

Strengthening Primary Health-Care Services to Help Prevent and Control Long-Term (Chronic) Non-Communicable Diseases in Low- and Middle-Income Countries

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Abstract: The prevalence of long-term (chronic) non-communicable diseases (NCDs) is increasing globally due to an ageing global population, urbanization, changes in lifestyles, and inequitable access to healthcare. Although previously more common in high- and upper-middle-income countries, lower-middle-income countries (LMICs) are more affected, with NCDs in LMICs currently accounting for 85–90% of premature deaths among 30–69 years old. NCDs have both high morbidity and mortality and high treatment costs, not only for the diseases themselves but also for their complications. Primary health care (PHC) services are a vital component in the prevention and control of long-term NCDs, particularly in LMICs, where the health infrastructure and hospital services may be under strain. Drawing from published studies, this review analyses how PHC services can be utilized and strengthened to help prevent and control long-term NCDs in LMICs. The review finds that a PHC service approach, which deals with health in a comprehensive way, including the promotion, prevention, and control of diseases, can be useful in both high and low resource settings. Further, a PHC based approach also provides opportunities for communities to better access appropriate healthcare, which ensures more significant equity, efficiency, effectiveness, safety, and timeliness, empowers service users, and helps healthcare providers to achieve better health outcomes at lower costs.

Keywords: primary health care, PHC, prevention, control, chronic, long-term conditions, non-communicable diseases, NCDs, lower-middle-income countries, LMICs

→ Video Abstract



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Introduction

Global healthcare is currently struggling with a massive burden of long term (chronic) non-communicable diseases (NCDs) which risks slowing the growth of the human development index, which comprises life expectancy, education, and per capita income.^{1–3} Whilst NCDs are not infectious or transferable directly from one person to another, they are frequently long-term (chronic) conditions, which can last a lifetime in some cases. NCDs result from a combination of “genetic, physiological, environmental” and lifestyle issues.⁴ The major categories of NCDs are cardiovascular diseases (ischemic heart and brain disease), cancers, chronic respiratory diseases [eg, chronic obstructive pulmonary disease (COPD), and bronchial asthma] and Type 2 diabetes.⁴ NCDs were initially seen as a public health (PH) problem for wealthy countries;⁵ however, NCDs are rapidly increasing even among rural

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populations of low- and middle-income countries (LMICs).⁶ Although most NCDs are often preventable, globally, they kill 41 million people per year: 71% of all deaths.⁴ NCDs are also responsible for many premature deaths, with 15 million people aged 30–69 years dying prematurely; of these, 85–90% are from LMICs.^{4,7} In High-Income Countries (HICs) and LMICs alike, NCDs contribute to the poor health status of both individuals and communities. NCDs are a significant burden on healthcare systems, increasing healthcare overheads for governments as well as being costly for individuals in terms of out-of-pocket expenses.^{8–13} They also impact the broader economies of countries because people are unwell or dying early, therefore, they are not contributing fully to society economically or socially. Considering the impact of NCDs on health, the World Health Organization (WHO) has developed a global strategy and action plan for the prevention and control of NCDs,^{14,15} aiming for a “25% relative reduction in premature mortality” from long-term NCDs by 2025.¹⁶ This narrative review (NR) paper will primarily focus on the potential and role of PHC services in the prevention and control of NCDs in LMICs.

Primary Health Care: A Brief Introduction

Primary Health Care Experience in the United Kingdom: A Case Example

Many countries overhauled their health and social systems as a response to the first World War (WW1) massive loss of life, and the social reconstruction required as countries started to recover. In the UK, a series of health and welfare reforms had begun to be implemented after the Crimean war, which was stimulated further during and after WW1. These reforms were primarily a response to the realization that many of the soldiers recruited were in very poor health, and the liberal government of the day wanted to provide a comprehensive welfare system for its people. In 1919, Lord (Dr.) Bertrand Dawson was appointed by the government to chair a commission for the improvement of the health system. Dawson was a doctor at the London Hospital and was very motivated by the groundbreaking progress in the healthcare of the Soviet Union, where the new healthcare structure utilized local administrative bodies to provide health care services which employed both generalists in local polyclinics, with more specialized care being provided in tertiary hospitals. In 1920 he reported back to the government, suggesting that the

British healthcare system was inadequate, deteriorating in both quality and quantity and that health professionals were failing to upgrade their knowledge and practice as per scientific progress. The health system was, therefore, not delivering an effective healthcare service for the general public.^{17–20} Dawson presented his vision of replacing the existing disorganized and profit-making healthcare system with coordination between primary and secondary healthcare centers, with tertiary/teaching hospitals for a defined geographical area, to ensure the best healthcare for all communities.^{19,20} A central part of this would be “Primary Health Centers.” “The distinguishing feature of these Primary Health Centers ... would be that they would be staffed by general practitioners.”²¹

At the time, this vision was never operationalized because of a lack of political commitment and huge resistance from the medical profession, as doctors’ earnings were based on private fees, and they did not want to be in a public salary-based system. The medical profession said that Dawson’s plan would increase healthcare costs for individuals and for public systems.¹⁹ After the Second World War (WW2), the second series of welfare reforms were put in place, which included the formation of the National Health Service (NHS) in 1948, free at the point of use and available to the whole population. This enshrined Dawson’s idea for primary health care (PHC), secondary care (provided by local general hospitals), and tertiary care provided in super-specialized centers and teaching hospitals.^{20–23} The PHC system in the UK continues to provide the first point of contact for healthcare for the whole population, with general practitioners (GPs, family doctors) acting as gatekeepers for access to secondary care.^{24,25}

The Alma Ata Declaration

Although many examples of PHC systems were emerging around the world, including the UK example described above, it was not until the mid-1970s that the concept of PHC as a central and vital part of any health system took root globally. The concept of primary health care (PHC) as a strategic direction for international health systems was first tabled to the Executive Board of the WHO in January 1975. It took the form of seven principles that should be implemented by national health systems aiming to develop their health care services.^{26–28} These principles emphasized that PHC should be framed

Around the life patterns of the population; for their involvement; for maximum reliance on available community resources while remaining within cost limitations; for an integrated approach of preventive, curative and promotional services for both the community and the individual; for interventions to be undertaken at the most peripheral practicable level of the health services by the workers most simply trained for this activity; for other echelons of services to be designed in support of the needs of the peripheral level.²⁷

It was expected these PHC principles would be put in place in collaboration with other health promotion elements of local communities and national governments to ensure the best possible healthcare for the global population.^{29,30} An International Conference held in Alma Ata, Kazakhstan in 1978, jointly organized by the WHO and the United Nations Children's Fund (UNICEF), placed the PHC plan as central to the strategy to ensure health for all.^{31,32} Subsequently, 134 countries around the globe endorsed the motion of the Alma Ata Declaration.^{31,32} The Alma Ata declaration was disseminated widely and centralized PHC as an official part of health policy planning strategy for all WHO affiliated nations^{31,32} to accomplish "health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity".³³

Currently, PH and PHC (the terms are used interchangeably) are the foundation of maintainable and workable health systems and should be enshrined in national and international health policies.³⁴ Medical and other health professions' education programs should be provided to develop and implement effective, equitable, efficient, and affordable healthcare programs all over the world.³⁴ A recent scoping review suggests that defining the primary objectives of a PHC program and the aptitudes and capabilities of the workforce required are a fundamental first stage (particularly for LMICs) in designing and implementing robust and accountable PHC services that are responsive to community health needs.²⁸

The Burden of Long-Term (Chronic) NCDs in LMICs

As mentioned earlier, NCDs are not only a major cause of death but also the cause of many disability-adjusted life years (DALYs). DALYs are a measure of the overall disease burden expressed as the number of years lost due to ill-health, disability, or early death, with one DALY being

one lost year of a "healthy" life. DALYs for a disease or health condition are calculated as the sum of Years of Life Lost (LL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for people living with the health condition or its consequences.³⁵ Socioeconomic disparities and lack of access to preventive and primary health care services are a key factor in the initial acquisition of and complications from such chronic diseases, particularly in LMICs.^{36,37} Disease surveillance and reporting programs are officially recognized systems that systematically evaluate the health of the population to develop preventive, control, and treatment strategies aimed at reducing morbidity and mortality rates.^{38,39} The collection, preservation, analysis, and interpretation of accurate health-related data involves immense expertise and is highly resource-intensive. Disease surveillance programs in LMICs have been identified as a significant concern because of a lack of health informatics and data management skills.⁴⁰⁻⁴² The issue is further confounded in LMICs, as many have both NCDs and infectious diseases (IDs) as major public health issues and consequently there is a substantial double disease burden of both NCDs and IDs such as tuberculosis (TB), HIV/AIDS, malaria, and other parasitic diseases.⁴² Although TB is not strictly an NCD as it is a chronic infectious disease, it has a long-term impact on patients and communities and remains one of the top causes of death around the globe. This is particularly impactful in LMICs, including India, China, Indonesia, the Philippines, Pakistan, Nigeria, Bangladesh, and South Africa. The extent of the twin (NCDs and IDs) public health problem in LMICs has been widely reported.^{36,43-46} For example, the prevalence of both Type 1 and 2 diabetes is increasing all over India, and it has been reported that 5–15%, 4–6%, and 2–5% of Indian urban, semi-urban, and rural populations respectively are suffering from Type 1 diabetes.^{47,48} In 2008, it was reported that China has 92.4 million diabetic patients with a national prevalence of 9.7% among adults.⁴⁹ Therefore, LMICs need to adopt innovative strategies to reduce mortality and morbidity due to NCDs and IDs.⁵⁰⁻⁵⁴

Materials and Methods

This is a narrative review (NR) and not a systematic review or meta-analysis. It aims to provide a narrative, drawn from relevant literature, around the history and current state of PHC in helping to prevent and control NCDs and reduce their burden on populations' health. The review is based on published literature available to

the Universiti Pertahanan Nasional Malaysia (UPNM, National Defence University of Malaysia), searches were carried out using EBSCO, PubMed, and Google Scholar. The study was conducted between May-25-2019 to November-12-2019. Search terms were primary health care, prevention, control, long-term conditions, chronic non-communicable diseases, NCDs, LMICs, history, burden, strengths, epidemiology, and prevalence. Pertinent journals identified were also hand-searched, and references were scanned to find additional literature.

Epidemiology of Chronic NCDs in LMICs

Approximately 40.5 million people per year die from NCDs around the globe,⁵⁵ with around 13 million people between the ages of 30–69 years from LMICs dying prematurely from NCDs.⁴ Currently, 31.5 million (more than 75%) of global deaths occur in LMICs and whilst the WHO predicts that the global burden of NCDs will rise to 80% by 2020,⁵⁵ an excessive burden will be placed on LMICs, with 70% of deaths occurring in these countries, with at least 50% of these deaths being premature.^{16,56,57} We now highlight three regions as examples of the impact of NCDs on LMICs.

Sub-Saharan African Countries

One example of the disparity between high and low/middle-income countries is that whilst NCDs will increase in the next decade globally on average by 17%; it is predicted that the burden on African nations might increase by 27%.¹⁶ In sub-Saharan African countries, the death rate due to NCDs has been continually increasing.^{7,16,59,60} For example, in the small country of Malawi, NCDs related deaths account for 28% of the total deaths.⁵⁹ Alongside difficulties in gathering and analyzing health-related data, many African countries are also struggling with political and social unrest and environmental related issues, all which lead to a lack of robust data and slow implementation of policies. Therefore, despite a growing trend towards an increase in NCDs associated with morbidity and mortality, there has been a failure across the continent to achieve the WHO recommendations.⁶¹

India and Other Asian Countries

Almost 50% of NCDs related deaths occur in Asian countries, which accounts for 47% of the global disease burden.^{16,58} As with many other LMICs, India (one of the

highest populated countries) does not possess comprehensive data on NCDs and related issues, but they are ever-increasing, typically in the forty-five years' age group.^{62–64} From 1990–2016, India has developed a state-level epidemiological data bank, which was used in the Global Burden of Diseases, Risk Factors, and Injuries (GBD) study in 2017.^{65,66} From this, three papers published in the Lancet Global Health reported that NCDs, especially CVDs, respiratory disorders, and diabetes (both type 1 and 2), are increasing among Indian populations.^{41,67,68} Indian patients with NCDs comprised around 61% of the overall deaths per year,⁶⁹ with CVDs, chronic respiratory disease, cancer, and diabetes contributing to 45%, 22%, 12%, and 3% of all NCD deaths, respectively.⁷⁰ CVD-related disability-adjusted life years (DALYs) lost in the Asia Pacific region accounted for more than 50% of global DALYs lost due to cardiovascular issues in 2005.⁷¹ Four NCDs (CVDs, chronic respiratory diseases, cancer, and Type 1 and 2 diabetes) remain the top causes of mortality in South-East Asia, accounting for 8.8 million lives, ie, 64% of all deaths.⁷²

Central America, the Latin, and Non-Latin Caribbean Countries

Again, data is patchy across these regions, but similar trends, as discussed above, can be seen. Between 2010 and 2013, deaths attributed to NCDs ranged from 454.2 per 100,000 in Central America (the highest rate) to 297.3 deaths per 100,000 in the Non-Latin Caribbean (the lowest rate).^{73–75} In comparison, external causes of death, such as road traffic injuries and suicides, were also highest in Central America at 90.2 per 100,000 compared with the lowest at 38.7 per 100,000 in the Non-Latin Caribbean.⁷³ Central American countries, therefore, had the highest mortality rates of communicable diseases, NCDs, and external causes in 2010–2013.⁷³ Another study in 1990 reported death rates and DALYs of 69% and 65% in Latin American and Caribbean (LAC) nations, respectively.⁷⁴ Similar rates of mortality (73%) and DALYs (76%) were observed with CVDs being the major cause of NCDs related mortality, and psychiatric conditions and external injuries being the major reasons for DALYs.⁷⁴ The main reasons for the high rate of NCDs in LAC nations were attributed to increased life expectancy, changes in lifestyle, and rapid urbanization.^{75,76} The US Agency for International Development (USAID) reported that NCDs accounted for around 50% of all deaths, infectious diseases

for 30%, and injuries for 20% in LAC nations.^{75,76} The USAID also similarly reported that CVDs and psychiatric disorders were a principal cause of both deaths and DALYs in LAC countries, with around 31% of all deaths due to CVDs.⁷⁷ In 2006m the WHO estimated that in LAC nations, the NCDs-linked death rate would double, particularly due to ischemic heart disease, stroke, and Type 1 diabetes, with a potential increase in lung, breast, and prostate cancer-associated deaths.⁷⁸

Strengths of Primary Health Care

As described earlier, in 1978, 134 countries approved the Alma Ata declaration that “health as a foremost human right” and recognized PHC as essential to providing health to all by 2000. PHC was visualized as

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 constituting the first element of a continuing health care process.⁷⁹

PHC is essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families the 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.⁵⁵

The principles of PHC include: “accessibility, public or community participation, health promotion, appropriate use of technology, and intersectoral collaboration”.⁵⁶

The Alma Ata vision started to turn into reality as communities around the world began to use PHC for healthcare support, and its impact on curative and preventive health issues began to be measured.^{80,81} For example, by 2004, the World Bank was reporting that 90% of health issues were regularly resolved at the level of the PHC, with only 10% requiring specialist hospitalized medical care.⁸² This had specific impact on marginalized communities around the globe, both rural and urban, who often do not have access to high-quality secondary or tertiary healthcare services^{83,84} and for whom PHC ensures access to healthcare, irrespective of the individual’s or communities’ financial and social status.^{85,86}

In countries (such as those in Europe, Canada, and Australia) where PHC is more longstanding and robust data has been collected over many years, a body of evidence of the positive impact of a PHC based system is amassing. A European study analyzing PHC data from

2009–2010 found that effective PHC programs in Europe improved the overall health status of the ordinary people of the European Union (EU), ensured health-related equity, and reduced hospitalizations.⁸⁷ Another EU study conducted in twenty-nine European countries reported that patients with long term (chronic) conditions enjoyed good or perfect health in those EU countries, which had a useful and well-organized PHC program.⁸⁸ Additionally, patients with multiple co-morbidities obtain considerably more assistance from a robust PHC system.⁸⁸ In Canada, PHC has been categorized into five primary care organizational models, four professional and one community, with professional models (single-provider, contact, coordination, and integrated coordination) serving 90% of users.⁸⁹ A Canadian study found that the coordination-integrated and community models were more useful than PHC models in the management of more advanced long-term NCDs.⁹⁰ Multiple studies report that PHC initiatives are linked with higher quality healthcare.^{91–93} For example, PHC can reduce the total mortality rate, including premature death, often caused by chronic respiratory, CVDs, cancer, infant mortality, low birth weight, and self-rated health and the improved access to healthcare provided by PHC is related to a higher level of patient satisfaction and reduced total health spending.^{91–93}

Multiple Australian research studies also report that a comprehensive PHC strategy comprises a range of healthcare activities, including promotional, preventive, rehabilitative, and curative, which have a positive impact on population health.^{94–96} A comprehensive PHC strategy was subsequently reported as an effective method to address complex health issues and reduce inequities and was a better healthcare model in terms of ensuring the overall health of the whole population.^{97–99} Finally, we note that the Republic of Cuba had provided free government-run accessible healthcare to over 90% of the population by 1975. The country now offers accessible and affordable healthcare for the whole population, and whilst health statistics vary, historically, the country has had good health indices.^{100,101} The country also trains doctors and provides free medical aid to many LMICs and countries experiencing disasters around the world.¹⁰²

One area where high-income countries and NGOs (non-governmental organizations) might lend their know-how and expertise to LMICs is in the use of technologies, both in management systems as well as for medical use, such as point of care monitoring and diagnostics. The WHO describes Appropriate Healthcare Technology (AHT) as

methods, procedures, techniques, and equipment that are scientifically valid, adapted to local needs and acceptable to those who use them and to those for whom they are used, and that can be maintained and utilized with resources the community or country can afford.¹⁰³

Appropriate technology is essential for the proper care and prevention of NCDs, and the WHO suggests utilizing “cost-effective, affordable, safe, evidence-based, and proven”⁵² technologies for the prevention and monitoring of NCDs, especially in LMICs.^{52,104–106} However, running a successful NCD service in PHC needs skilled human resources, management systems, relevant medicines with an adequate supply, and appropriate equipment.^{107–109} In LMICs, these are often limited due to financial considerations or a weak health infrastructure.^{110,111}

In PHC specifically, incorporating technologies into the services provided has the potential to accelerate PHC

as the integrative hub for health care, supporting the efforts of patients, promoting collaboration with specialists, facilitating connections with nursing homes and home health, and advancing population health within a framework that improves the patient experience, quality, and value.¹¹²

As mobile and communication technologies are further developed and made more affordable, this provides many opportunities to involve patients in managing and monitoring their health. This is particularly relevant to the management of long term NCDs, as patients’ self-management of NCDs and comorbidities plays a vital part in reducing complications, reducing hospital admissions, and managing conditions well.^{112–115}

Despite challenges, in many LMICs, progress is being made towards implementing PHC systems and services. For example, fourteen LMICs (Costa Rica; Cuba; Brazil; Bolivia; Mexico; Niger; Ghana; The Gambia; Thailand; Sri Lanka; Kerala, India; Iran; Afghanistan and Liberia) have implemented large scale PHC programs and made significant progress in providing public healthcare.^{28,116} Another study found that providing health workers (not graduate medical doctors) ensured better coverage and quality care, but there is a need for enhancing cooperation and integration with the PHC services of LMICs.¹¹⁷ This study additionally found community-based healthcare services (CBHCSs) were most effective, observing that CBHCSs perform much better when these clinics are well-organized and integrated with proper referral systems, supervised support, and the medicine supply chain.¹¹⁷ This

highlights one of the issues for many LMICs in which have deficiencies in their health management and structural infrastructures due to lack of financial and human resources. Once these are addressed, then PHC services work more efficiently as part of a holistic systems-oriented approach to healthcare delivery.^{118,119}

PHC Is a Comprehensive Whole-System Approach

One of the great strengths of a PHC based system is its holistic, whole-systems approach from prevention through to long term health maintenance. From the outset, PHC was conceptualised as

comprehensive in that its related health services to the broader organization of society, calling for a new international economic order that would benefit developing nations, empowering democratic participation in health, and greater attention to social and environmental contexts that increased disease risks.¹²⁰

Intersectoral collaboration and communication is also vital in promoting health, defined by the WHO as

a recognized relationship between part or parts of the health sector with parts of another sector which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone.¹²¹

This reflects the wide definition of “health” taken by the WHO as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”,¹²² which was reaffirmed in the Alma Ata Declaration.⁵⁵ In order to achieve this, the involvement of multiple stakeholders from various sectors is a necessity.¹²³

Health and healthcare systems are dependent on multiple factors such as “social, political, economic and environmental”,¹²⁴ which for NCDs (such as CVD, Type 1 diabetes, chronic respiratory diseases, and cancers) include the environment, living arrangements, the effect of rapid urbanization, and food habits, which provides for access to wholesome and nutritious foods, and educational level.⁵² These factors impact personal health and that of communities, and therefore intersectoral collaboration is needed between public, private, and NGO stakeholders at international, regional, countrywide, provincial/county, and local levels, often co-ordinated most effectively within

a PHC system.^{124,125} Intersectoral collaboration, especially between the private sector and other health-related stakeholders, has been proven successful in significantly improving the impact of NCDs.^{126–129} In many LMICs, intersectoral cooperation is more challenging because of the more fragile, lower-resourced, and poorly integrated organizational and administrative healthcare system.¹²⁸ However, there have been successes in inter- or multi-sectoral collaboration in improving health for patients with NCDs' in LMICs.^{130,131}

Intersectoral teamwork is an essential component of person-centered healthcare aimed at meeting the Sustainable Development Goals (SDGs).^{128,132} As mentioned above, long term (chronic) NCDs are often associated with the overall quality of life, poverty, urbanization, the consumption of safe and nutritious foods, and educational level.^{77,133} Therefore, NCDs-related policies and planning activities need to involve all sectors responsible for health and wellbeing.⁴ Placing PHC as a fundamental partner in intersectoral collaboration helps to promote collaborative policies, including town planning, safe and nutritious food production, and widespread participation of the private health sector to address the impact of cardiovascular diseases, diabetes, lung diseases and many cancers.⁵² Meaningful and sincere collaborations between the public and private health sectors and other health-related sectors have proven effective in minimizing the impact of long-term NCDs.^{134,135} For example, in Denmark, intersectoral and private sector collaboration successfully resulted in producing safer food by minimizing saturated fat in factory processed food.¹³⁶ This initiative put an additional tax on foods with high saturated fat, and, across the country, the intake of saturated fat reduced by 4.0%, there was increased intake of vegetables and salt, and mortality caused by NCDs reduced by 0.4%.¹³⁶ Many countries have succeeded in improving health by introducing additional taxes on sugar and sugar-sweetened beverages (SSBs), which has reduced their consumption and, subsequently, the frequency of NCDs, as sugar and SSBs are positively correlated with a high incidence of NCDs.^{137,138} Similar success was obtained by reducing the consumption of tobacco by increasing the tax for tobacco and related products.^{139,140} Multiple studies reported that intersectoral collaboration combined with community engagement among all health care stakeholders of LMICs improves healthcare indices and access to healthcare in these countries.^{141–143}

PHC Enhances Community Participation

Community participation or engagement, another principal strength of PHC, has been reported as being highly influential on the prevention and control of NCDs.¹⁴⁴ Community participation is described as a method and practice by which ordinary people and societies are empowered to be involved dynamically and meaningfully in identifying and describing the health-issues concerning themselves.⁶⁹ It also includes communities making their own decisions about health issues that impact on their lives, formulating and implementing strategies, organizing, preparing, formulating, developing and delivering healthcare services, and taking action to accomplish significant improvements in healthcare.^{145,146} Multiple systematic reviews find that community participation and empowerment lead to improvements in health and healthcare by implementing policies and plans suitable for the local and national context.^{147–149} NCDs are complex in nature, frequently related to the lifestyle, activities, and socio-cultural norms of the community,¹⁵⁰ therefore community participation, which requires the “human science of communication and counseling,” can help enhance more traditional medical care.¹⁵¹

Community engagement has been described as an enabling instrument through which residents of the community take charge of identifying and analyzing their needs to resolve their own healthcare issues and future planning for development.¹⁵² A recent systematic review reported that community participation is central to developing a rights-based strategy to improve the overall healthcare system, and that community participation has proven its potential to act effectively in improving healthcare by enhancing positive public health perspectives.¹⁵³ This review also reported that, around the world, community participation has long-term positive health consequences and leads to more efficient spending on healthcare.¹⁵³ With specific relevance to LMICs, the active involvement of communities in PHC programs with governmental support led to improved health outcomes and health equity in fourteen LMICs.^{28,116} And in relation to the control of infectious diseases and NCDs around the world, multiple studies report that community participation and engagement play an essential and positive part.^{52,154–164}

PHC Emphasis on Promoting Health Equity

No single precise definition of equity exists, as it is a subjective concept encompassing notions of neutrality,

morality, equality, impartiality, and righteousness.¹⁶⁵ The Institute for Healthcare Improvement (IHI) suggests that

ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, no one should be disadvantaged from achieving this potential if it can be avoided

This is health equity.¹⁶⁶ The concept of equity is not new, however, and has its roots in ancient Greek philosophy. Aristotle defined two types of equity in relation to privileges and services: horizontal and vertical equity.^{167–169} Horizontal equity involves providing treatment to everyone equally, aiming to eliminate social and economic inequity (often through equality legislation or policies) based, for example, on race, gender, disability, and other factors.¹⁶⁵ Vertical equity refers to providing different treatment or care to various individuals or groups because their needs are different, even if they have characteristics in common.¹⁷⁰ Healthcare strategies and planning, therefore, need to consider how best to address inequities in health access and provision from both perspectives.^{171,172}

NCDs affect both poorer and richer communities in all high, middle- and low-income countries, however, they have the most impact on communities marginalized by reduced access to appropriate, timely healthcare, the majority of whom are in LMICs.¹⁷³ Access to healthcare can be limited for various reasons, either because the necessary healthcare facilities do not exist, or facilities are not equipped with essential equipment and trained healthcare staff, or there is poor availability of essential medicines.^{174,175} Health inequity is compounded by poverty and lack of health education.¹³⁴ For example, NCDs-related morbidity and mortality are often associated with high consumption of tobacco, alcohol, and unhealthy foods.^{38,176}

Horizontal equity in healthcare systems is seen as vital to improve the impact of NCDs,⁵² and PHC is central to this. PHC's main aim is to ensure equity of healthcare access to all individuals, irrespective of social status, which includes marginalized communities, more impoverished people in poorer countries, and older people who are disproportionately affected by NCDs.^{80,174,177,178} Another advantage of PHC is that health promotion and preventive care are provided alongside direct clinical care, therefore improving the health status of patients at risk of NCDs as well as those with NCDs, this is particularly impactful in LMICs where public health systems may be inadequate.^{179–181} PHC is, therefore, central to addressing issues of both horizontal and vertical inequity

and health care policies that address these improve the individual, community, and the country's overall earnings and economic growth.^{182–184} This has been confirmed by multiple studies that report that, after the adoption of a PHC program in LMICs, health equity has improved, especially in the management of NCDs.^{28,87,100,101,116,117,185,186}

In terms of long-term (chronic) NCDs, improving healthcare equity is vital. NCDs often do not produce any symptoms until the disease process damages the physiological system. For example, hypertension is frequently described as a “silent killer,” as often no symptoms emerge until vital organs such as the heart, brain, or kidney are damaged, with an individual typically first presenting with acute myocardial infarction, stroke, or renal failure.^{187,188} Screening programs to identify and monitor individuals at risk help alleviate such serious clinical consequences by preventing disease progression.¹⁸⁸ Both patients being monitored, and those who have been diagnosed with an NCD, need proactive, patient-centered, individually-oriented, and maintainable care, which may be for many years, even for the patient's whole lifetime. As the WHO recommends, in most countries, PHC is the most appropriate setting, and service for the provision of the longitudinal, patient-centered care that individuals with NCDs require.¹⁸⁸ This is supported by studies from many settings in LMICs. Multiple studies report on the success of PHC systems in the management and monitoring of NCDs, including hypertension and diabetes among Palestine refugees and in Malawi.^{189–195} A systematic analysis of the global burden of disease involving 187 countries concluded that PHC had great potential in controlling and prevention of NCDs in LMICs.¹⁹⁶ Another systematic review into the high volume of NCDs (principally cardiovascular disease, respiratory disease, diabetes, and cancers) in sub-Saharan African (SSA) countries concluded that health policies and strategies that incorporated political determination, health education and promotion amongst the public, and national and international collaborations were imperative to control and manage of NCDs.⁵⁴ Although a PHC system was not overtly discussed, the policy program principles suggested align with the inherent concepts of PHC.

Discussion and Conclusion

The prevention and control of long-term chronic conditions such as NCDs is a major public health challenge, being the primary cause of premature deaths and disabilities in all nations.^{150,173,197} This is a complicated and not

just a health service-related issue because many NCDs are disorders that reflect the cumulative effects of individual behaviors and lifestyle choices combined with environmental and socio-economic risk factors.^{198,199} Because of the complexity of factors influencing the acquisition and course of NCDs, an holistic, systems-wide approach to their prevention and control is required. This has proved effective in those countries which have a strong PHC system coupled with good public health and secondary care system.⁸⁹⁻⁹³ A condition or disease is usually referred to as chronic or long-term after a long latency period with no definitive cure. The course of these diseases varies, with most individuals seeing gradual changes and deterioration over time, but which can lead to the failure of the organ(s) affected.²⁰⁰ Currently, chronic diseases are predominantly managed within a clinical care model based on a biomedical system of classification, complaint, history taking, physical examination, investigations if needed for diagnosis, treatment, prognosis, and management plan.²⁰¹ However, this type of clinical care model is insufficient for the prevention and long-term control of incurable NCDs and requires more comprehensive care centralizing PHC as the lynchpin and coordinator of other services, including secondary care, public health and other social and community services.^{174,199}

Conceptually and pragmatically, PHC provides the opportunity for communities to more easily access healthcare, which helps to ensure the equity, efficiency, effectiveness, safety, and timeliness of healthcare and empower individuals to achieve better health outcomes, which is essential for those with long term NCDs.^{30,202} A reliable PHC system that provides the first line point of healthcare to communities, drawing together knowledge, skills, and resources through inter-sectoral collaboration helps in the early detection, prevention, and control of NCDs.²⁰³ At an individual patient level, PHC systems record their longitudinal personal and medical history, which helps in the understanding of the disease development process, especially for long term conditions.^{204,205} A PHC approach can also identify and address the community health needs of various population groups and respond to geographical differences through acceptable, affordable, and accessible prevention and control measures.^{34,206} Globally, PHC approaches have led to many achievements in public health in the last 50 years.²⁰⁷ Whilst much work is still needed to combat NCDs (primarily due to lifestyle factors such as obesity, sedentary lives, and poor diets) great strides have been made in the prevention and control of

infectious diseases, which has helped to increase life expectancy and reduce maternal and infant mortality, particularly in the LMICs.²⁰⁷⁻²¹¹

Where a PHC approach has been most influential is in those health systems which are wholly or primarily in the public sector, but this does not reflect the reality in many systems, in which various proportions of healthcare services are privatized, governed by the corporate sector, often urban-based, and dominated by clinical activities which take a cost-benefit approach to care rather than focusing on a preventive and holistic system approach.²¹²⁻²¹⁵ For NCDs, and for patients with long term conditions, a privatized, market-based approach to healthcare provision can lead to the poorer quality of care and can be very costly, especially when health insurance fails to address long-term or expensive health needs, such as medications or home care.^{150,173,216-219}

In many countries, especially those struggling economically, such as LMICs, all budgets are squeezed, and for healthcare, the focus tends to be on more high-profile acute service provision rather than prevention and control programs.^{220,221} All countries are also struggling with adapting to the significant socio-economic, lifestyle, and demographic shifts, including increased life expectancy, urbanization, environmental degradation, sedentary lives, personal risk behaviors, and changes in food habits. Overall, healthcare services have not adapted well to address long term and chronic diseases and NCDs, which are almost an “epidemic” in many LMICs.^{222,223} For many LMICs, whilst the PHC approach has not succeeded in meeting the health demands of ordinary people at an acceptable level, corporate-run costly privatized hospitals are not accessible and affordable to the general public either, which can lead to long term NCDs being undiagnosed and poorly managed, especially people who are more marginalized (eg, refugees, those living in poverty) or live in remote or rural areas.^{214,224,225} As discussed earlier, long term NCDs make a considerable contribution to overall mortality and morbidity in LMICs^{173,226} and although PHC has proven effective in preventing and controlling infectious diseases and in reducing maternal and child morbidities and mortality,^{52,227} it has yet to make significant inroads in reducing the impact of NCDs in LMICs. All countries who signed the Alma Ata declaration in 1978 expressed their commitment to implement a PHC approach to ensure the health of ordinary people⁵⁵ and PHC clearly has a central role to play in improving the

health of people with NCDs. However, political commitment is needed to enact the public's right to access to healthcare through active participation in healthcare activities.^{30,228} A comprehensive PHC approach should achieve more equitable, lower-cost quality health care for ordinary people living with NCDs and help reduce mortality and morbidity through active community participation, intersectoral-collaboration, and community empowerment.^{1,52,55,157,174,229,230}

Communities should be made aware that NCDs can be prevented through the various levels, namely primary, secondary, and tertiary levels of prevention.^{230,231} The fundamental level of prevention is to stop the development of diseases, mainly through health promotion and lifestyle changes, which should be part of PHC services.²³² Screening, another activity primarily carried out under the PHC services, is part of the secondary level of prevention for the early detection and prompt treatment of diseases to prevent the development of complications. This emphasizes that prevention does not stop even when diseases have developed.²³³ Similarly, tertiary prevention is essential for the rehabilitation of patients who suffer complications of NCDs. If carried out properly, these different levels of prevention should not only be able to reduce the morbidity and mortality from the NCDs but also improve patients' quality of life.^{174,231,234} Improved intersectoral collaboration and coordination between different stakeholders of healthcare has already occurred in many LMICs which has subsequently led to improvements in PHC and access to equitable healthcare^{128,132} and it has been suggested that other LMICs would benefit, particularly in relation to tackling the burden of NCDs, by adopting similar strategies.^{52,162,230} Effective long-term (chronic) disease management, requires a strong collaboration between all healthcare stakeholders, empowerment of communities, educational interventions for both providers and consumers, with focused, positive political decision-making and resource allocation to ensure all people from LMICs have equitable access to high quality preventive and healthcare services.^{235–238} Primary health care is central to achieving this in LMICs.

Key Findings

- NCDs are increasing in LMICs, causing increased morbidity and premature deaths in their populations;
- There is an urgent need for intersectoral collaboration among all stakeholders in the healthcare and broader systems;

- PHCs have already been successful in the prevention and control of NCDs in some LMICs;
- A PHC approach is essential in the prevention of NCDs through intersectoral comprehensive collaboration and emphasis on health equity.

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