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**THIRD CONSULTATIVE GROUP MEETING
ON ORGANIZATION OF HEALTH SYSTEMS
BASED ON PRIMARY HEALTH CARE**

New Delhi - 13-17 March 1989



WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTE

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ENGLISH ONLY



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SUMMARY, CONCLUSIONS AND RECOMMENDATIONS	1
GENERAL RECOMMENDATIONS	2
ISSUE-SPECIFIC RECOMMENDATIONS	2
OPENING OF THE MEETING	4
BACKGROUND TO PROGRAMME'S ACTIVITIES	5
PROGRAMME'S CURRENT ACTIVITIES	5
ISSUE 1: HEALTH FINANCING AND MANAGEMENT	6
ISSUE 2: PHC IN URBAN AREAS	10
ISSUE 3: QUALITY ASSURANCE IN HEALTH SYSTEMS BASED ON PHC ...	13
ISSUE 4: HEALTH IN PUBLIC POLICY	16
SUMMARY AND AREAS FOR ACTION AND SUPPORT	19

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SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The third meeting of the Consultative Group on The Organization of Health Systems Based on Primary Health Care was held in New Delhi, India from 13-17 March 1989. Four issues of current concern in the Programme's work were discussed:

- health financing and management;
- urban primary health care
- quality assurance in health systems based on PHC; and
- the promotion of health in public policy

The Consultative Group noted the achievements of the programme, and recognized the essential nature and growing importance of the Programme's work in achieving the implementation of the PHC strategy. The Group strongly expressed the view that support for countries in the organization of health systems based on primary health care should be pursued through an integrated approach to the strengthening of health services.

The Group observed that an adversarial relationship often existed between the needs of health programmes, on the one hand, and those of finance and planning ministries, on the other. Experience in some countries has shown that successful policy for improving health status requires special skills, which draw upon the scientific expertise of health professionals, and can anticipate economic counter-argument from finance and planning agencies. To mediate between the interests of health programmes, and those of central government finance agencies, skills in health economics, development planning, and political sciences are all required. Strengthening of WHO capacity to provide support to developing countries necessitates developing WHO's own capability in such areas.

The continued predominance of biomedical issues in much WHO-supported training and research was noted by the Group, who felt that WHO was moving too slowly to recognize the potential of health systems research and policy analysis in promoting and defending health interests.

Better communication, and joint working arrangements among individuals and institutions constitute important support mechanisms for the Programme's work. The PHC collaborating centres are a means to increase skill and information flows to and among those involved in PHC implementation. Schools of public health, universities and management institutes were all potential resources, and the Programme was urged to encourage countries to make better use of their institutions and local skills.

To guarantee that information is made generally available, WHO should ensure that its own networks contribute to country support, by increasing the availability of technical information to PHC managers, and improving the collection, dissemination, presentation and relevance of such information.

Better integration among WHO's own activities is needed if their potential effect is to be maximized. Health systems development units in WHO view the organization of health systems in an integrated way, and their catalytic potential should be strengthened. Some of the Programme's tools, such as the PHC review process and the district focus, were felt by countries to be valuable mechanisms for facilitating comprehensive delivery and monitoring of health care. The Group proposed the expansion of these reviews to more countries, with the development of appropriate follow-up processes.

The Group was of the opinion that the breadth of the Programme's concerns make its present resource base appear very inadequate, and it felt that an improvement in funding would allow a more than proportionate increase in country support activities on the above lines. The need for additional resources to strengthen activities was essential to allow accelerated progress with the four issues presented and reviewed. The Group expressed surprise that policy analysis in general, and a major health economics component in particular, were not more prominently represented in the Programme.

As a result of these discussions the Consultative group made five general recommendations directed to the strengthening of the Programme, and also made recommendations specific to each of the four reviewed components of the Programme's work.

GENERAL RECOMMENDATIONS

Recognizing the importance of the SHS programme and the essential nature of its concerns to the realization of the goals of Alma Ata, the Consultative Group saw the need for increasing the role for the Programme's work. The Group recommended:

1. That the Programme should strengthen coordination at all levels with other WHO programmes, to achieve better integrated support to countries for organizing their health systems based on primary health care. Areas in which tools and methods for such coordination have already been developed, include the PHC review process, and the district health systems approach.
2. Additional resource support should be sought for the programme, by:
 - a) enhanced mobilization of external technical and human resources, including collaborating centres, schools of public health and universities, and in supporting countries to develop and use local networks of their own institutions and resources; and
 - b) increasing the programme's financial resources from the regular budget, and the fullest mobilization of extrabudgetary support, including donor agencies.
3. The programme's capacity to support countries in the analysis and development of major health policy issues, influencing health care and health status should be substantially increased. Additional resources in health economics, management and political science are required as a principal component of this improvement in capacity, to support countries in the appraisal, formulation, implementation, and defence of their PHC strategy.
4. An enhanced role in the synthesis and documentation of methods, training materials, and country experiences is needed, both to reach larger audiences, and to increase the range of technical documentation support. Materials should be carefully tailored to the needs of specific countries and users. Support is needed for new mechanisms, including local adaptation, to ensure wider availability of such materials to key researchers, policy makers and implementers of PHC strategy.
5. At its regular biennial meetings the Consultative Group should review the Programme's emphasis and progress in implementing the recommendations of the previous meeting, and will make recommendations for change. Individual members of the Consultative Group should be regarded as part of the enlarged group of technical support for the Programme, and have agreed to be available for advisory purposes.

ISSUE-SPECIFIC RECOMMENDATIONS

(i) Financing and management

The Group recommended that:

1. The Programme should take a leadership role in promoting awareness by governments and international organizations of economic issues affecting the health sector, to ensure adequate financial support and efficient allocation of resources.
2. Monitoring of macroeconomic policies and its effect on health status and health services and provide early warnings to the global community of the seriousness of the economic situation and its health impact in developing countries, should be undertaken.

3. Increased technical support should be provided for the appraisal of financing, resource allocation, and management options, including evaluations of fee-for-service developments, in countries with shortages of the relevant skills, and for related health systems research.

4. The programme should continue and enlarge its role in supporting increased training opportunities, in line with the proposed activities in the programme statement "Health Economics - A Programme for Action", which distinguishes training needs in four areas:

- (i) familiarization seminars for policy level personnel from health, finance and planning ministries together;
- (ii) training courses on programme cost analysis for managers with implementation responsibilities;
- (iii) training in improved accounting and financial management for district level management teams; and
- (iv) orientation in health economics and epidemiology for trained economists.

(ii) PHC in urban areas

The Group recommended that:

1. WHO must take the lead in promoting activities to bring together all concerned agencies for collaborative efforts to work with national governments, municipal and local authorities in developing health, with primary health care as its strategy, in urban areas. Action at the planning level in cities should be emphasized. Health should become a unifying theme in urban development, in both the industrialized and the developing world.

2. The Programme should increase its role in analysing, documenting and disseminating positive and successful innovative programmes which have improved the quality of urban life and health status. To this end, WHO should support the provision of training materials and orientation activity for municipal health personnel.

3. Problem-solving research and development activities in the critical areas of urban health development should also be supported. Joint action involving communities, urban health services, environmental and social services, to alleviate poverty, should be promoted.

4. Methods of risk-identification and risk-management for vulnerable urban groups, particularly in inner city areas, should be developed.

(iii) Quality assurance

The Group recommended:

1. The promotion and advocacy of quality evaluation methods in health care at all levels should be encouraged, and a common glossary of terminology developed.

2. Support should be mobilized for research and development of methods for quality assurance, and specifically support for planning, implementation and documentation of action research in selected districts in a small number of selected countries.

3. Preparation and distribution of case studies and examples of training materials on quality assurance, based on country experiences. In addition, support for country adaptation of materials through workshops and collaboration with WHO Health Learning Materials programme.

(iv) Health in public policy

The Group recommended that the Programme should:

1. Provide documentation on the experiences of countries in containing the negative effects of development policies on health, particularly the institutional arrangements and the processes used. Develop and disseminate methodologies for assessment of the health impact of development programmes; and develop a directory to enable Ministries of Health, community groups and the media to have easy access to specific case studies and information, as a means to create further awareness and action.

2. Support countries in undertaking research and policy analyses to assess the health impact of development projects. The Programme should also strengthen institutions in countries for improving and developing methodologies for policy analysis, for calculating the risks in development choices and for undertaking problem-oriented research.

3. Mobilize support for institutions (training and research) to develop materials and support educational and promotional activities to improve understanding of the relationships between economic gains and health risks in public policy.

4. Promote and advocate through the convening of national and international conferences and symposia ways and means of mitigating the negative consequences of development policies on health, in collaboration with international agencies including donor countries, to ensure that their programmes protect health and do not contribute to unnecessary morbidity and mortality.

OPENING OF THE MEETING

The third meeting of the Consultative Group on Organization of Health Systems Based on Primary Health Care was held in New Delhi, India from 13-17 March 1989. At the Opening Session Dr U Ko Ko, Regional Director, welcomed the participants. He traced the development of health services, emphasizing events in developing countries from the early days of this century to the time of the Alma-Ata Conference. Dr Ko Ko emphasized the key role played by WHO, beginning in the nineteen fifties, in gathering together international expertise to a common forum to address pressing health problems in newly emerging countries.

While recalling the commitment to HFA/2000 made by Member States at the Thirtieth World Health Assembly, and the Declaration of Alma-Ata, he reiterated the underlying principles of the PHC approach and reminded the group of the Riga meeting in 1988 wherein progress achieved was reviewed and a ten-point action programme was formulated.

The Regional Director placed before the group these action areas and emphasized that all of them have a bearing on the four issues selected for discussion at the meeting, and then he proceeded to highlight key factors that influence development of health systems based on primary health care. He urged the group to have this totality in a clear perspective so that their recommendations would be within the framework of health systems based on PHC.

In her address the Honorable Minister of State for Health and Family Welfare, Ms. Saroj Khaparde reaffirmed that an integrated and comprehensive approach for health and human development, especially in closely related health sectors such as drugs, pharmaceuticals, agriculture, rural development, education, housing, water supply and sanitation, prevention

of food adulteration, etc., are the key factors for achieving the Health for All by the Year 2000.

Since independence considerable progress has been achieved in India in the promotion of health. Programmes like family planning, and the control of communicable diseases have proved to be a phenomenal success. Although reduction in birth rate over the years has fallen short of the planned targets, the programme has made a significant impact on fertility control. It is estimated to have prevented over 95 million births in the country so far. Simultaneously a sizeable infrastructure consisting of primary health centres, sub-centres and community health centres has been established to provide minimum basic health care based on PHC approach at the doorstep of the underserved and unserved. The Government has accorded an important role to the Indian system of indigenous medicine in the delivery of primary health care and envisages its eventual integration in the overall health delivery system in the context of the national goal of achieving HFA by the Year 2000.

The Minister emphasized that the World Health Organization is playing an important and crucial role in providing a common framework to formulate policies, strategies and plans of action for primary health care. This role includes promoting world wide understanding that Health For All by the Year 2000 is feasible through the primary health care approach and by facilitating coordinated development of strategies to reach the desired target.

The Annex to this report contains the List of Participants. Dr Quamina was elected Chairman and Dr Mukherjee Rapporteur.

BACKGROUND TO PROGRAMME'S ACTIVITIES

Since WHO's inception the role of the programme has evolved through several distinct stages, in response to changing needs and continuous scrutiny. Underpinning these shifts in emphasis has been the continuing concern of the programme with the appropriate organization and effective management of health systems designed so that all have access to regularly-available health care.

Four related phases in the programme's activity are discernible: i) early emphasis on health "systems", from 1948 to the mid 1950s; ii) focus on the need to integrate mass campaigns into national health services, to the 1960s; iii) the development and planning of basic health services infrastructure, to the mid 1970s; and iv) the primary health care approach, formally launched in 1978 with the declaration of Alma-Ata.

Other major initiatives have originated in the programme during this time, and subsequently have diffused through all areas of health action and thinking. These include appropriate technology in health, the use of norms and standards in health systems planning, and the primary health care strategy itself.

Continuing elements in the programme have been the concern with the development of health systems infrastructures, and in providing leadership in the search for new structures, methodologies and skills for implementing PHC.

PROGRAMME'S CURRENT ACTIVITIES

Three pillars of the PHC approach were identified at Alma-Ata: universal coverage according to need, community involvement, and linkages between health and other sectors in the development process. Monitoring of progress since 1978 shows that needs for essential care remain unmet in many countries. Response to the economic crisis has entailed cuts in government health spending, and unmet need has grown. Policy commitment, resource support, and management capacity have commonly been inadequate to allow perceptible progress in implementing PHC.

How does the programme respond?

Six broad categories of action are used in carrying out the programme's work.

1. Support to individual countries in strengthening their health infrastructure.
2. Promotion and advocacy of new directions and visions in the organization of health systems for PHC.
3. Search for new organizational structures, technologies, methodologies and skills for PHC implementation.
4. Intensified collaboration in implementation of selected activities on priority issues.
5. Information collection, synthesis, dissemination in relation to all of above actions.
6. Generating and mobilizing resources.

Detailed examples for each of the six action areas are given in Working Paper 4. These illustrate the diversity, in both type and content, of the programme's concerns. Such diversity is necessary to implement the broad scope of the programme's responsibility. Of equal importance is the programme's capacity to adapt to the changing circumstances of countries' needs, and to changes in its own capacity.

To provide focus for the discussions of the Consultative Group, four issues of current concern in the programme's work were identified. These are:

- health financing and management
- urban primary health care.
- quality of care, and
- promotion of health in public policy

The issues selected emerge from their importance in countries and the need for current WHO activities to be strengthened in these areas. The four issues are not, however, an exhaustive or exclusive summary of the programme's priority activities. The initiatives on District Health Systems, and Health Systems Research are reflected in the examples but not selected as an issue for detailed review by the Consultative Group. Similarly, the programme of Management, Maintenance and Repair of Health Care Equipment is not featured as a separate issue for this meeting. These initiatives which are also priority activities have been recently discussed in detail elsewhere (Harare 1987, Riga 1988, for District Health Systems; Botswana 1988, Global Advisory Committee on Health Systems Research; and Cyprus 1986 for Equipment.)

ISSUE 1: HEALTH FINANCING AND MANAGEMENT

The Consultative Group noted that the real value of Primary Health Care expenditures has been sharply eroded in most developing countries in the decade since Alma-Ata. Paradoxically, their potential cost-effectiveness is well documented, and is acknowledge by all shades of political opinion. Critical issues relate to the level of resource support, the pattern of resource allocation, and the quality of resource management.

WHO has provided technical support in health economics in the form of guidelines (e.g. "Planning the Finances of the Health Sector"), seminars and specialized consultancies. The importance of economic and financing issues will continue to grow, however, and the programme's priorities are summarized in the recent statement "Health Economics - A Programme for Action". Options for further action and the possible WHO/SHS role were discussed in relation to these three critical issues.

Critical Issue (1): Levels of Funding and Sources of Finance

Government expenditures for health have commonly been falling in real per capita terms, while overall demand has increased. Development expenditure for health has become increasingly dependent on external support. The recurrent budget for government health care has in some programmes been reinforced by external assistance, but has borne the major share of real cut-backs. This has meant sharp reductions in the real earnings of health workers. Other recurrent items of expenditure, such as for drugs, maintenance and transportation, have been spread so thinly that the continuity - and thus the credibility - of PHC provision has been interrupted.

Alternative sources of financing have been pursued. The introduction or increase of fees for government-financed health care has been widespread. Certain controls of private practice have been relaxed, particularly regarding the level of charges. Voluntary insurance schemes, ranging from community charges to Health Maintenance Organization, have been established. Each mode of financing carries distinctive implications for the type, location and accessibility of health care. Cost-recovery may widely be traded off against equitable access to PHC, except in uncommonly well-designed programmes. The effects of changes in the mode of financing on quality, access, availability and sustainability cannot easily be predicted.

Discussion of recent experience in the Gambia centred on the implementation of charges for prescribed drugs. All revenues collected remain in the health sector, and the government guarantees that the regular budget allocation for health will not fall below the base year percentage as in 1987. Utilization fell initially, but recovered within weeks though inadequate revenue is being collected to constitute a revolving fund. A serious problem has been deciding on which patients should be exempt from payment - the list has increased continuously. Health insurance prospects for the Gambia were found inappropriate in view of the small (<18%) percentage of regular income earners in the population, and the anticipated administrative costs of means-testing.

In Kenya, fees for government health services are widely accepted in principle, but implementation arrangements and alternative additional sources of finance remain under review. The existing National Hospital Insurance Fund may be given an enlarged role.

Inefficiency (low net yield after deduction of administration costs) and inequity in access have led Canada to reject user fees. Sharp reductions in access to health care in rural China were reported, following the withdrawal of public subsidies.

In Korea the 1989 extension of health insurance coverage to the entire population was described as trading off some efficiency loss in favour of greater equity. Upward pressure on total health expenditure is expected.

In Canada, personal health care falls within provincial jurisdiction but the federal spending power is unrestricted. The federal government has used that power to influence provincial health insurance programmes, currently through a system of equal per capita block grants. In exchange, for these federal transfers, provincial hospital and medical insurance plans must satisfy five criteria: universality, comprehensiveness, portability, public administration and accessibility. User fees have been eliminated. The system is funded by general taxation, the most important component of which is a progressive income tax. Canada thus has a system of universal, first-dollar, public health insurance for all necessary hospital and medical services.

The tax-based system of the British National Health Service has provided an effective mechanism for overall cost-containment, as judged from the percentage of GNP allocated to health in a system which provides equitable access to a comprehensive range of services, and where user charges are relatively low or non-existent.

Various cost-sharing schemes are in practice in Yugoslavia, where the share of health spending in GNP fell from 6% to 3.5% between 1976 and 1986. In some areas health care providers and consumers decide together on financing arrangements, reducing the administrative costs of health delivery.

Options for action

Better information, at macro and micro levels, on the sources and levels of financial support for PHC is needed at all levels. Documentation of resource trends still require special studies in many countries. Simple flow-of-funds summaries of what monies come from which sources are needed from district to national levels to help establish local monitoring mechanisms.

There is a shortage of empirical material on the consequences of organizational change on health services and health status. Where financing and administration changes are implemented, the effects of these on a) service utilization patterns, b) cost recovery levels and c) the use of net revenue, need to be analyzed and published.

Financial flow studies were reported to have been important bases for reviewing options in Kenya and the Gambia. It was suggested that in order to provide a minimum acceptable level of funding for preventive and promotive activities, separate budgetary provision of a guaranteed share of the total health budget might be considered.

Critical issue (ii): Resource allocation practices

Patterns of resource allocation in the public sector have become increasingly inimical to PHC in many countries. At the level of intersectoral allocations, directly productive sectors have typically been favoured in contrast with "social" sectors such as health ("Health Economics - A Programme for Action", page 6). The 5% of GNP target level for health spending remains way above actual achievement in many countries. Within the health sector, the concentration of resources at tertiary levels of care and in urban areas remains and often continues. Historical trends, rather than population-based measures of need, usually determine how the recurrent budget is allocated. Inefficient and inequitable patterns thus persist.

In discussion, it was noted that economic restructuring policies contained some positive opportunities to review resource allocation patterns. Manpower commitments, however, were commonly rigid and difficult to change; but rationalization in pharmaceuticals had produced savings in Kenya and other countries. Donor concentration on development activities, as opposed to recurrent budget support, had in some countries aggravated the problem of adequate funding of the current activities. Greater flexibility, and better coordination between donors, and with government, were commonly needed. Potential "efficiency savings" in major cost centres should be pursued, as studies in some countries have shown large scale wastage. Studies of resource allocation practices in the hospital sector in Latin American countries have identified potential savings averaging 40% of total expenditures, some US\$10,000 million annually.

Options for action

Intersectoral resource allocation decisions can be influenced by better documentation of the case for health spending - including demonstration of the cost-effectiveness of health spending as a way of reducing morbidity and premature mortality. Within the health

sector, allocative norms which relate to need can be developed and tested. The Group stressed that decision-makers in the health sector should recognize that success in maintaining financial support from government depends increasingly on economic arguments. It is necessary not only to learn the terminology of cost-effectiveness, but to demonstrate that efficiency in health services is being measured, evaluated and improved. Rational approaches to resource allocation must become widespread in management thinking at all levels. Major training and orientation within the health sector, and mobilization of economic skills in universities, planning and finance ministries, is needed. Much greater self-sufficiency in this area should be pursued as a short-term objective in many countries

Critical Issue (iii): resource management

Incentives for efficient, cost-conscious management are often absent in the public sector. Whilst the logic of programme budgeting remains compelling, experiences in many countries show its costliness and slowness to produce measurable improvement. The importance of improving financial information, as a step towards better resource management, was acknowledged, but existing accounting requirements had frustrated attempts at programme budgeting for health in the Gambia. Simpler approaches, beginning with the identification of expenditures on a facility-by-facility basis, are needed. Identification of operating costs for each health facility or "cost centre", fully attributing the value of supervision, pharmaceuticals supply etc., can be done quickly and without interference with accounting procedures. Use of financial information in conjunction with health activity data allows managers a) direct support for better decision-making, and b) indirect support (through demonstration of improvements for greater decentralized authority by managers.

In discussion it emerged that experiences with administrative and financial decentralization have sometimes been negative. Unless local capacity and accountability are developed, and popular involvement is secured, there are no guarantees against irresponsibility in decentralized decision-making.

Options for action

Promote cost-consciousness by allowing managers greater discretion and Establishing local accountability in budget management. Ensure existing accounting system is working as it was intended to work. Implement simple information systems to link cost and output records at health facility or district level. Monitor ways in which simple performance data contributes to decision-making and change. Decentralize within the district - e.g., in pharmaceuticals ordering with "shadow budgets" for health facilities.

Summary and areas for Action

The Consultative Group gave strong endorsement to an increased role in health economics by the Programme. Health financing and resource use are issues of major concern in countries at all levels of development. The profile of countries' economic problems differs widely, reflecting differences in their income levels, political orientation, and the public/private mix of their health systems.

It was stressed that health financing is not an end in itself, but a means to the attainment of countries' health objectives. Different instruments of financing, resource allocation and financial management (e.g. fees, insurance, planning norms and management systems) may contribute to health objectives in very different ways. Possible trade-offs between objectives such as quality, equity, accessibility, and the balance between preventive and curative care, have to be considered. Clear statements of health objectives are needed to ensure that financing instruments support health objectives and not vice-versa. Health economics can help to identify and quantify these choices.

Given the great variety of alternative financing, resource allocation and management mechanisms available, a broad strategy of option review and appraisal should be adopted.

Prospective assessments of health financing options should be made, which include:

- the level of costs and the principal cost-bearers, for each alternative;
- the degree and acceptability of administrative change; and
- the likely changes in the level, quality, mix and accessibility of health services, and the effect on health status, as well as the wider social consequences of such changes.

Retrospective reviews should be undertaken after the implementation of change, in a timely and economical manner.

Skills in health economics and financial management are in short supply, and are concentrated in a small number of high income countries. Training support is needed to accelerate greater national self-sufficiency in these areas. A broader introduction of health economics into the training curricula for health workers is required.

More frequent and more focused exchanges of countries' experiences in health financing and efficiency promotion are needed.

ISSUE 2 - PHC IN URBAN AREAS

The average annual rate of growth of population in the world during 1985 to 1990 is 1.6%. This rate for urban populations is 2.4% and for rural populations is 0.9%. During the years 2020-2025 the world's population growth rate will average 1%, with 1.9% for urban areas and -0.4% for rural areas. In developing countries between 1990 and 2020 urban populations in Latin America will increase to 85% of the total, and South Asia and Africa will almost double from 30 to 60%. In many countries, principally developing ones, 50% of the urban residents are poor. The health consequence of this process, particularly in low-income populations, is becoming ever more critical.

Despite the fact that cities have received more than their fair share of national health resources, these have not been allocated in either a rational or equitable manner. Indeed, in some cases national and city authorities have hesitated to provide basic services to people in unauthorized peri-urban settlements for fear of encouraging greater rural-urban migration.

In this context the Consultative Group reviewed critical issues and options related to rationalization of existing services, making them more accessible and relevant to the needs of the most deprived, the creation of new types of social support based in communities and creating opportunities for people themselves to play a much greater role in contributing to their own health and well-being. The Group outlined the critical health issues emerging from the unprecedented growth that is occurring in urban areas, particularly in the less developed countries of the world. Broadly, these issues concerned reorganization of health services, community organization support, social service support and some specific issues related to urban poverty e.g., accidents, crime, prostitution, etc. Action options for each of these issues were pointed out.

Critical Issue (1): How to reorganize the existing urban health care services

In many countries, the urban health care services are neither accessible to large proportions of the most needy population nor are they appropriate to their needs. Available health services neglect health promotion activities, including those involving environmental issues. Health personnel often lack motivation and their attitude towards the poor is often harsh. Moreover, many health care workers are not oriented towards community-based care and thus do not encourage community participation. There is also evidence to indicate considerable wastage of resources, for example through relative over-prescribing, over-staffing and inefficiency. Coordination among agencies involved in urban health is limited. PHC is relevant in an urban context every bit as much as in the rural. Several cities, such as Manila (Philippines), and Yantai in China have launched primary health care in urban areas. Recent development activity in Harbin city, China, has been concerned with the socioeconomic conditions of poor communities. But generally urban PHC receives less priority than other health services, and health resource distribution remains inequitable. A PHC approach emphasizing equity in health and social services has not been taken seriously by health related authorities. Leadership development, public information and education is lacking.

Options for action

The alarming growth of shanties in cities and the increasing numbers of urban poor who have limited access to health and health-related services calls for more concerted efforts both by governments and by international agencies and NGOs to find solutions to improve the health of the urban poor.

Urban PHC needs to be seen in the broader context of urban planning and development. For this there may be a need to restructure and strengthen local authorities/municipalities and to promote intersectoral approaches. The health sector must provide important inputs into the urban planning process (including healthy environment) which is often lacking a present. There is also a need to pay special attention to housing, safe drinking water and sewage/waste disposal systems in urban poor areas which have a direct impact on health.

In the restructuring of the health services organization, consideration may be paid to the special needs of the urban poor and particularly the newly 'socially displaced' migrants for whom provision of small health centre facilities and services would be more appropriate than the costly sophisticated large hospitals.

To ensure that even the poor can avail themselves of the highest health technologies, a suitable centre/hospital referral system should be established. More basic care should be provided to the community through outreach and mobile health services.

There is a need for more country-specific information on current urban health care organization with an emphasis on orientation towards PHC as a means of generating good examples of the changes required. More focused experimentation into methods of strengthening urban health care planning and management is also required, within the context of equitable allocation of resources not only within urban areas themselves but also the country as a whole. The Consultative Group emphasized that urban health systems and local municipal management should be restructured emphasizing decentralization of services. There is a great need for coordination on urban health planning to cover low-income and disadvantaged groups of populations. Standards of care, basic health-related needs require strong attention. Promotion and serious action is needed on family planning as more than 50% of urban growth is due to the natural increase, particularly in slums and low-income areas. Community outreach programmes have to be intensified and the working pattern of health centres and health institutions need to be oriented to the community-based health need. Health services should know how to deal with the changing needs of populations specifically in poor urban areas.

Critical Issue (ii): How to support community organization and action aimed at improving health status

The struggle for survival on the part of the very poor in urban settlements is often characterized by individual effort on behalf of immediate family members rather than well thought-out activities undertaken by communities on their own behalf. Even where elements of community organization exist, awareness about effective and feasible ways to deal with common diseases and improve health is often low.

The group emphasized that in many instances community organizations, women's groups, community health volunteers, religious groups and others have not been mobilized for health development and primary health care. In medical and nursing schools, field work and training has been limited to the institutional training and social workers have not been much involved in community mobilization on improving health status.

Options for action

Where community organizations exist, there is an obvious need to create awareness and interest about health and the possibilities for communities to tackle the health problems with which they are familiar. Much work needs to be done to develop effective training methods for health personnel so that communities are approached in appropriate ways and are supported throughout the process from problem identification to implementation of planned interventions. There is also need to identify appropriate mechanisms for community decision-making and action. Provision of information by municipal authorities about availability and allocation of resources is an important process in ensuring realistic expectations.

Even though community organizations are not as strong in the urban areas as in the rural, there do exist many, like women's groups and religious organizations that would need strengthening through training and provision of facilities leading to neighbourhood or even street health centres/clinics. Jakarta, Indonesia, has mobilized its women's organization on health actions for the poor sections of the city, extending health development to the home of poor families. In this context training of community health volunteers, as in rural areas, may be considered, and self-care and self-help movements should be emphasized. Community leadership must be promoted, facilitated and strengthened as part of the decentralization processes.

Voluntary organizations and women's groups are in particular important in promotion and development of personnel and community health workers and hence there must be a close working relationship between them and health services.

Critical Issue (iii): Developing community-based social support services as an important contribution to health development

Poverty is the primary problem linked to inadequate health of urban poor inhabitants. The overcrowded urban environment lacks adequate public health care, potable water and sanitation. This urban environment also fosters unique urban health problems brought on by poor living conditions, unemployment, insecurity of land tenure, poor shelter, industrial pollution, crime and drug abuse. City services are inequitably distributed to urban residents.

Options for action

Wide recognition of the central importance of poverty alleviation needs to be pursued. Income-generating projects would considerably alleviate some of the health problems present in poor urban areas. Additional income for families would have a positive cyclical effect allowing proper nutrition, shelter, purchase of drugs and health care, and would reduce unemployment-related health problems. Industries have to be stimulated and involved in health development activities and to this end their role in health, to create a healthy working environment, to protect the workers and their family as well as the community that they live in, should be emphasized.

However, broad-based community social support services are also required to complement and even facilitate poverty alleviation services such as community creches can facilitate income-generation by women whilst, at the same time, improving the nutritional status of young children. Legal advice services may prevent financial exploitation of the poor through rent control whilst the granting of legal status to recently arrived families can ensure their access to services, including health care, which they might otherwise be denied.

Innovative approaches to improving living conditions, jointly with people's involvement on critical issues such as water, shelter and environmental health, would have a sound impact on their health status.

Critical Issue (iv): Special issues related to urban poverty

The health situation that arises from rapid urbanization reflects the problems of poverty. Accidents, crime, drug abuse, prostitution, abandoned and street children, and youth unemployment are among the special issues related to urban poverty, all with serious health consequences. The AIDS epidemic and its spread to many countries particularly in urban settings has threatened the lives of people and this requires special attention and information on education to be given to the public.

Options for action

In many instances, city authorities need assistance in identifying special problems and problem groups and in developing effective intervention programmes. Support in developing and strengthening policies for action is needed. Of necessity these must include a wide range of sectors. Experimentation into new approaches involving target groups themselves, will be an important activity.

As a significant proportion of the slum population work in industries located in the cities, the occupational and work-related health services including health insurance, accident prevention, social security benefits, etc., need to be restructured, strengthened with the benefits extending also to the family of the worker.

Universities, medical schools and other training institutions must orient their students into research studies for the continuous assessment of the health needs of the slum populations. This would involve training within community settings. The Orangi project in Karachi has brought together student teachers to train communities in participating in the development of sewage, drainage and water supply, with support from a non-government organization. Other examples of community-based environmental improvement are in progress in such cities as Rio de Janeiro.

ISSUE 3 - QUALITY ASSURANCE IN HEALTH SYSTEMS BASED ON PHC

In the decade since Alma-Ata most countries have made considerable improvements in their health systems, greatly increasing the coverage of the population with basic services. However, these improvements have not been uniform either between countries or within them.

In recent years these gains have been threatened by the consequences of economic stagnation and decline resulting in diminishing resources for health care and, in turn, decreasing quality in the performance of health personnel. In many countries this is most evident in the basic health services which are provided in the networks of health posts, health centres and first referral hospitals which are the principal providers of care to countless millions of people.

At the same time, world health leaders have strongly reaffirmed their conviction that primary health care is the only feasible means to achieve the goal of Health for All (Riga and Forty-first World Health Assembly 1988). The challenge is to accelerate PHC implementation by strengthening systems of health care which are truly based on PHC principles.

Thus beyond the issue of improving the quality of delivery of the essential elements of PHC, which are the principal ingredients of basic health services, there lies the challenge of creating systems of health care which reflect the principles of equity, accessibility, emphasis on prevention and promotion, intersectoral action, community involvement, decentralization, integration of programmes and coordination of separate health activities. In this context the quality of primary health care depends on the development of appropriate managerial processes and skills.

Relevance of Quality Assurance as a Tool for Improving PHC Implementation

Recognizing that quality assurance in the context of the organization of health systems based on PHC is a largely neglected subject the Consultative Group devoted some time to discussing the relevance of the concept.

To date, most experience in the application of quality assessment and assurance has been gained from its application in the field of clinical practice in the industrialized countries. In recent years the concept has been applied more broadly, for example at patient satisfaction in general practice. The Group heard examples from India, Mexico and Indonesia illustrating attempts to introduce the concept in developing countries.

The Indonesian experience, in particular, showed the importance of laying stress on assurance of quality rather than merely its assessment.

Following an annual self-assessment of health centre performance staff decide on how to make improvements. In addition, incentives such as special prizes are given to the best performers. Over a three year period in one district the number of high standard health centres tripled.

The Group agreed that quality assurance is an important and relevant concept. However, experience in the clinical field shows that considerable caution is needed in its application. Since human beings are the most important determinants of quality there is a danger that quality assessment might be counter-productive unless the process actually involves health personnel and is perceived as being positive rather than threatening. For this reason it is important for personnel to be intimately involved in defining the standards which are to be used in assessing quality. Thus not only should standards be country specific but there should also be considerable flexibility within countries to ensure that standards are relevant to local circumstances. In view of the importance of community involvement in PHC it is essential that the community's voice should be well represented in the quality assurance process. Mechanisms such as the UK Community Health Councils show how this can be achieved.

In relation to health systems based on PHC it was pointed out that quality assurance should be directed towards the entire national health system in order to avoid unfair criticism of lower levels of the system whilst problems at higher levels go unnoticed. It was also stressed that assessment of quality of PHC must be based on relevance and impact on the entire population to ensure continued focus on the ultimate goal of Health for All. In this connection it was noted that there remains widespread ignorance and misunderstanding about the PHC strategy. Attempts to assess quality in the absence of action to improve awareness and knowledge would be a fruitless effort.

In the light of the above two critical issues were identified for further discussion. These are the identification of appropriate methods and methods for quality assessment and assurance and the identification of activities which, in themselves contribute to quality improvement.

Critical Issue (i): Appropriate methods and mechanisms for quality assurance

Country specific information is needed on the organizational processes required to enable a truly PHC-based health system to function effectively as well as development of performance indicators including impact and cost-effectiveness measurements. Many countries also require better information about minimum standards of basic health care activities which are both necessary and feasible at the various levels and types of health institutions which exist.

A practical starting point might include a definition of basic guidelines for practice in relation to management of common illnesses and injuries, including aspects such as history-taking, clinical examination, appropriate laboratory diagnostic procedures, standard treatments, and nursing care. Each of the essential elements of PHC could be scrutinized with a view to defining specific criteria for basic curative and preventive activities.

An additional set of criteria, for assessment of technology as well as for the design and condition of health facilities and the surrounding environment, also need to be developed given the strong influence of these on the ability of personnel adequately to perform basic health care procedures.

Provided such an exercise is participatory, with the close involvement of personnel at all levels, it could serve as a useful stimulus to defining more clearly how primary health care should be implemented, in addition to its assessment.

Current methods for assessment include special health services studies, patient surveys, household surveys and use of health information are likely to be both inadequate and inappropriate for assessing the quality of health systems. The need for participation by both health personnel and communities imply the need for new methods and mechanisms to be developed. Such methods would lay emphasis on process, i.e., how activities are carried out, since it is the performance by human beings which offer the greatest potential for improvement in PHC implementation.

Options for Action

Wider promotion of the concept of quality assurance in relation to health systems is required as a stimulus to both discussion and experimentation in countries. Incorporation of the subject in both basic and in-service training of health personnel would be an important contribution.

Action research as a means of developing criteria, methods and mechanisms for quality assessment and assurance will be important. In view of the importance of the district health systems approach it would be appropriate to start by integrating a simple quality assurance process in one or two whole districts and gradually refining it during a short period of learning-by-doing. Cautious development of the process upwards through the entire health system could then proceed based on the lessons learnt.

Critical Issue (ii): Activities which directly contribute to Quality Assurance

The Group strongly emphasized the fact that quality assurance must be a tool for improving quality of PHC implementation. Improving the knowledge and skills of all contributors to health development can make a major impact in this respect. Whilst health personnel are the most important target group, provision of information and even orientation training for community members should also be considered.

A stronger PHC orientation to the basic training of health personnel is essential whilst continuing education programmes should be created and strengthened so that multidisciplinary health teams can have regular opportunities to come together, in their districts for example, in order to exchange their experiences and learn new ways to improve the organization of their health systems. Support from higher levels, such as through the production of PHC Newsletter should be encouraged.

Action research, involving personnel in districts is an important means of local problem-solving. Provided such activities are well supported by the national level the lessons learnt from such "learning-by-doing" can be used to define more specifically job descriptions and basic procedures to the benefit of the health system as a whole.

ISSUE 4: HEALTH IN PUBLIC POLICY

In many countries economic conditions have undoubtedly contributed to improving the quality of life and the health status of the population. In some countries health improvement has taken place in spite of economic hardship.

Nevertheless, to promote economic development policies have also had adverse effects on the health status of populations in both industrialized and developing countries. Production methods and rapid urbanization have affected the social and physical environments in which people live today. For example, air pollution as a result of industrial emissions is increasingly responsible for health problems such as respiratory diseases of an acute nature, and for problems that manifest themselves after an appreciable length of time has elapsed. Such is the case with chronic bronchitis, cancer, hereditary disorders, etc.

The effects of development policies can also be seen in changes of life patterns that are responsible for an increase in the population suffering from mental stress affecting different age groups, the prevalence of cardiovascular disease, and a host of occupational diseases.

In addition, development policies have contributed to the emergence of disadvantaged groups that are suffering from preventable morbidity and unnecessary mortality. Because poverty is the underlying cause of most ill health in these population groups, the individual is left with very few options. Policy options themselves have to be analysed and adjusted and it is now opportune to strengthen concern with health objectives in public policies.

Critical Issue (i) Policy Analysis

The Consultative Group recognized that many of the development policies which have an adverse impact on health have been in place for many years and are firmly entrenched in national planning systems. Other policies threatening health have a much shorter history. Included in the latter, are policies deployed in recent years to weather economic crises and to mitigate the long term consequences of such crises. Illustrations of the latter were provided from country experiences; for example, in a country facing economic recession and high inflation, economic growth is the prime concern and an all out strategy of privatization with international firms is being pursued - the hazards created are not disclosed and the effects on health status are of little concern. While structures exist for discussing such issues, but frequently these are not functioning. The media is not always rightly informed and the messages reaching the wider public are incorrect creating a highly charged situation, frequently resulting in counter-productive setbacks.

Health ministries, in some cases, may lack the power to influence national planning bodies or to have a say in the formulation of specific policies. In other instances they may be involved in formulation of a policy, such as in India for food and drugs, but have

no legal authority to monitor their implementation. The contamination of food with pesticide, for example, is a serious issue in India.

The particular types of policy options possible and the political levers available to influence the decision making process may not always be apparent to health authorities. Developing countries may lack the resources and technical capabilities to assess the linkages between health and development policies and to recommend alternatives, or remedial interventions. Examples were given by the Group of how planning commissions take decisions that affect health negatively because health links were not obvious. Also, because many such meetings are attended by junior staff from the Ministry of Health (senior staff rarely have the time to attend all of these meetings) important opportunities are missed. Health sectors are currently faced with a number of major problems which further restrict their abilities to respond to the resulting health hazards and ill-health. These interrelated problems are: the magnitude and diversity of health hazards associated with economic development, the rising costs and intensity of treatment, prevention and control required for the emerging patterns of diseases, and the economic crises in many developing countries which have reduced the health resources available.

Work in Canada in the areas of tobacco policy, substance abuse, environmental policy and food policy provide tangible evidence of the positive contribution that an analysis of health implications of government policy can make towards the improvement of the health status of the population. The comprehensive range of options that have been provided to decision-makers and the level and quality of such analyses have succeeded in persuading the government to introduce wide-ranging reforms and regulations to control their harmful effects. The Canadian experience also clearly demonstrates the trade-offs and balance that could be introduced while negotiating for possible modifications to the development policies.

The Group indicated the need for WHO to develop and disseminate such positive examples to policy-makers and future opinion-makers and the community. Such examples hold tremendous promotive and advocacy value. The British example of the reprocessing of animal waste material leading to viral epidemics caused deep concern among the population and the prompt and decisive action that was taken intersectorally controlled and eliminated this problem.

Some of these examples highlight yet another problem. The conflicts that could arise between other development sectors and the health sector due to their goals being at variance with each other necessitate memoranda of understanding to resolve them. This again is a case in point where education and information could play a useful part. Reference was made to the situation in one country where the agriculture sector examines and stamps the food imports while the health sector is not involved in this process in any way.

Another notable issue that often arises is when one country, for economic considerations, adopts import or export policies that have deleterious effects on the health status of the people of other countries. The tobacco and insecticide industries provide many examples in this regard.

Options for Action

Analysis of public policy and relevant sectoral programmes and projects will have to be undertaken so as to uncover the factors which contribute to low health status of specific population groups. Based on this, the necessary policy changes that will ensure the protection and promotion of the health status and well being of the vulnerable groups will have to be introduced. Appropriate methodologies for policy analysis will have to be improved, taking into account changing circumstances and these should be made available to countries for their use in policy formulation and adjustment.

Critical Issue (ii) Health Promotive Interventions

There is strong evidence of the positive associations between improvements in health status and change in socioeconomic conditions and life patterns. Relevant factors include literacy levels, especially of women, income levels, food and diet, and the distribution of household income, among others. The Group considered it important to continue to document the cost-effectiveness of interventions reflecting different policy mixes, and to monitor their effect on health status and quality of life at the household level. The Group also stressed the importance of documenting of both positive and negative effects of development programmes/projects on health status, even though the negative effects tend to attract more worldwide attention.

Consumer education and consumer empowerment can be a powerful means of bringing about policy re-examination and reform. Visual and electronic media are useful instruments of such promotion. Experience has revealed that working with pressure groups on specific subject such as tobacco, and breast-feeding, has been effective in modifying development policies in a number of countries. Issues of human rights as well as appeals and challenges to national pride could also be employed for promotion and introduction of positive health interventions.

For monitoring and evaluation to be meaningful, the Consultative Group emphasized that more sensitive indicators will have to be developed for assessing health status and development profiles. Whereas infant mortality, literacy and life expectancy are suitable indicators for use in survival situations, they are less meaningful in situations which have moved to other stages of development and are facing post survival problems of mortality, malnutrition and poor quality of life.

In some countries vast sums of money are spent for medical check-ups and screening with little effort on the behaviour and life styles that pose threats to health status. Such expenditures need to be contained to enable such resources to be diverted towards promoting health.

The health sector has to assume its share of responsibility in promoting interventions that will improve health status. For it to be able to do so effectively, the officials concerned should be fully conversant with the relationships between economic gains and health losses. Often the expertise of the health sector is wanting in all these areas and they are unable to disaggregate the implications to be able to respond to the challenges authoritatively.

For the health sector to be able to advocate promotive interventions convincingly the machinery for its consultation with the other sectors, such as development planning, is very weak in most countries. These need to be improved and institutionalized.

Options for Action

Among the most effective ways of providing policy options and political levers for influencing decision making is to demonstrate that health status and quality of life can improve if certain measures are taken, and the appropriate mix of interventions are implemented. Resource materials in non-technical language and format should be available to inform key officials on such policy options and health promotive interventions. Similarly certain countries may require persons with such expertise at short notice and WHO may be able to assist them in obtaining such technical capability when needed. Similarly, strengthening local institutions, in both health and other sectors, to take an active role in developing educational materials promoting positive health behaviour should be undertaken. Further enlisting the support of consumer groups to encourage them to take active role on specific issues should be explored.

Critical Issue (iii) Health Risk Assessment

The discussions highlighted that many ministries of health do not carry out health impact assessments of development policies in order to provide the required information in time to development policy makers and planners.

In some instances even where assessments have been carried out, development planners have failed to utilize results and adequately respond to the risks involved. These failures are related to the lack of simple methodologies for carrying out health risk assessments, absence of trained personnel; the policy-making and planning process itself, and communication between sectors during initial stages of programme planning.

The health risks of policies pertaining to a number of areas such as nuclear power pollution and degradation of environment pertain to groups of countries and have to be addressed as global and regional issues - WHO is in a good position to do so in a dispassionate manner and to convince countries of these joint risks.

It was pointed out that all products contain a production cost that is overt and a hidden cost that is often a health risk. The health sector should be able to develop methodologies to externalize this cost.

Problem-oriented research needs to be strengthened in most countries on policy choices that pose health risks. Research infrastructure, including appropriate manpower, requires considerable upgrading.

Options for Action

Development projects and programmes have to be screened for potential positive/negative health consequences. Rapid, sector-specific health impact methodologies will have to be developed which incorporate epidemiology, risk assessment and socio-economic analysis in assessments which are feasible, and which require only limited financial resources. These assessments should take into consideration indicators and approaches to identifying vulnerable groups and the particular risks development policies pose for these groups. In addition, mechanisms will need to be developed to improve the review and utilization of health impact assessments in development planning and decision making, and to develop a legal framework.

SUMMARY AND AREAS FOR ACTION AND SUPPORT

The Consultative Group, while discussing the area of health in public policy and the issues related to it, stressed the importance and urgency for the health sector to gear itself to face the challenges before it. Health-affecting economic growth and development policies will continue to be pursued. There is an urgent need to develop courses of action to mitigate the unintended ill-health effects of development programmes and to make more explicit the health losses which may be involved in all such policies.

The Group's concluding remarks also recognized that intersectoral action for health, especially its cooperative and coordinative aspects, were best achieved at grassroots and district levels where people have closer personal contacts with each other on a continuing basis. At the national level the process is more difficult and greater results are likely to be achieved by a more focussed approach which concentrates on specific issues related to ill health and their relationship to public policy.

In order for WHO successfully to provide the support required by countries the Consultative Group recommended that the programme of organization of health systems based on PHC should increase its resource and expertise in order to provide information and documentation on the positive experiences of countries in this area; to make available methodologies for carrying out policy and health impact assessments, and to support countries in carrying out research and development in areas of critical concern. It was also felt that WHO should continue its advocacy and promotional role to alert the world community on the threat to health.