World Health Organization

Primary Health Care

Why now more than ever?

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Introduction

- Health systems are perceived as relevant and necessary tools to both facilitate health services delivery and scale up interventions implemented in more "focused" initiatives
- Primary Health Care has been put high on the agenda of WHO, and of many technical, scientific institutions and bodies
- Today's roadmap

1. Why PHC?
2. Four sets of reforms
3. The way forward

What do we talk about when we talk about PHC?

- *The mobilization of forces in society – health professionals and lay people, institutions and civil society – around an agenda of transformation of health systems that is driven by the social values of equity, solidarity and participation.*

How experience has shifted the focus of PHC

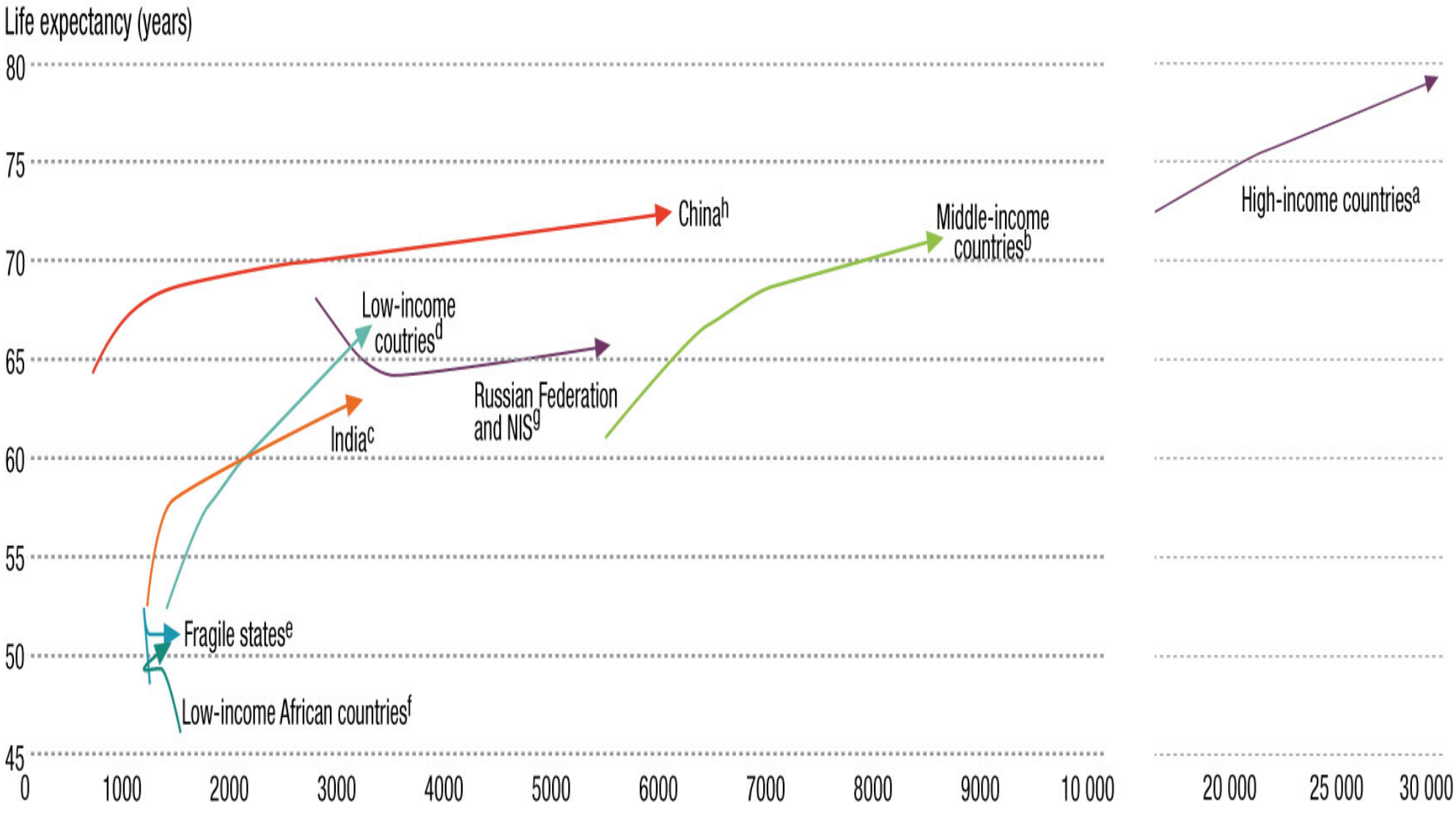
Early attempts at PHC	Current concerns of PHC Reforms
A basic package for the rural poor	Universal access, comprehensive services
Mother and child focus	All disadvantaged groups
Acute, infectious, diseases	Health risks, illness across life course
Healthy local environment	Healthy global and local environments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

A rationale that sounds familiar

- Unequal improvement and growing gaps
- New challenges to health and health systems
  - Scaling up services for HIV, TB, malaria, immunization
  - Urbanisation, aging, globalisation, ...
  - Chronic diseases, multimorbidity
- The social impact of business as usual
  - Within-country inequalties
  - Borrowing, asset depletion, poverty

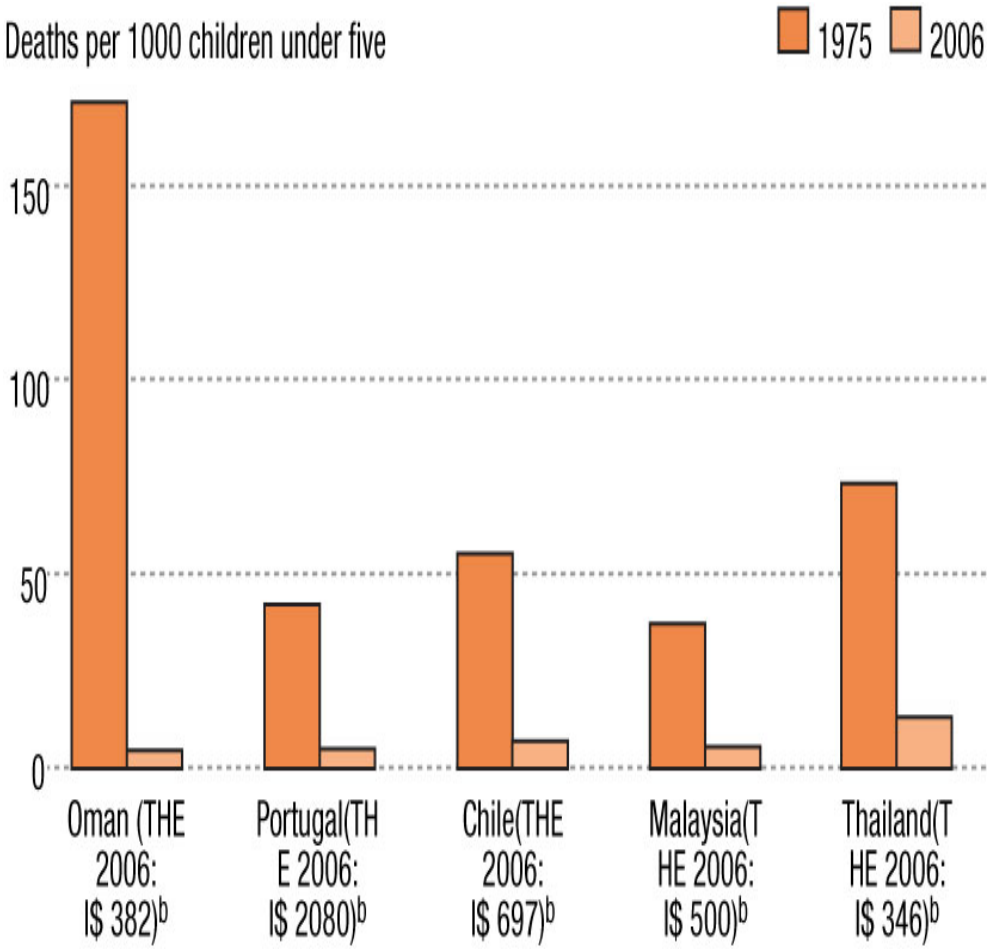
1. Uneven progress: wealth and health

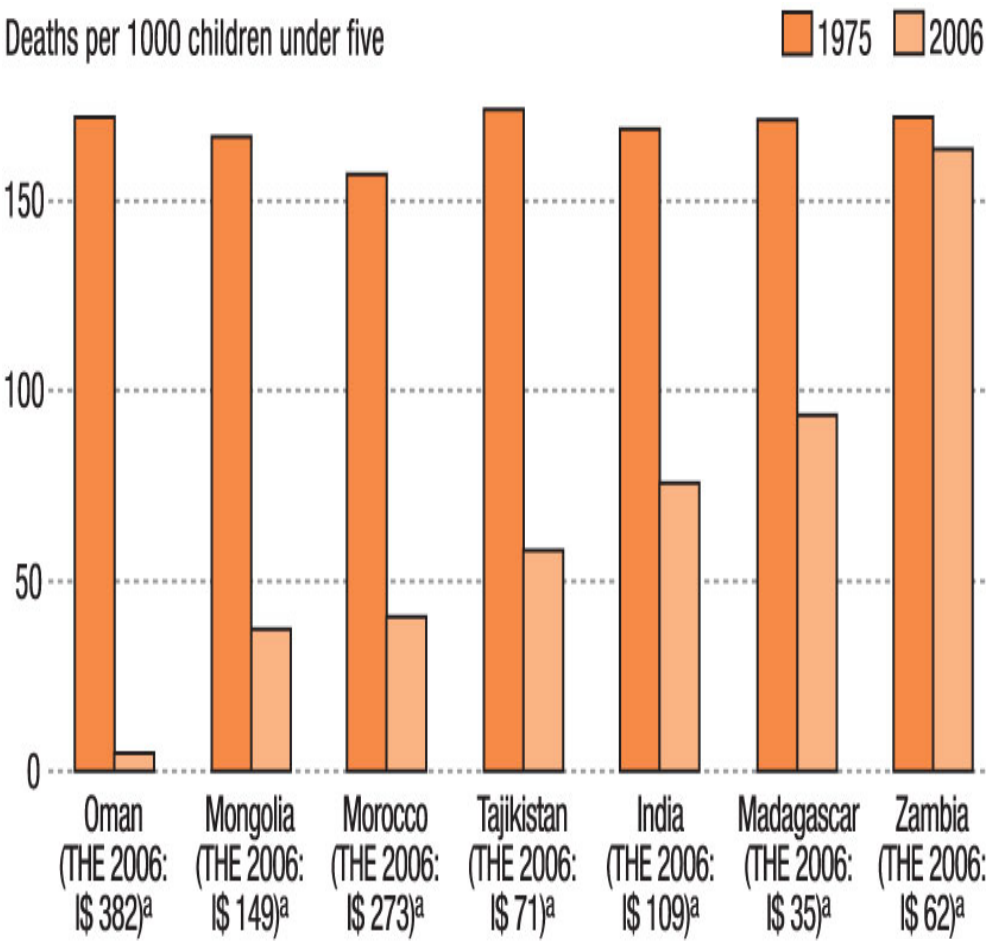
▲GDP growth is necessary but not sufficient



1. Uneven progress:

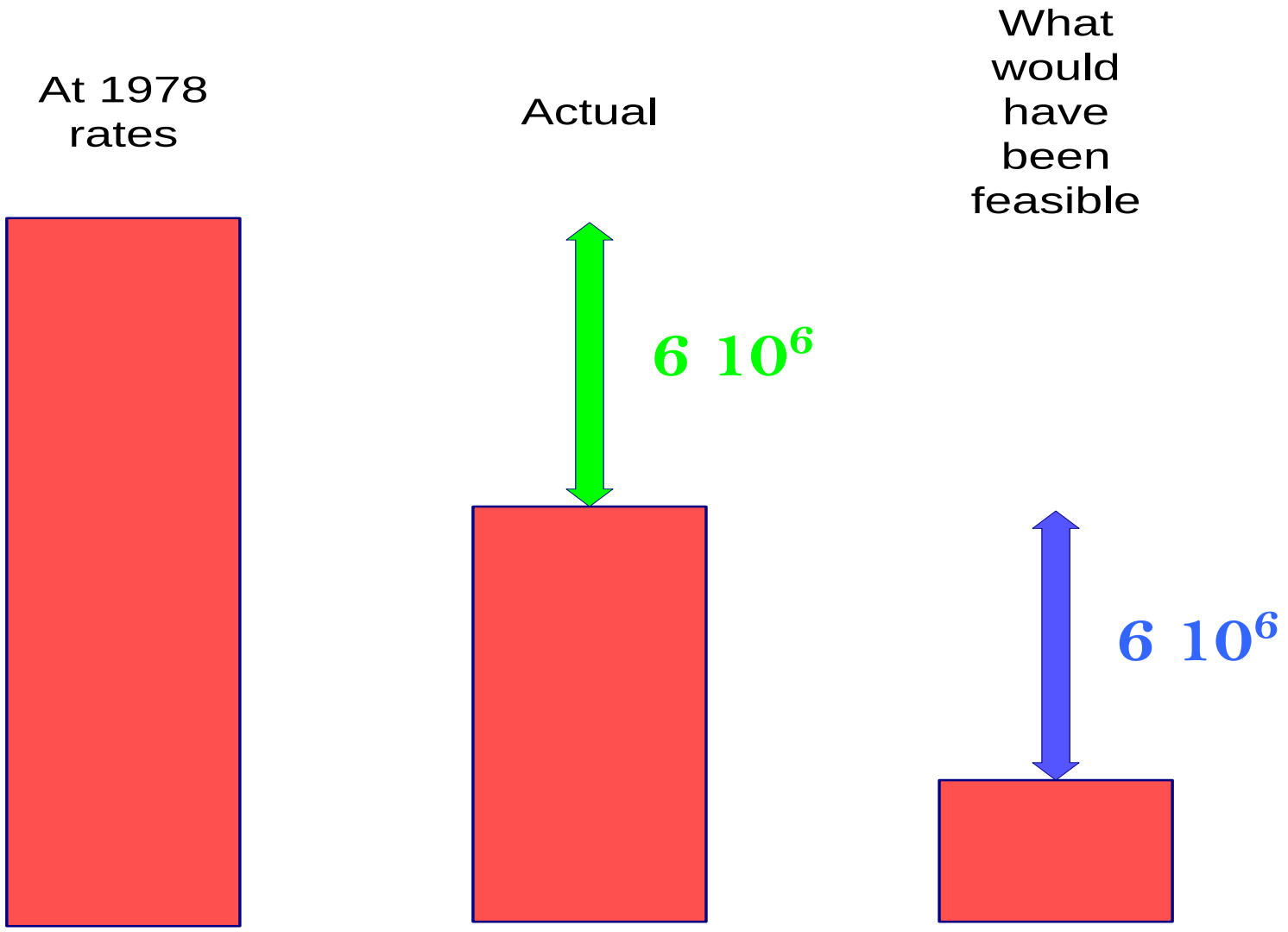
▲Sustained commitment and investment





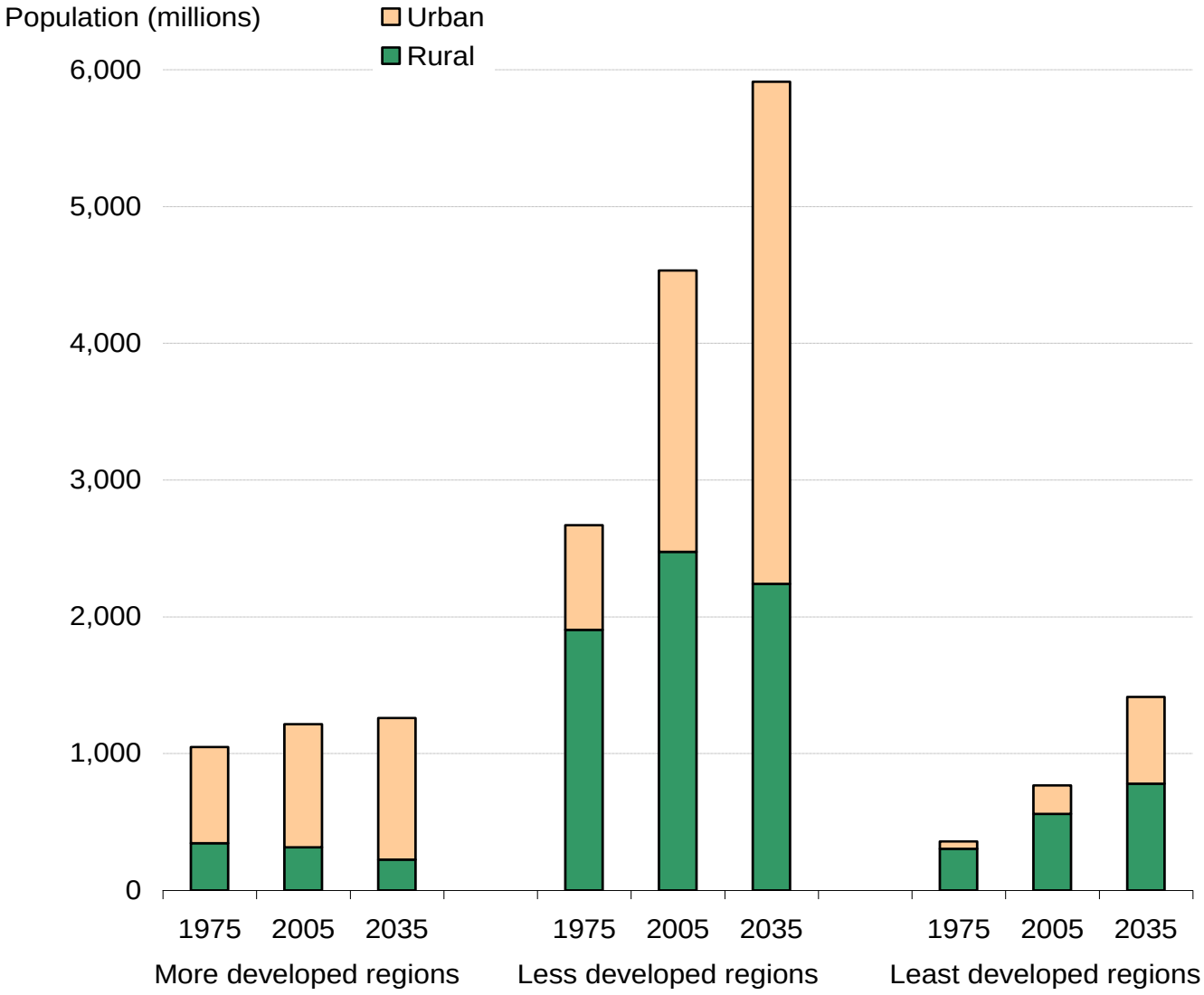
1. Uneven progress:

▲The world could have done better



2. New challenges:

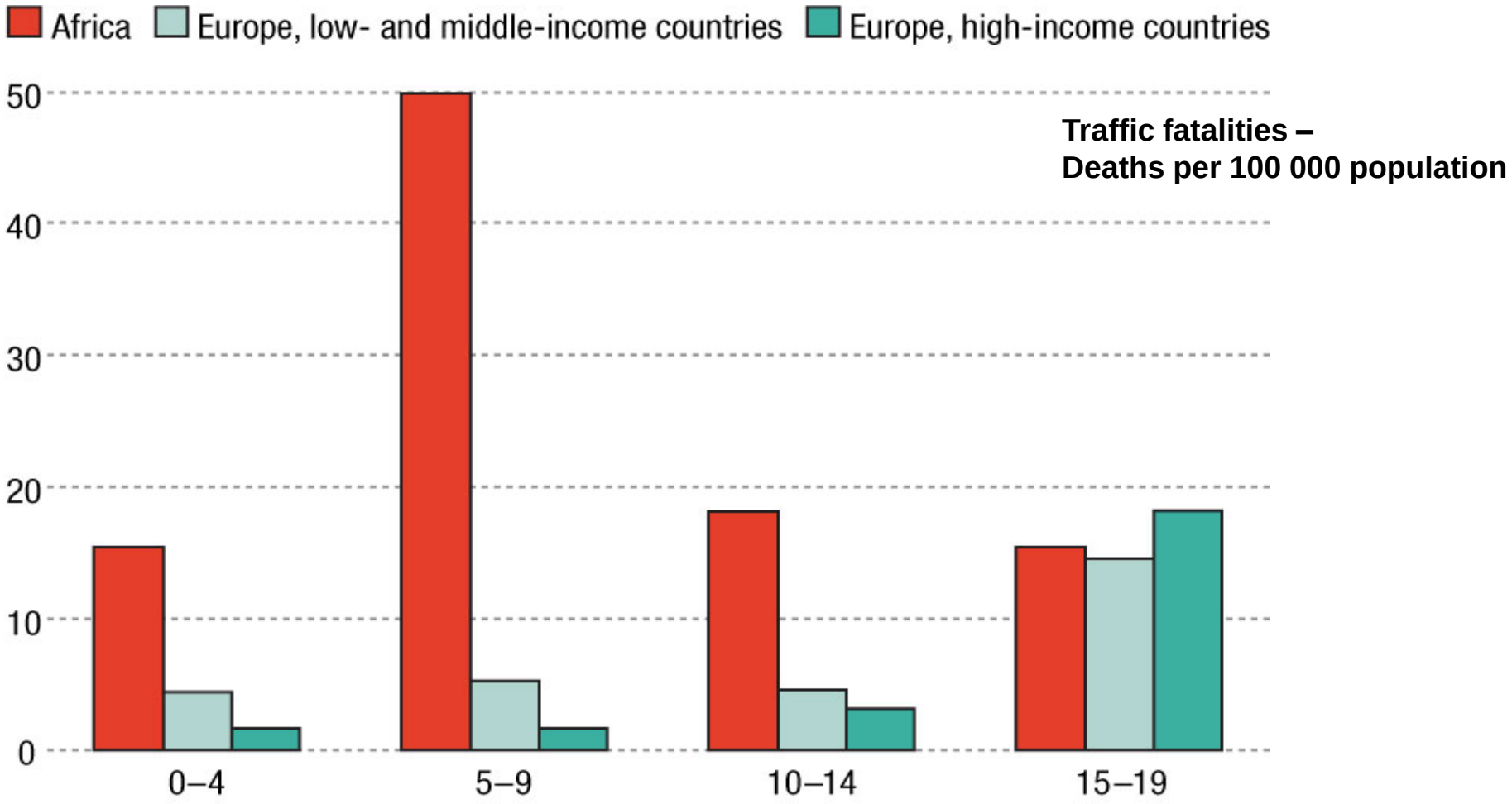
▲urbanization & globalization



Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Populati
Prospects: The 2006 Revision and World Urbanization Prospects: The 2007 Revision, http://esa.un.org/unup, September 14, 20

2. New challenges:

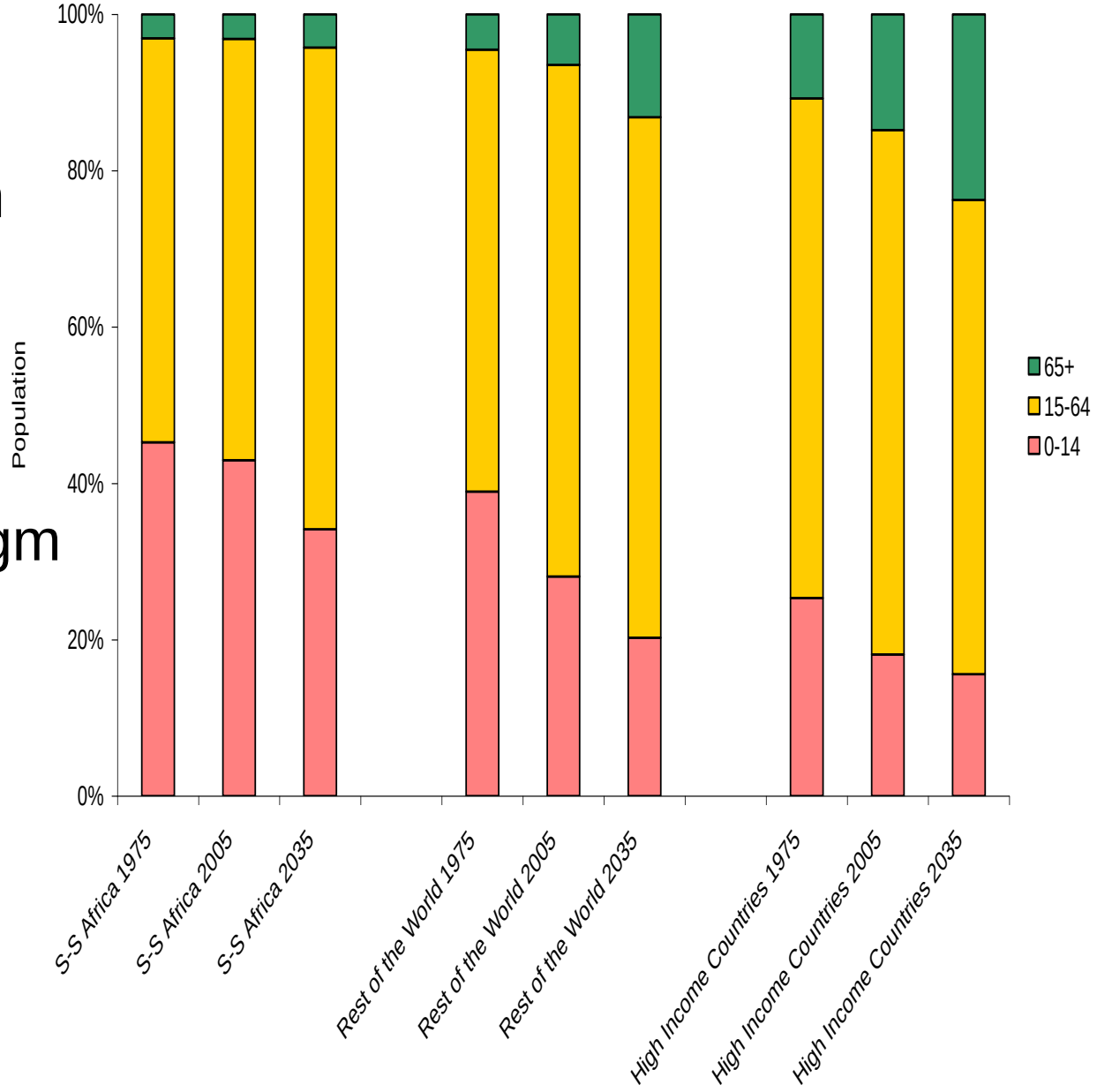
▲Changing behaviour, new risks



Traffic fatalities –
Deaths per 100 000 population

2. New challenges:
▲ageing

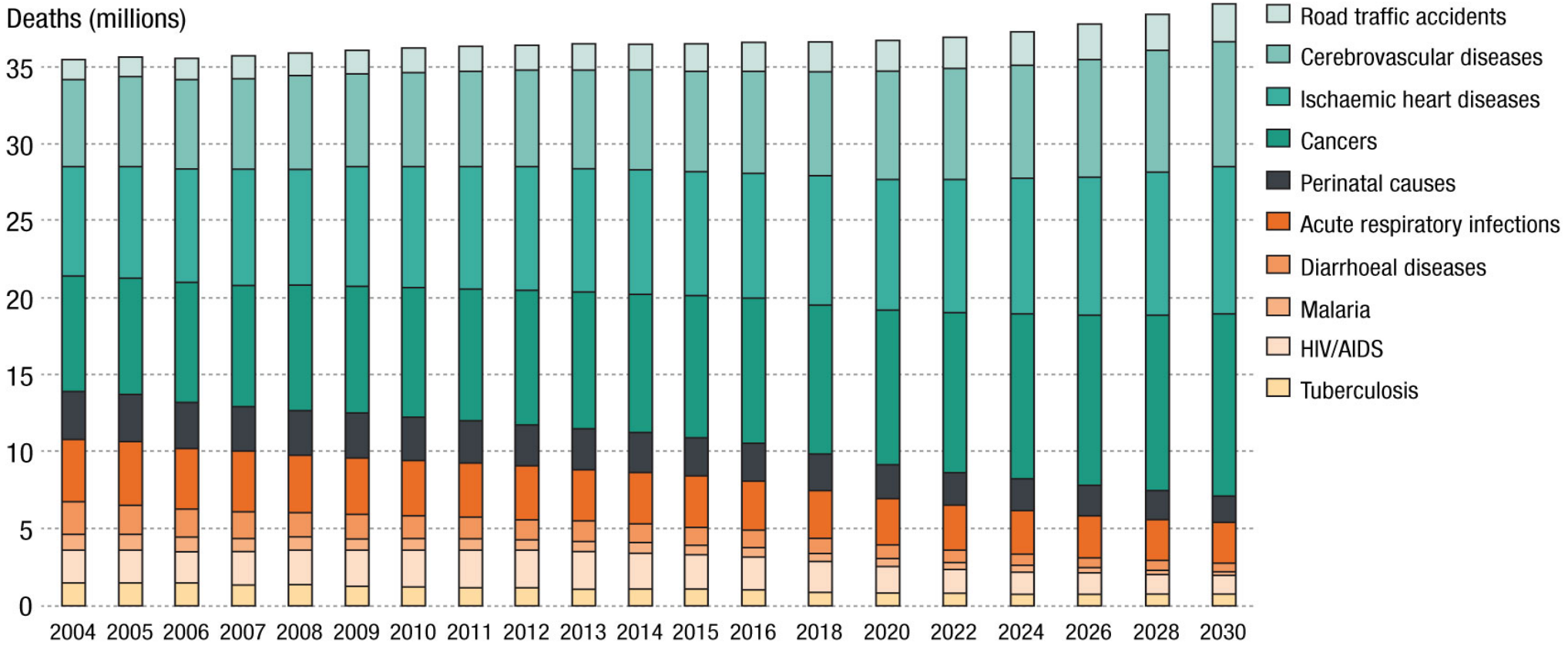
- Drives the demographic/ epidemiological transition
- Implications for
  - Human resources
  - Costs
  - The health care paradigm



2. New challenges:

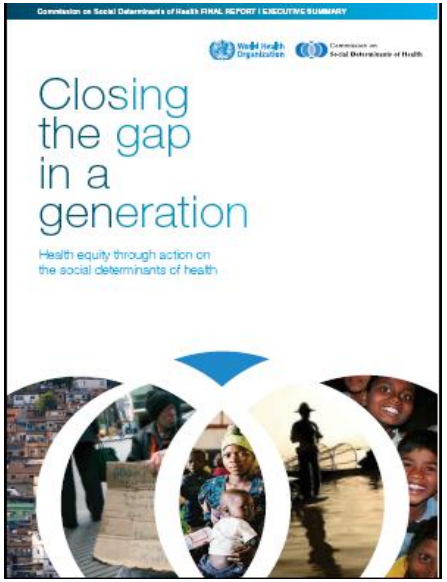
▲the shift towards chronic and non-communicable disease

▲multimorbidity



3. Inequalities

- In access
- In the way people are treated
- In financial burden
- In outcomes

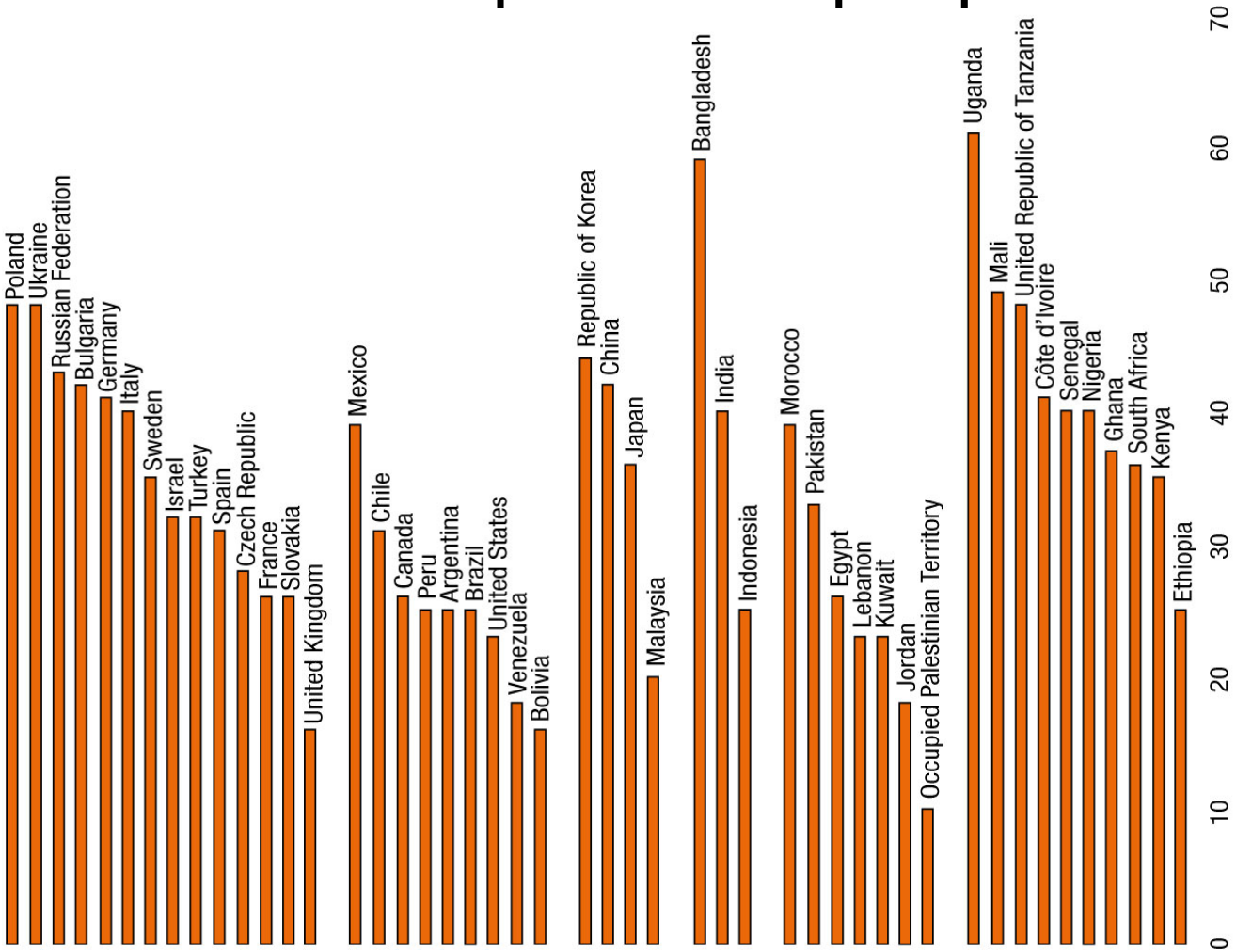


4. Growing dissatisfaction, rising expectations

- Alma Ata values are becoming mainstream expectations
- What citizens expect for themselves and their families
  - *Access to quality, people-centred care*
  - *Communities where health is promoted and protected*
- What citizens expect for their society
  - *Health equity, solidarity, social inclusion*
  - *Health authorities that can be relied on*
- Mismatch between expectations and performance is leading to a crisis in confidence

It's also about what people consider desirable

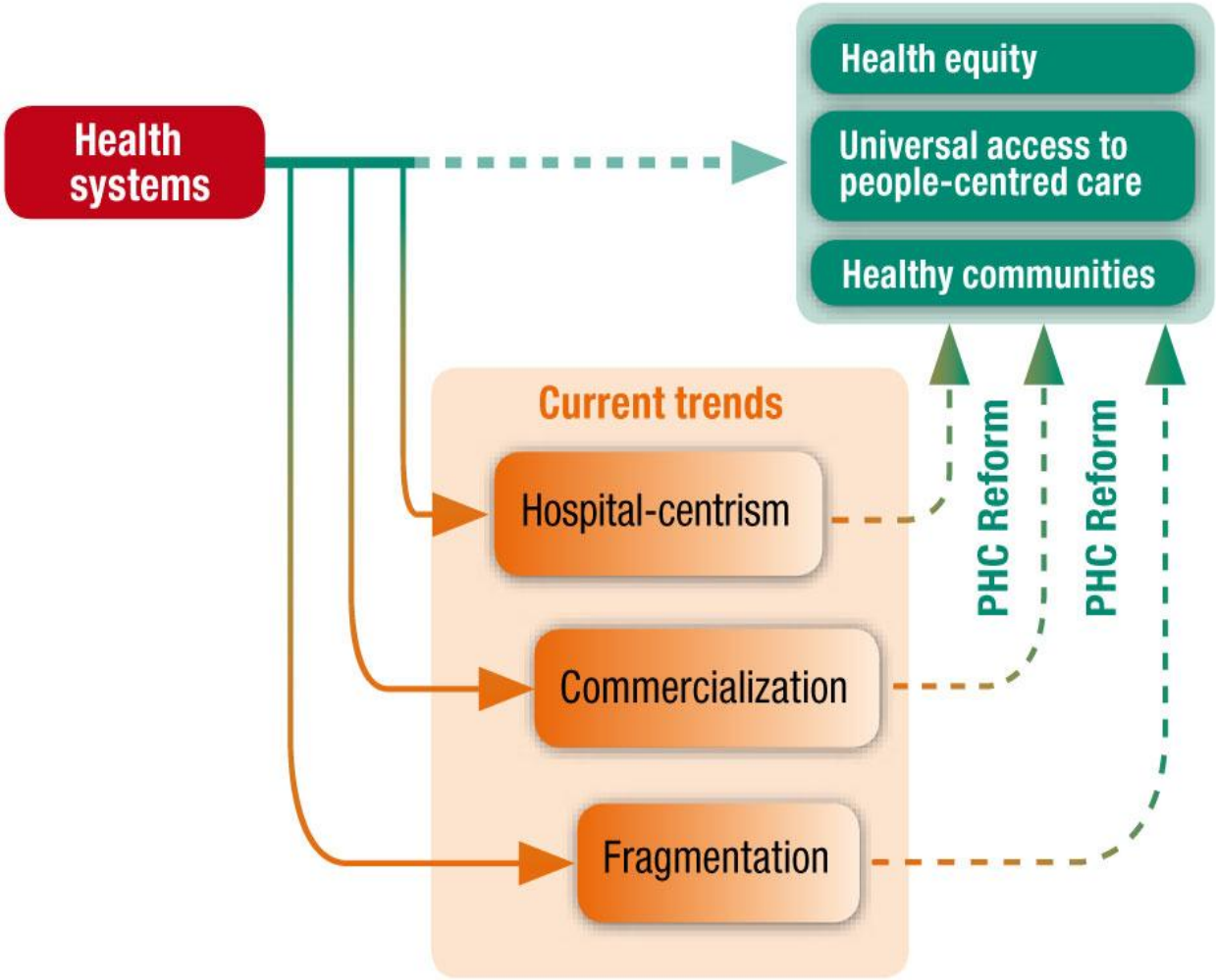
- Health is important to people



- Expectations grow:
  - Access & fairness
  - Quality of care
  - Protection against threats to health
  - Having a say in decisions
- Frustration grows
- New recognition of the need for leadership and steering

4. Growing dissatisfaction, rising expectations

- Current trends are worrying
- Health systems do not naturally gravitate towards
  - PHC values
  - Meeting social expectations
  - Value for money
- Growing demand on leadership for "PHC reforms"



Therefore, growing demand for a renaissance of PHC

- *A sense of direction for fragmented health systems*
- *Dealing with current and future challenges to health*

2. Four interlocking sets of PHC reforms

2.1. Service delivery reforms: the shift to primary care in order to put people at the centre

Public policy reforms

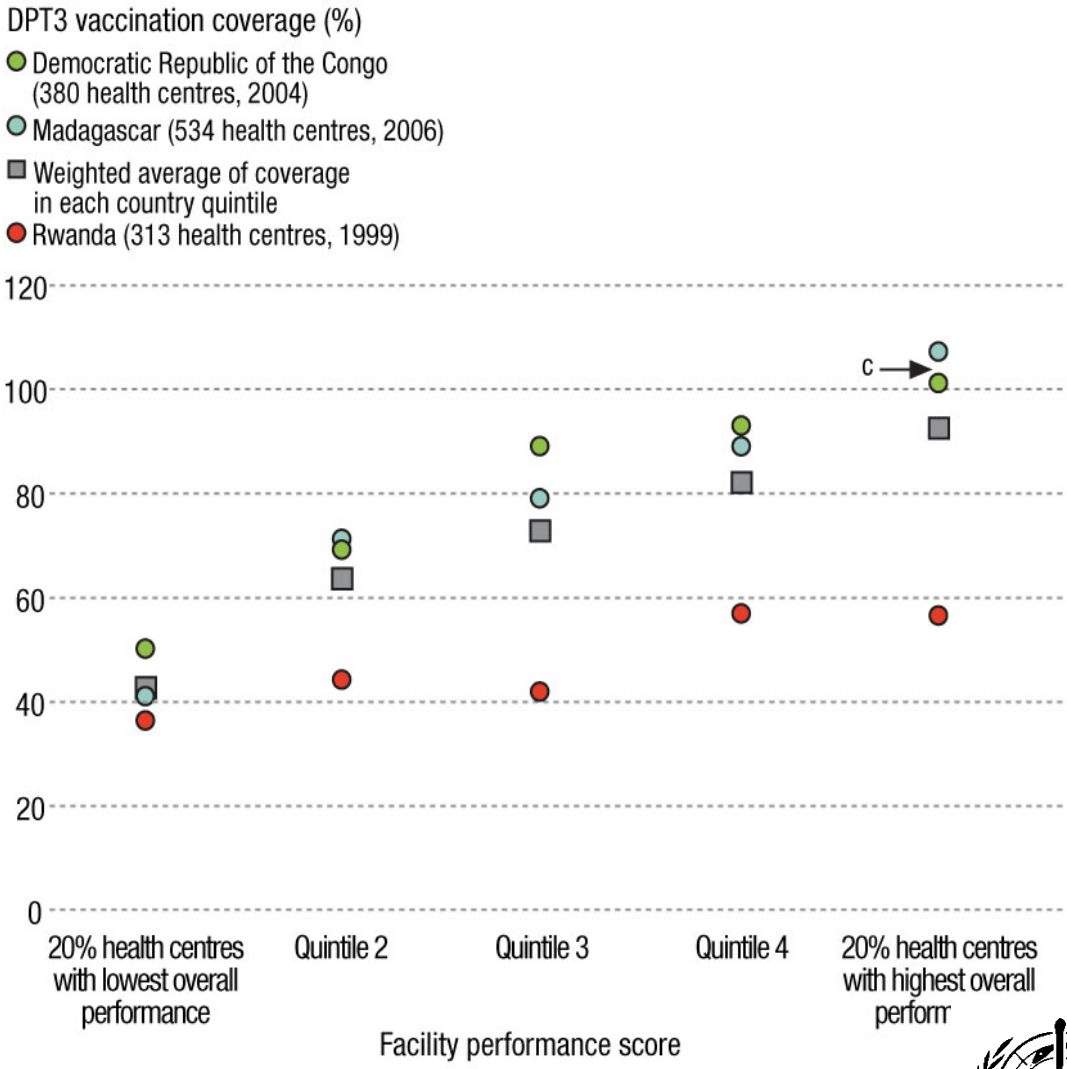
Universal coverage reforms

Leadership reforms

2.1 Service delivery reforms: the shift to primary care
a. four features of good care

1. Person-centeredness
2. Comprehensiveness and integration
3. Continuity of care
4. A personal relationship with well-identified, regular and trusted providers

- Makes the difference between primary care and conventional services
- Better satisfaction
- Better outcomes
- Better use of resources



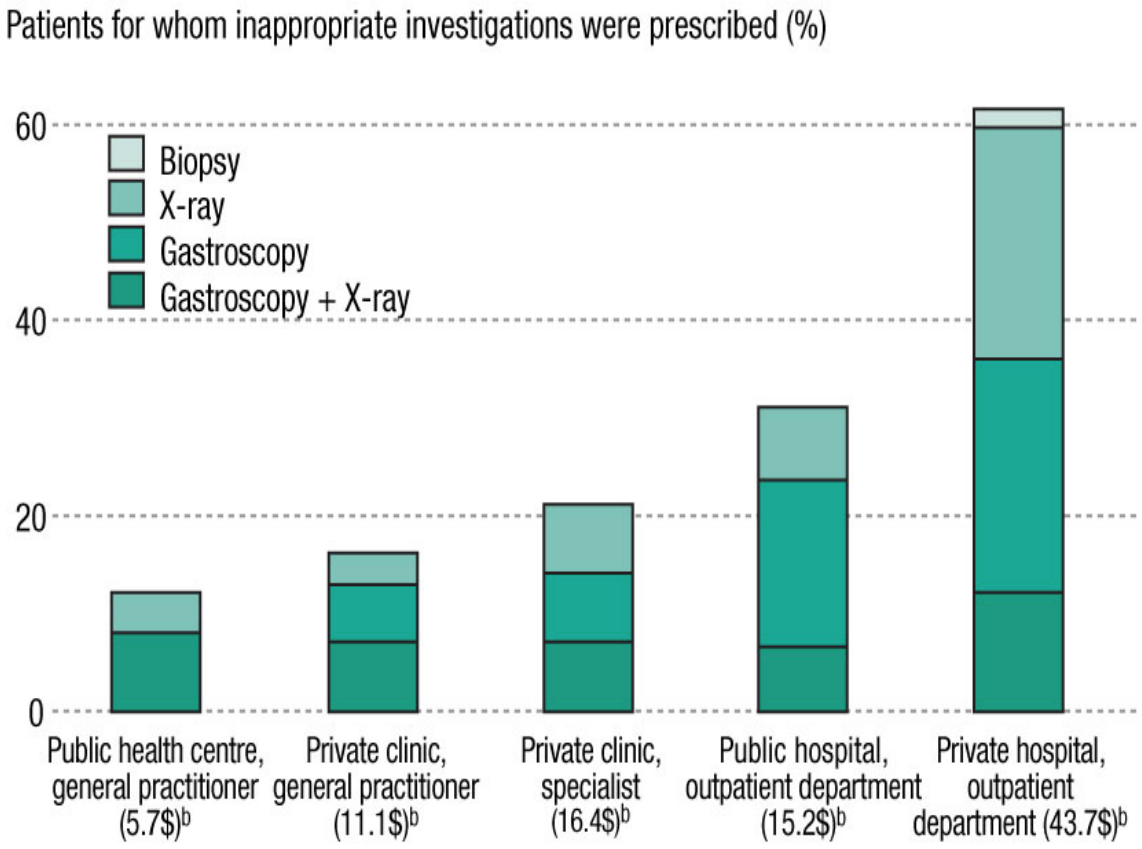
[a] Total 1227 health centres, covering a population of 16 million people.

[b] Vaccination coverage was not included in the assessment of overall health-centre performance across a range of services.

[c] Includes vaccination of children not belonging to target population.

2.1 Service delivery reforms: the shift to primary care
b. three organizational conditions

- Shifting the entry point: bringing care closer to the people
  - Relocate the entry point from hospital to generalist ambulatory services
  - Dense networks of small-scale, close-to-client service delivery points



[a] Observation made in 2000, before introduction of Thailand's universal coverage scheme.

[b] Cost to the patient, including doctor's fees, drugs, laboratory and technical investigations.

- Lower cost, less harmful, as effective, and with greater patient satisfaction

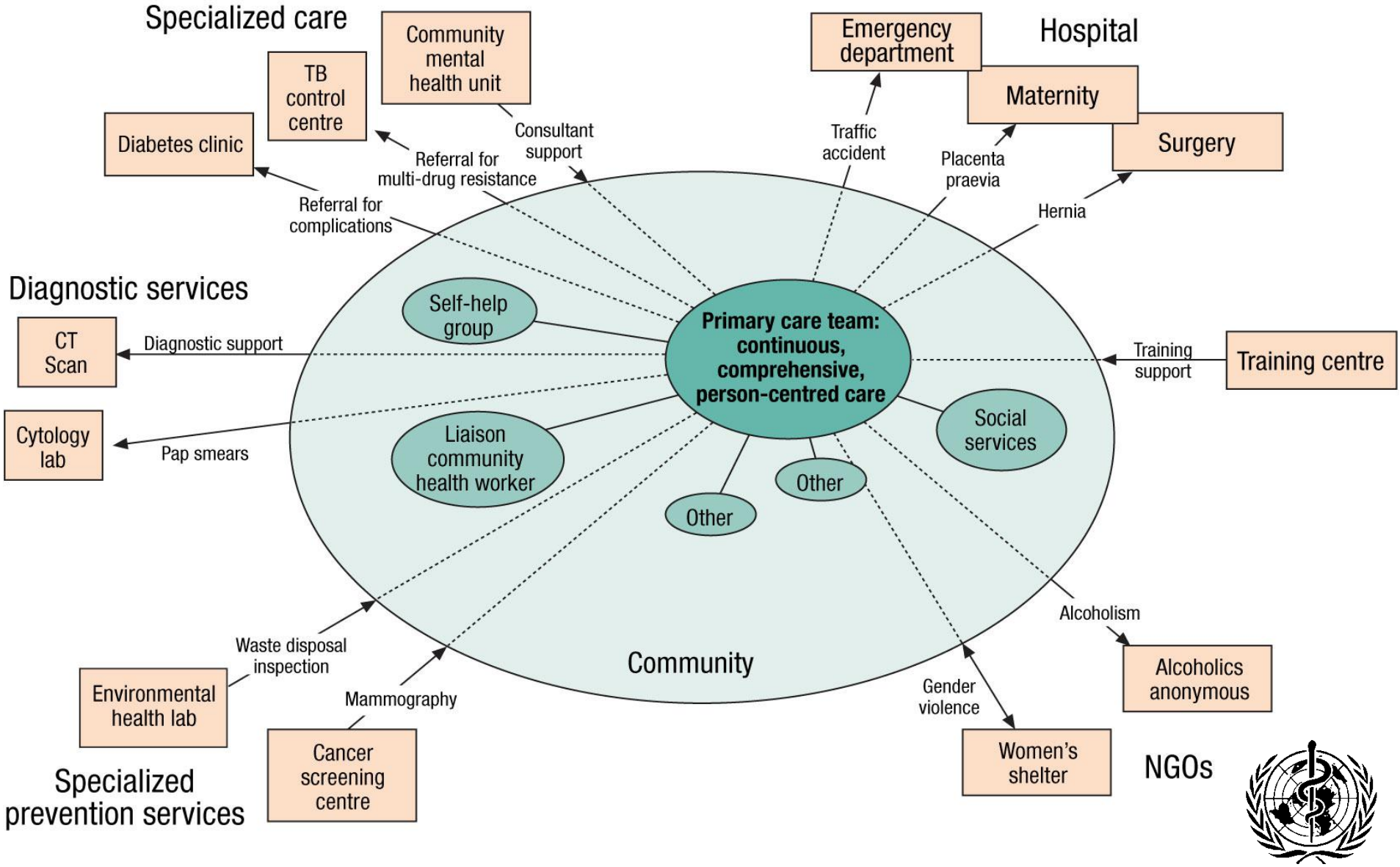
2.1 Service delivery reforms: the shift to primary care
b. three organizational conditions (cntnd)

- Shifting accountability: responsibility for a well-identified population
  - Broadens the portfolio of the team
  - Forces the team out of the four walls of their consultation room
  - Makes it possible to reach the unreached

  - Makes it possible to implement features of primary care
  - Better preparedness (eg heat wave)
  - Better uptake of services and programmes
  - Better outcomes (eg. Neonatal mortality: 60% drop in USA, 29% drop in Nepal)

2.1 Service delivery reforms: the shift to primary care

b. three organizational conditions (cntnd)



2. Four interlocking sets of PHC reforms

Service delivery reforms

2.2. Public policy reforms to secure the public's health

Universal coverage reforms

Leadership reforms

2.2 Better public policies to ensure the health of the public

- To address health systems constraints:
  - Aligning the HS building blocks to UC & PC

- To adress determinants of ill health:
  - Rehabilitate public health measures
  - Health in all policies, across government

2. Four interlocking sets of PHC reforms

Service delivery reforms

Public policy reforms

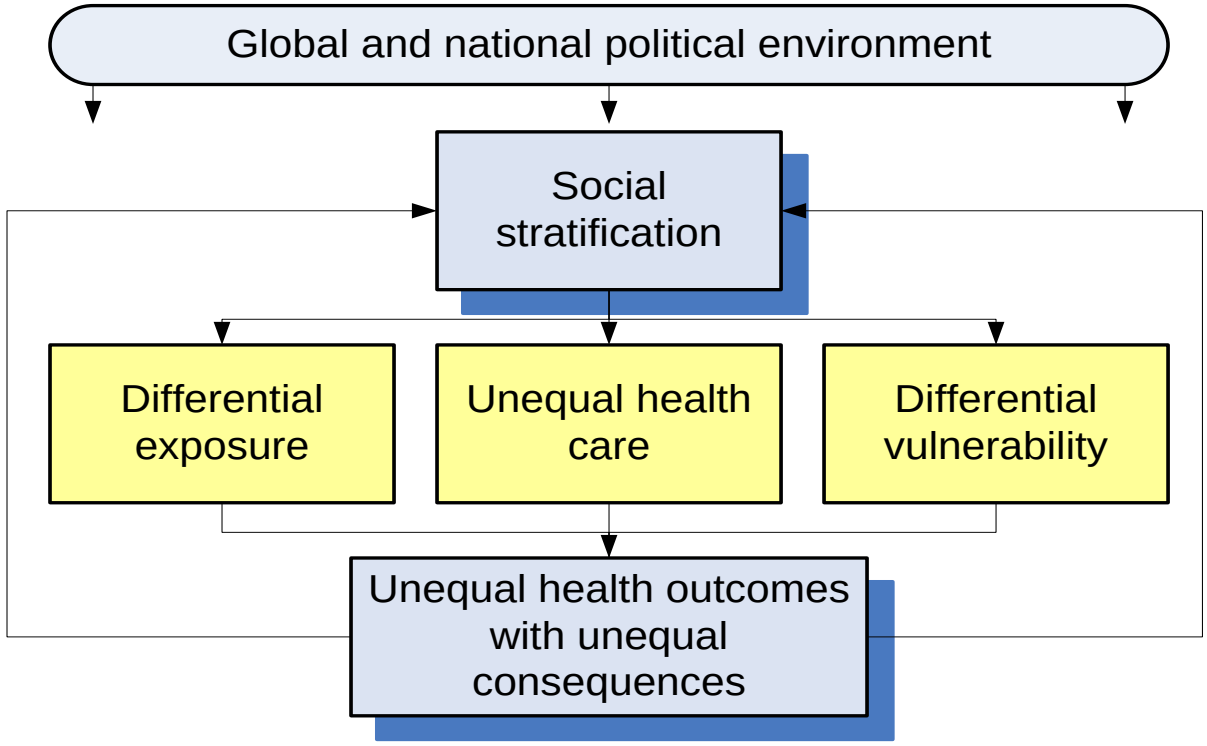
2.3. Universal coverage reforms: the health equity agenda

Leadership reforms

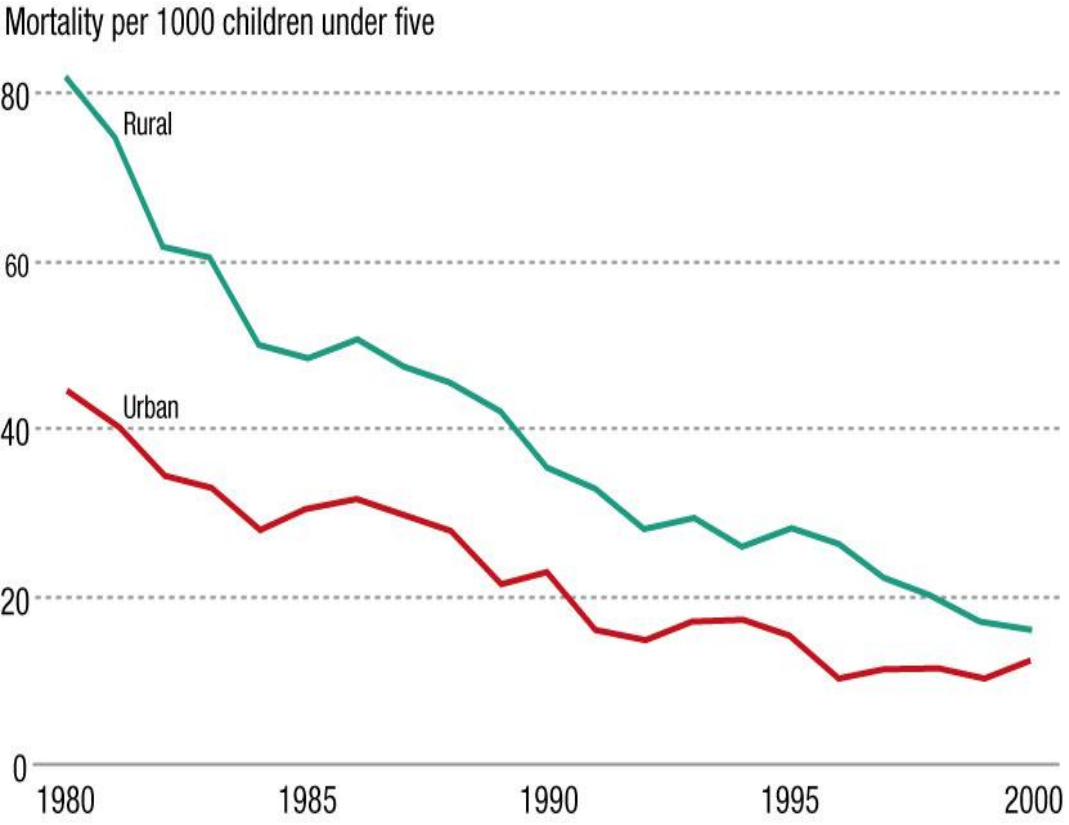
2.3 "Go without treatment or loose the farm" : universal coverage reforms

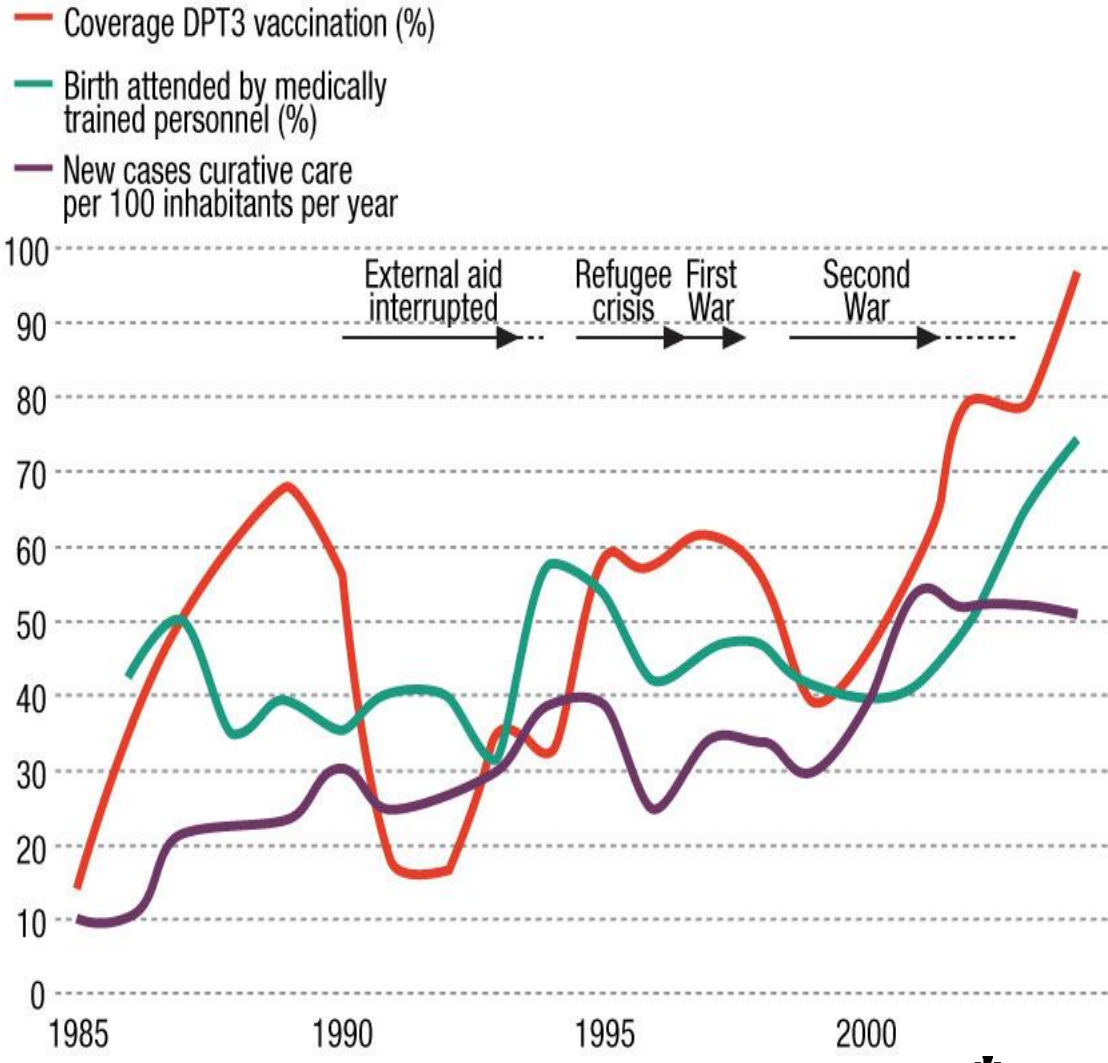
Address health inequalities:

- Mobilize beyond the health sector
- Reform the health sector itself: universal access + social protection

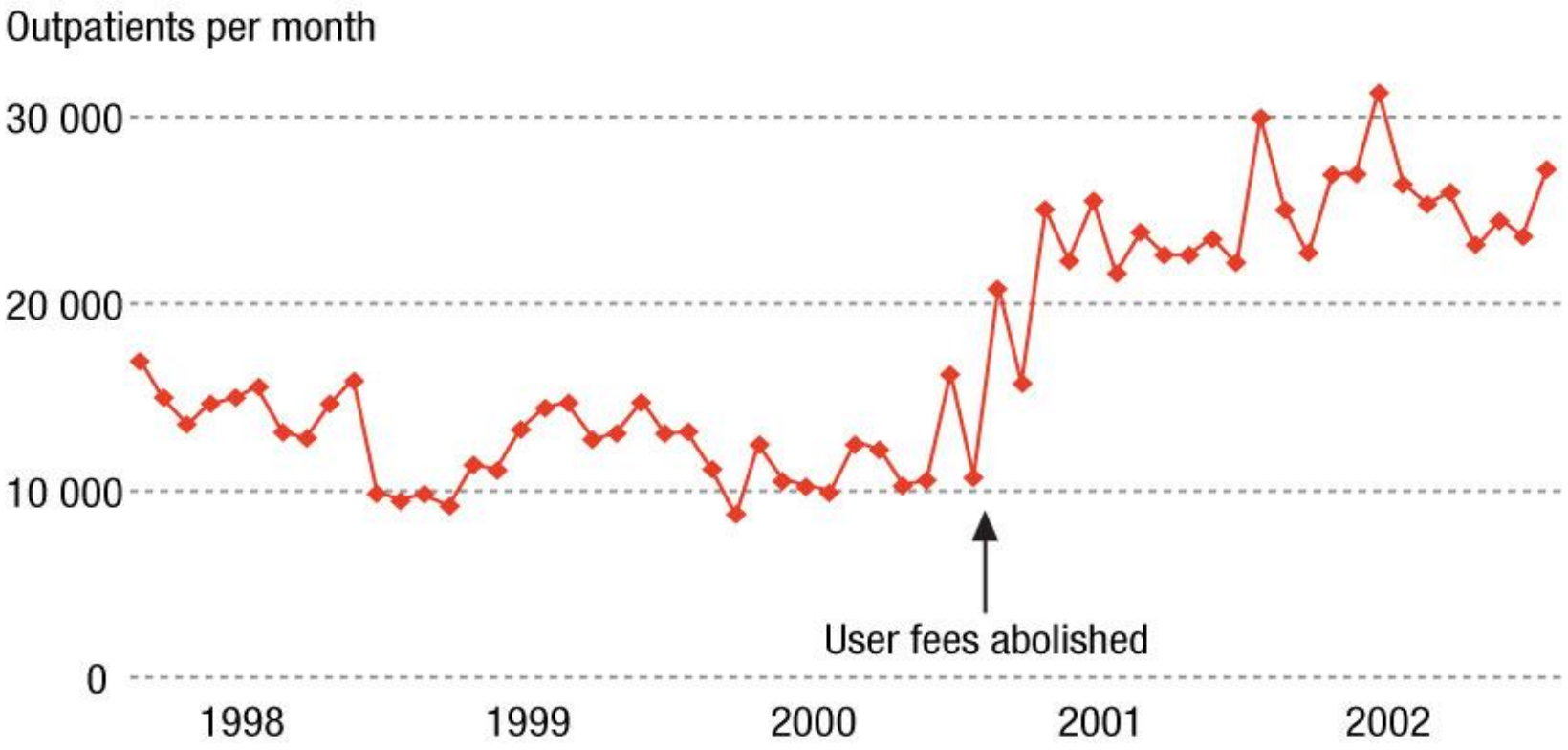


2.3 Universal coverage reforms:
a. Universal access: filling the availability gap



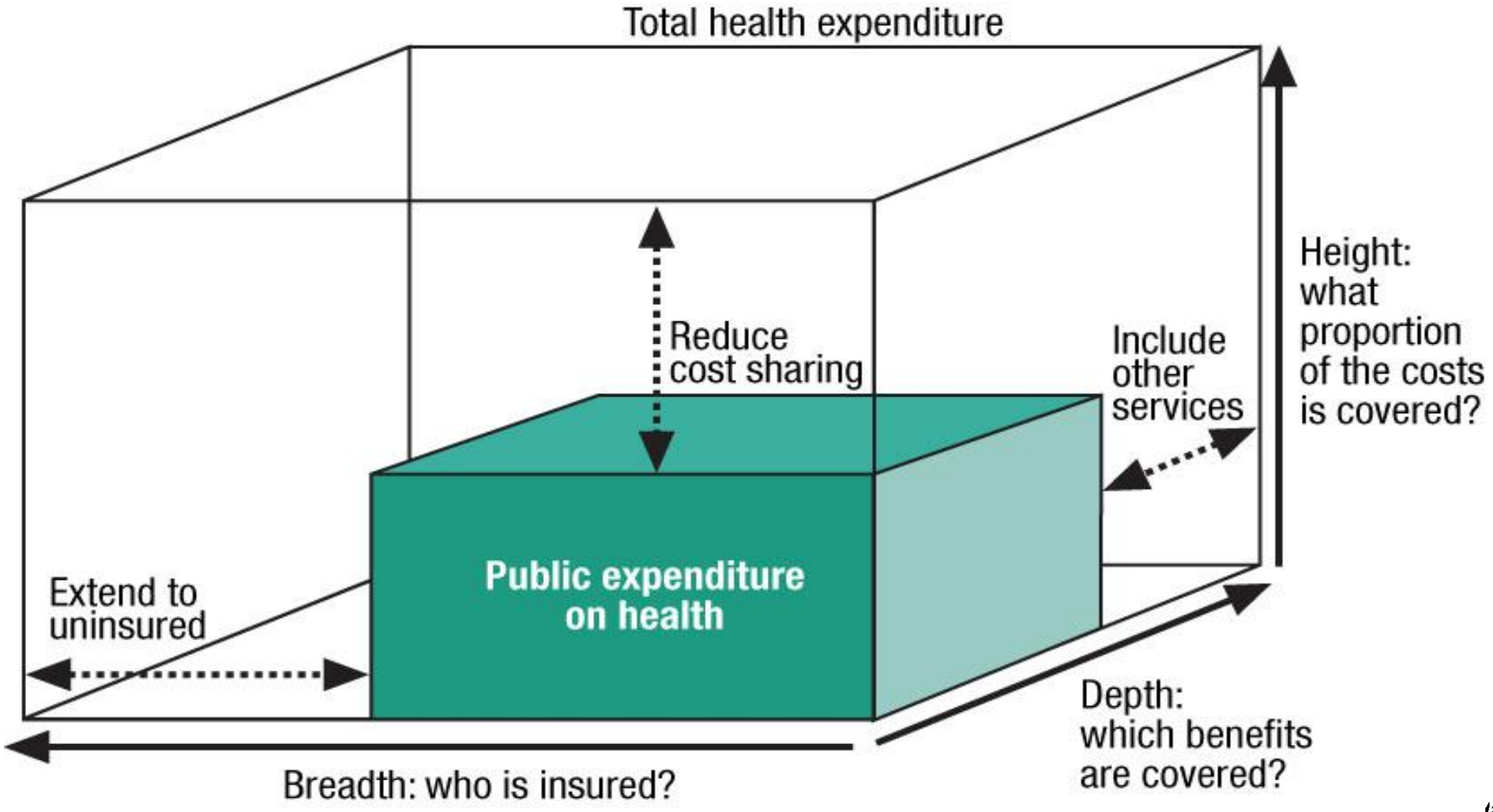


2.3 Universal coverage reforms:
b. from out-of-pocket payment to solidarity and pooling



2.3 Universal coverage reforms:

b. from "oop" payment to solidarity and pooling



[from Busse *et al*, 2007]

2.3 Universal coverage reforms: c. beyond financial protection

- Giving visibility to health inequities
- Tackling unregulated commercial care
  - Provide alternatives
  - Harness peer- and consumer-pressure to enable regulation
- Reaching the unreached: targeted interventions for the excluded

2. Four interlocking sets of PHC reforms

Service delivery reforms

Public policy reforms

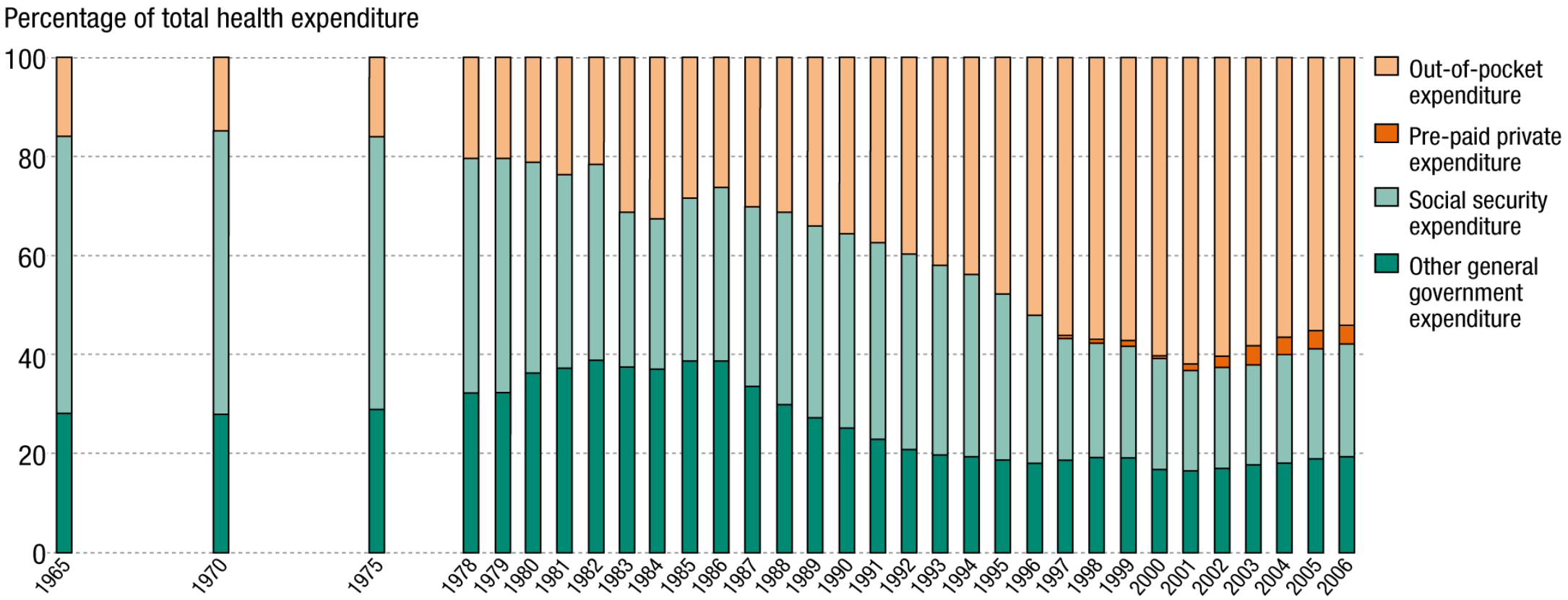
Universal coverage reforms

2.4. Leadership reforms: inclusive leadership and better government

2.4. Inclusive leadership and better government

- Governments as brokers for PHC reform
- Effective policy dialogue
- Managing the political process from launching the reform to implementing it
  examples: DRC, Rwanda

2.4. Inclusive leadership, effective government



Sources: 1965 to 1975; 1978 to 1994; 1995 to 2006.

2.4. Inclusive leadership, effective government

Paradigm changes:

- The value of activist government
- Reinvest in leadership and government capacity health sector
- From command-and-control to steer-and-negotiate
- Do more with less, but prepare to do more with more
- From technocratic to civil society driven pressure

3. As a conclusion, which way forward?

Between country specificity and global drivers...

3.1 Adapting reforms to country contexts

- High-expenditure health economies
- Rapid-growth health economies
- Low-expenditure, low-growth health economies
  example: a virtuous cycle in Mali

3.2 Mobilizing the drivers of reform

- Aid effectiveness and systemic financing mechanisms
  - ➲ IHP+
- Mobilizing the commitment of the workforce
- Mobilizing the participation of people
- Mobilizing the production of knowledge
  - ➲ performance - accountability