



6th December – Session 3
Health Systems IPHU- 2022
Bangkok



What is Comprehensive Primary
Health Care ?
Why has it been so difficult to achieve?



,

Presentation in 4 parts:



1. Conceptualization of Primary Health Care
2. Barriers to Implementation
3. Evolution of Primary Care under changing Governments
4. The Problematics of Primary Health Care



What is primary health care??

1

- It is an **approach** to organization of health care services which has a set of essential features-
- The key **strategy** for the achievement of health for all goal,

(The opposite of primary health care approach is a hospital centric, curative based approach...)

Essential Features of Primary Health Care



1. Comprehensive- all components, illnesses & levels
2. Emphasis on Prevention and Promotion
3. Population Based-
4. Community Based-
5. People-Centered-
6. Includes the referral – entire district health system
7. Gateway/facilitator function-
8. Without financial hardship



Community based and People-Centred



-requires a direct and enduring relationship between the provider and the people in the community served
-and it is essential to be able to take into account the personal and social context of patients and their families,
- ensuring continuity of care over time as well as across services.



Feature 5: Gate-keeper/Gateway/



- This role “effectively transforms the primary health care pyramid into a network, where the relations between the primary-care team and the other institutions and services are no longer based only on top-down hierarchy and bottom-up referral, but on cooperation and coordination.
- The primary-care team then becomes the mediator between the community and the other levels of the health system, helping people navigate the maze of health services and mobilizing the support of other facilities by referring patients or calling on the support of specialized services.
- They can help ensure that people know what they are entitled to and have the information to avoid substandard providers..”
(2)

Action on Social Determinants



- Social Inequalities- Primary health care cannot solve them- but must be designed for equity- which means affirmative action to reach those more on need
- Determinants related to food, nutrition, drinking water , sanitation, living conditions, working conditions, environmental hygiene etc- some of it must be addressed by health systems and frontline workers- but much of it requires action by other sectors- not be health systems per se
- The Commercial determinants of health- largely needs to be countered by inter-sectoral action- but health care providers have a role to play in education and advocacy



Striking the right balance



- Action on health systems is as important as action on social determinants. Not done to undermine the importance of either.
- Universal health systems especially access to primary health care is itself a major social determinant.
- The struggle for health rights is the core of the peoples health movement- and only equitable health systems, built around comprehensive primary health care can deliver this..



Why has primary health care been so difficult to realize?



2



BARRIERS TO IMPLEMENTATION

I. Confusion with Primary Level Care:



- It is NOT First Contact Care
- It is NOT care for simple ailments and symptomatic care/dispensary
- It is NOT reproductive and child health plus national disease control programs
- It is NOT limited to care you get at Primary Health Centres
- **Primary Level Care:** Is one sub-set of primary health care and describes what happens at point of first contact and close to community facilities- usually managed by primary care team - who can even be only nurses and paramedicals: Also referred to as entry point ambulatory care:
- **Primary Health Care-** is the key strategy to the achievement of Health for All goal



II. The Selective Health Care Approach



- 1950 to 1978 : The Capture by Family Planning (....and malaria and a few national programs).

- 1990 onwards: Health Sector Reform Under Structural Adjustment:

“ Beyond a well-defined package of essential services, therefore, the role of the government in clinical services should be limited to improving the capacity of insurance and health care markets” (WB Report, 1993)

- The essential services to be provided were to be based on an indicator- “ dollar spent per DALY saved.”



Impact of selective healthcare



- Peripheral facilities (sub-centers, PHCs and CHC) lose public trust and credibility. People prefer to bypass them
- Changes perception and de-skills medical officers
- Introduction of user fees contributes to exclusions
- Tertiary care hospitals became over-crowded and poorly functional.
- Vertical programs stagnate due to weak system
- Transfers the blame from the policy makers to the public health workforce and public systems- justifying lack of further investment – even for replacement in public health systems
- Huge increases in costs of care.



3. Systematic Under-funding:

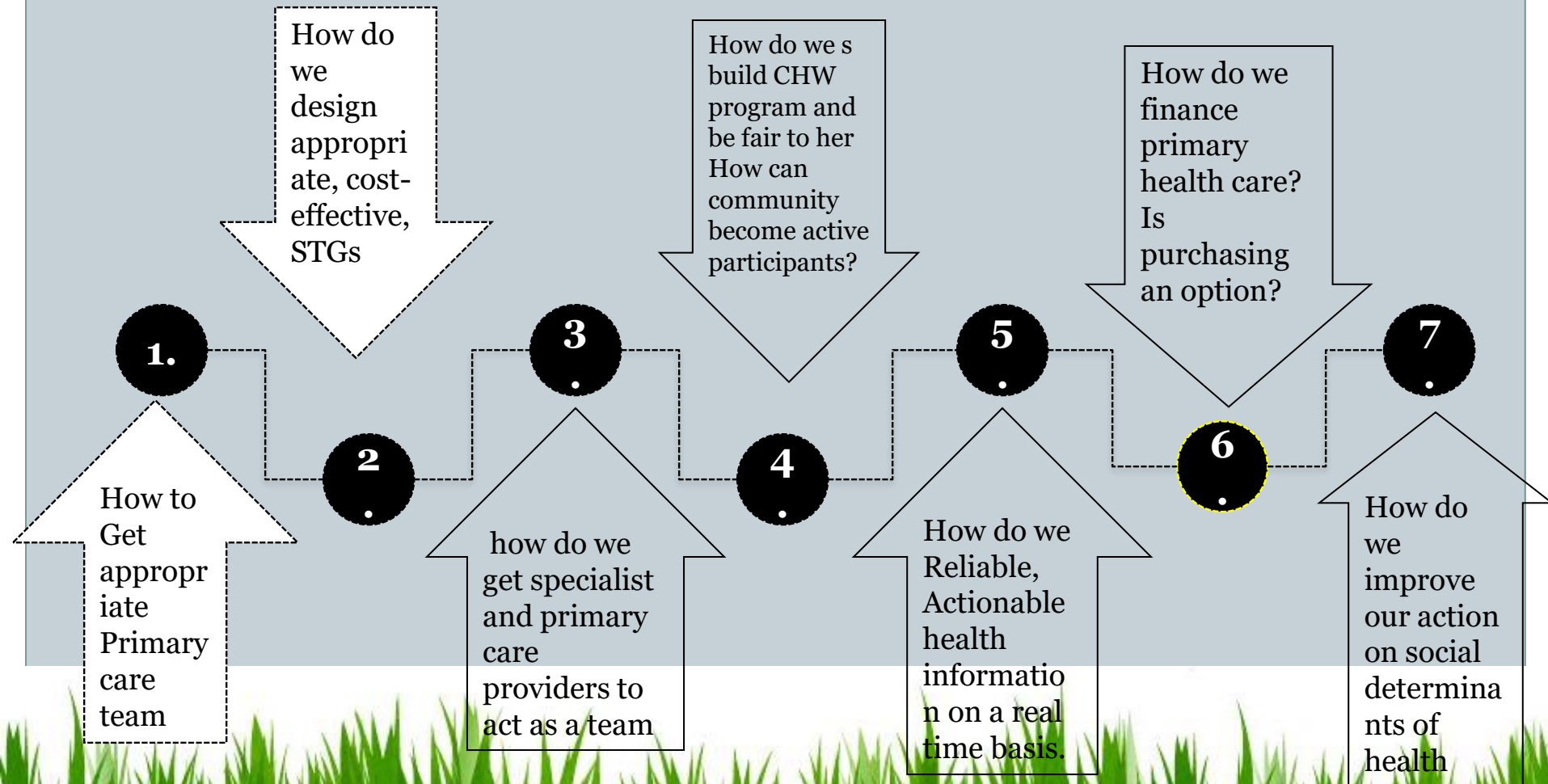


- Low public expenditures on healthcare –
- Most of the resources go into tertiary care sector-
- In most states the number of health centers were never created- and did not keep up with population.
- There was almost no additional beds, or health centers added on, even to keep to population norms
- HR in most facilities was far below required levels- and inconsistent.



IV. Other problematics of implementing primary health care.. & scope for design solutions...

14



1. Human resources for health



- What is the primary care team in the country? At a frontline facility and for a district:
- What are the terms of their employment?
- What are the gaps in health worker performance- and what do we know of how it can be addressed?
- Poor fit between the training provided and the needs on the ground
- Poor fit between aspirations of the providers and the requirements
- The changing culture of medical practice- especially specialist practice



2. How do we ensure a wider set of assured services



- **Does selective care persist, despite everything...**
- **For each chronic illness:**
 - What functions can be devolved to the primary care team?
 - What functions can be addressed on tele-medicine support
 - What functions require the hospital/consultant visit
 - What point of care diagnostics can be introduced
 - How do we standardize the drugs to be kept at PHC
- **For inclusion in the package of services?**
 - When do we consider it a question of cost-effectiveness and when is it a rights based issue?



3. The continuity of care problematic!!



- How do we get the specialists and the primary care providers to work as a team?
- What works: Help-desks, social workers, information technology, tele-medicine, mobile vans, mobile specialists
- Why has linkage between levels of care been so difficult?
- How do we retain doctors and specialists and interest them in working in primary health care



4. The community as active participant!!



- Are CHWs adequately integrated into health systems?
- How do we secure CHWs terms of employment without losing her solidarity with community?
- How do we secure CHWs accountability without losing her solidarity with community?
- What roles can Village Health Councils play & capacity building for these?
- What is the role for self-care, health education, etc
- How are issues of equity addressed.



5. Why has digitization been so difficult?



- “the techno-optimism paradox”: Introduction of IT is promoted as solving “all” problems- but it can hardly manage its own deliverables:
- Unlike in other sectors:
 - Little impact on outcomes/ data reliability
 - Huge increase in burden of work front-line workers:
 - Little evaluation and learning from the past, almost no research inputs...or use of evidence:
- How can IT help make it easier to Record, Report, Enable Care Continuity, Compute population based reports, provide disaggregate data- while reducing work burden. NOT a tool of surveillance.....
- How to promote use of information? And interoperability ?

6. How do we finance primary health care



Goals: Effectiveness, Efficiency in achieving health outcomes , responsiveness and social protection:

- Current public financing is budget line-item based! What are the problems?
- Other options are adjusted capitation based global funding, strategic purchasing using contracts,
- Why have PPPs for primary healthcare been do difficult to construct?
- Do monetary incentives work to improve performance?
- How important/desirable is provider-payment split?
- What is international experience in financing of primary healthcare wrt achievement of goals?



7. Addressing the Social Determinants of Health



- What are the functions that public health systems are carrying out- for example through the municipal health officer?
- What functions can be advanced for primary care teams to be engaged with with regard to
- Water, sanitation, nutrition, environment hygiene
- Inequalities, Caste and class based discrimination, exclusions, different forms of marginalization, exploitation?

Most of these are the responsibility of other arms of governance- how do we draw attention, build capacity, provide solutions..



V. Core Governance Issue



- Values- How much is role of government in provision of healthcare seen as a right- *how far is delivery of this right equated with good governance*
- Decentralization- How far are decisions taking place closest to where they can be acted upon-. Are management capacities built for this.
- Learning- Adaptive Systems:
 - ✦ How do we understand data? Evidence?
 - ✦ How do we encourage use of information
 - ✦ How can be correctives be implemented.
- Affirmative action to reach vulnerable sections: purchasing systems are necessarily iniquitous- how do we build health systems as public goods.



VI. The role of a legal framework



- For Right to Health Care:
- For Regulation of Private HealthCare-
- For public health- the right to the underlying determinants of health – Public Health Acts
- Are the laws designed
 - For effective delivery of services/rights-
 - Will the laws lead to too much litigation
 - Are they feasible, can they be financed?
- Both Thailand and Costa Rica have a legal framework in place- and one of the most affordable systems in the world.

Why PHM activists need to engage :



- To show that there are feasible solutions – to generate the necessary knowledge and optimism
- To expose false solutions that only lead towards privatization and poor working conditions.
- To ensure that people secure their health rights
- The issues of health systems is often the entry point for those working into health to approach the larger changes that are requires



Learning from Thailand



- Based on comprehensive primary health care-Every health need is included-only exclusions specified
- Thinking through how to deliver healthcare as a right- registration at PHC as gateway to entitlements.
- Strategic purchasing as responsive and responsible private financing.: 95% of CUPS/districts are public providers
- Adequate deployment of appropriately skilled public health workforce-) 1.4 million CHVs, 26,000+MLHPs, and 25 plus teams at DH(CHC)++) and infrastructure.

Learning from Costa Rica



- Rights driven- provision of healthcare as core value
- Political facilitators- de-militarization, democracy,
- Largely organized, urban work-force
- Built around social insurance
- Integration between social insurance and ministry of health team
- Multi-disciplinary Health teams provided universal primary healthcare- linked closely to secondary and tertiary care.
- Empanelment of Costa Ricans to these care teams to support population health management and continuity of care;
- Adequate management capacity



One can learn from many other countries- both on the strategy and on addressing barriers-



- Cuba as a socialist system
- Specific lessons from
 - Sri Lanka
 - Nepal
 - Brazil
 - Vietnam
- And indeed from all LMICs, there is something to learn.
- Also from the high income countries- UK, Spain, Germany, Japan, Australia, Canada, the Scandinavian countries..



Four Essential Messages from the PHM

- to the public and to the policy makers



1. Comprehensive Primary Health Care Approach is an essential strategy for achieving the right to health and Health for All.
2. The understanding of what primary health care is, has got distorted by three decades of selective health care- we need to explain this better
3. We need to be able to show that such free universal health care is not a dream- it has been done, it can be done.
4. The solutions to many of the barriers to public provision of comprehensive primary health care- does NOT lie in making it work more like markets. We need to approach these as public goods.



references



1. Primary Health Care- Now More Than Ever: World Health Report-2008- pages 41 to 62
2. Primary Medical Care in the United Kingdom : Martin Roland, DM, Bruce Guthrie, MB, BChir, PhD and David Colin Thomé, MBBS. *J Am Board Fam Med* March-April 2012 vol. 25 no. Suppl 1 S6-S11doi: 10.3122/jabfm.2012.02.110200
3. Pese M, Ratcliffe H, Bitton A. “Building a Thriving Primary Health Care System: The Story of Costa Rica.” Case Study, Ariadne Labs, 2017.
4. The Politics of Primary Health Care, David Sanders, International People's Health University; <https://doi.org/10.1093/acrefore/9780190632366.013.50>
5. Marcus Cueto; Public Health Then and Now |,American Journal of Public Health | November 2004, Vol 94, No. 11, 1864



Thank You

