Health system strengthening, principles for renewal of primary health care and lessons learned

At the European Ministerial Conference on Health Systems “Health Systems, Health and Wealth” in June 2008, the European Member States of WHO signed the Tallinn Charter committing themselves to improving people’s health by strengthening health systems. The Charter emphasized the following points:

- investing in health is investing in human development, social well-being and wealth;
- well-functioning health systems are essential to improving health and saving lives; and
- health systems need to demonstrate good performance.

The Charter also reiterated the view that effective primary health care (PHC) is essential for delivery of quality health services to individuals and populations and that it “provides a platform for the interface of health services with communities and families, and for intersectoral and interprofessional cooperation and health promotion”.

The following sections of this paper are arranged in accordance with the four broad policy directions identified in *The world health report 2008* for the renewal of PHC.

**EURO’s approach to universal coverage**

Through extensive advocacy and technical support to Member States on health financing and the other health system functions, the WHO Regional Office for Europe (EURO) is contributing to attainment of the goals of health systems as defined in *The world health report 2000* and restated in the Tallinn Charter. More specifically, these involve promoting:

(i) universal protection against financial risk;
(ii) more equitable distribution of the burden of funding the system;
(iii) equity in the provision and use of services relative to the need for them;
(iv) transparency and accountability of the system to the population;
(v) quality and efficiency in service delivery; and
Lessons learned
Making policy on universal coverage effective requires a thorough understanding of the starting point, i.e. the existing health financing arrangements in a country, in functional terms (collection, pooling, purchasing, entitlements and cost-sharing). It also requires a realistic understanding of contextual constraints, notably fiscal ones. We are therefore committed to the objectives of health financing policy, but not to any particular institutional form or model.

EURO's approach to people-centred service provision
How do we understand people-centred primary care in EURO? People-centred care is based on the four normative characteristics of a “good” primary care delivery system: accessible, comprehensive, coordinated and continuous – adapted to the context of each country. Based on this, we have developed a methodology that generates proxy indicators or dimensions for each of these characteristics. They in turn form our baseline for evaluating primary care in our Member States.

1. Good primary care provides accessible care without barriers. This relates to geographical barriers to reaching a doctor, for example in rural areas; it relates to financial barriers (e.g. when drugs are not reimbursed) and it relates to organizational barriers such as waiting times, appointment systems or the time available for a consultation.

2. Primary care should provide a wide range of comprehensive services, including curative, rehabilitative and preventive measures. Comprehensiveness depends very much on professional skills, practice conditions, facilities and available equipment, and it relates to community orientation.

3. Coordination is another characteristic of good primary care. This entails coordination within the practice between doctors and nurses and with other primary care professionals such as physiotherapists and pharmacists, and it rests on the key words of teamwork and networking. But it also relates to how the patient is navigated though the other levels of care – how the patient is managed – and ultimately to whether and how integrated care is provided. In the European Region, where a large number of Member States have inherited vertical public health service providers (“Sanepid” facilities), this requires for example also the introduction of mechanisms for coordination between person-based and population-based services (public health institutions) to improve synergies between them, focusing on the provision of primary and secondary preventive and health-promoting services.

4. Finally, good primary care ensures that health needs and risks are identified and kept in mind over time – and that personal relationships are built up and maintained. It includes also topics such as e-health and electronic patient records (information continuity).

We also support countries in assessing the responsiveness of services offered to specific population groups (i.e. adolescents, children, mothers) at all levels of care, be it primary or specialized outpatient or hospital care.

Lessons learned
Promoting and evaluating people-centred care requires both a framework and a baseline. We offer this by proposing to Member States our WHO Primary Care Evaluation Tool. This allows countries to identify the strengths and weaknesses of their primary care system. It also gives a direct say to primary care providers and patients, since the tool is survey-based. The latter aspect
is especially important in countries with little tradition of responsiveness and stakeholder consensus-building, and it is therefore highly valued by stakeholders, whether governmental or nongovernmental.

**EURO’s approach to multisectoral action and health in all policies (HIAP)**

There is a long history of WHO-led and collaborative initiatives that have created a strong platform for acceptance of, and evidence to support, HIAP as integral to achieving more sustainable health outcomes across the Region. These include: (a) the European regional strategy on Health for All (1980); (b) the Futures Forum tenth meeting (2006); (c) WHO support to the European Union (EU) presidencies of the United Kingdom (2005), Finland (2006) and Slovenia (2008) on health inequities, HIAP and cross-sectoral action in the areas of diet and physical activity, respectively; (d) the Rome Declaration on HIAP (2007); and (e) the report on progress towards the millennium development goals (MDGs) in the WHO European Region (document EUR/RC57/8), emphasizing the need for action across sectors to achieve health targets.

Consequently many European Member States already have, or are in the process of developing, partnerships with other sectors to strengthen delivery of programmes and coherence of policies that impact health either indirectly or directly.

Fundamental to the HIAP approach is the position that health is an asset for, as well as a product of, fair and sustainable growth and development and is thus a responsibility of all ministries.

HIAP/multisectoral action requires efforts aimed at aligning national and supranational policy and the broader development framework with the objectives of health improvement and health equity. EURO’s role in, for example, convening a meeting on health in times of global economic crisis (Oslo, Norway, April 2009) is an example of the approach to ensure dialogue between stakeholders and alignment of interests and resources that protect and improve health, as a public and productive good and as a human right.

HIAP/multisectoral action depends on the relevant health constituency (whether a nongovernmental organization, a health ministry or WHO) having a better understanding of other sectors’ priorities and the capacity to negotiate and sustain partnerships over time. Know-how and tools for scanning the policies of other sectors and for measuring their impacts on health and health equity are essential for building up policy coherence and need to be tailored to the differing political, developmental and governance conditions of the respective Member State.

**Lessons learned**

In order to make HIAP a systematic approach, support must be given to strengthening systems and human resources capacity within ministries of health and across government. WHO has developed expert-reviewed tools, guidance and technical assistance methods that help Member States (health ministries and governments) to strengthen and tailor HIAP to their health governance arrangements. A recent example is the support provided to a number of Member States in 2008–2009, where new public health laws have been developed and endorsed by parliaments with legal mechanisms foreseen to secure instruments for HIAP, including enforcing the role and responsibility of health ministries for steering the process.

**EURO’s approach to inclusive leadership and effective governance for health**

The 53 Member States in the WHO European Region endorsed Regional Committee resolution EUR/RC58/R4 on stewardship/governance of health systems in September 2008. A framework for ministries of health to assess the completeness and consistency of their health system stewardship function was developed as part of a background paper supporting the resolution.
Next steps agreed through adoption of the resolution include EURO supporting Member States in:

- developing their competences to carry out their health system stewardship function;
- facilitating the further development of relevant evaluation tools and performance indicators to assess the effectiveness of the stewardship function in a context of accountability, transparency and pluralism; and
- facilitating the collaboration of Member States on successful health system stewardship practices and promoting the sharing among Member States of case studies from the WHO European Region and beyond.

A mid-term report is expected to be presented to the Regional Committee for Europe in 2011 and a final report in 2015, in the framework of implementation of the Tallinn Charter.

**Lessons learned**

The effectiveness of the health system stewardship function depends on how close a match there is between the national context, the health system goals and the health ministry’s mobilization of the tools supporting their stewardship function. So far, little research has been done on the health system stewardship function of ministries of health in diverse national contexts, although this is an important area for our Member States. Countries have asked EURO to support them in gathering further evidence about good health system stewardship, in order to strengthen their national capacities.

**Current activities and examples of implementing PHC renewal (2008–2009)**

**EURO’s activities on universal coverage**

**Policy advice and support**

- Country-specific recommendations on how to:
  - reduce fragmentation in pooling funds (Albania, Kyrgyzstan)
  - extend coverage to the uninsured (Albania, Republic of Moldova)
  - make entitlement to PHC services universal (Republic of Moldova)
  - diversify financing sources (Estonia)
  - align benefit package revision with purchasing methods (Armenia)
  - align financing arrangements with service delivery strategies for TB and HIV (Estonia, Latvia, Lithuania)

- Conceptual and regional analytical work on sustaining universal coverage, including publication of *Health financing policy: a guide for decision-makers*¹ and *Addressing financial sustainability in health systems*², a EURO Health Evidence Network (HEN)/European Observatory on Health Systems and Policies background paper produced for the EU Czech Presidency conference on financial sustainability of health systems in Europe (Prague, 10–12 May 2009)

**Analytical work to highlight objectives**

- Equity in financing and use of services (Estonia, Hungary, Kyrgyzstan, Latvia)
- Financial protection (Estonia, Hungary, Kyrgyzstan, Latvia, Republic of Moldova)

EURO's activities on people-centred service provision

**Policy advice and support**

- Recommendations on how to:
  - improve coordination between the primary and secondary levels of care (Turkey)
  - better integrate reproductive health and TB services into primary care (Belarus)
  - create a culture for quality management in primary care (Slovenia)
- Assessment of aspects of quality of care, including client responsiveness, for specific population groups:
  - mothers (Albania, Republic of Moldova)
  - children (Armenia, Kyrgyzstan, Tajikistan, Uzbekistan)
  - young people (Kyrgyzstan, Republic of Moldova, Tajikistan, Ukraine)

**Analytical work to highlight objectives**

- Development and implementation of the Primary Care Evaluation Tool (Belarus, Kazakhstan, Russian Federation, Turkey, Ukraine)
- Development and implementation of the Primary Care Quality Management Tool (Armenia, Slovenia, Uzbekistan)
- Publication on health system actions to address socially determined health inequities, including examples of revitalization of primary care (EU health equity project, 2008–April 2010)

EURO's activities on multisectoral action and health in all policies (HIAP)

**Policy advice and support**

- Recommendations on how to improve the public health law (Albania, Armenia, Kyrgyzstan, Republic of Moldova)
- Evaluation of public health services – integration of disease prevention and health promotion into primary care (evaluation finalized in Estonia, Slovenia and the nine countries of south-eastern Europe (SEE), and in progress in Armenia, Tajikistan and Uzbekistan)
- Policy dialogue on HIAP (Baltic countries)
- Policy dialogue with newly independent states (NIS) (2008) on the role of “sanepid” facilities in modern public health
- Policy dialogue on lessons learned and implications for scaling up cross-sectoral strategies for health and health equity (Slovenia, May 2009).

**Analytical work to highlight objectives**

- Development and implementation of web-based self-assessment tool for evaluation of public health services
- Development and testing of a diagnostic tool to analyse governance (systems, policies and mechanisms) of socially determined health inequities (Slovenia). Implementation includes diagnosis of how to better integrate policies and actions of primary care, public health and other sectors in order to reduce inequities and improve synergies, and with a special focus on addressing the needs of vulnerable groups.
EURO’s activities on inclusive leadership and effective governance for health

Policy advice and support

- Defining the vision and strategy to achieve better health (Bosnia and Herzegovina, Portugal, Republic of Moldova)
- Defining the vision, strategy and action plans for streamlining, upgrading and improving the quality of public health services (Kyrgyzstan, Tajikistan)
- Applying intelligence and evaluating health outcomes (health system performance assessment in Armenia, Azerbaijan, Estonia, Georgia, Portugal, Ukraine)
- Strengthening analysis for improved targeting of policies (Lithuania)
- Governing the health system in a way that is value-based and ethical (Estonia, Portugal)
- Mobilizing legal and regulatory powers to attain goals (Albania, Armenia, Republic of Moldova)
- Ensuring that the health system is designed in such a way that it can adapt to changing needs (Portugal)
- Exerting influence across other sectors than health and advocating for better health (Lithuania, Slovenia)

Analytical work to highlight objectives

- Assessing the performance of national health systems (Armenia, Azerbaijan, Estonia, Georgia, Portugal)
- Assessing national health plans (Portugal)
- Developing frameworks for monitoring and evaluation of different aspects of health system reforms
- Strengthening capacity to develop health legislation (Armenia) or intersectoral action (Portugal)
- Use of Health System Performance Assessment as an analytical tool
- Development and testing of a diagnostic tool to analyse governance (systems, policies and mechanisms) and performance, in order to reduce socially determined health inequities

Efforts to institutionalize PHC-based health system strengthening by mainstreaming it in 2010-2011 biennial workplans at country and regional levels

EURO’s planned activities on universal coverage

- Continue to support the extension of effective financial protection to the population (Albania)
- Support the development of a strategy to ensure the system’s long-term capacity to sustain high levels of performance, including measures to more explicitly align financing with service delivery strategies (Estonia)
- Continue to support work on expansion of insurance, including the option of a universal PHC package (Republic of Moldova)
- Continue to strengthen national capacity to analyse the effects of national health reform programmes and link this to policy decision-making (Kyrgyzstan, Republic of Moldova and Tajikistan)
• Incorporate health system assessment into efforts to strengthen control of HIV and TB (Armenia, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Republic of Moldova, Romania and Ukraine)

**EURO's planned activities on people-centred service provision**

• Further implementation of the Primary Care Evaluation Tool (Latvia, Montenegro, Serbia, Slovakia, Tajikistan, Turkmenistan) and Primary Care Quality Management Tool (Romania) and follow-up of policy recommendations from earlier evaluations
• Policy dialogues and briefs on various aspects of primary care (Armenia, Estonia, Romania)

**EURO's planned activities on multisectoral action and health in all policies (HIAP)**

• Toolkit for policy-makers on cross-sectoral investment for health and reduction of inequities (April 2010). The tools will be used in technical assistance to Member States (Latvia, Serbia, Slovakia, Slovenia)
• Guidance, training and tools on health equity impact assessment will form part of technical assistance to Member States (Czech Republic, Latvia, Poland, Slovakia)
• Norms and guidance on intersectoral action and HIAP (global and interregional project): EURO participation in and coordination of component on evaluation of HIAP/intersectoral action
• Policy briefs on the role of health systems in addressing socially determined health inequities (EU health equity project), including through stewardship of HIAP/intersectoral action
• Continue to strengthen and/or initiate collaboration with the International Organization for Migration (IOM), the United Nations Children’s Fund (UNICEF), the United Nations Development Programme (UNDP), the International Labour Organization (ILO) and other multilateral agencies for action on the social determinants of health in the WHO European Region as appropriate for the specific needs of Member States, in the context of EURO’s biennial cooperation agreements (BCAs) and intercountry workplans
• Strengthen cooperation/synergies with the European Commission (EC) directorates-general for health and consumers (DG-SANCO) and employment (DG-EMPL), to follow up the proposed EC communication on “Solidarity in health: Reducing health inequalities in the EU” and support work on health inequities in the context of the EU year for combating poverty and social exclusion (2010)
• Strengthen synergies with the work of the Council of Europe, particularly that related to the forthcoming resolution on migrant health and the Council of Europe’s work on governance of health
• Strengthen synergies with the Organisation for Economic Co-operation and Development (OECD) on education as a social determinant of health. Build on cooperation related to the evidence base and policy implications linked to social outcomes of education and health (policy dialogue planned for February 2010)

**EURO's planned activities on inclusive leadership and effective governance for health**

• EURO will continue to support numerous countries in strengthening their health system stewardship function during the next biennium and has plans to carry out some case studies on health system stewardship, as well as to develop a framework to
evaluate the effectiveness of the stewardship function of ministries of health in their national context.