UPDATED DRAFT

Primary Health Care:

A Framework for Future Strategic Directions

Global Report

World Health Organization

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A Framework for Future Strategic Directions

Global Report

Noncommunicable Diseases and Mental Health
Evidence and Information for Policy
World Health Organization

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Preface

Primary Health Care (PHC) has been central to WHO policies and strategies since the Declaration of Alma-Ata in 1978 and has been a frequent focus of attention for the World Health Assembly. The Fifty-sixth World Health Assembly (May 2003) returned to PHC in its discussions and passed a new resolution (WHA 56.6) which requested the Director-General to take various actions including convening a meeting which would:

- "examine the lessons of the past 25 years" and

- "identify future strategic directions for PHC

A Global Meeting on Future Strategic Directions for Primary Health Care will be held in Madrid on 27-29 October 2003. Resolution WHA 56.6 also requests the Director-General to "report on progress to the Fifty-seventh World Health Assembly".

At the meeting of the WHO Executive Board in January 2000, the Director General proposed a review to focus on the challenges to PHC in the changing context of international health. That review has been ongoing since May 2000. This report is in two parts:

- The first four sections summarise the context for and outcomes from, the global PHC reviews to date,

- The remaining sections then suggest a range of possible "future strategic directions" which could inform policy development for PHC, particularly at country level.

The report is intended to provide a platform for debate at the Madrid meeting and subsequent reports to the Fifty-seventh World Health Assembly in May 2004.

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Section One

THE CONTEXT FOR THE REVIEW OF PHC

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I.   THE CONTEXT FOR THE REVIEW OF PRIMARY HEALTH CARE

1.1   The need to review PHC now

Primary health care (PHC) became a core policy for the World Health Organization (WHO) with the Alma-Ata Declaration in 1978 and the 'Health-for-All by the Year 2000' Programme. The commitment to global improvements in health, especially for the most disadvantaged populations, was renewed in 1998 by the World Health Assembly. This led to the 'Health-for-All for the twenty-first Century' policy and programme, within which the commitment to PHC development is restated.

> **PHC became a core policy for WHO in 1978. Since then, there have been rapid changes seen in health status and trends, demography, socio-economic trends, governments priorities, and WHO's priorities and ways of working.**

Whilst this history of policy development within WHO shows clear continuity, the current review was undertaken because of a fast changing world presenting ever new challenges.

In particular:
- Health issues and health status continue to change rapidly, with new health problems such as HIV/AIDS having emerged, with non-communicable diseases reaching epidemic proportions in developed and developing countries, and chronic conditions now presenting challenges for which most health systems are ill-equipped

- Population demographics continue to present new scenarios, with substantial increases in birth rates in some countries, declines in others, a much larger world population of the elderly, and dramatic changes in life expectancy in the countries most affected by HIV/AIDS

- Socio-economic trends such as globalization, industrialization and urbanization are transforming how populations live, our sense of community, and the determinants of individual health

- Member State governments continue to rethink their roles and responsibilities in relation to population health and the organization and delivery of health care, thus changing the context for health policy development and implementation locally, nationally and internationally

- WHO itself is going through a period of change, with new structures and ways of working, new commitments to results at country level, intensified engagement against HIV/AIDS through scaling up prevention, treatment and care, and new priorities reflected in the 'General Programme of Work'. Those priorities include significant issues in health and health care where PHC will be playing its part, including:

  Malaria, Cancer, TB, CVD, HIV/AIDS, Diabetes, Maternal Health, Tobacco, Mental Health, Health Systems, Food Safety.

- There have been important improvements from the extension of specific vertical programmes but it will not be possible to avoid the need to strengthen health care systems to cope with new challenges

- The new ways of working within WHO include 'The Country Focus Initiative'. This will significantly enhance the local focus for WHO's shared programme of work with member states, and change the framework within which any continuing development of PHC as a collaborative venture at a local level takes place.

Given this degree of change, and uncertainties about the future, there is a clear need to look, in a practical way, at the contribution that PHC can be expected to make in addressing the health issues of diverse populations in the 21st Century.

1.2 The purpose of the review

Against this background, the purpose of the PHC review has been to address three core questions:

a) What contribution does WHO see PHC being able to make, at Member State level, in improving the health of populations in the future?

b) How should WHO be helping countries to optimize the contribution PHC can make to improve population health?

c) What capacities will WHO need to operate in that way?

> **"Primary Health Care is an important feature of the health system. Over the years, it has drawn attention to the needs of the many, and has been a powerful instrument for making governments and their partners recognise that the provision of health care cannot be left to the professionals alone. Our focus on the diseases of the poor and our work on health systems is consistent with the messages of Primary Health Care. But many countries face new economic, institutional and social challenges. We will be carrying out a review which will focus on the challenges to Primary Health Care in the changing context of international health."** [1]

1.3 The Review Process

The review process started with the production of an 'Issue Raising Report' which described the context in detail, and suggested questions to be addressed. This provided the background for the main activities which followed. These were:

- Each WHO regional office has commissioned a region specific report in which the development of PHC, and the results achieved are examined. The focus of region specific reports is on:

> An 'Issue Raising Report' was used to provide the background and a common process for the region specific reports produced by each WHO region.

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[1] World Health Organization. *Towards a Strategic Agenda for the WHO Secretariat.* Statement by the Director-General to the Executive Board at its 105th session. January 2000. EB105/2

a) Member State policies and systems for PHC
b) How PHC systems are changing
c) Emerging health challenges
d) The impact of PHC on population health
e) Wider community development and the contribution of PHC
f) The role of WHO and other international agencies.

- For each WHO region, there has been a review workshop. The workshop participants were policy makers, health system managers, PHC professionals, NGOs and other international agencies. Whilst the region specific reports have concentrated on an assessment of available data and publications, the review workshops were used to draw out perceptions, experiences and ideas from participants. In particular, their focus has

> **Workshops held in each WHO region were used to gather the perceptions and experiences of health system managers, policy makers, and PHC professionals, in addition to NGOs and other international agencies.**

been on exploring the ways in which models of PHC and PHC policies at Member State level will need to change to meet the demands of the 21st Century. A report of the main outcomes has been produced following each review workshop.

- WHO commissioned a systematic review[2]. This examines the evidence of PHC programmes impacting on health outcomes and process outcomes.

WHO Regional Offices are producing a single report which integrates the outcomes from their region specific report and review workshop.

> **Regional reports present a more in depth analysis of trends in each region.**

1.4   What is meant by primary health care (PHC)?

Throughout the review process, there have been questions raised about definitions and understanding of PHC. It is not for us to suggest a single definition, and to attempt to do so would be a mistake. However, we are clear that PHC is all of the following:

- A set of PRINCIPLES. The 1978 Declaration of Alma-Ata proposed that primary health care should:

  1. "Reflect and evolve from the economic conditions and sociocultural and political characteristics of the country and its communities, and be based on the application of the relevant results of social, biomedical and health services research and public health experience"

  2. "Address the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly"

  3. "Involve, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works,

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[2] *The effectiveness of primary health care programmes: A Systematic Review.* Geneva, World Health Organization, 2002 (unpublished document).

communications and other sectors; and demands the coordinated efforts of all these sectors"

4. "Promote maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develop through appropriate education the ability of communities to participate"

5. "Be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need"

6. "Rely, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community."

- A set of CORE ACTIVITIES, which are normally defined nationally or locally. The 1978 Declaration of Alma-Ata proposed that these should include at least:

1. Education concerning prevailing health problems and the methods of preventing and controlling them
2. Promotion of food supply and proper nutrition
3. An adequate supply of safe water and basic sanitation
4. Maternal and child health care, including family planning
5. Immunization against the major infectious diseases
6. Prevention and control of locally endemic diseases
7. Appropriate treatment of common diseases and injuries
8. Provision of essential drugs.

- When PHC is considered in the context of the WHO's Corporate Strategy, clear STRATEGIC IMPERATIVES emerge:

1. Reducing excess mortality of poor marginalized populations:
   PHC must ensure access to health services for the most disadvantaged populations, and focus on interventions which will directly impact on the major causes of mortality, morbidity and disability for those populations.

2. Reducing the leading risk factors to human health:
   PHC, through its preventative and health promotion roles, must address those known risk factors, which are the major determinants of health outcomes for local populations.

3. Developing Sustainable Health Systems:
   PHC as a component of health systems must develop in ways, which are financially sustainable, supported by political leaders, and supported by the populations served.

4, Developing an enabling policy and institutional environment:
PHC policy must be integrated with other policy domains, and play its part in the pursuit of wider social, economic, environmental and development policy.

- These principles, core activities, and the Corporate Strategy lead towards a range of relevant POLICY QUESTIONS which inform our wider understanding of PHC, including:

> **The Principles and Core Activities of PHC lead towards a number of policy questions.**

1. Are the needs and demands of diverse populations, which are addressed through PHC, sufficiently understood?
2. Are the policy and health system responses to those needs and demands providing equity of access, and health services which are cost effective, evidence based and appropriate to their context?
3. Is PHC being developed within an integrated approach to wider health system and community development?

Section Two

PRIMARY HEALTH CARE IN A CHANGING WORLD

What's new?

♦ Since Alma-Ata there have been dramatic changes in the pattern of disease, in demographic profiles, and in socio-economic environment which present new challenges to PHC.

♦ There have been significant changes in how governments are interpreting their roles and this has implications for both policy development and globally driven health programmes.

♦ The policy environment now includes the wide-spread presence of Nongovernmental Organizations (NGOs) as major stakeholders in health and health care.

♦ The delivery of a wide range of WHO's own strategies is dependent on there being appropriate PHC capacity at a local level.

♦ Both the recommendations of the Commission on Macroeconomics and Health, and the Millennium Development Goals set out a future agenda which would see major new investments in health systems. It will be vitally important for WHO to offer guidance on the most effective health solutions including a contribution that can be expected from PHC/ "close to client" services.

♦ It is unrealistic to expect the achievement of the Millennium Development Goals without a health system driven by primary health care.

II.   PRIMARY HEALTH CARE IN A CHANGING WORLD

If the three core questions at the heart of the review are to be fully addressed, we need to have a thorough understanding of the sort of world in which PHC now operates, as a set of principles and as a component of health systems. We also need to anticipate how the world might continue to change, and the implications for PHC in the future. The review process has allowed us to explore this changing world in several areas, which are summarized below. In offering summaries, we are describing patterns and trends which are observable (and well reported) around the world. Taking a global perspective does mean that some important detail is lost, and that the picture being painted does not fit equally well to all regions and countries. These limitations make the reports produced by WHO regional offices, which integrate the local region specific reports and the outcomes from regional workshops, a vital contribution to the future development of PHC.

2.1   Changing health issues

The global burden of disease is in flux:

- The war against communicable diseases has not been won – old enemies such as TB and malaria are gaining some ground, new diseases such as Severe Acute Respiratory Syndrome (SARS) bring new challenges, and HIV/AIDS is having a devastating effect in many countries (especially in Sub-Saharan Africa). In the year 2001, HIV/AIDS was responsible for 5.1% of all deaths around the world[3]. Between 2000 and 2010, the burden of disease from HIV/AIDS is projected to increase by nearly 20%, before declining in the next decade

- As the World Health Report 2002[2] shows, risk factors that lead to both communicable and noncommunicable diseases are on the rise particularly in the poorest countries and communities. These risk factors are not yet under control, and will continue to cause avoidable deaths

- Excessive consumption of fatty, sugary and salty foods, the failure to take regular exercise, and tobacco and alcohol consumption are resulting in noncommunicable diseases reaching epidemic proportions around the world, in both wealthy and developing societies. This leaves many countries facing the double burden of both communicable and noncommunicable diseases

- Many of the most prevalent health problems, whether communicable or noncommunicable, whether in physical or mental health, are chronic in nature. They leave the individual (and the family) needing long-term support and care from their communities and the health system. These chronic conditions represent a growing proportion of the global burden of disease

- Injuries at home and in the workplace, street and domestic violence, road traffic accidents and armed conflict are adding significantly to the global burden of disease, and are expected to do so increasingly in the future

- As progress is made with providing child and maternal care, and infant mortality rates improve, more children with serious disabilities are surviving and needing lifelong care.

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[3] *The World Health Report 2002 - Reducing Risks, Promoting Healthy Life*. Geneva: World Health Organization; 2002.

All of these trends are well documented and their implications for PHC policy and service delivery are profound. Global projections suggest that the burden of diseases and risk factors (expressed as DALYs) will, over the next 20 years, see the burden from:

- diarrhoeal diseases reduce by 46%
- perinatal conditions reduce by 60%
- unipolar depression increase by 40%
- road traffic accidents increase by 88%
- ischaemic heart disease increase by 44%
- violence increase by 109%.

Global programmes, such as the Polio Eradication Initiative (PEI), will continue to make progress and impact on the pattern of morbidity and mortality (by June 2002, three of the six WHO regions were certified as polio free).

> **Models to deliver health services and policies will need to be adaptable and flexible to meet the rapidly changing population needs.**

Whatever the local version of this global picture, it is clear that shifts of this order will require models and policies to be adaptable and flexible if rapidly changing population needs are to be met.

2.2   Changing demography

As with the pattern of health issues, the population profiles of countries are changing and will continue to change:

- Overall improvements in diet, sanitation, disease prevention and health care are resulting in increased life expectancy and a general ageing of the population with the gap in life expectancy between industrialized and developing countries continuing to close

- This widespread ageing of populations is both one of humanity's greatest triumphs, and one of its greatest challenges[4]. Whilst older people are a precious resource who make an important contribution to the fabric of our societies, they make considerable demands on health and social care systems. World-wide, between 1970 and 2025, the number of older people is expected to increase by 223%

- Within those overall improvements in life expectancy, in some countries the gains of past decades have been totally reversed by the impact of HIV/AIDS. Here, life expectancy at birth may be only half of that in the healthiest nations

- Countries with some of the best life expectancy figures overall still experience wide disparities between communities, with disadvantaged areas experiencing significantly worse morbidity and mortality and reduced life expectancy

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[4] *Active Ageing : A Policy Framework*. Geneva: World Health Organization; 2002. WHO document WHO/NMH/NPH/02.8

- For some countries, the most significant demographic change is the increasing number of children, who present a different set of health and development problems to be addressed.

Whilst the degree and nature of demographic change will vary from community to community, again it is clear that local health policies and models of services need to adapt quickly in response to the implications of age profiles which can, and do, shift dramatically.

2.3   Social and economic change

The ways in which the world is changing, in social and economic terms, has major implications for population health, and for health systems. In many regions, the processes of industrialization and urbanization are proceeding at remarkable speed. Profound economic and social changes are happening in a decade, which in the early industrialized world took a century. One consequence is that some countries find themselves addressing the health needs of populations whose social conditions range from the most primitive and economically deprived, to the most advanced and affluent.

> **1.2 billion people live on less than $1 a day, and virtually half the population in the developing world live on less than $2 a day[5]**

Another consequence is that traditional community and family values and support systems are eroded. This has particular implications for chronic care, where the needs of the individual are best met by a combination of family, community and health system support.

These changes also have a largely negative effect on lifestyle. The habits of tobacco use, alcohol abuse, drug abuse, poor diet and insufficient exercise seem best learnt in deprived urban communities, and sow all the seeds of the noncommunicable disease epidemic.

Finally, the speed of industrialization and urbanization can leave health systems, and especially primary health care, struggling to adapt infrastructures and capacity to meet new needs.

Globalization of the world economy, and the development of open markets, has an equally dramatic impact on health and health systems:
- The resulting increases in population mobility can lead to the rapid transfer of communicable diseases for example SARS
- The resulting increases in the marketing of public health risks such as tobacco, alcohol and unhealthy diets is leading to the dramatic increase in noncommunicable diseases
- Open labour markets have obvious implications for human resource development in health systems as:
  - Public and private providers of health care compete for the same skilled labour force
  - The health sector competes with other sectors for scarce talents

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[5] *World Development Report 2000/2001- Attacking Poverty*. New York: Oxford University Press. 2001.

♦ More affluent nations with skills shortages are able to recruit scarce staff from less affluent countries.

WHO acknowledges the problems and impact of fluid labour markets on health systems. One of its reports[7] suggests that 'high turnover rates of staff dilute results. No programme can mitigate the effects of losing up to 50% of staff who have been trained. Simply training more staff is not an effective strategy. Attention must be directed at supporting and retaining the staff'.

> **In the South-East Asia Region, private hospitals have attracted doctors from the public sector, leaving community hospitals without doctors [6]**

The emergence of Nongovernmental Organizations (NGOs) has added a new dimension to policy development and health care delivery for most countries. Operating locally, nationally and internationally, NGOs in their advocacy role can have a major impact on the policies and priorities determined by governments and communities. Operating as providers or financers of services and care, NGOs can have a significant influence on the way in which PHC is organized and delivered, and experienced by populations.

> **The Aravind Eye Hospital in Madurai, India performs more than 20,000 free cataract extractions annually. The surgery is funded from paying patients and private voluntary organizations. [8]**

Differences in educational progress also have clear implications for health outcomes, and health status. It is well understood that levels of general education in populations and especially literacy, will have a significant effect on levels of understanding of important health promotion messages, on the extent to which individuals will change lifestyle habits, and on the use that will be made of the health care which is available. Particularly for the most disadvantaged populations, progress with general education will be a key to health improvement.

At the same time, a better-educated population will be a more informed population, with clearer expectations about what should be provided by local health systems. The necessary investment in education thus brings with it greater demands on policy makers, managers and professionals working in the health care system.

All of these complex social and economic changes combine to create a wider environment in which policy development and health and health services delivery has to assume that:

- Change will happen fast
- There are few certainties
- Today's priorities may not be tomorrow's priorities
- Today's solutions may not work tomorrow
- We cannot know in advance all of the problems we will face
- New opportunities will arise from developments such as the growth in partnership working.

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[6] *Primary Health Care Review.* New Delhi: World Health Organization South East Asia Regional Office; 2003.
[7] *The Effectiveness of Mental Health Services in Primary Care: A View from the Developing World.* Geneva: World Health Organization; 2001. WHO document WHO/MSD/MPS/01.1
[8] Javitt, C.J. Cataract. In: Jamison D et al., eds. *Disease Control Priorities in Developing Countries.* Oxford: Oxford University Press; 1993. P. 635-645.

2.4   Primary health care and changing government roles

The summary of changing health issues, changing demography and socio-economic change all illustrates the complexity of the policy environment in which decisions have to be made about PHC and its contribution to population health. It also suggests that future PHC policy and models will have to be flexible and fast moving to respond to population needs which can and will change with frightening speed. This diverse policy environment is further complicated by changes in how Member State governments are interpreting their roles and responsibilities in relation to health and health care. We therefore have a combination of a fast changing policy environment, and changing policy makers.

In practice, this means that, whilst governments continue to accept a central role in policy making in health, the instruments available to support policy implementation may now be much more wide ranging. Those instruments will depend on whether governments have developed roles which include some or all of:

> **In order to implement the PHC policy in Uganda, there is need to redirect resources to the PHC level and revive the referral system[9]**

• Funders of health systems
• Providers of health care
• Commissioners of health care
• Regulators/accreditors of health systems and health care providers.

The capacity of countries to successfully implement PHC policies and models is directly related to decisions made about these roles.

2.5   Primary health care and international development

Globalization requires new approaches to address a range of problems that cross national boundaries and provide a rationale for the implementation of global norms to deal with shared problems.[10] For example, the Framework Convention on Tobacco Control provides invigorated direction to enhance preventive and promotive strategies through the application of legal instruments to international health issues. This will provide an enabling environment for complementary action at the PHC level.

International attitudes to the reduction of poverty and the improvement of health for the world's most disadvantaged populations, are also changing. This is best illustrated by the recommendations of the Commission on Macroeconomics and Health, which was established by the WHO in January 2000.

In its report[11], the Commission on Macroeconomics and Health challenges traditional assumptions that the health of the world's poor will improve as a result of broader economic development. Its central proposal is that the world's low and middle income countries, working in partnership with high-income countries, need to significantly scale up the access of the world's poor to essential health services,

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[9] Okello D, Guwatudde D, Sebina A, Lubanga R. Low bed occupancy rates in Uganda's peripheral health units: is it a policy problem? *East Afr.Med.J.* 1994;71:601-603.
[10] Taylor A, Bettcher D. WHO framework Convention on Tobacco Control: a global "good" for public health. *Bulletin of the World Health Organization* 2000;78:920-29.
[11] Commission on Macroeconomics and Health. *Macroeconomics and health: investing in health for economic development.* Geneva: World Health Organization;2001.

if the Millennium Development Goals (MDGs) adopted by the United Nations in September 2000 are to be met. It is unrealistic to expect the achievement of the MDGs (reduce child mortality; improve maternal health; combat HIV/AIDS, malaria and other diseases), without an organized PHC. Furthermore, the achievement of health targets including the 3 by 5 requires strengthened PHC.

> **It is unrealistic to expect the achievement of the Millennium Development Goals without an organized PHC.**

Local priorities for PHC, and the tasks to be undertaken by PHC teams, continue to be affected by programmes and interventions which address major areas of morbidity and mortality, and the reduction of risk factors. An example is access to safe water for populations. Ensuring an adequate supply of safe water is one of the original core activities of PHC, and is now reflected in the Millennium Development Goals. Safe water is one of the environmental determinants of health which account for up to one third of the global burden of disease.

Whenever populations do not have access to safe water, a central competence for PHC workers is the ability to administer oral rehydration therapy. However, when national and international initiatives, such as the WHO 'Healthy Environments for Children' programme, impact on access to safe water, the significance of oral rehydration to the PHC team declines. The team would need to preserve its knowledge and skills in this area, but capacity would be released for other priorities.

The Commission on Macroeconomics and Health also argues that the most effective interventions can be delivered through health centres and similar facilities, and through outreach, which they collectively describe as 'close to client' (CTC) systems. This is an obvious endorsement of both the principles and the best practices of PHC.

If the recommendations of the Commission are adopted and applied by the international community, Member State governments in low and middle income countries will have new opportunities to make progress, and will inevitably wish to review their own policies and systems for PHC, in light of available evidence on its effectiveness.

Section Three

PRIMARY HEALTH CARE: PERCEPTIONS AND COMMITMENT

What's new?

♦ Despite the many changes that have taken place, countries still view PHC as a policy cornerstone, and there is a general move towards PHC led health care systems. There is hardly any health system reform in developed countries in the past five years which has not given PHC higher relative importance. The world is still interested in PHC and wants support and guidance from WHO.

♦ The principles of PHC are also being seen as relevant to all populations and all communities, and counter any arguments that:
- PHC is for poor and disadvantaged populations only
- PHC is for rural, and not urban, communities
- PHC is for developing, and not developed, countries.

♦ In developed and middle income countries with health care networks, which have largely resolved problems of access, PHC is mainly seen today as a level of care. In low resource countries where there are still significant access challenges, the PHC concept which still prevails is the perception as a system-wide strategy for development. In this latter context, PHC is considered synonymous to health for all (HFA).

♦ There is now enormous diversity in the models of PHC being implemented. This together with the speed of change means that there is no place for a "blue print" approach to implementing PHC.

♦ In general, governments use public finance to organize social protection, and there are many innovations in PHC such as micro-insurance and other complementary community- financing schemes.

♦ There are now wide-spread innovations such as developing community-based integrated health care with a system perspective, as well as, numerous experiences which try to relocate public health functions within primary care.

♦ Many innovations have emerged for effectively preventing and managing chronic conditions within PHC.

III.   PRIMARY HEALTH CARE: PERCEPTIONS AND COMMITTMENT

The review process has looked at published evidence of the impact of PHC, but has also explored attitudes towards PHC (largely through the regional workshops). The picture that emerges when perceptions and commitment are explored has the following main elements:

3.1   The principles of primary health care continue to be valid

There appears to be commitment, at every level, to the original principles of PHC, as first described in the Alma-Ata Declaration in 1978. This is reinforced by a view that they are as relevant to the problems faced by communities and health systems in the 21st Century, as they were to the problems of the 1970s. The emphasis placed on community participation and intersectoral collaboration is especially appropriate now, when so many health issues (be it AIDS, violence, drug abuse, or Lymphatic Filariasis) cannot be effectively addressed by health systems working in isolation.

> "Most of the principles, goals and objectives in the New Zealand Health Strategy will only be achieved through a strong primary health care system[12]".

The principles of PHC are also being seen as relevant to all populations and all communities. This counters any arguments that:
- PHC is for poor and disadvantaged populations only
- PHC is for rural, and not urban, communities
- PHC is for developing, and not developed, countries.

This inclusive view is born out by:

> Our objective is to turn the objective of a "primary care led" health service into a reality through investment in and development of primary health care teams throughout Wales[13].

- The extent to which Member State PHC policies address whole populations
- The extent to which the richer nations continue to keep PHC as a central component of health policy
- The extent to which WHO policy advice draws upon PHC principles and does not exclude population groups
- The extent to which NGOs and not for profit organizations involved in health and health care support and apply PHC principles when developing their own services and models.

3.2   Primary health care making a difference

This broad commitment to the principles of PHC has been matched in some countries by the development of effective PHC policies, which have been implemented with sustained local and national leadership and appropriate resources. Where this has happened, the impact on population health has been considerable.

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[12] *The Primary Health Care Strategy*. Wellington: Ministry of Health; 2001.

[13] *Improving Health in Wales: The Future of Primary Care*. Cardiff: Ministry for Health and Social Services; 2001.

This perception is supported by published evidence from WHO and other United Nations funds, programmes and agencies. 'Health – a Key to Prosperity', jointly published in 2000 by WHO with five other UN agencies, points to two examples. In Brazil, the launch of a community-based family health programme has led to a sharp drop in infant mortality rates in several of the states involved. In one city, infant death rates fell by almost 75% over a six-year period.

In Benin, community involvement in primary health care has helped reduce child death rates, boost immunization coverage, and increase access to antenatal care.[14].

3.3 Problems with the implementation of primary health care

There is evidence that the implementation of PHC (turning the principles into operational systems) is incomplete, or is not delivering the expected results, in many countries.

Problems of implementation are explained in many ways, for example:

- Inadequate resources and insufficient emphasis on sustainability
- Unrealistic expectations of PHC
- A lack of practical guidance on implementation
- Insufficient evidence on which to base local policy
- Poor leadership and insufficient political commitment
- Failure to address the demands, as well as the needs, of populations.

Such problems do not seem to detract from the strong underlying commitment to the principles of PHC.

3.4 Primary health care as a policy cornerstone

It is clear that PHC continues to be a fundamental component of health policy, and of health systems, in most of the world. Most are revisiting their policies and PHC models to address a range of different health and social issues.

> **"To strengthen the primary health care approach in delivery of health care"** is one objective of the 8th Malaysian Health Plan (2001-2005).

In addition to countries continuing to see PHC in this way, WHO itself demonstrates its continuing commitment. A recent example is the World Health Report 2001[16]. The report's ten recommendations for action resonate strongly with the principles of PHC, including:

- Providing treatment for mental disorders in primary care settings
- Making psychotropic drugs available at all levels of health care, including primary care
- Involving communities in decision making
- Building an intersectoral approach.

> **In the words of the First Ministers in Canada:** "Improvements to primary care are crucial to the renewal of health services"[15].

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[14] *Health – A Key to Prosperity*. Geneva: World Health Organization; 2000.
[15] *Building on Values: The Future of Health Care in Canada*. Saskatoon: Commission on the Future of Health Care in Canada; 2002.
[16] *The World Health Report 2001- Mental Health: New Understanding, New Hope*. Geneva: World Health Organization;2001.

Also the WHO Director-General, in her address to the Fifty-fourth World Health Assembly[18] confirmed that: "we will continue to draw on experience to date, including the primary health care and health for all movements".

> **In Ireland, the document "Primary Care: A New Direction" acknowledges the central role of primary care in the future development of our health services...[17]**

3.5 Diversity and innovation in primary health care

The widespread commitment to the principles of PHC is matched by an equal commitment to diversity in the way in which those principles are applied.

A recurring theme throughout the review has been the importance of recognizing the enormously varied circumstances in which policy makers, and PHC professionals and managers seek solutions to the health problems of their populations. Given this variety, there can be no standardized PHC solutions, and this is reflected in the very considerable diversity found in local models of PHC around the world.

The need for diversity is fully acknowledged by WHO itself, where there is a commitment to helping countries establish the ways in which the available interventions can be made as effective as possible in different country settings.

Increasingly, those interventions are likely to be incorporated in a local 'Country Co-operation Strategy' as part of the current WHO initiative to improve its performance and collaboration at Member State level (The Country Focus Initiative).

a) Opportunities for Learning
Whilst there can be no standardized solutions, there are ample opportunities to learn from experience elsewhere. Whether it is the Bamako Initiative in Malawi, Community-Based Care in Iran, or the Community Oriented Primary Care model (which has been applied in many countries) there is no shortage of

> **The model in Bolivia combines a high level of community involvement in determining health priorities, using locally recruited programme leaders[19].**

ideas to draw upon when the search for appropriate local solutions is under way.
It is also clear that the commitment to finding innovative solutions to population health problems, by applying the principles of PHC, is alive and well. New PHC strategies, such as those for New Zealand and Ireland, are developing new PHC models which will become the basis for future learning, as will separate initiatives such as the creation of Primary Care Trusts in England, and new PHC solutions for remote communities in Brazil.

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[17] *Quality and Fairness- A Health System for You*. Dublin: Department of Health and Children; 2001.
[18] World Health Organization. Address by Dr Gro Harlem Brundtland, Director-General to the Fifty-fourth World Health Assembly, Geneva, Monday 14 May 2001. A54/3
[19] Perry et al. Attaining health-for-all through community partnerships: principles of the census-based, impact-oriented (CBIO) approach to primary health care developed in Bolivia, South America. *Social Science and Medicine* 1999;48:1053-67.

b) *Complementary Community Health Insurance Schemes*

Another interesting innovation is the work undertaken on community-based health insurance schemes, also referred to as micro-insurance schemes. Slow economic growth, collapsing economies and consequently poor financing of health systems has given rise to such complementary approaches. The review confirms that many policy makers believe governments must continue to organize public finance in order to provide for social protection, especially for poor populations. However this has proven difficult in most poor nations especially those which have large rural and informal sectors.

> **Governments must continue to organize public finance in order to provide for social protection, especially for poor populations, and complementary financial schemes should be tested.**

Complementary approaches such as the organization of micro-insurances give expression to the traditional community participation aspiration of PHC. Community health funds, mutual health organizations and revolving drug funds are examples of initiatives designed to improve coverage. Their role in improving coverage and working in a complementary way to other more nationally oriented financing systems needs to be emphasized. [20] In addition to continuing to provide a national service, governments also need to continue to oversee the health sector and ensure preventive interventions. However, more recently they may also be taking a facilitating role in creating conditions for new community health financing schemes.

Micro level household data analysis indicates that community financing improves access by rural and informal sector workers to health care and provides them with some financial protection against cost of illness. New types of insurance schemes demonstrate benefits mainly in events that put an insurmountable burden on individuals and families [21]

In recent years there has been increased interest in micro-insurance and its potential for protecting populations for PHC related activities as well as for catastrophic health care. These complementary routes to protect populations from unpredictable health care expenditures were non- existent in the period of Alma-Ata when it was assumed that the public sector would be the significant player in coverage**.** Since then, the increased emphasis placed on community participation has spurred governments and international organizations to stimulate and build the capacity for such schemes.[22] Consequently there is now an emerging body of knowledge and lessons about how to set up

> **The Bamako Initiative adopted by Ministers of the African Region in 1987 to provide needed assistance to the PHC sector, and serve as a catalyst to mobilize community and domestic resources to sustain and expand the efforts to support PHC implementation.**

micro-insurance schemes. For example, the Bamako Initiative introduced a clear target of district and community management and a commitment to a local financial contribution as a means to make PHC/MCH systems operational and more sustainable.

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[20] *Community-based health insurance schemes in developing countries: facts, problems and perspectives.* Geneva, World Health Organization, 2002 (Health Financing Technical Brief).
[21] *Health care financing for rural and low-income populations: the role of communities in resource mobilization and risk sharing.* A synthesis background report to the Commission on Macroeconomics and Health 2002. Available at URL: http://www.cmhealth.org/wg3.htm.
[22] Community-based Health Insurance Schemes in Developing Countries: facts, problems and perspectives. Health Financing Technical Brief. World Health Organization 2002.

Micro-insurance schemes can serve different types of communities and many have different objectives. Full evaluations of micro-insurance schemes need to be further researched but those that have been undertaken[23] suggest that certain micro-insurance schemes have been developed to cover for PHC related services. One important example is the Self-Employed Women's Association's (SEWA) Integrated Social Security Scheme that was set up in 1992 to provide insurance coverage to self-employed woman workers in Gujarat, India. This scheme which mainly covers hospitalization costs has recently been assessed concluding that such schemes can effectively protect poor households from uncertain risks of medical expenses, and can be implemented in areas where institutional capacity is weak[24]. The Bwamanda Health Insurance Scheme is an example of a scheme that introduced strict gatekeeping and referral practices to contain costs as a result of introducing a broad benefit package. In this scheme, patients could only get access to insured hospital care after being referred by a primary health care centre.[25] Other examples include the Thai health card scheme which started with benefits that covered several outpatient visits a year, and was later complemented to provide much larger catastrophic coverage. Another example is the development of a scheme to expand coverage for PHC services in Guinea Bissau[26].

As with many issues reflected in this report there is no blueprint approach for all schemes but rather the need for a process to support communities to develop such schemes according to their own objectives, but coherent with nationally set objectives for universal coverage.

c)   Blurring the Boundaries
In some health systems, the focus on delivering health care in primary care settings wherever possible is being preserved as part of an integrated approach. In these models, the traditional distinctions between primary and secondary care are blurred. Instead, emphasis is placed on delivering health care at the right place, at the right time, and to the right standard. Driven by this focus on improving access and quality with constrained resources, an integrated whole system approach frequently leads to the conclusion that the majority of health care is most effectively delivered in primary care settings. This is even more important in the context of a world in which the total elderly population (60+) will grow from the current 600 million today to 1,4 billion in 2025. The only way to ensure that those who are adults today will grow older in good health is to focus on a seamless continuum of care throughout the life course.

d)   Reinforcing the role of public health in primary health care
The past years have witnessed the difficulties that health systems, even in developed nations, can have in addressing broader health goals and health inequalities. One innovative trend, which aims to correct this are structural efforts to strengthen the public health function in local PHC settings. This can improve local public health surveillance, reinforce health promotion and disease prevention interventions, and activate a local health inequalities agenda.

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[23] Dave P, Berman P. Costs and Financing of Health Care: Experiences in the Voluntary Sector. New Delhi: Ford Foundation; 1990.
Atim, C. Contribution of Mutual Health Organizations to Financing, Delivery, and Access to Health Care: Synthesis of Research in Nine West and Central African Countries. Technical Report No.18. Bethesda, MD.: Abt Associates Inc., Partnerships for Health Reform Project; 1998.
[24] Ranson M. Reduction of catastrophic health care expenditure by a community-based health insurance scheme in Gujarat, India: current experiences and challenges. *Bulletin of the World Health Organization* 2002;80(8):613-21.
[25] *Community based health insurance schemes in developing countries: facts, problems and perspectives.* Geneva, World Health Organization, 2003 (Health Financing Technical Brief) (unpublished document).
[26] Chabot J, Boal M, Da Silva A. National community health insurance at village level: the case from Guinea-Bissau. *Health Policy and Planning* 1991;61:46-54.

This trend involves existing public health specialists working more closely with the local PHC team and local community. The intention of these innovations is to complement the dominating clinical approach with population-based approaches.

e) *Innovations in health care for chronic conditions*

While the global disease burden has been shifting towards chronic conditions, health systems - including PHC - have evolved around the concept of acute care, and as a result they perform best when addressing patients' acute and urgent symptoms. Many innovations signalling the need to handle differently chronic conditions in health care have emerged, such as Innovative Care for Chronic Conditions (ICCC) Framework[28] (ICCC). The ICCC Framework is an expansion of the Chronic Care Model[29], with greater emphasis on community and policy components of health care for chronic conditions, to better suit the context of international health care.

In developing countries, chronic conditions present mainly at the primary health care level and need to be handled principally in these settings. Yet, most primary health care is oriented toward acute problems and the urgent needs of patients. As part of overall improvement efforts, an evolution in primary health care is imperative to effectively handle a double burden.

All of these innovations show that the trend to organizing PHC is as part of a whole system, and it carries the following concepts:

- It builds on the principles of primary health care;
- It is organized to address broader population health;
- It creates conditions for the effective provision of primary preventive and medical care;
- It is organized to provide integrated and seamless care.

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[27] Department of Health. Health Action Zones. [Online]. 2003. Available from: URL: http://www.doh.gov.uk/pricare/haz.htm
[28] *Innovative Care for Chronic Conditions: Building Blocks for Action.* Geneva: World Health Organization;2002. WHO Document WHO/MNC/CCH/02.01
[29] Wagner EH, Davis C, Schaefer J, Von Korff M, Austin B. A survey of leading chronic disease management programs: Are they consistent with the literature? *Managed Care Quarterly*, 1999;7(3):56-66.

Section Four

PRIMARY HEALTH CARE AND EVIDENCE

IV.   PRIMARY HEALTH CARE AND EVIDENCE

As already highlighted, many countries have included PHC as a policy cornerstone in their health system reforms. As part of these reforms, many have carried out reviews of the available and relevant evidence.

While research and reviews[30] provide sufficient confidence to base policy recommendations on PHC, some problems still exist. In its report the Commission on the Future of Health Care in Canada recommended PHC policy reinforcement and noted that "some aspects of primary health approaches are not necessarily grounded in research and evidence, but rather appear to be based on good ideas or preferences".[31] They also noted that there is "insufficient and even contradictory evidence on important characteristics of PHC". Hutchison et al observed that "systematic policy-informing evaluation of primary care innovations in Canada, including those that have been in existence for several decades are remarkably limited, often narrowly focused and not readily generalizable".[32]

An earlier review of international literature also noted that "the paucity of rigorous evaluation research in such a broad policy area as PHC delivery is striking." They concluded that "whatever policies are contemplated for the reform of PHC systems around the world, their implementation should be considered in the context of a strong policy-informing research agenda." [33]

Not surprisingly the systematic review[34] carried out as part of the review process, concluded that whilst there is a clear and substantial body of evidence of positive outcomes from initiatives being taken in PHC, that evidence is not always clear cut. This report noted that there are examples of similar initiatives being taken across countries, with very different results. The implication for policy makers is clear: a successful change in the context of one health system may not translate into success in another system, and reforms should be accompanied by a research agenda.

Other conclusions that can be drawn from the reviews are:

- There is a continuing problem of building a coherent base of evidence to support policy development and innovation. The availability and credibility of evidence to support future PHC policy development at the national and local levels would be enhanced if:
  i) There was a greater commitment to building systematic evaluation into the design and implementation of new PHC initiatives, by all health systems
  ii) There was a greater emphasis on health outcomes in the design of systematic evaluations
  iii) More studies were commissioned which included control or comparison groups in order to meet stricter methodological requirements.

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[30] Starfield B, Shi L. Policy-relevant determinants of health: an international perspective. *Health Policy* 2001;60;201-218.
[31] Commission on the Future of Health Care in Canada. *Building on values: the future of health care in Canada.* Saskatoon, 2002.
[32] Hutchison B, Abelson J, Lavis J. Primary Care in Canada: so much innovation, so little change. *Health Affairs* 2001;20(3):116-31.
[33] Abelson J, Hutchison B. Primary Health Care Models: A Review of International Literature. Hamilton, Centre for Health Economics and Policy Analysis, 1994 (Working Paper 94-15).
[34] *The effectiveness of primary health care programmes: A Systematic Review.* Geneva, World Health Organization, 2002 (unpublished document).

Promoting the availability of valid evidence on which both policy and practice can be based, is one of the core functions of WHO. There is therefore a strong case for WHO to be actively involved in addressing these needs in relation to PHC in the future (see Section 7 – WHO and its Support to countries). In particular 'Country Cooperation Strategies' will provide an opportunity for WHO to promote systematic evaluation as an element of new country initiatives to develop PHC.

- Some of the most positive outcomes from interventions seem to result from taking a multi-strand approach to change. In a quoted example from one systematic review[35], one intervention combined introducing work-based primary care to workers and their families, with continuing education and support for health care providers, and assistance in the use of decision support tools. The result was improved access to health care, increased immunization coverage and greater cost effectiveness.

- The change process for many PHC models where health systems are seeking innovative solutions to their problems, frequently centres on:
  i) Creating multi-disciplinary PHC teams; and/or
  ii) Extending the range of skills and competencies of individual members of the PHC team; and/or
  iii) Co-locating PHC teams and specialist services.

Co-location is endorsed in the recent WHO report on the effectiveness of mental health services in primary care.[36] The report advocates mental health specialists working alongside PHC staff to advise on differential diagnosis and appropriate treatment.

Co-location is also a characteristic of several European health care systems and of organizations such as Kaiser-Permanente in the USA, with specialists in paediatrics, maternal care and other disciplines working alongside primary care physicians in the setting of a Primary Care Campus. These approaches are, in their different ways, pushing out the boundaries of PHC, and blurring many of the traditional distinctions between PHC and specialist care. This reflects a movement towards whole system thinking, resulting in greater integration, to the benefit of the populations served.

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[35] Foreit KG, Haustein D, Winterhalter M, La Mata E. Costs and benefits of implementing child survival services at a private mining company in Peru. *American Journal of Public Health* 1991;81(8):1055-7.
[36] *The Effectiveness of Mental Health Services in Primary Care: A View from the Developing World.* Geneva: World Health Organization;2001.

Section Five

LOOKING TO THE FUTURE: SOME POSSIBLE STRATEGIC DIRECTIONS FOR PRIMARY HEALTH CARE DEVELOPMENT

What's new?

♦ **A range of scenarios could be the basis for Countries identifying development needs and taking forward their PHC policies and models in the 21st century:**
- **Completing implementation**
- **Strengthening to meet new challenges**
- **Locating PHC in a new paradigm.**
- **Responding to a population health crisis**

B.   FUTURE STRATEGIC DIRECTIONS FOR PHC

5   LOOKING TO THE FUTURE: SOME POSSIBLE FUTURE STRATEGIC DIRECTIONS FOR PRIMARY HEALTH CARE DEVELOPMENT

The outcomes form the Primary Health Care Review, summarised in the previous sections of this report, reflect experience, evidence and perceptions from around the world of 25 years of PHC policy implementation. They also provide a platform for thinking about the future.

The remainder of the report begins to address the future. In particular, it attempts to identify different "Future Strategic Directions" which could be helpful to countries in considering their policies and priorities for PHC development. In doing so it is a direct response to resolution WHA 56.6 made at the Fifty-sixth World Health Assembly in May 2003.

This section of the report describes four basic scenarios, which could inform Member State decisions about the direction that their PHC development might take. The scenarios are derived from the PHC review process and reflect situations which can be observed now and which seem likely to be relevant for the future.

The scenarios are not meant to be mutually exclusive. The process of developing and implementing PHC policy at Member State level will need to be based on a careful analysis of current reality and likely future challenges. That analysis may conclude that one of the suggested scenarios is a perfect "fit" for a local situation. In contrast, it may be that elements of all four scenarios are present and need to be taken into account.

Whatever the local context may be, the challenge for the future, for both countries and WHO will be to ensure that:

- PHC development leads to improved health outcomes for populations

- Future strategies for PHC will make an effective contribution to the achievement of the United Nations Millennium Development Goals.

- The principles of PHC are respected when responding to related policy initiatives such as the Commission on Macroeconomics and Health

The four suggested scenarios are:

5.1   Completing implementation

In this situation, existing PHC policies and models are seen as not delivering to their full potential, largely because the process of implementation of PHC is incomplete. The immediate challenge to governments, policy makers, and PHC professionals and managers, is to understand why implementation has failed, take remedial action, and secure the benefits of PHC for their populations. (A deeper understanding of the problems of policy implementation is relevant to the other scenarios described below).

5.2   Strengthening to meet new challenges

In this situation, the nature of the future environment in which PHC will operate is fully appreciated, in terms of health challenges, demographic change and socio-economic change. PHC is seen as having the potential to deliver effective responses to those future challenges, but may need to be strengthened, particularly in terms of responsiveness and flexibility. The challenge to governments, policy makers, and PHC professionals and managers, is to identify the areas where strengthening is most important, and initiate a coherent process of change.

5.3   Locating PHC in a new paradigm

In this situation, it is recognised that the fundamental social and political problems which trouble the world, and in particular issues of social justice, human rights and equity, must have primacy. PHC will have its part to play in this broader agenda, but as a secondary consideration.

In particular, this scenario recognises that PHC as both a set of values and a model has limitations. It cannot solve all of the problems which concern communities, and which impact on health outcomes.
PHC would still be a cornerstone of health policy, and an important component of wider social policy, but would need to refocus to take account of these more fundamental concerns.

The challenge to governments, policy makers and PHC professionals and managers, is to identify the role that PHC should play in pursuing broader policy goals, clarify its limitations and boundaries, identify how priorities, attitudes and processes within PHC would need to be adjusted, and initiate the process of change.

5.4   Responding to a population health crisis

In our final scenario, health systems and their PHC components may have progressed well on a coherent development pathway only to be thrown into turmoil by a large-scale population health crisis. The most obvious example is the impact of HIV/AIDS in sub-Saharan Africa. In that context, the effects on life expectancy and the economic well-being of the worst affected countries are well documented. At the same time, many local PHC system have been overwhelmed by the scale and rapid growth of the epidemic,

The challenge to both policy makers and practitioners is then to develop responses in which the epidemic is contained and reversed, whilst preserving a commitment to the principles of PHC and the wider health needs of the whole population.

The impact of HIV/AIDS best illustrates the need for future strategic directions to take account of large-scale crisis in population health. In doing so policy makers will need to be responding to both known problems and those which will arise in a future which we cannot fully predict.

The following sections of this report now focus on these four basis scenarios and suggest the implications of each for key stakeholders.

Section Six

RESPONDING TO THE SCENARIOS FOR DEVELOPMENT

WHAT IMPLEMENTING DIFFERENT STRATEGIC DIRECTIONS COULD INVOLVE

What's new?

♦ Dependence on international resources often results in the donors influencing and conflicting with national policy-making bodies in ways that are not always helpful to the receiving nations.

♦ There is recognition that where implementation of PHC has been incomplete or is not delivering the expected results, this is due to lack of practical guidance on implementation; poor leadership and insufficient political commitment; inadequate resources and unrealistic expectations placed on PHC.

♦ There is recognition that the various PHC models often do not reach their target populations, such as the poor and other disadvantaged groups. This may be a failure of implementation or of other complex socio-economic and political factors.

♦ The central characteristics of any effective local PHC model in the future will be:
1. Adaptability to rapidly changing circumstances
2. Responsiveness to locally defined needs.

♦ Capacity building approaches for PHC and vertical programmes do not have to be in conflict. It is possible to integrate and find synergy between these approaches at national and local levels.

♦ PHC will have a major contribution to make in the future in relation to addressing lifestyle issues and reinforcing prevention and better management of chronic conditions.

VI. RESPONDING TO THE SCENARIOS FOR DEVELOPMENT: WHAT IMPLEMENTING DIFFERENT STRATEGIC DIRECTIONS COULD INVOLVE

6.1 Completing implementation

In this scenario, the challenge to key stakeholders is to understand why implementation is failing, and plan remedial action to secure the benefits of PHC for their populations.

The PHC review has highlighted some recurring weaknesses in PHC implementation. These are now summarized, and suggestions are added on where attention could focus in planning remedial action.

Problem: A lack of political commitment and leadership, and insufficient policy continuity as a result.

Focus on:
- Building the widest possible stakeholder commitment to new solutions, by involving them in the analysis of the current situation and letting them influence policy decisions
- Keeping stakeholders involved in reviewing progress with subsequent implementation
- Stressing the importance of policy continuity in the achievement of long-term health goals.

Problem: Initial objectives were unrealistic, and are not being achieved.

Focus on:
- Deciding which are the most important health and social problems to address now, and in the future. Make PHC as focused and problem oriented as possible. Recognize that PHC cannot do everything
- Designing future PHC models and services around the selected health and social priorities
- Involving stakeholders in the choice of priorities
- Selecting clear milestones as well as longer-term objectives, so that future progress is measured systematically, and problems with under achievement are identified early
- Putting in place the information systems which will allow progress to be monitored.

Problem: Local PHC services are seen as inappropriate, and are bypassed by the communities they serve.

Focus on:
- Identifying health needs at the local level
- Involving communities in decisions about which PHC services they need most, and how they are best delivered
- Collecting community and user views on performance, systematically and continuously
- Having local quality policies in place
- Improving accessibility
- Ensuring the availability of basic resources, such as drugs.

Problem: There is a lack of integration between PHC and other parts of the health (and social care) system.

Focus on:

- Strengthening referral systems and protocols which link primary and secondary health care in particular
- Building mechanisms, and a culture, for local collaboration between health and social care organizations
- Building PHC capacity and minimizing vertical programmes
- Setting national and local priorities and targets, which apply to the whole health system, irrespective of how organized and funded
- Using legislation, accreditation and standards to reinforce integration.

Problem: PHC staff have the wrong skills, and are not motivated.

Focus on:

- Ensuring that health workers are paid in a timely manner
- Devolving decisions about skill-mix and staff deployment to a local level, so that local managers can find the best match between available human resources and community needs
- Developing leadership capacity at a local level
- Developing a team-based approach, because that will have more impact
- Revising curricula and training programmes to reflect new priorities and challenges for PHC
- Programmes of continuing professional development which allow PHC staff to regularly update their skills
- Multi-skilling, so that PHC staff feel confident to take on a wider range of tasks, related to clear health priorities
- Changing the providers of education and training
- The use of rewards and incentives.

Problem: An effective intersectoral approach has not been developed.

Focus on:

- Giving greater prominence to the public health functions within primary care
- Using leaders to promote intersectoral collaboration
- Using evidence to demonstrate how important health and social outcomes can only be achieved through intersectoral collaboration
- Involving intersectoral stakeholders in agreeing health goals and priorities
- Building the mechanisms for collaboration at every level, from national to local
- Integrating health into definitions of, and processes of, wider community development
- Developing appropriate attitudes to collaboration and power-sharing
- Developing influencing skills amongst PHC professionals and managers at the local level.

Problem: PHC policies and models are not sustainable.

Focus on:

- Reorienting PHC policies and models to focus on a core range of health priorities
- Reviewing the roles of different stakeholders in funding and providing PHC
- Targeting PHC resources, particularly towards the most disadvantaged groups in the population
- Involving communities in decisions about which PHC services are most valuable
- Using evidence to identify the most cost-effective practices

- Planning for appropriate numbers of staff at the PHC levels
- The multi-skilling of PHC staff
- Making the most effective use of community volunteers
- Rewarding innovation
- Devolving authority so that decisions can be made at a local level about the most effective use of limited resources.

Problem: Community Involvement is not working.
Focus on:
- Devolving authority to the local level, so that communities can see resource deployment changing in response to their views and needs
- How local PHC is made accountable to local communities
- Understanding cultural obstacles to community involvement
- Building mechanisms for involving communities in decision making which are sensitive to cultural issues
- Recognizing, and working with, natural communities at a local level, which may not coincide with administrative boundaries.

6.2.   Strengthening PHC to meet new challenges

Our second development scenario focuses attention on ways in which PHC models and policies at Member State level may need to be strengthened to meet new challenges, even when current arrangements are seen as effective.

> **To be successful community participation must become part of a community's common experience and not just imposed from outside[37].**

The review process has suggested that the process of strengthening needs to be considered at both national and local levels, with a particular focus in each case.

a)   Strengthening the PHC model at the local level

The most important concern for the future at local level will be to ensure that PHC models have the capacity and capability to respond quickly to emerging health and demographic challenges and the consequences of social change. A central concern will therefore be to ensure that locally based PHC is robust, flexible and adaptable. The development agenda for creating these characteristics may need to focus on:

> **In many countries, capacity building needs to be linked to the development of new ways of working that encourages intersectoral action, high levels of flexibility and adaptability, and a broadening of the sense of ownership[38].**

- Ensuring that there is the capacity at a local level to continuously assess health needs, and identify trends at an early stage

- Local empowerment and the devolution of authority and responsibility, so that:
    i)   local priorities can be decided in response to local needs assessment
    ii) Services can be modified, and resources redeployed, without unnecessary bureaucratic delay

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[37] Zakus D, Lysack K. Revisiting community participation. *Health Policy and Planning* 1998;13(1):1-12.
[38] McKee M, Zwi A, Koupilova I, Sethi D, Leon D. Health policy-making in Central and Eastern Europe: lessons from the inaction on injuries?. *Health Policy & Planning 2000;15(3):263-9.*

iii) The configuration of the local PHC workforce can be modified quickly, as priorities are modified and services reconfigured

- Building a new culture for PHC which values:
  i) A spirit of enquiry and innovation
  ii) Evidence-based practice
  iii) Continuous learning
  iv) Collaboration and networking
  v) Success

- Making the PHC model 'problem oriented', so that PHC teams and managers, and the communities they work with, see themselves as:

  i) Staying focused on key problems, which may be about health outcomes or about weaknesses in how health services are delivered
  ii) Finding effective and innovative solutions to those problems, and implementing them quickly
  iii) Reviewing results, and making changes if solutions are not effective
  iv) Moving on when a problem is solved

- Further reinforcing community involvement (including collaboration with NGOs) as a direct response to the growing chronic care agenda

- Further reinforcing intersectoral collaboration at a local level, as a response to the increasing burden of noncommunicable diseases

- Strengthening the local mechanisms and processes for integration of PHC with other health (and social care) organizations, so that the most effective responses to health (and social care) problems are being delivered. This may involve a particular emphasis on referral systems and protocols, and care pathways

- Strengthening the local capacity to promote the value and effectiveness of PHC, and win community support

- Building leadership capacity and skills in change management within the local PHC team (without which the impact of all of the other interventions to build capacity and capability would be reduced).

b)   Policy alignment at a national level

Another critical determinant of the success and impact of PHC policies and models in the future is seen as the extent to which countries achieve clear alignment between their policies for PHC, and their policies for population health and health care more generally.

> **Dependence on international resources often results in the donors influencing and conflicting with national policy-making bodies in ways that are not always helpful to the receiving nations[39].**

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[39] Okuonzi SA, Macrae J. Whose policy is it anyway? International and national influences on health policy development in Uganda. *Health Policy and Planning* 1995;10 122-32.

The impact of central policies which develop and promote PHC will be less if:

- Intersectoral collaboration is not reinforced at government level. Local initiatives to build intersectoral collaboration as part of strengthening PHC for the challenges of the 21st Century, will have less impact, and credibility, if central government does not take the lead and demonstrate its own commitment.

- Policies for devolution are not consistent across sectors. Devolving authority and responsibility to local PHC models, in order to strengthen flexibility and responsiveness, will have reduced impact if other sectors, such as housing, education and social care, do not have the same devolved authority. The ability of sectors to collaborate successfully in solving health problems is dependent on the partners having equal or similar authority to act and deploy resources.

- The drive for integration of PHC with other parts of the health and social care system is undermined. Integration is seen as a fundamental aspect of strengthening local PHC models for the future, but is easily subverted. One obvious example is the creation of autonomous hospitals which can work against an integrated approach to improving health, which operates across organizational boundaries. Any adverse impact of autonomous hospitals on PHC values and objectives can be avoided, however, if:

  i) Information is integrated and shared freely between local PHC systems and Autonomous Hospitals
  ii) Referral processes and protocols are put in place
  iii) Care pathways are used to ensure continuity of care.

  Another example is in the field of accreditation. Accreditation is a legitimate and important tool used by governments as part of their stewardship role. However, there is a danger that a fragmented approach to accreditation will work against the principle of integration. This danger is averted when:

  i) The accreditation process for any one part of a health system (such as an Autonomous Hospital) looks closely at the way in which that part connects with the other parts
  ii) The system of accreditation relates to major programmes, such as cancer or diabetes or HIV/AIDS, rather than individual institutions. In this model, a programme would be accredited with all of the constituent organizations (including PHC) being involved, and with a particular emphasis on how their contributions are integrated.

- Tensions between vertical programmes for health improvement and the development of PHC are not addressed.

  Vertical programmes, at national and local levels, offer the opportunity to make rapid progress with addressing major health issues such as polio, malaria and TB.

  Irrespective of the stage of development of PHC, vertical programmes do require strong central management to be effective, because of the need for robust quality and risk management in critical areas such as the appropriate storage and distribution of vaccines. There is also a clear role at the centre to

promote research, evaluation, and education, and ensure that programme design reflects the true geographical distribution of a disease.

At the same time, the failure to develop basic local (PHC) infrastructures, such as access to thermometers and weighing scales, can diminish the impact and cost effectiveness of vertical programmes by leading to inappropriate referrals for diagnosis to higher levels.

Evidence also suggests that programmes to eradicate particular diseases in impoverished communities will be less effective if they do not simultaneously address wider health needs.

The investments often made in vertical programmes can be seen as an opportunity for wider infrastructure development. In Sudan, an initiative to address guinea worm was broadened to address pneumonia, diarrhoea and malaria, and focused on outreach, the use of village volunteers and the development of new assessment tools to broaden population coverage (all consistent with PHC principles and best practice).

Similarly, surveillance systems introduced for a single disease as part of a vertical programme can be adapted to cover a range of health issues.

Perhaps the best example of an approach which brings together the principles and systems of PHC, and the logic of vertical programmes, is the WHO's 'Integrated Management of Childhood Illness' (IMCI) programme. This programme, which is tailored to address individual Member State needs, is an efficient approach to the prevention and treatment of the major causes of childhood illness and death, and to the promotion of children's healthy growth and development.

IMCI focuses on malnutrition and the five main causes of death for children in developing countries (diarrhoea, acute respiratory infections, perinatal infections, measles and malaria). It also reflects the principles and core activities of PHC by its emphasis on:

- Adaptation to local needs
- Identification of the main health problems in the community
- Working with communities and families
- Ensuring the supply of appropriate low cost medicines
- Upgrading care in local settings by training health workers in new methods.

Based on that learning, a similar approach is being used by the Integrated Management of Adult Illnesses (IMAI) project.

The challenge to policy makers, at all levels, is therefore to recognize the potential for synergy between the vertical programme approach and the continuing development of PHC infrastructures. Where these synergies are not recognized, and policies are not aligned, there will be continuing tension between these policy goals.

6.3   Locating PHC in a new paradigm

The third development scenario for PHC in the 21st Century goes beyond issues of implementation and strengthening of PHC policies and models to meet new challenges. It sees the need to re-energize political agendas, to the advantage of populations whose needs are still not met. It argues that placing more emphasis on PHC policy development and effective implementation of those policies may prove an inadequate response. It suggests that PHC may have become marginalized, and increasingly irrelevant to governments and populations. In particular, it assumes that governments, international agencies and populations will increasingly want to respond to issues of social justice, human rights and equity which are the seed-corn of social unrest. In this context, PHC would move from:

- Attempting to co-opt wider society to attain goals defined in health terms,
  to
- Integrating health goals in the larger and transcendent goals of social justice, human rights and equity.

Such a repositioning goes beyond reaffirming commitments to established PHC principles and values, such as community participation and intersectoral collaboration. It would change what was done and how things were done within PHC in a profound way. Examples are:

- Wider social change, in areas such as gender, children's rights, education and employment, would be treated as key levers for improving both social justice and equity, and health outcomes

- The process of policy development as a multi-sectoral and multi-level activity would become even more critical. The process would take more time, be more complex, and require real listening. It should, however, produce policies more capable of delivering broader social, and health, goals

- Changes in our understanding of quality, what we measure, and the information we collect. In addition to a focus on activity levels, clinical effectiveness, and cost effectiveness, we would incorporate our concerns for social justice and equity by focusing on issues such as which populations do not access PHC, and why?

- Changes in the leadership and advocacy roles at every level in PHC, to reflect the concern for social justice, human rights and equity

- Changes in the processes of education and development for PHC practitioners and managers, to reinforce a values system centrally concerned with social justice, human rights and equity

- Life becoming more demanding for governments, communities and PHC practitioners and managers, because addressing the needs of those parts of populations who suffer the most from inequality and social justice is more difficult and expensive than meeting the needs of mainstream populations.

6.4   Responding to a population health crisis

The key feature of the fourth development scenario is that PHC infrastructure (and wider health systems) can face a crisis in population health which has the potential to overwhelm them. The obvious examples are HIV/AIDS, particularly in sub-Saharan Africa and SARS.

Looking to the future, new pandemics will be characterised by their scale, the speed at which they spread and their socio-economic impact as well as their effect on population health status.

Experience with HIV/AIDS over more than two decades and more recently with SARS, demonstrates that, differences in policy responses can lead to dramatically different outcomes. The same experience suggests that well founded PHC systems alone cannot possible contain and reverse this sort of health crisis; but they do have an important part to play in a wider response.

Central to that wider response in the future is likely to be the extent of international collaboration between agencies, nations and the global scientific community. That collaboration will continue to focus on understanding the biology and pathogens giving rise to the crisis; developing diagnostic tests; and developing effective and cost-effective treatments. International collaboration is also likely to be the main vehicle for ensuring that individual countries have access to the resources that will enable them to make an appropriate response to the health crisis in their country (so reflecting the central recommendations of the Commission on Macro Economics and Health). Promoting this type of international collaboration, whilst clearly not a component of PHC, is arguably critical in making it possible for PHC systems to respond effectively at a local level.

A new population health crisis presents major challenges to governments and the evidence from HIV/AIDS suggests that at this level, the policy choices made are critical. The experiences of countries such as Brazil and Uganda, where there have been recognised successes, suggests that the key contributions to be made at government level are to:

- Provide clear leadership, change attitudes and beliefs, counter stigmatisation and deploy resources effectively
- Use legislation to protect the most vulnerable against discrimination
- Develop intersectoral strategies at a national level
- Develop and sustain national programmes of education and prevention
- Maintain effective surveillance systems
- Ensure that access to primary health care is continued for all populations
- Ensure access to relevant drugs

Appropriate action by the international community and by governments are important responses to any population health crisis. They also create the context within which PHC systems make a local response.

The challenge at local level is to be able to move out of the paradigm of the stable system and deliver rapid responses to an emergent health crisis. To do this successfully, future PHC capacities will need to include:
- Strong local leadership to match that at a national level, able to mobilise civil society and NGOs in support of local strategies and programmes
- The ability to innovate and find local solutions to problems
- A commitment to integration and collaboration, so that combined community and PHC solutions to the population health crisis are seen to bring together the elements of prevention, diagnosis, treatment and care
- High levels of local empowerment, so that resources can be deployed and redeployed in response to changing circumstances
- The technical and interpersonal skills that will enable local programmes of education and prevention to be designed and delivered in support of national initiatives

- The technical and interpersonal skills that will allow effective local programmes of contact tracing to operate
- Access to information and training which will allow PHC practitioners to stay in touch with new knowledge and experience related to the population health crisis

Section Seven

WHO AND ITS SUPPORT TO COUNTRIES

What's new?

♦ **International Organizations must improve access to current evidence about the effectiveness of PHC models and interventions.**

♦ **Contradictory messages on health systems from different international agencies should be avoided.**

VII. WHO AND ITS SUPPORT TO COUNTRIES

WHO has six core functions, as follows:

    (i) Advocating evidence-based policy
    (ii) Managing information
    (iii) Catalyzing change through technical and policy support
    (iv) Building national and global partnerships
    (v) Developing norms and standards
    (vi) Developing new technologies tools and guidelines.

In its 'General Programme of Work 2002-2005' WHO describes several new ways of working which underpin its core functions, including:

(i)   Adopting a broader approach to health within the context of human development, humanitarian action, equity between men and women, and human rights, with a particular focus on the links between health and poverty reduction

(ii)   Assuming a greater role in establishing wider national and international consensus on health policy, strategies and standards

(iii)   Triggering more effective action to promote and improve health and to decrease inequalities in health outcomes, through partnerships and by making use of the catalytic action of others

(iv)   Creating an organizational culture that encourages strategic thinking, prompt action, creative networking, and innovation.

It is against this background, that the PHC review process sought views and ideas on the role that WHO should take in supporting countries as they consider the future of their own PHC policies and models. The detailed advice received is incorporated into the regional reports from each WHO region, which integrate the outcomes from their review workshops and region specific reports.

This report does not attempt to capture all of that advice, but instead will concentrate on recurring themes that have appeared in many, or all, of the six regions.

These suggest the following priorities:

- To move the focus of WHO activities in relation to <u>PHC from advocating principles to supporting practical implementation</u> at Member State level, across the six core functions

- To improve international <u>access to current evidence</u> about the effectiveness of PHC models and interventions

- To <u>build new networks</u> to facilitate the sharing of best practice and experience

- To develop a coherent 'Programme of Work' for PHC which effectively integrates all levels of WHO

- To <u>avoid contradictory messages on health systems</u> from different international agencies by strengthening work with the other international agencies (especially the World Bank) to produce policy advice on PHC which is aligned and consistent.

- To develop <u>an evaluative framework</u> and a review process which would help countries to:

  i) Review their existing policies and models of PHC
  ii) Review their progress with implementation, and identify obstacles
  iii) Plan any necessary changes
  iv) Repeat this process at regular intervals (e.g. every three years)

- To develop systems of classification which go beyond clinical activity and embrace other aspects of PHC such as preventative interventions.

In terms of its own capacity and capability to support countries in these ways, the review process has suggested that WHO needs to:

- Strengthen its feedback systems, particularly through WHO representatives in countries.
- Build current expertise in PHC development into its internal capacity, and keep that refreshed
- Strengthen its own processes for inter-agency collaboration.