

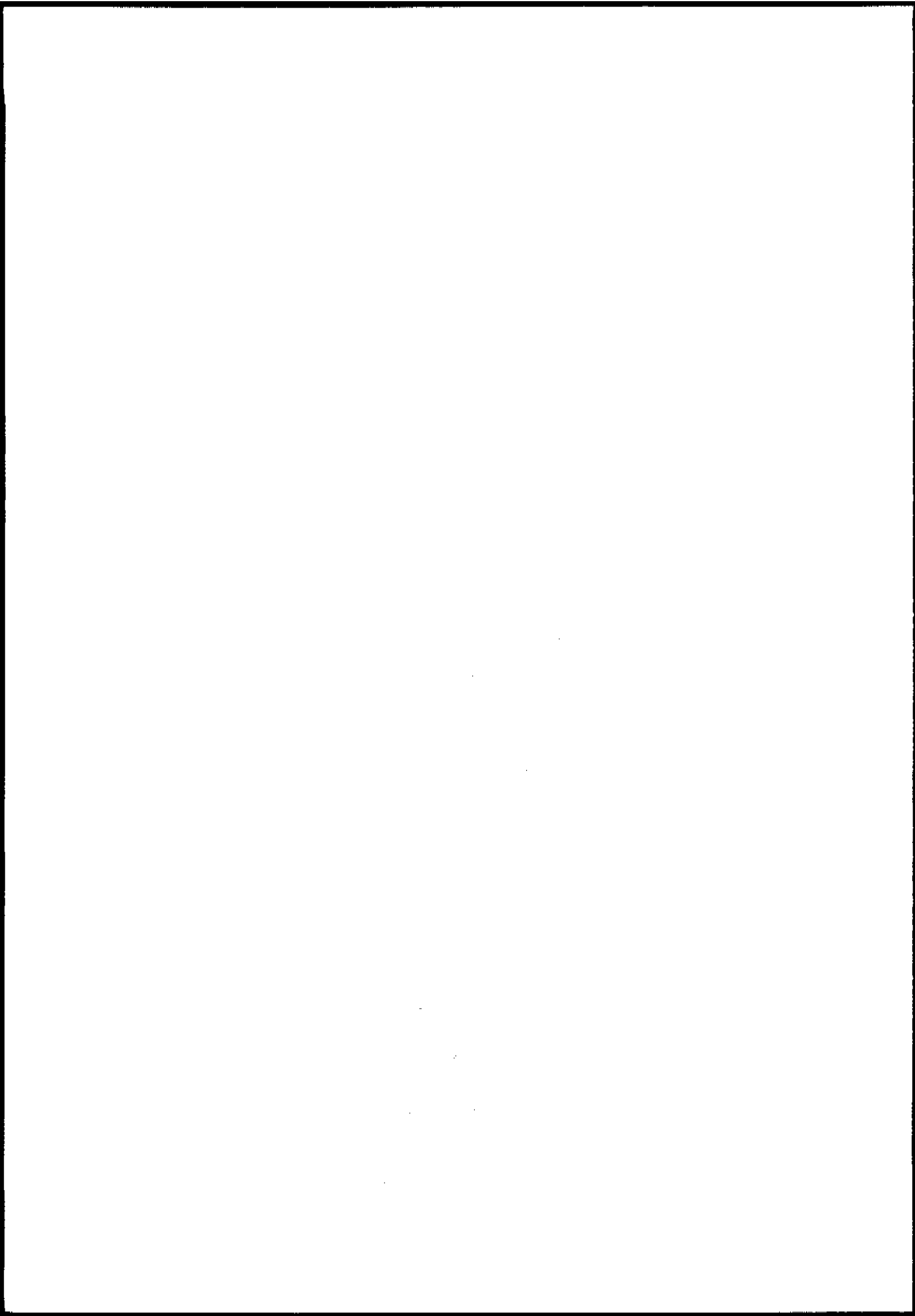
Sixth Consultative Committee

*on
organization
of health systems
based on
primary health care*

*Geneva
7-10 November, 1994*



**World Health Organization
Geneva**



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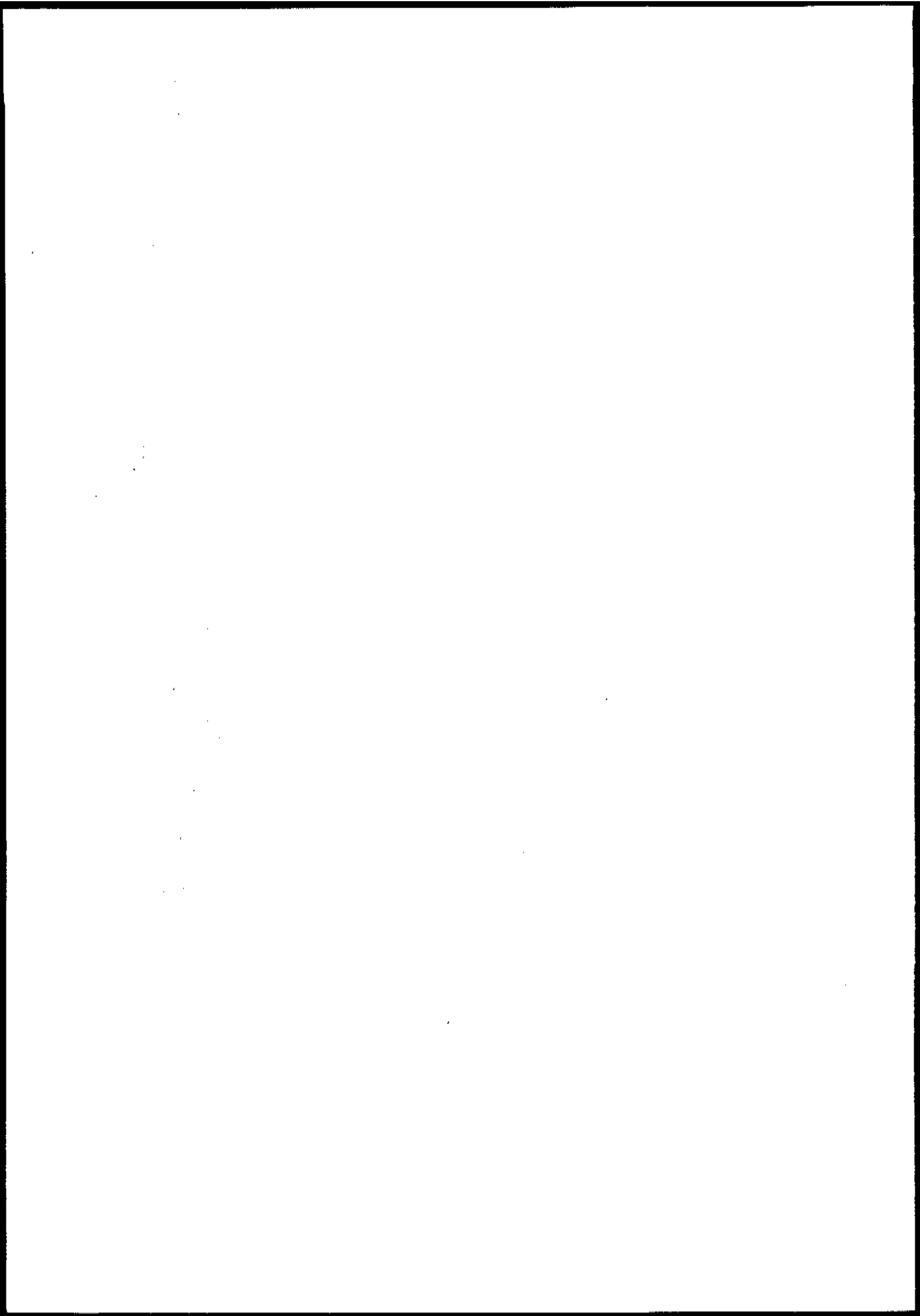
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CONSULTATIVE COMMITTEE ON ORGANIZATION OF HEALTH SYSTEMS BASED ON PRIMARY HEALTH CARE

Opening

The Sixth Consultative Committee on the Organization of Health Systems based on Primary Health Care was held in Geneva from 7 to 10 November, 1994.

In welcoming the participants (see Annex 1), the Assistant Director-General, Dr F. S. Antezana, recalled that in supporting health sector reform for better implementation of primary health care (PHC) the aim was to attain goals that are consistent with Health for All. These goals are:

- (a) to improve health status by increasing the effectiveness and quality of services;
- (b) to obtain greater equity by improving the access of disadvantaged groups to quality care;
- (c) to obtain greater value for money through improvements in the distribution of resources to priority activities and the better management and use of the resources that have been allocated; and
- (d) to raise levels of user satisfaction by improving the accessibility and quality of services and providing greater choice.

Economic pressures for health sector reform were being experienced in nearly all countries, albeit in different degrees. Financial support from governments was unlikely to expand, and health ministries were considering (or implementing) reforms to make better use of existing resources and to increase nongovernmental economic support.

Strengthening health services at the district level was essential for the successful implementation of PHC. The long-term success of PHC also depended on the capacity of those who manage the system to make improvements and respond to changing conditions. There was a need for a continuous stream of policy-relevant information about health and health systems from a variety of sources. Effective health systems research was therefore a critical factor to the success of PHC.

Dr Antezana concluded by stressing that progress towards the goal of Health for All requires coordinated activity in PHC, district health systems, health systems research, and the financing and organization of health care.

Objectives

The principal objective of the Consultative Committee was to foster implementation of the PHC approach in the current climate of change. Other objectives were to identify major problems in the implementation of PHC that need priority attention; to determine ways of dealing with them; to suggest strategies and activities to be pursued by WHO; and to consider mechanisms for improving resource mobilization.

Introduction

The basis of primary health care was established at Alma-Ata in 1978. First, PHC is concerned with improving social justice and recognizes the special needs of those least able to take the initiative in seeking health care and those who are most vulnerable or at general risk. Second, PHC is envisaged as participatory, involving communities in the planning and management of health activities. Third, it is recognized that while health services play a role in guaranteeing people's health, other sectors have to be mobilized if health status is to improve. Fourth, PHC has to be affordable in different communities and countries.

The Alma-Ata meeting provided the impetus for a radical rethinking about health policies, which influenced the planning, organization and management of health sectors all over the world. In spite of rapid changes in global economic and political circumstances after 1978, much was achieved by countries that endorsed the change in health policy towards PHC. Shifts in health budgets promoted more equitable distribution of health resources, expanding services to previously under-served populations. Hundreds of thousands of new types of health workers were trained to provide health promotive and preventive services to their own communities. Greater emphasis on prevention and advances in appropriate technology led, among other things, to improved immunization coverage and contributed to the overall decline in infant and child mortality. The role of other factors, such as education, family planning, water and sanitation, in improving health status became widely accepted.

The achievements in PHC are the more remarkable given the deteriorating environment in which PHC policy had to be implemented. The economic recession began in the 1970s, accelerated in the 1980s, and is still taking its toll in the mid-1990s. It has resulted in increased levels of poverty and greater inequalities between groups in many countries. The advent of AIDS, the resurgence of communicable diseases such as tuberculosis, and large-scale and complex disasters have further stretched constrained economies.

Political change catapulted socialist countries into market capitalism, strengthening policies in favour of market reforms and retrenchment of the public sector. Instability has grown in many countries. Rapid population growth and urbanization have characterized the poorest countries, while poor economic growth rates and aging populations have posed particular problems for industrial countries.

This changed world environment has had profound implications for PHC. In 1978 it was assumed that the ministry of health - the public sector - would be responsible for implementing PHC policies, but today it is clear that the ministry of health's role will be very different, with greater emphasis on coordination and seeking partnership with the private sector. In 1978 most attention on financing was focused on the costs to government of health care. Today, methods of health financing from all sources are central to discussions on health policy and negotiations on health reforms.

Increasing emphasis is being put on health sector reform and, although there is no universal package of measures that constitutes a model for reform, most countries are engaged in a process of transformation of the health sector - albeit at different speeds and levels of enthusiasm.

The Consultative Committee affirmed that even in such a changing environment, the goals of PHC should underpin health sector reforms, and it identified five key PHC requisites as central to any new health sector policy agenda.

- (i) Ensure that the PHC approach is the leading force for social justice in the reorganization of health systems and sectors. This principle arises through a concern with equity. Economic recession has led to increases in inequalities both within and between communities and countries, and it is therefore essential to preserve equity as a goal in reformed health systems.
- (ii) Ensure that the provision of equitable and efficient health care is the basis for choosing and monitoring options for change. As the role of government in funding health and financing health systems changes, the ultimate impact of reforms on efficiency, equity, and improved health status will depend, among other things, on human resources policies that focus on remuneration and incentive structures, on the physical and managerial infrastructure of the health sector, and on the ability of management to apply specific regulatory mechanisms and monitor their effects. Additional information needs to be provided to assess the impact of such changes on health status.
- (iii) Ensure and maintaining the relevance and responsiveness of district health systems to community needs. A common desire to see health decisions taken at the local level has focused attention on the district and particularly on decentralization. Much needs to be done to strengthen the abilities of district health systems to implement PHC by working in partnership with all the other agencies in the district, both public and private. The close involvement and participation of the community in health decision-making is essential.
- (iv) Ensure that decision-making at all levels of the health system is based on scientific evidence acquired from health systems research. Health reforms have an impact on health status and on the provision and utilization of health services. Policy-relevant and timely information about health and health systems is necessary at all levels of the health infrastructure. It can

provide ways of involving communities in health decision-making and also encourage evaluation and feedback for the early identification of problems as implementation proceeds.

- (v) Build partnerships to mobilize resources for health and manage external relationships by reducing duplication and ensuring that external assistance corresponds to country priorities. In the current environment of health sector reforms, strong and coordinated efforts are needed on the part of governments and donors, and the responsibilities of each need to be explicitly defined in order to mobilize resources to renew the emphasis on PHC. New mechanisms to strengthen and build partnerships need to be identified to meet these goals.

The Committee focused on the above-mentioned five key themes using a common analytical framework. All the groups considered new directions for PHC, reviewing the case for a comprehensive approach to health and health systems.

The Committee rejected the narrow view of health that concentrates only on health care services and the financing and management of the health sector in favour of the holistic PHC approach, which takes these into consideration but also advocates intersectoral policies. The Committee also strongly endorsed the PHC principle of social justice through equity and democracy.

The deliberations of the Consultative Committee in each of the five areas are summarized in the next sections.

ENHANCING THE PHC APPROACH AS A LEADING FORCE FOR SOCIAL JUSTICE

The Consultative Committee noted that the social goal of Health for All by the Year 2000, and PHC as the approach to achieve that goal, had won widespread acceptance by governments and international agencies. In the last 16 years, PHC principles had influenced health development in practically all countries. It was therefore a matter for concern that pessimism about PHC was often encountered in a number of agencies. The Consultative Committee emphasized that there was no need to be apologetic about PHC's performance and achievements. Apart from improving the health status of millions of people throughout the world, PHC had spearheaded projects that had later led to the development of democratic processes and mechanisms in a number of countries. In Latin America PHC had proved to be a major force for democratization.

The Consultative Committee identified seven priority issues for making the PHC approach a leading force for social justice they are discussed in the following sections.

(i) Reinforcing the concept of PHC

In the process of implementing the principles of primary health care under widely varying national circumstances, differences in interpretation had arisen. Some of the most common misinterpretations are: that PHC is just the first level of health care; that PHC is cheap; that PHC calls for action on all fronts without deciding on priorities; and that the concept of PHC is relevant only to poor countries.

The Consultative Committee emphasized that PHC is a philosophy - an approach to health and development that applies the values and principles of social justice. While decentralization of resources and management towards the periphery of the health system is essential for the implementation of the principles of PHC, decentralization was often wrongly being equated with privatization or with the abandonment of peripheral components of health systems.

The Consultative Committee emphasized the need for constant clarification to be made by countries and agencies about misconceptions and misinterpretations of the concept of PHC that arise from time to time in its implementation. Such clarification was all the more necessary in view of the huge turnover of decision-makers in the health sector.

An issue that was addressed by the Consultative Committee was whether the slogan Health for All by the Year 2000 should be changed. A number of participants felt that it was not realistic to expect that the goals of Health for All would be achieved by the Year 2000 by many of the poor countries. However, the conclusion of the Consultative Committee was that such a change was not needed. The values, principles and practices of the PHC approach were seen as valid for health development by the year 2000 and beyond. One participant described PHC as a timeless goal. There was, however, a need to review existing health policies, strategies, and activities and make the

necessary modifications in response to the changing situations and needs at the local, national and international levels.

(ii) **Resources for health**

Three interrelated issues were considered, namely the level of resources allocated to the health sector, the reallocation of resources within the health sector, and the better use of available resources.

Levels of resources allocated to the health sector

The low level of resources allocated to the health sector in a number of poor countries, sometimes less than 1% of GNP or 5% of government resources, was of great concern. A number of these countries were, in fact, spending less than US\$5 per capita on health care, which fell far short of the recommendations of a number of agencies that at least US\$13 per capita should be made available for essential health care packages. These countries need to make a greater effort to increase the resources available for essential health care. As discussed later under the section on health systems research, the availability of data on the current health situation and a well-argued presentation of what can be achieved with additional funding would strengthen the ministries of health in their efforts to obtain more resources from the government. In this respect, donor agencies and international organizations can also play a role in convincing recipient governments of the need to invest greater portions of national and international resources to the health sector.

The Consultative Committee strongly recommended to countries that have had to reduce their levels of budget to the health sector to make every effort to increase the budget levels of the sector to that existing before the economic crisis.

Reallocation of resources

This has proved difficult, particularly in countries where chronic underfunding exists at all levels of the health system and where hardly any new resources have become available. The percentage of national health expenditure devoted to local health systems has increased in developed countries but has stagnated or declined in the poor countries.

The Consultative Committee emphasized that cost-effectiveness should not be the only parameter for priority-setting and decision-making. Allocations should be made according to need and to the scope for improving efficiency.

Making better use of available resources

There are great opportunities to decrease wastage and duplication and thus make better use of resources in the health sector. In this respect, the community itself should be seen as an important resource. The decentralization of programme implementation to district and local levels also has potential for improving the use of resources. Some recent examples from Latin America and Africa, particularly Zambia, clearly showed that direct provision of donor and national support to districts improved the performance of

district health systems. However, there is a danger that donors may preferentially select to support those districts with good infrastructure and motivated staff and thus leave the worse-off districts even further behind. A number of donors in Latin America have overcome this problem by targeting their support to a mix of districts including those that are currently weak in health development.

(iii) Equity and the targeting of underprivileged groups

Equity in health and health care is the area where PHC has made least progress. Concern was expressed that most countries did not even have data to indicate what was happening in this area. In the few countries with data there was evidence that inequalities in health and health care were either static or increasing.

The Consultative Committee emphasized that governments have a responsibility to ensure that underprivileged individuals and communities have access to essential health care. At the national level, governments and ministries of health should give priority in resource allocation to districts that are weak in health development. To this end, the health profiles of the populations of all districts must be known and taken into consideration. Within districts themselves, priority should be given to population groups and geographical areas that are relatively underprivileged.

At least two aspects of equity should be considered. The first is equitable health financing, implying that contributions to health should be graduated according to peoples' ability to pay. This can be implemented in various ways including income tax, capital gains tax, or income-related insurance premiums and other payments. The main point is that people who cannot pay should still have access to basic health services. The second aspect is equity of access implying that services should be available according to need and not according to ability to pay. For this, a sound knowledge of the community and its health needs must be established.

(iv) Role of different partners

Ministries of health need to work with various partners for the development of the health sector. These partners include the government as a whole, individuals and communities, health workers, donor agencies, nongovernmental organizations and universities.

The Consultative Committee emphasized the need to ensure that health personnel are properly remunerated. It was noted that owing to inadequate salaries and incentives, many health workers were unmotivated and thus minimally productive. The brain-drain was another manifestation of deficiencies in incentives. Incentives should be worked out by individual countries to encourage health workers to work in remote areas.

(v) Code of conduct

The Consultative Committee spent considerable time reviewing different ways in which the development of a code of good practice by the different partners of the PHC

movement could enhance implementation. The deliberations and conclusions on this matter are further elaborated in the final section of this report.

(vi) **Priority-setting**

Concern was expressed by the Consultative Committee at a number of simplistic priority-setting approaches currently in use, which centred on selecting diseases or interventions for the selective targeting of resources. It was emphasized that priority-setting of essential health care, packages or baskets, should be holistic and should also reflect community priorities. Priorities should include components of environmental health, health promotion, disease control, health care, and maternal and child health, as well as the organizational and administrative elements that are essential for the sustainable development of PHC. Packages should be defined locally on the basis of an epidemiological evaluation of local data, including demographic information, and they must be responsive to the holistic needs of individuals, families, and communities. Priority-setting should always include an educational component stressing what people can do by themselves to meet their health needs.

(vii) **Quality assurance**

Various reviews and reports indicate that countries are having great difficulties in the area of quality assurance. PHC is often wrongly seen as second-rate care for people who cannot afford quality care. The Committee felt that greater effort was needed in this area. This effort might take the form of elaborating a process of accreditation for compliance with PHC norms. A minimum set of criteria on PHC standards should be developed, and countries should be supported in using them to assess their health systems and to identify areas that need increased support from WHO. The actual process of accreditation might involve periodic reviews of progress and compliance with PHC norms at the district/local, national and international levels. Many countries were carrying out joint PHC reviews with WHO. The Eastern Mediterranean Region (EMRO) and the American Region (AMRO) have compiled recent experiences and findings of such reviews.

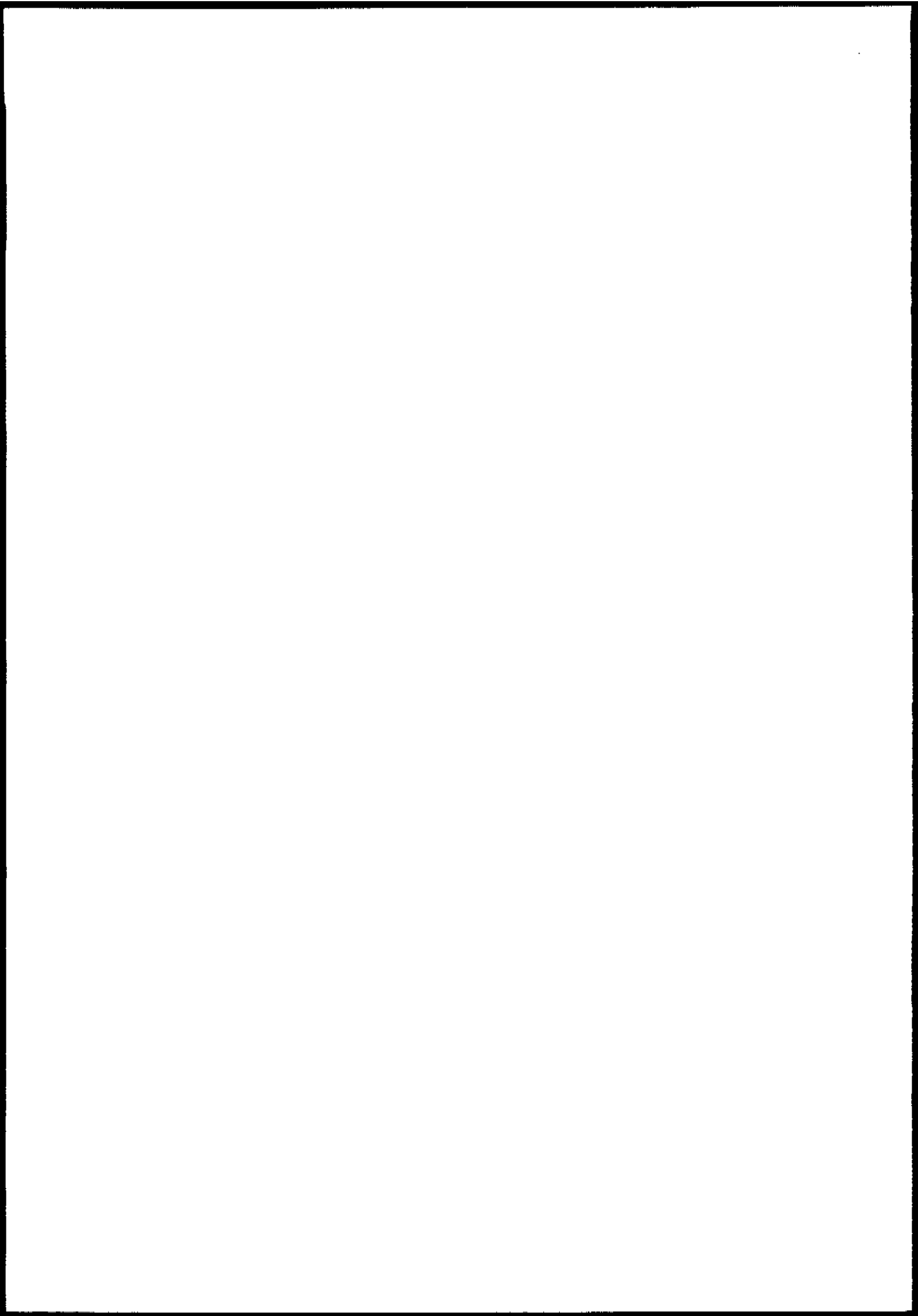
The Consultative Committee strongly recommended that the methodologies for PHC reviews should be sharpened and disseminated widely for use by individual countries.

The role of WHO

- The leadership role of WHO was considered crucial for the success of the PHC movement. More effort was needed by WHO to enhance the movement and raise awareness about the good results in health and social development that it had achieved so far, through more extensive use of the media and better marketing of the concept in general. It was also necessary to clarify misconceptions and misinterpretations about PHC; in particular there was a need to clarify the relationship that should be established between PHC principles and the on-going health sector reforms. Efforts should be made to explain the principles of PHC in

the context of the changing environment and conditions in both developed and developing countries.

- Equity should continue to be the guiding principle of PHC and WHO should strengthen its leading role for national and global activities aimed at targeting health action to underprivileged individuals, families, and communities and at decreasing the inequities in health and health care within and between districts. The development of indicators that use disaggregated data to identify under-served populations, both at the local and national levels should be supported, as should capacity building in countries.
- In relation to the allocation of resources, WHO should develop approaches to cost-effectiveness that are more comprehensive and include organizational issues of health care. WHO's priority in this area should be in collecting and disseminating different experiences of cost-effectiveness and priority-setting problems. It should put more emphasis on the documentation of programmes and projects that demonstrate the impact and cost-effectiveness of health activities.
- WHO should disseminate information about methods to enhance community participation. These tools should empower communities to take a leadership role in the effort to improve their health in a holistic way, and in a manner that builds on their cultural beliefs and recognizes the rights of communities and indigenous peoples to participate in programmes for their advancement.
- WHO should pay special attention to mobilizing universities and professional associations with the aim of enabling these institutions to play a more active role in implementing the PHC approach. The Consultative Committee specifically recommended that one of the future Technical Discussion subjects at the World Health Assembly should be devoted to the role of universities in PHC. The discussions would provide an opportunity to review achievements and constraints since the subject was first discussed during the Technical Discussions in 1984.
- WHO should be active and innovative in mobilizing PHC partners including international agencies, parliamentarians, and other pacesetters. In particular it should make more effort to mobilize the World Bank positively to advocate PHC. Action in this area should aim at ensuring that messages sent by the World Bank to countries are consonant with PHC principles. It might be possible for WHO and the World Bank to reach an agreement on a set of criteria for health projects in countries and on the production of joint guidelines to be used in this area.



POLICY, ORGANIZATION, AND FINANCING

Many countries are reviewing the scale and sustainability of government commitments. At one end of the spectrum, richer countries are concerned to limit the growth of total health expenditure while improving value-for-money. At the other, poor countries are recognizing that many routes need to be explored to improve the financing of health care. In many cases, countries are introducing far-reaching changes in the health sector, including the introduction of a variety of market mechanisms. Any change in the organization and financing of health care may affect its quality and accessibility, and thus the health of the people. To support the vision of PHC, health sector reform programmes need to be clearly oriented to promote equity of access, service quality improvement, cost-effectiveness, and consumer satisfaction.

In this connection the Consultative Committee identified three priority issues, as described in the following sections.

(i) Ensuring that health system equity and efficiency and the quality of services are the criteria for evaluating options and monitoring progress

It was generally recognized that in many countries PHC has not been defined in operational terms with clear criteria for evaluation. Thus, the status of progress on PHC is not well known. Commonly, resources are not allocated in a cost-effective manner because of organizational, political, and structural obstacles within ministries that impede reallocations more consistent with PHC.

The Consultative Committee stressed that an overall policy framework is needed to define the broad values underpinning health development, and to outline the roles of government, providers, and consumers. Updating the PHC approach requires a recognition that governments cannot do everything, but also that there are some functions that only governments can undertake. Overall policy directions, regulation, monitoring and strategic planning are public responsibilities in health policy, which often need to be substantially strengthened. Governments are also responsible for ensuring that the needy have access to care regardless of their ability to pay. Unless carefully planned and regulated by Ministries of Health and governments, nongovernmental providers can compete with basic PHC services for resources and adversely affect equity and efficiency in PHC. Several service provision and supporting functions, however, may be as efficiently provided by private sources as by the public sector.

(ii) Organizational reforms

A number of reforms have helped to operationalize the goals of PHC. These include decentralization; changes in policy regarding the role of the private sector, including service contracting the use by private practice of public facilities new regulatory approaches; and the creation of semiautonomous operating units such as hospital boards, environmental health units, and teaching hospitals.

Decentralization requires not only the willingness of central government to devolve some authority but the capability of local government to assume it. Local institutions must be strengthened and staff properly trained and supplied with valid and useful information. The most important condition for the success of decentralization is the existence of managerial capacity at the local level together with appropriate technical assistance, monitoring, and performance assessment from the centre.

(iii) Financing reforms

Several financing reforms are being widely implemented to support the goals of better equity, efficiency, and/or improved quality of care in PHC. They include user charges systems and health insurance schemes of different types. However, experience has shown that, when poorly designed, these reforms can cause great harm to these goals and so must be packaged carefully and in a culture-specific milieu. In all cases, a range of supporting measures are required such as: the periodic adjustment of fee levels to keep up with inflation; the retention of the collected revenues for use within the collecting health facility and the availability of appropriate managerial skills and financial institutions.

In parallel with new financing mechanisms, improvements in resource allocation must have a high priority for improved efficiency. Even where reallocation between different levels of care is difficult, there is much to be gained potentially from improved management practices.

The Consultative Committee expressed concern that "magic bullet" solutions, and over-simplified models of reform were sometimes advocated. It was stressed that no single model can be recommended. What is needed is more information on the different strategies and methods that have proved effective.

As stated above, there is commonly a need for clearer policy frameworks, giving goals and objectives and specific regulatory mechanisms. Negotiating the policy framework is only partly a technical exercise it also entails important political alliance-building. For instance, a policy framework on cost recovery should clarify improved quality and better access as objectives, and identify mechanisms for accountability by revenue-holders to the population. The development of such a framework should be supported by careful publicity so that government intentions are not misunderstood.

The crucial importance was stressed of choosing appropriate performance indicators in relation to policy objectives. For example, if cost recovery is to improve service quality by improving the availability of drugs, a mechanism to monitor and report out-of-stock periods is more useful than an account of revenue collected. In the revision of indicators and the formulation of new ones, the areas of interest of health-related sectors should be taken into account. For instance, "key inputs" such as essential drugs, fuel, and appropriate staff may assist in monitoring service quality. A "basket" of low-cost and relevant indicators is necessary so that equity, quality, efficiency, consumer satisfaction, and sustainability can all be assessed. A composite index would allow the assessment of change of several indicators simultaneously.

Simple utilization and equity indicators can be developed based, for example, on attendance figures by target populations analysed by gender, age grouping, ethnicity, or other social groupings (in percentages or attendances per person/year - identifying nonattenders). Simple resource equity indicators could include actual budget per head of population and beds or other "key inputs" per head of population.

The analysis of the existing situation, the monitoring of progress towards stated policy objectives, and the trade-offs that might be arranged between policy objectives will depend on the availability of such indicators and of a functioning monitoring and reporting system.

A major problem in many countries is getting the ministry of health to look at the needs at operational level and to allocate resources to them. Menus of policy options are needed for countries, with detailed guidance on how to tailor them to local needs and how to make them operational at district level. A step-by-step guide to implementation, based on other countries' experiences, would be valuable.

Dissemination of experience can, however, be discouraging. Reform is often a lengthy, acrimonious, and costly process - often with little visible improvement in the short term, the so-called "trough". There is need to investigate the causes of the trough and provide critical support to prevent and minimize the temporary hardships that can cause the whole reform process to be diverted. However, an understanding of the entire package of support measures - including the promotion of public awareness and acceptance - is essential if the mistakes of one country are to be avoided by others.

The role of WHO

To reach equity, efficiency, access, and quality goals, the traditional focus on health skills alone is not enough. WHO must develop stronger analytic capability in the field of health economics, particularly at regional and country levels, either within the Organization itself or within collaborating centres in order to support consideration of important health financing options by government in the implementation of PHC.

WHO should support the documentation of problems and achievements in resource reallocation, financing, and organization and the dissemination of these experiences. It should also advocate and support the incorporation of health economics into the basic training curricula of health workers.

The susceptibility of governments to pressure from international agencies can be considerable - even destabilizing. Capacity building and confidence building in ministries of health is therefore a key role for WHO. Despite the fact that governments and ministries are assuming new roles in the fields of regulation, incentive-setting, and the management of private suppliers of services, and others, some ministries are now worse off in terms of capacity than they were ten years ago. Capacity building must involve: the development of new tools on specific aspects of the reform agenda; reviews of experience-in-use, setting performance standards both for individual facilities and for the overall health system; better surveillance and information handling (from peripheral health units right up to the centre) and better analytical skills. When donors engage

consultants to enhance the capacities of ministries of health, WHO should enter into a dialogue with them.

WHO's role, in these days of limited resources, should be to assist policy-makers in government and ministries of health in developing their capacity and confidence in dealing with policy development and associated reform issues, aiming at a clear understanding of the issues and types of analysis needed for decision-making. Ministries of health should have a capability for understanding the specific strengths, weaknesses, opportunities, and dangers of particular health-sector reform options. WHO's capacity to assist the implementation process will in this way be stronger and more effective.

DEVELOPMENT BASED ON DISTRICT HEALTH SYSTEMS

District health systems

The district health system based on primary health care includes all institutions (whether governmental, social security, nongovernmental, private or traditional) and individuals, providing health care in a clearly defined administrative and geographical area. Its components include the overall organization, planning, and management of resources, as well as the implementation of the elements of primary health care. The concept of district health systems came into existence because it was clearly realized that PHC activities cannot be determined, planned, and organized from the central level. The district health system initiative represents a renewed effort to implement primary health care strategies more effectively and to strengthen the intermediate level of the health system. The objective is to ensure and maintain the relevance of the district health system to community needs.

At the district level the "top-down" and "bottom-up" approaches meet, and integration between vertical programmes, and between government and private sectors can be achieved. The district health system contains, in addition to health care services, the capacity to deal with health related concerns such as health promotion and protection, sanitation, the environment and various aspects of community involvement to achieve sustainable health development. In addition, many key development sectors are represented at this level thereby facilitating intersectoral cooperation and management of services across a broad front. Hence it is at the local and district levels that health is seen as a holistic approach. Yet it is precisely in this area of organization and management that many countries are weak and the attention on under-served areas or populations should be focused.

To address population needs as well as their demands, a range of health development and health care activities need to be implemented. The Consultative Committee identified a number of entry points for district health development such as family planning, MCH, the nutrition programme, and EPI activities and affirmed that the involvement of the community in the development of appropriate health services is essential. It expressed concern about waste and duplication of programme management and emphasized its belief that integration of programmes at the district level was the most appropriate solution. There should be encouragement of the team approach to management and the development of leadership skills. The integration of programmes facilitates comprehensive planning and programme development, resulting in the optimum use of resources without loss of accountability.

The crucial role of a sound infrastructure was emphasized. A number of poor countries have weak, fragmented infrastructures, which need to be strengthened and extended as a basis for sustainable delivery of programmes.

Due to the variety of situations and administrations in existence, approaches to solutions cannot be generalized globally nevertheless certain principles have to be

followed so as to be able to manage the district health system more efficiently.

Five priority issues were identified by the Consultative Committee for ensuring and maintaining a proper balance between district and national level concerns relevant to community health needs, as described in the following sections.

(i) Assessment of needs and capacities in district health systems

To facilitate planning, decision-making and the regional and local allocation of resources, it is necessary to collect accurate and relevant information. This should include population structure, health status, the identification of marginal groups, the adequacy or otherwise of services, the resources available, and resource distribution.

Programme activities should be costed. This requires identification of existing resources within the district, i.e., the nongovernmental organizations, private medicines, and other sectors, in order to ensure that there will be no duplication but rather complementarity for the betterment of the health of the community.

The development of a health information system at district level is an important component of activities aimed at improving management.

(ii) Strengthening the process of decentralization and enabling the achievement of district health goals

Decentralization is essential if resources at the district level are to be used and managed to best effect. It is a process and not merely a policy declaration or a one-time effort. It involves the delegation of managerial functions and financial authority to regional, district and municipal levels. It should apply not only to the health sector but also to health-related sectors, and it should permit broad social participation. Decentralization should result from a national policy supported by enabling legislation, which should respect the cultural values of the people.

The capability of the district management system should be developed and administrative procedures adapted to the local capacity and government system. Authority should be transferred in exchange for increased transparency and accountability.

The desired level of decentralization should be determined by the capacity to provide the basic health needs of the community. Care should, however, be taken lest overdecentralization make things unmanageable at the district level.

Studies should be undertaken to review and analyse the process of decentralization and to assess achievements and setbacks. Guidelines should be elaborated to facilitate the process.

(iii) Allocation of resources according to community-based needs

Government should provide assistance to meet the deficit of the district health system allocations in order to overcome the problem of equity. Equity has to be

considered in terms of access to services, especially in remote areas, and to indigenous and poor populations. This might involve a higher cost of service for a period of time.

National resource allocation should be based on equity and population needs between districts, while district resource allocation should be based on population needs within the district. This will compensate the more disadvantaged districts and populations. Donor agencies should consider supporting the activities of district health systems, in particular for disadvantaged areas. This should be integrated in the resources available to districts.

(iv) Promotion and assurance of quality of care

In many countries, the district health systems have not yet addressed the problem of the quality of care, which should be approached in two ways. The first is at the level of process improvement. The second is through institutional strengthening, i.e., by providing training, encouraging job satisfaction (including the provision of appropriate work environments and tools), promoting appropriate incentive systems, and developing appropriate indicators. There should also be institutional strengthening of health centres, reference centres, and district hospitals in terms of appropriate facilities, equipment, and supplies. Appropriate standards of practice should be set for each level in the system and reviewed on a regular basis.

Achieving the optimum quality of care can be approached through a variety of methodologies such as accreditation, quality assurance, and total quality management. The pursuit of quality should apply to all health-related sectors, including environmental health programmes.

(v) Improving the performance of health institutions and extending their coverage

Improving the performance and coverage of health institutions must be addressed by appropriate operational planning and implementation at all levels of the district. This can be achieved through the integration of activities, the establishment of appropriate referral systems and networking, and the implementation of outreach activities supported by appropriate funding. Capacity building for planning, management and supervision skills should be constantly strengthened, and adequate funds for this should be included in the budget. Where a method of user charges is used, it can have a positive outcome if a percentage is retained at the district level by the facilities and utilized to improve the quality of the services.

It should be emphasized that improving performance should be given special attention in all sectors and institutions of the district so that partnership can be improved. Because of their pivotal position in the health system, special attention should be given to health centres.

The role of WHO

WHO could assist in the further development of district health systems by carrying out promotional activities. It should support capacity and capability building to improve management skills so as to enable the district health system to become a self-sufficient and self-sustaining entity. It should also assist in the elaboration of performance criteria and indicators, and in developing methodologies for quality assurance

Resource mobilization

In the course of reviewing the broader aspects of PHC development at the district level, the Consultative Committee regretted the low level of resources presently allocated to infrastructure issues by multilateral and bilateral agencies.

In order for WHO to help sustainable health systems at local and district levels and to assist in the generation of additional support for the vital development of health infrastructure in developing countries, it is necessary to enlarge the focus on infrastructure programmes and encourage donor funding in this area. Donors should be encouraged to consider allocating part of their extrabudgetary contributions to special programmes specifically to infrastructure development. Recipient countries should also be encouraged and assisted by WHO to prepare proper project proposals for funding - e.g., by including quantitative measures, appropriate performance indicators, and budgeting procedures.

HEALTH SYSTEMS RESEARCH - LINKING RESEARCH TO DECISION-MAKING AND CAPACITY BUILDING

Health systems research (HSR) has been defined as "the scientific method for acquiring information which can be used for rational decision-making in health management".

Its scope and purpose have been, and continue to be, to provide decision-makers with useful evidence as to which health policies are likely to be the most effective, efficient, economic, and relevant to their needs. It also provides managers with the technical knowledge to translate these policies into action.

The field of HSR has advanced substantially over the past few years with the development and testing of new research methodologies and innovative strategies for setting research priorities, as well as the building of research capacity and the sustaining of the HSR process and the structures that support it. Much remains to be done, however, both to apply lessons learned more widely and to tackle remaining and emerging challenges.

Despite its overt usefulness in addressing priority health problems and in assisting the strengthening of health systems management by providing problem-solving approaches and meaningful information for decision-making, HSR has not yet become part of the managerial process and has not been institutionalized in many countries. It remains a long-neglected management tool.

The importance of HSR was stressed during the Technical Discussions at the Forty-third World Health Assembly, which identified a number of obstacles to the implementation of HSR including inadequate financial, human, and institutional resources, failure to tackle critical issues and insufficient interaction among researchers, managers, and decision-makers. Recommendations were also made on how to enhance the demand for HSR, how to strengthen national capacities, and how to institutionalize the efforts into a sustainable process.

The Consultative Committee reaffirmed the conclusions of the Technical Discussions and identified the following as the key issues needing priority action:

- creating support for HSR at country, regional and global levels;
- capacity building for HSR; and
- institutionalizing HSR.

(i) Creating support for HSR

In many countries HSR policies are inadequately developed. These policies are often not systematically formulated or based on an analysis of the real needs, the problems to be solved, and the priority areas where further information for decision-making is needed. An important mechanism for ensuring a favourable policy

environment for HSR is systematic sensitization of policy-makers and senior administrators to the need for, and value of, HSR in their work.

There is a recognizable communication gap between communities, health care providers, researchers, and decision-makers. Many policy-makers are biased against HSR because of the feeling that it is an academic exercise yielding slow results. It is therefore important that efforts be made to overcome this attitude where it exists and to strengthen the link between research and policy by enhancing the dialogue between all parties concerned so as to ensure that the relevance and importance of HSR are fully understood. Such dialogue will also help to ensure that any projects undertaken will address priority needs and be well managed.

Priority-setting in the field of HSR is essential. Health care decision-makers and other potential HSR "users" should provide clear guidelines to researchers concerning the problem areas where HSR can contribute with critical data to the decision-making process. In most countries there is little systematic attention to priority-setting for HSR, although this should take place periodically, both at national level and below, so that guidelines for HSR remain up to date and relevant. A series of general health-system-related issues for HSR were identified at the Consultative Group Meeting on HSR in 1991, which are still relevant. Key issues for HSR include equity, financing mechanisms, decentralization, empowerment of communities, and quality of care.

HSR should be integrated into the decision-making and managerial process at all levels of the health system. It is advisable to have the development of the HSR policy approved by the minister of health. Regular budget provision for HSR together with the establishment of HSR units in ministries should be encouraged. Cooperation between ministries, national research centres, universities, and NGOs should be strengthened.

(ii) Capacity building for HSR

There are two forms of HSR: a policy-related HSR undertaken at a national level and geared to major health problems or to problems relating to the organization and management of health systems (such as, for example, EPI coverage or the effects of decentralization and financing changes) and an operational HSR that aims at providing answers to operational problems emerging at the district level and below.

The critical mass needed to build strong national HSR programmes in developing countries covers a wide spectrum of personnel. These include: (a) the professional researchers to work with health-system decision-makers and communities on policy-related HSR, (b) less-specialized researchers who focus on less complex research problems, and (c) health care managers and providers at the provincial, district, and hospital levels dealing with narrow operational problems.

In practice HSR is a tripartite team effort. It requires managers, health workers, and academics to work closely together. If their efforts are extended by effective involvement of the community itself, the likelihood of sustainable solutions is enhanced. Throughout, the participation of managers is essential in order to avoid the perception of decision-making and research as two separate processes.

In conventional research, the community is seen as the beneficiary of research, so *there is a tendency to exclude them from involvement in planning and conducting studies.* It is important to have a paradigm shift and not see HSR as something that can be delivered only by outside researchers. For many problems research done with or even by the community has greatest impact. Efforts should be made to involve community through an interactive process.

Medical, nursing, and public health schools as well as programmes in other health-related fields should offer specific training in HSR. This component of the curriculum should aim at increasing the awareness of physicians, nurses, managers, and other health personnel to the importance of HSR and to endow them with the necessary skills and attitudes to develop research protocols, conduct the research, analyse results, and work with research users to review findings and plan their application.

The modalities of training may range from conventional courses to on-the-job training. It is essential and feasible to train health care managers and providers through their active involvement in appropriate HSR studies contributing important solutions to specific health problems. Those working within the health system should be seen as the priority group, and capacity-building activities focused at this level should be strengthened and expanded. Providers should be targeted not only in the public health system, but also in private and nongovernmental health institutions and programmes.

Career structures and incentives for research workers in developing countries are generally unfavourable. Restricted career paths, intellectual isolation, limited choice of research topics, and low salaries fail to attract scientific talent. These issues should be considered closely, and incentives and opportunities for advancement should be provided that are comparable to those available within the basic sciences.

(iii) Institutionalizing HSR

Most countries have a variety of structures at the national level to foster and support health and biomedical research. Specific mechanisms to support HSR are less common, although the number of countries actively organizing support structures for this important field of research has grown in recent years. This is one of the most important priorities at country level in order to increase and sustain the contribution HSR can make to health and social development.

Experience has shown there is a need for at least two types of structure at national level. The first is a focal point in the form of a small HSR unit, which should be organized either within the ministry of health or in a ministry-linked national research institute. The unit should be multidisciplinary, with part- or full-time expertise from the health sciences, social sciences, and health economics. It should concentrate on promoting HSR, organizing training and technical support, mobilizing financial resources, conducting or commissioning research, and disseminating findings and promoting their application. Such a focal point should be able to establish networking and develop linkages between decision-makers, researchers, health personnel, and the community.

The other type of structure is a coordinating committee such as a multisectoral HSR advisory committee to bring together health policy-makers, health managers, researchers, representatives of other health-related ministries, NGOs, and donors. Its mandate should include reviewing and revising HSR policy, setting research priorities, reviewing research proposals, ensuring that priority research is conducted, and facilitating the review and application of research results.

The HSR unit and HSR committee should be aggressive in attracting donor support, both from within and outside the country. Appropriate presentation of important research results and the development of a long-term HSR plan can provide the rationale for major donor support over a longer period. A major emphasis should be placed on developing good marketing mechanisms and strengthening the marketing skills of staff involved in HSR.

Government support is essential, and, if sustainability is to be guaranteed, it is critical that the ministry of health include funding for HSR in its regular budget covering personnel, facilities, research, and training.

The process of developing a sustainable HSR process must also include strengthening the capabilities of national and local organizations working in HSR. Donor agencies should be encouraged not only to support research itself but to focus a substantial portion of their funding on institutional strengthening.

An additional essential step is the decentralization of HSR activities and support structures. Only when health managers and providers throughout the health system begin to use HSR regularly as a problem-solving strategy will HSR be on the way to becoming a permanent tool for decision-making.

The role of WHO

At the global and regional levels, WHO should provide strong leadership in the field of HSR for development. It should promote the importance and strong potential of HSR among health policy-makers and managers as a critical tool for decision-making. The impact of HSR could best be demonstrated through a variety of publications and meetings for the exchange of information.

WHO should foster the collection of country experiences and the dissemination of comparative analyses of HSR results, mechanisms, and processes. It should further promote and strengthen initiatives such as networking at intercountry, regional, and global levels of the institutions undertaking HSR, the active collaboration with other international agencies dealing with HSR, and the international programme on Essential National Health Research (ENHR). Every WHO programme has an element of HSR, and the Division of Strengthening of Health Services covers the overall HSR coordination, but it would be desirable to strengthen in-house networking and collaboration. This should include the coordination of research policies with the Advisory Committee on Health Research (ACHR).

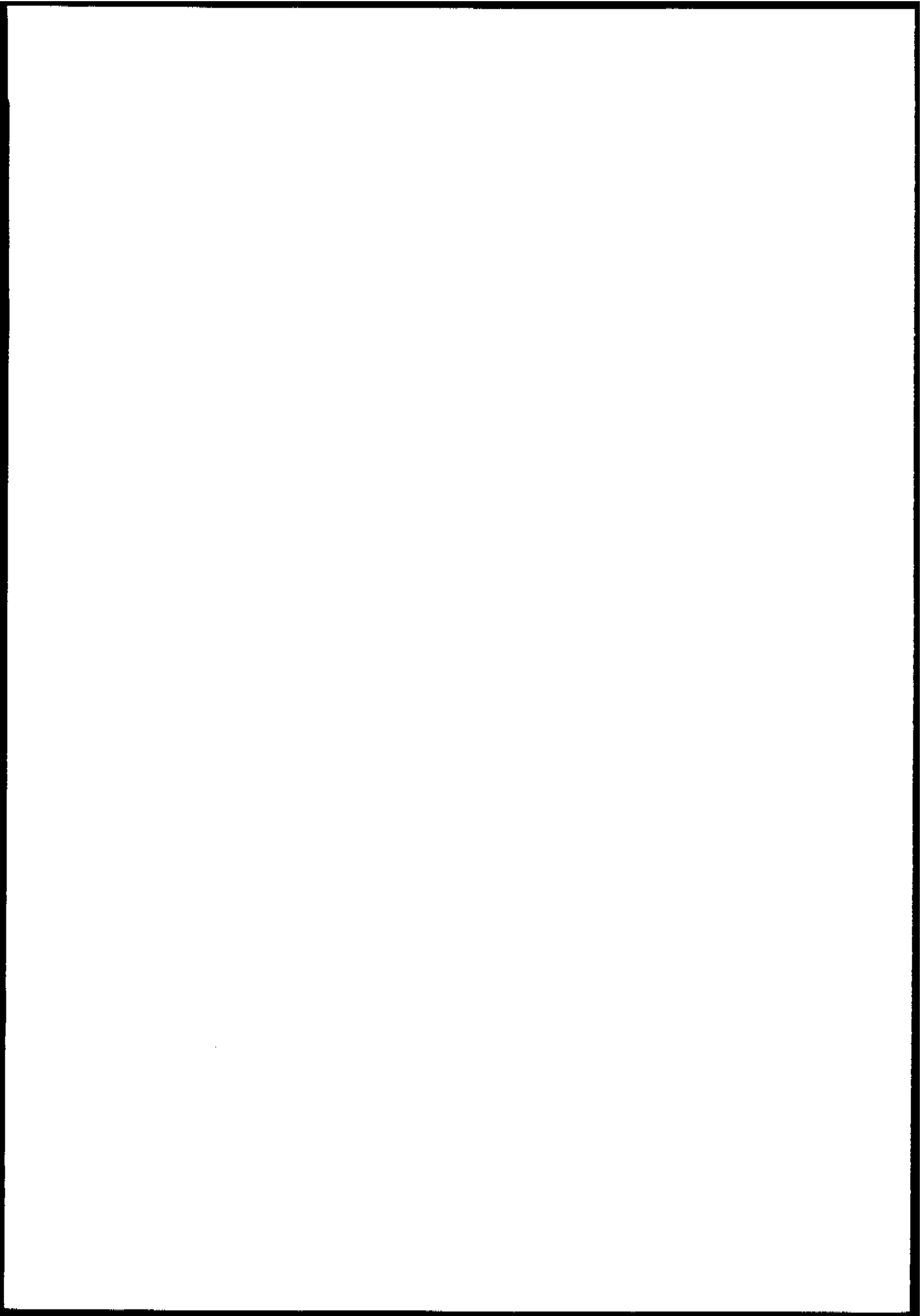
WHO should actively support country HSR initiatives. This should include funding for HSR in country programmes where this is required and the provision of seed money for projects resulting from HSR training programmes. It should also encourage donors to mobilize funds in order to support capacity building through research and training activities.

The establishment of HSR advisory committees, task forces and more visible focal points at regional and country levels should be encouraged.

WHO collaborating centres for HSR should be identified within each WHO region, and their active contribution to national and international HSR activities should be promoted and facilitated.

WHO should persuade donor agencies to reach common agreement to support the national HSR policy and agenda. Policy-makers should be persuaded to include an HSR component in each project submitted to donors.

Should it be decided to proceed with Technical Discussions during World Health Assemblies, it is recommended that another session of such discussions be devoted to the role of universities in HSR (see also page 9).



EXTERNAL SUPPORT TO STRENGTHENING HEALTH SERVICES; ROLES OF MULTILATERAL, BILATERAL, AND NGO AGENCIES

The Consultative Committee considered the subject of external support to strengthen health services and the roles of various partners including multilateral, bilateral and NGO agencies.

In addressing this subject, the priority issues were defined as the need to reduce duplication and fragmentation in external assistance and the need to ensure that it corresponds to priorities defined by the recipient country. The Consultative Committee also proposed a code of conduct in donor/recipient negotiations.

Considering the vastly differing economic conditions in different parts of the world, countries in the South have seen remarkable progress in health status in the last decades. Yet these achievements are threatened by dwindling resources. The most powerful causative factors are the worldwide economic crisis and the high population growth that many countries have to face. In addition, many countries had to introduce a reduction in budgetary allocations to the social sector, particularly to health, as a consequence of structural adjustment policies. Thus the proportion of the national budget allocated to health has been reduced in many countries during the last two decades.

The process required to redress the imbalance between health needs and the services provided has been given increased attention internationally following the publication of the World Development Report.

In the current environment of health sector reforms, strong and coordinated efforts are needed on the part of governments and other partners, and the responsibilities of each must be explicitly defined in order to mobilize resources to renew the emphasis on primary health care.

By and large, donor support over the years has been universally recognized as having had a beneficial effect on health services development throughout the developing countries. Nevertheless, mistakes have been made and lessons have been learned.

Donor interests have at times been at odds with recipient countries' needs and priorities. Donor support has often not been geared to ensure sustainability of projects and initiatives, and the resource flows from donors have often been totally unpredictable. Geographical areas have been selected for preferential attention to the detriment of other areas in the same country.

In many cases, external consultants and other health workers have been implanted by donors to work in countries at salaries which could have provided employment for many times the same number of competent indigenous personnel.

The indiscriminate sponsoring of NGOs by donors to such an extent that they developed services independently from, and sometimes in competition with, government structures was counterproductive. Tendencies to thwart national policies, e.g., in the field of drug manufacture were unhelpful. Furthermore, the "peace dividend" did not materialize, and there has been recent concern that the focus of the major donors' attention has shifted from the South to countries in Central and Eastern Europe.

At the same time, recipients have not helped their cause in a number of ways. Governments and ministries of health have often failed to elaborate clear and prioritized health master plans, coordinate donors' support, or allocate a reasonable percentage of the national budget to health. Many ministries of health have lost their leadership role, with the result that donors are turning to ministries of finance and planning in order to discuss and negotiate health aid. Ministries of health must be empowered to regain the ability to coordinate inputs from donors, NGOs, and other partners rationally, and to liaise effectively with multilateral agencies, as well as to maintain an essential dialogue with other sector ministries.

The Consultative Committee, in order to assist the process of health sector reform and strengthen the impact of external support, suggested the following strategy.

Recipient countries should develop health master plans linked to national development plans, which would provide a common vision for both donors and governments to use as a common agenda. The elaboration of master plans would also serve as frameworks for integrating all foreign assistance in national health development efforts.

There should be joint reviews between donors and recipients to identify problems and agree solutions. Building partnerships between donors and recipients is critical to the success of collaborative ventures, and coordination between the two is vital for smooth project implementation.

A code of conduct should be elaborated that could provide guiding principles for negotiations in reforms or policy implementation. The code of conduct should comprise the elements outlined below.

Code of conduct

The code of conduct should be based on the acceptance of equity in health for all.

Negotiations should be based on a health master plan, which should be developed prior to donor-supported intervention and should define priorities, include clear national policies on areas of interest (taking into account technology and research) and on disaster preparedness, and assure the qualification of the beneficiary. It should provide a reasonable percentage allocation of the national budget to health as well as allocating a reasonable percentage of sector contributions to research.

In negotiating assistance on the basis of the master plan, donors should endeavour to identify innovative community and government initiatives and, wherever possible, use national resources first.

Where donors select a part of the master plan to receive their support, this should be done in accordance with the overall objective of full coverage, thus ensuring that target groups' needs are incorporated into the plan.

Donors should provide inputs in a predictable and transparent fashion and adjust planning cycles to national patterns rather than to donors' needs.

Where appropriate, donors should be willing to sign contracts with recipients.

Every effort should be made to avoid unethical objectives. To the extent possible, there should be a reduction in the practice of allocating donor funds for specific purposes that may not be a priority need. Inputs should not be primarily driven by donor objectives. It makes no sense if donors support some limited project while recipients cannot solve other important problems such as the provision of hospital services, essential drugs, or safe water.

Donor agencies should come together in order to avoid duplication, fragmentation of assistance, and competition for influence. At the same time recipients should endeavour to coordinate donor assistance and avoid adopting an attitude of divide and rule.

Donors should, in their home countries, promote fair information on developing countries and counteract media campaigns that distract attention away from the real needs of the people of those countries.

NGOs and other donors should mention the code of conduct when signing agreements with recipients.

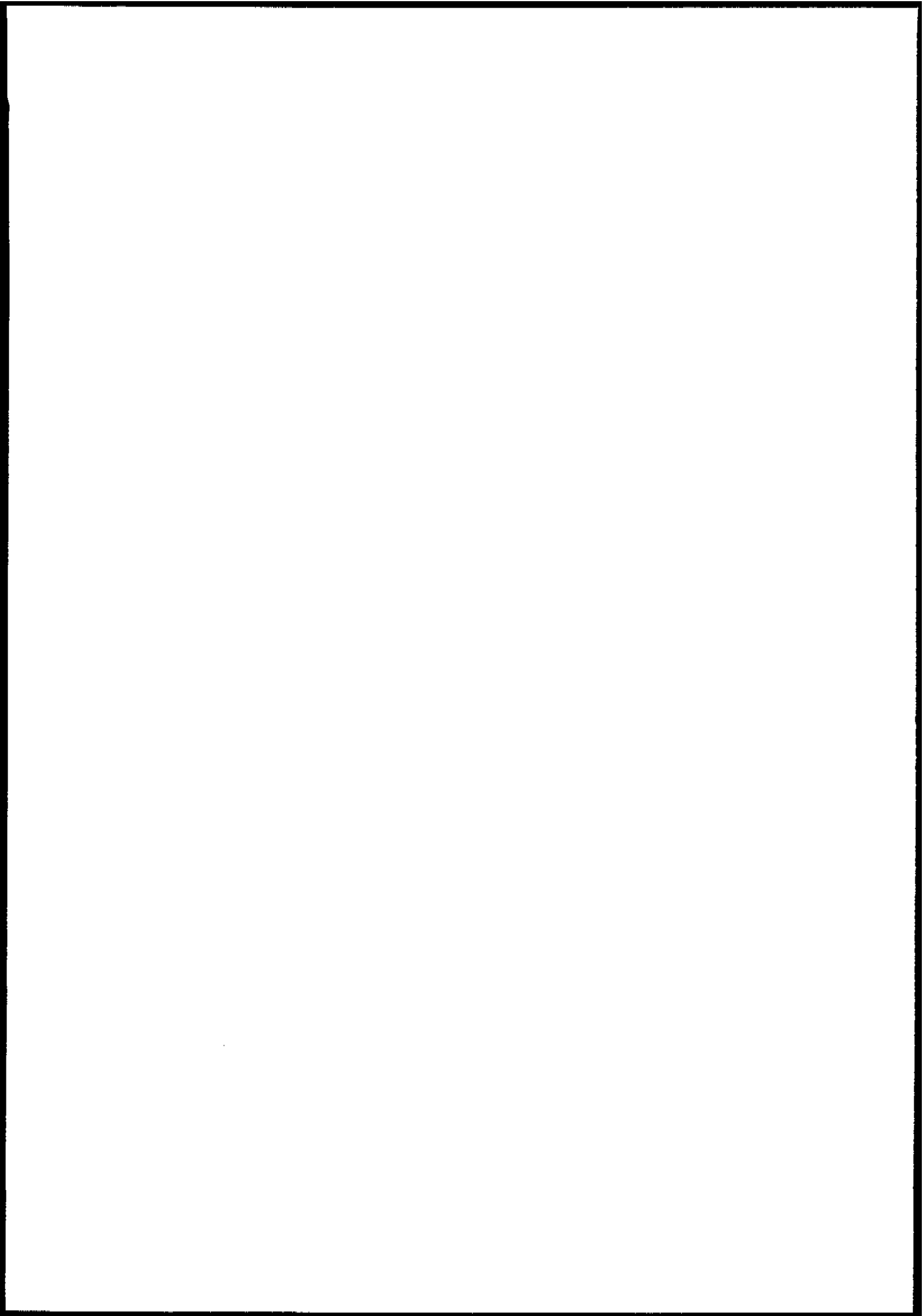
A national or regional arbitration committee should be set up to monitor adherence to the code.

The role of WHO

WHO should act as a moderator between donors and recipients. It should identify "minimum standard countries" in PHC and take a proactive role in mobilizing resources for them.

It should also assist countries to develop health master plans and to establish "rapid assessment" tools and operational indicators.

WHO should, above all, endeavour to strengthen national planning and management capabilities to achieve true partnership in the development process between donors and recipients.



SIXTH CONSULTATIVE COMMITTEE ON
 ORGANIZATION OF HEALTH SYSTEMS BASED
 ON PRIMARY HEALTH CARE
 GENEVA, 7-10 NOVEMBER 1994
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