In the name of God the compassionate and the merciful

NEW DIMENSIONS OF PRIMARY HEALTH CARE IN THE EASTERN MEDITERRANEAN REGION

Lecture of Dr H. Gezairy, Regional Director , WHO / E M Region

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Ladies and gentlemen , colleagues ,

I would like to express my thanks for inviting me to speak on an important topic which we in WHO feel is a vital subject of the present and future directions of working together with countries for a better PHC system .
The world community since the advent of PHC in 1978 as a global public health initiative has agreed to the reorientation and reorganisation of the health systems in line with Primary Health Care (PHC) philosophy and strategy which is recognised as a means of realising the goal of health for all by the year 2000. HFA is now an everlasting goal. Member States of the Eastern Mediterranean Region (EMR) have endorsed PHC approach to develop their health system infrastructure, policies in support of the PHC initiatives and its implementation. The achievements since launching PHC in l978 are substantial and numerous. The desired goals were incorporated in the national constitutions and health policies in all the countries. National health plans detailing also resource commitment towards achieving the national goals and the planned physical targets were laid down. Accessibility to

health care has improved to reach more than 80%. Coverage with essential care had also increased. Infrastructure development of PHC, Basic Developmental Needs, the action-oriented school health curriculum, healthy community programmes all have made advances and paved the way for acceptance of health as part of development. Attempts were made to introduce approaches and technologies adding new impetus for further improvement of the quantity and quality of health care provided to the people. Various degrees of accomplishment in addressing equity to health care, community involvement and intersectoral collaboration have also been achieved.
In spite of all the above mentioned achievements, **gaps and challenges** in health still prevail. The PHC systems in the EMRegion differ in their performance from one country to another and even in the same country. There are several challenges facing the health systems which are amenable to solutions through the PHC approach, principles, techniques and methods. Let me first review with you some of the new developments which are affecting PHC and Health for All (HFA). Shifts such as ageing of population with most countries of the Region having life expectancy at more than 60 years. The rapid urbanisation where approximately 50% of the population in the Region are at present living in urban areas. The Region had also witnessed a shift in epidemiological patterns: countries are reporting more and more chronic diseases, and there was shift from childhood and communicable disease to behavioural chronic and adulthood patterns of disease. In addition to the above and to some extent as a result of demographic changes, the families' role and expectations have changed. The extended family which used to be a prominent feature with its solidarity relationship is now changing into "nucleus family" type. Such a change has its effect on health delivery and care. The role of the government as the sole provider and responsible for health is now shifting towards more of a co-ordinator, evaluator and broker. The health economic shifts from mainly public services to involving private sector seeking a mixed financing scheme. Communities are now more demanding of transparency and accountability of health providers. Indicators of health also had witnessed a shift from disability, morbidity and mortality measurement towards measuring quality of life. These are challenges to be faced by the PHC/HFA movement which will influence our direction of action and which call for innovative methods of work.

The following is not an exhaustive list of future dimensions of PHC and not necessarily that all of them are needed in one setting .

Health in development is perhaps our most important dimension at present times. Improvements in public health is affected by many partners . Better health is the outcome of concerted efforts of all related sectors . **People's health is one of the most important parameters of quality of life. Measurement of HFA should detect differences in the different strata of society.** Poverty had been highlighted as the most important factor affecting health. It was more evident than before that reforming and improving health starts from domains mainly outside the hierarchical set up of health services. Experience gained and methodologies developed so far in the community development, such as the basic developmental needs (BDN) approach and district health systems, should be further strengthened. Future health strategies should take stock of these experiences to enhance the health care delivery system and management for primary health care in the l990s and beyond.

In line with health in development is another dimension which is **centering on people**. People are most important assets for attaining better health. Major achievements in health status were brought about when simple and appropriate technologies such as breast feeding , oral rehydration were introduced and people were the main actors. The role of communities in the health sector needs to be revisited to further improve the community ownership of the programme and countries need to strengthen and/or initiate the process of health care reforms - a reform that will address the challenges and changes affecting the implementation of a sustainable primary health care service in the l990s and beyond. Almost all countries in the Region have realised the strong link between health and development.

Another dimension which has proved its relevance and its importance is **the development of PHC Infrastructure .** By this is meant not only the physical infrastructure but also the human , the organisational , the managerial , the norms , and the knowledge and practice of the system .This pertains more to the PHC system orientation and its development . That is the way the PHC system performs in terms of equity ; its sustainability ; its adequacy and continuity ; its transparency and accountability to the community ;its partnership with sectors , groups , and organisations involved in health of the people . The scope of this dimension - the development of PHC Infrastructure - is wide and complex and expands beyond the

mere medical arena to involve many other partners whose potentials should be prudently tapped to achieve sustainable HFA .Two points I will tackle briefly upon under this dimension . The first is that PHC Infrastructure should focus more on the conceptual , social and spiritual aspects of the PHC approach . PHC should not be restricted or equated to only medical care . This is a severe hindrance to PHC and HFA, more even so in our Region which is very rich in values and principles which are favouring solidarity , equity , social justice , community partnership and human integrity and dignity. The other point still under this dimension of PHC Infrastructure is the notion of **integration** . Now there is more awareness of the importance of integrating health into the overall development. The forms of integration are various. They can be organisational , technical or operational delivery of services. An issue over a long period argued was the vertical versus horizontal approach. The challenge was how to use vertical inputs as a resource and a reference to support integrated approaches. Whether this support is for technical, logistic or administrative purposes. Challenges of integration are also seen in how to strike the balance between the curative , and preventive and promotive care ; the medicalization of health services or technical obsession , and on the other hand focus on developmental health establishing health systems and human solutions to health care problems . In other words how to fit in the notion of cure to the overall well being and quality of life of individuals and communities. This is a long-term political and technical commitment. This challenge is sometimes described as the "top down" versus "bottom up" approaches where decentralisation and centralisation are envisaged as two mutually exclusive phenomena. In fact they should not be . In PHC development both centralisation and decentralisation are needed to ensure a balanced health system development in which short term versus long term vision should be integrated . Immediate outcomes could be necessary to promote and advocate and provide models for the long term sustainability of health care. The ultimate goal is of course sustaining PHC. Countries were and are still striving to make both short- and long-term programmes compatible.

Improving and institutionalisation of quality of health care is another dimension I will dwell upon. Quality of health care is an important attribute of any public health action . It is recognised that the quality of PHC services is affected by the health infrastructure , its actions and improved performance by other sectors outside the

health sector. Here I would like to stress the point that quality should not be for those who can afford it . It should be for all. This is important to save against discrimination and to ensure equity of PHC. Efforts of countries in the EM Region in quality of health care could be grouped into three main categories.

The first category is what can be labelled as "episodic" that is when Quality Health Care (QHC) programmes are introduced as pilot projects in selected few institutions e.g. hospitals . The different methods, techniques of QA are introduced in these institutions and as expected their performance improve. However such episodic quality remained restricted to limited institutions but not replicated to cover the health infrastructure. Many countries in the Region have marks of this "episodic QA" and the challenge is how to move from such episodic to "modelling of QA".The second category which is "modelling QA". By this I mean that the scope of QA as well as its inputs cover a whole level of the health services such as health centers . This is an advanced step whereby the health system has QA built in the planning, implementation and evaluation of a substantial proportion of the health services. It is heartening to see the advances in implementing QHC in the PHC centers in the Kingdom of Saudi Arabia . The efforts of MOH in the Kingdom in QHC are made use of in other countries of our Region . In this category usually investment of QA is well established and substantial. Sustainability of QA is also a major feature of modelling QA experiences**.** The third category is the stage where Quality is a culture and a daily practice by all health workers at all levels of care in all aspects of health care. This is when Quality is institutionalised and this is the ultimate goal of all health systems . That is to say that quality is for all every where, anytime .This is one of the dimensions we should invest on further .

Another major PHC dimension is ensuring **sustainability of health care and its sound financing** .HFA through PHC is a human right, is cost-effective and everlasting public health concept. At present in most countries of the Region, governments are the major health care providers . It is increasingly being recognised by the countries in the Region that health care is becoming an expensive service warranting serious consideration, analysis and review of the current policies of health care financing . There is a growing demand for quality health care by the people in the face of limited resources available . Also technological advances in medicine, particularly the production of expensive pharmaceuticals, and changes in the

demographic, epidemiological disease pattern and trade have had tremendous impact on health care financing in many countries of Region. For example it is more costly to provide care to the increasing proportion of ageing population, with a corresponding rise in the incidence of degenerative diseases in many countries of the Region. Other factors that had influence on the escalating cost of health care includes the uncontrollable rapid urbanisation with its devastating effects on the environment in many overcrowded cities in some countries of the Region. In an attempt to respond to the rapid global and the regional economic and social changes, countries in the Region are contemplating on the course of change in health care financing. It is realised that proper forecasting of the direction and intensity of these changes, and effective use of the internally controllable resources in adopting the changing global economics will significantly help countries in the Region to reshape their health care financing policies . Policies that will guarantee the delivery of a balanced, sustainable and equitable health care to the people . Different options are debated as possible ways and feasible mechanisms of introducing a cost-recovery system and other means of generating funds for the health sector: such as the involvement of the private sector; health insurance policies; out-of-pocket; cost-sharing and co-payment system which directly involve communities. Financing of health care and its provision are to be worked to ensure fair and equitable services that will not lead to marginalisation of some groups of the population. There is a consensus among development planners in the Region that investment in the social sector including health care, is equally productive in a longer perspective, and these products in the form of human development and a healthy population can be projected as marketable similar to other industrial products. The introduction of health financing policies requires a well-studied and well-designed government rules which regulate the application of payment procedures of health care. This should be done, inter alia , to ensure access of health services to the poor and destitute families. In this regard individual countries may choose to decide what type of regulatory financial mechanisms they wish to adopt. In conjunction of this, rigorous selection of an effective, appropriate and inexpensive medical technology should be observed in order to curb the use of expensive, sometimes non-essential medical technology.

In closing there have been considerable gains in health improvement and gaps during the last 18 years. There are rapidly changing scenarios in the social , demographical , technological,

epidemiological and economical situation in the world in general and in the Region in particular . These changes call for review of the present status of the policies of health system infrastructure development, resources available, technology used and mechanisms for maintaining it in order to ensure the provision of equitable and quality essential health care to people in the Region. **The forces of change influencing the future health directions are outside the health care system and to some extent within it.** New dimensions such as harmony of health and development , health care infrastructure reform , sound financing and its sustainability, quality of health care ,and focus on users and community are needed to ensure continuous improvement of performance of primary health care in the future .

Thank you again and I wish you success in your work.