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STRENGTHENING OF HEALTH SERVICES

WHO's response to the changing needs of countries

Division of Strengthening of Health Services
World Health Organization

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Preface

The Founding Fathers of the World Health Organization gave high priority to the requirement that the new world body to coordinate international public health should "assist Governments, upon request, in strengthening health services." Nearly half a century later, it is gratifying to see what progress has been made. Many millions — more millions than those pioneers could possibly have foreseen in the aftermath of World War Two — now have access to undeniably effective health services, especially to what we now define as primary health care.

On the other hand, there are still millions of people without that access. The nature of health problems in countries is constantly changing. So the work of what has long been known as the Division of Strengthening of Health Services at WHO needs to be expanded and sensitive to the changing health needs of the 1990s and beyond. Particularly in the developing world, governments need encouragement and help in pushing forward the frontiers of their health services in an effort to reach the unserved and the underserved.

It was therefore considered timely to produce a brief history of the Division's work, which has evolved very considerably since the late 1940s in order to keep pace with — and indeed to set the pace for — the changing patterns that can now, with the wisdom of hindsight, be seen in the field of international public health.

I am pleased to commend this booklet to the attention of public health administrators, health practitioners at all levels, medical students, and

indeed to all members of the general public who are anxious to see the fruits of health and medical progress brought within range of the greatest possible number of human beings on Planet Earth.

Director
Division of Strengthening of Health Services
World Health Organization
Geneva

1.

Post-war health services

The World Health Organization (WHO), in common with the entire United Nations system, was born out of the destruction, death and suffering of the Second World War. In 1948, the year that WHO was born, there was still a degree of euphoria. The terrible years of warfare had ended three years earlier, and the world could look forward to making steady progress towards prosperity, technological improvement and better health.

The existing models of health services were quite exemplary for their time. In the industrialized world, many of these models were based on the principles of compulsory health insurance, with the state taking responsibility for the poorest people. Each individual would contribute according to his or her means, but would also pay for health care according to his or her own wealth.

But the principles were also utopian. Indeed, Mr Aneurin Bevan, the architect of the United Kingdom's National Health Service, which was introduced in 1948 when he was Minister of Health, truly believed that the costs of running the service would become cheaper and cheaper, since disease would be reduced and the nation would get ever more healthy. The medical budget, he believed, would steadily fall as a result of treating free everybody who was in need.

In the event he was proved wrong. Demand for health treatment has constantly risen, in all countries, to outstrip every successive increase in the supply of health care. Furthermore, it has been found that, in some European countries where surgeons are paid for their services, people have twice as many operations as people living in countries where sur-

geons are paid a salary. Nevertheless, this kind of health service was a good and valid one for countries with a strong existing health infrastructure, a full complement of trained health personnel at all levels, and an informed public capable of paying the necessary contributions through taxation or in other forms.

Imposed models

In the late 1940s, a great many of the poorer countries were still classed as colonies, in practice if not in constitution. So it was not considered unusual for European or North American models of health services to be imposed on those countries. As "the wind of change" began to blow, not only through Africa but all over the world, and as small countries in increasing numbers demanded and received independence from the old colonial powers, those same health service models remained in position.

Yet there were dissenting voices. It was very soon apparent that these imposed health service systems simply could not work in countries where there was virtually no formal medical treatment, other than by mission clinics or traditional healers, outside the big cities; where there were far too few doctors and nurses for the fast-growing population; and where a large proportion of that population would never be able to make regular cash contributions to support a national health service.

Something had to change. The Founding Fathers of WHO had drawn up a particularly far-seeing Constitution for the infant Organization. In two resounding statements which so far have well stood the test of time, they defined Health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," and the Objective of WHO as "the attainment by all peoples of the highest possible level of health."[1]

Furthermore, in listing 22 functions which the new Organization would have, the Constitution gave third place (after "to act as the directing and coordinating authority on international health work" and "to establish and maintain effective collaboration with the United Nations, special-

ized agencies, governmental health administrations, professional groups and such other organizations as may be deemed appropriate") to the requirement "to assist Governments, upon request, in strengthening health services."

> "While it is believed that decentralized preventive effort brings, comparatively, the greatest benefit to the health of the rural population at relatively the smallest cost, the means of applying this principle must necessarily vary with local conditions and resources ... Progress will depend on gaining the confidence of the people ... It is advisable that the principle of local support be inculcated whenever possible." Resolutions from a conference on rural health, held in Java, Indonesia, under the auspices of the League of Nations' Health Organization, 1937. [2]

WHO thus gave high priority, from the start, to the need for all nations to have a strong health infrastructure. This marked a definite move away from the pattern set by the three forerunners of WHO — the Pan American Sanitary Bureau (PASB), the Health Organization of the League of Nations and the Office International d'Hygiène Publique (OIHP). These had dealt mainly with the control and treatment of epidemic diseases and international sanitary regulations. Now the scene was set for a new star in the firmament of public health: not a supranational body armed with "magic bullets" to heal all the world's ills, but a body capable of grouping resources, concerting health goals and providing a forum for the exchange of information and experiences that would be of direct value to governments and health administrations.

2.

Phase I: The Early Years: 1948 to 1958

Emphasis on public health administration

The decisions of the First World Health Assembly (WHA), held in Geneva in June 1948, reflected the importance that was to be attached to strengthening the public health service. Indeed public health administration was officially according second priority, just behind the "top priorities" of malaria control, maternal and child health, tuberculosis, venereal diseases, nutrition and sanitation.[3]

Over great areas of the world, health services were simply not accessible to most people. In many cities of Europe, North Africa and Asia, existing health institutions had been grievously battered by warfare. Furthermore the old thinking died hard; the medical wisdom of that period was that public health began and ended at the hospital, and that the only health staff who mattered were doctors. In the industrialized world, the hospital had become the dominating feature of medical care services; the experiences of the Second World War and advances in medical technology had served to reinforce the status of the hospital above all other features of medical and health care. Evolution from this entrenched position was bound to be slow.

The First World Health Assembly recommended that a study should be made of public health administration in the various member countries. This should encompass the areas of: hospitals and clinics, medical care, medical rehabilitation, nursing, medical social work, health education (popular), industrial (occupational) hygiene and the hygiene of seafarers.

Functions of the Division

The Division of the Organization of Public Health Services had existed in WHO since 1948. The fifth session of WHO's Executive Board, in 1950, described the functions of this Division as: assisting governments in strengthening the organization of their public health services, including public health administration and hospital administration, mental and dental care, environmental sanitation, nursing services and health education of the public; this in addition to promoting maternal and child health, nutrition, and social and occupational health.

The Division was to plan, coordinate and administer activities concerned with these services. This would include reviewing and evaluating programmes proposed by the Regional committees; offering technical advice on demonstrations of modern methods of health administration; the prevention and treatment of disease; and the training of local personnel. The Division was also to be responsible for collaborating with the other divisions of WHO; advising and collaborating with the United Nations, its specialized agencies and nongovernmental organizations; and participating in the work of the various Expert Committees then existing.

In 1951, the Division started health demonstration areas in Egypt, El Salvador and Sri Lanka (then Ceylon) involving rural populations of between 70 000 and 180 000. The object was to show how a well-planned and well-run medical and health service could raise the standard of the health of the people and improve their economic condition. Similar health demonstration areas were planned for each of WHO's Regions.

A WHO Expert Committee on Public Health Administration in 1951 outlined the problems that needed to be dealt with before health services could become accessible to the majority of the population. These included the fact that the authorities and functions of national, provincial and local health administration had not been clearly defined; the integration of health services had not been well-established; public health functions were being carried out by a number of different ministries such as agriculture, labour, education and social welfare, so that there

was a lack of coordination among the health services provided by the different ministries, and no systematic approach was being taken to the organizing of medical and health services. These were stumbling-blocks in the way of providing a health system capable of reaching the rural populations and providing the necessary services on a decentralized basis.

The Expert Committee felt that there was a pressing need for a decentralized administration geared effectively to the policy of the central authority, and to the active participation of local people.[4]

In that early post-war era, no international body committed to health could do other than try to alleviate the widely prevalent epidemics of communicable, parasitic diseases and deficiency diseases, some of which affected the more developed but war-ravaged parts of the world as well as colonial possessions and newly-independent countries of Asia. In any case, the WHO Constitution laid down as one of its functions "to stimulate and advance work to eradicate epidemic, endemic and other diseases." New methods and chemical agents were available which offered great hopes of eradicating or controlling many epidemic and endemic diseases: DDT for malaria, penicillin for yaws, the BCG vaccine for tuberculosis. Progress in medical science and technology seemed to offer unlimited opportunities for a short-cut to health, or at least to the control of mass diseases. Moreover, it was mainly in this field of epidemic disease control that the Member States first requested assistance; they saw these diseases as their principal and pressing health problem.

Nearly three decades were to pass before the notion became commonplace that medical care alone was not the answer to disease control, and that health cannot be attained and maintained without the active involvement of communities, coupled with social and economic development.

Health for rural areas

Nevertheless, a positive step forward was the convening at the end of 1953 of an Expert Committee to consider "the methodology of plan-

ning an integrated health programme for rural areas." Here the idea was first put forward of a rural health unit, to be regarded as the nucleus of a rural health service in any area. The rural health unit was defined as "an organization providing or making accessible, under the direct supervision of at least one physician, the basic health services for a community." While great stress should be laid on preventive services, the Committee felt that the rural health unit could not operate satisfactorily unless it gave its people a sense of confidence by also making curative — i.e. hospital — services accessible to them.[5] This opened up the idea of having small hospitals to serve local areas. At this time, particularly because of the lack of trained personnel, hospitals provided very few components of primary health care.

The Technical Discussions held concurrently with the Fifth World Health Assembly in 1952 had examined the kind of medical care to be provided by the local health unit. The main questions that arose were: "Should the health unit and its centres work only in the field of preventive medicine? Should medical care also be given? Should that medical care include the care of inpatients?" The report on these Discussions commented: "The argument against including medical care was that it complicated administration unduly. On the other hand, public interest could be aroused more readily if medical care were obtainable at a health centre. The pill of preventive medicine must be covered with the sugar coating of medical care — even though the pill was in the long run the more important constituent."[6]

In practice, it proved to be the case that many requests from countries for assistance in organizing rural health services evolved from projects originally undertaken to deal with a particular disease. Health education, maternal and child health, nutrition and rural sanitation were added to the tasks of the original health centres or mobile clinics, which in this way became the basis for the development of general rural health and medical services.

In effect, an evolutionary change in the basic health services was already getting under way. The success of the original disease control projects

created a popular demand for these small health units to expand into other fields. For example, a WHO-assisted malaria project was started in Chiangmai, Thailand, in 1949. After some years, a rural health unit was grafted on to this in order to provide maternal and child health services, environmental sanitation and the training of health personnel.

Community health protection

The next big milestone in the development of public health services was the 1956 Expert Committee on the Organization of Medical Care, which devoted special attention to the role of hospitals in programmes of community health protection. The Committee proposed the following definition: "The hospital is an integral part of a social and medical organization, the function of which is to provide for the population complete health care, both curative and preventive, and whose outpatient services reach out to the family in its home environment; the hospital is also a centre for training of health workers and for bio-social research."[7]

The recommended forms of health administration laid down by this Expert Committee and others during this period were taken up by WHO's Division of Organization of Public Health Services, which then applied them in its advisory role to governments and in demonstration projects set up by governments. The fundamental belief at this time was that the type of services offered at centralized and sophisticated hospitals would eventually "trickle down" to the local and rural levels. This belief was founded on the confident assumption that rational planning was all that was needed, together with properly coordinated, hierarchical health services, paying little or no attention to the prevailing social, economic and cultural conditions.

As early as 1952 an inter-agency group of the Administrative Committee on Coordination, had produced a definition of community development as "the processes by which the efforts of the people themselves are united with those of governmental authorities to improve economic, social and cultural conditions of communities."[8]

The time for putting these pious statements into action had not yet come. Little effort was being made to reach out to the community. Consequently preventive care was really only available to those who came to the hospital for treatment — a tiny percentage of the population in need. In many countries different aspects of preventive and curative care were provided in isolation, and the health authorities paid little or no attention to putting into effect an integrated, comprehensive health service, managed as a whole system.

The less developed countries and non-self-governing territories of the time, and later the newly independent countries, were not in a position to create in a short period of time a countrywide infrastructure, nor the kinds of local government that could support basic health services for whole populations. Indeed, the newly independent countries tended to emulate the industrialized countries in devoting their scant resources to building, equipping and staffing hospitals in their cities, and little or nothing to creating nationwide public health infrastructures.

3.

Phase II: The late 1950s and early 1960s

The era of mass campaigns

By the mid-1950s it was clear that WHO's target of attaining the highest standard of health for all people was not going to be attained in the short term. In many countries, particularly in the countryside, there simply were no health services to speak of. Everywhere trained health manpower was extremely limited, and a majority of people had no access to health care. It was generally accepted that the provision of adequate health could best be achieved by creating permanent, well-organized health services, able to expand and evolve according to the resources available and to the changing health and social needs of the community. Since this would take years to bring about, there was a great incentive to take effective measures against certain endemic and epidemic diseases.

The decision to launch mass campaigns stemmed mainly from the scientific advances that had been made in creating residual insecticides, improved vaccines, and long-lasting antibiotics and sulfonamides. Better control and even the eradication of some diseases seemed to be just around the corner. Mass campaigns were also seen as a rapid means of meeting the rising expectations of ordinary people and solving their pressing health problems. Finally, they were highly visible activities which could attract donors to the various UN and other agencies involved, particularly if they proved successful.

The campaign to eradicate malaria was launched in 1955 and the one aimed at smallpox eradication began in 1958. Yaws was already a target, through mass treatment with penicillin, from 1950 in Haiti and from

1951 in the Philippines, and WHO took over full responsibility for the mass BCG vaccination programme against tuberculosis in 1951. Mobile health teams and mobile clinics extended coverage, in theory, to the most remote geographic areas, and the teams and clinics were formally linked with hospital networks, where they existed. WHO's First General Programme of Work, 1952-1957, endorsed such "projects in specialized fields" but noted that they "should be a stage towards the ultimate goal — a balanced and integrated health programme for the country."[9]

There followed years of valiant effort, which all too often led to frustration and disappointment. The campaigns were largely funded from bilateral and sometimes national resources which, after early spectacular successes in the operational stages, were withdrawn or severely cut. The crucial pre-eradication phase of the malaria campaign and the maintenance phases of all the campaigns were left to the impoverished and underdeveloped health services, while the better-off hospital or curative services had no part to play. Attempts at integration simply overstretched the often rudimentary existing health services. In the end, only the smallpox eradication campaign was brought to a triumphant conclusion in October 1977, when the last ever case of endemic smallpox was recorded in Somalia.

Three competing groups

In effect, during the late 1950s and early 1960s there were three competing groups: the mass campaigns and disease control programmes; the hospitals; and the basic health services. Each had different forms of funding, different objectives, different power structures and different types of professionals. All wanted to remain independent. This unhealthy competition was also reflected within the structure and administration of WHO. Perhaps the one benefit to emerge from this generally discouraging period in public health history was that, in many parts of the world, it was the mass campaigns which stimulated the initial proposals for universal coverage by the basic health services.

As we have seen, the assumption of policy-makers at this time was still that the largely medical care services being established at the centre would "trickle down" to the periphery, eventually covering the entire country, and would broaden so as to encompass public health. The apparent logic underlying this view took little account of the social and cultural anthropology of rural populations, nor of the economics of the types of health care service that were envisaged. Nor did it foresee the complex of factors that came to constitute the "rural hopelessness syndrome" — the explosive growth of population, the massive surge of young people from the countryside to the bright city lights, and the consequent complications of unplanned urbanization. The "brain drain" of trained health personnel from poor countries to rich ones was just one more factor confirming that "integrated health services" were still, at this point in time, a pipe dream.

In fact, WHO did not neglect the question of health services for rural populations. Back in 1956, for example, the Expert Committee on the Organization of Medical Care had recommended that the existing systems of regional hospitals should be supplemented by networks of intermediate and local hospitals and health centres. This would be a means of integrating curative and preventive services in local communities.

"The First Ten Years of WHO" commented: "Because rural health problems have been dominant in most of the regions, requests for assistance in organizing rural health services have been increasing; and such services have been started in many countries. In many instances they have evolved from projects originally undertaken to deal with a particular disease — yaws, tuberculosis or malaria. Health education, maternal and child health and rural sanitation are added to the function of the original health centres or mobile clinics, which in this way become the basis of general rural health and medical services. The success of the original special campaigns has created a popular demand in many countries which has led to their expansion into comprehensive health services."[10]

There were some positive outcomes from the mass campaigns. Health planners realized the direct contribution that epidemiology can make to

health interventions, and the importance of efficient management at all levels, including sectors outside the narrow one of health. And they saw clearly that health actions in general, and health education in particular, could do little unless the community itself was positively involved from the start. Finally the campaigns proved the potential of local "voluntary collaborators" — the precursors of community health workers.

4.

Phase III : Mid-1960s to 1973

A learning period

The world was changing fast, and public health in the broad sense was struggling to keep pace. The world population was rising at an unprecedented rate, far outstripping the capacity of the health infrastructure in most countries to meet demand. A great many countries had moved out of the colonial sphere and were finding their feet as independent nations. This was especially true in Africa, where the continent as a whole faced an acute shortage of trained health manpower; indeed only a small percentage of the population had enjoyed education beyond secondary level.

Several of the control and eradication programmes had not come up to expectations. In particular, malaria was beginning to return to areas from which it had been "eradicated."

As early as 1957, a rural health conference in New Delhi was inaugurated with the blunt statement that "rural health programmes which are not supported by programmes of rural reconstruction... embracing the basic requirements of agriculture, education and economic and social betterment have little chance of producing the results which may be expected of them."[11] Such a notion had been expressed time and again in the councils of WHO, but it was only from the mid-1960s to the early 1970s that governments began responding to the view that the provision of basic health services was one of the better means of achieving wider health coverage and so bringing about economic improvement.

New emphasis on planning

The Division of Organization of Health Services had hitherto responded more or less on an ad hoc basis to the specific demands of Member States, but from this point on, much greater emphasis was placed on planning — planning which would not merely paint a rosy picture of a disease-free world but would take into account the manpower, material and financial resources available in each country. Member States became increasingly convinced that health planning needed to be integrated into national policies for social and economic development.

By 1970, WHO was providing help with planning, putting into effect and assessing projects on comprehensive basic health services in some 60 countries: 20 in the African Region, 23 in the Region of the Americas, six in the South-East Asia Region, four in the Eastern Mediterranean Region, and seven in the Western Pacific Region.[12]

The common aim of these projects was to establish simple health care systems, adequately staffed to provide preventive and curative services to all the neighbouring population, and financed from locally available resources. They included in-service training of all categories of professional and auxiliary health personnel, with adequate guidance and supervision, and assistance in strengthening the systems of health administration at the national, intermediate and local levels.

Most projects still made no provision for, or gave little priority to, any type of self-help component in which local inhabitants were involved in planning, construction or carrying out of facilities and programmes. Few attempts had been made to establish ties with traditional healers and birth attendants. Most community health workers were provided by the government and did not identify with or relate well to the local population. Basic health services continued to rely on technologies which were neither culturally nor financially acceptable to large sections of the population.

Alternative approaches

Meanwhile, in several developing countries of Africa and Asia, governments and various voluntary or nongovernmental organizations (NGOs) were themselves experimenting with alternative approaches to health services. The experience of the voluntary bodies was of special interest to WHO, since they were not constrained by the structures and methods of intergovernmental organizations and were therefore free to innovate or to use unconventional resources. This greatly influenced WHO's thinking. UNICEF, the United Nations Children's Fund, made particularly useful contributions to policies and practice in child health, always as a partner of WHO, with the guidance of the WHO/UNICEF Joint Committee on Health Policy (JCHP). It was during this period that UNICEF developed its Basic Needs Policy.

New thinking about forms of basic health services received a boost from changes taking place in such countries as China, Cuba and Tanzania, where unconventional patterns of peripheral health services were directly linking the problems of poverty with efforts to meet basic health needs. The Christian Medical Commission and other NGOs were supporting pilot projects of the primary health care type, which involved communities in determining their own health and other developmental needs and maintained links with non-health sectors.

It was clear at this period that new approaches would call for a total overhaul of the functions and duties of the Division of Organization of Health Services, which in 1972 merged with WHO's Division of Research in Epidemiology and Communication Science and was renamed the Division of Strengthening of Health Services (SHS).

A study report presented to the Executive Board in January 1973 confirmed that in many countries the health services were not keeping pace with the changing populations in either quantity or quality. There appeared to be widespread dissatisfaction of ordinary people with their health services, in the developed countries as well as in the Third World. Most countries' state-supported health services were insufficiently funded for providing adequate coverage of their populations. The more inad-

equate the services, the less they were used and the more ordinary people bypassed them.

This report made a case for a complete revision of the way in which the health services as a whole should be viewed, what their objectives should be and how they should be administered. It did not describe an action programme — it recognized that there was no universal blueprint for the structure of health services. It was, rather, a politico-social document which related health and health services to society.[13]

The Twenty-Sixth World Health Assembly in 1973 endorsed the Board's recommendations about the steps needed to rectify this situation.[14] WHO pledged to put the development of health services at the top of its priorities during the next decade. Each Member State should have a health service accessible and acceptable to the total population and at a level of health technology considered necessary to meet the problems of that country at a given time. WHO should develop guidelines for national health service systems which could be adapted and developed according to each country's needs. And it should assist countries to express their health services structures in operational terms with resource allocation, systems analysis and management methods that would enable the decisions taken to be put in train, and should assist them also in developing national capabilities in these skills within the shortest possible time. The Division of Strengthening of Health Services was to be the main tool for converting these guidelines into action at country level.

5.

Phase IV: 1974 to date

The age of primary health care

The springboard for Primary Health Care (PHC) was the study set up by WHO and UNICEF in 1974, on "Alternative approaches to meeting basic health needs in developing countries." This was to concentrate on solutions rather than on the description of health problems, and on qualities of success rather than reasons for failure. Only a very small proportion of the areas and programmes selected for the study related to WHO programmes. Some were independent national initiatives, and others were programmes supported by nongovernmental organizations and religious groups. The study showed that, in many countries and in many ways, "with the appropriate will and imagination," health services could be designed and operated in ways that directly met community needs and could be integrated with other developmental activities.[15]

The study was in turn followed by the publication of a book "Health by the People," which presented the study's findings in the words of those people in the various countries and organizations who had been concerned directly in setting up and running the programmes.[16]

A working document submitted to the 28th World Health Assembly in 1975 described the magnitude and seriousness of the public health problems afflicting the world. The rural and peri-urban populations which constituted between 80% and 85% of the total population — some 550 million people — lived in absolute poverty, had very high morbidity and mortality rates, and suffered chronically from malnutrition, communicable diseases, parasitic infections and other diseases. Children particularly were at high risk.[17]

"If a widely based rural primary health care service was developed and proved to be largely locally financed, the moral, political and other strains of having the poorest rural people paying for themselves and government expenditures being directed to the more privileged or to the urban population could well prove to be intolerable. There seem to be four interconnected solutions:

(1) to reallocate health resources more equitably between all segments of the population;

(2) to introduce a programme of self-reliance and self-sufficiency to all segments of the population (urban as well as rural);

(3) to reserve a larger proportion of national health funds for the development and capital costs of the primary health care services;

(4) to redesign the existing government-supported (and other) health services to give them a more clearly defined supporting role in relation to the wide primary health care base."

Poor health was holding back human development and undermining the capacity of the people for developing their potential and leading productive lives. In many countries most people had no health services, or no access to them. Where there were health services, they remained largely isolated from other development sectors, cooperation with which was essential if health was to improve. The services were still either geared to highly sophisticated medical care for selected big city populations or were in other ways unrelated to local realities. Financial and human resources were dedicated to maintaining such health services. The people themselves had rarely been given any opportunity to play an active role in deciding the type of health activities they wanted, and had not participated in the services they received.

The working document warned of a "a major crisis" in the making, and stressed the need for "continued socioeconomic development efforts in-

cluding health programmes and the active participation of the people." The crisis referred not so much to disease and ill-health and the lack of services but rather to populations being denied basic rights, to social injustice and inequity in the distribution of resources, and to gross inequality.

PHC: the best solution

Primary health care offered itself as the best solution. And the Assembly document WHA 28/9 offered the first formal description in WHO's records of the meaning and content of PHC. "Primary Health Care is taken to mean a health approach which integrates at the community level all the elements necessary to make an impact on the health status of the people. Such an approach should be an integral part of the health care system. It is an expression or response to the fundamental human needs... A response to such needs must be a series of simple and effective measures in terms of cost, technique and organization, which are easily accessible to the people in need and which assist in improving the living conditions of individuals, families and communities. These include preventive, promotive, curative and rehabilitative health measures and community development activities."[18]

In suggesting national action to bring about this new approach, the working document referred to certain features common to all communities and countries: the use of health workers resident in each community, selected locally, supported by the community, and trained, supported and supervised by a member of the health service staff; a close link between health workers and the personnel of other sectors concerned with community development; the involvement of all members of the health team in primary health care programmes and the promotion of positive attitudes towards PHC in health professionals; and changes in the training, functioning and outlook of existing health services workers and health institutions so that their role in relation to PHC could better reflect countries' priority health and social objectives.

The World Health Assembly in 1975 approved the recommendations of the working document, and supported the proposal that an international

conference should be convened to bring the PHC programme to the attention of the highest national authorities and obtain the widest possible agreement of governments on the issues involved and the action to be taken.

There was some resistance to this innovative approach, especially from the ranks of the professionals who had been the main supporters of the conventional health care delivery systems of the past. WHO's Director-General, Dr Halfdan Mahler, in a speech at the end of 1975, stressed the need for the "demystification" of medical technology and for some of the power to be transferred from the medical and paramedical staff to the people themselves. Health from then onwards needed to be considered by the populations concerned, who should regard health care as their own responsibility.[19]

In order to strengthen the efficiency and effectiveness of health systems, people at all levels have to be involved — from the top, where responsibility rests with the medical staff, down to the village health workers who are in direct contact with the community. Medicine has not provided the answers to the health problems of the majority. While the principles laid down were unexceptional, their implications were almost revolutionary. It required a sustained effort to disabuse many people of the notion that primary health care was something that could be added to existing systems without disturbing them unduly or requiring any special effort on the part of health professionals.

In the years following the 1975 Assembly, the PHC approach was gradually accepted by governments as the right solution. Putting PHC into effect was accelerated by the process of Country Health Programming — the development of rational programmes and systematic planning efforts tailor-made to each country's needs. This task became the responsibility of the Division of Strengthening of Health Services. The ways in which PHC was interpreted in practice tended to differ from country to country. In some, it developed as an extension of the government's basic health services, in others as part of community-initiated action supported by the central authorities.

The Health for All concept

The Thirtieth World Health Assembly in 1977 adopted the concept of Health for All by the Year 2000, to be attained on the basis of primary health care. In this truly seminal move, Health for All was defined in the following terms: "The main social target of governments and WHO is the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life."[20]

The concept of Health for All, to be attained through the PHC approach, was then resoundingly endorsed at the Alma-Ata Conference, held in the capital of Kazakhstan in September 1978 and sponsored jointly by WHO and UNICEF. The Conference unanimously approved the statement that "PHC is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally acceptable to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination."[21]

The Thirty-fourth World Health Assembly in 1981 adopted the Global Strategy for Health for All by the Year 2000, and invited Member States to enter into a solemn agreement for health of their own volition, to formulate or strengthen and carry out their strategies for Health for All accordingly, and to monitor their progress and evaluate their effectiveness, using appropriate indicators.[22]

Countries then faced the task of putting into practice the concepts contained in those strategies, with the support of WHO's Seventh General Programme of Work covering the period 1984-1989 (approved by the Assembly in 1982). Evaluation of progress by countries and development agencies in the early 1980s showed that almost every developing country had taken appropriate national policy decisions. Evidence of real progress in health, on the other hand, was sparse. Investigations in rural areas reported difficulties and failure to put the strategies into action.

As identified in the Declaration of Alma-Ata in September 1978, primary health care is intended to include "at least" the following eight elements:

1. Education concerning prevailing health problems and the methods for preventing and controlling them.
2. Promotion of food supply and proper nutrition.
3. Ad adequate supply of safe water and basic sanitation.
4. Maternal and child health care, including family planning.
5. Immunization against the major infectious diseases.
6. Prevention and control of locally endemic diseases.
7. Appropriate treatment of common diseases and injuries.
8. Provision of essential drugs.

Declaration of Alma-Ata, September 1978

The fact was that, when the Health for All movement was launched, it was assumed that economic growth would continue everywhere, with the possible exception of Sub-Saharan Africa, and that the richer countries would give substantial assistance to the poorer, provided their case was well presented. The world economic crisis of the late 1970s and early 1980s undermined both assumptions.

Average living standards fell sharply in Latin America and much of Asia. The developing countries had fallen heavily into debt, to the point where high interest rates and devaluation took up to one third or even a half of their export earnings. Austerity policies brought reductions in health budgets, and forced cuts in imports of drugs and medical equipment. There were recurrent famines and droughts in Africa. The response of countries everywhere was determined by what the health sector could afford, not by what was needed.

A particular aspect of the weakness of health ministries was the lack of professional capacity to identify needs and to design proposals for external funding — then to defend them before national planning commissions in competition with the needs of other sectors. This lack of professionalism also meant that such external resources as materialized were not used effectively. Weak management capability proved to be a serious impediment to development in all sectors.

SHS was involved in a number of studies on the economics of PHC, concerning methods of generating financial support within communities, and of finding more cost-effective means of supporting PHC. In 1983, for instance, SHS published "Planning the finances of the health sector — a manual for developing countries."[23] The Division also collaborated in studies in such countries as Egypt, Indonesia, Malawi and Sri Lanka on the financing of national health care delivery systems. All such studies proved time and again that health spending in the developing world was falling further and further behind health spending in the industrialized countries and that a widening gap was emerging within countries between the "haves" and the "have nots". For instance, in the countries of the African Region far less than the estimated basic need of about US $15 per person per year was being spent in the public sector in 1982; the average expenditure in the developed countries was US $244 per person per year.[24]

In 1986, no fewer than 147 countries submitted reports on the evaluation of their national strategies for HFA. A resolution at the 39th Assembly in 1986 urged the countries "to pursue vigorously actions aimed at strengthening the management of their health systems based on primary health care." It also called for support for countries "in particular in establishing or strengthening district health systems based on primary health care."[25]

An Expert Committee on Strengthening Ministries of Health for PHC, convened in 1987, listed the reasons for the failure of ministries to serve as the directing and coordinating authorities for all health activities in national health systems. They included: an inadequate or inappropriate

range of responsibilities, and too much centralization of responsibilities; an isolated role in national health systems; poor management and weak leadership; inadequate links with other social sectors; limited links to the population; and meagre economic support.

In the latter context, the Expert Committee commented: "Money is needed for resources and services of all types, including personnel, facilities, drugs, equipment, transport, manpower training, maintenance of quality standards, regulation, evaluation, preventive services, treatment and rehabilitation. Its lack inevitably leads to health services of poor quality." The share of the central government's budget allotted to health had declined in many developing countries. In the competition among ministries for a share in the national budget, the voice of the ministry of health had generally been weak; the ministry of health still seemed all too often to be regarded as marginal to development.[26]

Intersectoral action

Primary health care, as defined in the Declaration of Alma-Ata, "involves in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, public works, communications and other sectors; and demands the coordinated efforts of all those sectors."[27] Intersectoral cooperation became the subject of the Technical Discussions held at the time of the 39th World Health Assembly in 1986. The five major areas for action were defined as:

- the introduction of health objectives into public policies;
- assessment of the effect of social and economic factors on health status;
- monitoring of health resource allocation in the light of risk factors;
- the development of institutional mechanisms and of training; and
- promotion and advocacy.[28]

Evolution of PHC

The development of national health systems during the past three decades has been marked by two major trends:

— the establishment of so-called "vertical" programmes aimed at controlling specific priority health problems through a specialized infrastructure built around uni-purpose workers;

— the development of general health service infrastructures focusing on the provision of curative services plus a variable range of preventive services.

The evolution of primary health care — from basic health services with a curative orientation, to vertical programmes functioning more or less independently of other health services, to integrated approaches to PHC — involves a distinct pattern of historical change. At the national level, there are changes peculiar to the social, political and technical milieu of each nation, while globally there are shifts in which collective trends become clearly apparent. The current state of these changes appears to have progressed well beyond the purely vertical programmes, but not yet to have reached fully integrated PHC. Most nations are engaged in the transition, which makes it all the more important to understand the evolution of vertical and integrated approaches as well as the dynamics of the transition from one to the other.

A particularly important meeting took place in New Delhi, in June 1984, on operational issues in the transition from vertical programmes towards integrated PHC. This set the stage for much of the ensuing work that has been accomplished in tackling such aspects of the issue as management, the community perspective, intersectoral and intrasectoral relationships, and the reorientation of human resources.[29]

Some of the shortcomings of Third World health services were underlined at a meeting in Riga, Latvia, in 1988 — called to mark the ten years since Alma-Ata — by Professor John H. Bryant, head of the Department of Community Health Sciences at the Aga Khan University, Pakistan. One pervasive deficiency in the Third World, he said, "relates to health

personnel who are not adequately prepared to function effectively in community-based or district level health services. This is true of workers at all levels, but the most damaging deficiency is at the level of the doctors." The medical education of doctors, he said, was typically curative-oriented and hospital-based, so such health professionals "are unlikely to be useful in leadership roles that require them to relate to communities, assess needs, and plan, manage and evaluate programmes, and oversee the in-service training of other personnel." Meanwhile health services, particularly in Third World cities, "are an ineffective mixture of high technology care for those who can afford to pay, with few or no services designed to reach out to the burgeoning squatter settlements."[30]

Fifteen mid-term accounts of progress in achieving Health for All by the Year 2000 are contained in a book published in 1990. These reports show how individual countries have adapted the PHC approach to meet their own special, and evolving, circumstances. In all of them, issues of financing and health economics emerged as priority concerns.[31]

Three pillars of SHS

The Division of Strengthening of Health Services now developed three approaches which became the main pillars of its global strategy. These were: **National Health Systems and Policies, District Health Systems, and Health Systems Research.**

The Division fulfils its mission in four main ways:

i) *identifying and leading with action on emerging issues*, such as analysis of change in the public and private mix in health, option and impact assessments in health sector reform;

ii) *providing methods and tools* to support the development of PHC-based health systems. Recent examples include: Cost analysis in primary health care; Social health insurance — a guidebook for planning; Improving urban health — guidelines for rapid appraisal to assess community health needs; Community involvement in district health systems — guidelines for assessment;

iii) *supporting WHO's regions*, as in health economics capacity building, urban health, health centres and district structure studies; and

iv) *building partnerships* with other agencies: DANIDA (Strengthening Ministries of Health); USAID (health economics programme); SIDA (equity and health sector reform); ODA (policy and strategy development). Also with numerous academic centres in the developed and developing world, as well as with NGOs, such as Metropolis, World Federation of Public Health Associations, Aga Khan Foundation.

National Health Systems and Policies

The time had come for the Division to examine the role of WHO in the development of national health systems, and to analyse what had in the past caused the lack of impact of WHO projects in the field. A national health system is seen as an entity which embraces **health economics, policy planning, overall management and maintenance.**

A primary health care approach requires suitable policies and structures at all levels if it is to be meaningful in a tangible way. At national level there has to be an entity responsible for strategic decision-making and for ensuring that these structures and the functions within them — be they at national, provincial or district levels — are consistent with PHC objectives.

Economic and social policies have undergone substantial changes in countries at all levels of development since Alma-Ata. At the same time, continuing problems of recession and indebtedness have led to widespread acceptances of structural adjustment. This willingness implies a recognition of the limitations of government and the importance of the role played by individuals, households and the private sector resources in health development. Accompanying these changes is the political movement away from centralized, single-party systems to a more pluralistic environment.

The important role of ministries of health too has increasingly been seen as that of overall policy-makers and regulators within a complex health

> "To succeed, primary health care must be supported by clear national policies and firm support from the top. But its full realization depends crtically on people's acceptance and participation, including those who are responsible for management and implementation within the district itself."
>
> *Dr Hiroshi Nakajima, Director-General of WHO, at the Latin American Health Services Congress, Sao Paulo, Brazil, 15-17 June 1994*

care system encompassing many actors. Command and control approaches, such as legislation to forbid private practice, proved to be unworkable, and national policy-makers have begun to take into fuller account the nongovernmental providers and sources of health care. The Interregional Meeting on "The public/private mix in national health systems and the role of ministries of health," held in Mexico in July 1991, was an important milestone in this evolution.[32]

A WHO Study Group on "The evaluation of recent changes in the financing of health services," held in Geneva in December 1991, took this a step further, and provided a framework for countries to monitor the consequences of financing changes on access to and the use made of health services, as well as the outcome in terms of health status.[33]

Concerns at national level to redefine and re-establish the role of the Ministry of Health as the ultimate source of authority in drawing up National Health Policy will continue to require a better understanding of the complex interactions among government providers and consumers. Decentralization of decision-making is now a widespread process. The Division is leading a major international comparative study of the process and its effects.

One often neglected component of PHC is logistics. Consequently, SHS has drawn up a Logistics Action Plan in order to strengthen the process of procuring, storing, transporting and maintaining the supplies, equipment and facilities that are needed. The key areas, apart from policy and planning for such logistics, are procurement (to encourage standardiza-

tion and ensure favourable prices, coupled with acceptable quality and reliable delivery), logistics operation management (to improve efficiency), maintenance and repair (to ensure the best possible use of equipment), transport (including delivery of supplies, transport of patients and support of health care personnel), and communications (for administrative, educational, consultation and social purposes). The Action Plan also envisages the development of management information systems, training and supervision, and an element of monitoring, evaluation and operations research (for instance, to identify areas of inefficiency).[34]

In conjunction with all the above, there is a widespread need to review and improve the principal management systems necessary to support integrated PHC delivery in a cost-effective manner. These systems include budget and finance, personnel, information and reporting, training and supervision, logistics, supplies, planning and policy. Much of this is relevant to the work SHS has done on Primary Health Care Reviews in countries and the methodology that has been refined from the different experiences over the years. SHS continues to provide the necessary technical support for such reviews and for improved management of health systems.

The Division of Strengthening of Health Services insisted that health must be seen within a wider social and economic context and needed to be fully integrated into the development process. Its aims were "to promote and support the appropriate organization and effective operation of comprehensive health systems that provide the essential elements of Primary Health Care to entire populations, utilizing appropriate he besthealth technology and services, including referral and specialized support, when necessary, and that involve communities and health-related sectors in responsible and coordinated ways."[35]

The Division thus recognized that PHC implied individual and collective participation in decision-making and the management and control of health programmes, technology, institutions and resources. It involves drawing in health-related sectors such as agriculture, housing, food production, industry, public works and communications. In order to bring together all these elements, PHC calls for an equitable distribution of

resources for health care and requires governments to assume their responsibilities and exercise the necessary political will to bring these changes about.

In the past, health systems had been primarily oriented towards specialized programmes. PHC on the other hand called for an entire restructuring and reorientation of health systems, with the necessary adaptation and strengthening of institutions and managerial processes at all levels. SHS aims to assist Member States to adapt their own health systems in order to put PHC into effect, and today is directly involved in assisting ministries of health to reorganize and strengthen their capacities to carry out new health care strategies.

District Health Systems

The expansion of PHC at the local level had made increasing demands on support infrastructure, particularly at the district level — that is, from less than the provincial level, but extending right down to the local, grassroots level. Consequently, SHS put increasing emphasis on district level support for PHC, and on strengthening those levels so as to ensure the necessary technical and material support.

The district came to be defined as the organizational unit that had the following eight essential characteristics of a district health system: equity, accessibility, emphasis on promotion and prevention, intersectoral action, community involvement, decentralization and integration of health programmes. The district managerial process also included an analysis of the current health situation, a definition of objectives and, where necessary, a reorganization of the supporting structures.

An interregional meeting on the district approach, held in Harare, Zimbabwe, in August 1987, drew up a number of concrete recommendations. In sum, these were to ensure sustainability by developing a decentralized district planning process; to redefine the role and functioning of hospitals; to strengthen community involvement and develop district leadership; to promote intersectoral action; to make use of health

systems research; and to encourage the mobilization of international, multilateral and bilateral resources.[36]

> A District Health System is a unit of the national health system which at the same time enjoys a certain degree of autonomy with respect to establishing health priorities, based on local needs. It operates within a clearly-defined geographical and administrative unit of local government — which we call the "district", though it may have different names in each country. The size of, and degree of autonomy accorded to the district varies greatly from country to country, as does the district's population, which may be less than 50 000 or more than half a million.[37]

The UNICEF/WHO Joint Committee on Health Policy, at a meeting in Geneva in January 1992, agreed that the district is the key level of the health system to implement, monitor and expand the health delivery system. The two agencies agreed to work together — at the country, regional and global levels — to strengthen district health systems through a variety of programme approaches, including the Bamako Initiative, which was itself launched by African Ministers of Health at the WHO Regional Committee Meeting in September 1987.

In particular it was agreed that they should systematically incorporate advocacy for district health systems into their discussions with governments and with external agencies. They should also promote the development of alliances with and among nongovernmental organizations, in order to influence their strategies for support of district health systems.

Collaborative action will also be vital to support countries in developing their district health system infrastructure so as to ensure sustainable health care delivery services. This will require the reorientation of health systems, focusing on districts and a decentralized and integrated approach. Support will be needed for the reallocation and effective utilization of resources. And in both rural and urban areas, it will be essential to mobi-

lize both communities and external resources in order to enable district management and health care delivery to function in an efficient and effective manner.

Support to countries for revitalizing and strengthening their district health systems equally presents a challenge for other international organizations, and calls for a different type of *modus operandi*, revised priorities and plans of action. Moreover, since there are no real "experts" in this field, all these organizations should support countries in "learning-by-doing" as they seek to strengthen their district health systems.[38]

A number of publications which describe how district health systems can be improved have been issued.[39, 40, 41] These are not intended to be comprehensive manuals but rather stimulii to action and to the acquisition of skills required to improve district health systems.

A 1985 Expert Committee on the Role of Hospitals at the First Referral Level identified the proper place of the first referral level hospital as a cornerstone of the district health system,[42] and a 1990 Study Group on the Functions of Hospitals at the First Referral Level, analysed its functions.[43] In 1994 the Hospital Advisory Group (HAG) noted that many countries did not have hospital policies as part of their overall national health policy and made practical suggestions on how these policies could be developed, in particular with regard to options for financing hospital services and technology assessment. The HAG also made some specific suggestions on the governance of teaching hospitals.[44]

Many countries are experiencing difficulties in introducing quality assurance in their health services. Activities carried out by the programme include the publication of "Quality assessment and assurance in primary health care" in 1988,[45] and the organization of interregional technical meetings on quality assurance as an essential part of health systems and services in Shanghai, People's Democratic Republic of China in 1990, Pyongyang, DPR Korea in 1992, Maastricht, Netherlands, in 1993, and Amman, Jordan in 1994.

Different methodologies and terminologies, such as Total Quality Management (TQM), Continuous Quality Improvement (CQI), and ser-

vice accreditation, continue to be used by different institutions and countries. A WHO Working Group was convened to provide guidance to countries on the principles and similarities between the different methodologies and their implementation. This working group brought together leading people in the area of quality assurance in the world.[46]

The health centre, which is the backbone of health services, has so far received little attention. To promote interest and developmental skills for improving the performance of health centres, a primer on health centres was published in 1994.[47] This has been followed by a series of research and development studies in a number of countries, aimed at documenting different options for improving the performance of health centres in both urban and rural areas. The studies were reviewed by an interregional meeting held in Surabaya, Indonesia, in late 1994, the results of which will be published in the near future.

A concept of "reference health centre" has been developed to improve the delivery of health services in urban areas. A Study Group in 1992 analysed different experiences and drew conclusions and lessons for countries interested in exploring ways of improving health services in urban areas.

WHO has realized that a useful tool to help countries in improving their district health systems is to facilitate the exchange of experiences. Three interrelated activities have been carried out in recent years. First, an interregional consultation held in Bandung, Indonesia, in 1993, analysed experiences from countries, and secondly, a Study Group convened in Geneva in 1994 reviewed recent trends and innovative approaches for the integration of health care delivery. Based on this review a series of recommendations to countries and international agencies to promote and support integrated delivery of health care in countries was made. The report of the Study Group will be issued in the near future. Thirdly, to address the fragmentation of training programmes, the Division of Strengthening of Health Services, in collaboration with other programmes, has developed a series of integrated learning materials under the title of "The Learning District".

Health Systems Research

Health systems research (HSR), the third pillar of SHS, again involves the Division with national programmes. Its aim is "to develop, in collaboration with Member States, appropriate methodologies for HSR as an integral part of the managerial process for national health development, and to promote their continuous application in order to generate the knowledge required to improve the planning, organization and operation of health systems."[48]

The Consultative Group Meeting on the role of Health Systems Research in PHC, which met in Geneva in November 1991, reconfirmed the crucial role to be played by HSR in furthering PHC, and endorsed the programme's major strategic options. The Group also identified five issues of general concern within the health system in general which HSR would have to confront in the coming decade. They are:

- the measurement of objective and subjective health care needs;
- the description and evaluation of impact of various approaches to the organization and financing of personal health care services;
- the study of the variations in health care resource allocation and levels of utilization of services;
- the measurement of health care system performance (effectiveness);
- the definition and measurement of health care outcomes.[49]

Within the context of the project on health systems research for Southern Africa, administered jointly by WHO, the Netherlands Ministry for Development Cooperation and the Netherlands Royal Tropical Institute, some 250 health workers, mostly at subnational level, have been trained up to now. This training resulted in a number of studies, and a recent evaluation confirmed that — for a vast majority — the recommendations of these studies were put into effect and resulted in improved management of health services and more efficient use of resources.

WHO/PAHO and the International Development Research Centre (IDRC) have developed a package of materials to support training for

> The three major strategies of the Health Systems Research Programme are:
>
> 1. to encourage the use of HSR as a tool for more informed decision-making;
> 2. to strengthen national capacities;
> 3. to organize national efforts in a sustainable process.

five essential partners in HSR: decision-makers, managers, university-based researchers, trainers and research managers.

Capacity building in HSR has been further facilitated by publishing, in conjunction with the Foundation for Health Services Research (USA) the first Directory of Training Programs in HSR, containing practical information about some District learning150 training programmes in this area.

One of the tools which HSR has developed to ensure a regular exchange of information and experiences is Bridge, an international newsletter linking the producers and users of health systems research and clinical epidemiology. Appearing three or four times a year, with 4500 copies in English, 3500 in Spanish and 3500 in Arabic, the newsletter is a joint activity ofWHO/HSR, the International Clinical Epidemiology Network and the Foundation for Health Services Research, with support from the Rockefeller Foundation and the International Development Research Centre.

Another way in which SHS disseminates information about its activities is through Current Concerns, a series of publications dealing with key issues in the management of health systems. Their purpose is to give a wider audience to contemporary issues in achieving Health for All, as reflected through the work of SHS. Recent titles of Current Concerns issues include "User Charges for Health Care," "Equity in the use of Health Care Resources," and" A Time of Change: health policy, planning and organization in Ghana."

Evolution and achievements of SHS

Throughout the past four decades, WHO's Division of Strengthening of Health Services has responded and adapted to the changing needs of Member States and the evolution of health systems. During the earliest years of WHO, the programme focused on the exchange of information, statistical and data collection, manpower development, the setting up of at least a skeleton health infrastructure in rural areas, and hospital-based services.

That early period was also characterized by the debate on the integration and functions of preventive and curative services to be offered, particularly at hospital outpatients' departments and at the level of the rural health unit.

Throughout the 1950s, mass campaigns aimed at specific diseases were useful in reducing the prevalence and incidence of certain diseases afflicting large populations. But the achievements of those campaigns could not be sustained without the presence and support of general health services. General health services were often set up merely to serve the purposes of the mass campaigns; as a consequence, basic health services neither met the needs of the population nor did they gain its support.

In the third phase of health systems development, basic health services expanded in the rural areas, and there was increased emphasis on planning and the integration of a health component into broad social and economic development plans. By the early 1970s, it was clear that the benefits from central planning of health services were not reaching the majority of people, and that health systems needed to be re-evaluated and reoriented towards the goal of worldwide health.

One of the Division's most important achievements has been the development of the concept of PHC in the mid-1970s. The Conference of Alma-Ata of 1978 was a seminal event. It launched the world on the primary health care approach to Health for All, and laid down such "stepping-stones" towards that goal as community participation and intersectoral cooperation. Almost by definition, PHC entailed a definite shift away from a directive and prescriptive role for WHO and towards

more of a catalyst role. No longer were policies designed at headquarters and laid down as the "right path" for Member States to follow. It was up to countries themselves to determine the purposes, content and projects of PHC. This gave rise to new challenges which included redefining the role and responsibilities of health ministries, strengthening managerial practices at district and local levels, and advising on the allocation of health manpower and resources.

The Division of Strengthening of Health Services has been particularly instrumental in the past decade in developing support systems which facilitate and accelerate the drive to attain Health for All through PHC. The lessons learned have demonstrated obstacles to be overcome and problems that need to be solved. In the mid-1980s the Division developed the concept of the district health system as the backbone for PHC.

A UNDP report published in July 1992, entitled *Programme Assessment and Future Development of the WHO Programme on Strengthening District Health Systems based on PHC*, declared that the concept and practice of the district health system, as the proven vehicle for PHC, "now transcends definition as an operational project, or even as a development programme. It is, in effect, a widespread managerial movement." Furthermore it considered the programme "vaults over the metropolitan barrier that confines most external cooperation within central ministries of government. It is lodged in a sensible level of decentralization; it is small enough in most instances to be a practical management unit, its targets are modest enough so that achieving self-sustaining growth can be a real possibility."

Emphasizing that the District Health System had come to stay, the report said the programme would be a powerful agent for alleviating policy and enhancing the quality of life of disadvantaged people. It concluded: "The programme is moving; there is a ground swell, and the international community will surely wish to share in this vast exercise."[50]

More recently the Division has promoted and developed activities focusing on health centres, quality assurance and priority-setting in health care.

"Few countries have disaggregated data which shows levels of health and access to health care by population groups. Where data is available, the gap between richer and poorer population groups is increasing. Few countries have clear ideas on policies, strategies and programmes to reduce inequities in health/health care.

WHO will intensify its effort in this area. Special effort will be made to monitor impact of reforms on people's access to health care, in particular, access by the poor. A number of agencies will support comparative studies to examine how different approaches to reform affect the provision, quality and use of services.

WHO has promoted and supported the concept of district health systems as the level to implement equitable and sustainable PHC. However, as your meeting has pointed out, more concerted effort is needed to realize the potential of district health systems. Special effort is needed to improve quality and performance of health centres. But improvement of health centres is not sufficient or feasible without support from hospitals. WHO is mobilizing global effort to improve performance of hospitals."

Dr Hiroshi Nakajima, Director-General of WHO, in his closing statement to the Sixth Consultative Committee on Organization of Health Systems based on Primary Health Care, Geneva, 7-10 November 1994

Challenges for the future

A survey entitled "Strategic Changes for the 1990s," prepared jointly by SHS and some of the major donors in February 1992, describes the profound economic and political changes that are now affecting both poor and rich countries. It comments: "The implications of these trends for health, and for health services, are complex. Firstly, it is clear that the egalitarian thrust of the PHC philosophy runs counter to the logic of a pure private market, where production and distribution are founded on

the prevailing distribution of income. A tendency for rapid cost escalation has also been shown to accompany private provision of services, particularly where there is an important component of public or third party financing. Yet equity in health remains an important principle for most governments, for both reasons of social justice and political security. A growing challenge is how to ensure that the health needs of the weakest — where the biggest health improvement are possible — are protected in a climate of change and scarce resources."[51]

The Sixth Consultative Committee on Organization of Health Systems Based on PHC, 7-10 November 1994, outlined future challenges to countries under five headings, namely: making the PHC approach a leading force for social justice in the reorganization of health systems and sectors; ensuring that the provision of equitable and efficient health care is the basis for choosing and monitoring options for change; ensuring and maintaining the relevance and responsiveness of district health systems to community needs; expanding the dissemination and use of existing knowledge to improve the quality of decision-making at all levels of the health system; and building partnerships to mobilize resources for health and manage external relationships by reducing duplication and ensuring external assistance corresponds to country priorities.

Approved activities for the immediate future comprise:[52]

Health systems research

- Strengthen coordination of health systems research, gathering and disseminating relevant information, and promoting such research through the establishment of focal points at global, regional, national and district levels;
- analyse and disseminate experiences on the use of findings of health systems research and development in decision-making (global and all regions);
- analyse impact of changes in financing, organization and delivery of services on health (Europe);

— assess the use and impact of WHO training materials; strengthen national capabilities for health systems research and support future development;

— strengthen cooperation with leading research institutes and WHO collaborating centres (Africa, the Americas, Eastern Mediterranean, Western Pacific).

Restructuring of health systems based on primary health care

— Conduct comparative studies on experiences in organizational reform and structural change in six countries (global);

— organize consultation to review country experiences with decentralization and its effect on health systems performance (global);

— document and exchange experience on changing trends in public and private sector interaction (global);

— design methods and tools for assessing and strengthening managerial and institutional capability for policy analysis, and health systems reform and performance; support their application (global, Africa, the Americas, Europe);

— strengthen national capability for planning and management of physical resources for health through design of methods and tools and support for their application; improve management and technical training, and information support (global, the Americas);

— convene the biennial meeting of the Consultative Committee on Organization of Health Systems Based on Primary Health Care (global).

Appplied health economics and management

— Cooperate with at least two additional institutions in offering intercountry training in applied health economics (Europe, Western Pacific), and with those providing intercountry training that have been supported since 1992 (Africa, South-East Asia, Eastern Mediterranean);

— design and implement training programmes for target groups, including training of trainers and distance learning (global);

— develop training materials in health economics and management, in collaboration with other international organizations and centres of excellence (global);

Resource allocation and financial management

— Undertake comparative studies on innovative methods of financing and resource allocation, and their effect on access to care and on health system efficiency (global, the Americas, Europe); prepare manual on options for financing health care systems (global);

— in collaboration with multilateral and bilateral partners, promote and support national analysis of health expenditure, using jointly sponsored materials; encourage cross-national comparisons of trends (20 countries) (global);

— support in four countries assessment of potential financing systems for social insurance for health using WHO/ILO materials; produce review document based on experiences as a contribution to a study group on social insurance for health (global);

— analyse cost and financing in district health systems and design tools for improving ability to establish accounting and auditing systems, draw up programme budgets, assess different methods of health-care financing, etc.; prepare a manual on micro-level budgeting (global);

— analyse cost to the health sector and means of financing promotion of and support to community health action, and contribution of community health workers and of other sectors to primary health care (global).

District health planning and management (global and all regions)

— Strengthen primary health care planning based on assessment of the overall rise in health status — or health gain — that would result

from cost-effective activities designed to improve equity of access to care; apply methodology for micro-level planning in at least 20 other countries; devise methods for setting priorities, monitoring health and determining standards for evaluating performance and impact of health programmes and services; support operation and management of integrated health services in the 20 countries; enhance capability of health personnel in districts, including through networks of primary health care training centres;

— build up community involvement and intersectoral action for health through, for example, identification of basic minimum needs, support for global monitoring of situations and trends, exchange of experiences based on country studies to be reviewed at an interregional meeting, and advocacy of social participation in decision-making;

— organize global consultation to review health development, focusing on districts in the 1990s, and advocate strategies for the twenty-first century.

Quality assurance in health institutions (global and all regions)

— Intensify collaboration on quality assurance among organizations and follow up joint action;

— prepare and update technical guidelines and methodologies for countries and interested parties;

— organize consultation to exchange information and identify innovative ways of advocating quality assurance, such as sponsoring competitions for the "best district award"; discuss the integrated approach to health development with local government and leaders of health-related sectors in various forms.

Hospital performance (global and all regions)

— Review hospital policies, including relevant legislation, in at least eight countries;

— identify options for improving hospital performance, through review of different management and financing alternatives in countries;

— carry out state-of-the-art reviews on technology use in hospitals.

Performance of health centres (global and all regions)

— Study options for making the health centre the key entity at district level; identify priorities based on local needs;

— continue multicountry research and development using the learning-by-doing approach in order to improve health centre performance in collaborating districts in 10 countries; disseminate findings.

Urban health systems (global and all regions)

— Promote and support health prorammes for urban disadvantaged populations through collaboration with nongovernmental and other organizations; enhance the role of municipal authorities in health development;

— analyse health and social problems, such as disease patterns and the aging population in urban low-income areas, the adequacy of health organization responses, and experiences of six cities in developing countries;

— follow up development of "reference health centres" in large urban areas.

The Division of Strengthening of Health Services has, throughout WHO's life-span, demonstrated an increased ability for timely and effective response to mandates from WHO's policy-making bodies. It has assumed a prominent and consistent position in the international arena on operational activities, and is at the forefront of analysis of current and emerging issues in the organization of health systems. Experience gained so far will be of great help in responding to future challenges.

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