

Transforming Primary Health Care
for Universal Health Coverage



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Transforming Primary Health Care for Universal Health Coverage

Anchor

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It is our pleasure to welcome our followers to this maiden edition of our **E - Book Technical Series on Health System in Nigeria, on Transforming Primary Health Care for Universal Health Coverage.**

The initiative is borne out of our new effort on **Knowledge Management and Translation (KMT)**, and belief that "a little knowledge that is shared (acts) is worth more than much knowledge that is idle" - Kali Gran.

We are optimistic that this initiative will be well received and found valuable by health system stewards and other stakeholders in the health system.

We will welcome your feedback on how our contribution can make significant impact and help improve access to healthcare delivery in Nigeria.

Editorial Note

Initiative for Health Accountability and Transparency (IHAT) was founded to be a STRONG AND INFLUENTIAL VOICE in the Health System, Promoting Accountability, Better Health-Equity and an End to Social Exclusion.

The Alma-Ata Conference mobilized a “Primary Health Care movement” of professionals and institutions, governments and civil society organizations, researchers and grassroots organizations that undertook to tackle the “politically, socially and economically unacceptable” health inequalities in all countries.

However, 40 years after Alma-Ata declaration, there is a recognition that populations are left behind and people are increasingly becoming impatient with the inability of health services to deliver levels of national coverage that meet the changing needs and demands, and with its failure to provide services in ways that correspond to the expectations.

Moving towards Universal Health Coverage requires that health systems respond to the emerging health and healthcare challenges, and growing expectations for better performance. This involves substantial reorientation and reform of the ways health systems operate and the financing of healthcare services: those reforms constitute the agenda of the renewal of PHC.

In furtherance of our mission, Initiative for Health Accountability and Transparency has strategically chosen this chronicle on Transforming Primary Health Care for Universal Health Coverage Systems to further facilitate better understanding of necessary primary health care reforms for renewal of PHC arising from expectations for better performance of the health system.

Content

The Contents of this edition of E-Book Technical Series include:

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About Us

Initiative for Health Accountability and Transparency is a Health Non-Governmental Organization founded to promote accountability, health equity and mobilize towards ending social exclusion.

We are Accredited by the Medical and Dental Council of Nigeria (MDCN) as Continuing Professional Development provider on Health Leadership, Management and Governance.

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Engagement with Strategic Stakeholders

Transforming Primary Health Care for Universal Health Coverage



IHAT Exploratory Meeting With the World Bank Group



Partnership Meeting with Garki Hospital

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Why Transforming Primary Health Care is Important Now.

The Alma-Ata Conference mobilized a “Primary Health Care movement” of professionals and institutions, governments and civil society organizations, researchers and grassroots organizations that undertook to tackle the “politically, socially and economically unacceptable” health inequalities in all countries.

In the past 40 years, PHC has remained the benchmark for most countries’ discourse on health precisely because the PHC movement tried to provide rational, evidence-based and anticipatory responses to health needs and to these social expectations.

The Declaration of Alma-Ata was clear about the values pursued: social justice and the right to better health for all, participation and solidarity.



Providing *functional* network of health facilities is required to extend access to basic package of integrated services

Transforming Primary Health Care for Universal Health Coverage

Today, there is a recognition that populations are left behind and people are increasingly becoming impatient with the inability of health services to deliver levels of national coverage that meet the changing needs and demands, and with its failure to provide services in ways that correspond to the expectations.

There is also a sense of lost opportunities that are indicative of what gave rise, over forty (40) years ago, to Alma-Ata's paradigm shift in thinking about health.

The PHC values to achieve universal health coverage require health systems that “Put people at the centre of health care”. Achieving this requires taking into account citizens “expectations about health and health care” and ensuring “that [their] voice and choice decisively influence the way in which health services are designed and operate”

Moving towards Universal Health Coverage requires that health systems respond to the emerging health and healthcare challenges, and growing expectations for better performance. *This involves substantial reorientation and reform of the ways health systems operate and the financing of healthcare services: those reforms constitute the agenda of the renewal of PHC.*

The Concept of Universal Health Coverage

Today, like the Primary Health Care, Universal Health Coverage has become the global touch bearer and a powerful concept in public health for promoting better health equity and an end to exclusion.

Universal Health Coverage is defined as the ability of all people who need health services to receive them without incurring financial hardship, thereby achieving equity in access.

Components of Universal Health Coverage are:

1. Access to quality health services, including promotion, prevention, treatment, rehabilitation and palliation
2. Coverage with financial protection for everyone.

Progress is Possible and Can be Accelerated.

There has been substantial progress and gains. People are healthier, wealthier and live longer today than 40 years ago. If children were still dying at 1978 rates, there would have been 16.2 million deaths globally in 2006. In fact, there were only 9.5 million such deaths. This difference of 6.7 million is equivalent to 18, 329 children's lives being saved every day.

There are ground-breaking impact of essential drugs and significant improvements in access to water, sanitation and antenatal care.

This shows that progress is possible. It can also be accelerated.

Knowledge and understanding of health are growing rapidly. The accelerated technological revolution is multiplying the potential for improving health and transforming health literacy in a better-educated and modernizing global society.

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A global stewardship is also emerging as a result of better understanding and recognition of shared threats, challenges or opportunities; from growing solidarity; and from the global commitment to eliminate poverty exemplified in the Sustainable Development Goals (SDGs).

Recognizing New Trends

There are emerging trends that must not be ignored.

First, is growing **INEQUITY**. The substantial progress in health over the recent decade has been deeply unequal. While there is considerable improvement in health in a large part of the world, many countries lagging behind.

There is now ample documentation of growing inequalities between and within countries that was not available 40 years ago.

Second, is the new health problems. The nature of health problems is **CHANGING**. Changing lifestyles, aging and effects of urbanization and globalization and climatic change accelerate worldwide transmission of communicable diseases, and increase the burden of chronic and noncommunicable diseases.

There is also growing reality that many individuals present with complex symptoms and multiple illnesses which constitute challenges to service delivery, to develop more integrated and comprehensive case management.

A complex web of interrelated factors is at work, involving gradual but long-term increases in income and population, climate change, challenges to food security, and social tensions, all with definite, but largely unpredictable, implications for health in the years ahead.

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Third, health systems are not isolated from rapid pace of change and transformation that is an essential part of today's globalization. Economic and political crises challenge state and institutional roles to ensure access, delivery and financing. Unregulated commercialization is accompanied by a blurring of the boundaries between public and private actors, while the negotiation of entitlement and rights is increasingly politicized. The information age has transformed the relations between citizens, professionals and politicians.

While the health sector remains massively under-resourced in many countries, the resource base for health has been growing consistently over the last decade.

However, the opportunities offered by the growing resource base for making health systems more effective and equitable is sorely missed by poor leadership, management and governance system.

Furthermore, health systems do not gravitate naturally towards the goals of health for all through primary health care as articulated in the Declaration of Alma-Ata.

Quite often, health systems are developing in directions that contribute little to equity and social justice and fail to get the best health outcomes for their money.

Three particularly worrisome trends can be characterized as follows:

1. health systems that focus disproportionately on a **narrow offer of specialized curative care;**
2. health systems where a command-and-control approach to disease control, focused on **short-term results, is fragmenting service delivery;**
3. health systems where a hands-off or laissez-faire approach to governance has allowed **unregulated commercialization** of health to flourish.

In a number of countries, the resulting inequitable access, impoverishing costs, and erosion of trust in health care constitute a threat to social stability.

Growing Support for Renewal of Primary Health Care

There is growing support for renewal of PHC arising from expectations for better performance of the health system due to:

1. growing realization among health policy-makers that it can provide a stronger sense of direction and unity in the current context of fragmentation of health systems, and an alternative to the assorted quick fixes currently touted as cures for the health sector's ills.
2. growing realization that conventional health-care delivery, through different mechanisms and for different reasons, is not only less effective than it could be, but suffers from a set of ubiquitous shortcomings and contradictions.
3. mismatch between expectations and performance is a cause of concern for health authorities.
4. growing economic weight and social significance of the health sector. Business as usual for health systems is not a viable option.
5. realization that if the shortfalls in performance are to be redressed, the health problems of today and tomorrow will require stronger collective management and accountability guided by a clearer sense of overall direction and purpose.

Also, as societies modernize, people demand more from their health systems, for themselves and their families, as well as for the community in which they live.

Thus, there is increasingly popular support for:

1. better health equity and an end to exclusion;
2. health services that are centred on people's needs and expectations;
3. health security for the communities in which they live;
4. and for a say in what affects their health and that of their communities.

These expectations resonate with the values that were at the core of the Declaration of Alma-Ata. They explain the current demand for a better alignment of health systems with these values and provide today's PHC movement with reinvigorated social and political backing for its attempts to reform health systems.

Common Shortcomings of Health Care Delivery

Inverse care

People with the most means – whose needs for health care are often less – consume the most care, whereas those with the least means and greatest health problems consume the least. Public spending on health services most often benefits the rich more than the poor, in high- and low-income countries alike.

Impoverishing care.

Wherever people lack social protection and payment for care is largely out-of-pocket at the point of service, they can be confronted with catastrophic expenses. Over 100 million people annually fall into poverty because they have to pay for health care.

Fragmented and fragmenting care.

The excessive specialization of health-care providers and the narrow focus of many disease control programmes discourage a holistic approach to the individuals and the families they deal with and do not appreciate the need for continuity in care. Health services for poor and marginalized groups are often highly fragmented and severely under-resourced, while development aid often adds to the fragmentation.

Unsafe care.

Poor system design that is unable to ensure safety and hygiene standards leads to high rates of hospital-acquired infections, along with medication errors and other avoidable adverse effects that are an underestimated cause of death and ill-health¹⁸.

Mis-directed care.

Resource allocation clusters around curative services at great cost, neglecting the potential of primary prevention and health promotion to prevent up to 70% of the disease burden. At the same time, the health sector lacks the expertise to mitigate the adverse effects on health from other sectors and make the most of what these other sectors can contribute to health.

Reforms for the Future

Rising expectations and broad support for the vision set forth in Alma-Ata's values have not always easily translated into effective transformation of health systems.

The PHC movement has oversimplified its message, resulting in one-size-fits-all recipes, ill-adapted to different contexts and problems. As a result, national and global health authorities have at times seen PHC not as a set of reforms, as was intended, but as one health-care delivery programme among many, providing poor care for poor people.

In contrast, in well resourced-context, primary care has been defined, described and studied, often with reference to physicians with a specialization in family medicine or general practice. These descriptions provide a far more ambitious agenda than the unacceptably restrictive and off-putting primary-care recipes that have been touted for low-income countries.

What has been considered primary care in well-resourced contexts has been dangerously oversimplified in resource-constrained settings

Transforming Primary Health Care for Universal Health Coverage

- primary care provides a place to which people can bring a wide range of health problems – it is not acceptable that in low-income countries primary care would only deal with a few “priority diseases”;
- primary care is a hub from which patients are guided through the health system – it is not acceptable that, in low-income countries, primary care would be reduced to a stand-alone health post or isolated community-health worker;
- primary care facilitates ongoing relationships between patients and clinicians, within which patients participate in decision-making about their health and health care; it builds bridges between personal health care and patients’ families and communities – it is not acceptable that, in low-income countries, primary care would be restricted to a one-way delivery channel for priority health interventions;
- primary care opens opportunities for disease prevention and health promotion as well as early detection of disease – it is not acceptable that, in low-income countries, primary care would just be about treating common ailments;
- primary care requires teams of health professionals: physicians, nurse practitioners, and assistants with specific and sophisticated biomedical and social skills – it is not acceptable that, in low-income countries, primary care would be synonymous with low-tech, non-professional care for the rural poor who cannot afford any better;
- primary care requires adequate resources and investment, and can then provide much better value for money than its alternatives – it is not acceptable that, in low-income countries, primary care would have to be financed through out-of-pocket payments on the erroneous assumption that it is cheap and the poor should be able to afford it.

In the light of the foregoing, we must understand that providing a sense of direction to the health system requires a *set of specific and context-sensitive reforms* that respond to the health challenges of today and prepare for those of tomorrow.

The focus of the reforms goes well beyond “basic” service delivery and cuts across the established boundaries of the building blocks of national health systems.

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People all over the world are becoming more vocal about health as an integral part of how they and their families go about their everyday lives, and about the way their society deals with health and health care. The dynamics of demand must find a voice within the policy and decision-making processes.

Thus, PHC reforms today are neither primarily defined by the component elements they address, nor merely by the choice of disease control interventions to be scaled up, but by the social dynamics that define the role of health systems in society.

Four sets of PHC reforms

PHC reforms can be structured in four groups that reflect the convergence between the evidence on what is needed for an effective response to the health challenges, the values of equity, solidarity and social justice that drive the PHC movement, and the growing expectations of the population.



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1. reforms that ensure that health systems contribute to health equity, social justice and the end of exclusion, primarily by moving towards universal access and social health protection through **universal coverage reforms**;
2. reforms that reorganize health services as primary care, i.e. around people's needs and expectations, so as to make them more socially relevant and more responsive to the changing world while producing better outcomes through **service delivery reforms**;
3. reforms that secure healthier communities, by integrating public health actions with primary care and by pursuing healthy public policies across sectors through **public policy reforms**;
4. reforms that replace disproportionate reliance on command and control on one hand, and laissez-faire disengagement of the state on the other, by the inclusive, participatory, negotiation-based leadership required by the complexity of contemporary health systems through **leadership reforms**.

Universal coverage reforms

The first of these four sets of reforms are aimed at *diminishing exclusion and social disparities in health*.

Health inequalities are often shaped by the:

1. inequalities in availability,
2. access and quality of services,
3. by the financial burden these impose on people, and
4. even by the linguistic, cultural and gender-based barriers that are often embedded in the way in which clinical practice is conducted.

If health systems are to reduce health inequities, a precondition is to make services available to all, i.e. to bridge the gap in the supply of services.

Service Availability: Service networks are much more extensive today than they were 40 years ago, but large population groups have been left behind. Supply gaps are still a reality in many countries, making extension of their service networks a priority concern, as was the case 40 years ago. As the overall supply of health services has improved, it has become more obvious that barriers to access are important factors of inequity: user fees, in particular, are important sources of exclusion from needed care.

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User Fees Reform: Moreover, when people have to purchase health care at a price that is beyond their means, a health problem can quickly precipitate them into poverty or bankruptcy. That is why extension of the supply of services has to go hand-in-hand with social health protection, through pooling and pre-payment instead of out-of-pocket payment of user fees.

The reforms to bring about universal coverage – i.e. universal access combined with social health protection – constitute a necessary condition to improved health equity.

Reaching the Un-reached: Such reforms need to be complemented with another set of proactive measures to reach the un-reached: those for whom service availability and social protection does too little to offset the health consequences of social stratification.

Service Delivery Reforms

Optimizing People Centred Primary Care: Many individuals rely on health-care networks that assume the responsibility for the health of entire communities. The service delivery reforms are meant to transform conventional health-care delivery into primary care, optimizing the contribution of health services – local health systems, health-care networks, health districts – to health and equity while responding to the growing expectations for “putting people at the centre of health care, harmonizing mind and body, people and systems”.

Service delivery reforms are but one subset of PHC reforms, but one with such a high profile that it has often masked the broader PHC agenda.

There is a substantial body of evidence on the comparative advantages, in terms of effectiveness and efficiency, of health care organized as people centred primary care. Despite variations in the specific terminology, its characteristic features (person-centredness, comprehensiveness and integration, continuity of care, and participation of patients, families and communities) are well documented.

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Care that exhibits these features requires health services that are organized accordingly, with close-to-client multidisciplinary teams that are responsible for a defined population, collaborate with social services and other sectors, and coordinate the contributions of hospitals, specialists and community organizations.

Combined with the growing demand for better performance, this creates major opportunities to reorient existing health services towards primary care – not only in well-resourced settings, but also where money is tight and needs are high.

In the many low and middle-income countries where the supply of services is in a phase of accelerated expansion, there is an opportunity now to chart a course that may avoid repeating some of the mistakes high income countries have made in the past.

Primary care can do much to improve the health of communities, but it is not sufficient to respond to people's desires to live in conditions that protect their health, support health equity and enable them to lead the lives that they value.

Public Policy Reforms

People also expect their governments to put into place **public policies to deal with health challenges**, such as those posed by urbanization, climate change, gender discrimination or social stratification. These public policies encompass the technical policies and programmes dealing with priority health problems.

These programmes can be designed to work through, support and give a boost to primary care. Health authorities have a major responsibility to make the right design decisions. Programmes to target priority health problems through primary care need to be complemented by public-health interventions at national or international level.

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There is overwhelming evidence that selected interventions, which may range from **public hygiene and disease prevention** to health promotion, can have a major contribution to health. Yet, they are surprisingly neglected, across all countries, regardless of income level.

Primary care and social protection reforms critically depend on choosing health-systems policies, such as those related to essential drugs, technology, human resources and financing, which are supportive of the reforms that promote equity and people-centred care.

Health in All Policies: Furthermore, population health can be improved through policies that are controlled by sectors other than health. School curricula, the industry's policy towards gender equality, the safety of food and consumer goods, or the transport of toxic waste are all issues that can profoundly influence or even determine the health of entire communities, positively or negatively, depending on what choices are made.

Lessons of Past Successes and Failures: Health authorities can do a much better job of formulating and implementing PHC reforms adapted to specific national contexts and constraints if the mobilization around PHC is informed by the lessons of past successes and failures.

Leadership Reforms

The governance of health is a major challenge for ministries of health and the other institutions, governmental and nongovernmental, that provide health leadership.

They can no longer be content with mere administration of the system: they have to become learning organizations. This requires inclusive leadership that engages with a variety of stakeholders beyond the boundaries of the public sector, from clinicians to civil society, and from communities to researchers and academia.

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Strategic areas for investment to improve the capacity of health authorities to lead PHC reforms include making health information systems instrumental to reform; harnessing the innovations in the health sector and the related dynamics in all societies; and building capacity through exchange and exposure to the experience of others – within and across borders.

Exploring New Opportunities



Good Utilization of Healthcare Services Ensures Extended Access to Basic Package

The four sets of PHC reforms are driven by shared values that enjoy large support and common challenges.

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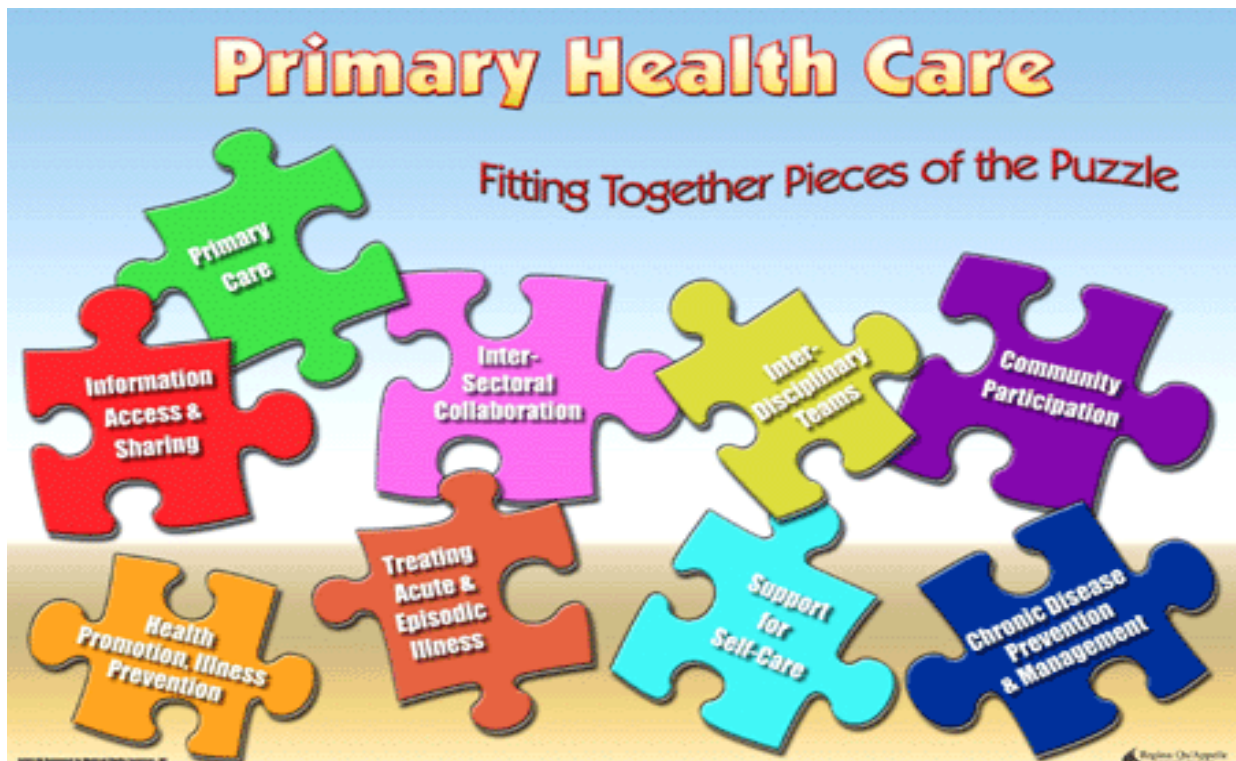
The health authorities and political leaders are uncomfortable with current trends in the development of health systems and with the obvious need to adapt to the changing health challenges, demands and rising expectations.

There are clear and welcome signs of a desire to work together in building sustainable systems for health rather than relying on fragmented and piecemeal approaches.

The current national and international environment is favourable to a renewal of PHC and achieving substantial progress in the *operationalization of universal coverage, service delivery, public policy and leadership reforms is not impracticable we understand the building blocks of the health system and setting the pieces appropriately in a systematic manner.*

Specific Agenda for PHC Transformation

The legitimacy of governments and health authorities at all levels increasingly depends on how well they assume responsibility to develop and reform the health sector to attain the highly valued health system objectives.



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Specifically, the health system objectives include the following:

1. Improving the health status of the population by lowering morbidity and mortality rates
2. Protect the population against financial risks of health problems
3. Responsiveness to the needs and demands of the citizens in a timely and positive manner, and according to what people value in terms of health and of what is expected of the health system.

People's frustration and pressure for more equitable health care and for better health protection for society is building up: never before have expectations been so high about what health authorities and, specifically, ministries of health should be doing about this. By capitalizing on this momentum, investment in PHC reforms can accelerate the transformation of health systems so as to yield better and more equitably distributed health outcomes.

Transforming Primary Health Care for Universal Health Coverage

Towards, sustainable progress in Universal Health Coverage, we must as a matter of policy options and directives, and priority, focus on the following:

1. Full Operationization of the National Health Act and the Revised Health Policy in a manner that guarantees universal access to basic health services for ALL Nigerians through a functional primary health care system.
2. Putting Health on the National Political Agenda: A National Health Agenda that will have buy-in of all political stakeholders and fully domesticated in the manifestos of all political parties, whose underpinning principle will be Universal Health Coverage to be delivered in a truly Nigerian way, with voice and accountability to the citizenry.
3. Repositioning of the Ministries of Health and Functional Integration: The role of the Federal and State Ministries of Health should be re-examined for its repositioning as Chief Health Policy Maker and regulator of Quality of Care among other relevant strategic functions. Repositioning should aim at moving towards functional integration of primary and secondary care levels.
4. Institute Innovative Health Capital Funding and Financing Mechanisms: Inadequate budgetary allocation and financial barriers to access to health service are very significant constraints to improving geographical and financial access.

There is the need for effective Implementation of Basic Health Care Provision Fund (BHCPF) as a funding mechanism and direct support to the PHC at the LGA level rather than as implementing mechanism.

However, to ensure financial integrity in the BHCPF, transparent Public Expenditure Management System should be instituted and Social Accountability approaches introduced.

Strengthening and expanding the National Health Insurance Scheme. This will accelerate implementation of financial protection mechanisms and offer possibilities to expand health systems and services. Out-Of-Pocket Payments at points of delivery is inequitable and counterproductive.

5. Strengthening the LGA Health Authority: The LGA Health Authority holds the key to functional and effective primary health care in Nigeria. LGA is the operational level and the structures and institutions at the LGA level provide overlapping operational support. For meaningful and sustainable progress in primary health care development, this level must be sufficiently empowered in all ramifications.

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6. There is the Need to Undertake PHC Human Resources Reform & Capacity Development. By default, Primary Health Care facilities are traditionally manned by low level professionals in Nigeria. It is time to move away into an era when our communities deserve more professional care at the frontline facilities. This will require deployment of nurses and midwives and family physicians to the PHC level.

7. Promote Community and Client-focused Health System: The Nigerian health system is focused more on the health providers than the people. The discussion is usually about the availability of health facilities, equipment, drugs and health care workers, with little attention to responsiveness of the system.

8. Promoting Citizens Engagement and Accountability: Lack of accountability has been cited as one of the underlying causes of poor performance in the health system. In the absence of accountability, merely allocating public resources for health goods and services may not necessarily lead to desirable health outcomes. Failed accountability fuels abuses, non-compliance with ethics, standards and procedures and undermine health care delivery and result in poor performance. The community based platforms, like the Ward Development Committees, civil society, media and other societal actors should promote or facilitate social accountability efforts.

9. Other Strategies:

Increasing investing in primary health care and avoiding disproportionately investment in tertiary care. This will facilitate the expansion of physical access to primary health care facilities. This offer opportunities to base the health system on sound primary care and universal coverage principles.

Expansion of Performance-based Incentive System for PHC service delivery

Implementation of innovative Public-Private Partnership for delivery of PHC services.

Improving health data availability for evidence-based decision making and making health information systems instrumental to reforms.

Investing in healthy public policies

Transforming Primary Health Care for Universal Health Coverage

Fortunately, Nigeria health system is receiving unprecedented attention with Basic Health Care Provision Fund (BHCPF) which represent a new opportunity of enhanced domestic investment in re-invigorating the health system around PHC values, but REAL PROGRESS will come from better health leadership, Management and Governance

Furthermore, there is growing interest in innovative global funding mechanisms such as global financing facility.

Better technology and better information are increasingly available. We must leverage on it to maximize the return on transforming the functioning of health systems.

There is also the growing civil society involvement in health and collective global thinking that can further contributes to the chances of success.

During the last decade, the global community started to deal with poverty and inequality across the world in a much more systematic way – by setting the MDGs and later the SDGs, and bringing the issue of inequality to the core of social policy-making. Throughout, health has been a central, closely interlinked concern. This offers opportunities for more effective health action. It also creates the necessary social conditions for the establishment of close alliances beyond the health sector. Thus, intersectoral action is back on centre stage.

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System Thinking for Making Health System Work for All