Equitable Health Systems and UHC´s discussions on PHC

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In the People's Health Charter (2000), the People´s Health Movement stated that the health crisis of the poor and the marginalized had worsened and that the root of this crisis was the deepening of "inequality, poverty, exploitation, violence and injustice…". Twenty-two years later, the OECD (2022) states that "We live in an era of multiple crises, shocks and uncertainties" that will affect at least 24% of the world population that lives in 60 fragile contexts of growing conditions of poverty and inequality.

However, today we are not only experiencing the crisis of these contexts but a more general one resulting from the systemic crisis of capitalism, ecology, and wars. This crisis explains the greater frequency and recurrence of epidemics and pandemics, migrations, the persistence of CNCDs, the reemergence of the threat of nuclear hecatomb and the extinction of life itself.

Behind the knotting of this crisis is an economic system of large TNCs that has captured multilateral agencies and states to control and expand markets to accumulate profits, reducing their ability to respond to the consequences of the crisis and create conditions to guarantee people´s well-being and the care of health and life.

This context has led to fragile health systems to become incapable of responding to the challenges of the present. The fragility of health systems refers to their inability to meet the needs of communities and contribute to avoiding the sanitary dangers that threaten us. For instance, the Covid-19 pandemic showed that the disruption of essential health services in Latin America and the Caribbean was 80% in low-income countries, 35% in middle-income countries, and 24% in high-income countries.

The region's health systems were not only overwhelmed in their ability to mitigate the damage caused by the pandemic, except for Cuba and Costa Rica, but they were also unable to implement effective strategies to prevent and control it. For instance, Primary Health care did not work in most of the Latin American health systems because of underfunding, shortage of health workers or simply because of the lack of a Comprehensive PHC approach.

The commodification and privatization of Latin American health systems is what made them less effective in health surveillance, prevention, and health promotion; made them inadequate to address the inequitable access to health services and prevent them from allocating resources with equity among regions and social positions. Furthermore, the region's health systems have been dominated by a biomedical approach to healthcare reinforced by decades of commodification and privatization that excludes indigenous communities knowledge and practices and makes interculturality difficult.

For instance, Latin American countries have on average two doctors per 1000 people, while Haiti, Guatemala and Honduras have on average only 0,3 doctor per 1000 people. Although the health spending in Latin American countries grew on average 3.6% per year while the gross domestic product grew 3% per year, health spending was approximately USD 1,000 per person on average, while that of the OECD countries was four times as much (*Panorama de la Salud: Latinoamérica y el Caribe 2020*).

If the Latin American countries try to reach the level of health care expenditure of developed countries with the actual model of biomedical health systems, the level of health expenditure needed to meet their people´s needs would be unreachable for most of them. Scientific evidence tells us that the "Global health spending doubled between 2000 and 2013 to USD$7.35 trillion, most growth driven by technology costs and rising demand. In 2021-22, OECD countries spent an average of around 9.5% of GDP on health care – the US spending a heftily inefficient 17%. In 2020-21 alone, US expenditure on prescription medicines was USD$348 billion – the upper end of total estimated annual costs of achieving universal health coverage across all countries by 2030. Any even remotely genuine attempt at universal health care incorporating access both to basic public health and more advanced NCD treatments would drive many low- and middle-income countries into a form of health bankruptcy within months (Jakovljevic et al, 2016; Papanicolas et al, 2018)".

Behind this growing tendency of healthcare expenditure is the TNCs drive to profit-making which is not possible to achieve without unlimited economic growth which at the same time explains the continuous trend of privatization and commodification of health system in both hight-income and Low-middle-income countries. To achieve this end, the current universal health coverage policy has been formulated as a component of the current neoliberal economic order.

However, we must bear in mind that the proposal to build a New International Economic Order has been re-emerging to counteract the unequal economic exchange that hinders the economic and social development of the countries of the global south. The same group of actors that today leads this proposal also proclaims the need to constitute again a Movement of Non-Aligned countries in the face of the pretensions of installing a cold war scenario again.

The dominant and highly expensive model of Universal Health Coverage promoted by the World Bank and the World Health Organization goes against the need of a broader socioeconomic transformation linked to a comprehensive, intercultural, and equitable health system since it emphasizes on domestic resource mobilization, public single payer financing, and an anthropocentric, biomedical and disease centered healthcare model that is functional to the privatization and commodification of health systems.

PHC is a strategy that could give us a different content to a new health system policy embedded in a NIEO. However, PHC has been emptied of its comprehensive and intercultural content (Alma Ata, 1978) towards a Neo selective approach (Astana, 2018) to make the Universal Heal Coverage policy reforms functional to private and market interests.

In the Declaration of Alma Ata (1978) it was established that PHC "forms an integral part both of the national health system, of which it constitutes the central function and the main nucleus, and of the overall social and economic development of the community". But most importantly, para 3 of the 1978 Alma-Ata Declaration on Primary Health Care (WHO and UNICEF 1978) states: "III. *Economic and social development, based on a New International Economic Order, 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. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace"* (Quoted by Legge, 2023).

In this sense, PHC was understood as a strategy that would contribute not only to improving average health outcomes, but also health equity and an efficient use of health systems resources.

In its recent book "Walking the Talk, 2022" the World Bank has recognized the importance of the Alma-Ata principles to guarantee healthcare centered on the population through multidisciplinary teams that ensure first contact, integration, coordination, and continuous individual care throughout the healthcare system levels. It has also recognized the need for intersectoral action and community participation to respond not only to clinical care needs but also to other social determinants of health. But one of the problems of this World Bank approach is that it does not acknowledge the interrelations between health systems, PHC and the international/national economic order. Other problem is that the World Bank proposal on PHC is it is again based on the principles of cost-effectiveness and cost-efficiency.

The World Bank (WB, 2022), and even WHO (2008), does not recognize the need to change the prevailing international/national economic order, to transform and decolonize health systems and to strengthen CPHC to face poverty and health inequalities, the socio-ecological crisis, and the greater frequency and recurrence of pandemics and other sanitary emergencies.

The NIEO, as it was adopted by the Sixth especial session of the United Nations General Assembly in 1974, was subsequently eroded, and reversed by the debt crisis and structural adjustment policies of the eighties, by the Uruguay Round which led to the launch of the World Trade Organization in 1994, and by the rise of neoliberalism" (Legg, 2023). Now it has been replaced by the Sustainable Development Goals, and contrary to Alma-Ata Declaration, PHC has been made dependent on the nature of neoliberal health care system policies within the same capital accumulation regimen. In this sense, PHC has been made functional to the privatization/commodification of health systems through a Neo Selective PHC approach centered on a basic biomedical care model (GHW6, p. 85).

We know that for the Global South to achieve the targets of improving health, health equity and preserving life a NIEO is an unavoidable condition. The call for a renewed vision of the NIEO adapted to the XXI century has been made explicit by the Declaration of Santa Cruz: For a New world Order for Living Well, that was adopted by the G77 and China in June 2014 on the 50th anniversary of the formation of the G77; by the UNCTAD´s 2022 Trade and Development Report; and by the Declaration of the 50th Anniversary of the NIEO, 1974-2024, Havana Congress, January 2023.

This NIEO proposal would include: the regulation of global finance; the taxation of Transnational Corporations and the promotion of domestic tax reforms; access to know-how and health technologies; the regulation and supervision of the activities of transnational corporations (through the creation of a code of conduct); the respect of economic, social, and cultural people's rights at the national and global level; the transformation of the current practice of the investment agreements and of unequal exchange amongst nations; the promotion of global solidarity and the decolonizing of aid; and the protection of the environment.

However, instead of promoting a NIEO and a Comprehensive approach to PHC, the World Bank has been involved in the Sustainable Development Goals (SDG) program and on several neo

selective primary care programs to maintain the actual capital accumulation regimen and to narrow down the comprehensiveness of the Alma-Ata Declaration (WHO, 1978).

This selective approach to PHC, which has contributed to the organization of targeted and cost-efficient packages of individual biomedical interventions and insurable benefit plans, now seeks to integrate essential public health functions and social assistance activities, generalizable through the Universal Health Coverage policy.

This model (Neo selective PHC) allows public/private insurers and health care providers organizations to create markets for the provision of primary care services directly or through private managers that contract to networks of private/public primary care service providers based on the use of multidisciplinary teams in areas with assigned population, gateway schemes, continuity and coordination of care, capitation payment methods, financial incentives and free choice of provider by patients (WB, 2022). With this approach, it is possible to end up creating integrated networks of insurers, managers and providers that can give rise to private primary care corporations. Certain financing designs linked to strategic purchasing arrangements and payment methods, may end up fragmenting the PHC strategy and/or limiting its comprehensiveness, as is currently the case in the Colombia's General Health System of Social Insurance (SGSSS, in Spanish), if there is not a strong and organized government intervention.

These World Bank approach maintains an unnecessary separation between clinical interventions and public health. It prevents PHC from being linked to the good living of communities and territories by drastically separating sectoral health actions (primary clinical and public health care through multidisciplinary teams) from intersectoral actions and community involvement.

As Some PHM Colleagues say: 1) “The model of primary health care offered in the Alma-Ata Declaration suggests that, as well as focusing on primary care, health care practitioners and agencies can find ways of working with their communities on understanding and addressing the structural barriers to better health, ranging from the locally specific to the global barriers (Sanders 1998; Schaay and Sanders 2008, quoted by Legge 2023). “The struggle for a NIEO will not be determined in the health sector alone but health is universally valued and perhaps can provide a narrative of change which can be shared across boundaries. The language of social determinants (and social determination) of health provides an existing narrative regarding the links between the local and the global; the micro and the macro” (David Legge, 2023).

We cannot give up changing society and transforming/decolonizing health systems. The time has come to reconnect the struggle for health with the struggle for a NIEO and the struggle for peace of the Non-Aligned Movement. As the Havana declaration said: we must build a planetary bloc led by the South and reinforced by the solidarities of the North to make feasible the NIEO and peace.

References

https://progressive.international/blueprint/b262a535-7fcd-449e-94b8-73590c3db6a7-declaration-on-the-establishment-of-a-new-international-economic-order/en

Presenting: The Havana Declaration on the New International Economic Order - New Cold War: Know Better

https://docs.google.com/document/d/1DQaZtaCZnsBeJIOgrBoC2KPdyze6tw2x/edit?usp=sharing&ouid=101384208752085024578&rtpof=true&sd=true

Legge, D, “Political economy for health: Key Terms in Political Economy and their Implications for Population Health and for Health Care”, Draft March 8, 2023

Morales, E 2014, ‘Towards a new world order for living well: For a global brotherhood among the peoples’, G77 Special Summit of Heads of State and Governments, Santa Cruz Santa Cruz de la Sierra, Plurinational State of Bolivia, 14 June 2014.

The Lancet Commissions, Alma-Ata at 40 years: reflections from the Lancet Commission on Investing in Health, www.thelancet.com Vol 392 October 20, 2018

UNCTAD, 2022, Trade and Development Report UNCTAD, Geneva,

United Nations General Assembly 1974, General Assembly Resolution 3201 (S-VI): Declaration on the Establishment of a New International Economic Order, and General Assembly Resolution 3202 (S-VI): Programme of Action on the Establishment of a New International Economic Order, Official Records of the General Assembly, United Nations, New York.

Walsh JA, and Warren KS, Selective Primary Health Care — An Interim Strategy for Disease Control in Developing Countries. N Engl J Med 1979; 301:967-974

WHO & UNICEF 1978, Alma-Ata 1978. Primary Health Care., World Health Organisation, Geneva.

World Bank 1993, 'Investing in Health', World Development Report, World Bank, Washington DC.

World Bank 2022, walking the Talk: reimagining primary health care after covid-19. Washington D.C.