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**PRIMARY HEALTH CARE: 25 YEARS AFTER ALMA-ATA**

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## **EXECUTIVE SUMMARY**

Primary health care became a core policy for WHO with the Declaration of Alma-Ata on primary health care in 1978 and the subsequent development of the Global Strategy for Health for All by the Year 2000. Alma-Ata positioned primary health care as a philosophy, a level of care and a set of services. It is also considered the strategy to achieve health for all and to ensure universality, quality, equity, efficiency and sustainability of essential services. The philosophy of primary health care continues to represent a radical strategic shift in the way we think about health and health care. Since 1978, the primary health care movement has had tremendous influence on the way national health systems in the Eastern Mediterranean Region view health development and provide health services and will continue to be a valid approach regardless of the terminology that may be applied to the tools and strategies of its implementation. Primary health care created a conducive environment for many of the initiatives and successes we are witnessing now.

The potential of primary health care in the Eastern Mediterranean Region is enormous, and the 25th anniversary is an opportunity for a drastic review of national health systems. This is the time to develop a new vision taking into consideration the new challenges, changes, and initiatives and strategies worldwide. At the same time it should build on previous primary health care experiences and existing, specific socioeconomic realities.

The paper suggests strategic directions, including harmonizing health development with overall development which will require a proactive leadership role of the Ministry of Health in order to steer the provision and financing of health care and the national health system as a whole. Strategic planning, career development, strengthening managerial and technical skills of health personnel, and developing incentives for health personnel are also crucial. Enhancing efficiency of the national health services should be a major focus, whether at central level or at the operational level. In summary an organizational culture which aims to build a credible national health system based on primary health care and which provides accredited quality health care at all levels should be the target.



## 1. INTRODUCTION

Primary health care became a core policy for WHO with the Declaration of Alma-Ata on primary health care in 1978 and the subsequent development of the Global Strategy for Health for All by the Year 2000. The World Health Assembly renewed in 1995 (WHA48.16) the commitment to global improvements in health, especially for the most disadvantaged populations. This led in 1997 to *Health for all in the twenty-first century*, a policy document and programme of action, within which the commitment to primary health care development is restated.

Since Alma-Ata (1978) significant health gains have been achieved, as evidenced by the global increase in life expectancy and in total adult literacy, and the reduction in infant mortality and under-5 mortality. National health systems based on primary health care undertook a radical reorganization in health services in order to achieve their aims. The 25th anniversary of primary health care is an opportunity for a drastic review of national health systems. This is the time to develop a new vision, taking into consideration the many changes affecting global health and the strategic developments in health of recent years. At the same time it should build on previous experiences and existing, specific socioeconomic realities.

The philosophy of primary health care represented and continues to represent a radical strategic shift in the way we think about health and health care, implying as it does the use of strategies such as intersectoral collaboration, legislative reform, reassessment and reallocation of human resources and the application of cost-effective interventions. Since 1978, the primary health care movement has had tremendous influence on the way national health systems in the Eastern Mediterranean Region view health development and provide health services and will continue to be a valid approach regardless of the terminology that may be applied to the tools and strategies of its implementation. Primary health care created a conducive environment for many of the initiatives and successful programmes we are witnessing now. The potential of primary health care in the Eastern Mediterranean Region is enormous and this paper suggests directions for the future based on review of past experience, constraints and achievements.

## 2. LOCATING AND DEFINING PRIMARY HEALTH CARE

Alma-Ata positioned primary health care as a philosophy, a level of care and a set of services. It is also considered the strategy to achieve health for all. The philosophy of primary health care is based on the following pillars.

- **Universality:** all citizens should be assured coverage with the same basic set of primary health care services.
- **Quality:** primary health care services should be socially and culturally acceptable and in line with standards of scientific and clinical practice, and at a level that will be perceived as adequate by beneficiaries.

- **Equity:** no one should be denied services for want of ability to pay. The financial burden of providing primary care services should be shared fairly. Pro-poor initiatives form a major component of primary health care strategies. This is clear from the vision of Health for All.
- **Efficiency:** services should be provided in a cost-effective way both at the level of the unit of service as well as in the structure of the system, in keeping with the principles of universality, quality and effectiveness.
- **Sustainability:** there should be enough resources to adequately finance and manage the basic set of services in the short and long-term.

Based on this philosophy, the Alma-Ata Declaration identified five components and values of primary health care, which are as valid now as they were in 1978:

- active community participation, and joint monitoring and control over the content and implementation of primary health care;
- social relevance, with western medicine complementing local systems;
- involvement of other sectors, including education, water and sanitation, and agriculture;
- health service provision and health promotion;
- use of appropriate and effective technologies.

In terms of level of care, primary health care is the first point of contact for service users within an organized health care system. This point of contact may be at the level of the health centre, the polyclinic or hospital ambulatory care. However, the level at which primary health care is actually delivered is determined by the set of services considered essential.

As a set of activities, primary health care depends on synergy. The health system based on primary health care focuses on improving the overall health of the population rather than just the treatment of disease. The original eight primary health care elements considered essential were immunization, health education, nutrition, safe water and basic sanitation, maternal and child health care including family planning, prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries and provision of essential drugs. Nowadays different names are given to the concept of primary health care, such as basic benefit package, core package, essential core services. These terms are mainly used because they reflect an emphasis on cost of services or health insurance premiums.

### **3. ACHIEVEMENTS OF PRIMARY HEALTH CARE**

#### **3.1 Global vision**

A major achievement of the primary health care movement was the creation of a value system. The primary health care philosophy of universality, equity, quality, efficiency and sustainability was the basis of different models initiated throughout the world and created a conducive environment for many of the successful initiatives we are witnessing now. It drew attention to the needs of the many, and was a powerful instrument for making governments

and their partners recognize that the provision of health care cannot be left to the professionals alone. WHO's current focus on the diseases of the poor and work on health systems is consistent with the messages of primary health care.

### **3.2 Reorientation of health care institutions and provision**

The main achievement in provision of care has been the improved coverage by primary health care. For example, accessibility in countries of the Region has improved substantially, to reach 84% in 2000. The base of the health care pyramid became broader. Emphasis was placed on the first level of care which caters for the majority of diseases and health problems. It is claimed that 80% of health needs can be met by primary health care. The wide primary health care infrastructure allowed effective preventive programmes to be implemented. Eradication (e.g. poliomyelitis) and elimination (e.g. measles) campaigns were made possible because of the wide network of primary health care facilities and workers.

The building block of the national health system is the district health system, through which the notion of decentralization, which is the key to primary health care, was introduced. The district health system encourages interaction with all stakeholders at the grass roots level, and paved the way for later work on defining geographical and functional boundaries of health systems. In addition to that it was meant to be feasible and operational. In implementing the district health system alternative financing mechanisms were explored without undermining the commitment to population needs and social responsibility for health promotion, at risk-groups and the marginalized poor. Within the district health system, some countries adopted the catchment area focus initiative, which ensures links with health institutions, better use of potential, especially in the community, and intersectoral action. It is an attempt to fully engage local communities and settings in the planning, management and supervision of public resources through community participation, and is characterized by being both integrated and decentralized.

Health for all monitoring and evaluation exercises as well as The World Health Report 2000 clearly show that countries who invested in primary health care and based their systems on its principles score high on performance and effective coverage. In conjunction with development of the network and infrastructure, efforts were made in some countries (Egypt, Jordan and the member countries of the Gulf Cooperation Council) to develop family practice as a strategy for effective coverage through gatekeeping and screening of users of services. The Declaration of Al Manama 2003 emphasized the role of the family physician in health care delivery.

Some low and middle-income countries in the Region have developed "core packages," which define health interventions that should be available at the health centre and district hospital levels. This idea of defining the scope and content of services is in line with the eight elements of primary health care defined at Alma-Ata. Effective packages respond in a cost-effective way to needs, especially those of targeted groups and of the poorest segments of the population, and represent priority activities for public financing. The district health system creates a conducive environment for implementing a core package.

In the early 1980s quality assurance and improvement (QA/I) in primary health care occupied an important position in the agenda of most countries in the Region. Almost all countries have developed a QA/I plan in primary health care since then. Several countries (Jordan, Pakistan, Saudi Arabia, Sudan and Syrian Arab Republic) conducted a comprehensive primary health care quality assessment, either nationally or in pilot areas. Almost all countries started the training and development of local professionals in QA/I techniques. Several workshops, seminars, courses and conferences were conducted in countries at the national and district levels. Saudi Arabia, for example, established a national diploma course on quality management for local health care professionals.

### **3.3 Democratization of health through community-based initiatives**

For primary health care to succeed it requires organization and mobilization of the community and this has taken different forms in the Region. One form of community organization is the basic development needs (BDN) approach which has been implemented in many countries of the Region. This approach shifts focus on to community leadership and sustainability and away from short-lived interventions. In areas where BDN programmes and initiatives have been implemented the accessibility of and coverage with health care services has increased, and morbidity and mortality have decreased. BDN has also accommodated concepts such as poverty alleviation and healthy villages and enriched them with a community methodology, which puts harmony and balance into social and economic development. This is what is sometimes called “development with a human face”. Other initiatives where the community has a say are the healthy city and healthy village programmes.

Experience with community health workers in the Region has been evolving since long before the Alma-Ata conference on primary health care in 1978. Some countries have trained community health workers to extend accessibility and coverage by health care. Other countries have focused on traditional health workers, such as traditional birth attendants, *hakeem* and local healers. Tapping such traditional resources means that use is made of community-based workers who are already accepted by the community and have long been familiar with it. One of the main functions of community health workers is to motivate and mobilize the community. Other countries have sought to mobilize the community through volunteers, mainly part-time workers who are traditional or trained health workers, and sometimes activists, often women, who are members of unions or nongovernmental and other philanthropic organizations. Volunteers may come from a variety of backgrounds and interests but they are basically active members in their communities. Women’s organizations give more say in health affairs to a vulnerable social group whose members are also the beneficiaries of improvements in health care management. Such clubs provide more access to health care and services as well as a forum for exchange of concerns, priorities, problems and decisions related to health status of women. They empower women in particular and the family in general in health decision-making and this thus leads to democratization of health and to community partnership.



### **3.4 Highlighting intersectoral collaboration for health development**

Despite its importance in attaining health for all and better health status, intersectoral collaboration has proved difficult to achieve in practice. Primary health care's recognition of the vital role of other sectors in health policy formulation, financing of health and generating resources has proved to be sound. Involvement is essential to address the main factors of ill health and the burden of disease in all countries. The main killers are noncommunicable diseases and injuries. These can only be reduced through the involvement and commitment of related sectors which will play their role in controlling tobacco, obesity, physical inactivity, alcoholism, addiction etc. While primary health care may not have achieved much in developing intersectoral action for health, it has enlightened health planners to its importance and this is becoming crucial. Examples of intersectoral collaboration do exist however: the BDN approach and the action-oriented school health curriculum approach. The latter approach to community partnership regards the school as an asset that can be used as an agent for change. Trained schoolteachers teach the children how to address health and health-related issues at home, in the community and at school.

### **3.5 Paving the way for new initiatives**

The reorientation of health systems in the Region as a result of primary health care, together with the many trials and errors in implementing it, facilitated the development and acceptance by ministries of health and donors of new tools, such as national health accounts and burden of disease assessment, which are, indeed, built on the primary health care movement. There is a common misconception that these tools are designed to replace primary health care when in fact they serve the principles and strategies of primary health care, and support it. Among the global initiatives that support primary health care are the Commission on Macroeconomics and Health, which quantified what comprises the basic set of services and its cost, the UN Millennium Development Goals (MDG) and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

### **3.6 Creation of a critical mass**

There are considerable differences in how primary health care has been understood and, more importantly, applied, at country level. This suggests that there is no common blueprint relevant to all primary health care experiences around the world. Such variation is inevitable, as systems are bound to vary in how they adopt and adapt new concepts, knowledge and realities. The various models of primary health care have only added to the richness of primary health care implementation and experiences. The adaptation of the primary health care approach was possible because of the critical mass of creative and innovative health professionals who used the approach to fit the realities of their countries. The innumerable models and versions that were developed indicate the strength and relevance of the concept. Civil society organizations interested in the principles of primary health care carried its spirit further, for example the Primary Health Care Association in Qatar, and the People's Health Movement, which is active worldwide.

### **3.7 Health as a human right**

The primary health care concept with its deep rooted values of equity and social fairness has placed health high on the political agenda and created a commitment to health for all as a global movement among civil society organizations. Equity must be ensured for all geographic, economic and ethnic groups regardless of sex as well as for the elderly and special groups. The heritage of 25 years of primary health care experience in promoting equity and health for all now attains greater prominence in light of some of the extreme views expressed by proponents of the free market and the global trend towards the commercialization of health. This heritage is also helping to some extent in the debate by pressure groups on international trade agreements that may jeopardize the gains made by the health for all movement.

## **4. REASONS FOR UNSUCCESSFUL IMPLEMENTATION OF PRIMARY HEALTH CARE**

The process of implementing primary health care and national health for all policies and strategies has faced numerous problems, some of which were identified by the regional health-for-all policy and strategy for the 21st century *Health 21*. The Regional Office conducted a review of progress in implementing primary health care in the Region. The review came out with the following reasons responsible for unsuccessful implementation of primary health care.

- Lack of community participation. Community involvement is poor as a result of conviction that the state is responsible for providing the totality of health services. In addition, the civic infrastructure and civic organizations are not well developed.
- Lack of intersectoral collaboration. This has led to limited intersectoral cooperation for health development.
- Lack or misuse of human resources and material resources. The review reported inappropriate human resources policies and planning, leading to imbalances between the number of health professionals in different disciplines and categories and to inequitable geographical distribution. As well, in some countries working conditions of health workers are unsatisfactory, with low salaries, poor living conditions and inadequate career structures.
- Concentration on sophisticated technology. Inappropriate use of medical technology leads to escalating cost of health care services. In addition to inefficient use of national resources, such concentration has resulted in inequitable and insufficient resource allocation, with limited resources for promotive and preventive activities and programmes.
- Mismanagement. A major reason was weaknesses of national health systems with respect to policy analysis and formulation, coordination and regulation. Weak managerial capabilities at all levels of care have hindered the effective and efficient implementation of health programmes. Weak management also caused poor organization and delivery of health services at all levels including ineffective referral systems. The weakness of health information systems at central and peripheral levels

has resulted in difficulties in collecting and using information to measure performance of health facilities.

- Lack of intercountry collaboration and lack of operational research.

## **5. INNOVATIVE APPROACHES IN THE EASTERN MEDITERRANEAN REGION**

In response to the findings of the regional primary health care review, the Regional Office has promoted a number of initiatives to remedy the shortcomings in implementing primary health care in the Region.

- a) Action-oriented integrated school health curriculum. This initiative aims at reorienting health, educational, instructional and public information institutions in a manner that promotes health and encourages healthy lifestyles. Curricula for schoolchildren should include action-oriented health behaviour in all subjects taught to students at the early stages of their education. In this initiative, the school becomes an agent of change for better health. The schoolchildren, through their involvement in health projects, acquire long-lasting life skills which allow them to lead healthier lifestyles.
- b) Family self-care. It is the family which essentially manages most minor conditions for which there is no need to go to the doctor (e.g. headache, minor eye infections, minor colic, constipation, diarrhoea), and even some more complicated conditions (e.g. tonsillitis, cold), including care for the disabled, handicapped and elderly. Healthy living, disease prevention and health protection services in the home are essential components of an integrated approach to improving the health of family. The emphasis is on preventing exposure to risks and adopting healthier habits at home to cover all preventable conditions that affect life. The initiative of family self-care is not only a contribution to health care but also a timely, efficient and educational process to make communities responsible for their well being. Guidelines on family self care were developed to ensure the adoption of sound approaches towards prevention and management and to bridge the gap between health facility and family.
- c) Development of healthy lifestyles. WHO/EMRO, recognizing the new shift of disease patterns toward noncommunicable diseases, has launched programmes promoting lifelong healthier lifestyles. The lifestyles followed by human beings have a major impact on their health and well-being. Healthy lifestyles embrace positive patterns that promote health and reject and behaviour which is unhealthy or deleterious to health. This initiative encourages the comprehensive development of local communities, and supporting them in attaining their basic needs through self-reliance, this being a practical introduction to the implementation of healthy lifestyles. The Regional Office initiated, in collaboration with religious leaders, the Amman Declaration on Health Promotion through Islamic Lifestyles, which addresses 60 healthy lifestyles, supported by the Quran and by traditional practice (*sunna*).

- d) Promoting the spiritual dimension in health. The Eastern Mediterranean Region is the cradle of the divine religions. Its rich heritage and deep rooted spiritual beliefs are great assets to build on for better quality of life and healthy living. The spiritual dimension is an appropriate entry point to mobilize the individual, family, community and the nation to what the religious teachings require. The Regional Office issued a series of health educational booklets for health education through religion, under the title “The Right Path to Health,” on different important subjects, such as *Islamic ruling on smoking*, *Islamic ruling on male and female circumcision*, *Health: an Islamic perspective*, *Environmental health: an Islamic perspective* and *The role of religion and ethics in the prevention of control of AIDS*. The Regional Office published and circulated a formal religious opinion (*fatwa*) issued by His Eminence the Mufti of Egypt condemning smoking and tobacco consumption and distributed it in the form of posters among tens of thousands of mosques, which proved, according to an evaluation study, instrumental in convincing a large number of smokers to quit or plan to quit smoking. This *fatwa* is now gaining impetus in the Region.
- e) Community-oriented medical education. To meet the challenges of health for all, a well educated and trained health workforce must be developed that is oriented to meet the needs of the communities. Curricula of training institutions should be dynamic and responsive to new changes in knowledge and technology and the new settings where health workers will perform. The curricula of all health care providers should provide the graduates with greater responsiveness to society’s needs. This could be achieved through expanding community-oriented and community-based medical and health personnel education, as well as promoting research in educational technology, educational methodology and new learning settings. Community-based and community-oriented education of health professionals strengthens partnership between the health care delivery system and training institutions. Efforts are directed towards involving those who teach as full partners in health care delivery and those who provide services as full partners in training different categories of health personnel.
- f) Leadership development. A leadership development programme has been initiated in the Region. In particular, it aims to develop the leadership talents of health personnel of different levels, to ensure performance of their tasks in the best manner possible. The programme was conducted in its early years in the Regional Office and its modules were prepared. It included field training in the Regional Office and in the countries of the Region. Data on the programme were transferred to countries of the Region. A leadership programme in Arabic was created in Egypt, a counterpart in French in Morocco and a third in English in Pakistan. The leadership programme in the Region has taken different forms and levels. Some countries have adopted it as a diploma course.
- g) Basic development needs approach. The basic development needs (BDN) initiative is a comprehensive approach addressing overall local development in order to achieve better quality of life. Basic development needs initiatives include community-identified projects that integrate social, economic, health and environmental issues. BDN projects are organized and managed by the community, supported by a coordinated intersectoral team, including health-related sectors such as education, water supply, agriculture and housing.

Development projects are implemented in partnership with the local population and nongovernmental organizations. BDN projects target income generation and poverty alleviation by implementing realistic, achievable activities, which have to include a “basic” health component. The BDN initiative entails political commitment, community organization, motivation and involvement, intersectoral action and integrated, decentralized, comprehensive development. Thus, it tackles the determinants of health, with consequent improvement in health status.

## **6. AGENDA FOR CHANGE**

It is clear that primary health care is facing a new agenda in a challenging environment. One challenge is the current relevance of primary health care as an approach to health system development. WHO has recently developed a health system framework and several tools to fill in the gap in assessing, quantitatively and based on evidence, the main functions of health systems, such as performance, stewardship, financing of health care, generation of resources and provision of care. These are positive developments that will add to the impetus of primary health care. The availability of robust tools should provide the evidence that was hitherto incomplete for accepting the values and principles of universality, quality, equity, efficiency and sustainability.

The major issues facing primary health care include securing adequate political, financial, human and material commitments; optimal use of available resources; changing management techniques including decentralization; and ensuring effective community participation and intersectoral collaboration. Feasible and attractive models have to be developed for primary health care financing and management; primary health care for the urban areas; appropriate use of new technologies; role of alternate therapies; quality assurance; and health systems research in support of primary health care.

Since more than 90% of the population of the Region live in low-income and middle-income countries, economic constraints are reflected in the rising levels of poverty and social deprivation in many countries. Many health systems in low-income countries and parts of middle-income countries are under-funded, while high-income countries are concerned about the escalating costs of health care. The overall trend in health care financing in the Region shows a clear shift of the burden from government to households, even in oil producing countries and those that provide social welfare.

Countries are considering the options for relief of government budgets, such as the adoption of user charges and risk sharing schemes, e.g. health insurance. The contribution of social health insurance to public spending is still relatively limited. The expansion of health insurance coverage is hampered by the large numbers of workers in the informal or self-employed sectors and by the limited capacity for collecting and administering payroll tax-based funds. Direct out-of-pocket spending by households will account for a major portion of private spending in most countries. This reliance on out-of-pocket spending means that households may bear a substantial proportion of health care costs while having little or no financial protection (i.e. insurance) when major illness or injury occurs.

Management, which is already weak, is further challenged by the changing environment created by globalization and international economic agreements; advances in health technology; ageing and urbanization patterns; as well as the double burden of disease. Many developing countries are facing an unfinished agenda of infectious diseases, malnutrition and complications from childbirth, and simultaneously a growing epidemic of noncommunicable diseases, mental health disorders, injuries and violence. The double burden of communicable and noncommunicable disease has serious health and health care implications, and requires the development of new strategies and policies and the adaptation of existing ones, including for primary health care. Priority-setting in a double burden context will be a complex exercise but an inevitable one.

The rapid changes taking place in the social, demographic, technological, epidemiological and economic spheres, both in the world in general and in the Eastern Mediterranean Region in particular, call for review of the present status of policies for health system infrastructure development, the resources available, the technology in use and the mechanisms for maintaining that technology, in order to ensure the provision of equitable and quality essential health care to people.

Gaps in service delivery and utilization due to lack of coordination should be addressed. Health services in the Region are currently managed and delivered by two major and distinct sectors: government and public on the one hand, and private on the other. There is a big gap in coordination of the two sectors and efficient use of their resources. For example, in regard to distribution of outpatient visits by type of provider and income, it has been found that per capita visit rates are positively correlated with income level, showing unequal coverage with care. Designers of programmes and systems continue to give too much attention to the perceived needs of populations, and insufficient attention to peoples' expectations and their demands for health care.

Governments face a potentially confusing array of policy tensions and choices of types of health care delivery especially since: decentralization of authority to local level is coupled with inability to move resources between curative, promotive and preventative activities; the unsettled issue of provision of care versus financing of care is still a major concern of many national health authorities and planners; and the relationship between the public and private sectors is complex and should be put into an operational framework as part of the leading role of government health authorities.

Government contracts with physicians in most countries of the Region contain little in the way of enforceable performance standards. The result is poor quality and inefficient services. Multiple employment is a common feature among the health workforce in some countries and this will continue if privatization is not regulated and monitored. Within the primary health care system itself, the careful design of incentives for health personnel may play an important part in achieving desired quality improvement and other policy outcomes. Internal and external incentive structures, and related management processes, have been shown to have a significant impact on the motivation and behaviour of general practitioners in other systems worldwide. Reducing costs of health services can be achieved by intelligent and

careful adaptation of internal and external incentives to improve the productivity of the health workforce.

In short, the principal concern is how primary health care structures and processes are to cope with change and challenge.

## **7. THE WAY FORWARD**

### **7.1 Strategic directions to support/ revitalize primary health care in the Region for the next decade**

The diversity of the countries of the Region in terms of political, economic, demographic, epidemiological and environmental situation explains the variety and degree of magnitude of change and challenge and their impact on health systems in the Region. Most countries have to deal with a growing interest in decentralization and civil society involvement in managing public affairs and in implementing health-for-all policies and strategies. The first challenge is to recommit to the basic principles of health for all based on the primary health care approach. Mobilizing support to reinvigorate a system that is capable of leading the pursuit of health for all should follow this. Subsequently, there is a need to create the necessary resources to ensure maximum impact on the health status of the entire population. However, the most important characteristic of a primary health care system to deal with new challenges will be its capacity to adapt quickly to demographic and epidemiological transitions and to the enhanced need for monitoring to improve equity to access and care.

### **7.2 Harmonizing health development with overall development**

In view of the strong mutual linkages between health and development, it is necessary to consider all the related factors, such as economy, environment and social determinants in health and development. Community-based initiatives are broad-based health development activities that consider the social, economic and environmental dimensions of overall development in an integrated and balanced way. Community-based initiatives include the healthy cities, healthy villages and basic development needs (BDN) programmes. All three programmes have a community-based approach and are thus interrelated, aiming to improve health and quality of life of people in an integrated and sustainable manner. Health authorities and leaders should make use of the recommendations of the report of the Commission on Macroeconomics and Health which specified a minimal financial requirement to run essential health care services. National pro-poor policies based on the BDN approach, the report of the Commission on Macroeconomics and Health and the initiative of the Global Fund to Fight AIDS, Tuberculosis and Malaria need to be formulated and supported through national and international aid.

### **7.3 New leadership modalities and the role of ministries of health**

A core responsibility of government in mixed health systems is to exercise effective oversight. Steering becomes more important as governments shift from direct service

provision to a role dominated by policy formulation; priority-setting; assessment of needs for health service population-based interventions; financing; regulation of providers and insurers; guidance of the system and how it behaves through research (e.g. on cost-effective interventions); provision of information; quality enhancement activities; coordination of all stakeholders/sectors involved in health delivery; and careful use of financial subsidies. This leadership role may be seen as 'proactive', i.e. regulating in advance to prevent certain outcomes, or 'reactive', i.e. regulating in response to emerging outcomes to minimize any negative effects. At present primary health care has more leverage and there are more instruments available than ever before to guide, assess and evaluate the progress of equity, universal coverage, effectiveness and efficiency of national primary health care programmes. Health planners and policy-makers can use the tools now available to assess burden of disease; healthy life expectancy; fairness of financial contribution and the extent of catastrophic expenditures on health; utilization patterns and coverage through household surveys; cost-effectiveness of interventions; and prioritization of interventions.

#### **7.4 Strategic planning for health workforce development**

##### *Developing the primary health care workforce*

One of the major strategies in human resources development is the optimum utilization, updating and management of human resources for health. Capacity-building in health services planning and management is among the requirements for health system and service development. Primary health care needs to go beyond the traditional emphasis on production and distribution of the workforce and make efforts to develop human resources to ensure more responsive, user-oriented health services. The challenge is to provide the right incentives to work, and to ensure health personnel are accountable for their performance. Efforts are being made in the Region to train managers at various levels and to introduce innovative approaches for training focused on problem-solving and community involvement.

##### *Involvement of and incentives to health care providers*

With the ever increasing expectation of the community, technological development, and the present health financing system, resources will never be sufficient for any health care system. In addition to the various efficiency measures which need to be introduced, there is a great need to make primary health care physicians and teams accountable, not only for their patients' health, but also for the wider resource implications of any treatments involved, including referrals from primary care into secondary and tertiary care. There is a need to adopt management protocols in order to curb the cost of services and to improve the quality and accessibility of care. Efficiency gains could also be achieved through appropriate selection of biomedical technology.

Efforts should be made to carry out needs assessment studies for human resources in various fields based on health needs (public and private) as reflected in burden of disease studies. Studies on workload for various health professionals could also help in improving human resources management aimed at reducing imbalances between regions and specialties. Providers should be involved in determining the best use of scarce resources. Career



development, licensing and relicensing should be linked to ensure the credibility and quality of national health services. Providing on-the-job training and education to health staff in cooperation with the training and education institutions will provide further incentives and motivate health personnel and contribute to career development.

#### *Developing accreditation systems for health personnel education*

Accreditation systems are an essential requirement for quality care and recognition by international education institutions and have become even more relevant with globalization and world trade agreements, such as the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). It goes without saying that the development of strategic planning for human resource development should be part of strengthening policy and strategic planning functions in the ministries of health in partnership with the related ministries of planning, finance and higher education.

### **7.5 Primary health care budgeting and financial management**

It has been recognized that in order to meet the economic, social and technological challenges there is a need to focus on innovative approaches to ensure efficiency and effectiveness of the health system and to achieve the right balance between financing and provision of care. The largest gains in terms of reducing costs and thus making the funding of primary health care affordable could come from improvements in the efficiency of both the government and private sectors. Countries have found that poor management is a major obstacle to the proper performance of health systems and has led to wastage of health resources. Reducing such inefficiencies would result in savings that could be used for expansion of access to health services or for improvement of the quality of health services. However, the ways in which health care is paid for and organized today constrain the potential for efficiency and quality improvements.

Most countries need to develop capabilities in policy analysis and formulation including economic analysis. Planned reforms should focus largely on improving health care financing and on increasing equity and health system efficiency through the following:

- focus on cost effectiveness and efficiency indicators in the national procedures for budgeting and in the financial proposals made by the Ministry of Health;
- advocacy to ministries of finance and planning that investment in health has high economic return;
- mobilization of additional resources for health development from taxation (e.g. profit of pharmaceutical companies, tax on tobacco products) and other means (e.g. vehicle insurance for road traffic accidents) and reduction of out-of-pocket spending on health;
- allocation of international aid resources to health priorities, such as those identified by the Commission on Macroeconomics and Health which suggested essential care financing especially in low income countries, for example, and this would be helpful to the five least developed countries in the Region.

- improvement of financial management through capacity-building and strengthening decentralization in hospital management to increase efficiency and improve performance.

## **7.6 Improving efficiency and effectiveness of health care settings**

Many countries are attempting efficiency measures in their health system and to rein in total costs. New methods of payment for services are being designed in order to introduce efficiencies in the provision of care services. How to coordinate with and integrate the private sector into the national health system is a major challenge. A review of all services should be undertaken which takes into account the new movement in primary health care to provide services to patients in less costly settings, such as through ambulatory care and community-based approaches, e.g. home-based care and long-term care. The aim of such is to use acute care facilities more efficiently, reduce the length of stay in hospitals and increase the utilization of beds and services. However this movement is still in the experimental phase.

It should also take into account the need to change the working environment while developing the capacity of individuals and teams to manage effectively. This would include:

- decentralization of responsibility for financial control to the clinicians who commit the expenditure (with appropriate financial, managerial and information support);
- increasing the awareness of staff and the wider population of the costs of providing health care and the opportunity cost of inappropriate use of health service resources;
- giving clinical staff who have administrative responsibility as heads of services or departments allocated time, relevant training and managerial support to undertake this role.

## **7.7 Selection of appropriate technology**

Biomedical technology is contributing worldwide, and in the Eastern Mediterranean Region, to the increasing costs of health care. In some countries magnetic resonance imaging (MRI) facilities to population ratios are among the highest in the world (e.g. Jordan, Lebanon) but utilization rates are low. Greater attention needs to be paid to the selection of appropriate technological inputs in health systems in the field of medicines, vaccines and bio-medical equipment.

As medicines represent an important component in health care spending, ministries of health should pursue implementation of their national drugs policies and use of the national essential drugs list in order to improve the rational use of drugs. The availability of drugs affects the clinical quality of health services, costs and the perceptions of clients. Purchase of medicines through the private sector is also one of the main out-of-pocket expenditure items for the poor. Key aspects of the policy to be addressed include selection, procurement, distribution, pricing and quality.

In the efforts to enhance primary health care a national committee for technology development and assessment should be established. Such a committee should include all

concerned parties and should help in developing policy options for technology selection using the findings of assessment activities.

### **7.8 Organization, management and reorientation of primary health care service provision**

Coverage and utilization of health services need to be assessed based on population figures and incidence of condition(s). Services should be reviewed regularly identifying performance levels and available resources and assessing implementation of quality care standards and the surrounding environment of the facility. Such continuous review of available care is necessary to identify lessons and experience elsewhere and identify best practice.

#### *New organizational culture*

Primary health care requires a new organizational culture which should prevail at all levels and sites. This culture is crucial for expanding the delivery of primary health care services to all population groups in an efficient, integrated and simplified manner. It should be client focused, team oriented and based on information and knowledge sharing. Leadership in a health facility enhances the new management culture and can be responsive to changing needs. Actions might include:

- changing the existing organizational structure within the Ministry of Health to support a general management or business management style; personal accountability is seen as the key to improving commitment and taking responsibility for the management of services and resources;
- changing the different lines of accountability of health facilities and their staff members to operate more efficiently by introducing multidisciplinary management teams working within each service and department; clear lines of accountability and communication need to be developed and the services need to be managed through a flatter structure;
- harmonizing the relationship between the different levels of care such as health units, health centres and referral hospitals; one way of improving this harmony is by developing and enforcing guidelines and agreed protocols for referral to secondary care and back to primary care;
- review of coverage by primary health care services to improve access by expanding health insurance to the uninsured rest of the population. There is a need to study and make necessary interventions regarding the unmet needs of marginalized segments of the population as expressed in the national health accounts and/or household surveys which will reveal the percentage of out-of-pocket spending and/or catastrophic expenditure by households.
- developing a strategy to find the best balance of public-private mix and a partnership role for the private sectors; as the private sector plays an important and growing role in most countries, the mix in provision of health care needs to ensure that encouragement

of more privatization does not focus on clinical care alone to the detriment of health promotion and disease prevention and control.

- collaboration and joint planning between private and public sectors to ensure mutual benefits, especially since the private health care sector is expanding with limited control; information on the performance of the private sector and its contribution to health care delivery is needed; the private sector often depends on public financing for growth, as in Lebanon and Jordan.
- revision and regular updating of the terms of reference of each category of health facility to meet the changing needs and demands of the users and the career development and skills needs of the workforce.

#### *Formulation of sustainable universal core packages of health care*

The Declaration of Alma-Ata clearly spelt out the essential priorities for launching primary health care in any setting, usually known as the eight elements of primary health care. Defining the content of a basic package proved to be necessary for costing and financing of essential care, for training, monitoring and evaluation, for coordination between the three levels of care and for developing an effective and efficient referral system. Each country may need to review, test and assess the efforts in implementing the universal package at various levels by:

- reviewing different packages of care provided by different providers and purchasers of services in the country;
- reviewing periodically the division of tasks and balance of care provided in primary care and secondary care and exploring options for intermediate care;
- focusing primary care on cost-effective interventions which produce the highest health gains to the community;
- considering opportunities for working with the private health care sector in areas where they have particular experience, capability or capacity or better economies.

#### *Referral system support*

Referral support is indispensable to the proper functioning of first level health facilities in a health system based on primary health care. At the same time, the proper functioning of the first level service is a guarantee for equity of accessibility to secondary and tertiary services and can act as a guard against overuse.

#### *Family practice*

Efforts should be made to enhance the strategy of family practice which, in addition to the technical health skills, should also include:

- training in financial, planning, and administrative skills for family physicians;

- decentralization of budgetary responsibility to clinical departments and teams; at present very limited control is exercised by clinical staff on expenditure and they have neither the responsibility, the information nor the support to do so. It is difficult to ascertain whether cost bears any relationship to activity performed and there are no widescale attempts to continuously evaluate the use of resources in terms of economy or effectiveness.

It would require a management development programme such as the WHO Management Effectiveness Programme (MEP) to equip staff and teams with the relevant skills and improve understanding of their role.

#### *Balancing hospital and ambulatory care*

Ministries of health spend over half their budget on hospital-based curative services. Many hospitals operate at very low occupancy rates, employ excess staff and use resources inefficiently. There is evidence to suggest that there is an oversupply of hospital beds especially in the urban areas of many countries in the Region. Rationalizing the number of beds, staffing and associated costs in this sector has the potential to release funds to cover some of the costs of the primary care services, which cater for the majority of the prevalent ailments.

Ambulatory care has recently been developed, driven by economic factors and its attractiveness to patients. However this shift in case management requires high level administrative, technological and technical skills, such as surgical and anaesthetic skills, careful selection of patients, and adequate postoperative pain control/relief. Introducing ambulatory care requires in-depth review of the organization, resources, competence and logistics of the emergency care system. Due consideration should be given to:

- redesigning the patient pathway to ensure continuity of care;
- the roles of primary and secondary care in the management of priority health conditions, especially noncommunicable diseases and clear definition of these roles in the context of ambulatory care;
- using cost-effective tools to correct ineffective interventions or treatments in use;
- matching staffing levels to activity;
- training of staff in new ways of working.

#### *Reorientation of health services towards health promotion*

Responsibility for health should be shared between individuals, communities, health professionals, health services and governments. Health services need to move increasingly in a health promotion direction, beyond the responsibility for providing clinical and curative services alone. This requires a change in attitude and organization of health services that refocuses on the total needs of the individual.

Adoption of a risk reduction approach will allow countries to tackle the increasing trend in diseases related to unhealthy lifestyles. It is important to start reorienting health services so

that they are able to address the risk factors responsible for the increasing magnitude of these diseases.

The role of health workers in promoting healthy lifestyles can be augmented through continuing education programmes directed at informing all health workers about approaches and methodologies in health education of the public, in addition to enhancing workers' skills in increasing demand for promotive and preventive care (comprehensive risk management), such as screening services.

## **7.9 Enhancing decentralization**

### *Decentralization through district health systems development*

The district health system in countries has received special attention through convergence of resources at the operational level. The integrated primary health care model advocated by WHO highlights the importance of focusing on catchment areas, strengthening decentralization and community participation and community and health personnel ownership, and nurturing of quality assurance. WHO is also promoting within the district health system, health care that is not based in institutions, such as community and family care and family practice. Appraisal tools, targeting health providers, managers and users in the health care facilities, health directorates and the community at large, should be designed to assess situation and identify needs for managerial and technical interventions within the district health system in order to improve primary health care coverage.

### *District team problem-solving technique*

Institutionalization of the district team problem-solving technique (DTPS) is crucial to the sustainability of the partnership with community and related stakeholders and their involvement. DTPS brings the health services nearer to the people in the catchment area. This initiative which is both integrated and decentralized, combines medical education and health service delivery within identified catchment areas and should be advocated and implemented in many settings, including hospitals. The WHO generic DTPS manual should receive wide dissemination and training sessions in the target districts.

### *Investing in nongovernmental organizations*

Nongovernmental organizations are well equipped to work in close contact with communities. There are many national nongovernmental organizations working in the Region and the work of many of these includes the delivery of primary health care services to the urban poor and peri-urban dwellers. However, most of their work is dependent on the individual motivation of community members. Nongovernmental organizations usually have strong relations with women's unions, youth federations, etc. Their widespread presence at the grass roots level, their experience and their commitment allow them to play an important role in community partnership. Access to primary health care can be increased through collaboration with nongovernmental organizations.

### *Hospital autonomy*

Strengthening the autonomy of a hospital means strengthening its relationships with the other care facilities with which it should be integrated, in a national complementary system. This does not mean that hospitals are no longer accountable for implementation of national policy and standards. If management autonomy is increased at the hospital level, managers should be publicly accountable for how they exercise that autonomy. Autonomy requires development of staff skills in all aspects of management of the hospital, whether at the policy-setting level or at the operational level. Autonomy is often narrowly interpreted to mean recruitment, dismissal, pay etc. However, it also includes incentives, evaluation, continuous training, budgeting, accounting, income-generation, borrowing, etc. Efforts to establish this initiative as part of primary health care revitalization should be encouraged and monitored.

### **7.10 Accreditation of health care facilities**

Health systems currently operate within an environment of rapid social, economic and technological change. Health systems are also nowadays under continuous scrutiny by planners, purchasers and users of the services. Most health managers and policy makers now view as imperative the evaluation and control of quality.

Improving quality of care, ensuring continuous quality improvement and institutionalizing improved quality of care through accreditation requires more than a technical approach, more than the application of tools and methods. Failure to change the behaviour of people and organizational attitudes is the commonest cause of ineffective quality initiatives. Sustained improvements often require a change in attitude and acquisition of a sense of ownership with regard to the quality of services provided by an organization. Many supporting factors are required to integrate accreditation into the structure and function of an organization. The strategies in setting and measuring against standards are largely technical; the strategies in making appropriate change are social and managerial. Sustainable quality needs a supportive environment of leadership, clarity of purpose and organization. Primary health care can provide such an environment. A strong accreditation programme can be the single most important approach for improving the quality of health care structures. It would include:

- development of standard operating procedures (SOPs) for primary health care facilities, especially health centres and district hospitals;
- adopting clinical practice based on evidence;
- agreeing protocols and guidelines for formulating standards of care both within and between primary, secondary and tertiary care;
- applying total quality management (TQM) experience in the different levels of care, documenting TQM experience, and developing guidelines and tools for quality assurance and improvement.

WHO and Member States should continue the current work on accreditation and develop a strategy for accreditation of health care facilities in the Region. Accreditation

guidelines and capacity-building should also be further developed through regional expert groups.

## 8. CONCLUSIONS

Since the Declaration of Alma-Ata, fundamental changes have occurred affecting health service delivery, such as economic development and financing approaches, globalization of trade and knowledge, and the shift to privatization. Pressures on health systems include demographic change, changing disease patterns, increased environmental hazards, emerging technologies, global communication networks and increased expectations of users. All these changes have further increased the critical importance of primary health care and its central role in sustainable development. In order to revitalize primary health care as the central focus of national health systems in the Region there needs to be:

- renewal of the commitment of politicians and decision-makers towards primary health care/health for all and translation of that commitment into reality through increased budget allocation for primary health care and expanding the delivery of health care services to all population groups in an efficient, integrated and simplified manner;
- initiation of frank and wide-ranging discussion to unify international vision, strategies and support to primary health care;
- orientation and reorientation of all health workers to the relevance of primary health care/health for all through the revision of training curricula and on-the-job training;
- integrating health and in particular primary health care into the socioeconomic development process through community-based initiatives and the use of problem-solving techniques;
- improving management skills and capabilities at all levels with emphasis on financing of health care;
- developing feasible models and strategies for urban primary health care and recognizing the role of alternate therapies of proven value;
- introducing continuous quality improvement and accreditation programmes;
- formulation of rules and regulations for the private sector as well as plans for cost sharing without marginalization of the poor;
- coordination between the levels of care and development of an effective and efficient referral system.

In addition to its traditional role, primary health care must build up its ability to carry out a range of country-specific functions. It should aim to remain as the leader and the means to achieving health for all. It must be able to lead partnerships with all health care providers, influence the policies and action of other sectors, and inspire the support of and collaborate with community organizations and the media to create an informed and supportive environment for primary health care.



## **9. RECOMMENDATIONS**

### **Member States**

1. Conduct a primary health care review (based on the WHO/EMRO guidelines) every four years as part of the Joint Programme Review and Planning Mission.
2. Conduct a national conference on the “way forward” during the biennium 2004–2005.
3. Develop national strategic directions for primary health care, including for financing, and review the impact of global and national changes and challenges.
4. Develop a five-year plan for achieving full health care coverage of the population through the primary health care network; the development of such a wide network should be coupled with intensive training, continuing education and supervision in order to improve performance and quality of care.

### **WHO**

1. Upgrade the protocol developed for primary health care periodic review.
2. Develop enabling tools to improve performance of health care, in collaboration with WHO headquarters.
3. Promote the development of a comprehensive district health system based on the primary health care experience in the Region.
4. Encourage the family practice and family doctor initiatives in the Region
5. Continue supporting countries in developing standard operating procedures and essential sets of services (primary health care packages).
6. Encourage development of national programmes of accreditation for primary health centres as well as hospitals.
7. Re-endorse the Al Manama Declaration on Primary Health Care and promote it in the Region.