Health for All Now!
People's Health Movement

Has the Leopard Changed its Spots?

A PHM Policy Brief on World Bank's Rethink on Primary Health Care

Purpose: This policy brief is to inform People's Health Movement (PHM) country circles and allies in country circles on recent developments in the policy discourse around Primary Health Care (PHC) at the global level. This could help health activists leverage some positive developments in this discourse to shape national policies, as well as alert and educate countries on some problematic aspects of these proposed design changes that should be negotiated with, or even resisted and rejected. The most articulate expositions of this new discourse is the World Bank document: "Walking the Talk- Reimagining Primary Health Care" (World Bank, 2021) but there is one more document from the World Bank "Change Cannot Wait: Investing in Health System Resilience for the Anthropocene" (World Bank, 2022) and a WHO document on "Operational framework for Primary Health Care" (World Health Organization & United Nations Children's Fund, 2020) which promote the same discourse. The Lancet Commission on Financing of Primary Health Care (Hanson *et al.*, 2022) is more nuanced on some of the key features, but essentially it is also very much within this framework.

Context: It was the World Bank which actively promoted/imposed selective PHC across most LMICs. This it did as part of its Structural Adjustment driven Health Sector Reforms (HSR) in the nineties. Its power lay in making the loans conditional on accepting these reforms, but even more powerfully by setting up a policy discourse that legitimised and justified in the language of science and technical advice, the negation of the entire spirit and substance of the Health for All Declaration of Alma Ata. This HSR discourse was set out in its book: "World Health Report 1993- Investing in Health"(World Bank, 1993). Most of the elements of the HSR are now acknowledged to have adversely affected the development of equitable health systems. The few successes of this period like Thailand and Costa Rica or Cuba were countries that had taken a conscious decision not to go with the World Bank's prescriptions. So now when the World Bank comes out with another document that lays out its latest diagnosis of the problems and prescriptions to PHC, without once owning or acknowledging its own contribution to the creation of these problems, there is a need for alertness from both civil society and LMIC (low- and middle-income countries) governments about this change of heart. There is a need for LMICs and health activists to ask hard questions of these new prescriptions instead of passive submission to the knowledge hegemony of the western nations.

One reason why the World Bank has had to back-track is the experience of COVID-19. The COVID-19 pandemic undermined all economic and social growth world-wide. The pandemic exposed and exacerbated pre-existing weaknesses in the health systems and caused significant loss of life across populations. The fact that more comprehensive and effective primary healthcare systems were a key factor in countries that withstood the crises better was now increasingly recognized by policymakers and people. The main focus of the World Bank reforms had been to limit the scope of public health systems to a very narrow selective package while leaving the major part of healthcare needs to the private markets. Also to introduce market like mechanisms and contracts with the private sector as major forms of health sector delivery. But such systems had little resilience when faced with a crisis. Clearly as a result of the pandemic, with or without the Bank, countries would be re-examining national UHC strategies with this learning. Even the WHO leadership was now talking of health and health products as Global Public Goods and the case was being made for strengthening public health

services. The UHC agenda had tried to substitute or incorporate in a diluted the PHC, as in the Asthana declaration(WHO, 2018), but clearly PHC as conceived by the Alma Ata's Health for All declaration was back on the agenda, and the global institutions had to deal with it.

The stated rationale of the World Bank's "re-imagination" of PHC is that despite the ideal and well-intentioned vision of the drafting of Alma Ata and the PHC model that developed around it, PHC failed to provide desired results. Noting that there have been changes in the world in the last 40 years (demographic changes, population growth, NCDs) and more recently a pandemic the document envisions what it calls a new "fit-for-purpose primary health care" model. The World Bank then goes on to propose why, why, what and how to achieve such a PHC.

Positive Features of the new World Bank Discourse.

One clear strength of the World Bank's recent documents is its clear position against the many distortions of primary healthcare, especially its dilution and distortion as selective care. The definition of PHC in terms of what it is and what it is not (given in box 1.1, page 19) (World Bank, 2021) is a most useful summary definition of primary health care and its distortions. Selective primary health care or mere primary level care or basic services or first contact care are all distortions and not the same as Primary Health Care. To quote: " Selective PHC, a concept introduced shortly after the 1978 Alma-Ata Conference and widely applied subsequently, is *not* PHC. It distorts the concept of PHC by focusing on selected diseases rather than the whole person and the full spectrum of services from promotive to palliative" (Kluge, Kelley, Barkley, *et al.*, 2018; Kluge, Kelley, Swaminathan, *et al.*, 2018). It even favourably cites PHMs statement in Lancet to state that from its inception PHC was understood to involve equitable access to health service and people centred health services (Sanders *et al.*, 2019). Further in its definition, Public health as action on social determinants is seen as an integral part of PHC but it clarifies that "PHC's concern with underlying health determinants does not downplay the importance of quality personal health care services for those who need them (Frenk, 2009). All of this is music to the ears of the people's health movement activities who have fought long and hard against these distortions.

The World Bank document then identifies four important barriers and follows it by calling for four strategic shifts. All of these shifts are basic features of PHC that PHM has been championing for many long years and there is reason for celebration of the World Bank accepting these principles – better late than never. These four barriers and shifts are:

a) Moving away from the concept of PHC as limited to a very selective package of services delivered by a skeletal workforce. Instead it calls for PHCs having multi-disciplinary teams that provide access to clinical services to meet the full range of local health needs. Clinical services address acute illnesses and injuries and manage chronic conditions, including mental health needs. Teams expand community health education, health and nutrition promotion, and disease prevention.
b) Moving away from PHC as a dysfunctional gate-keepers limiting access to higher facilities. Instead it calls for PHCs to be viewed as active care coordinators, facilitating access to a comprehensive package of healthcare services that includes all levels of care and ensuring the continuity of care between the different levels as the important aspect of people-centered care.

c) Accepting that "Shared anger at such inequities was one of the main reasons that the original PHC movement was launched and gained global support" and that today, PHC's potential to tackle equity gaps remains unfulfilled in many settings. It also accepts that there are strong examples where countries have harnessed PHC's distinctive capacities to address inequities in health and health care and where healthcare has remained free to the user.
d) Accepting that PHC is the cornerstone of health systems resilience. It further defines that a PHC system is resilient if it is well prepared for health emergencies, and is able to effectively respond to it when it happens, maintaining access to routine high quality services including both personal and public health services, recovers promptly after the crisis and learns from it. Resilience also means public health surveillance and outreach capacity, and that financial and human resource surge capacities are built into health sector planning and resource allocation at the local level.

We also welcome what is stated as a priority reform across the documents- the development of adequately staffed, trained and supported multi-disciplinary teams at every level, but especially at the primary level, where they also act as care coordinators as well as provision of supportive care other than healthcare. This call for an expanded workforce deployment also acknowledges the contribution of community health workers (CHWs) as part of the primary level team. Though the documents mention the problem as related to unfair terms of their employment, lack of safety and security are mentioned, the reasons for this current situation and need and way forward to address these issues are not. This is important since the reduction in public health workforce was a consequence of the Structural adjustment programs that pushed for "keeping governments small" and reducing regular employment in government services and this mind-set still persists.

The Concerns about the New World Bank Discourse:

1. Purchasing or Public Health Systems Strengthening

The naïve reader would expect, that as a consequence of the formulations above, a strong call for strengthening public health systems would follow and for putting in place a regular, well paid, and well-trained workforce. These are no doubt mentioned, but almost in passing and without enough engagement as to current barriers to achieving this.

The World Bank's main concern in the document is how to include and shape strategic purchasing from private providers so as to address these four strategic shifts. Clearly both public health services and strategic purchasing have failed on all the above four concerns. However, since in the second wave of UHC linked health sector reforms, strategic purchasing from the private sector was projected as the solution to the failure of public health services, the Bank and its academic support are hard-pressed to maintain this narrative. To people's movements the lessons are obvious- that strategic purchasing from the private sector does *not* work, and one has to find creative ways of understanding and overcoming weaknesses in public sector provision. But this is not the lesson that the World Bank and those in the neo-liberal framework are willing to learn. For them it's just re-imagining the nature of contracts with the private sector.

Thus for each of the barriers and shifts, the document presents a number of ways in which within "mixed health systems" private sector providers can be or have been shaped to make the shift. For example for ensuring population coverage, "geographic empanelment," which is the term that the World Bank invents to describe government facilities obliged to provide care to the entire population of a district, would be replaced by empanelment (and contracting) of privately owned networks which have a similar responsibility. But to address the inevitable problem of inequities and those left behind, a proposed innovation is a civil society organization that would survey and identify those with special needs and those left out and add them into the system by identifying providers for them that the government would pay. Similarly innovations in payment approaches are expected to deliver accountability and performance. Innovations in team compositions and referral systems in contracts are projected as overcoming problems of providing a larger range of services.

The examples of strategic purchasing that make the desired purchases are mostly from high-income countries and are descriptions of attempts made, with little information that they succeeded. There is also an overlap in these examples of what works or could work only with public providers, with what is meant to work with private providers. Many of the examples proposed imply large corporate agencies which have empanelled small providers and where these policy shifts are built into the contractual terms. It is difficult for us to comment on all these examples, but we can state that in the countries where the PHM has presence, our feedback is that most of these examples cited did not work and were shut down, or just lingering on. In our understanding many of these barriers are linked to how markets and strategic purchasing will not be able to change commercial behaviours in favour of equity and rights. We therefore need to caution our country level decision makers that the evidence for such strategic purchasing is thin, and there are few or no examples where purchasing primary healthcare on contractual terms from private providers has ever worked. The Lancet issue on the financing of primary health care has the same problem. While much of its problem identifications are welcome, its push towards strategic purchasing as the solution is completely without evidence.

2. Back-door to selective health care?

There is also a strong call in these documents, for determination and priority setting in the composition of the essential services package. The earlier now discredited selective package of the nineties was based on a criteria of dollar spent per DALY saved- a very technocratic and non-transparent exercise. This time the call is for basing the package on techniques of Health Technology Assessments (HTA)- that are in essence cost-effectiveness studies. In countries with near universal healthcare in place, the use of HTA for including another new and costly therapeutic or diagnostic procedure with uncertain advantages has its merits. But in countries where most basic healthcare is not available, use of HTA for what is called priority setting is not. It threatens to become a back-door to introduce selective healthcare and also to prefer interventions that are favourable to commodities linked to corporate profits over those that are the real needs. While HTA for choice of appropriate technology for decision on *how best to* address a health need is welcome, *whether* to address a health need is a human rights and equity question and not to be left to HTA as it is currently constituted. We further note that on the grounds that many nations do not have HTA capacity, the prescription is for such nations to accept global Cost-Effectiveness Analysis findings, which would further compound the problem. The document fails to note that in countries with universal healthcare the general principle to define "essential health services" is that all preventive and promotive care, and all diagnostics and therapeutics which have known clinical effectiveness are

included. Only exclusions need to be specified, and that too with justification. The meaning of "essential" in 'essential health package' is similar to how essential is used in the phrase "essential medicines list."

Another worrying development in the discourse, is the extension of the selective approach from individual biomedical interventions (insurable benefit plans), to integrate essential public health functions and social assistance activities, generalizable through the UHC policy. A report in The Lancet(Jamison *et al.*, 2018; Watkins *et al.*, 2020) differentiates between sectoral and intersectoral interventions. The report selects 218 sectoral health interventions that the UHC can deliver: 13 Population-Based Health (Essential Public Health Functions); 59 community-based interventions; 68 health center interventions; 58 interventions from first level hospitals; 20 reference interventions and specialized hospitals. Of these interventions, 198 packaged interventions can be delivered by PHC platforms of the UHC. It then postulates 71 intersectoral public policies based on cost-effectiveness criteria that can reduce or eliminate behavioural and environmental risk factors. This includes four groups of intersectoral interventions: 1. Financial/fiscal (taxes on tobacco, alcohol, sugar); 2. Regulatory (air and indoor environment pollution, and consumption of harmful products); 3. Built environment (traffic injuries, water supply, sanitation); 4. Informative (consumer education on insufficient consumption of micronutrients, unsafe sex). Social protection assistance interventions such as Conditional Cash Transfers for the use of health services are also included.

3. Creating space for corporate domination.

In world experience, the strategic design based on a package of primary care benefits selected with cost-effectiveness and cost-efficiency criteria, and centered on the person, is to enable purchasing through commercial players and is part of the neo-liberal objective of commodification and corporatization of PHC. This model, (which we could term the Neo selective PHC approach), allows public/social/private insurers and health care providers to create markets for the provision of primary care services directly or through corporate "Health Management Organizations" that are contracted to provide care to assigned populations, operationalize gateway schemes and continuity of care, and are paid by capitation payment methods with financial incentives… all presumably for providing an illusory free choice of provider by patients (World Bank, 2021).With this approach, it is possible to end up creating integrated networks of insurers, managers and providers that can give rise to large private primary care corporations- the corporatization of primary healthcare- overwhelming both the public system and the competitive small own-enterprise private providers . Certain financing designs, purchase arrangements, and payment methods for providers typical of this model, end up increasing fragmentation and sharply limiting 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. Similar examples can be cited from almost all regions.

PHC as philosophy and ethics.

At the core of these differences lie the basic question. What values govern us?? Is health and healthcare to be seen as opportunities for private profits, which are reflected in economic growth rates. Or are these global public goods that must be provided and protected from the problems of market transactions.

The World Bank and the Lancet approaches maintain an unnecessary separation between individual interventions and public health and find different ways of including it within market dynamics. However in the 21st century, it's not the old laissez faire regime, but a proactive powerful government, that must take over the entire function of purchasing so as to re-organize it in terms where corporate power and monopoly can be built up. It is, so to speak, socialization of financing (taxes and pooled public funds), but is done at terms where it favors the commodification and corporatization of health systems. The World Bank's past prescriptions have failed to ensure these ideological and commercial objectives, at least not to the extent desired. And now they stand exposed by the pandemic. And so as in the post Covid context autocratic governments reach out for more loans from the World Bank and IMF to bail them out of the financial crisis triggered by a health crisis, an opportunity presents for them to try again.

On the other hand for people's movements the concept of PHC is inseparable from the good living of communities and territories and there is a unity between sectoral health actions (primary clinical and public health care through multidisciplinary teams) and intersectoral action. PHC is also about social and community participation in the decision-making processes, democracy, public reasoning and public participation, multi/intercultural autonomies in health, and the integration of the different health traditions in single health systems. We cannot give up the unity of changing society, transforming health systems and working to develop a comprehensive PHC.

Recommendations and Call for Action:

1. The World Bank must be asked to acknowledge that its own policies, and policies imposed by other global health and financial institutions have played a key role in creating the distortions and weaknesses and PHC as are present today and pointed out in these documents
2. The policy articulation requires to emphasize that currently the primary health care approach has worked in LMICs, only where the dominant providers of health services are publicly administered and public financed. Strategic purchasing from the private sector could supplement or complement, but never substitute for reliance on public provision to ensure health equity and health rights.
3. There is a need to share widely the considerable body of accumulated evidence that strategic purchasing from commercial providers is not working. Rather than push such failed strategies on unsuspecting nations, where private sector engagement is sought, it is better to work on contracting arrangements where clinical decisions are ring-fenced from commercial returns and give preference to not for profit agencies.
4. There is a need for countries to accept that considerable public health systems strengthening is required to address the barriers and make the strategic shifts that these documents have brought out and which have been pointed out by people's health movements over all these years. This means that it cannot be business as usual, but needs greater investment, more public participation and many creative and innovative design solutions.
5. That "assured essential health services" in a PHC approach, should include all health services that are known to be effective. Only exclusions need be specified. If the fiscal space limits the budget, then the poorer quintiles of the population should receive more comprehensive financial protection, rather than limiting the range of services included in the essential health service "package."

6. While we welcome the use of health technology assessments for appropriate choice of technology to address health needs, we caution against it becoming a back-door for selective health care. Further HTA must go beyond only cost-effectiveness to include considerations of equity, gender and ethics.
7. Governments must be encouraged to ensure that the size of the health workforce deployed for public health services should be commensurate with what has been described as the desired healthcare teams in these documents- if not more. Further World Bank and external aid agencies must be held accountable to ensure that they do not push policies which either reduce the workforce in numbers or encourage precarious terms of employment with reduced social and financial protection. Safeguarding the rights of health of the community requires safeguarding the rights of health of the health workforce.
8. The World Bank and external aid agencies are known to legitimize their presence using a number of feel-good schemes that legitimize their role in sustaining the neo-colonial agenda. However they are known to use their influence in national finance and health ministries to support the agenda of international corporations- not in the least because there are divisions of the World Bank, specifically meant for supporting and lending to the corporate private sector and another for securing corporate private investment. These feel-good documents are silent on these conflicting roles. But the entry of the world bank must alert us to such conflict of interests. Corporate agencies in health care which are defined by the fact that they pay dividends to shareholders or participate in equity markets should not be contracted for or engaged in any manner using public funds, for the delivery of primary healthcare services. Under current national and international laws, it is difficult, if not impossible, to hold them accountable for denial of health rights or minimum standards of transparency. Their business models which require constant increases in return on investment to individual shareholders, will necessarily have a conflict of interest with generating larger health value for the money. While the World Bank may not upfront support such trade clauses, countries must specifically be alert against trade partnerships that include clauses where on the grounds of protecting their investment, the corporate health sector can intervene in national health policies.

References:

Frenk, J. (2009) 'Reinventing primary health care: the need for systems integration', *The Lancet*, 374(9684), pp. 170–173. Available at: https://doi.org/10.1016/S0140-6736(09)60693-0.

Hanson, K. *et al.* (2022) 'The Lancet Global Health Commission on financing primary health care: putting people at the centre', *The Lancet Global Health*, 10(5), pp. e715–e772. Available at: https://doi.org/10.1016/S2214-109X(22)00005-5.

Jamison, D.T. *et al.* (2018) 'Universal health coverage and intersectoral action for health: key messages from Disease Control Priorities, 3rd edition', *The Lancet*, 391(10125), pp. 1108–1120. Available at: https://doi.org/10.1016/S0140-6736(17)32906-9.

Kluge, H., Kelley, E., Swaminathan, S., *et al.* (2018) 'After Astana: building the economic case for increased investment in primary health care', *The Lancet*, 392(10160), pp. 2147–2152. Available at: https://doi.org/10.1016/S0140-6736(18)32859-9.

Kluge, H., Kelley, E., Barkley, S., *et al.* (2018) 'How primary health care can make universal health coverage a reality, ensure healthy lives, and promote wellbeing for all', *The Lancet*, 392(10156), pp. 1372–1374. Available at: https://doi.org/10.1016/S0140-6736(18)32482-6.

Sanders, D. *et al.* (2019) 'From primary health care to universal health coverage—one step forward and two steps back', *The Lancet*, 394(10199), pp. 619–621. Available at: https://doi.org/10.1016/S0140-6736(19)31831-8.

Watkins, D.A. *et al.* (2020) 'Resource requirements for essential universal health coverage: a modelling study based on findings from Disease Control Priorities, 3rd edition', *The Lancet Global Health*, 8(6), pp. e829–e839. Available at: https://doi.org/10.1016/S2214-109X(20)30121-2.

WHO (2018) *Declaration of Astana*. Available at: https://www.who.int/publications-detail-redirect/WHO-HIS-SDS-2018.61 (Accessed: 20 April 2023).

World Bank (1993) *World Development Report 1993: Investing in Health*. Washington, DC: World Bank. Available at: https://doi.org/10.1596/0-1952-0890-0.

World Bank (2021) *Walking the Talk: Reimagining Primary Health Care After COVID-19*. Washington, DC: World Bank. Available at: https://doi.org/10.1596/978-1-4648-1768-7.

World Bank, W. (2022) *Change Cannot Wait : Building Resilient Health Systems in the Shadow of COVID-19 - Investing in Health System Resilience for the Anthropocene*, *World Bank*. Available at: https://documents.worldbank.org/en/publication/documents-reports/documentdetail/099716312222212271/P1761800ec94f607d08d260c86c34c4b559 (Accessed: 18 April 2023).

World Health Organization & United Nations Children's Fund (2020) *Operational framework for primary health care: transforming vision into action*. Available at: https://www.who.int/publications-detail-redirect/9789240017832 (Accessed: 18 April 2023).