Primary health care as a strategy for health equity in Arab countries

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Introduction

Inequalities in health status within and between countries have been growing since the mid-1990s in Arab countries and globally. Within countries there is an increasing gap in health status between the most advantaged and disadvantaged social groups. These stark differences reflect contrasts in the conditions in which people are born, grow, live, work and age. These conditions we term the social determinants of health. They are patterned social differences, rather than biological differences, such as those due to genetic make-up or physiological differences between male and female. They are avoidable and can be addressed by appropriate social action. Such social inequalities can be seen as unfair and unjust, and hence as inequities.

Primary health care (PHC) is presented as a strategy for achieving health equity, for decreasing the gap in health status and outcomes between advantaged and disadvantaged groups and geographical areas. The synergy between PHC, health equity and the social determinants of health provides values and principles, and guidelines for public policies and interventions that can improve health, especially for the most disadvantaged groups. A number of Arab countries have pioneered the development of primary health care since the Declaration of Alma Ata, in 1978, and helped to put primary health care on the global agenda.

The synergy between PHC, health equity and SDH

PHC

PHC has been defined as "a set of values and principles for guiding the development of health systems".[1] PHC is often thought of as the first ("primary") level of care, the initial contact between patient and professional health care worker. An important aspect of this first stage care is to act as a screening device, to identify those cases which need to be referred to a higher level facility for further care. The disjunction between "primary" and a more advanced facility has often been identified as a major failure of the earlier attempts to achieve PHC. If the first stage of care is to be effective and equitable, it should be seen as part of a full range of treatment, prevention, health promotion and outreach, and linked through referrals to secondary and primary care. We argue here that all three levels of care should be properly integrated, embracing the whole of the government health system, as in PAHO.

Health equity

Health equity is defined as the absence of inequalities in health outcomes and opportunities to enjoy good health. In the words of the report of the Commission on Social Determinants of Health: "…inequities in health, avoidable health inequalities, arise because of the circumstances in which people are born, grow, work and age".

These differences in health between social groups and between countries, and parts of countries, have increased dramatically in the last twenty years. This has been largely due to health "reforms" which have severely limited the scope of universal first level care, and policies which have focused on increasing "average" levels of health, without taking into consideration the distribution of such social differences and the social needs of the most disadvantaged sectors of society. [2] [3] Inequalities may be absolute, as when some sectors of society have insufficient resources to supply basic needs, or relative, in which case the consciousness of inequality and the lack of opportunity rob many of the disadvantaged of a sense of worth and of the "fairness" of the society in which they live. Both kinds of inequality have adverse impacts on all sectors of society, endangering social harmony.[4]

Indicators of health equity are rarely used, and thus are not found in health data bases. The most straightforward, pragmatic measure of health equity that can be used by policy makers can be expressed as a relationship between two measures: 1) a health outcome and health opportunity, and 2) a "stratifier", identified in terms of differentials within a social, cultural or economic grouping, or a geographical area. This is a key definition as it incorporates a third element, a framework for measurement.[5]

Health equity can be measured, but it is also important to recognize that the concept represents a value, a widely recognized "public good", considered important in contributing to human development. Health equity is now supported by a body of human rights law which provides a comprehensive base for advocacy leading to action on health equity. The WHO constitution, promulgated in 1946, stated: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." A key provision of the Universal Declaration of Human Rights, 1948, article 25, states: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." [6] These declarations have been followed by instruments on the rights of women, children, social and cultural minorities, refugees, the disabled and the mentally ill. In 2000 human rights law was strengthened with additions to the landmark 1976 International Covenant on Economic, Social and Cultural Rights (ICESCR), which obligated health policy makers and practitioners to ensure the right of equitable access to health care and health facilities.[7] [8] This clearly demonstrated the imperative to recognize human rights in the delivery of care and the implementation of public health programs.[9] The EMR has been actively involved in promoting human rights in support of health.[10]

SDH

Evidence for avoidable health inequities accumulated from the mid-1990s, contributing to the establishment by WHO of a Commission on Social Determinants of Health in early 2005. The Commission documents adopted a definition that identified the social determinants of health as "both specific features and pathways by which societal conditions affect health and that potentially can be altered by informed action".[11] These were the subjects of enquiry by "knowledge networks", theme

groups, and include such issues as gender equity, early childhood development, employment conditions, urbanization, social exclusion, and lifestyle and behavior. Structural determinants were identified as originating in global and national patterns of the distribution of power and resources, which placed limits on local action on societal conditions. One long recognized example of the way in which social conditions can determine health outcomes, is the influence of a mother's level of educational attainment on the health and survival of her children, a relationship that holds for a wide range of different geographical and social settings.[12] For this reason, social surveys such as Demographic and Health Surveys (DHS) ask women about their educational status as well as the health of their children.

Work on SDH originated in the European Regional Office of WHO, and the broad theme areas are relevant globally. The need for on-going global work on health equity was emphasized in the final report of the CSDH, entitled *Closing the gap in a generation: Health equity through action on the social determinants of health.*[13] However, analytical frameworks and measurements have had to be adapted to local conditions and cultural specifics in Non-Western middle and lower income countries. In the Eastern Mediterranean Region country based studies identified themes of particular local relevance, including the importance of conflict as a SDH.[14 15]

Primary Health Care: the vision of Alma Ata and its challengers

The International Conference in Alma-Ata, Kazakhastan, in 1978, which was sponsored by WHO and UNICEF, established Primary Health Care, and its values and principles on the global public health agenda. In addition to the provision of essential health services for all as a right, stating that inequality in health status was "politically, socially and economically unacceptable". The Declaration envisaged tackling underlying social, economic and political causes of poor health, a task which they acknowledged required going beyond the usual remit of ministries of health.

Box 2: Declaration of Alma-Ata

Article I:

- "health…is **a fundamental human right** and…… the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

Article II:

- "The **existing gross inequality in the health status of the people particularly between developed and developing countries, as well as within countries is politically, socially and economically unacceptable** and is, therefore, of common concern to all countries."

Article V.

- "**Governments have a responsibility for the health of their people** which can be fulfilled only by the provision of adequate health and social measures."

Article VI.

- "**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 and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.**"** [16]

Primary Health Care was soon challenged by a "selective" PHC strategy which focused on a small number of proven medical interventions directed against specific diseases, delivered through vertical programs. These vertical programs had a narrow, disease-based remit, focused on a small number of interventions whose effectiveness was judged on the basis of cost effectiveness. The so-called "neoliberal" policies of some Western donors and international agencies continued to challenge the values of PHC and health equity through the 1990s. In order to deliver equitable care, Primary health care was envisaged as being provided directly by ministries of health. But the introduction of private for-profit partners, who neglected unprofitable preventive and promotive activities in favour of more profitable curative care, by-passed ministries of health and deprived them of funding.[17] By the early years of the new millennium, commentators began to stress the need to remedy the neglect of equity in health sector reforms.[18] The Millennium Development Goals for health were expressed in terms of a percentage improvement in average health measures; yet studies showed that the child health targets could be achieved without addressing the needs of children living in the poorest settings and with the worst health status.[19]

Implementing equitable Primary Health Care – today's challenge

There is a need to act on the overwhelming evidence that countries with health systems organized on the foundation of truly equitable primary health care have better health outcomes at lower cost.[20] In the *World Health Report 2008, Primary Health care now more than ever* it, Dr Margaret Chan, Director-General of WHO, wrote of the need for "universal coverage reforms that ensure that health systems contribute to health equity, social justice and the end of exclusion, primarily by moving towards universal access and social health protection". [21] The comprehensive nature of primary health care offered "a way to organize the full range of health care, from households to hospitals, with prevention equally important as cure, and with resources invested rationally in the different levels of care." Revitalizing primary health care, and honouring its values and principles in the twenty-first century also involved recognizing new situations that could not have been envisioned twenty years ago, such as structural adjustment programmes, the oil and food crises and global recession.[22] It also meant designing PHC programmes that were appropriate for local needs and resources, while maintaining the values intrinsic to PHC.

The Eastern Mediterranean Region of WHO can claim to have been steadfast in its support for PHC, with its focus on universal care and provision for the disadvantaged, especially the rural poor, over the thirty years since the Alma Ata Declaration.[23] The practical expression of "health for all" is demonstrated by a unique programme in EMR, the Community Based Initiative, which addresses health and social needs through participatory action in the community. The basic development needs (BDN) component, first introduced in Somalia in 1988, focuses on improving health in disadvantaged communities through tackling social determinants of health. This regional initiative is supported by WHO in 12 countries of the Region.[24] Regional commitment to health equity was expressed in the regional meeting on primary health care, in November 2008, in the Doha Declaration on Primary Health Care.[25]

In implementing PHC, flexibility is essential to address health problems in the national and local context and to preserve the original values of health equity and fairness. Since the Declaration of Alma Ata, high, middle and low income Arab countries have experienced a demographic transition – with an increasingly older population, a "youth bulge" resulting from earlier high fertility, and a transition from a predominantly rural to an urban based society. This has been accompanied by the rapid growth of a disadvantaged urban population. These countries have also undergone an epidemiological transition from communicable to non-communicable diseases.

Primary health care and health equity in Egypt

In Egypt the "social contract" established at the time of the Free Officers Revolution in 1952, guaranteed free health services, as an essential step towards improving the conditions of very poor rural dwellers, at that time comprising a large majority of the population. The government constructed a network of health facilities reached of 95% of the population in the densely populated Nile delta and river valley to the south. These facilities were staffed by a growing cadre of Egyptian health professionals who graduated from new or expanded medical schools. The government also guaranteed social protection in the form of subsidized food and grants to bring the living standards of the disadvantaged majority up to a basic minimum, free education at all levels, followed by government guarantees of employment. Land reform sought to return land to cultivators who had for so long been tenants forced to pay a proportion of their crop to landlords.[26]

The reforms of the 1950s and 1960s aimed to unify society, claiming to represent all Egyptians, and building on the "positive values found in Egypt's popular heritage regarding social solidarity". The reforms were seen as a "social contract", providing for the basic needs of all citizens in exchange for their total loyalty to the state and its institutions.

The new health system was largely responsible for remarkable improvements in health status. Overall health status increased but inequalities in health outcomes between governorates persisted. For example in 1961, the Red Sea Governorate had the highest IMR, 191, compared to the lowest figure, 60, in Kafr el Sheikh in the Nile Delta; in 2005 the highest infant mortality rate was in the southern governorate of Assiut, 37, and the lowest, 10.4 in Kafr el Sheikh. The poor health outcomes in southern Egypt persisted, illustrated by the difference in the percentage of births attended by health personnel in 2005, with the lowest proportion in the southern governorate of Sohag, 62.4%, compared to the highest figure, for the urban Port Said Governorate, 93.3%.[27]

The Egyptian system put in place in the 1950s and 1960s was financially unsustainable, as the growing population created demands that could not be met. As the population increased and made greater demands on limited resources, the original concept of universal health care was not maintained.

The "open door" policy of the 1970s under President Sadat was intended to generate resources for national development by encouraging the private sector involvement in health and other government dominated sectors. As elsewhere in the Region, during

the 1980s global recession, accompanied by restrictive donor funding for health, education and welfare support, resulted in higher prices for public goods. In Egypt, the poor, and the government employees who had benefited from the original "social contract", felt that they were being denied opportunities to improve their economic and social status.[28]

Health reform during the 1980s and 1990s was supported by USAID under what came to be called "the Washington consensus".[29] It focused on training physicians and nurses, upgrading facilities, and on the delivery of maternal and child health programs. A new phase in health reform was first mooted in 1997, responding to concern about the centralized, vertical and high fragmented services, which produced poor health outcomes and failed to provide equity and access for all. It was piloted in 2000/01 in Alexandria, in Menofia Goverornate in the delta, and Sohag Governorate in southern Egypt. It was promoted as a Primary Health Care program following the Family Practice model with each family receiving services, and referral as needed, from a personal physician. Physicians and nurses were trained and facilities in the pilot areas upgraded. The ministry stated that the program was based on that in UK and New Zealand.[30] Discussions are on going about whether or not to introduce fees for some first level services: for the family folder, examination ticket, for medicines, x-rays and various other examinations.

At the turn of the millennium differences in health status between different parts of the country and between different social groups were identified, as were inequalities in the social and spatial distribution of health financing.[31] Civil society activists questioned whether the health reforms would result in greater equity, would be genuinely universal, available to all, and whether the physicians in health centers would be able to oversee a program that could effectively reach out, beyond health facilities, to disadvantaged groups.

Civil society organizations continue to provide services for the disadavantaged, thus filling some of the space that had been evacuated by the state. But the role of civil society was limited. For civil society to expand beyond the provision of health care, and actively advocate for a return to the value of equity would, from the government's point of view, violate the original "social contract". The 2005 and 2008 Human Development Reports presented the case for a new social contract, pointing out that the terms of this contract would need to be entirely reformulated to include civil society, which had no role in the paternalistic Egyptian state established in 1952.[32]

Primary health care and health equity in Oman

Oman presents a much more recent attempt than that of Egypt to institute primary health care. It has used oil wealth available since the mid-1970s to provide universal care for Omanis who where, at that time, mostly poor rural dwellers. Today it serves just under 2 million Omani citizens. The Primary Health Care foundation for the health system in Oman has been claimed as responsible for the vastly improved health status of Omanis; for example, the under 5 mortality rate declined from 149 in 1975 to 13 in 2007.[33]

The comprehensiveness of the PHCH system is likely to have fostered health equity, with differences in health outcomes between Omani social groups and between the

capital and the rural, mostly desert, areas decreasing. The health situation in Oman has changed dramatically since the Oman Family Health Survey, 1995. Even at that time inequalities in children's health outcomes by gender, in infant mortality rate, wasting, stunting, in ARI and immunization levels, were minimal. Differences according to the education level of the mother were more marked.[34] It is likely that increasing levels of education for girls since 1995 would have had the effect of narrowing these gaps.

Non-communicable diseases, related to life style, are now a major concern in Oman, with some evidence of differences between males and females, and social groups. In a recent survey of Nizwa District, the prevalence rate of overweight (BMI $\geq$25 and <30) was 25% among females and 31% among males. The prevalence rate of obesity (BMI $\geq$ 30) was higher among females (17%) than among males 8.6%. A high proportion of adult females in Nizwa reported not participating in sports or regular physical activity (73%) compared to 47.5% of males. The lack of facilities, and for women a cultural bias against such activities, were given as reasons for a lack of exercise.[35]

The values, aims and objectives of the Ministry of Health in the Sultanate provide a framework for the institutional structure that supports the PHC approach and emphasizes health equity as a desirable outcome. Before 1970, and before the oil boom, health care services in the Sultanate of Oman were restricted to two hospitals in the capital, Muscat, and a few scattered rural dispensaries. In 1970 a royal decree established a Ministry of Health responsible for the provision of health care for all Omani citizens and comprehensive primary care was established as the first point of entry to all levels of health care. The Second Five Year Health Development Plan (1981-1985) expanded the coverage of the population, especially for mothers and children and people living in remote areas. It established health programs for mothers and children, for EPI, TB, prevention of blindness, and the control of diarrheal diseases. In 1985, an "Inter-Ministerial Health Committee" was established by a Royal Decree with representatives from ministries concerned with health; thus initiating an institutional base for inter-sectoral action to address social determinants and health equity.

In 1992, further promotion of PHC called for the integration of curative and preventive care in the "Wilayat Health System". This allowed further decentralization to the wilayat, or district, level. The Wilayat is the most peripheral unit and the closest to the community and thus is able to promote health equity by identifying local needs and the proper management of the local resources. Wilayat Health Committees address social determinants and health inequities through intersectoral action with other government departments, and other agencies and civil society.

The system is in line with current WHO strategies for decentralized, PHC based health systems that are able to respond to local health and welfare needs.

In 1995 Wilayat Health Teams were established and trained to identify local health problems and to produce proper plans to reduce magnitudes of such health problems through "Wilayat Team Problem Solving (WTPS)" techniques. By early 1997 435 health workers had been trained and 77 senior health workers also trained as trainers. 1n 1998, a Central Committee to Strengthen Community Participation to Promote

Primary Health Care was established. Among its functions was to: Coordinate efforts for promoting collaboration of different health related sectors and provide the opportunities for community participation to promote primary health care. Community participation was seen as central to the efforts to achieve effective PHC, to ensure universal coverage and effective delivery of care. Educational programs were directed towards women, to encourage them to make effective informed decisions about maintaining family health using available services. The program supported women volunteers "Community Support Groups" to deliver important health messages to mothers in the community.

On the basis of this description of PHC by the Omani Ministry of Health, the country promotes the values of PHC, including health equity, and is justified in attributing the rapid improvement of the health status of its citizens to the effectiveness of a health system based on primary health care.[36] The Commission on Social Determinants of Health, and EMRO have recognized the Omani experience as a regional example of country which has achieved remarkable improvements in health status for its population, through a PHC based health system that encourages equity in health services, better coverage, efficient health care delivery, community participation and self-reliance.[37]

Non-Omani citizens and their dependents constitute a quarter of the population of the country. The Ministry of Economy estimated that in mid 2006, more than 700,000 non-Omanis were living in Oman. As of 2006, only those with high status occupations, such as the 4.5% of expatriates working in the government sector, were covered by the Omani health care system. As the 1995 Family Health Survey covered only the Omani population, it was not possible to assess the health status of non-Omanis compared to Omanis.[38] Current efforts are directed towards providing effective, universal care to the less advantaged non-Omanis.

Concluding comments

In addition to facing the powerful interests favouring health sector reform which so often fail to recognize the need for health equity, all countries implementing PHC have to consider how the values of PHC can be transformed into effective strategies in the twenty-first century. They need accurate information about the extent of health inequity, strategies to identify the most disadvantaged groups, and a health system capable of delivering PHC within the national context.[39]

The earliest moves towards an equity-based PHC, as envisioned thirty years ago at Alma Ata, focused on providing the previously neglected rural populations with facilities and staff to deliver proven treatment and preventive activities for communicable diseases: childhood immunization, ORT for diarrhea control, and treatment for respiratory infections, as well as improved water supplies. New disease patterns and changing demographic and social conditions have required a reassessment of established PHC programmes and the development of different models to suit different settings. These changes have necessitated a change in the focus of PHC while keeping in mind the need to preserve its values and principles, especially health equity.

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