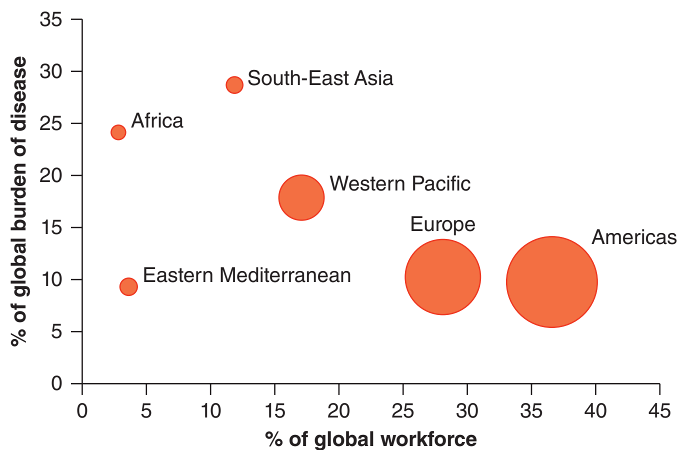

FIGURE 13e-5 Global burden of disease and health workforce. *(Source: World Health Organization: Working Together for Health, 2006.)*

Critical diagnostics and drugs often do not reach patients in need because of supply-chain failures. Moreover, facilities fail to provide safe care: new evidence suggests much higher rates of adverse events among hospitalized patients in low- and middle-income countries than in high-income countries. Weak government planning, regulatory, monitoring, and evaluation capacities are associated with rampant, unregulated commercialization of health services and chaotic fragmentation of these services as donors "push" their respective priority programs. With such fragile foundations, it is not surprising that low-cost, affordable, validated interventions are not reaching those who need them.

STRATIFYING SOCIAL CONDITIONS

Health care delivery systems do not exist in a vacuum but rather are embedded in a complex of social and economic forces that often stratify opportunities for health unfairly. Most worrisome are the pervasive forces of social inequality that serve to marginalize populations with disproportionately large health needs (e.g., the urban poor; illiterate mothers). Why should a poor slum dweller with no income be expected to come up with the money for a bus fare needed to travel to a clinic to learn the results of a sputum test for tuberculosis? How can a mother living in a remote rural village and caring for an infant with febrile convulsions find the means to get her child to appropriate care? Shaky or nonexistent social security systems, dangerous work environments, isolated communities with little or no infrastructure, and systematic discrimination against minorities are among the myriad forces with which efforts for more equitable health care delivery must contend.

SKEWS IN SCIENCE

While science has yielded enormous breakthroughs in health in high-income countries, with some spillover to low- and middle-income countries, many important health problems continue to affect primarily low- and middle-income countries whose research and development investments are deplorably inadequate. The past decade has seen growing efforts to right this imbalance with research and development investment for new drugs, vaccines, and diagnostics that effectively cater to the specific health needs of populations in low- and middle-income countries. For example, the Medicines for Malaria Venture has revitalized a previously "dry" pipeline for new malaria drugs. This is but one of many such efforts, but much more needs to be done.

As discussed above, the primary constraint on better health in low- and middle-income countries is related less to the availability of health technologies and more to their effective delivery. Underlying these systems and social challenges to greater equity in health is a major bias regarding what constitutes legitimate "science" to improve health equity. The lion's share of health research financing is channeled toward the development of new technologies—drugs, vaccines, and diagnostics; in contrast, virtually no resources are directed toward research on how health care delivery systems can become more reliable and overcome adverse social conditions. The complexity of systems and social context is such that this issue of delivery requires an enormous investment in terms not only of money but also of scientific rigor, with the development of new research methods and measures and the attainment of greater legitimacy in the mainstream scientific establishment.

These common challenges to low- and middle-income countries partly explain the resurgence of interest in the primary health care approach. In some countries (mostly middle-income), significant progress has been made in expanding coverage by health systems based on primary care and even in improving indicators of population health. More countries are embarking on the creation of primary care services despite the challenges that exist, particularly in low-income countries. Even when these challenges are acknowledged, there are many reasons for optimism that low- and middle-income countries can accelerate progress in building primary care.

PRIMARY HEALTH CARE IN THE TWENTY-FIRST CENTURY

The new millennium has seen a resurgence of interest in primary health care as a means of addressing global health challenges. This interest has been driven by many of the same issues that led to the Declaration of Alma Ata: rapidly increasing disparities in health between and within countries, spiraling costs of health care at a time when many people lack quality care, dissatisfaction of communities with the care they are able to access, and failure to address changes in health threats, especially noncommunicable disease epidemics. These challenges require a comprehensive approach and strong health systems with effective primary care. Global health development agencies have recognized that sustaining gains in public health priorities such as HIV/AIDS requires not only robust health systems but also the tackling of social and economic factors related to disease incidence and progression. Weak health systems have proved a major obstacle to delivering new technologies, such as antiretroviral therapy, to all who need them. Changing disease patterns have led to a demand for health systems that can treat people as individuals whether or not they present to a health facility with the public health "priority" (e.g., HIV/AIDS or tuberculosis) to which that facility is targeted. We discuss experiences in low- and middle-income countries in relation to primary care in greater detail below. First, we consider the features of primary health care and primary care as currently understood.

REVITALIZATION OF PRIMARY HEALTH CARE

At the 2009 World Health Assembly (an annual meeting of all countries to discuss the work of the World Health Organization [WHO]), a resolution was passed reaffirming the principles of the Declaration of Alma Ata and the need for national health systems to be based on primary health care. This resolution did not suggest that nothing had changed in the intervening 30 years since the declaration, nor did it dispute that its prescription needed reframing in light of changing public health needs. The 2008 WHO World Health Report describes how a primary health care approach is necessary "now more than ever" to address global health priorities, especially in terms of disparities and new health challenges. As discussed below, this report highlights four broad areas in which reform is required (Fig. 13e-6). One of these areas—the need to organize health care so that it places the needs of people first—essentially relates to the necessity for strong primary care in health systems and what this requirement entails. The other three areas also relate to primary care. All four areas require action to move health systems in a direction that will reduce disparities and increase the satisfaction of those they serve. The World Health Report's recommendations present a vision of primary health care that is based on the principles of Alma Ata but that differs from many attempts to implement primary health care in the 1970s and 1980s.

Universal Coverage Reforms to Improve Health Equity Despite progress in many countries, most people in the world can receive health care services only if they can pay at the point of service. Disparities in health are caused not only by a lack of access to necessary health