

Chapter 1

Seeking Solutions to the Challenges in Health Services in Developing Nations: Primary Health Care Revisited

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ABSTRACT

The Global Burden of Disease (GBD) study, 2010, confirmed that the world's population is living longer and we are now less likely than a decade earlier to die from an infectious disease but also more likely to live our twilight years with morbidity (Murray et al., 2012). We will also most likely die from a chronic non-communicable disease (NCD) such as cardiovascular diseases, cancers, respiratory diseases, and diabetes (Beaglehole, et al., 2008). However this brief glimpse at the trends in the health of the world's population obscures massive inequalities in the burden of disease as well as variations across the globe. In this piece, we will revisit primary health care, both at its dawn, its contribution to developing nations, and the ills it struggled through over the years. Cuba and Thailand are the key examples of developing nations that have experienced the contribution of primary health care more than most other countries.

INTRODUCTION

Many Sub-Saharan Africa countries have been, and will continue to be, overwhelmed and devastated by infectious diseases such as HIV, malaria and tuberculosis. The success of antiretroviral treatments for HIV in extending people's lives has transformed HIV into a chronic disease which places different

DOI: 10.4018/978-1-4666-8702-8.ch001

demands on health systems (Beaglehole et al., 2008). These demands are further increased in the context of dual epidemics of HIV and tuberculosis. Beaglehole et al. point out that the management of chronic diseases is quite distinct from acute care and requires a different approach including prevention but also long term treatment, monitoring and care.

In regions that have experienced substantial economic growth in recent times, including parts of Asia (e.g. India and China), there has been a rising middle class and an increase in non-communicable disease related morbidity and mortality (Murray et al., 2012). Many low and middle income countries are battling a growing 'double burden' of disease in both communicable and non-communicable disease as well as experiencing increases in work and traffic accidents as more of their populations are working in industrial environments and affording to drive motor vehicles (Murray et al., 2012).

Notwithstanding the substantial variation in the burden of disease across the world, one clear global trend is the reduction in deaths caused by maternal, perinatal and infectious communicable disease, which is causing an increase in life expectancy (Salomon, 2012). What we are observing is an epidemiological transition where there are now proportionally fewer deaths amongst infants and young children and more people dying in old age (Lozano et al., 2012). Also evident are the effects of a demographic transition, with fertility rates trending lower as development and economic conditions improve (Murray et al., 2012). One of the likely consequences of these global trends is an expanding ageing population with high levels of morbidity (Beaglehole et al., 2008). This scenario raises a serious challenge about how countries will be able to provide for the health needs of future ageing populations. More specifically, how will countries that have disproportionally fewer people who are of a working age generate sufficient economic activity and growth to support the health needs of an ageing population? And these are not the only pressing issues.

As the world's middle class expands, so do our expectations and demands for health services (Hughes, Leethongdee, & Osiri, 2010). Health needs across the globe are already outpacing the capacity of many health systems to cope ("A renaissance in primary health care", 2008). Private health operators have filled some of the void in resourcing but in the absence of effective public health systems, access to health services is often the privilege of the wealthy or those who live in highly urbanized areas (Waterston, 2008). Quite simply, health systems in many countries today are inequitable, are failing to meet the changing needs and demands of their people and are ill prepared to meet patient demand in the future (Chan, 2008). Health systems globally are in crisis and sustainable solutions are required.

According to some health experts, looking for answers to the current health crisis may be a matter of revisiting our recent past and taking a stronger look at primary health care (PHC). To prevent, manage and treat the predicted increases in chronic disease, Beaglehole et al. have called for substantial primary health care strengthening. PHC has been making quite the resurgence since it dipped into obscurity during the eighties and nineties and has been described as offering "global health a lifeline" ("A renaissance in primary health care", 2008, p.863). There is growing momentum about PHC with high level support. WHO, for example, has reaffirmed its commitment to PHC ("A renaissance in primary health care", 2008).

To mark the thirtieth anniversary of the 1978 Declaration of Alma-Ata on Primary Health Care, the Director General of the World Health Organization (WHO), Dr Margaret Chan, noted in the World Health Report, *Now more than ever* (WHO, 2008a), that member states were calling for information about how to make their health systems more equitable. The Director General pointed out that there has been a general shift in thinking about health systems in more comprehensive and holistic ways, as well as there being an urgent need to bridge the "intolerable gaps between aspiration and implementation" (p. 2).

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