on command and control and laissez-faire by state with an inclusive, participatory, negotiation-based leadership, which is required by the complexity of contemporary health systems.

### Recommended shift in PHC conceptual theoretical framework

According to the World health report of 2008, Primary care should provide a platform for people to bring a wide range of health problems. This is in contrast with what obtains in low-income countries where primary care deals with a few "priority diseases". Primary care should be the hub/ compass on which patients are guided through the health system, however, in low-income countries, primary care has been reduced to a stand-alone health post or isolated community-health worker [1].

Primary care sets the stage for the ongoing relationships between patients and clinicians, and offers a platform for the patients to participate in decision-making about their health and health care. It should provide the link between personal health care and patients' families and communities; however, this is different in low-income countries, where primary care is restricted to a one-way delivery channel for priority health interventions [1].

Primary care should offer opportunities for disease prevention, health promotion and early detection of disease, in contrast with what obtains in low-income countries, where primary care is all about treating common ailments. In developed economies, primary care requires teams of health professionals such as physicians, nurse practitioners, and assistants with specific and sophisticated biomedical and social skills, whereas in low-income countries, primary care is synonymous with low-technology and non-professional care for the rural poor.

Primary care requires adequate funding to enable it provide much better value for money than its alternatives rather than what obtains in low-income countries, where primary care is funded through out-of-pocket payments on the erroneous assumption that it is cheap and the poor should be able to afford it.

## Conclusion

The four main models of PHC include the selective PHC, primary care concept, comprehensive PHC and health and human rights concept. Countries differ greatly in their approach to implementation and management of PHC. The PHC concept and implementation should be context sensitive in order to address the citizens' needs and expectations. There is need for the doctors' roles to change with regards to the expanding service coverage to rural communities. The doctor should be able to perform three critical functions in the PHC system, i.e. consultation, supervision, and training. The deficiency of the traditional system of medical education in preparing doctors for their expected leadership role in primary health care has been emphasized. The adoption of the WHO's recommended shift in the focus of PHC as well as the implementation of health reforms remains the panacea for achieving the objective of health for all.

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