The WHR 2008

Bringing Primary Health Care Back To Business

Denis Porignon

WHO/HQ - Health Systems and Services Cluster

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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.*

- *The PHC movement puts particular emphasis on four areas of strategic importance to deal with current and future challenges to health:*

  - *Addressing health inequalities*

  - *People-centered care*

  - *Better public policies*

  - *Stronger leadership*

How experience has shifted the focus of PHC

Early attempts at PHC

A basic package for the rural poor

Mother and child focus

Acute, infectious, diseases

Healthy local environment

Scarcity and downsizing

Government, top-down services

Bilateral aid, technical assistance

First level care, not hospitals

PHC is cheap

Current concerns of PHC Reforms

Universal access, comprehensive services

All disadvantaged groups

Health risks, illness across life course

Healthy global and local environments

Managing growth to universal coverage

Public/private mixed health systems

Global solidarity, joint learning

Coordinated referral to appropriate care

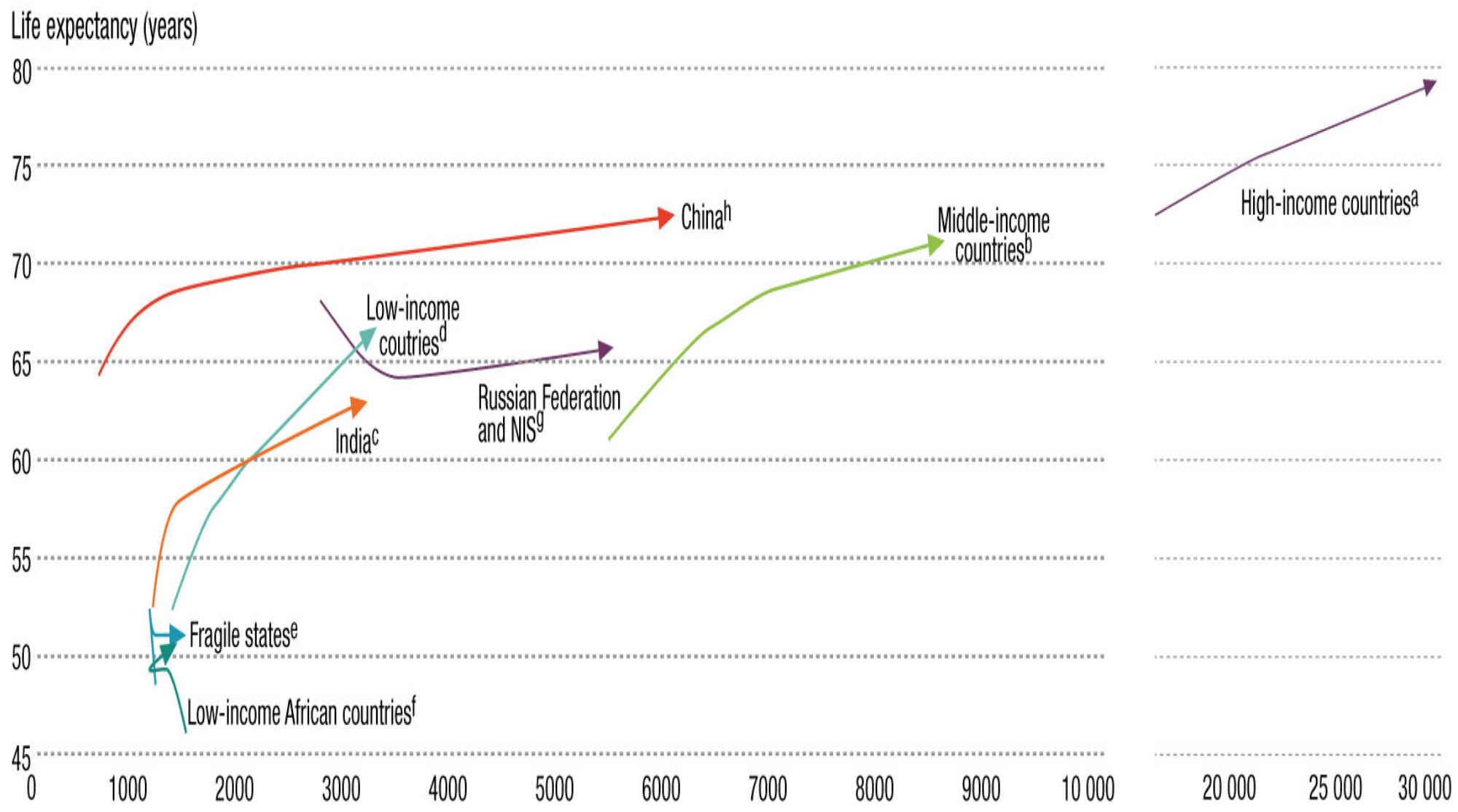PHC is not cheap, but good value for money

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

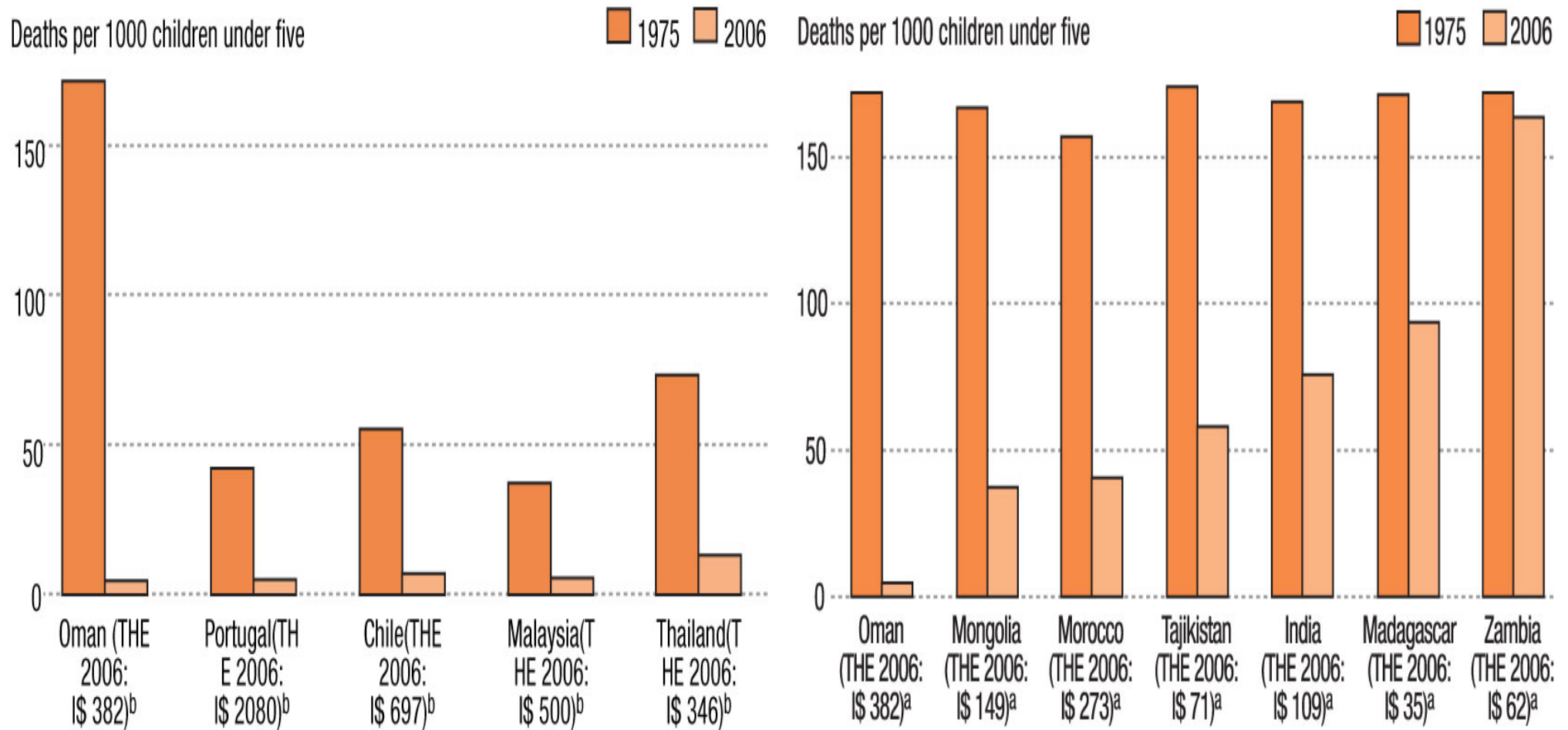 ➤ Within-country inequalties

  ➤ Borrowing, asset depletion, poverty

1. Uneven progress: wealth and health
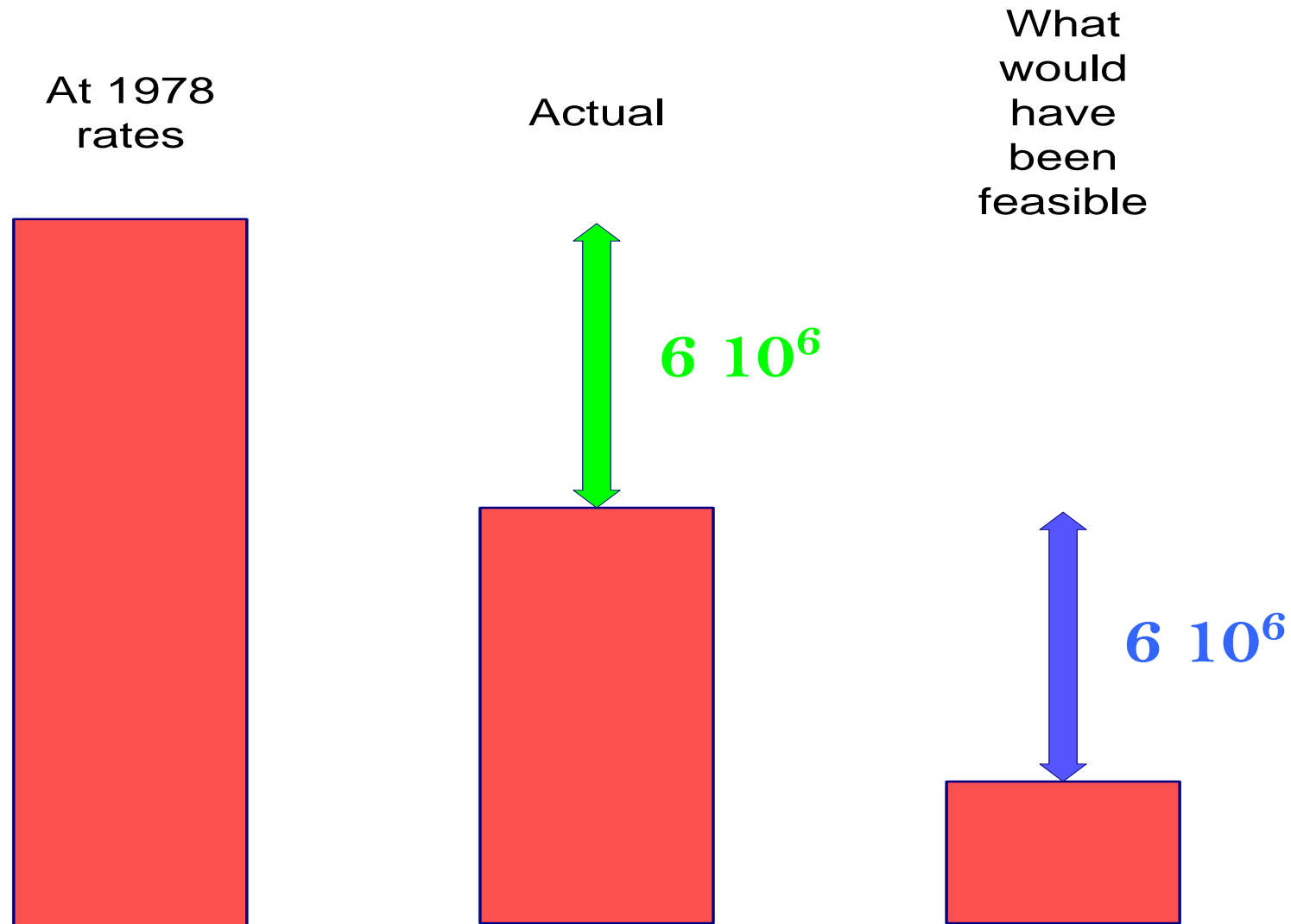## ▲ GDP growth is necessary but not sufficient

Life expectancy (years)

Labels within the figure: China[h], Middle-income countries[b], High-income countries[a], Low-income countries[d], Russian Federation and NIS[g], India[c], Fragile states[e], Low-income African countries[f]

1. Uneven progress:
▲ Sustained commitment and investment

Deaths per 1000 children under five   ■ 1975 □ 2006

- Oman (THE 2006: I$ 382)[b]
- Portugal(THE 2006: I$ 2080)[b]
- Chile(THE 2006: I$ 697)[b]
- Malaysia(THE 2006: I$ 500)[b]
- Thailand(THE 2006: I$ 346)[b]

Deaths per 1000 children under five   ■ 1975 □ 2006

- Oman (THE 2006: I$ 382)[a]
- Mongolia (THE 2006: I$ 149)[a]
- Morocco (THE 2006: I$ 273)[a]
- Tajikistan (THE 2006: I$ 71)[a]
- India (THE 2006: I$ 109)[a]
- Madagascar (THE 2006: I$ 35)[a]
- Zambia (THE 2006: I$ 62)[a]

1. Uneven progress:
▲ The world could have done better

At 1978
rates

Actual

What
would
have
been
feasible

$6 \ 10^6$

$6 \ 10^6$

2. New challenges:
▲ urbanization & globalization
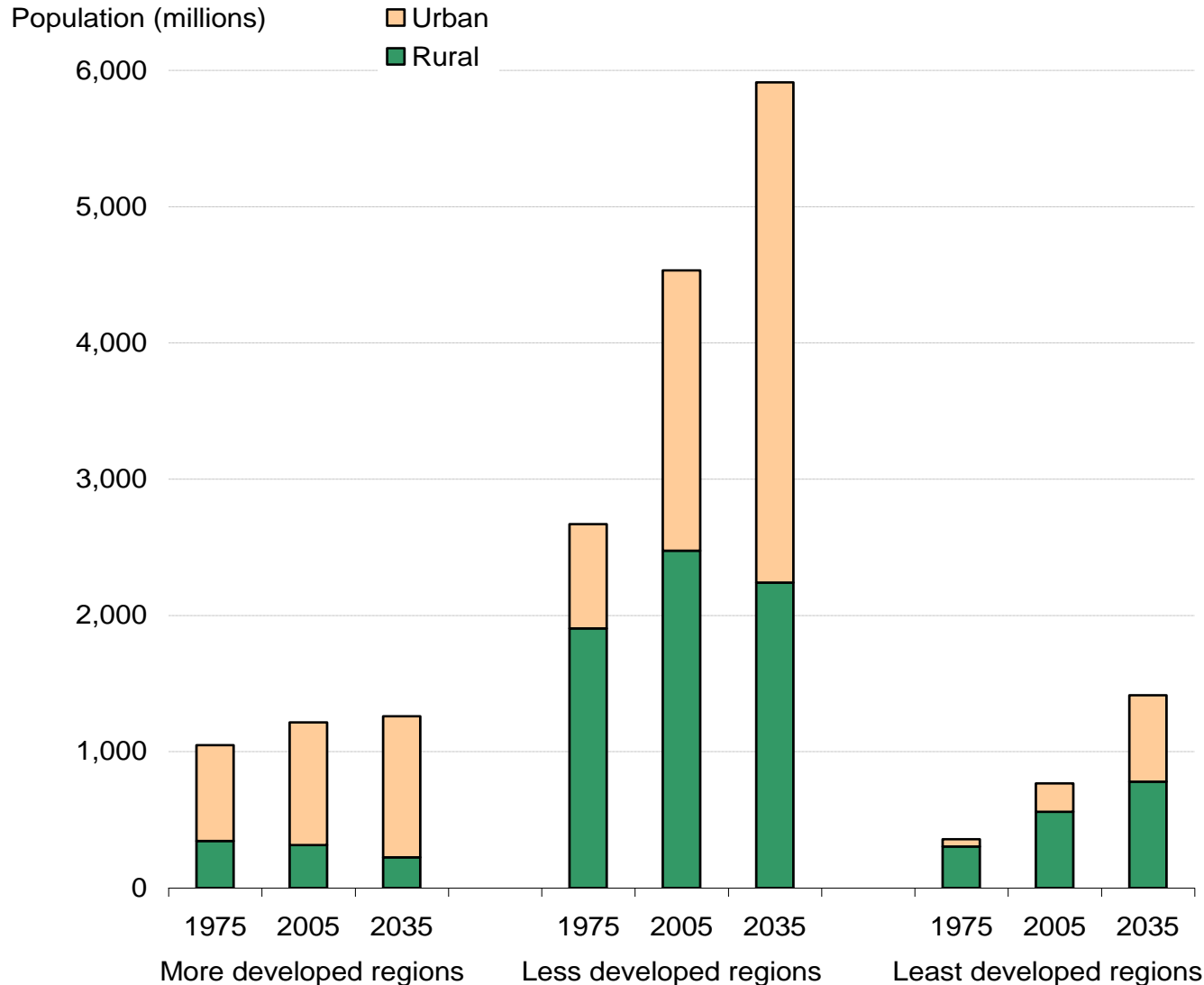
Population (millions)

◻ Urban
◻ Rural

More developed regions | Less developed regions | Least developed regions

2. New challenges:
▲ Changing behaviour, new risks

Africa ☐ Europe, low- and middle-income countries ☐ Europe, high-income countries

**Traffic fatalities –
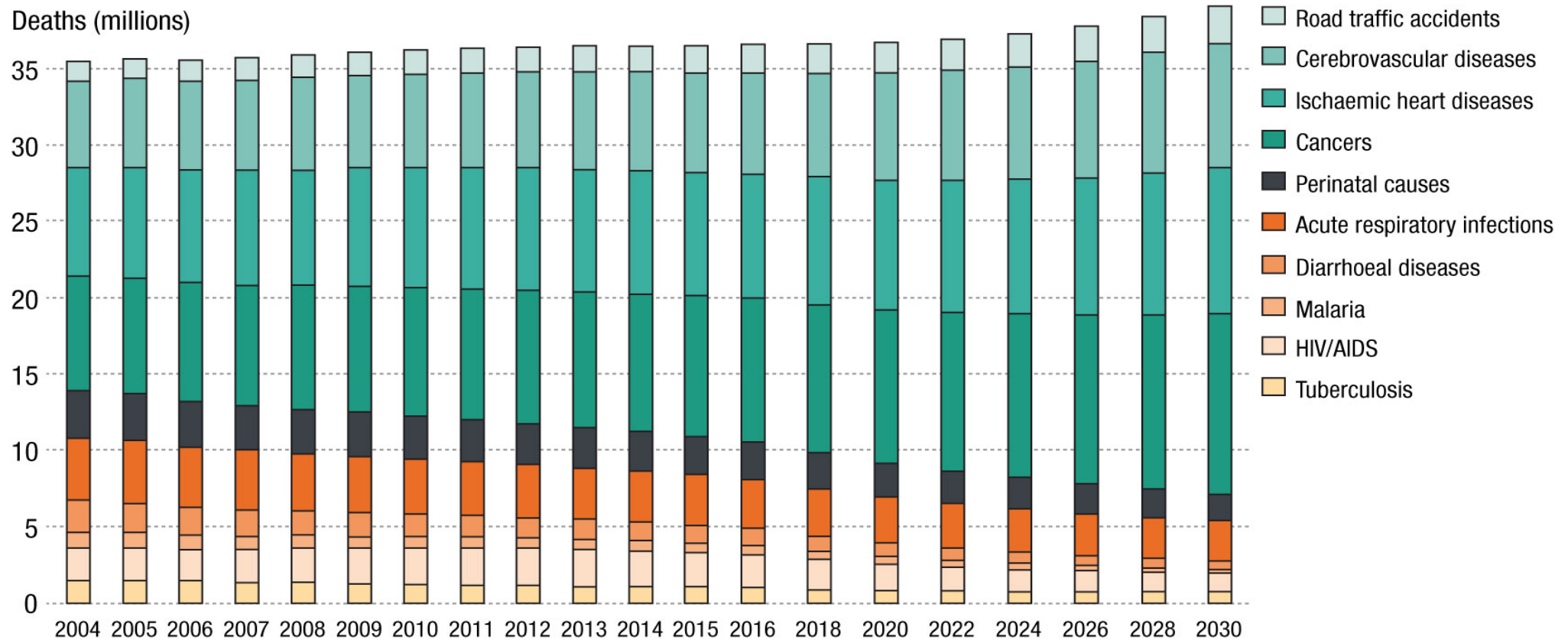Deaths per 100 000 population**
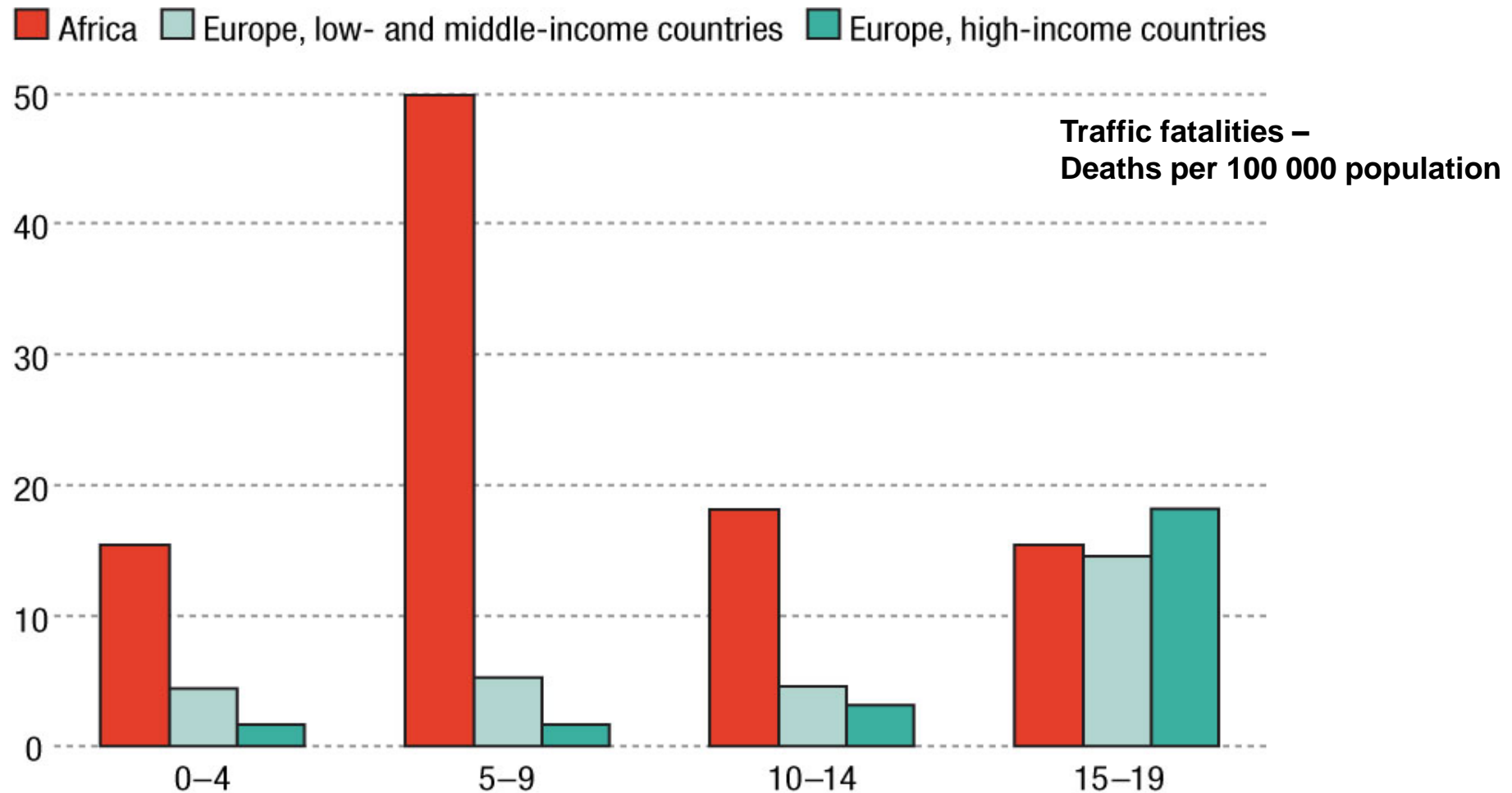
2. New challenges: ▲ageing

- Drives the demographic/ epidemiological transition
- Implications for
  - ➤ Human resources
  - ➤ Costs
  - ➤ The health care paradigm
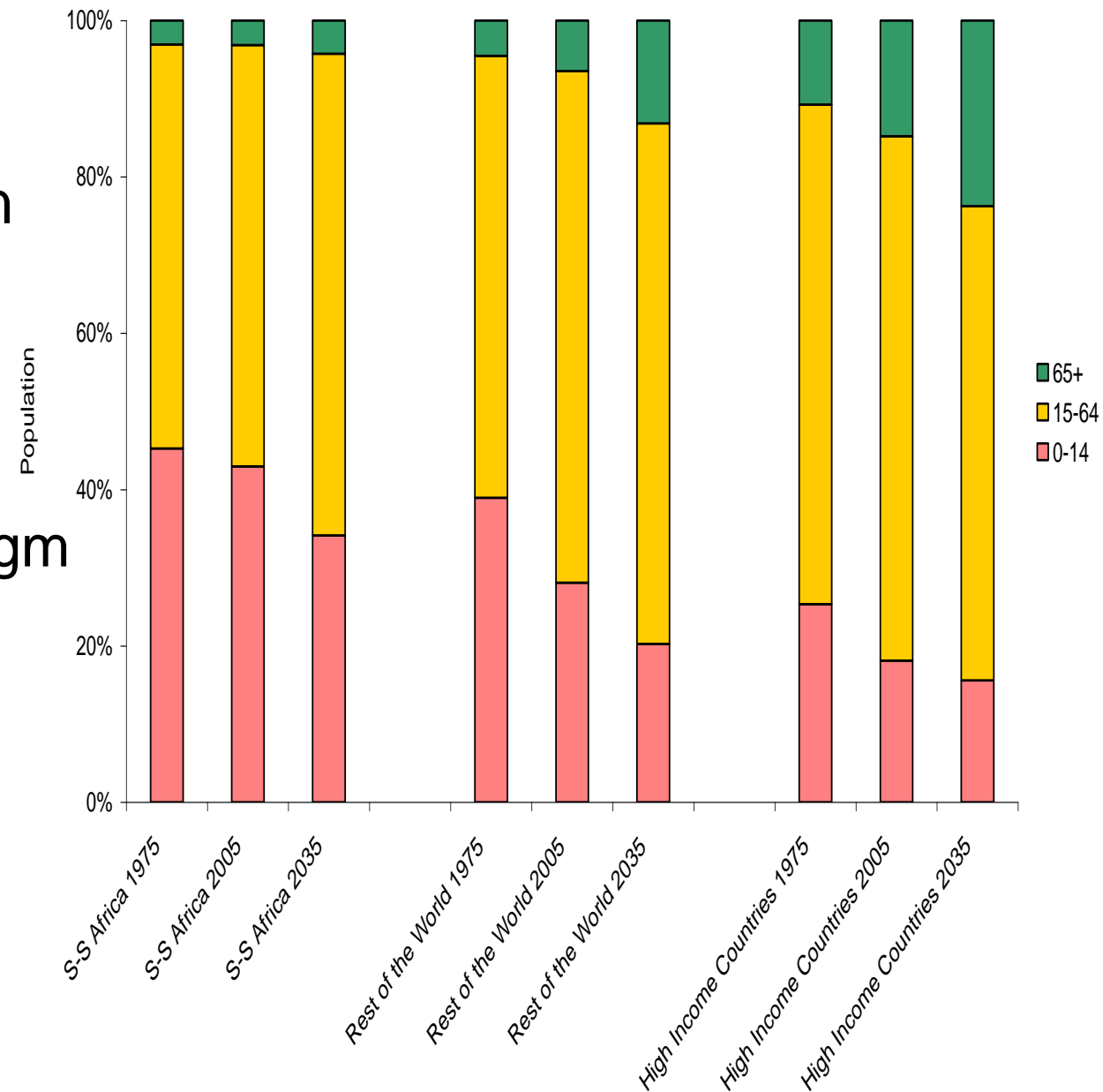
2. New challenges:
▲ the shift towards chronic and non-communicable disease
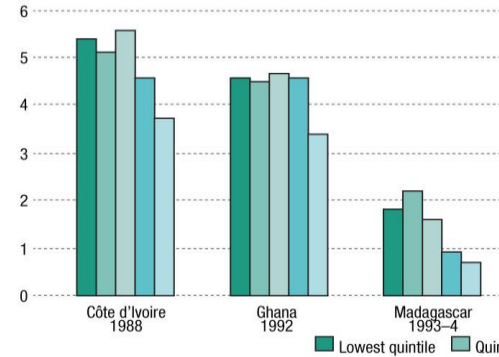## ▲ multimorbidity
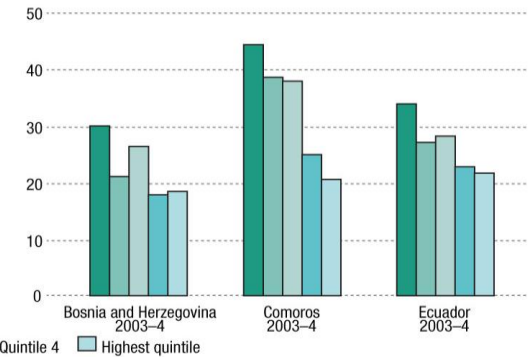
3. Inequalities

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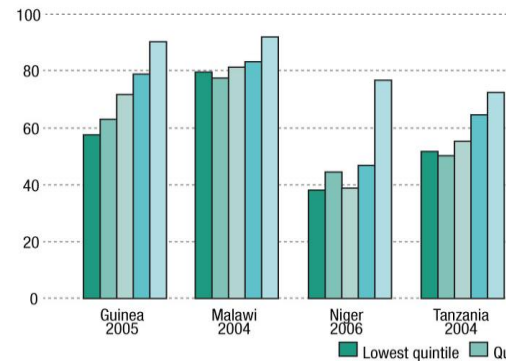- In financial burden
- In outcomes

Per capita household spending on health as percentage of total household spending, by income group
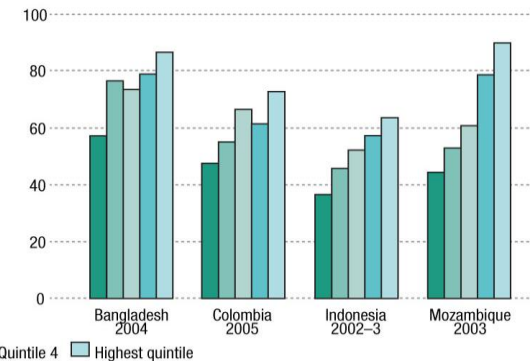
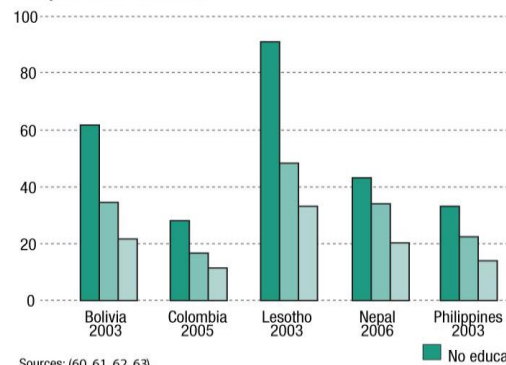Mean time (minutes) taken to reach an ambulatory health facility, by income group

Côte d'Ivoire 1988 / Ghana 1992 / Madagascar 1993–4

Bosnia and Herzegovina 2003–4 / Comoros 2003–4 / Ecuador 2003–4

Lowest quintile / Quintile 2 / Quintile 3 / Quintile 4 / Highest quintile

Women using malaria prophylaxis (%), by income group

Full basic immunization coverage (%), by income group

Guinea 2005 / Malawi 2004 / Niger 2006 / Tanzania 2004

Bangladesh 2004 / Colombia 2005 / Indonesia 2002–3 / Mozambique 2003
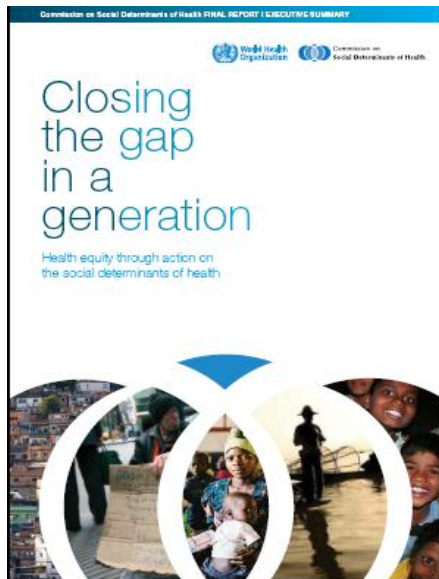
Lowest quintile / Quintile 2 / Quintile 3 / Quintile 4 / Highest quintile

Neonatal mortality rate, by education of mother

Births attended by health professional (%), by education of mother

Bolivia 2003 / Colombia 2005 / Lesotho 2003 / Nepal 2006 / Philippines 2003

Benin 2001 / Bolivia 2003 / Botswana 1998 / Cambodia 2005 / Peru 2000

No education / Primary education / Secondary or higher education
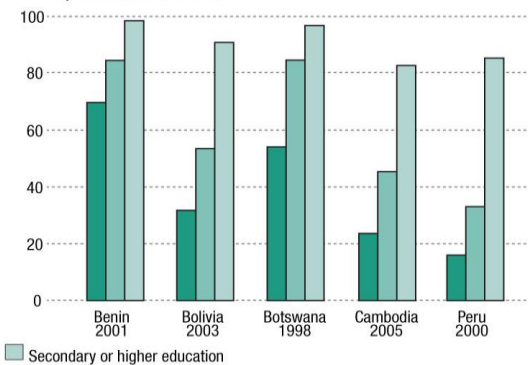
Sources: (60, 61, 62, 63).

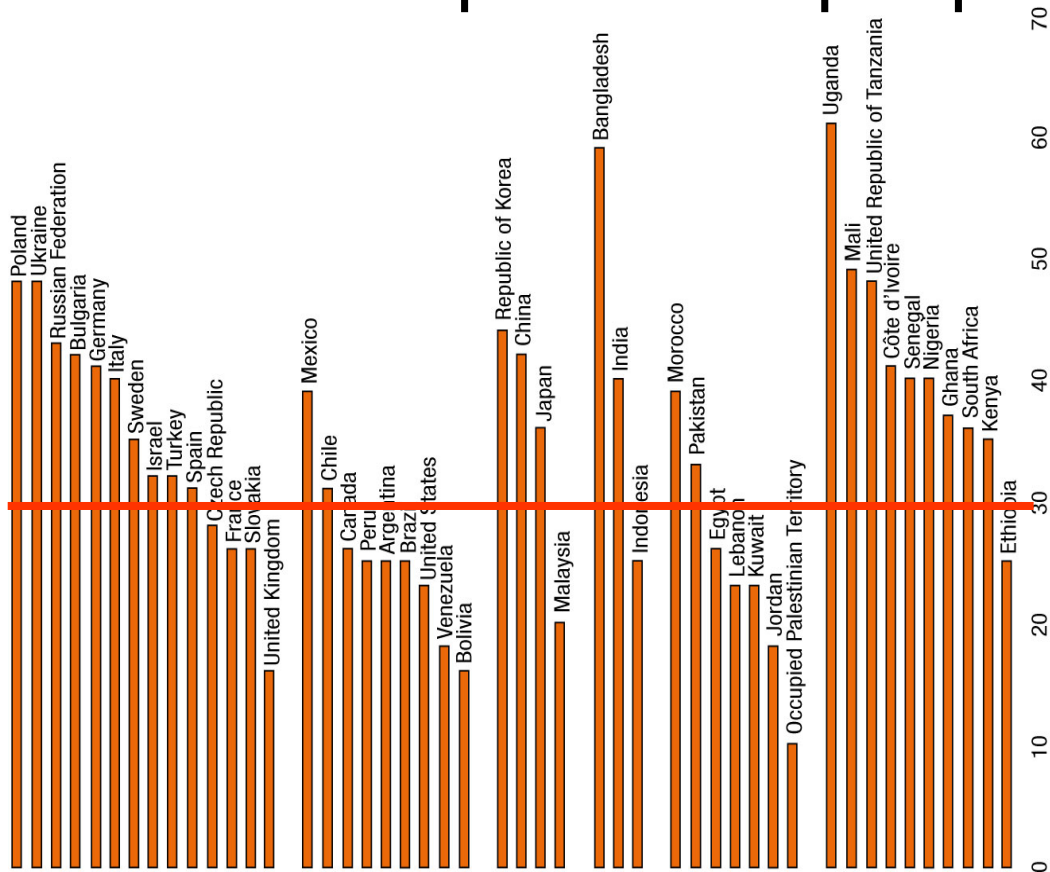# 4. Growing dissatisfaction, rising expectations

- 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
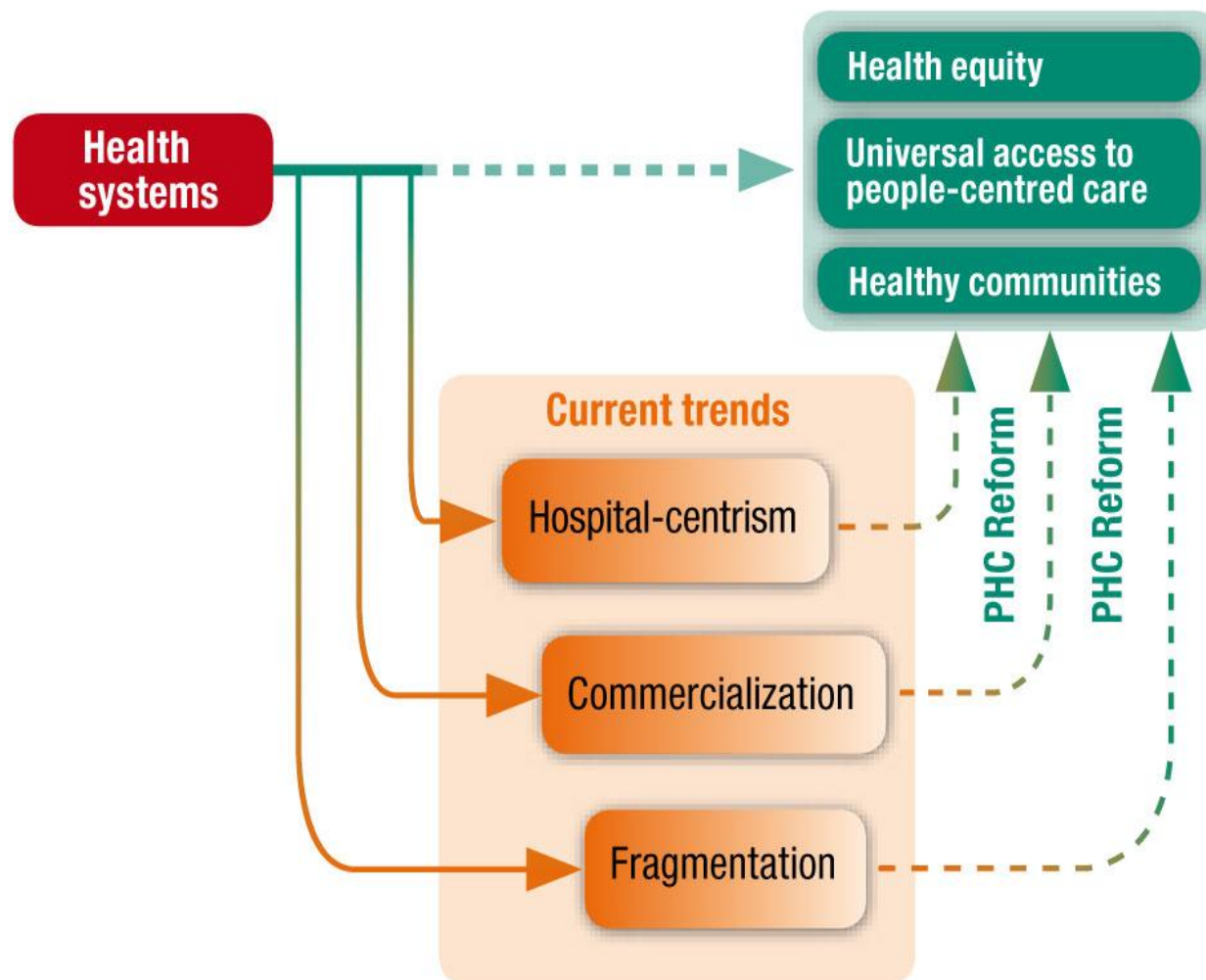 - ➤ Having a say in decisions

- 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

Health equity
Solidarity
Social inclusion

Universal coverage reforms
Chapter 2

People-centred care

Service delivery reforms
Chapter 3

Health authorities that can be relied on

Leadership reforms
Chapter 5

Communities where health is promoted and protected

Public policy reforms
Chapter 4

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

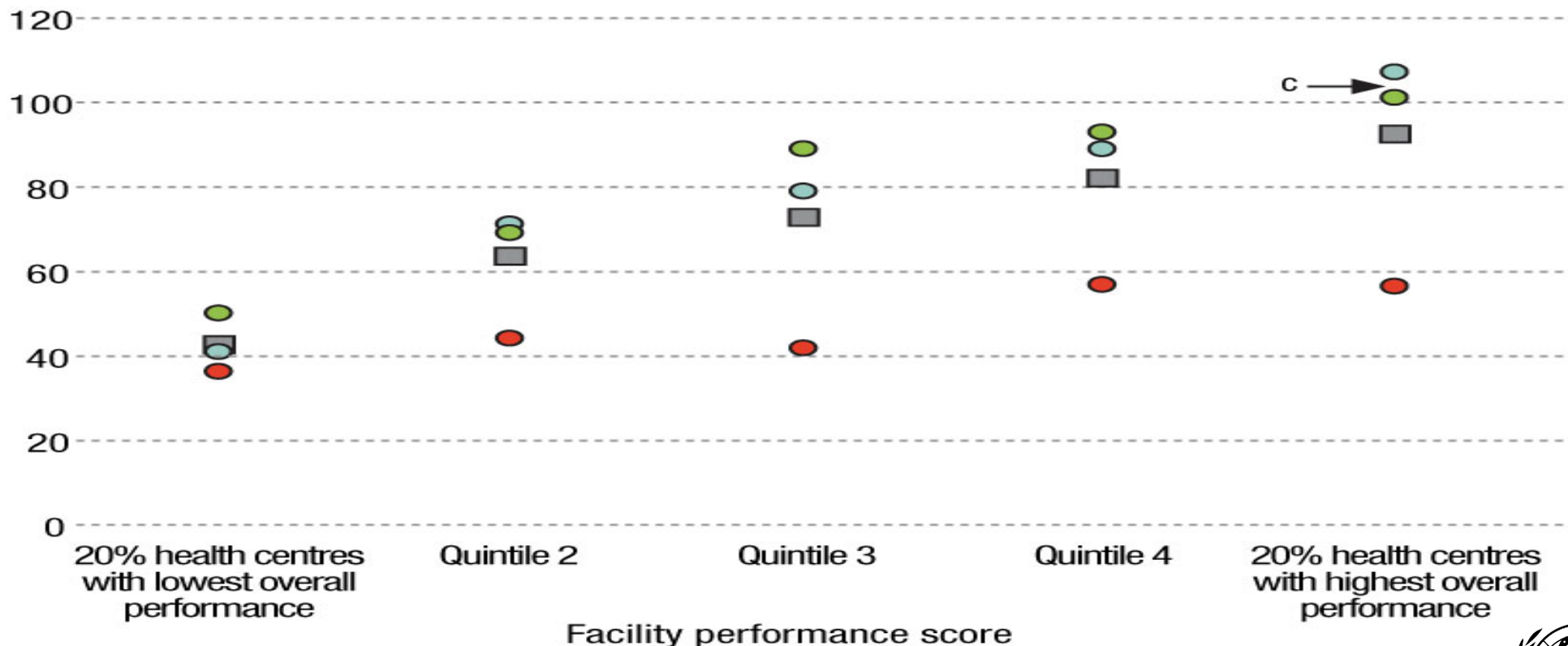Universal coverage reforms

Leadership reforms

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

DPT3 vaccination coverage (%)

- Democratic Republic of the Congo (380 health centres, 2004)
- Madagascar (534 health centres, 2006)
- Weighted average of coverage in each country quintile
- Rwanda (313 health centres, 1999)

Facility performance score

X-axis categories: 20% health centres with lowest overall performance | Quintile 2 | Quintile 3 | Quintile 4 | 20% health centres with highest overall performance

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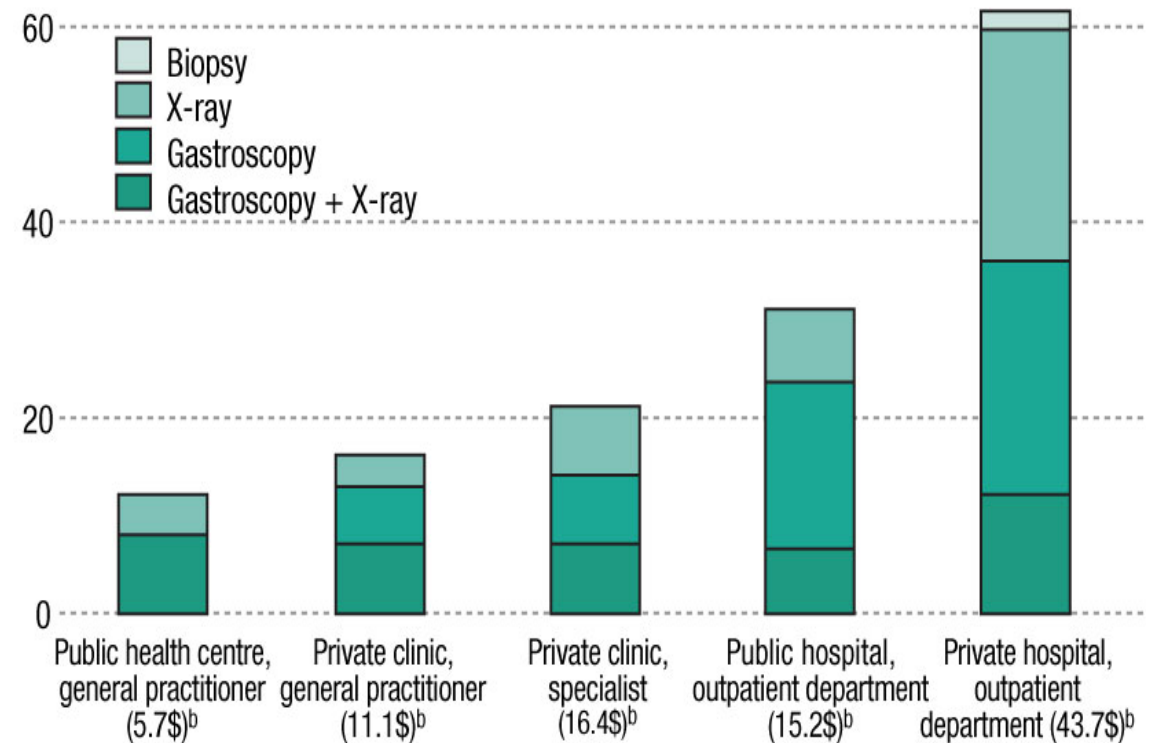c Includes vaccination of children not belonging to target population.

❑ **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

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

Patients for whom inappropriate investigations were prescribed (%)

Legend:
- Biopsy
- X-ray
- Gastroscopy
- Gastroscopy + X-ray

Categories:
- Public health centre, general practitioner (5.7$)[b]
- Private clinic, general practitioner (11.1$)[b]
- Private clinic, specialist (16.4$)[b]
- Public hospital, outpatient department (15.2$)[b]
- Private hospital, outpatient department (43.7$)[b]

[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.

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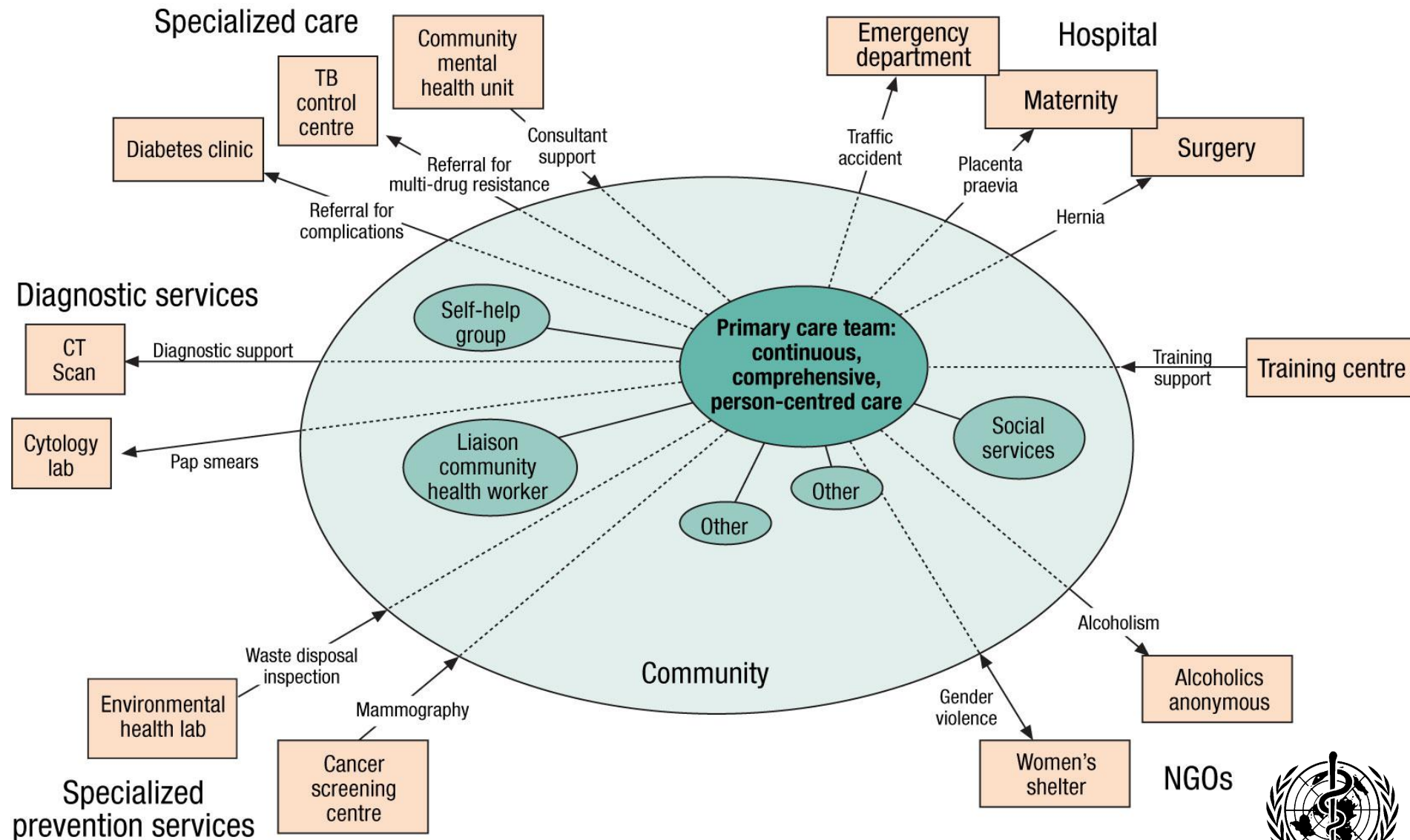## b. three organizational conditions (cntnd)

❑ 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. Four interlocking sets of PHC reforms

UNIVERSAL COVERAGE REFORMS to improve health equity

SERVICE DELIVERY REFORMS to make health systems people-centred

LEADERSHIP REFORMS to make health authorities more reliable

PUBLIC POLICY REFORMS to promote and protect the health of communities

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

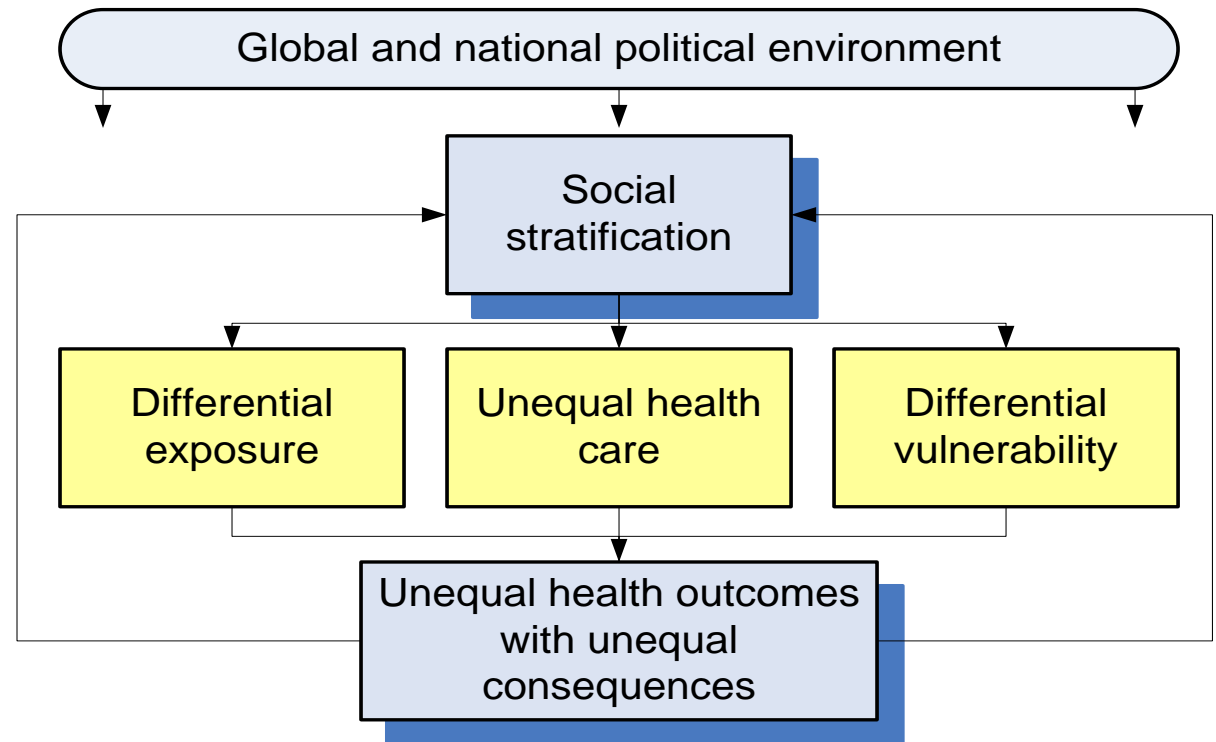*2.3. Universal coverage reforms: the health equity agenda*

Leadership reforms

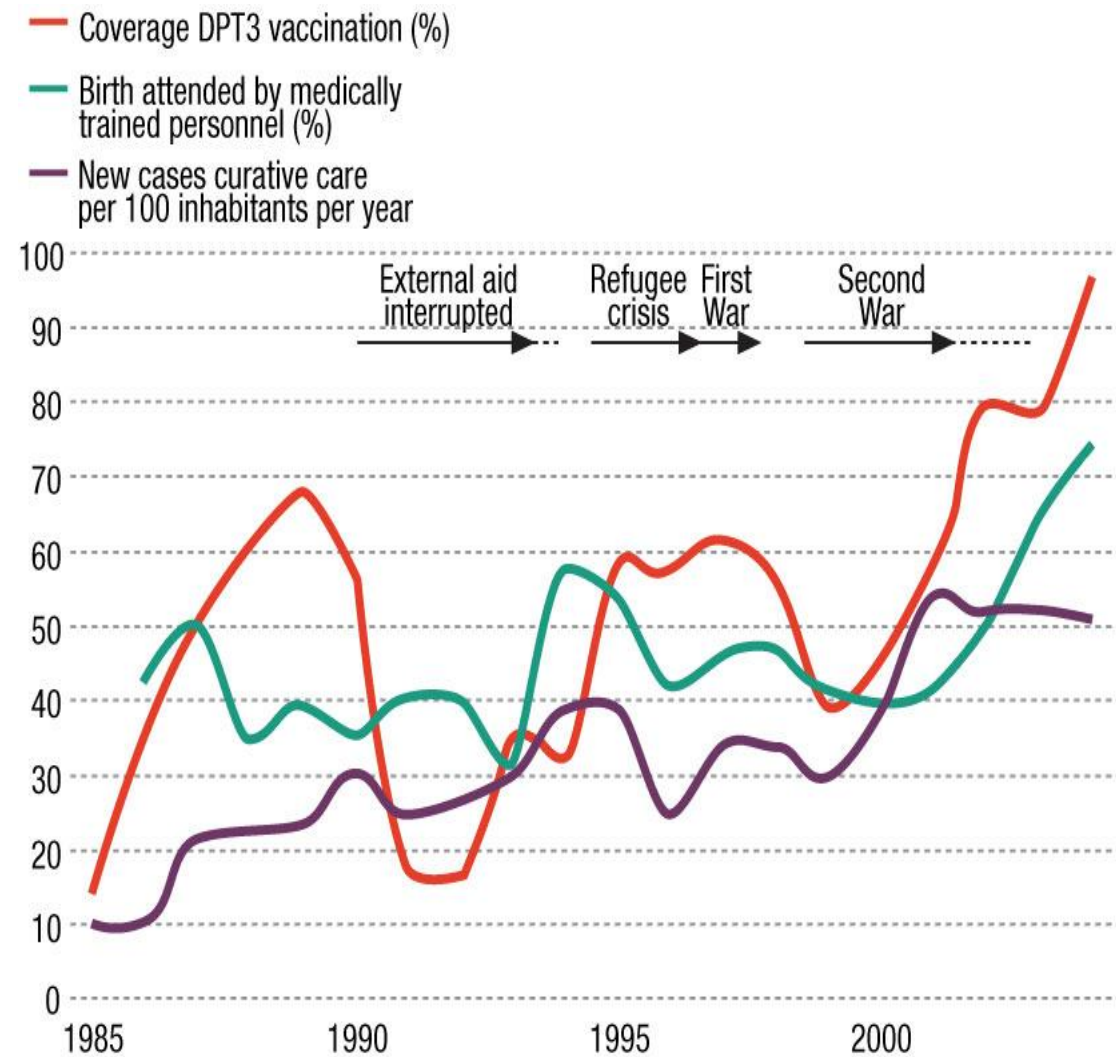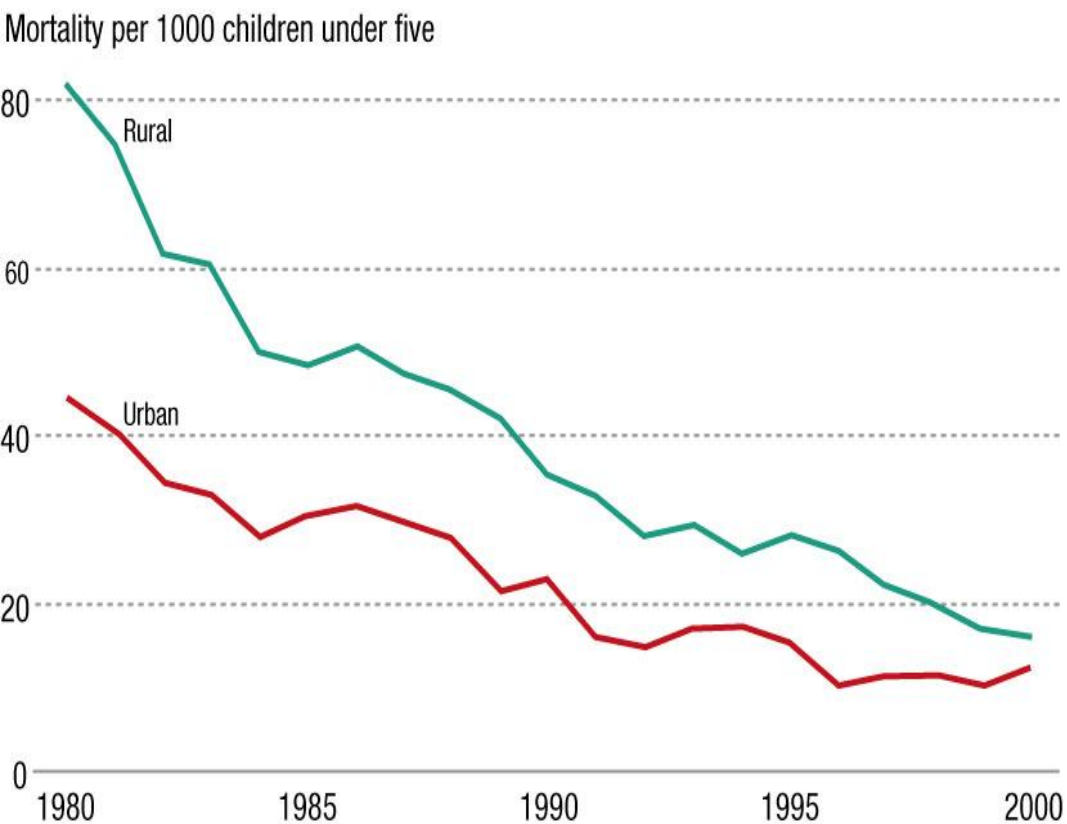# 2.3 "Go without treatment or loose the farm" : universal coverage reforms

Address health inequalities:

o Mobilize beyond the health sector

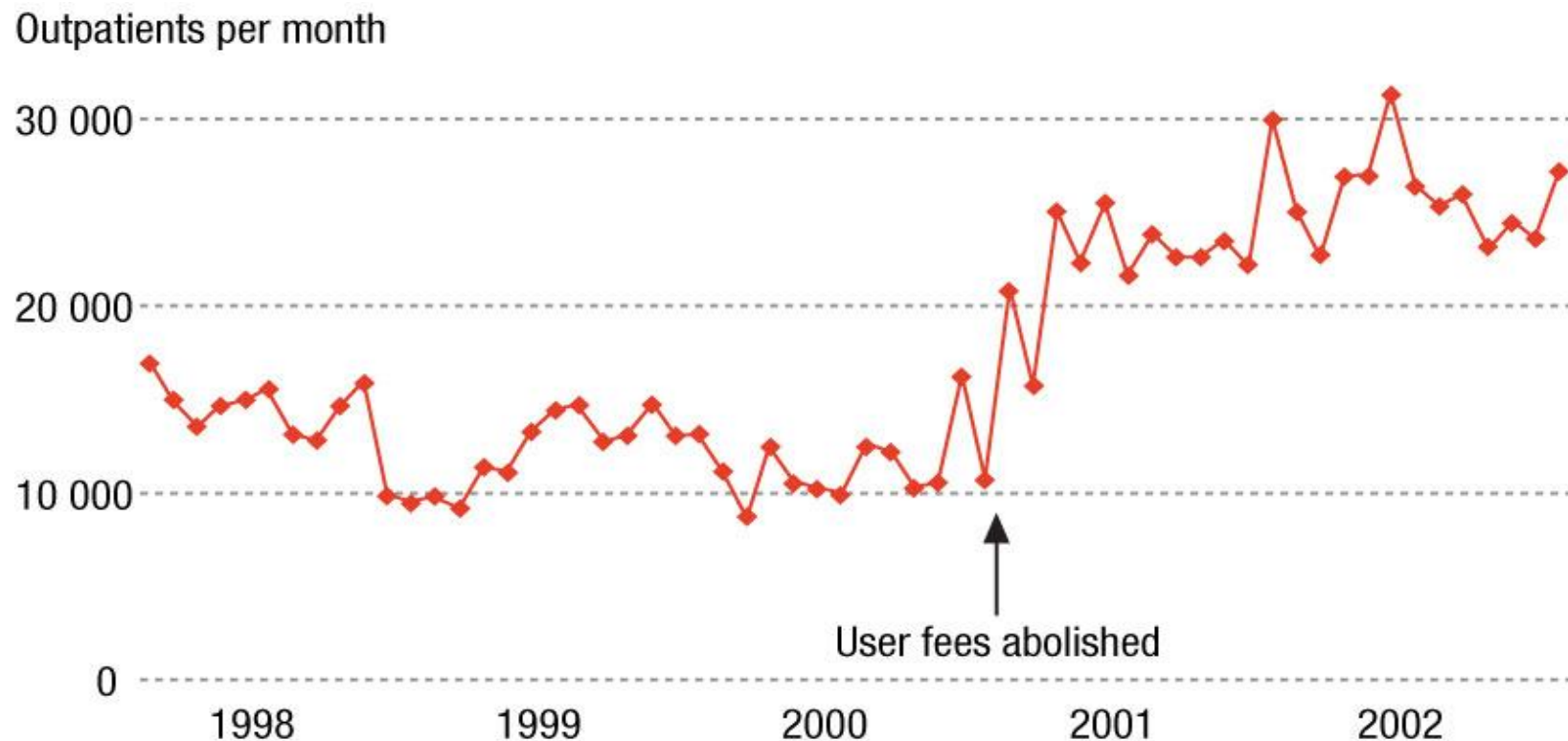o Reform the health sector itself: universal access + social protection

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

Outpatients per month

User fees abolished

1998   1999   2000   2001   2002

2.3 Universal coverage reforms:
b. from "oop" payment to solidarity and pooling
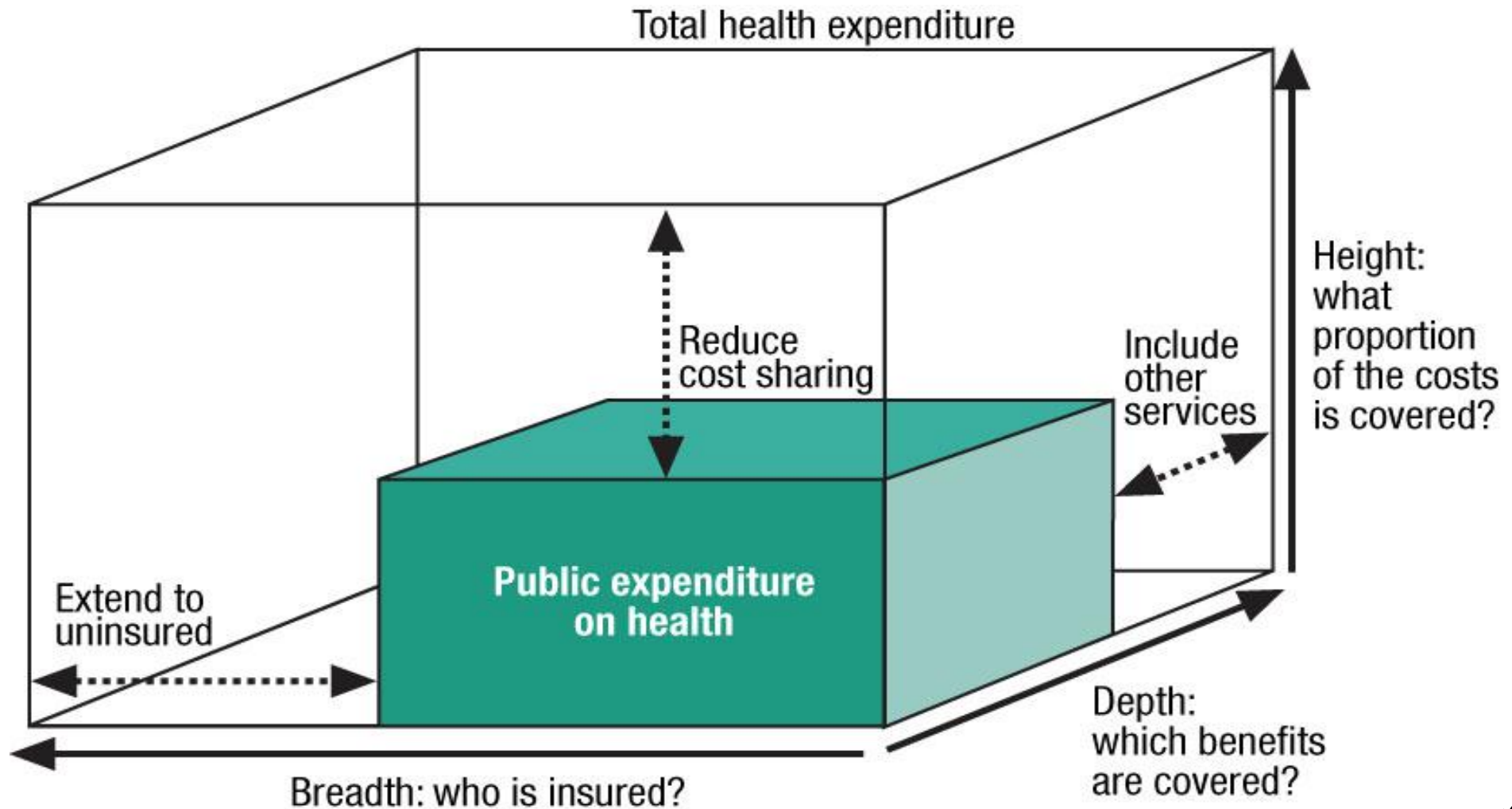
Total health expenditure

Reduce cost sharing

Include other services

Height: what proportion of the costs is covered?

Extend to uninsured

Public expenditure on health

Breadth: who is insured?

Depth: which benefits are covered?

[from Busse *et al*, 2007]

- 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

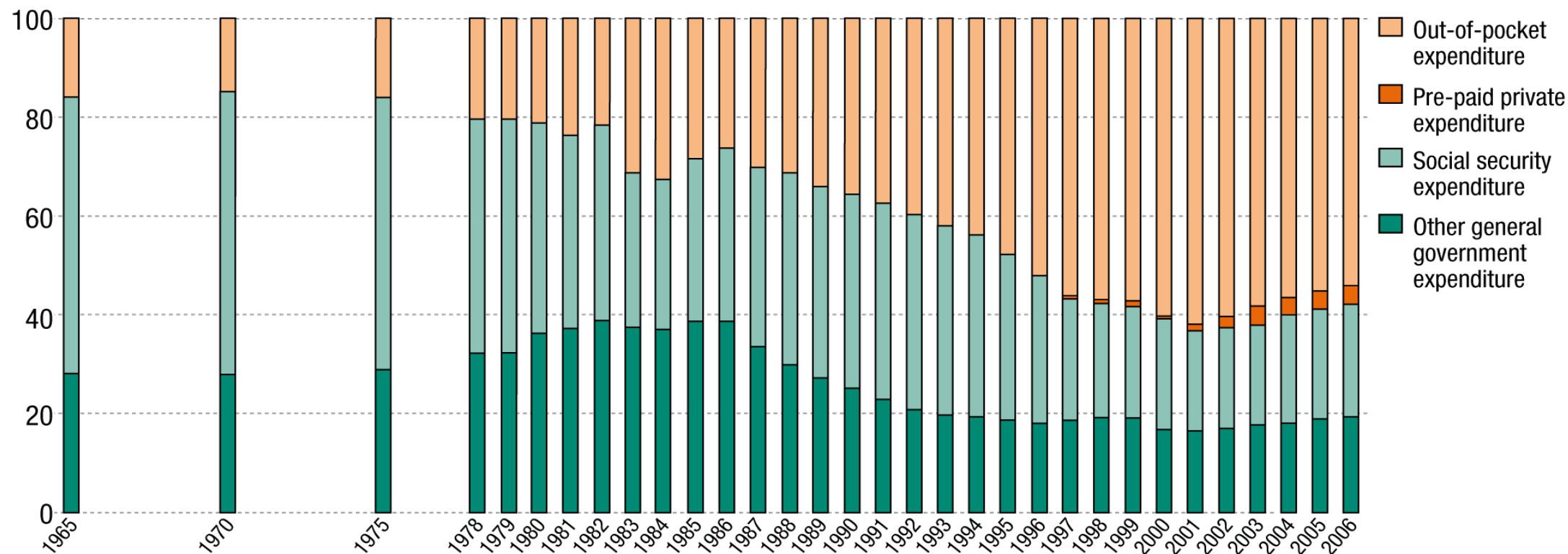*2.4. Leadership reforms: inclusive leadership and better government*

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

Percentage of total health expenditure

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

Thank you

1. the equity agenda

o Moving towards universal coverage:

Ensure availability

Eliminate barrier to access

Organize social protection

o Plus

    o mobilize beyond the health sector;

    o give visibility to inequalities;

    o reach the unreached

PHC?

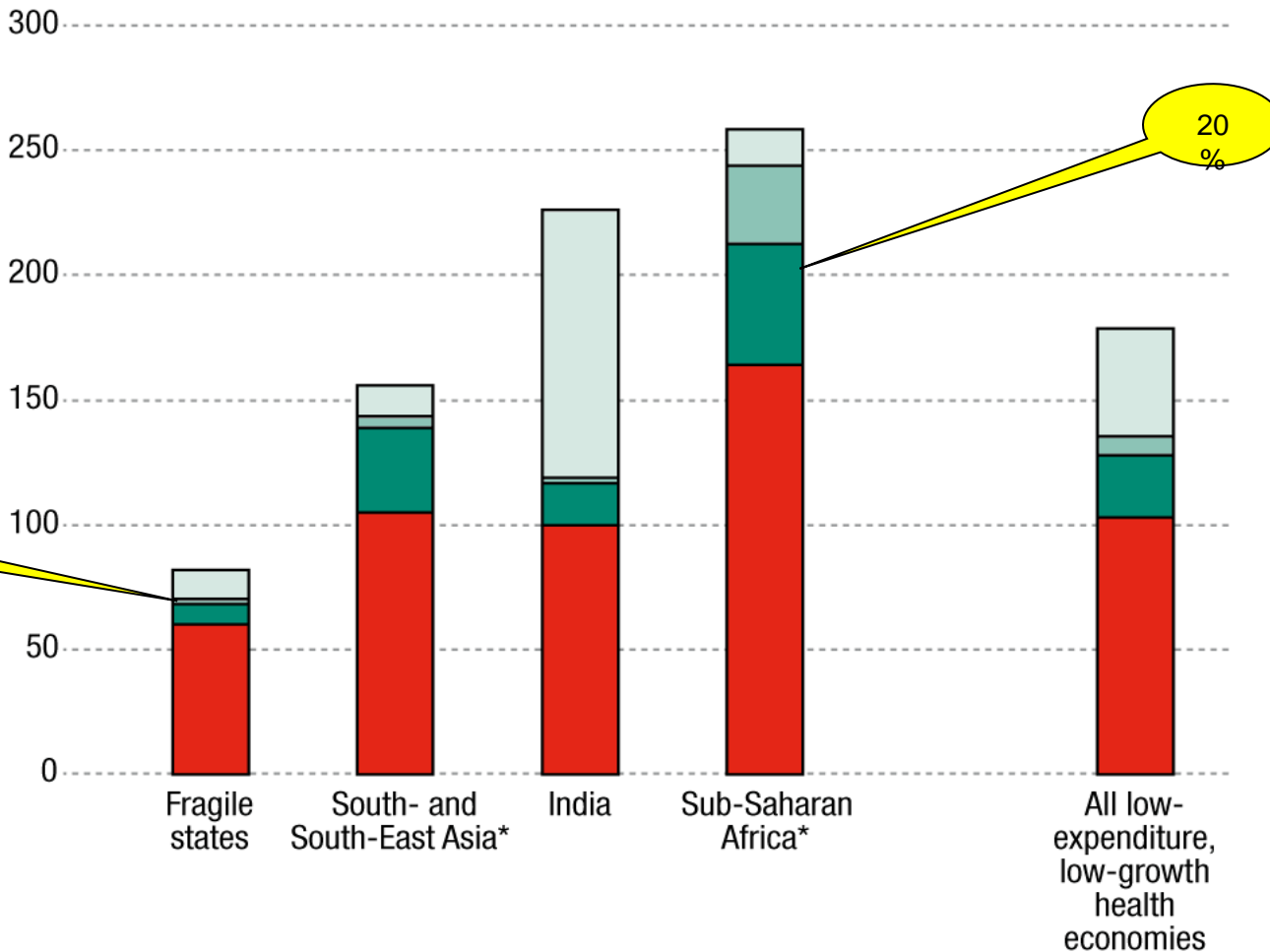"Back to the basic values and principles"

- *A sense of direction for fragmented health systems*
- *Dealing with current and future challenges to health*
- *While contributing to social values of equity, solidarity and social justice*

Growing frustration

World Health Organization

4. Inclusive leadership, effective government

Projected health expenditure per capita, I$, 2015

- Projected growth in out-of-pocket expenditure
- Projected growth in private pre-paid expenditure
- Projected growth in government expenditure
- Level of total health expenditure in 2005

* Without fragile states.