

B1 | PRIMARY HEALTH CARE: A REVIEW AND CRITICAL APPRAISAL OF ITS 'REVITALISATION'

Introduction

In 2008, the 30th Anniversary of Alma-Ata, primary health care (PHC) was reaffirmed as the key global strategy for attaining optimal health. Celebratory meetings were held under the auspices of the World Health Organisation (WHO) in all its regions. The WHO World Health Report 2008 (WHRo8) was devoted to PHC (WHO 2008). In 2008 *The Lancet* produced a themed issue on PHC.

Notwithstanding these activities and publications there remains confusion, disagreement, and controversy around PHC in terms of its content, emphasis and application.

This chapter analyses the current discourse on PHC, noting different interpretations that threaten its revitalisation as a strategy for both health improvement and the struggle for social justice. The chapter then briefly reviews selected examples of current large-scale (mostly national) experiences that exemplify innovation in PHC implementation. It concludes with some guiding perspectives on the role of social movements in promoting PHC.

Progress and context

In the thirty years since the Alma-Ata Declaration there has been significant progress in global health with an overall increase in life expectancy. However, rapidly widening inequalities in health experience between and within countries – and even reversals in Africa and the former Soviet bloc countries – have led to a re-examination of the current context and content of health policies and why the Alma-Ata Declaration failed to lead to health for all (Commission on Social Determinants of Health 2008).

The key question is whether PHC, as originally elaborated at Alma-Ata, remains a feasible option.

This re-examination shows that a series of reform projects, with some key common features, driven by vested interests and short-sightedness, have perpetuated or aggravated the conditions that underpin ill-health and undermined the ability of health systems to function appropriately. Key among these are selective PHC, health sector reform, and the global health partnerships. These have depoliticised health and undermined the spirit of PHC.

Selective PHC

While progress in implementing the PHC strategy in most low and middle income countries (LMICs) has been greatest in respect of certain of its more medically-related elements, the narrow and technicist focus characterising what has been termed the ‘selective PHC’ approach (Walsh and Warren 1979) has at best delayed, and at worst undermined, the implementation of the comprehensive strategy codified at Alma-Ata. The latter insisted on the integration of rehabilitative, therapeutic, preventive and promotive interventions with an emphasis on the latter two components. Selective PHC (SPHC) took the form in many LMICs of certain selected medical – mostly therapeutic and personal preventive – interventions, such as growth monitoring, oral rehydration therapy (ORT), breastfeeding and immunisation (GOBI). These constituted the centrepiece of UNICEF’s 1980s Child Survival Revolution, which, it was argued, would be the ‘leading edge’ of PHC, ushering in a more comprehensive approach at a later stage (Werner and Sanders 1997). The relative neglect of the other PHC programme elements and the shift of emphasis away from equitable social and economic development, intersectoral collaboration, community participation and the need to set up sustainable district level structures suited the prevailing conservative winds of the 1980s (Rifkin and Walt 1986). It gave donors and governments a way of avoiding the fuzzier and more radical challenges of tackling inequalities and the underlying causes of ill-health. Some components of comprehensive PHC, especially the promotive interventions, have remained marginalised ever since Alma-Ata. These require for their operationalisation the implementation of such core principles of PHC as ‘intersectoral action’ and ‘community involvement’, and, increasingly with economic globalisation, intersectoral policies to address the social determinants of health (SDH) (Sanders et al. 2009).

PHC has been defined (even in the Alma-Ata Declaration) as both a ‘level of care’ and an ‘approach’. These two different meanings have persisted and perpetuated divergent perceptions and approaches. Thus, in some rich countries and sectors, PHC became synonymous with first line or primary medical care provided by general doctors, and simultaneously PHC has been viewed by many as a cheap, low technology option for poor people in LMICs.

The Alma-Ata Declaration was one of the last expressions of the development thinking of the 1970s where the non-aligned movement declared its commitment to a ‘New International Economic Order’ (Cox 1997) and a ‘Basic Needs Approach’ to development. These visionary policies were buried in the 1970s debt crisis, stagflation, and the dominance of global economic policy by neoliberal thinking. This, together with rising unemployment and changes in the labour market, changes in demographic and social trends, and rapid technological advances with major cost implications for health services, has, over the past two decades, driven a process of ‘health sector reform’ in industrialized countries and LMICs.



6 Woman in a shanty in Cape Town, South Africa: persisting social and economic inequity in LMICs (Louis Reynolds)

Health sector reform

While there is no consistently applied, universal package, ‘health sector reform’ reflects and reinforces neoliberal policies. It includes the restructuring of national health agencies; planning of more cost-efficient implementation of strategies and monitoring systems; the introduction of user fees for public health services; introducing managed competition between service providers; and involving the private sector through contracting, regulating and franchising different private providers (Cassels 1995).

Although these aims appear rational, health sector reform has sometimes aggravated inequities (as with user fees in several countries) or led to a deterioration of local health services as decentralisation of responsibility has occurred without the accompanying decentralisation of resources and enhancement of local capacity. The reform process has evolved at different rates and to different extents in different countries. In many LMICs the rhetoric obscures the fact that fundamental change has not occurred (Mills 1998).

The combined impact of recession, deteriorating terms of trade, debt and harsh economic policies and health sector reform had damaging effects in LMICs, resulting in:

- persistent social and economic inequity and lack of progress in addressing the social determinants of health;
- declines in real public health expenditure and increasing donor dependency, including for recurrent health spending on wages, equipment and supplies;
- deterioration of health facilities and equipment;
- shortages of drugs and other supplies;

- dwindling patient attendance at public facilities as the quality of care worsened; and
- a catastrophic loss of morale and motivation of public health workers as the value of their salaries plummeted and as expenditure constraints undermined their ability to work (Segall 2003).

Global health partnerships

In response to this health crisis – starkest in Africa – and in line with greater engagement with the private sector, a plethora – around 100 – of global health partnerships (GHPs) or global health initiatives (GHIs) have emerged in the late 1990s and 2000s (Brugha 2008). These include the Global Alliance on Vaccines and Immunisations (GAVI), the Global Fund to Fight AIDS, TB and Malaria (GFATM), the World Bank Multi-country AIDS Programme (MAP) and the US President’s Emergency Plan for AIDS Relief (PEPFAR). Although these GHIs have brought welcome increased funding for priority diseases, they have at the same time reinforced the selective approach to PHC by privileging vertically implemented and managed programmes that mainly emphasize therapeutic (e.g. antiretroviral treatment) and personal preventive (e.g. prevention of mother to child transmission of HIV) interventions while significantly neglecting upstream determinants of these diseases – such as gender oppression and violence – as well as their broader consequences, such as AIDS orphans.

There is compelling anecdotal evidence that these target-driven, performance-based funding mechanisms pressurise countries to ‘focus on more easily reached target populations and politically high profile treatment campaigns, thereby exacerbating inequities, neglecting population-wide public health programmes’ (Brugha 2008), including shifting health personnel away from general health care, and fragmenting services into a set of parallel ‘vertical’ programmes.

Key points of confusion and controversy in the current discourse

The Lancet series on PHC In 2008, an important and timely series in *The Lancet* reflected the renewed interest in comprehensive primary health care in the last years, and the recognition that mainstream health reforms (many inspired by neoliberal policies) have failed to achieve the desired health gains and have almost certainly contributed to greater health inequity.

While the Lancet Series assembles much evidence supporting the positive impact of primary health care, its bias towards selective PHC is reflected in one of the key articles (Rohde et al. 2008). This article analyses the 30 countries – with more than 100,000 births per year – which have achieved the highest reduction in under-five mortality. All are assessed as having scaled up selective primary health care (SPHC) and 14 are said to have progressed to comprehensive primary health care.

Throughout the series there is inconsistency in the use of the term ‘com-



7 Demise of primary health care (indranil mukherjee)

prehensive PHC'. The above article defines comprehensiveness in terms of the range of clinical interventions which are funded and provided: 'We selected immunisation coverage ... (DPT3) and contraceptive prevalence rate as indicators of selective primary health care implementation, and skilled birth attendance coverage as a marker of the development of a comprehensive primary health care system' (ibid.).

It is clear that 'comprehensiveness' here is used to refer to a larger range of health care interventions compared with a more restrictive 'selective' approach. The analysis of the phased implementation of primary health care is limited to expansion of health services which are predominantly facility-based and curative. The emphasis in this article – and indeed in the whole series – is narrowly on health care, i.e. the supply of more effective service, leaving out the essential elements of PHC, including intersectoral collaboration and community participation. Even health extension workers (including community health workers) are seen as an interim way to increase coverage of services which can then give way to more skilled workers in a more mature ('comprehensive') health system. This approach is really an analysis of a phasing-in of a broader set of selective interventions rather than of a comprehensive primary health care approach.

By contrast, the first article in the series exemplifies a broader and more comprehensive view of PHC in its review of the policy history since 1978 (Lawn et al. 2008). It refers to 'the comprehensive process of local community involvement, and improving health and the social environment through effective intersectoral action'. It is this second construction of comprehensiveness that is correct (Legge et al. 2009).

For example, in addressing diarrhoea in children, a selective PHC approach would focus solely on oral rehydration, breastfeeding and integrated clinical management protocols. A comprehensive approach would also catalyse (or take)

action on issues of water supply, sanitation and food security. The Alma-Ata Declaration projected an image of community mobilisation around the struggle for water supply, sanitation and food security and identified supporting this process as part of a PHC approach.

Another of the articles representing this second, broader and more authentic perspective on PHC is the paper on community participation (Rosato et al. 2008). The authors identify a crucial policy question: Can specific community participation interventions aimed at women and their families have a direct effect on maternal and child health? If so, how do these interventions work most effectively, and how can they be taken to scale? The authors then identify and review 13 intervention trials which are consistent with a definition of community mobilisation as ‘a capacity-building process through which community individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others’. Convincing evidence is presented for the eight completed trials of marked improvement in maternal, newborn and child health.

The WHO World Health Report 2008 (WHRo8) The WHRo8 report, although purporting to be devoted to primary health care (its title being ‘Primary Health Care: Now More Than Ever’), is more about health systems framed within WHO’s rather mechanistic and ‘supply-side’ framework than about PHC in its more comprehensive and empowering sense. Indeed, in WHRo8 ‘primary health care’ is often termed ‘primary care’, betraying an overweening emphasis on health services.

While the WHRo8 acknowledges the importance of urbanization, climate change, gender discrimination and social stratification, the health content of school curricula, industry’s policy towards gender equality, and the safety of food and consumer goods, there is no mention of the fundamental role of economic forces represented primarily by massive transnational corporations, which have flourished as trade liberalisation has broadened and deepened, nor of the international financial institutions (IFIs), or the global capitalist economic architecture exemplified by such organisations as the OECD, the G8 summits, or the World Economic Forum (Katz 2009).

The recent WHO Commission on Social Determinants of Health points the way to an understanding of the link between poverty and health, and to the imperative to address the upstream determinants of health that lie beyond the health sector. It notes: ‘The combination of binding trade agreements ... and increasing corporate power and capital mobility have arguably diminished individual countries’ capacities to ensure that economic activity contributes to health equity, or at least does not undermine it’ (Commission on Social Determinants of Health 2008: 133).

Unlike these later versions of PHC, the Alma-Ata Declaration emphasised

the fundamental importance of the economic and political context to PHC's success. Early in the Declaration it is stated: 'Economic and social development, based on a New International Economic Order (NIEO), is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries' (WHO and UNICEF 1978: 2). Indeed, the reference to a NIEO was removed from the abridged version of the Alma-Ata Declaration presented in the first paper of the Lancet Series (Lawn et al. 2008). The call for a NIEO in the Alma-Ata Declaration reflected the aspirations of the Non-Aligned Movement since the Bandung Conference of 1955 and the first UN Conference on Trade and Development in 1964. The significance of an unfair global economic regime in reproducing the health disadvantage of poor people is clearly articulated in the report of the WHO Commission on Social Determinants of Health.

The reference to the need for a NIEO in the Alma-Ata Declaration suggests that popular mobilisation to address unfair economic relationships is a legitimate and appropriate challenge for PHC practitioners. And, as indicated above, the notion of 'community participation' in these influential documents is overwhelmingly restricted to the arena of health care, eschewing the more radical notion agreed to by the member states of WHO in 1978 that health development through 'community participation' necessarily involves action on the broader environmental and social determinants, and that PHC can catalyse such action.

In summary: both the Lancet Series and WHRo8 have been important in contributing to the renaissance of primary health care. However, in the process of revision they have created a version of PHC that has been tamed and depoliticised.

Examples of successful implementation of PHC

Several programmes embodying the PHC principles were initiated before the Alma-Ata Declaration and some still continue to operate. Some of the best known are in India – for example, Jamkhed Comprehensive Rural Health Project and Deenabandhupuram Project (John and John 1984; Arole and Aroe 1994). There are others in Asia and in South America which demonstrate innovative applications of CPHC and achieved significant and durable improvements in health. These have shown consistent commitment to equitable, broad-based and multisectoral development. They include Sri Lanka, Costa Rica (we discuss these two in detail in Chapter B3) and Kerala State in India, all of which invested substantially in the social sectors, and particularly in women's education, health and welfare (Halstead et al. 1985).

The political commitment to social and health provisioning in these countries has been sustained through strong citizen participation. This has been achieved in Costa Rica through a long history of democracy and egalitarian policies and in Kerala through activism by disadvantaged political groups.

In rich countries such as Britain, Canada and Australia, while much of the clinical care remains with medical practitioners operating alone or in group practices, there have been some successful initiatives in comprehensive primary health care through community health centres. Typically these centres have been managed by community boards which have been a mechanism for moving community participation beyond rhetoric. Their activities have included: providing services to individuals (including medical, nutrition, counselling, podiatry, physiotherapy, speech pathology); support groups (e.g. stress management, dealing with violent behaviour, parenting skills, illness support groups for chronic diseases such as cancer, diabetes, asthma); community development and social action on issues such as domestic violence and local environmental concerns.

These centres had their heyday in the 1980s, but have suffered from the trends towards privatization, contracting out of government services and a retreat to 'core business' which is seen as treating disease rather than preventing it. In South Australia and Victoria, for instance, the network of community health centres with local boards of management have been amalgamated and found it more and more difficult to do the innovative primary health care work they engaged in in the 1980s. They have struggled to justify their existence as managerial reforms to the health system have introduced an emphasis on market economics (Baum 1995).

More recently several other countries have attempted to roll out PHC as state- or nation-wide programmes. These include such diverse examples as Thailand (discussed in Chapter B3), Rwanda, Iran and Brazil. Common features of all of these examples are: a coherent focus and consistent efforts to develop integrated health systems, the participation of communities through structures at different levels, use of community health workers (CHWs) and a focus on intersectoral actions to address the determinants of selected major health problems.

Thailand began implementing PHC in 1977 using Village Health Volunteers and Village Health Communicators, who are in high concentration at community level, and who are supported by paid health workers or 'facilitators' in a ratio of one facilitator to 10–20 volunteers. Collaboration in community development with other sectors, notably education and agriculture, was key in this strategy. Child nutritional status improved from 47 per cent in 1979–82 to 79 per cent, showing normal growth by 1989. Similar successes were achieved in immunization status, access to clean water and sanitation, and the availability of essential drugs (Nitayarumphong 1990) and the country is well on track to achieving its Millennium Development Goals and demonstrates much better health indicators than would be expected for a country of its level of wealth (Bureau of Policy and Strategy 2007).

Rwanda's 1994 genocide decimated its fragile economic base, destroyed a large share of the country's human capital, and eroded the country's health

infrastructure, reversing gains made in the previous 15 years. However, Rwanda has made dramatic progress in reconciliation and in reintegration of ex-combatants. Approximately 3.5 million Rwandan refugees out of a total population of 9 million have been repatriated and resettled. Sharp economic growth has occurred, but most remarkable has been progress in primary health care.

Two volunteers (one woman and one man) are elected by each village (100 to 150 households) to serve as CHWs. They are trained to monitor growth and development in children, to care for people living with HIV, to distribute family planning supplies, to treat certain diseases such as malaria and pneumonia, and to refer sick patients to the nearest health facility. In response to the effects at the community level of a mature HIV/AIDS epidemic, Rwanda has dedicated two other village-elected CHWs, one woman and one man, to dealing solely with end-of-life issues. These CHWs help ease the burden on family members by taking responsibility for caring for people in the late stages of any disease. Their care also reduces the number of dying patients brought to the hospital.

As there is still a high maternal mortality rate in Rwanda, traditional birth attendants are also being trained as CHWs to promote delivery at health facilities and are paid for every delivery they transfer to the local health centre.

A decentralised district health service has been implemented using performance contracts with local governments. At all levels of the district, health decisions are made collectively through various committees, which facilitate community participation in the health sector. Communities participate in the planning, implementation and monitoring of primary health care activities, including the provision of certain services at the grassroots level (nutrition, mental health, family planning, etc.) and propose appropriate solutions to local health problems.

Allocation of expenditure on human resources (HRH) to provinces and districts as a proportion of the total has increased between 2003 and 2007 from 37 to 85 per cent. Innovative schemes are being piloted to address the shortage of human resources in the sector, including hardship allowances for work in rural areas and performance-based financing for high impact services. These interventions have shown remarkable results: the total number of health personnel in publicly funded facilities almost doubled between 2005 and 2008 from 6,961 to 13,133. By 2008 80 per cent of nurses and 64 per cent of doctors were working at primary and secondary levels. The improved staffing, particularly at community and primary levels, together with access to health insurance, which is unique in Africa, the number of people covered expanding from 3 to 70 per cent of the population between 2002 and 2007, has resulted in greatly increased use of health services.

As with many other African countries finance for the health sector in Rwanda is dominated by donor project support, with donors contributing 43 per cent of all health sector funding and government 32 per cent. However, in

contrast to many other countries where such donor assistance has contributed to the verticalisation and fragmentation of services, the Rwandan Ministry of Health, through a donor mapping study and a systematic costing of the health sector strategic plan, has managed to direct donors to align their contributions with national policies. Each year all donors meet with government to evaluate progress made and plan future activities.

The results are starting to show – Rwanda become the only African country with near-universal access to HIV treatment. Immunisation rates, at 95 per cent, are among the highest in sub-Saharan Africa. Those using insecticide-treated bed nets increased from 4 to 70 per cent of the population between 2004 and 2007.

The infant mortality rate increased dramatically as a result of the genocide from 85 deaths per 1,000 live births in 1992 to 107 in 2000. As a result of the above interventions Rwanda is demonstrating impressive progress in health. The infant mortality rate had dropped to 62 deaths per 1,000 live births by 2007 and similarly, in the same period, under-five mortality fell from approximately 170 to 103 per 1,000 live births (Paulin et al. 2008).¹

Iran during the last three decades has implemented significant changes in its health system structure and witnessed major improvements in the health status of its population. Health system reform coincided with the Iranian revolution in 1979, which spawned enormous political change within the country.

The new health system was based on comprehensive primary health care and also saw the integration of medical education and health care services (since 1984) in response to health workforce shortages. A particular feature of the PHC reforms was a refinement and expansion of a community health worker (CHW) programme begun decades earlier. The expansion of the programme was specifically intended to extend basic health services to underprivileged areas. Iranian CHWs, called *behtarz* in Farsi, are locally sourced health workers with specialised training in the health needs of the rural population. *Behvarzes* are permanent employees of and paid by the Iranian health system. The village health house is the most peripheral health delivery facility in rural areas and the place from which the *behtarz* works. There are currently almost 31,000 male and female *behtarzes* working in these facilities which cover most of Iran's 65,000 villages (Javanparast 2011).

The country has made remarkable progress in a range of health indicators. Since 1974 the neonatal mortality rate (NMR), infant mortality rate (IMR), under-five mortality rate (U5MR), and maternal mortality ratio have declined dramatically. Life expectancy has increased from 55.7 in 1976 to 71.6 in 2003. Furthermore the rural–urban health gap has been greatly narrowed. In 1974 there was a striking difference in infant mortality rate between rural areas (120 per 1,000 births) and urban areas (62 per 1,000 births), attributable mainly to disparities in income, living standards and access to basic health and social services. This gap narrowed by 1996 (30.2 infant deaths per 1,000 live births



8 Rally for equity in health at Peoples Health Assembly, Cuenca, Ecuador, 2005 (David Legge)

in rural areas compared with 27.7 deaths in urban areas), with rural infant mortality declining further to 23.7 in 2003 (Mehryar et al. 2005).

In the mid-1980s, following the overthrow of the dictatorship and democratisation, Brazil initiated a large-scale community health worker programme, which preceded and contributed to the development in 1994 of the national Family Health Programme (Programa Saúde da Família or PSF in Portuguese). By 2010 this government-funded programme consisted of 33,000 community-based teams of physicians, nurses, nurse assistants and community health workers that cover over 60 per cent of Brazil's population of 190 million. Infant mortality, in Brazil, which was 114 per 1,000 live births in 1970, had declined to 19.3 per 1,000 live births in 2007 and life expectancy at birth increased by nearly 40 per cent, to 72.8 years in 2008.

These impressive advances cannot be attributed to the health sector alone but are significantly the result of several large-scale social reforms. School attendance has increased since 1990, and illiteracy rates decreased from 33.7 per cent in 1970 to 10.0 per cent in 2008. Between 1991 and 2008, Brazil's gross domestic product doubled and its high degree of income inequality decreased substantially as a result of a combination of social policies, including the social security system, the *Bolsa Família* conditional cash transfer programme, which covers 10.5 million families, and increases in line with the legal minimum wage. Living conditions have also improved substantially,

Box B1 PHC and the Aboriginal community in Australia

Aboriginal people pioneered the development of primary health care in Australia. A grassroots Aboriginal movement in collaboration with non-Aboriginal activists led to a referendum in 1967 which, for the first time, gave full constitutional rights to Aboriginal people, and subsequently a new period in Aboriginal affairs was established – the era of self-determination (Anderson 1997: 123). Aboriginal community-controlled health services developed within this context. In the mid 1970s Aboriginal health services developed the first national peak body – the National Aboriginal and Islander Health Organisation or NAIHO (Foley 1982), which developed into the National Aboriginal Community Controlled Health Organisation (NACCHO: www.naccho.org.au/) in 1992 as part of the implementation of the National Aboriginal Health Strategy.

Several years after the emergence of Aboriginal community-controlled health services in Australia, international commitment to primary health care (PHC) as a policy model was formalised in 1978 with the Alma-Ata Declaration on PHC. The significance of the Chinese model of barefoot doctors in inspiring the Declaration is well known; less well known is the participation of NAIHO representatives in the drafting of the Declaration.

Today there is a network of Aboriginal community-controlled health services in Australia which are committed to implementing comprehensive PHC. They offer a full range of PHC clinical and preventive programmes. Many also assume a strong advocacy role (Barlett and Boffa 2005). A recent example is the advocacy from 1995 to the present from the Central Australian Aboriginal Congress about the need to raise the unit price of alcohol to help prevent alcohol abuse (Senior et al. 2009). A recent review of the management and funding arrangements of these services demonstrated that they are overburdened by accountability requirements from the federal and state governments which fund them (Dwyer et al. 2009). This review recommended that the services need much simpler lines of accountability that are based on trust rather than distrust.

with dramatic increases in provision to households of indoor water, sewage disposal and electricity (Paim et al. 2011).²

The above examples comprise a spectrum of PHC experience which reflects the different histories and contexts of each country. In terms of community-based care the spectrum extends from approaches that have a strong emphasis on community-controlled, part-time workers (Thailand, Rwanda) to those where CHWs are formal members of sub-district health teams (Iran, Brazil).

Similarly, intersectoral action in Iran comprises a significant component of CHWs' activities, while in Brazil CHWs act primarily as health care workers and refer clients where necessary to other sectors for assistance. In Rwanda CHWs are permitted to treat illnesses, including childhood pneumonia with antibiotics, while in the other countries CHWs' roles are mainly promotive and preventive. In all the countries community participation occurs through structures within the health sector.

Fundamental to these countries' adoption of PHC and its innovative implementation have been facilitatory political movements and consistent actions by influential leaders and health professionals to support reform, although in Thailand, Rwanda and Iran there are aspects of government that are authoritarian.

Thailand has implemented many innovative health policies in spite of repeated military coups and an authoritarian government because of a progressive movement of social thinkers and health professionals. The Rural Doctor Society, which was formed in 1978, undertook various innovative activities to support rural district hospital directors and in 1982 established the Rural Doctor Foundation to sustain its activities. They were also active in the national movement for democratisation and political reform and played a watch-dog role to counteract corruption in the health sector (Wibulpolprasert 1999). In Rwanda, the determination of its people to overcome the horror of the genocide and visionary leadership have combined to build a strong movement to achieve social justice and democracy.

In Iran a radical revolution, which resulted from prolonged massive mobilisation against a long-standing dictatorship, although characterised by an Islamic authoritarian conservatism, spawned many progressive social reforms in health and welfare. Brazil's long struggle against a military dictatorship gave rise to a popular movement which brought together grassroots movements, trade unions, then illegal left-wing political parties and progressive academics and researchers. Such popular mobilisation has waned somewhat over the past decade, but 'social participation' in local government remains active and is structured through such bodies as the National Health Council, which plays an ongoing role in democratising policy development (Paim 2011).

The role of social movements in catalysing comprehensive primary health care

Notwithstanding the encouraging indications of renewed efforts for the revitalisation of PHC, there remains an overwhelmingly technocratic conception of its implementation. It is often implied that policy development and institutional reform take place because international policy experts and donors have identified the need and have decided to put in place the necessary implementation mechanisms ('scaling up', 'task shifting', etc.). In contrast, as we discuss in the country examples, commitment to universal primary health care reflects both the strength and the perspectives of social movements with

roots in political and social struggles. Simultaneously, in all the high-performing low income countries, these movements have thrown up national leadership committed to equity and PHC. One of the challenges, as the recent negative experience of China demonstrates (discussed in Chapter B4), is to sustain such political commitment and ensure continuing popular participation in health policy development and implementation.

Considerable historical evidence indicates the importance of power and politics in influencing the emergence of policies that have resulted in health improvement. The public health historian Simon Szreter, in analysing the British experience, states: ‘[w]hile economic growth may be necessary, it is never a sufficient condition for improved population health ... Significant health improvements only began to appear when the increasing political voice and self-organisation of the growing urban masses finally made itself heard ...’ (Szreter 2003).

More recent evidence for the role of power, politics and policies, and confirming Szreter’s analysis, comes from Sri Lanka, Costa Rica and Kerala State in India, as well as the above-mentioned examples of Rwanda, Thailand, Iran and Brazil. All of these examples demonstrate that investment by the state in the social sectors, and particularly in education, health and welfare, has a significant positive impact on the health and social indicators of the whole population. These examples provide further evidence that a strong, organised demand for government responsiveness and accountability to social needs is crucial in securing healthy public policies. A process of social mobilisation involving broad civil society, which may take different forms in different contexts, is essential to achieve and sustain such political will. ‘Strong’ community participation is important not only in securing greater government responsiveness to social needs but also in providing an active, conscious and organised population so critical to the design, implementation and sustainability of comprehensive health systems (Sanders 1998).

Notes

1 The above section on Rwanda draws heavily on Paulin et al. (2008), and Paulin, B., personal communication.

2 The above section on Brazil draws heavily on Paim et al. (2011).

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