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## Examining Universal Primary Healthcare Through Community-Based Initiatives

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## Examining Universal Primary Healthcare Through Community-Based Initiatives

For six days, the International Conference on Primary Health Care met in Alma-Ata, USSR (now Kazakhstan) and, on September 12, 1978, produced an eloquent ten-point declaration. One-hundred-thirty World Health Organization member states signed this document with the lofty goal of “health for all the people of the world by the year 2000” (Declaration of Alma-Ata X). Almost four decades later, universal primary healthcare still does not exist throughout the global community. Valiant efforts have been made since 1978, but these efforts have met various barriers that prevent global success. Most researchers focus on programs in Asia or Africa with great success, and many governments attempt to further universal primary healthcare through legislation in their countries. The most effective form of distributing primary healthcare to all is through community-based programs. The most pressing barriers to success these scientists and politicians face are fiscal, social and logistical barriers (Stoermer et al. 21).

Policy makers typically worry about the fiscal nature and responsibilities of a program when developing impactful and meaningful programs. Since the late 20<sup>th</sup> Century, especially in the United States, the penurious budgets of governments and grants are frightening, and often governments and organizations deal a deathblow to well-founded programs. Research organizations in the United States, like the National Aeronautics and Space Administration (NASA) and the National Institutes of Health (NIH), contribute significantly to science research in the United States. The 2014 budget cuts NASA's education allocations by one-third (United States BUD-1). “About 80 percent of all funding for medical research in American universities comes from the NIH;” however, significant cuts to their budget were made and are expected to reduce GDP by \$200 Billion in the next few years (Levine). Many of these projects go towards preventative medicine. There is a steep cost to cutting medical research in the United States.

Luckily, some programs find funding through government or private means. Dr. Abhay Bang, founder and director of SEARCH, demonstrated a worthwhile and lifesaving program to the Indian government. For centuries, British colonial governments and private religious groups chose to build hospitals in order to combat a lack of healthcare. Many Christian hospitals arose as result of mission work. According to Dr. Henry Perry, a professor at Johns Hopkins' Bloomberg School of Public Health, the Christian Medical Commission conducted a world-wide study in which “they looked at the health of the people who lived close to a mission hospital, and they compared it to health of people who lived further away from the hospital, and they concluded that there was no difference in the health” (Historical Perspectives on Primary Healthcare). The

most funded strategy for bringing health to the people does not provide better care for the people in the end. Whenever the health quality of individuals nearest and furthest from hospitals is nearly identical, then there exists a clear problem in the methodology. A clear problem of interests exists when one chooses an inefficient method, like building large mission hospitals, over a proven method, like community-based programs. One of the primary reasons that community-based initiatives do not have funding is because most building projects construct large mission hospitals instead of enacting community-based programs. Indeed a need for hospitals exists; however, the majority of projects ought to create community education and empowerment – putting medicine and knowledge in the hands of the people. Reallocating funds would greatly increase quality and efficacy of care, and keep current fiscal expenditures at their current level.

Physician findings and the Declaration of Alma-Ata support the stance of many physicians who advocate a new policy. One of the tenants of Dr. Bang's program states that programs should "begin with the people" (Bang). Every person in the world has the "right and duty to participate individually and collectively in the planning and implementation of their health care" regardless of any circumstances (Declaration of Alma-Ata IV). The once hospital-dominated world of primary healthcare sees this as a foreign concept. The newest course of action for increasing global health focuses on community education, which is based on the principle that "knowledge is the lever of change" (Bang). Dr. Bang's program focuses on the very poor district of Gadchiroli in Maharashtra, India and works by training community members to decrease the neonatal mortality rate. In villages that implemented his program, neonatal mortality rates dropped 30% in ten years. These results are significant because the community relies on the distribution of knowledge rather than on the use of fancy machines or doctors. The concept of the "barefoot doctor" has existed since the Ding Hsien project of the 1930s and was wildly successful in China. The "barefoot doctor" model showed continued success until the 1980s and 1990s when "[t]he central government provided less financial support for the program, and the country's emerging free-market system began forcing farmers to pay for their health care" (Valentine). Furthermore, the "barefoot doctor" campaign may not have always had data to back up its successes, but Dr. Victor Sidel of Princeton University "praised [the program] for supplying health care where previously there had been none; he also singled out the barefoot doctors themselves for their role as patient advocates" (Valentine). The "barefoot doctor" program shows the efficacy of such programs in developing nations of the past; however, Dr. Bang's work demonstrates to western nations that education of the people provides the most economical and impactful results on primary healthcare in modernity (Historical Perspectives on Primary Healthcare). Additional locations in India, as well as many African nations implement this program with great success. Showing the

clear successes of community-based primary healthcare over traditional primary healthcare emphasizes the improvement in care to those nations looking for a better way to deal with the sick. Community-based programs achieve the tenants of the Declaration of Alma-Ata. Many physicians, economists, politicians, and activists share this ideology with Dr. Abhay Bang. There will always be a need for institutions of medicine to treat more serious ailments such as cancer, but community-based initiatives prevent and treat common ailments. As more people realize the importance and success of these programs, humanity will see a fundamental shift in our fiscal policies, and finances will no longer obstruct the goal of bringing primary healthcare to all.

The social hindrances of universal primary healthcare lie in the name. Universal primary healthcare reminds people of socialism, and the western world has developed a state of fear concerning the word socialism ever since the fear mongering of McCarthy era politics and the Cold War. According to Frank Llewellyn, “national health care systems are so popular that once they have been established it is politically impossible to eliminate them.” He further states that the constant mudslinging directed towards the word socialism decreases the likelihood that administrations “will consider public initiatives,” especially those concerning healthcare (Llewellyn). The proper denotation of socialism, Marxism, or Trotskyism cannot overcome the automatic sensationalized connotation of Josef Stalin’s armies marching across Siberia. Money must come from politicians and organizations, and both of those get their funding from constituents and donors. When constituents disagree with proposed legislation and politicians proceed with passing the legislation anyway, then those politicians will likely lose the next election. Therefore, activists must dispel fallacies produced by an overly melodramatic media and false ideas that become ingrained in society’s mind. Educating the people about community-based primary healthcare dispels these fallacies. Once explained, community-based primary healthcare appears no different from legislation that increases education. Moreover, increasing the amount of programs being enacted in countries with less socialist connotations helps to dispel the misconceptions of the people. People begin to associate community-based primary healthcare initiatives with human issues rather than political issues.

Some of the first plans for community-based primary healthcare originated in China, not because China utilized a socialist government, but due to necessity because of a lack of doctors and incredibly high mortality rates. For activists like John B. Grant, China became the perfect place to introduce such programs. The people wanted and needed more healthcare. The government agreed to pay for the health services because the people needed them, and the government understood that healthy people make a healthy economy. Workers need to be healthy in order

to work. John B. Grant believed in creating health programs “by combining preventive and curative medicine” (Bu and Fee). Grant’s projects focus on the community level in an effort to educate and protect the people from easily prevented illnesses. Grant developed a system that works regardless of political leanings because of its roots in the people’s best interests. Grant “applied the lessons learned in China to many other countries” to fundamentally change the way people look at administering universal healthcare (Bu and Fee). The work developed by John B. Grant propelled the concept of community-based healthcare to a more acceptable place in society’s mind. Although this type of healthcare is not yet mainstream, the scales are shifting. When empirical evidence compounds and misguided connotations are destroyed, minds change. The acceptance of universal primary healthcare is not farfetched. Enacting community-based programs provides a healthier population, something both politicians and their constituents want for society. Contemporary and future researchers will catapult this fundamental shift in the way humans think of healthcare into the mainstream.

One of the biggest barriers to increasing global health is a lack of infrastructure in the developing world. Indeed, the western world easily distributes vaccines to its people. Herd immunity must be achieved in order to protect the majority of people in a population. Herd immunity occurs when a certain percentage of a population receives immunization, and essentially lowers the chances that a sick person will meet a healthy, unvaccinated person. Herd immunity overcomes the logistical problems of vaccinations. Obviously, 100% of the population will not receive vaccinations because they live too far from the vaccination centers, they are too elderly to get there, they are afraid of the potential harmful side effects of the vaccine, or they may just be apathetic. Herd immunity solves these problems because it determines that 100% of a population does not require vaccination. Percentage estimates vary based on the ailment. Pedro Plans-Rubió stated in *Preventative Medicine* that the optimal percentages for herd immunity for influenza are “80% in healthy persons and 90% in high-risk persons.” He concludes that even in the United States and Europe, inoculation rates remain too low for proper herd immunity. Western nations exhibit difficulties in inoculating their populations, and these nations have the money and infrastructure to succeed. Inaccurate studies that cite vaccinations as harmful have set back herd immunity in modern nations. Modern nations show the necessity of educating the people about their health and provide sufficient infrastructure. In every society, some people will not be vaccinated due to personal, medical, or religious exemptions, but it is still important to maintain herd immunity to prevent epidemics and pandemics that could potentially destroy the populous and economy of a nation.

Community-based primary healthcare relies on the distribution of vaccines and the training of community members in medical skills. This distributes the maximum amount of quality primary healthcare for the most people. The developing world has great difficulty in transporting educators and vaccines to remote locations around the world. Rough or nonexistent roads hinder the transportation of medical supplies. The governments lack the ability and will to send educators to smaller villages, and “limited resources and accessibility play a significant role in which vaccines are offered” (The Children’s Hospital of Philadelphia). It is extremely difficult for a financially struggling nation to justify preventative medicine, when preventative medicine does not show immediate results. Moreover, the initial costs of building new roads and other infrastructure to transport educators, other professionals, and medicine is high. “[I]n many developing countries key infrastructure services are still in serious short supply and of poor quality,” an accurate statement for both rural and urban areas (Briceño-Garmendia, Estache, and Shafik 2). Production speed slows the process and obstructs effective vaccine distribution in the west; however, for a less developed country (LDC), the roads prevent distribution of vaccines. Distributing vaccines to LDCs in combination with infrastructure projects creates a more fertile environment for introducing community-based primary healthcare programs. Increased awareness and financial backing leads to both improved roads and better healthcare for the community.

Remote locations in LDCs need the vaccinations, but they also need someone to administer the vaccinations. “LDCs form the group of countries with the lowest medical density: .12/1000” (UNCTAD 101). Essentially, twelve doctors serve every 100,000 people. Even in LDCs with higher densities, it never reaches about .5 per 1000 people. To give perspective, the World Health Organization recommends two physicians per 1000 people (UNCTAD 101). LDCs cannot send physicians to these remote areas because the physicians must focus on present health issues. Less developed countries lack the ability to teach the people in community-based medical training initiatives not only because of a lack of infrastructure, but also because of a lack of educated medical professionals. Two solutions exist. First, many LDCs experience brain drain. When natives of a nation receive their education at a national college, and then leave the country to go practice elsewhere, this is called brain drain. Job outlook and salary contribute the most to causing brain drain. The brain drain rate is classified as “‘high’ in 30 of the 48 LDCs” and is only “‘close to the ‘optimal’ level” in five others (UNCTAD 103). The brain drain of health professionals can only be solved by giving these professionals “the tools they require to do their job, training opportunities, a network of supportive colleagues, and recognition for the difficult job they do” (Dodani and LaPorte 490). Therefore, LDCs and more developed countries (MDCs) need to create hospitals, clinics, and other medical

facilities. Building these structures will retain more physicians – a tourniquet for brain drain. Successful implementation of community-based education programs can happen when the country reaches an acceptable, stable density of physicians. Second, medical professionals from MDCs need to receive incentives to travel into LDCs and help train community members while the LDCs build their medical foundation. The best way to incentivize would be through government grants or advertising such programs as *pro bono* opportunities. When these two concepts come together, a real, meaningful difference will occur in the health of people worldwide. An influx of medical professionals into areas with extremely low medical densities will show a host of benefits. New medical professionals can serve as regional doctors and simultaneously educate community members on practical medical procedures. This will lead to better medicine and health for both serious ailments and curable or inoculative illnesses. Endless possibilities exist to improve global healthcare; however, if the world leaders remain nescient to the existence of these opportunities, the global community will continue to experience barriers to success.

Although the Declaration of Alma-Ata was written in 1978, the subject still holds true today. Vast numbers of people exist without any primary healthcare in both MDCs and LDCs. Dr. Henry Perry states that there is “an increasing emphasis on community oriented approaches and responsiveness to local community health needs” (What is Primary Health Care). Without the existing fiscal, social, and logistical barriers to healthcare for all, the easiest, most affordable, and most efficient plan of action requires implementing education, community-based primary healthcare programs globally.

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