Primary Health Care and the Social Determinants of Health: Synergies for equity in health

Competences for Poverty Reduction (COPORE) Project Conference
Hogeschool van Amsterdam
23-24 April 2010

Dr. Rüdiger Krech, Director
Anand Sivasankara Kurup, Technical Officer
Department of Ethics, Equity, Trade and Human Rights

World Health Organization
Outline

• Primary health care
  – WHO constitution
  – What it entails: Alma-Ata declaration
  – Renewal of Primary Health Care

• Social determinants of health
  – Why should we address social determinants of health?
  – Commission on Social Determinants of Health: Key recommendations

• Synergy between primary health care and social determinants of health
  – Health equity
  – Intersectoral action
  – Community mobilization
Primary health care
WHO Constitution - 1948

- Health is a state of **complete physical, mental and social wellbeing**, and not merely the absence of disease or infirmity.

- 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.

- **Governments have a responsibility for the health of their peoples** which can be fulfilled only by the provision of adequate health and social measures.
**Declaration of Alma-Ata 1978**

- **Defined primary health care as**
  - 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
  - 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.
  - 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 is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.
Values of Alma-Ata Declaration

- **Equity**
  - Fairness and social justice
- **Universality**
  - Access, affordability, health as a human right
- **Community participation**
  - Participation in the planning, organization, operation and control of primary health care,
- **Solidarity**
  - Community and individual self-reliance
  - Making fullest use of local, national and other available resources
- **Intersectoral action**
  - Within health sector
  - Outside health sector
Renewal of Primary Health Care - 2008
The four reforms

- **UNIVERSAL COVERAGE REFORMS** to improve health equity
- **SERVICE DELIVERY REFORMS** to make health systems people-centred
- **LEADERSHIP REFORMS** to make health authorities more reliable
- **PUBLIC POLICY REFORMS** to promote and protect the health of communities

[World Health Organization logo]
## How experience has shifted the focus of PHC

<table>
<thead>
<tr>
<th>Early attempts at PHC</th>
<th>Current concerns of PHC Reforms</th>
</tr>
</thead>
<tbody>
<tr>
<td>A basic package for the rural poor</td>
<td>Universal access, comprehensive services</td>
</tr>
<tr>
<td>Mother and child focus</td>
<td>All disadvantaged groups</td>
</tr>
<tr>
<td>Acute, infectious, diseases</td>
<td>Health risks, illness across life course</td>
</tr>
<tr>
<td>Healthy local environment</td>
<td>Healthy global and local environments</td>
</tr>
<tr>
<td>Scarcity and downsizing</td>
<td>Managing growth to universal coverage</td>
</tr>
<tr>
<td>Government, top-down services</td>
<td>Public/private mixed health systems</td>
</tr>
<tr>
<td>Bilateral aid, technical assistance</td>
<td>Global solidarity, joint learning</td>
</tr>
<tr>
<td>First level care, not hospitals</td>
<td>Coordinated referral to appropriate care</td>
</tr>
<tr>
<td>PHC is cheap</td>
<td>PHC is not cheap, but good value for money</td>
</tr>
</tbody>
</table>
Why renewal of PHC?

Significant progress but not a given: *child deaths in 1975 and 2006*

Deaths per 1000 children under five

- Oman (THE 2006: $382)^b$
- Portugal (THE 2006: $2080)^b$
- Chile (THE 2006: $697)^b$
- Malaysia (THE 2006: $500)^b$
- Thailand (THE 2006: $346)^b$

World Health Organization
Why renewal of PHC? (cont’d)

Significant progress but not a given: child deaths in 1975 and 2006

- Mongolia (THE 2006: $149)\textsuperscript{a}
- Morocco (THE 2006: $273)\textsuperscript{a}
- Tajikistan (THE 2006: $71)\textsuperscript{a}
- India (THE 2006: $109)\textsuperscript{a}
- Madagascar (THE 2006: $35)\textsuperscript{a}
- Zambia (THE 2006: $62)\textsuperscript{a}
Why renewal of PHC? (cont’d)

Significant progress but not a given: child deaths in 2006

At 1978 rates

Actual

What would have been feasible

At 1978 rates

Actual

What would have been feasible
Social determinants of health
Why treat people ... then send them back to the conditions that made them sick?
Mortality from Tuberculosis in England and Wales

Social determinants is NOT a new finding!
Global Plan: TB not eliminated by 2050

Current trend (0.5%) extrapolated

Global Plan prediction: incidence falls 5-6% per year

Desired trend

Elimination target: 1 / million / year by 2050
Why is this happening?

Lonnroth et al. 2008
Pattern of inequity matters for intervention strategies

% of children receiving six or more child-survival interventions

Socio-economic group

<table>
<thead>
<tr>
<th></th>
<th>Brazil</th>
<th>Benin</th>
<th>Cambodia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poorest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4th</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Least poor</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

World Health Organization
<table>
<thead>
<tr>
<th>Location</th>
<th>Life Expectancy at Birth (men)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glasgow, Scotland (deprived suburb)</td>
<td>54</td>
</tr>
<tr>
<td>India</td>
<td>61</td>
</tr>
<tr>
<td>Philippines</td>
<td>65</td>
</tr>
<tr>
<td>Korea</td>
<td>65</td>
</tr>
<tr>
<td>Lithuania</td>
<td>66</td>
</tr>
<tr>
<td>Poland</td>
<td>71</td>
</tr>
<tr>
<td>Mexico</td>
<td>72</td>
</tr>
<tr>
<td>Cuba</td>
<td>75</td>
</tr>
<tr>
<td>US</td>
<td>75</td>
</tr>
<tr>
<td>UK</td>
<td>76</td>
</tr>
<tr>
<td>Glasgow, Scotland (affluent suburb)</td>
<td>82</td>
</tr>
</tbody>
</table>

% of poorest smoking tobacco is almost double as that of the % of richest smoking tobacco daily in low income countries, where as this difference in upper middle income countries is very low.
What are the social determinants of health?

• The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by:
  – **Structural determinants**: the unequal distribution of power, income, goods, and services, globally and nationally,
  – **Conditions of daily life**: the consequent unfairness in the immediate, visible circumstances of peoples lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life.
  – Together, the structural determinants and conditions of daily life constitute the **social determinants of health**.

Source: Commission on Social Determinants of Health (2008)
Social determinants of health conceptual framework

Figure 4.1 Commission on Social Determinants of Health conceptual framework.

Source: Amended from Solar & Irwin, 2007
Commission on Social Determinants of Health, 2008
# Common Social Determinants of Health

<table>
<thead>
<tr>
<th>Level</th>
<th>NTD</th>
<th>TB</th>
<th>HIV</th>
<th>Injuries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socio-economic context</td>
<td>Socio-economic status, gender, ethnicity</td>
<td>Socio-economic status, gender, ethnicity</td>
<td>Socio-economic status, Gender</td>
<td>Socio-economic status, ethnicity</td>
</tr>
<tr>
<td>Differential Exposure</td>
<td>Social norms, cultural beliefs and practices, living conditions, poor nutrition, crowding, conflicts &amp; natural disasters</td>
<td>Social norms, cultural beliefs and practices, living conditions, crowding, conflicts</td>
<td>Social norms, cultural beliefs and practices, lifestyle, conflicts</td>
<td>Social norms, cultural beliefs and practices, living conditions, crowding, conflicts</td>
</tr>
<tr>
<td>Differential vulnerability</td>
<td>Poverty, low access to health care</td>
<td>Poverty, low access to health care</td>
<td>Poverty, low access to health care, gender, early childhood experiences, abuse</td>
<td>Gender, early childhood experiences, abuse</td>
</tr>
<tr>
<td>Differential health outcomes</td>
<td>Inadequate health services, use of treatment and care</td>
<td>Inadequate health services, use of treatment and care</td>
<td>Inadequate health services, use of treatment and care</td>
<td>Inadequate health services, use of treatment and care</td>
</tr>
<tr>
<td>Differential consequences</td>
<td>Social and financial, stigma, exclusion</td>
<td>Social and financial, stigma, exclusion</td>
<td>Social and financial, stigma, exclusion</td>
<td>Social and financial</td>
</tr>
</tbody>
</table>
Why emphasise social determinants?

- Social determinants of health have a direct impact on health
- Social determinants predict the greatest proportion of health status variance
- Social determinants of health structure health behaviours
- Social determinants of health interact with each other to produce health
Overarching Recommendations

1. Improve Daily Living Conditions

2. Tackle the Inequitable Distribution of Power, Money, and Resources

3. Measure and Understand the Problem and Assess the Impact of Action.
Action on the Social Determinants of Health and Primary Health Care

• Much common ground
  – Both advance holistic view of health, with primary value of health equity
  – The Declaration of Alma implicitly referred to the social determinants

• Different relationship to health systems and broader context
  – Primary health care starts with the health sector and reaches out to other sectors
  – Social determinants discourse sees health sector as one of the social determinants

• Synergistic
  – Report of the Commission and the WHR on Primary Health Care thus complement each other
Synergies between primary health care and social determinants of health

• Health equity
• Broad view of health
• Universally applicable
• Key role for health sector
• Health in all policies
• Multisectoral action
• Role of communities and social environment
• **DIFFERENCE** – Perspective/ Lens
What can we do about it?

• As planners and policy makers understand and actively promote in our policies and plans that:
  – health is created mostly outside the health sector
  – to reduce inequities, addressing social determinants is essential, and multisectoral action is the only way forward
  – achieving health equity contributes to social and economic development of the society, and ensures social justice
  – involvement of communities is a must for achieving the desired goals of health equity

• As researchers:
  – Actively undertake and promote research that explore the underlying social determinants of health issues, and contribute to the knowledge base
  – disseminate good practices of addressing social determinants of health and primary health care