Health for All Now!
People's Health Movement

Primary health care and universal health coverage: The roadmap to achieving health for all as assessed over the response to the c-19 pandemic

Introduction

The movement towards universal health coverage (UHC) is currently among the most prominent global health policies[1]. According to the United Nations Sustainable Development Goals, all UN Member States agreed to work towards achieving Universal Health Coverage by 2030[2]. This includes financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. As more countries make commitments to universal health coverage especially in these tough times caused by the C-19 pandemic, they face challenges on how to quantify it and track progress towards its key goals, both in terms of health services and financial protection coverage. The Joint WHO/World Bank Group report released on 2015 entitled 'Tracking universal health coverage: First global monitoring report'' provided guidance about how states can achieve universal health coverage and build more resilient health systems[3] and we the People's Health Movement Uganda chapter believe that some of the suggested guidelines are ether realistically non-applicable or pose a barrier to attainment of sustainable development goals and Universal Health Coverage all together most especially in the face of Covid-19 pandemic.

PHM Uganda recognises the importance of universal health coverage (UHC) although it needs to be qualified due to its interpretation proximity with primary health care and the diversity of interpretations of both PHC and UHC circulating. Some of these interpretations, such as the World Bank's multi-player, stratified access, mixed delivery models, as PHM we believe are affecting health for all as clarified In the foregoing.

The marketisation of UHC most especially at a time of the raging COVID-19 pandemic did undermine the implementation of comprehensive primary health care in most countries like Uganda. Health care was unaffordable and it reduced PHC to arbitrarily defined 'interventions' and as a result limited and distorted the analysis of needs and priorities; precluded effective community accountability; ignored public and

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[1] Rumbold B, Baker R, Ferraz O, Hawkes S, Krubiner C, et al. (2017) Universal health coverage, priority setting, and the human right to health. Lancet 17: 30931-30935.

[2] WHO (2016) Health topics, World Health Organization.

[3] WHO (2016) Tracking universal health coverage: First global monitoring report. Health statistics and information systems World Health Organization /World Bank Group report.

community action around the social determination of health; and prevented best use of limited resources. Uganda experienced the emergency of public health policies and laws that criminalized illness. The contemporary policy debates around UHC

being framed by macroeconomic instabilities globally and the neoliberal policies being put in place to manage those instabilities has weighed in negatively. Widening social and economic inequalities associated with neoliberal economic policies have greatly contributed to the fraying of social solidarity and consequently weakened political support for single pool single payer systems. Transnational corporations, as the principal conduits of foreign direct investment, are driving a race to the bottom with respect to tax policies (through tax competition) with increased restrictions on public funding of health care as a consequence. Neoliberal pressures to open new markets for corporate investors through health system privatization (supported by trade in services provisions and investor protection provisions in contemporary trade agreements) contributed to the privileging of market models in health policy debate.

The Social, Political, and Historical Context and the approaches used by the government to prevent and control the pandemic.

PHM Uganda is particularly concerned by the proposed UHC Model of marketisation of UHC (driven by the Bank, accepted by WHO) which undermines the implementation of comprehensive primary health care. There is widely acclaimed evidence in Uganda that reducing PHC to an arbitrarily defined 'intervention' has limited and distorted the analysis of needs and priorities; precluded effective community accountability; ignored public and community action around the social determination of health; and prevented best use of limited resources to comprehensive primary health care (CPHC) as has been re-affirmed in Ugandan health policies as the basis for health policy by WHO member states. The dominant approach ('selective' PHC) in Uganda is characterised by the neglect of promotive and preventive aspects of care and the exclusion of inter-sectoral collaboration, community participation and sustainable district level structures. The best example manifests within the UNICEF GOBI package for child survival which privileges a few selected interventions hence allowing donors and the government of Uganda like many others around the world to avoid tackling inequities and the social determination of ill-health (SDH). Reducing comprehensive PHC to a set of commodified interventions funded through benefit packages has greatly disemboweled the Alma-Ata vision of PHC. In particular, it has precluded systematic stewardship regarding the social determination of health, including the engagement of local PHC staff in working with communities in relation to the SDH. A case in point

is community education around hand-washing which is widely advertised and included in the Uganda MINISTRY OF HEALTH SECTOR STRATEGIC PLAN 2020/21 – 2024/25[4], benefit packages but there are no supportive community actions for this approach like improved water supply and sanitation excluded from consideration. Another inconsistency is recalled in history from the World Bank's conclusions in 1993

highlighting that expenditure on clean water and sanitation was not cost effective but did not offer viable alternatives (a conclusion reached by assigning the full cost of water and sanitation to the health sector and ignoring inter-sectoral benefits). The implication of benefit packages in PHC is that services which are outside the essential 'package' are necessarily funded by direct user charges and are provided by the private sector, thus further supporting private medical care. Private practice and fee for service reimbursement make it much harder to realise the vision of comprehensive PHC.

A description of the actions in which health activists engaged

Health Activists in Uganda have engaged in a coalition for vaccine monitoring and access while highlighting the discrepancies in access and acceptability of vaccines. COVAX, a global vaccine distribution facility established in mid-2020 was created to ensure global access to COVID-19 vaccines. This arrangement has struggled with its ambitious promise. Beset with delays and doubts over its ability to deliver on its goals, the initiative once heralded as the "only truly global solution" to the pandemic has found itself severely underfunded and hampered by vaccine hoarding in high-income countries. PHM Uganda with partners has joined the campaign to advocate for vaccine access and acceptance though a project called vaccine advocacy accelerator Uganda (vax) project.

PHM Uganda has placed its advocacy emphasis on the role of primary health care in achieving universal health coverage[5]. An essential component of primary health care is universal health coverage which should be Universalist, based on social solidarity and built on a unified public funded system, with most service provision through public institutions.

Evidence in a Ugandan perspective shows that UHC faces diverse challenges relating to how it tries to shape up due to the opposition by the formal sector service holders to pay anything on top of existing income tax; 'private interest' (strong lobbying by private health insurance providers in fear of dilution of their existing profit) ; 'institutional conflict of interest' (fear of the existing service providers to lose their authority); and 'technical barriers' (difficulty in collection of premium from a massive

[4] https://www.health.go.ug/cause/ministry-of-health-strategic-plan-2020-21-2024-25/ Accessed at 8:25 am 2/14/2023
[5] Rao M, Pilot E (2014) The missing link--the role of primary care in global health. Glob Health Action 7: 23693.

informal sector) and finally the high costs associated with establishing the mechanism (necessitating a referendum to okay the government to levy such fees on the population at hand). Much of the attention in relation to UHC has focused on financial risk protection: less has been said about coverage by effective services. Coverage can be achieved in many different ways, but will always include some community based services as an essential link in the service delivery chain.

Since the protection and attainment of health by people in any one country directly concerns and benefits every other country, development assistance, including donor programs, must be accountable to and strengthen national public health systems and address the social, environmental and ecological determinants of health.

PHMUganda in partnership with various civil society, through a coalition of budgetary Advocacy engaged the parliament budget committee to advocate for acceptable level of health budgetary allocation with analysis of where cutbacks to raise funds enabling the monetary allocations can come from, a case in point is the considerable amount of resources in Uganda is now spent on armaments and military fatigue purchases. A reduction in this kind of expenditure, with genuine health rights policies, and peace could release additional resources that could well be devoted to peaceful aims and in particular to acceleration of social and economic development of which primary health care as an essential part, should be allotted its proper share.

The experiences and lessons learned

The PHM experience has shown that achieving UHC in a country like Uganda is a gradual process. Over time, provision can expand to include an evolving range of preventive, promotive and curative services, including palliative care and rehabilitation. Each country has a different starting point in terms of its disease profile, gaps in service coverage and level of health spending. However for the Ugandan case whatever the circumstances, community-based services are vital in achieving universal health. Community-based health services need to continue to adapt to a fast changing world and the challenges that come with UHC. It is a lesson we have learnt as PHM Uganda that the feature of community-based service delivery lies in systematic documentation of the whole range of services being provided by health workers in communities. This is an area of focus that the People's Health Movement (PHM) in Uganda motivated by the need for social justice in health care, to push political leaders to opt for UHC. As a civil society platform 'Community empowerment' as a key aspect of social movements emerges as one of the most important pre requisites for establishing UHC. It is imperative that we build the evidence on community empowerment to support and create evidence for policy formulation on UHC.

More specific approaches towards UHC need consideration, first the use of "defined benefit packages" in insurance dominated systems; and second, the methods and mechanisms through which equitable and efficient resource allocation can be promoted in tax-funded, public delivery systems.

The opportunity costs of implementing the defined benefits package strategy with integrity are particularly high in the context of private insurance and private practice. Resource allocation in tax-funded public delivery systems can be efficient and effective; critical elements include: adequate funding, planning and budgeting at the district health system level, the role of senior clinicians in budget management and guidelines implementation at the clinical level, and community accountability with respect to both funding and administration.

Implementation of UHC without capacity building for priority setting as well as technical capacity to implement UHC which includes community capacity and norms and structures to support dialogue and accountability is fatal to its efficiency. The PHM encourages the need to include capacity building for priority setting in programs for health systems development both community capacity as well as technical capacity, and it should also include the norms and structures needed to support professional and community dialogue.

A critical review of actions developed from the lessons learned

The People's Health Movement strongly rejects the narrative that frames PHC primarily as a "cornerstone" or foundation of Universal Health Coverage (UHC). PHC, is broader and indeed subsumes UHC, which is, in many countries, being implemented by private health insurance companies and aggravating health inequities. While the official declaration recognises that it is "ethically, politically, socially and economically unacceptable that inequity in health and disparities in health outcomes persist" it does not acknowledge that health gains in some places are being reversed.

People should be afforded every opportunity to participate individually and collectively in the planning and implementation of their health care. This participation should respect age, gender, ethnicity and socio-economic status and use digital technologies where appropriate.

Effective and accountable global governance for health is required to realise PHC. This should include means of effective taxation to ensure that all individuals and corporations pay their fair share of taxes to enable the funding of health and other services beneficial to health;

Primary health care is essential health care based on practical, scientifically sound

and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation in the spirit of self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It gives particular emphasis to the household and community levels and the first level of care, bringing comprehensive health care as close as possible to where people live and work, and is fully integrated with other levels of care.

An essential component of primary health care is universal health coverage which should be Universalist, based on social solidarity and built on a unified public funded system, with most service provision through public institutions.

Health gains from the implementation of an effective primary health care system can be easily undermined by the commercial determinants of health, including promotion and trade of health harming commodities. Global and national policies, including effective regulation, are needed to prevent their adverse impacts.

Conclusions

The social and political determination of health looms large at this time and comprehensive PHC is a powerful strategy for engaging with such processes. The marketised model of health care, which the World Bank offers under the rubric of UHC, has no strategy for addressing the SDH and would preclude the implementation of PHC. WHO should not be participating in a campaign that has the effect of precluding the implementation of comprehensive PHC. The regulation of resource flows for equity and efficiency in marketised health systems is complex, expensive and often just not possible. Judgements regarding the effectiveness of interventions require the integration of evidence regarding efficacy with an understanding of that particular health care environment. It is easy to list or delist particular interventions for reimbursement. It is far harder to ensure that listed interventions are only used in clinical situations where they are known to be effective. It is even harder to include workable protocols for considering clinical exceptions for interventions which are not listed. In publicly owned and managed health care systems equitable and efficient resource allocation can be assured under conditions which are much easier to implement. Discussions of health system models, including UHC and methods for priority setting, are framed by prevailing ideological currents; in the present period these currents are dominated by neoliberalism. The privileging of marketised models for health care in such discussions reflects corporate pressure to access new markets; tax competition and pressure on public funding; widening inequalities and

the weakening of social solidarity.

PHM calls upon policy makers to approach UHC with full consideration of the policy advantages of single payer financing and publicly managed health care delivery, including equitable resource allocation for efficient, safe and high quality care.