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Retracing loss of momentum for primary health care: can renewed political interest in the context of COVID-19 be a turning point?

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ABSTRACT

The COVID-19 pandemic has revealed major weaknesses in primary health care (PHC), and how such weaknesses pose a catastrophic threat to humanity. As a result, strengthening PHC has re-emerged as a global health priority and will take centre stage at the 2023 United Nations High Level Meeting (UNHLM) on Universal Health Coverage (UHC). In this analysis, we examine why, despite its fundamental importance and incredible promise, the momentum for PHC has been lost over the years. The portrayal of PHC itself (policy image) and the dominance of global interests has undermined the attractiveness of intended PHC reforms, leading to legacy historical policy choices (critical junctures) that have become extremely difficult to dismantle, even when it is clear that such choices were a mistake. PHC has been a subject of several political declarations, but post-declarative action has been weak. The COVID-19 provides a momentous opportunity under which the image of PHC has been reconstructed in the context of health security, breaking away from the dominant social justice paradigms. However, we posit that effective PHC investments are those that are done under calm conditions, particularly through political choices that prioritise the needs of the poor who continue to face a crisis even in non-pandemic situations. In the aftermath of the 2023 UNHLM on UHC, country commitment should be evaluated based on the technical and financial resources allocated to PHC and tangible deliverables as opposed to the formulation of documents or convening of a gathering that simply (re) endorses the concept.

SUMMARY BOX

⇒ Primary health care (PHC) has been fronted as a pivotal strategy since the 1970s, yet it has largely been neglected.
⇒ The contemporary interest in PHC within the context of COVID-19 and health security provides a window of opportunity for progressive reforms.
⇒ Understanding the underlying drivers for the loss of momentum for PHC and failure of repeated revitalisation efforts is critical to ensure that there is no misplaced optimism on the power of COVID-19 to transform PHC systems.
⇒ The interaction of vested global interests and negative portrayal of the concept has led to the pursuit of piecemeal PHC policies that have disrupted political momentum, dissipated public pressure and built-up sources of resistance to more comprehensive reform.
⇒ COVID-19 should be seen as a critical event to stimulate PHC debates but tangible reforms would be driven by decisive political action to address fundamental PHC bottlenecks that continue to disproportionately affect the poor.

INTRODUCTION

Primary health care (PHC) concept was embraced at the Alma Ata conference in 1978.[1] Yet, despite its fundamental importance and incredible promise, it remains a 'receding dream'[2] in need of 'revitalisation'.[3] Several factors have favoured the need to revitalise PHC in low-income and middle-income countries (LMICs). In South East Asia, PHC revitalisation efforts have been driven by the need to strengthen health systems through intersectoral approach in light of rising burden of non-communicable diseases and rural–urban inequities in accessing health.[4] Efforts to revitalise PHC in the WHO African region date back to the late 1980s with the Bamako Initiative which focused on the need for PHC self-financing mechanisms, community participation and provision of essential drugs and child health.[5] Although there have been several attempts to revitalise PHC, a new wave of interest has been spurred in the wake of COVID-19 based on PHC's potential to support the twin goals of Universal Health Coverage (UHC) and Global Health Security (GHS).[6] UHC has been defined as the ability of all people who need health services to receive them without incurring financial hardship[7] while GHS is about the containment of potentially serious and rapidly spreading infectious disease threats.[8] The nexus between PHC and

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UHC rests on the notion that by orienting health systems towards first contact, continuous and comprehensive care (core PHC focus), households and communities are more likely to access the healthcare they need without facing barriers; which is the essence of UHC.

The COVID-19 is certainly not the first event to favour PHC's re-ascendancy to the health agenda, but it has largely been portrayed as a 'focusing event'[9] for PHC. In other words, the pandemic has been viewed as a catalytic occurrence that exposed gross inadequacies in PHC and the related adverse consequences, thus opening a new window of opportunity for renewed interest in PHC revitalisation in LMICs.[10] While we acknowledge the potential of COVID-19 as a defining moment in which to re-affirm PHC, we posit that if lessons from past revitalisation efforts are not taken into consideration, the renewed interest will be to no avail. Indeed, some scholars have argued that revitalisation of PHC is insufficient unless the concept is 'reframed'.[11] In this paper, we seek to understand why, given that PHC had so much promise, it apparently lost momentum. While technical reasons, particularly lack of material resources, are normally put forward to explain revitalisation failure, two aspects are largely ignored: (1) how the portrayal of PHC itself favour or hamper intended reforms and (2) how historical policy choices influence ongoing revitalisation efforts. We argue that well-intended PHC revitalisation efforts applied in ignorance of historical facts miss an opportunity for learning and are doomed to fail or generate unintended consequences. The aim of this paper is to draw historical lessons while welcoming the current 'comeback' of PHC.

Conceptual framework: policy image and critical junctures

Policy image encompasses a mixture of empirical information and emotive appeals that explain the issue,[12] which forms the foundation of policy-making process.[13] Actors use positive policy images to legitimise issues that are in their favour and use negative policy images to discredit issues that are not in their favour. Policy images are critical because they influence the nature of policy responses and what is considered as appropriate or inappropriate. Once a certain policy image has gained traction over rival images, it has the power to shape the future policy direction or define a critical juncture. The lasting impact of choices made during those critical junctures is that such choices are extremely difficult to dismantle.[14] Critical junctures are shaped by antecedent conditions (factors preceding a critical juncture) and cleavage (crisis). Although critical juncture theory emphasises the role of history, permissive conditions represent the easing of the constraints for change while productive conditions produce the outcome after the permissive conditions disappear and the juncture comes to a close.[15] In the context of this study, productive conditions would facilitate sustained (favourable) attention towards PHC beyond the COVID-19 crisis. In other words, the attention generated towards PHC as a result of COVID-19 (permissive conditions) would be maintained under 'calm conditions'.

POLICY IMAGE AND CRITICAL JUNCTURES

Positive image (1): PHC as part of the decolonisation strategy leading to Alma Ata

In the 1960s and 1970s, prevailing disease oriented programmes carried a negative policy image of reinforcing dysfunctional health systems inherited from the colonial era, and became a subject of intense criticism by newly independent LMICs.[16] A critical juncture emerged with the declaration of Alma Ata in 1978 based on PHC's positive image to move towards addressing the political and socioeconomic determinants of health[17] through promoting universal accessibility, equity and community participation. This policy image resonated with the prevailing discourse of decolonisation in line with the 'New International Economic Order'.[18] PHC's policy image—both as a philosophy and a strategy—became the centre of hope for achieving 'Health for All by the Year 2000.[19] PHC's policy image also recognised the central role of the state in implementing intersectoral policies for health which led several LMICs to embrace the concept in the quest to reduce endemic health inequalities.[1]

Negative policy image (1): Comprehensive PHC as wishful thinking and emergence of selective PHC

During the Alma Ata Conference, some actors attached the negative image of PHC as a form of socialist medicine.[20] Soon after the conference, PHC was viewed as 'unrealistic'[21] and a form of 'wishful thinking'.[22] The process of looking for a set of technical interventions that could be easily implemented and measured led to the emergence of a PHC variant known as 'selective PHC'[23] which sidelined the comprehensive notions embraced during Alma Ata.[24] The concept of selective PHC was eagerly embraced and spearheaded by influential global institutions with rapid diffusion to LMICs.[25] Despite criticisms, selective PHC became the dominant modus operandi, because it fitted the paradigms and agenda of many influential stakeholders at international and local level.[23] Thus, rather, the envisioned emphasis on addressing the social determinants of health, PHC implementation in LMICs became focused on vertical programmes.[26] Although selective PHC has been lauded for improving key health indices, there has been major concern that the approach undermined comprehensive PHC.

Negative policy image (2): role of the state discredited and adoption of neoliberal policies

In the early 1980s, major global institutions pushed for the adoption of neoliberal economic ideals in LMICs[27] under the auspices of structural adjustment programmes.[28] The approach emphasised reduced government expenditures for health in favour of free markets[19] which resulted in a drastic decline in the quality of healthcare that mainly affected the poor.[29] To cover the shortfalls, international organisations promoted a policy of cost recovery often included among the conditions of loan or aid agreements.[30] By conditioning access to healthcare through people's own ability to pay, the introduction of user charges led to

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a further widening of health inequities in many LMICs[31] while challenging the policy image of health as a human right.[32] The inequities, particularly between the private and public sector gave an image of national health systems as second class and cheap alternative for the poor.[33]

Positive image (2): PHC as the foundation of health systems

Since the 2000s, there has been renewed international focus on PHC,[34] including attempts to reverse the adverse effects of neoliberal policies such as abolition of user fees.[35] The period also coincided with PHC's positive image as the cornerstone for strengthening health systems[36] and addressing the social determinants of health.[37] To mark the 30th anniversary of the declaration of Alma Ata, PHC was the theme of The World Health Report in 2008, and it became the topic of a series of significant conferences and high level commitments around the world throughout the same year.[3] To mark and commemorate the 40th anniversary of the Alma Ata declaration and to renew political and cross-sectoral commitment for health, in October 2018 the Declaration of Astana was ratified at the Global Conference on PHC to affirm the central role of PHC in achieving UHC and the Sustainable Development Goals (SDGs).[38] In the wake of COVID-19, PHC has been framed as a foundation for health systems under emergency and 'calm' conditions.[39] Calm conditions are periods where health priorities are guided by the need to address routine problems as opposed to dealing with a crisis. In terms of policy-making dynamics, decisions made under calm conditions tend to be incremental or influenced by 'business as usual politics'—which favours the status quo—while the decisions made under crisis situations tend to be non-incremental with the potential to destabilise existing policies.

Mixed image: PHC in the context of millennium development goals

The millennium development goals (MDGs) initiated an unprecedented global effort to promote health and well-being across LMICs, largely through vertical diseases programmes.[40] Major concerns are that a focus on disease-specific programming undermine country efforts to strengthen integrated health systems.[30] At the same time, the unveiling of the MDGs also gave a boost to reimagine health in terms of social determinants.[41] In the mid-2000s, international agencies realised that vertically oriented approaches were ineffective due to weak health systems and started directing attention towards health systems strengthening (HSS).[42] Although the efficacy and sustainability of externally HSS funded initiatives remains unclear,[43] the approach reinforces the ethos of Alma Ata declaration that single disease focus is untenable.

HOW DO PAST POLICY IMAGES AND CRITICAL JUNCTURES INFLUENCE CURRENT REVITALISATION EFFORTS?

The adoption of selective PHC constituted a critical juncture that continues to shape health systems approaches.[16] For example, despite that 91% of essential UHC related interventions can be classified as PHC,[44] and up to 75% of the projected health gains from the SDGs could be achieved through PHC,[45] vertical programmes and hospital-based and specialist-based care models are regularly prioritised over PHC.[46] 'Diagonal' approaches that seek to reconcile this long-standing tension between vertical and horizontal approaches continue to be undermined by limited support and externally driven austerity concerns.[47]

The path towards neoliberal policies continues to influence health systems. Despite incessant calls to remove user fees for PHC services, they remain the dominant financing method in most African countries and represent the most formidable barrier to UHC.[48] In South East Asia, although user fees have been largely removed in the public sector, poor access to services in government facilities forces people to rely on private sector where they incur high levels of out-of-pocket payments for primary care services.[49] In some settings where user fees have been formally abolished, they continue to be informally imposed to the users of PHC services .[50] Neoliberal policies also created dualised and fragmented health systems, where the elite minority have access to sophisticated healthcare in the private sector while the majority of the population relies on heavily under-resourced public sector[28] . This further reinforces the negative image that the public health sector is an inferior alternative for the poor. The fragmentation of health systems between the rich and the poor may help to explain the reluctance for meaningful PHC revitalisation since policy-makers (who are likely to be powerful and amongst the elite) might lack the motivation to reform what they do not use. The experience of COVID-19 pandemic has indeed shown that when policy-makers personally face the same (underfunded) health systems that traditionally serve the poor, action can be taken. As noted by Gish (1979), the real obstacle to successful PHC programmes is not lack of resources but 'rather social systems that place a low value on the healthcare needs of the poor'.[51]

WHAT CAN BE DONE TO STEER MEANINGFUL PHC REVITALISATION?

First, it is important to dismantle the well-entrenched (negative) image that PHC is unaffordable. From an issue-prioritisation perspective, summarily invoking unaffordability as the reason for non-investment in PHC negates the fact that resources cannot go towards an issue that is under-prioritised. For example, available funds tend to be diverted from PHC in favor of large infrastructural projects that court political mileage[52] or provide opportunities for corruption.[53] Second, it is important to restore the role of the state through reversal of neoliberal ideals and reduction in donor reliance. Third, it is important to understand PHC within the lens of reform politics. Central to our argument is that PHC revitalisation (its reappearance on the agenda), particularly through high level endorsements, has been mistaken as 'political will' that would be followed by country level action. However, the revitalisation agenda is simply issue recognition which does not necessarily imply

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commitment to act. Fundamentally, issue recognition is politically convenient and less costly while action on the ground demands political redistribution of resources. The differential politics between issue recognition and action could partly explain why 50 years after the declaration of Alma Ata, it appears world leaders still need to be convinced to act on PHC, which mirrors the experience with UHC.[54] We therefore propose that the metrics for progress on PHC be shifted from endorsements and declarations (which are not very different from Alma Ata) to action on the ground.

PHC has also been sidetracked by a growing tendency to endorse lofty goals that presume the presence of welldeveloped health systems when in reality LMICs are struggling to provide the very basics. For example, majority of primary facilities in sub-Saharan Africa lack reliable electricity,[55] basic water services[56] and are insufficiently equipped to provide basic clinical services.[57] There is also severe shortage of healthcare workers at primary care facilities, and the available personnel often works under poor conditions characterised by excessive workload, poor salaries, demotivation and poor organisation of care.[58] We put forward these are some of the real issues that need to be tackled first instead of refreshing declarations that are overly focused on the end without due regard on the means. Box 1 below provides a policy analysis for PHC in the context of past revitalisation

Box 1 PHC reforms: a policy analysis

Explaining failures to revitalise primary health care (PHC) through the lens of public policy reform

The public policy process involves agenda setting, formulation, implementation and evaluation. Agenda setting is the process by which problems and alternative solutions gain or lose public and elite attention. The major challenge has been that PHC has remained hemmed in agenda setting and policy formulation with ad hoc implementation. In other words, PHC has been legitimised as an issue of importance while its demands have been largely neglected. During each wave of PHC revitalisation, policy-makers and proponents of PHC tend to portray PHC problems as a new crisis, whereas in fact the problems have always been there. This tends to trigger a sense of urgency to act on PHC, characterised by convening of meetings and issuance of elaborate documents that often recycle the (known) importance of PHC. PHC's policy image and revitalisation efforts have therefore coalesced in the immediate aftermath of a crisis, followed by loss of steam as the crisis fades away. This suggests that meaningful revitalisation of PHC cannot rely on charged frames that go along with crisis situations, since the dynamics of policy-making under crisis are totally different from those under non-crisis situations.[60] PHC revitalisation ought to rely on deliberate choices to improve the absolute welfare of the poor, because in essence, poor people continue to suffer a crisis even when a sense of calm is seemingly prevailing for the rich. Similarly, PHC is not just a health strategy but a redistributive philosophy that thrives in an environment where political settlements are receptive and committed to the idea of dismantling health inequities.

COVID-19: new turning point for revitalisation of PHC?

We examine the potential of COVID-19 as a turning point for PHC revitalisation through the lens (and interplay) of permissive and productive conditions described earlier.

Permissive conditions: The COVID-19 pandemic served as a focusing event that highlighted weaknesses in PHC systems, and the danger it poses to humanity. While previous PHC revitalisation efforts have relied on moralisation—emphasising the role of social justice and human rights—COVID-19 invoked the importance of PHC through the lens of securitisation—portrayal of an issue as a serious threat to humanity necessitating an emergency response.[61] Thus, for the first time, the neglect of PHC ceased to be considered just as a disregard for social justice but as a security threat. The discursive 'reconstruction' of PHC in the context of health security also ignited a 'rethink' on the robustness of instruments designed to safeguard populations against public health threats. For example, Erondu *et al* argued that the International Health Regulations had a major focus on the core capacities of public health (ie, surveillance, risk communication and coordination) with minimal attention to PHC functions.[62] Normatively, since 2020, the WHO has launched some key initiatives and frameworks that 'securitised' PHC in the context of pandemic response. In 2021, the Working Group on Strengthening WHO Preparedness and Response to Health Emergencies group called for the need to 'achieve universal health coverage (UHC) and health system strengthening, which includes the enhancement of PHC'.[63] The centrality of PHC in pandemic response is also reiterated in the zero draft of the WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response that was released in early 2023.[64] The other peculiar feature about COVID-19 is that it forced the rich and poor to rely on the public health sector. Thus, political leaders had to witness first-hand the neglected state of PHC systems in their own countries. The 2023 UNHLM on UHC is therefore a unique platform where political leaders will deliberate on PHC based on personal experiences. This is of significance since the personal experience of policy makers during a crisis can potentially induce them to take action on previously neglected problems.[65]

Productive conditions: If the COVID-19 pandemic is to mark a turning point, the above permissive points need to be complemented by productive conditions that would sustain the momentum for PHC post-COVID-19 (under calm conditions). The main productive condition required is to invest in health systems that prioritise the needs of the poor or pursuit of equality under routine (non-emergency situations). The creation of productive conditions will rely on policy entrepreneurs who can tenaciously advocate for PHC. While policy entrepreneurs have emerged at global level, the presence of country level champions will be key in translating commitments into action. Policy entrepreneurs should capitalise on the fact that COVID-19 shifted the image of who is affected by weak PHC systems and the implications. By framing weak PHC as a universal weakness for entire health systems and a source of insecurity, policy entrepreneurs can potentially expand what is at stake and alter interest group participation to push for desired PHC reforms. The positive experience of PHC initiatives under 'calm conditions' in countries such as Ethiopia demonstrate that resonance of PHC with political settlements, in particular the ideology of the ruling coalitions, is fundamental in driving reforms.[66] On the other hand, high level of political commitment, respect for the citizenry, retraining and patience among professionals and high regard for improving access to health among marginalised populations shaped PHC choices in Eastern Mediterranean countries.[67] To improve the feasibility of desired reforms under calm conditions, policy entrepreneurs should therefore strive to move beyond demanding political will for PHC and endeavour to situate PHC within the prevailing political economy in a given context. This involves strategic framing, including explicit linkages of PHC to electoral cycles and highlighting the political benefits and consequences of investing or not investing in PHC thereof.

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efforts and the prospects of COVID-19 as a new turning point.

POLICY AND RESEARCH IMPLICATIONS

This study carries important policy implications. First, the study shows that it is not lack of appreciation on the merits of the PHC amongst decsion makers that constrains action on the ground, but rather the political demands it imposes on actors at global and national level. This underscores that the terms of global health debates need to shift from just propounding PHC benefits (policy content) and move towards understanding the influence of actors, processes and context as explanatory variables for why desired PHC outcomes fail to emerge.[59] This emphasises the central role of policy analysis for PHC and the importance to develop a multidisciplinary approach to the analyses of PHC reforms, including building capacity for policy and political analysis. The second policy implication is that PHC is unlikely to thrive if it is viewed as a purely health strategy. PHC has better prospects when it resonates with long-term developmental aspirations within the political settlement. There is a need for national-level policy entrepreneurs who strategically position gaps in PHC as a social problem and attach policy solutions that consider the prevailing political dimensions. However, it is important to acknowledge that efforts to institutionalise comprehensive PHC during moments of 'calm' present a huge undertaking which can be subject to political contestation between PHC proponents and relevant authorities. As a result, propounding the merits of PHC is important but insufficient to drive relevant reforms, which calls for a thorough understanding of the context in which desired reform is expected to occur. In contexts where few elites dominate policy decisions, and where there is shrinking or closed space for citizen participation in policy-making, PHC proponents may need to highlight the consequences of PHC policies on elite interests, including the effects on electoral legitimacy. In contexts where citizens have a voice to shape policies, formal ways of institutionalisation PHC may be more appropriate, such as enactment of relevant PHC legislation. The third policy implication is the role of prioritisation and sequencing in policy reform, where LMICs should maintain high level aspirations whilst progressively investing in the basics . Fourth, the PHC revitalisation agenda needs to consider the context relevance of some global recommendations. For example, population-based provider payment mechanisms, such as capitation, have been proposed as the cornerstone of financing PHC.[46] While this is technically sound, it may not be immediately applicable to many LMICs that are still grappling to finance the very basics of PHC.

CONCLUSION

Despite several attempts to re-assert PHC on the global agenda and repeated calls for its revitalisation, negative policy images and suboptimal historical policy paths continue to obstruct meaningful PHC revitalisation efforts. The COVID-19 pandemic provides strong and unique permissive conditions for strengthening PHC. However, action and positive outcomes are not guaranteed. Strengthening of PHC on the ground would rely on investments in PHC under calm conditions, particularly through political choices that prioritise the needs of the poor. In the aftermath of the 2023 United Nations High Level Meeting on UHC, there should be a reconstruction of PHC's positive policy image and a break from historical suboptimal choices. To track progress, countries should be judged based on (concrete) plans to revitalise PHC and tangible deliverables as opposed to the formulation of another document or convening of a gathering that simply (re) endorses the PHC concept.

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