Regional Conference on
Revitalizing Primary Health Care
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Working paper and selected abstracts of presentations
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Message from Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region

The Regional Conference on “Revitalizing Primary Health Care” is an important milestone in our quest for health for all. It not only commemorates the 30th anniversary of the historic Declaration of Alma-Ata on primary health care, but also signifies renewed determination by Member countries in the South-East Asia Region to realize the cherished goal of “health for all”.

The conference will primarily examine ways to revitalize primary health care in the changing context of health development and to take forward the primary health care agenda in the Region. Most importantly, the conference will make recommendations on the subject for consideration by the Sixty-first Session of the WHO Regional Committee for South-East Asia to be held in September 2008 at the WHO Regional Office in New Delhi.

Equity and social justice are the cornerstones of primary health care. With rapid globalization and commercialization, providing universal access to health care, particularly to vulnerable and marginalized groups, is becoming a formidable challenge. I am sure that among the outcomes of this conference will be recommendations that will help to address some of these basic issues.

I am happy to note that we have as keynote speakers internationally eminent health leaders who have pioneered the concept of primary health care. Dr Halfdan Mahler, Dr Amorn Nondasuta and Ms Erna Witoelar have, in their own way, made landmark contributions in the area of health development and we look forward to their continued guidance and advice in taking the movement forward.
The next few days promise to be most rewarding in terms of the wealth of experience that we will be sharing and in the recommendations that will emerge from our deliberations. These, I am confident, will provide the much-needed momentum to revitalize primary health care in the Region and help us to achieve the goal of health for all as well as the Millennium Development Goals.

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Regional Director
Attaining good health is one of the basic fundamental rights for every human being\(^1\), as well as a human investment for national development programmes\(^2\). Health is defined as a state of complete physical, mental and social well-being, not merely the absence of disease and infirmity.

To attain good health, several efforts need to be carried out. One of the efforts is provision of health services.\(^3\) Health service is part of a health system. Health system has a broader scope since it includes all the organizations, institutions and resources that are devoted to producing health actions. A health action is defined as any effort, whether in personal health care, public health services or through intersectoral initiatives, whose primary purpose is to improve health.

The Health for All (HFA) movement was part of the Alma Ata Declaration on Primary Health Care (PHC) in 1978. HFA was to be achieved by the year 2000. This target is not yet achieved till date; therefore, we will continue in pursuing it as a vision of health development. Thirty years after PHC was adopted as an approach to operationalize health systems, we observe different perceptions of PHC that sometimes yield unfavourable health outcomes. Now it is very timely to revitalise PHC in light of the changing disease burden, globalization, trade agreements, social determinants of health, climate change, etc.

In 2000 world leaders reached a consensus on a new movement, termed Millennium Development Goals (MDG), to be achieved by 2015. Five out of eight goals are health-related. The World Health Organization sees the MDGs as milestones on the road to HFA since they set clear goals and distinct targets compared with HFA.

This working paper intends to chalk out the road map for Member countries for achieving their health goals as well as health-related
Millennium Development Goals through health systems strengthening using the PHC approach, taking into consideration social determinants of health. The paper will start with revisiting PHC and redefining HFA to have common perceptions in implementing PHC through health systems. Then it continues with MDGs and health systems using the PHC approach. Achievement in health development follows and continues with challenges in implementing PHC. The last part illustrates the need to revitalize PHC. Finally, multitudes of ways forward are proposed to the conference on PHC for its deliberations.

Figure 1: The conceptual framework used in this working paper is shown below:
Primary Health Care: then and now

The concept of Primary Health Care emanates from the International Conference on Primary Health Care, jointly organized by WHO and UNICEF in Alma-Ata, the capital city of the Kazakh Soviet Socialist Republic, from 6 to 12 September 1978. Primary Health Care according to the Alma-Ata Declaration is an essential care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation at a cost that community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

As a concept PHC offers a comprehensive guide on equity, what to prioritize, technology to be applied, sociocultural aspects, target groups, full involvement of the community, cost-effectiveness and efficiency. Perhaps due to its rich and comprehensiveness nature, PHC is oftentimes misperceived. Many misperceive PHC as cheap, second-grade health care, health care at grassroots level, health care for the rural and the poor, health care in developing countries, etc. These misperceptions to some extent are understandable considering that PHC has a multiplicity of meanings depending on which perspective we look into:
(i) a package or a set of activities
(ii) level of care
(iii) an approach, which has been termed interchangeably PHC principle, PHC pillar and PHC strategy.

(i) From a “package” perspective, PHC was defined in Alma-Ata to consist of at least eight activities or elements, namely:

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

Later on this package was labeled as essential health care package, basic health package, essential health services, etc. The content of the package largely depends on the main health problems prevailing in each country. Thus it is not meant to be a rigid package for worldwide implementation. In general, public health problems do not constitute major health problems in most high-income or developed countries. Furthermore, usually there are public institutions that are responsible to carry out public health programmes. For this reason, Primary Health Care in several developed countries focuses more on medical services where family (primary) physicians usually become the main backbone of the health system.

Implementation of the above package, known as comprehensive PHC, requires strong health systems which most low-income countries do not possess. The oil boom in the 1970s brought temporary relief to some countries. Some bilateral and multilateral donors, interested in tackling the unacceptably high child and maternal mortality, were
quick in realizing the shortcomings. They are of the opinion that to
deal with high mortality conditions, selective PHC, better known as
the vertical approach, is preferable; hence, the launch of the Child
Survival and Safe Motherhood Project. The smallpox eradication
programme was launched by WHO in 1968 and was successful in
eradicating it in 1980; this apparently influenced various vertical or
semi-vertical programmes in the twentieth century and continues
till date.

Implementation of comprehensive care as advocated by the
Alma-Ata Declaration is essential in Primary Health Care. However
in practice, this strategy, considered to produce the most just
outcome, is not easy to achieve. There are two main reasons, namely:

(1) Role of physicians: in many countries, training for medical
doctors is focused on medical sciences and technologies.
As a result, their competence, attitude and behaviour
toward public health are not up to the mark. Not surprising
then that their focus in delivering care is biased towards
medical care.

(2) Limited resources for health, particularly in human and
financial resources.

This constraint has prompted adoption of single disease
programmes or selective Primary Health Care. As a result, only a
few components of services are provided, which clearly contradicts
the original idea of comprehensive Primary Health Care. Some
consider implementation of selective Primary Health Care as a threat
and regard it as a counter-revolution.

In 2001 the Commission on Macroeconomics and Health,
established by WHO, recommended an Essential Health Care Package
to be implemented at $34 per capita. GAVI (Global Alliance on
Vaccines and Immunization) and the Global Fund for HIV/AIDS,
Tuberculosis and Malaria are global health initiatives that pursue
selective PHC. The oil crisis, a global recession and the introduction
of structural adjustment programmes reduced resources for health.
This has resulted, as mentioned earlier, in selective PHC using different
packages of interventions gaining favour, over the intended aim of fundamentally strengthening of health systems for delivering comprehensive PHC.

To date more and more global health partnerships/initiatives and multilaterals recognize that sustaining the success of more vertical initiatives is going to depend on the fundamental strengthening of health systems. In 2007 GAVI introduced a health systems support programme that enables countries to tackle critical bottlenecks to improve immunization coverage.

(ii) From a “level of care” perspective, there are three levels of care with different characteristics for each level of care, in terms of personnel, problems encountered and available facilities, which is depicted below:

1. Primary care: personnel serving this level are called generalists. Health problems encountered, medical and non-medical facilities available are usually simple.

2. Secondary care: personnel serving this level are called specialists; health problems encountered, medical and non-medical facilities available are more complex.

3. Tertiary care: personnel serving this level are called sub-specialists; health problems encountered, medical and non-medical facilities available are the most complex and sophisticated.

Primary Health Care is frequently equated with primary care. Both bring health care as close as possible to where people live and work, thus constituting the first element of a continuing health care process, but the concept of Primary Health Care is different from primary care. Primary Health Care encompasses personal health care (medical care) and public health care. The medical care focus is on treatment and rehabilitation of individuals while public health is on prevention of disease or ill-health and promotion of health of the community. PHC gives higher priority to primary level of care and to public health compared with medical care.
The emphasis put on primary level of care is justified from the point of view of cost-effectiveness and feasibility of implementation. Many ill-health conditions can actually be prevented at this level by implementing primary prevention and promotion measures before they manifest or progress to a higher degree of illness. This is also the focus of public health, where the emphasis of intervention is the community, as opposed to medical care, which deals more with curative and rehabilitative aspects of health care with the focus on individual and institutional care. Health promotion and disease control, either through immunization or case treatment, are best implemented at the primary level of care. For example, evidence is accumulating for treatment of pneumonia in children with antibiotics: the result achieved in treating them in hospital is almost the same as treatment at home. Currently, more and more countries are examining the possibilities of lowering the level of care to reduce cost without compromising quality and safety of care.

iii) From an “approach” perspective: Primary Health Care is an approach to health development. The Primary Health Care concept refers to implementation of a total health development strategy with emphasis on developing primary care as the first level of care of a continuum of care.

The application of the Primary Health Care concept in total health development requires an integrated and comprehensive approach. It implies the use of the four approaches described below in an integrated manner. While more resources and efforts should be focused on provision of essential or basic health care at the first point of contact with the health system, development of various sophisticated hospitals as referral facilities should also receive appropriate attention in program planning. The four approaches/principles/strategies arise from the concept of Primary Health Care, namely:

(1) Universal accessibility and coverage. Primary Health Care strives to ensure universal accessibility and coverage. This translates into the task of fulfilling needs of the vulnerable and the marginalized such as women and children as well
as those living in remote areas and the poor. This principle also implies that equity or social justice be upheld while trying to cover the whole population.

(2) Community and individual involvement and self-reliance. Health should not be the sole responsibility of the government. Each individual and the community should be held responsible as well by involving them from the planning stage down to the implementation and monitoring and evaluation of health programmes. By so doing the sense of ownership will be promoted that eventually ensures sustainability of the health programme. Evidences are accumulating that community empowerment and advocating self-reliance will further sustain the health programmes.

(3) Intersectoral action for health. The causes of ill-health are twofold, namely health risk and health determinants. Health risks emerge from people’s lifestyles, such as use of tobacco, alcohol consumption, food consumption and physical exercise. The determinants of health cover a broad spectrum of factors that include social, educational, economic, gender, political, security and physical environment, such as water and sanitation. These determinants are certainly beyond the health domain to influence. The implication is that successful implementation of Primary Health Care requires intersectoral action, as well as ability to coordinate with other sectors. Mainstreaming health is the manifestation of intersectoral action for health. One way of mainstreaming health is to advocate the importance of having Healthy Public Policy or policies of other sectors that promote health. One such policy is making all development projects subject to health impact assessments besides enforcement of environmental impact assessment.

(4) Appropriate technology and cost-effectiveness. Right choice of technology (i.e. appropriate and cost effective
technology) will ensure better efficiency of the health system. Appropriate technology does not automatically translate into cheap and simple technology like ORS (oral rehydration salts), ITN (insecticide-treated nets) and “kangaroo care” for pre-term infants. We notice that earth satellites for transmitting data for communication in general (telephone, radio and TV) and e-Health in particular (e.g. telemedicine) are not at all simple and cheap technology if considered in isolation. By comparing it to other technologies that seems to be cheap, such as the use of land or sea cable for telephonic communication, the use of satellites, looks exorbitant. But if we take into account indirect benefits like speed and numbers of people served, it will certainly otherwise. Another example is the use of GPS (Global Positioning System) units in disease surveillance. Cost-effectiveness alone should not be used as determining criterion for developing policy and priorities. It has to be coupled with feasibility for implementation and acceptability by the people at large. The focus on prevention and promotion in Primary Health Care, without neglecting curative and rehabilitative care, is derived from this principle.

By using the Primary Health Care approach as a health development strategy, many developed/high income countries in North America and Western Europe are able to provide effective and efficient health services to the community, through provision of accessible, affordable and quality family health services by family doctors as the first point of contact. At this point, services provided follow the basic principles of family practice, which include (1) continuous, comprehensive and integrated health services; (2) commitment to the person rather than to a particular body of knowledge, group of diseases or special techniques; (3) sees every contact with patients as an opportunity to provide prevention or health education; (4) emphasis on evidence-based medicine; and (5) sees him/herself as part of community-wide network of supportive and health-care agencies.
In developing/low- and middle-income countries in Asia and Africa, the use of the Primary Health Care approach as a health development strategy is manifest as the provision of basic health services to the community through the establishment of community health centres/health posts in every village.
The basis of the Health for All policy can be found in the WHO constitution. It is mentioned that the objective of WHO is the attainment by all people of the highest possible level of health. The goal of Health for All by the year 2000 embodies this objective and emphasizes the highest possible level of health. At the minimum, all people in the country should have at least such a level of health that they are capable of working productively and participating actively in social life and community activities. This is popularly known as Health for All by the year 2000.  

Health for All as a movement, articulated in the Alma-Ata Declaration, does not mean that in the year 2000 health professionals would provide health care for everybody or that nobody would fall sick or disabled. Health for All is a process leading to progressive improvement in the health of the people. Health for All means:

1. People use better approaches for preventing disease and alleviating unavoidable disease and disability and have better ways of growing up, growing old and dying gracefully.

2. There is an even distribution among the population of whatever resources for health are available.

3. Essential health care is accessible to all individuals and families in an acceptable and affordable manner and with their full involvement.

4. People realize that they themselves have the power to shape their lives and the lives of their families, free from
the avoidable burden of disease and aware that ill-health is not inevitable.

Since Health for All emphasizes the highest possible level of health, each country will have different health targets, which depend on the current status of health, their social and economic condition. Therefore, the Primary Health Care activities that need to be implemented in order to achieve the Health for All goals will vary from country to country. In the current context, HFA can be defined as: "a stage of health development whereby everyone has access to quality health care or practice self-care protected by financial security so that no individual or family is experiencing catastrophic expenditure that may bring about impoverishment".

As a vision, HFA does not need a concrete timeline as is the case of MDGs adopted by world leaders in 2000. We can consider health MDGs as the mission or objective of HFA till 2015, and simultaneously as proxy indicators to HFA.
Since their adoption by all United Nations Member States in 2000, the Millennium Declaration and the Millennium Development Goals have become a universal framework for development and a means for developing countries and their development partners to work together in pursuit of a shared future for all. These goals gave continuity to the values of social justice and fairness articulated at Alma-Ata. They further affirmed the central place of health on the development agenda as a key driver of social and economic productivity and a route to poverty alleviation.

For health systems, commitment to reach the health-related Millennium Development Goals has two main implications. First, delivery systems must do a better job of reaching the poor, who tend to live in remote rural areas and urban shantytowns. Second, schemes for financial protection must be in place to ensure that the costs of health care, especially catastrophic expenses, do not themselves cause poverty.

MDGs constitute a challenge to Member countries in the South-East Asia Region, not only in deploying actions for achieving them but also in monitoring them on annual basis.

The health-related MDGs are still achievable if Member countries act now. This will require sound governance, increased public investment, economic growth, enhanced productive capacity, and strengthening of health systems.

Routine monitoring of MDGs should be undertaken and reported to the concerned officials. For indicators that can be obtained through population-based surveys such as Under-five Mortality and MMR some proxy indicators have been added (Annexure 1).
A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example, a mother caring for a sick child at home; private providers; behaviour change programmes; vector-control campaigns; health insurance organizations; occupational health and safety legislation. It includes intersectoral action by health staff, for example: encouraging the Ministry of Education to promote female education, a well-known determinant of better health, and to the Ministry of Transport for the use of safety belt to prevent severe injury to the driver and passengers of motor vehicles.

Health systems of some sort have existed as long as people have tried to protect their health and treat disease, but organized health systems are barely 100 years old, even in industrialized countries. They are political and social institutions. Many reforms have taken place, shaped by national and international values and goals. PHC as articulated in the Alma-Ata Declaration of 1978 was a first attempt to unify thinking about health within a single policy framework.

Developed when prospects of growth in many countries were bright, PHC remains an important force in shaping health care worldwide till date. The financial optimism in the 1970s was soon dispelled in many parts of the world by a combination of high oil price, low tax revenue and economic adjustment. Countries seeking to prescribe essential health care as prescribed by the Alma-Ata Declaration were faced with two difficult options: (i) focus public
spending on interventions that are both cost-effective and possess public goods characteristics, and (ii) boost financing through applying user’s fees. While many governments started to levy fees, the poor were deterred from receiving treatment. Limited income yielded from user’s fees has prompted many governments to focus on single disease programmes/selective PHC, which further exclude the poor from getting proper care.

As the crisis in many countries deepened in the 1990s, so many governments looked to the wider environment for new solutions. Infused with ideas from market-based reforms in Europe’s public services and with new experiences emerging from transitional economies, health sector reform focused on improving efficiency. Finally, they arrived at the conclusion that running the health system on $10 per capita or less is not viable. The Commission on Macroeconomics and Health in 2001 came up with a more acceptable proposition i.e. $34 for delivering only essential health care.

Health systems are highly context-specific; there is no single set of best practices that can be put forward as a model for improved performance. The Pan American Health Organization (PAHO)/WHO Regional Office of the Americas defines Health System using PHC approach as follows11:

(i) A PHC-based health system is composed of a core set of functional and structural elements/building blocks that guarantee universal coverage and access to services that are acceptable to the population and that are equity-enhancing.

(ii) It provides integrated and appropriate care over time; emphasizes health promotion and prevention; and assures first contact care.

(iii) Families and community are its basis for planning and action.

(iv) It requires a sound legal, institutional and organizational foundation as well as adequate and sustainable human, financial and technological resources.
(v) It employs optimal organizational and management practices at all levels to achieve quality, efficiency and effectiveness and develops active mechanisms to maximize individual and collective participation in health.

(vi) It develops intersectoral actions to address determinants of health and equity.

In 2007, based on the functions defined in the *World Health Report 2000*, six building blocks of the health system were identified: (i) service delivery; (ii) health workforce; (iii) information; (iv) medical products, vaccine and technologies; (v) financing; and (vi) leadership and governance (stewardship). Figure 2 depicts the health system framework. It should be noted that the building blocks are closely intertwined; therefore efforts to strengthen health systems should be directed in an integrated manner and not in isolation.

**Figure 2:** The WHO Health System Framework

(i) **Service delivery**

In any health system, good health services are those which deliver effective, safe, good quality personal and non-personal care to those
who need it, when needed, with minimum waste. Services delivered, be they prevention, treatment or rehabilitation, may be delivered in the home, the community, in the workplace or in health facilities.

Although there are no universal models for good service delivery there are some well-established requirements:

- **Demands for service**: raising demand requires understanding the user perspective, raising public knowledge and reducing barriers to care: financial, cultural, social or gender barriers.

- **Package of integrated services**: based on population need, of barriers to equitable access and available resources.

- **Organization of provider network**: The purpose is to ensure close-to-client care as far as possible, contingent on the need for economies of scale, to promote individual continuity of care where needed, over time and between facilities and to avoid unnecessary duplication and fragmentations of services. This means considering the whole network of providers, private as well as public, the package of services, whether there is over- or under-supply, functional referral system, etc.

- **Management**: the aim is to maximize service coverage, quality and safety and minimize waste. Whatever the unit of management, any autonomy, which can encourage innovation must be balanced by policy and programme consistency and accountability. Supervision and other performance incentives are also key factors.

- **Infrastructure and logistics**: this includes buildings, equipment, utilities, waste management and transport and communication.

(ii) **Health workforce**

Health workers are all people engaged in actions whose primary intent is to protect and improve health. A country’s health workforce consists broadly of health service providers and health management and support workers. This includes: private as well as public sector
health workers; unpaid and paid workers; lay and professional cadres. Countries have enormous variation in the level, skill and gender-mix in their health workforce. Overall, there is a strong positive correlation between health workforce density and service coverage and health outcomes. In any country, a “well-performing” health workforce is one that is available, competent, responsive and productive. To achieve this, actions are needed to manage dynamic labour markets that address entry into and exits from the health workforce, and improve the distribution and performance of existing health workers.

It goes without saying that most countries experience a mismatch in distribution between urban—rural, public health and medical care and between supply and demand. The matter is further aggravated by external as well as internal migration. Since solving these mismatches is very time consuming, we need to fully explore the potential of expanding the role of community-based health workers and community health volunteers in public health activities.

Community-based health workers include all health-care workers who are part of the formal health organization, and have undergone formal training to carry out a series of specified roles and functions, and spend a substantial part of their working time actively reaching out to the community, discharging their services at the individual, family or community level. These may include doctors, nurses, midwives who fulfill above criteria, public health inspectors, health attendants, health supervisors, family health visitors, etc. who spend a substantial part of their working time actively reaching out to the community.

Community health volunteers mean members from communities selected by communities and answerable to them. They have undergone shorter training than professional workers, not salaried, but may receive financial and other incentives. They are predominantly involved in health promotion and prevention of health problems, supported by the community and the health system but are not necessarily a part of its formal organization. In some countries, community health volunteers are basically village members who work
on a voluntary basis and are called village health volunteers. In specific settings, such as post-emergencies, these categories could be rapidly trained and employed to provide very basic health services and to assist the trained health-care workers in service delivery.

To increase the number of public health specialists to cope with increasing demand, public health education has to be enhanced. Health workforce is important since on average it consumes the highest health expenditure with a range of 40% to 50%.

(iii) Information

The generation and strategic use of information, intelligence and research on health and health systems is an integral part of the leadership and governance function. In addition, however, there is a significant body of work to support development of health information and surveillance systems, the development of standardized tools and instruments and the collation and publication of international health statistics. These are the key components of the information building block.

Information in health is increasingly more than just a national concern. As part of efforts to create a more secure world, countries need to be on the alert and ready to respond collectively to the threat of epidemics and other public health emergencies. A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely health information by decision-makers at different levels of the health system, both on a regular basis and in emergencies. It involves three domains of health information: i) on health determinants; ii) on health systems performance; and iii) on health status.

To achieve this, a health information system must:

- Generate population and facility-based data from censuses, household surveys, civil registration data, public health surveillance, medical records, data on health services and health system resources (e.g. human resources, health infrastructure and financing).
• Have the capacity to detect, investigate, communicate and contain events that threaten public health security at the place they occur, and as soon as they occur.

• Have the capacity to synthesize information and promote the availability and application of this knowledge.

Health information plays a pivotal role in making good policy analysis and policy decisions. Besides monitoring inequity, segregation of data by important equity stratifiers such as wealth, education, geography and sex is mandatory. This kind of segregation, unfortunately, is not routinely available. Community-based surveys such as Demographic and Health Surveys, Household Health Surveys and Socioeconomic Surveys are the way out.

Advances in information technology make it possible to link remote health centers with higher levels of expertise. As suggested by some pilot studies, these advances can also revolutionize the collection and use of data within district health systems, thus addressing the perennial problems of inadequate monitoring and evaluation while supporting better priority-setting. Knowledge development and management as part of health systems research undoubtedly can contribute a lot to health systems strengthening.

(iv) Medical product, vaccine and technologies

A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness and their scientifically sound and cost-effective use. To achieve these objectives, the following are needed:

• National policies, standards, guidelines and regulations that support policy.

• Information on prices, international trade agreements and capacity to set and negotiate prices.

• Reliable manufacturing practices and quality assessment of priority products.
• Procurement, supply, storage and distribution systems that minimize leakage and other waste.

• Support for rational use of essential medicines, commodities and equipment, through guidelines, strategies to assure adherence, reduce resistance, maximize patient safety and training.

Medical products, notably medicine, vaccines and technology, are the second-largest health expenditure after that of health workforce. The application of the list of essential medicines coupled with the rational use of medicines has been shown to improve efficiency, quality and safety of health care. The use of generic medicines will reduce the current expenditure. Traditional medicine as an alternative care is not yet gaining momentum although in some countries parallel application of traditional and modern medicine has been practiced. This is partly due to difficulties in measuring its safety and efficacy.

Vaccines are the most cost-effective public health intervention known so far. Yet, in many instances, it is not easy to implement to its fullest, notably in achieving universal coverage. Wrong choices of technologies may lead to technical inefficiency. Research has greatly expanded the range of technical tools suitable for use in households and communities. Some recent examples include drug regimes for the home-based treatment of malaria and childhood pneumonia.

(v) Financing

A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. Health financing systems that achieve universal coverage in this way also encourage the provision and use of an effective and efficient mix of personal and non-personal services.

Three interrelated functions are involved in order to achieve this: (1) the collection of revenues from households, companies or external agencies; (2) the pooling of pre-paid revenues in ways that allow risks to be shared, including decisions on benefit coverage and
entitlement; and (3) purchasing, or the process by which interventions are selected and services are paid for or providers are paid. The interaction between all three functions determines the effectiveness, efficiency and equity of health financing systems.

Like all aspects of health system strengthening, changes in health financing must be tailored to the history, institutions and traditions of each country. Most systems involve a mix of public and private financing and public and private provision, and there is no one template for action. However, important principles to guide any country’s approach to financing include:

- Raising additional funds where health needs are high, revenues insufficient, and where accountability mechanisms can ensure transparent and effective use of resources.
- Reducing reliance on out-of-pocket payments where they are high, by moving towards prepayment systems involving pooling of financial risks across population groups (taxation and the various forms of health insurance are all forms of pre-payment).
- Taking additional steps, where needed, to improve social protection by ensuring the poor and other vulnerable groups have access to needed services, and that paying for care does not result in financial catastrophe.
- Improving efficiency of resource use by focusing on the appropriate mix of activities and interventions to fund and inputs to purchase, aligning provider payment methods with organizational arrangements for service providers and other incentives for efficient service provision and use including contracting, strengthening financial and other relationships with the private sector and addressing fragmentation of financing arrangements for different types of services;
- Promoting transparency and accountability in health financing systems;
• Improving generation of information on the health financing system and its policy use.

It is ubiquitous for low- and middle-income countries to have a low level of per capita health expenditure. This problem is further exacerbated by misallocation of funds to less cost-effective interventions, resulting in allocative inefficiency. Many Member countries including some countries in the South-East Asia Region have a total per capita health expenditure of less than $34, the level recommended by the Commission on Macroeconomics and Health for implementing an essential health care package. Despite this fact, it is encouraging to note that in some countries or parts of countries, universal coverage with low inequity in health outcome has been achieved.

What matters is high political commitment to allocate sufficient resources to public health and payment schemes that prevent catastrophic expenditure. This kind of third-party payment is preferable to out-of-pocket expenditure which, in many countries, accounts for up to 80% of total health expenditure. Out-of-pocket expenditure is responsible for catastrophic expenditure, which in turn impoverishes the spender.

WHO estimates that, each year, health expenses cause 150 million people to suffer financial catastrophe and push 100 million below the poverty line. Poor households face a double challenge: they experience more illness and thus need more care, yet they are least able to afford the cost of services, especially when paid for out-of-pocket. Government has to increase its role in spending for health and in stewardship. With good stewardship even in highly privatized health systems, good health outcomes can be attained.

(vi) Leadership and governance

The leadership and governance of health systems, also called stewardship, is arguably the most complex but critical building block of any health system. It is about the role of the government in health and its relation to other actors whose activities impact on health. This involves overseeing and guiding the whole health system, private
as well as public, in order to protect the public interest. It requires both political and technical action, because it involves reconciling competing demands for limited resources in changing circumstances, for example, with rising expectations, more pluralistic societies, decentralization or a growing private sector.

There is an increased attention to corruption and calls for a more human rights-based approach to health. There is no blueprint for effective health leadership and governance. While ultimately it is the responsibility of government, this does not mean all leadership and governance functions have to be carried out by central ministries of health. Experience suggests that there are some key functions common to all health systems, irrespective of how these are organized:

- **Policy guidance.** Formulating sector strategies and also specific technical policies; defining goals, directions and spending priorities across services; identifying the roles of public, private and voluntary actors and the role of civil society.

- **Intelligence and oversight.** Ensuring generation, analysis and use of intelligence on trends and differentials in inputs, service access, coverage, safety; on responsiveness, financial protection and health outcomes, especially for vulnerable groups; on the effects of policies and reforms; on the political environment and opportunities for action; and on policy options.

- **Collaboration and coalition-building.** Across sectors in government and with actors outside government, including civil society, to influence action on key determinants of health and access to health services; to generate support for public policies, and to keep the different parts connected — so called “joined up government”.

- **Regulation.** Designing regulations and incentives and ensuring they are fairly enforced.
- System design. Ensuring a fit between strategy and structure and reducing duplication and fragmentation.

- Accountability. Ensuring all health system actors are held publicly accountable. Transparency is required to achieve real accountability.

An increasing range of instruments and institutions exist to carry out the range of functions required for effective leadership and governance. Instruments include: (i) sector policies and medium-term expenditure frameworks; (ii) standardized benefit packages; (iii) resource allocation formulae; (iv) performance-based contracts; (v) explicit government commitments to non-discrimination and public participation; (vi) public fee schedules. Institutions involved may include other ministries, parliaments and their committees, other levels of government, independent statutory bodies such as professional councils, inspectorates and audit commissions, NGO “watch dogs” and a free media.
Achievements in health development

Three decades have elapsed since the inception of Primary Health Care in 1978. All countries in South-East Asia Region have implemented Primary Health Care. Achievements can be measured through three major areas, namely health systems based on PHC, health status improvement and inequities in health outcomes.

1. Health systems based on PHC

All countries in South-East Asia Region, despite different demographic profiles and widely varying economic and social challenges, have developed their health system based on Primary Health Care. Since the beginning of the 1990s all Member States began to reform their health systems by implementing the district health systems with Primary Health Care at their core. 12,13

The physical infrastructures of health services in many SEA Region countries have expanded significantly, particularly at the primary and first referral levels. Most countries have given priority to upgrade the health infrastructure, particularly in rural areas. Practically all Member countries have comprehensive networks of health facilities that extend to the village level. The establishment of primary care infrastructure in rural areas, supported by strong referral system, intersectoral collaboration, and community participation are the characteristics of the health system development based on Primary Health Care in the Region.

Activities or programmes implemented depend on specific health problems encountered and the ability to solve them. All countries in the Region implement both, medical care as well as public health
services. In some countries, public health services play more significant roles. Through organized community efforts, these countries implement public health services that reach to the very remote areas in the countries. By encouraging community participation, the health professionals at village level work hand in hand to improve water and sanitation condition. By mobilizing community resources, the community health centre implements the community nutrition improvement programme.

Provision of medical care by family physicians, as practiced in many developed countries, is available only in big cities. The service, however, is still not optimized. The practice of continuous, comprehensive and integrated health services, are not fully implemented, as the payment system is mostly out-of-pocket. In this Region, development of family practice is still in its infancy.

The Prince Mahidol Award Conference in 2008 reviewed the past and defined the future of Primary Health Care, and revealed several obstacles and mistakes in implementing Primary Health Care as follows:

(a) Financial resources become scarcer, due to unexpected and unprepared for world-wide economic crises.

(b) Lack of community participation. Many countries fail to maximize and mobilize the energies and ambitions of locals, civil officers, NGOs and the private sectors.

(c) High expectation from people for better health care and quick results with various choices.

(d) Shortage of human resources, especially trained and motivated health workers who are willing to work at primary care level.

(e) Emergence and re-emergence of infectious and preventable diseases and increased pace of spread of serious and unusual disease events. This has resulted in the implementation of more selective Primary Health Care that will not solve most of the health problems.
(f) Health services have become market- and profit-oriented. Moreover, corruption occurs at many levels of the health sector, making matters worse.

(g) The growing world population has made consumption of food, drugs and fundamental resources increase. People are moving more than ever, seeking greener pastures for survival, wealth or tourism, and giving us greater connectivity. The more interconnected world leads to the rapid spread of epidemic and pandemic diseases. Universalizing of certain food tastes could lead to greater breeding and slaughter of food animals which could lead to greater danger from animal related diseases. Public health events in one location/region may be a threat to others.

(h) Mental health problems, stress and dysfunctional families are all on the increase.

(i) Inequity due to differences in economic growth and geographical challenges. Two-thirds of the vision impaired people in the high-income countries who are not yet blind have cataract surgery whereas a much greater number of blind people in the developing world have no access to such basic remedies.

Most countries in South-East Asia were turning to community participation as a part of the action needed to reinvigorate the Primary Health Care strategy. In India, community participation was being encouraged for the procurement of medical equipment for hospitals, and cost-sharing schemes have been introduced for the maintenance of health facilities. In Indonesia, dominant community participations were lead by the women’s welfare movement. For improving drug accessibility and affordability, community cost-sharing schemes were implemented in Indonesia, Myanmar, Nepal and Thailand.
## Recent Initiatives in PHC in the Region

<table>
<thead>
<tr>
<th>No</th>
<th>Country</th>
<th>Initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bangladesh</td>
<td>National health systems development has given high priority to ensure universal accessibility to and equity in healthcare, with particular attention to the rural population.</td>
</tr>
<tr>
<td>2</td>
<td>Bhutan</td>
<td>Bhutan has evolved strategies to reach the “unreached” through decentralization of planning and management systems. In recent years the country has also been able to shift the focus from expansion to improvement of quality of services.</td>
</tr>
<tr>
<td>3</td>
<td>DPR Korea</td>
<td>In DPR Korea, all the health establishments are run as public and state responsibilities. Now, with improvement in national economic situation, the country is also witnessing some progress in the health sector with the prospects of better health indicators.</td>
</tr>
<tr>
<td>4</td>
<td>India</td>
<td>The National Rural Health Mission launched in 2005 aims to provide accessible, affordable and accountable quality health services even to the poorest households in the remotest rural regions.</td>
</tr>
<tr>
<td>5</td>
<td>Indonesia</td>
<td>Indonesia has significantly scaled up coverage and accessibility of essential health services through establishing a medium of financial protection for its population. In 2006, the Government launched an initiative to develop “Alert Villages” (Desa Siaga) nationwide.</td>
</tr>
<tr>
<td>6</td>
<td>Maldives</td>
<td>The Government of Maldives has expanded curative services to establish a multi-level referral system, which is more decentralized and has greater NGO and private sector involvement in service delivery. Efforts are also being made to establish a social security system, that includes basic healthcare and to encourage individual organizations to establish mechanisms for covering the health expenses of their employees.</td>
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<tr>
<td></td>
<td>Country</td>
<td>Description</td>
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</tr>
<tr>
<td>7</td>
<td>Myanmar</td>
<td>Myanmar has given high priority to develop an adequate number of workforces of qualified health personnel. To ensure equity in healthcare and reduce discrepancies between different geographical areas, new universities have been opened in Central and Upper Myanmar.</td>
</tr>
<tr>
<td>8</td>
<td>Nepal</td>
<td>The Government is: (a) working to make essential healthcare services available to all people through primary healthcare centers, (b) trying to decentralize health systems management to encourage greater people participation, (c) trying to promote and facilitate public-private/NGO partnerships in the delivery of health services, and (d) making efforts to improve the quality of healthcare through total quality management of human, financial and physical resources.</td>
</tr>
<tr>
<td>9</td>
<td>Sri Lanka</td>
<td>Sri Lanka has been able to scale-up accessibility and coverage of primary healthcare. To tackle the increasing problem of non-communicable diseases, the Ministry of Health will lead in planning and sponsoring a major national behavior change communication program and set-off activities aimed at healthy lifestyle changes in targeted population groups. It will be carried out through inter-sectoral and multi-sectoral collaboration with relevant departments and agencies.</td>
</tr>
<tr>
<td>10</td>
<td>Thailand</td>
<td>Recent initiatives in strengthening primary healthcare in Thailand include (a) giving primary care centre a new look through renovation, refurbishment of physical structure of public health facilities with adequate supply of medical and non-medical equipments, establishment of some public primary care centers with full-time physicians and involvement of private clinics by using the financing mechanism of the 30 Baht scheme, (b) increasing competency of health personnel at primary care centers through upgrading the General Practitioner Residency Training Program to Family Physician Training Program, (c) establishment of Referral Coordinating Centre (RCC) to manage referral systems effectively and providing financial incentives to hospitals that provide reserve beds for admissions, and (d) integrating community-based preventive and health promotion and Thai traditional medicine in primary care centers.</td>
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</tbody>
</table>
2. Health status improvement

Despite the application of the PHC approach in health system development by all countries in the Region, the health status of the people had not improved significantly. The global community admitted that the Health for All by the year 2000 was not achieved by that target date. As a result, many people in the Region have not achieved the level of health that would make them able to work productively and participate actively in social life and in community activities. The health status of the people in this Region is still unsatisfactory (Table 1)\(^1\).

Table 1: Health status in countries of the South-East Asia Region

<table>
<thead>
<tr>
<th>No</th>
<th>Country</th>
<th>IMR</th>
<th>U5MR</th>
<th>MMR</th>
<th>LE</th>
</tr>
</thead>
</table>

Source: WHO-SEARO, 2007
Achievement in health-related MDGs is as follows:

- The progress on Target 2 of Goal 1 (reduction in numbers of underweight children) needs to be accelerated as only three countries show a good progress rate whereas seven countries are making slow progress and that of one Member country is considerably slower than the rest.

- Goal 4 (reduction of under-five mortality, infant mortality and immunization against measles) shows a better progress in the Region, with eight countries having made palpable progress and insufficient progress in two countries. One Member country has, however, registered no progress in this goal.

- Efforts to achieve Goal 5 (reduction of maternal mortality) needs serious attention of everybody concerned as only three countries have made good progress whereas the rest have been very slow and unlikely to achieve the targets by 2015 with their current rate of success.

- There has been uneven progress with respect to the targets 7, 8 and 9 set under Goal 6 (combat HIV/AIDS, malaria and other diseases) in most countries of the SEA Region. While the HIV/AIDS epidemic remains at a low-level with the regional prevalence of disease estimated to be 0.3%, five countries (India, Indonesia, Myanmar, Nepal and Thailand) are experiencing high burden of HIV epidemics. Thailand is the only country in the Region that has successfully reversed the HIV epidemic. There are early indications of decrease in HIV prevalence in Myanmar and southern states of India. Unsafe sex and injecting drug use are currently the main drivers of the epidemic in the Region. A scaled-up integrated package of prevention, care and treatment services is necessary to halt and reverse the epidemic and mitigate its impact.

- An estimated 1.2 billion people or 83% of the total population of the SEA Region live in malaria-risk areas. All
countries except Maldives have indigenous malaria transmission, predominantly *Plasmodium vivax*. Sri Lanka is targeting eradication of local transmission of malaria by 2012, which will transcend MDG targets.

- Trends in the estimated TB incidence rates with reference to the baseline in 1990 indicate that the SEA Region as a whole has already achieved a reversal in TB incidence. The estimated tuberculosis prevalence and mortality rates similarly reflect a decrease in most Member countries, indicating that the expected reductions in prevalence and mortality will also be achieved by 2015. This is also supported by the current trends in treatment success and case detection rates.

- Goal 7 (ensure environmental sustainability: access to safe drinking water and improvement in sanitation) calls for further accelerated work in the area of sanitation. Available data indicate that the majority of SEA Region countries have made important strides towards increasing water supply coverage during the last decade. However, 14% of the population of the Region (approximately 212 million people) still lacks access to improved water supply while as many as 900 million people lack access to improved sanitation.

- As far as Goal 8 (develop global partnership for development: access to affordable essential drugs) (Target: in cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries) is concerned, access to essential medicines has been improved, and will continue to be the core element of health care in the Region. Member countries are bolstering their national drug policies, promoting rational use and ensuring quality, safety and efficacy. With the expansion of the private sector in health care, access to essential medicines has become an important issue.
3. Inequities in health outcomes within and across countries

Although equality and equity are used interchangeably, equity should be differentiated from equality. Equality does not take into account whether the existing disparity/gap/difference is fair or just. Simply put, inequity is unfair or unjust inequality.

Data only from seven countries are available namely Bangladesh, India, Indonesia, Maldives, Nepal, Sri Lanka and Thailand, but not for all equity stratifiers, i.e. socioeconomic status, gender/sex, ethnicity and geographical area.

3.1 Infant mortality

In Bangladesh, India and Nepal, infant mortality rates exceed 65 deaths per 1000 live births (Table 2). However, the rate for Sri Lanka was significantly lower at 19 deaths per 1000 live births, while the available data indicate that the infant mortality rate in Maldives is similar to that of Sri Lanka. In both Sri Lanka and Maldives there is greater access to maternal and child health services as evidenced, for example, by their high rates of skilled birth attendance.

**Table 2:** Selected health outcomes, health systems and health determinants indicators for SEA Region countries

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Bangladesh</th>
<th>India</th>
<th>Indonesia</th>
<th>Maldives</th>
<th>Nepal</th>
<th>Sri Lanka</th>
<th>Thailand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health outcomes</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>USM</td>
<td>88</td>
<td>110</td>
<td>128</td>
<td>101</td>
<td>53</td>
<td>71</td>
<td>108</td>
</tr>
<tr>
<td>% Covered by skilled birth attendant</td>
<td>13</td>
<td>12</td>
<td>8</td>
<td>42</td>
<td>66</td>
<td>43</td>
<td>84</td>
</tr>
</tbody>
</table>

Source: WHO-SEARO, 2007
The difference in infant mortality rates between children in the poorest quintile and those in the richest quintile are large for Bangladesh and Nepal, but even more substantial for India and Indonesia (Figure 3). The gap in infant mortality between the rich and the poor has narrowed marginally for Bangladesh and Indonesia, and to a larger extent for Sri Lanka. It should be noted, though, that in both Bangladesh and Sri Lanka the richest quintile has experienced a slight increase in infant mortality between the last two survey years. No assessment of inequities in infant mortality rates by income level could be made for the Maldives and Thailand due to unavailability of appropriate data. Differences in infant mortality rates by educational attainment and by urban/rural residence are high in India, Indonesia and Nepal but not as large for Bangladesh (Figure 4 and Figure 5).

**Figure 3:** Inequities in infant mortality rates between the poorest and richest wealth quintiles by country and survey year

Source: WHO-SEARO, 2007
Legend: NEP: Nepal; IND: India; BAN: Bangladesh; INO: Indonesia; SRL: Sri Lanka

### 3.2 Under-five mortality

There is a wide range in under-five mortality rates across countries; from less than 20 in Sri Lanka and Thailand to more than 100 in India and Nepal (Table 2). Variations in under-five mortality rates are more likely to reflect differences in access to child health services than in the case for infant mortality. Infant mortality is also influenced by access to adequate maternal care.
In general, under-five mortality rates are two to three times higher in the poorest quintile than in the richest quintile in almost all the countries. Inequities are higher in countries where average under-five mortality rates are also higher (Figure 6). Inequities are greatest in India and Indonesia, where mortality in the poorest groups is more than three times than that in the richest group, while this ratio is less than two in Bangladesh and Sri Lanka.

**Figure 4:** Inequities in infant mortality rates by mother’s education by country

**Figure 5:** Inequities in infant mortality rates by urban/rural residence by country
Similar patterns are observed when viewing differences in under-five mortality rates by education (Figure 7).
In India, Indonesia and Nepal, rural children are much more likely to die before their fifth birthday than their urban counterparts (Figure 8).

Figure 8: Inequities in under-five mortality rates by urban/rural residence by country

![Inequities in under-five mortality rates by urban/rural residence by country](image)

Source: WHO-SEARO, 2007
Legend: NEP: Nepal; IND: India; BAN: Bangladesh; INO: Indonesia; SRL: Sri Lanka

3.3 Coverage of skilled birth attendance

Having a skilled birth attendant present during the birth of a child improves the likelihood of a safe delivery. A skilled birth attendant is either a medical doctor, midwife or nurse who has been given appropriate training to care for mothers giving birth. The global experience and scientific evidence is very clear that skilled birth attendance and access to emergency obstetric care from adequately equipped hospitals are essential and critical to substantially reducing maternal mortality, which is one of the key health MDGs.

Unfortunately, skilled attendance at childbirth is relatively uncommon in most countries of South-East Asia, except Sri Lanka, Maldives and Thailand, where skilled birth attendance is almost universal (Table 2). Almost all babies in Sri Lanka (96%), Maldives (85%) and Thailand (97%) are born with a skilled birth attendant present. In these latter countries, coverage rates are high regardless of socioeconomic, educational and geographical differences.
This seems to be in part because a large percentage of the population in the other countries lives in rural areas, where access to medically trained individuals is in practice limited. This is the case in Bangladesh and Nepal, where only 13 percent of children were delivered with a skilled birth attendant present. Rural areas account for 84% and 74% of the total population in Nepal and Bangladesh, respectively, in 2006.

The gap in coverage of skilled birth attendance is high between the rich and poor, and has remained the same or increased between the 1990s and post-2000 (Figure 9). However, in India the richest 20% of women are five times more likely to receive skilled attendance and, in Indonesia, they are four times more likely to do so than the poorest 20%.

**Figure 9:** *Inequities in skilled birth attendance between the poorest and richest wealth quintiles by country and survey year*

![Graph showing inequities in skilled birth attendance](image)

*Source: WHO-SEARO, 2007*

Legend: NEP: Nepal; IND: India; BAN: Bangladesh; INO: Indonesia; SRL: Sri Lanka; THA: Thailand

Similar patterns of coverage are seen with respect to educational attainment of the mother (Figure 10). Mothers with higher levels of education are more likely to have a skilled birth attendant present at their births than those with lower educational levels.

Mothers who reside in urban areas have higher rates of skilled birth attendant present at their giving birth than those residing in rural areas (Figure 11).
**Figure 10:** Inequities in skilled birth attendance by mother’s education by country

Source: WHO-SEARO, 2007
Legend: NEP: Nepal; IND: India; BAN: Bangladesh; INO: Indonesia; SRL: Sri Lanka

**Figure 11:** Inequities in skilled birth attendance by urban/rural residence by country

Source: WHO-SEARO, 2007
Legend: NEP: Nepal; IND: India; BAN: Bangladesh; INO: Indonesia; SRL: Sri Lanka
Challenges in implementing Primary Health Care

Despite much progress revealed by many countries in implementing PHC through their health systems, the following are some challenges that need to be addressed if we are to achieve health goals in general and health MDGs in particular.

1. **Misinterpretations of the concept of Primary Health Care**

Due to the comprehensiveness of the PHC concept mentioned earlier misinterpretations can easily occur. It may include incomplete, erroneous or misleading view of Primary Health Care as follows:

(a) Primary Health Care as community-based care only therefore is not suitable for the entire population.

(b) Primary Health Care as only the first level of contact of individuals and communities with the health system.

(c) Primary Health Care as only care for poor people in developing countries, who cannot afford real doctors.

(d) Primary Health Care as only a core set of health services, often referred to as the eight essential elements of Primary Health Care.

(e) Primary Health Care is concerned only with rural areas, simple, low-tech interventions, and health workers with limited knowledge and training as opposed to doctors, hospitals and modern technology.

(f) Primary Health Care as a cheap and low quality of health services.
2. **Burden of diseases**

Demographic, epidemiologic and social transition have brought a double disease burden of communicable and noncommunicable diseases. In many developing countries noncommunicable diseases surpass communicable diseases. Added to this is the burden of aging population, and of maternal and infant death. Shifts in disease burden necessitate mandatory changes in the strategy of health development using the PHC concept. Considering that ill health is the result of various health risks and health determinants that lie beyond the mandate of health sector, strengthening of intersectoral coordination in disease prevention and control and health promotion activities cannot wait.

The burden of noncommunicable diseases is closely related to risk factors. Risk is defined as "probability of an adverse outcome, or a factor that raises this probability". The ten leading risk factors globally are: underweight; unsafe sex; high blood pressure; tobacco consumption; alcohol consumption; unsafe water, sanitation and hygiene; iron deficiency; indoor smoke from solid fuels; high cholesterol; and obesity. Together, these account for more than one-third of all deaths worldwide.  

3. **Inequity in health**

Health inequities are found in all countries. The magnitude of these inequities, however, varies significantly between countries. South-East Asia is characterized by substantial health inequities both across and within countries. The Region also lags most other regions in its overall health attainments.

A child born in Nepal is twelve times more likely not to live till his or her fifth birthday compared to a child born in Thailand. Within India, children born in the poorest 20% households are more than three times as likely to die before their fifth birthday compared to children in the richest 20% households. Within-country health inequities are dramatic, except in Sri Lanka and Thailand, even though in all countries economic growth has been generally strong and
improvements in overall levels of health are visible. Maternal and child health are still major concerns. For example, skilled birth attendance, an important determinant of maternal mortality, is less than 5% among the poorest 40% women in both Bangladesh (2004) and Nepal (2001).

Although the health status of poorer populations has improved, in all countries, the gap between the poor and the rest of the population is getting wider. In Bangladesh, for example, the national average for under-five mortality rate has dropped by 31% from 1997 to 2004, but among the poorest 20% population, it fell by only 14% in the same time period. It has to be remembered that equity is the main value upheld by PHC and constitutes the most important approach in health development.

4. Escalating health-care cost

Despite increased funding, resources for health will always be limited; there is a responsibility to achieve the maximum possible with available resources. The expectations of consumers are rising both in terms of responsiveness and in quality of care. This may lead to unnecessary use of medical technology that ultimately increases cost. The matter is further aggravated by out-of-pocket payment and asymmetry in information. Health systems will not automatically gravitate towards greater efficiency or greater equity in access. Unless deliberate steps are taken, through good stewardship, steady advances in medical care will continue to increase health-care cost and benefit a privileged minority. The poor will continue to be excluded from basic essential care, and the gaps in outcomes will grow wider, both within and between countries. A world that is greatly out of balance in matters of health is neither stable nor secure.

5. Trade agreements

Various trade agreements influence the global availability and prices of commodities, including food and pharmaceutical products, often with little regard for the impact on health for low-income countries.
6. **Interdependence of the world**

Interdependence means that health increasingly has global consequences as well as global causes, especially when health emergencies require international assistance. Most experts agree that countries with resilient, community-based systems of care will be best able to respond to the shocks caused by global events, such as food crises, climate change and pandemic diseases.

7. **Inadequate performance or low efficiency of the health system**

Waste and inefficiency need to be addressed. Better incentive schemes are needed to improve performance. The need for incentives also applies to the health workforce. Pending the training and deployment of more health workers, ways need to be found to motivate service in rural areas and to ensure that different conditions are managed at an appropriate level of skills. A solid body of evidence demonstrates the contribution of a Primary Health Care approach to greater efficiency in the use of resources and better overall performance of health systems. As a way of organizing the health system, Primary Health Care is a gatekeeper that helps keep patients with minor complaints from flooding emergency wards. By ensuring that conditions are managed at an appropriate level of skills, Primary Health Care contributes to the more efficient use of human as well as financial resources.

8. **Need for more research**

Research has greatly expanded the range of technical tools suitable for use in households and communities. Some recent examples include drug regimes for the home-based treatment of malaria and childhood pneumonia, "kangaroo care" for pre-term infants, ready-to-use-therapeutic foods for the home management of severe malnutrition, simplified test kits for malaria, heat-stable drugs for chronic care and simplified tools for the early detection and management of cervical cancer. Research in general is needed for health systems, practically covering all its six building blocks.
9. Financing the health system

Despite recent increases in external financial assistance for health, more than 75% of all funds for health in an average low-income country continue to come from domestic sources. Total health expenditure, from all sources including external assistance and loans, averaged less than US$ 30 per capita in 43 low-income countries in 2005. This amount is well below what is considered necessary to purchase an essential set of health interventions. Clearly, many developing countries will need to depend on external financial support for health for some years to come. The need to invest in strengthened health systems has recently been recognized by the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance. In addition, the importance of well-functioning health systems is being addressed in new initiatives, such as the International Health Partnership. Experiences in pilot countries should be translated into lessons for use in multiple countries.

10. Need for integrated services

The success of the WHO/UNICEF Integrated Management of Childhood Illness (IMCI) initiative, which has been adopted as the child survival strategy in 100 countries, paves the way for the future of integrated approaches. IMCI delivers quality clinical care, in a public health approach, according to the principles of Primary Health Care, and within the constraints of the existing health system. It includes provisions for training, the selection and quality assurance of essential medicines and the shifting of tasks to the lowest level of safe and acceptable competence. In addition, the related approach, for Integrated Management of Adult Illness, provided the backbone for scaling up coverage with antiretroviral therapy, which is now reaching nearly 3 million people in low- and middle-income countries. Another example is integration of HIV/AIDS and TB control.

11. Public—Private Partnership

Past efforts to implement a PHC approach focused almost exclusively on the public sector. In reality, for many people – poor, as well as
rich – private providers are the first point of contact; hence, revitalizing PHC should also involve private as well as public providers. While keeping its focus on the community and first contact care, Primary Health Care needs to recognize the problems associated with relying on voluntarism alone.

In most Member countries the private sector is growing at an unprecedented rate. Even the poor are using the private health care provider as their first contact. Yet full information related to the private sector activities in health is mostly unavailable, making it difficult to regulate. Ideally, the government should focus its attention to provision of non-personal health services that are public goods in nature and are mostly in the domain of public health such as health promotion, disease prevention through immunization and control of various communicable diseases. The private sector should be mainly made responsible for personal health care or medical care without preventing them to get involved in public health actions. In big cities the private practitioners are already providing immunization services for children, although still mainly for the middle- and high-income group.

12. Climate change

Global climate change will further burden the already overstretched health system. Till date natural disasters have occurred more frequently: flood, drought and typhoons to mention but a few. The emergency conditions that follow will influence smooth operation of the health system. As a result, many people will not receive adequate health service. The impact is that the mortality rate, especially among the vulnerable group such as children and women, will increase dramatically. Vector-borne diseases such as malaria and dengue will increase due to additional breeding places of the vector. Climate change also influences food production, resulting in severe shortage of various food crops leading to hunger and malnutrition.
The global health community agrees that the PHC concept, value and approach are still valid. What is needed is political commitment and consistency in adhering to those aspects. The relevance of the Alma-Ata Declaration stands even stronger today. Many principles of the Alma-Ata Declaration have been integrated in government policy documents. The strong characteristic of the declaration has been its dynamism, which protects it from becoming obsolete. The realization of the Alma-Ata principles is a cost-effective and appropriate tool for achieving the Poverty Reduction Strategies and Millennium Development Goals. Every government should take health back to basics, and adopt the Primary Health Care approach in the development of the national health system.

The Prince Mahidol Award Conference, aiming to review the past and define the future of Primary Health Care, stated that PHC must be given top priority and we must take advantage of this new high status as a contributor to poverty reduction and economic gain. Health is being seen as a foundation for prosperity and social stability. These assets give health care more political clout.

Primary Health Care remains an important force in shaping health care in both the developed and developing world. The term Primary Health Care signifies an important approach to health-care organization in which the primary or first contact, level – usually in the context of a health district – acts as a driver for the health-care delivery system as a whole.

Various challenges in implementing PHC mentioned earlier will serve as a road map in revitalizing PHC. Revitalizing PHC will be
done through strengthening the health system using the PHC approach. The success in revitalizing PHC will be partly measured through annual monitoring of health-related MDG; besides being will be used as a proxy for measuring the status of Health for All.

Some of the focus in revitalizing PHC is outlined below to be used as guideline for the Regional Conference on PHC in its deliberations:

1. Reaffirm high political commitment toward PHC. The government should strongly support the concept and the implementation of PHC through health system strengthening as well as in health development. Prioritize allocation of funds to public health.

2. Improve health equity through specific actions in the health sector as well as other sectors that influence health outcomes i.e. social determinants of health. Equity or social justice is the most salient feature of PHC. Pro-poor policies in national development in general and in health in particular should be continually promoted.

3. Foster more effective multisectoral collaboration for establishment and implementation of Healthy Public Policy, i.e. policies of other sectors beyond health that promote health. Health Impact Assessment is one manifestation of Healthy Public Policy that should be implemented along with Environmental Impact Assessment. Implementation of Healthy Public Policy is becoming more important in light of climate change.

4. Strengthen health workforce including Community-Based Health Workers (CBHW) and Community Health Volunteers (CHV). To ensure the availability of health workforce for Primary Health Care, three strategic pillars have been recommended, namely:

   (a) renew political commitment and recognize the importance of Community-based Health Workers and Community Health Volunteers;
(b) strengthen the Community-based Health Worker and Community Health Volunteer system; and

(c) ensure a supportive environment for effective functioning of Community Based Health Workers and Community Health Volunteers.

(5) Implement equitable health-care financing such as tax-based and social health insurance and various community-based health financing. Out-of-pocket health expenditure has been blamed as one factor that leads to widening health inequity and at the same time increases the number of the poor. The aim is to achieve universal coverage of financial security to the population in getting quality and safe health care. This may take years. Germany needs more than 100 years while South Korea and Japan need 50-75 years in attaining universal coverage of their health insurance. In the current globalized world where expertise in health insurance and experience pertaining to it is easily available, targeting universal coverage will take much shorter time.

(6) Strengthen partnership with civil society that includes the community, the private sector and NGOs. The community should be empowered for their active participation in health development. The role of the private sector in health development, which was not given due consideration in the Alma-Ata Declaration, should be better acknowledged and regulated.

(7) Promote better transparency and accountability of the health systems through improved leadership and governance (stewardship). All governments are faced with the challenge of defining their role in health in relation to other actors. For many this is changing, for example, with decentralization. Any approach to leadership and governance must clearly be contingent on national circumstances. Some points for consideration:

(a) Develop health sector policies and frameworks that fit with broader national development policies and
resource frameworks, and are underpinned by commitments to human rights, equity and gender equality.

(b) Regulatory framework. Design, implement and monitor health-related laws, regulations and standards, especially in the areas of International Health Regulations; regulation of medical products, vaccines and technologies; regulation concerning occupational health and workplace safety.

(c) Accountability. Support greater accountability through the Organization’s work on monitoring health system performance as set out in the building block on information.

(d) Generate and interpret intelligence and research on policy options.

(e) Build coalitions across government ministries, with the private sector and with communities, to act on key determinants of health.

(f) Work with external partners to promote greater harmonization and alignment with national health policies.

(8) Utilize to its fullest various global health initiatives (e.g. GAVI and Global Fund for HIV/AIDS, Tuberculosis in Malaria) and partnerships in health (International Partnership in Health) that have shown interest in health systems strengthening.
References


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Annexure 1

Revised MDG monitoring framework including new targets and indicators, as noted by the 62nd General Assembly, and new numbering, as recommended by the Inter-agency and Expert Group on MDG Indicators at its 12th meeting, 14 November 2007

All indicators should be disaggregated by sex and urban/rural as far as possible.

<table>
<thead>
<tr>
<th>Millennium Development Goals (MDGs)</th>
<th>Indicators for monitoring progress</th>
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</thead>
<tbody>
<tr>
<td><strong>Goals and Targets</strong> (from the Millennium Declaration)</td>
<td><strong>Goal 1: Eradicate extreme poverty and hunger</strong></td>
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<tr>
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<tr>
<td>Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day</td>
<td>1.1 Proportion of population below $1 (PPP) per day¹</td>
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<tr>
<td></td>
<td>1.2 Poverty gap ratio</td>
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<td></td>
<td>1.3 Share of poorest quintile in national consumption</td>
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<tr>
<td>Target 1.B: Achieve full and productive employment and decent work for all, including women and young people</td>
<td>1.4 Growth rate of GDP per person employed</td>
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<td></td>
<td>1.5 Employment-to-population ratio</td>
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<td></td>
<td>1.6 Proportion of employed people living below $1 (PPP) per day</td>
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<td></td>
<td>1.7 Proportion of own-account and contributing family workers in total employment</td>
</tr>
<tr>
<td>Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger</td>
<td>1.8 Prevalence of underweight children under-five years of age</td>
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<td></td>
<td>1.9 Proportion of population below minimum level of dietary energy consumption</td>
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<td><strong>Goal 2: Achieve universal primary education</strong></td>
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<tr>
<td>Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling</td>
<td>2.1 Net enrolment ratio in primary education</td>
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<td></td>
<td>2.2 Proportion of pupils starting grade 1 who reach last grade of primary</td>
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<tr>
<td></td>
<td>2.3 Literacy rate of 15-24 year-olds, women and men</td>
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<tr>
<td><strong>Goal 3: Promote gender equality and empower women</strong></td>
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<tr>
<td>Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015</td>
<td>3.1 Ratios of girls to boys in primary, secondary and tertiary education</td>
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<td></td>
<td>3.2 Share of women in wage employment in the non-agricultural sector</td>
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<td></td>
<td>3.3 Proportion of seats held by women in national parliament</td>
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<tr>
<td><strong>Goal 4: Reduce child mortality</strong></td>
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<tr>
<td>Target 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate</td>
<td>4.1 Under-five mortality rate</td>
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<td></td>
<td>4.2 Infant mortality rate</td>
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<td></td>
<td>4.3 Proportion of 1 year-old children immunised against measles</td>
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</tbody>
</table>
### Goal 5: Improve maternal health

| Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio | 5.1 Maternal mortality ratio  
|  | 5.2 Proportion of births attended by skilled health personnel  
| Target 5.B: Achieve, by 2015, universal access to reproductive health | 5.3 Contraceptive prevalence rate  
|  | 5.4 Adolescent birth rate  
|  | 5.5 Antenatal care coverage (at least one visit and at least four visits)  
|  | 5.6 Unmet need for family planning  

### Goal 6: Combat HIV/AIDS, malaria and other diseases

| Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS | 6.1 HIV prevalence among population aged 15-24 years  
|  | 6.2 Condom use at last high-risk sex  
|  | 6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS  
|  | 6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years  
| Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it | 6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs  
| Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases | 6.6 Incidence and death rates associated with malaria  
|  | 6.7 Proportion of children under 5 sleeping under insecticide-treated bednets and Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs  
|  | 6.8 Incidence, prevalence and death rates associated with tuberculosis  
|  | 6.9 Proportion of tuberculosis cases detected and cured under directly observed treatment short course  

### Goal 7: Ensure environmental sustainability

| Target 7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources | 7.1 Proportion of land area covered by forest  
|  | 7.2 CO2 emissions, total, per capita and per $1 GDP (PPP), and consumption of ozone-depleting substances  
|  | 7.3 Proportion of fish stocks within safe biological limits  
|  | 7.4 Proportion of total water resources used  
| Target 7.B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss | 7.5 Proportion of terrestrial and marine areas protected  
|  | 7.6 Proportion of species threatened with extinction  
| Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation | 7.7 Proportion of population using an improved drinking water source  
|  | 7.8 Proportion of population using an improved sanitation facility  
| Target 7.D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers | 7.9 Proportion of urban population living in slums  

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1For monitoring country poverty trends, indicators based on national poverty lines should be used, where available.
The actual proportion of people living in slums is measured by a proxy, represented by the urban population living in households with at least one of the four characteristics: (a) lack of access to improved water supply; (b) lack of access to improved sanitation; (c) overcrowding (3 or more persons per room); and (d) dwellings made of non-durable material.
Panel discussions

**Health System Strengthening using Primary Health Care approach**

**Panel A: “Equity in Health”**

1. **Role of Health Sector in Promoting Health Equity**
   Speaker: Professor Vinod Paul

2. **Healthy Urbanization and Social Determinants of Health**
   Speaker: Dr Jacob Kumaresan

**Moderator:** Dr Gado Tshering
1. Role of Health Sector in Promoting Health Equity

By: Professor Vinod Paul

The health sector can and must, promote health equity by increasing its efficiency and effectiveness with which it reaches the poor and the disadvantaged. There are several evidence-informed ways in which the heath systems can alleviate the current inequities in service provision and utilization.

Equity principles must be reflected in the entire landscape of health action, including, program goals, financing, infrastructure, human resources allocation, grassroots activities as well as monitoring. Objectives / targets of the program, and monitoring indicators should be equity-sensitive – i.e., stated in terms of coverage levels and outcomes among the poor.

Health infrastructure and worker density among the disadvantaged populations and regions should receive priority attention and resources. Program interventions need to be channelized through the workers and facilities that the poor reach out to.

Poor communities are often better served by services delivered at their door-step, and by those that mobilize local resources such as community-based health workers/ volunteers. In specific situations, targeting of interventions to the most needy is the best approach. Targeting may be direct or individual, or based on a specific characteristic such as pregnancy or HIV status.

Public-private partnerships may be more successful in reaching the poor and the vulnerable than the government. User fees are a deterrent against service utilization by the poor. Innovative demand generation strategies, in particular, the conditional cash transfers, have been shown to benefit the poor.

Primary health care approach aims at making basic health services affordable and widely available, especially to the poor and
the rural populations. The pro-equity underpinnings are germane to the primary health care approach, and it is therefore logical to mainstream them into our strategies to strengthen, reposition and reform the health systems to make them pro-poor especially in the context of the MDGs.
2. Healthy Urbanization and Social Determinants of Health

By: Dr Jacob Kumaresan

Global estimates show that three billion people, or half of humanity, now live in urban areas. The impact of urbanization on health is significant for the South-East Asia Region, due to the sheer size of its urban population (520 million in 2005) and more importantly because it houses nearly half of the world’s poor. The urban setting is a determinant of health, a lens that modulates other social determinants of health.

The Declaration on Health Development in the South East Asia Region in the 21st century reaffirmed the unstinted commitment of local stakeholders to address the rising challenges of health gaps and inequities.

Healthy urbanization is the assessment and promotion of the reduction of health inequity in urban settings, recognizing that cities have distinct qualities, resources and problems.

In 2006, with collaboration of SEARO, the WHO India Country Office and the Bangalore Municipal Government, the WHO Centre for Health Development supported an integrated and multisectoral process in Bangalore to address strategic local health issues in the community.

This approach led to several action research projects where a blend of community health, public health and public policy interventions were made through the participation of decision makers and stakeholders in health, education, welfare, law, transport, gender issues and faith. This resulted in 34 recommendations, of which 25 were translated into concrete actions so far. This overwhelming success has led to ongoing efforts by the Bangalore Municipal Government to institutionalize this process by setting up an intersectoral board to promote health of the city dwellers. The experience is an excellent example of how city officials and leaders can reduce health inequities among the local residents.
Rapid and unplanned urbanization results in new challenges for global health and primary healthcare systems. Ensuring that urbanization is beneficial for health and a driver of positive health outcomes should be addressed through good governance, which includes empowering individuals and communities to achieve collective social action. Primary healthcare can contribute to this goal due to its community-based dimension, comprehensiveness and coordination with other sectors. Achieving healthy urbanization and health equity in all countries is a global and shared responsibility.
Panel discussions

Health System Strengthening using Primary Health Care approach

Panel B: “Multisectoral Collaboration and its Impact on Health and Quality of Life”

1. Healthy Public Policy
   Speaker: Dr Arum Atmawikarta

2. Use of Positive Indicators to Measure Quality of Life
   Speaker: Professor Dasho Karma Ura

Moderator: Dr George Fernando
1. **Healthy Public Policy**  

*By: Dr Arum Atmawikarta*

The health system in Indonesia has been improved in the last three decades. This improvement is indicated by an increased rate of life expectancy and a decreased rate of infant and child mortalities. However, Indonesia is still facing significant health development challenges. The maternal mortality is considerably high and prevalence of malnourished children is also high. The health status of Indonesians also varies considerably depending on their socio-economics circumstances. Moreover, the existing health status disparities between urban, rural and remote areas are influenced by poverty related health inequalities. Demographic and epidemiologic transition will result in the increased demand of the health services. Economic growth, political stability, democratization process and decentralization policy would provide opportunities of the health development in the future.

Currently, health development in Indonesia has a strong legal basis. It is integrated into the Long Term Development plan, Medium Term Development Plan, and Annual Development Plan. Health development plan has been associated as an integrated part of human resource development, economic development and poverty reduction. Political support from legislative and executive bodies has been continuously provided. It is indicated by significant increased of the budget allocation since the year 0r 2004. Beside, health has been put as one of the priorities in the national development which is equal with education sector and infrastructure.

Inter sector collaboration has been strengthened in health development. Health is now becoming a central issue of any campaign for the election of local government at some areas. Many local government have issued the local government regulation to show commitment for the health sector. Health development programs such as: nutrition, water supply, sanitation, maternal health, CDC, and non communicable disease control, are no longer health issues,
but have been considered as inter sector issue of concern for central and local government.

However, significant efforts must be made to link economic, social, and health policies into integrated action. Significant challenges are primarily associated with regulation structures. Continuous efforts to improve advocacy to the stakeholders is necessary in order to assure the sufficient support especially from local government, which take also into consideration the regular turn over of the players in the democratic system.
2. Use of positive indicators to measure quality of life

By: Professor Dasho Karma Ura

Gross National Happiness (GNH) is the official development philosophy of Bhutan, stemming from HM Jigmi Singye Wangchuck who proclaimed it. Happiness is the main objective and value of Bhutanese society and government and policies and programmes aims to promote GNH.

This presentation will focus on policy tools and criterion used to promote GNH, based on research carried out on GNH.

The presentation on GNH will draw on Buddhist perspective as they relate to contemporary development planning, wellbeing and happiness, his presentation will argue, should be used as the new indicators of any good society.
Panel discussions

Health System Strengthening using Primary Health Care approach

Panel C: “Health Financing and Poverty Alleviation”

1. Equitable Health Financing
   Speaker: Dr Pongpisut Jongudomsuk

2. Health Insurance for the Poor
   Speaker: Professor Dr Ali Ghufron Mukti

3. Health, Income Generation and Poverty Alleviation
   Speaker: Ms Mittal Shah

Moderator: Dr J.P. Gupta
1. Equitable Health Financing

By: Dr Pongpisut Jongudomsuk

Thailand has achieved universal coverage of healthcare since 2002 and entire population are covered by three main public health financing schemes. The Social Security Scheme (SSS) covers the formal sector employees while the Civil Servants’ Medical Benefit Scheme (CSMBS) covers government employees and their dependences. The rest of population is covered by the Universal Healthcare Coverage (UC) Scheme which is the most recent scheme being implemented since 2002. This paper is aimed to update development of the UC Scheme and success of the scheme especially in equity improvement both in terms of access to healthcare and financial protection. Key policy features ensuring benefit of the poor would be analyzed to provide some recommendations.

The UC Scheme has been implemented for six years with its management structure becomes more and more institutionalized. However, main characteristics of the scheme remain the same since the beginning. The scheme could improve access to healthcare of beneficiaries both for ambulatory services and hospital admissions. In addition, it was found that the poor benefited from this improved access to healthcare more than the rich especially at public health facilities and this led to prevention of medical impoverishment. Financing of the UC Scheme is progressive although it is tax based system.

Key policy features ensuring benefit of the poor include universal approach, health service provision based on primary care and district health system, and tax based financing system. The administrative system for implementation of these policy features is less complex and improves its management efficiency. Health service provision based on primary care improves access to healthcare for the poor as well as improves system efficiency. Quality of healthcare provided by primary care needs to be improved continuously to increase confidence of beneficiaries.

Key words: universal coverage of healthcare, equity, the poor
2. Health insurance for the poor

By: Professor Dr Ali Ghufron Mukti

As in other developing countries, Indonesia is facing problems of access, equity, efficiency, quality of health services and approximately 70% of health care expenditure is currently paid "out-of-pocket". These problems have been exacerbated by the 1997/98 economic crisis and the implementation of decentralization since 2001. The most vulnerable and affected group is the poor. To protect the poor and reducing out-of-pocket payments, the central government started in 1998 with the development of a health social security program (JPS-BK). The name of this program has changed several times. In 2005, it became known as Poor Community Health Security (JPK-MM), then as Health Insurance for Poor (Askeskin) and it has been known as Community Health Security (Jamkesmas) since 2008.

Health-care programs in Indonesia have elements of a three-tiered health insurance system. Under the first tier, social health insurance is provided through PT Askes and PT Jamsostek. Askes is a compulsory health insurance scheme for active and retired civil servants, retired military and police officers, veterans and national patriots, and their families. Jamsostek is the social security scheme for private sector workers and includes a health component. It provides health insurance for some formal sector workers. Under the second tier, private health insurances provided through private insurance companies, self-insured schemes and other initiatives. Under the third tier, the Ministry of Health and local authorities run public health-care systems for the uninsured through Jamkesmas and Jamkesda (local government initiatives).

Jamkesmas covers about 76.400,000 people with an almost unlimited benefit package. The premium per person for the poor is paid by the Government, and is currently IDR 5,000 ($ 0.50) per person per month. Jamkesmas allocates a down payment to both public and private contracted hospitals. Hospitals are reimbursed by Jamkesmas using a package payment system and INA-DRG
(Diagnosis-related groups Indonesia). Primary care services are allocated directly.

This scheme has improved the financial protection and access to the poor. The utilization of health care services, both in primary care and hospitals, has increased dramatically. However, the scheme has some challenges; for example, transport costs for those who live far from health facilities are high. Some hospitals are facing difficulties to cover the cost of drugs prescribed outside the standard formulary. Some patients admitted to hospitals incorrectly claim to be a Jamkesmas card holder, etc.

The number of the poor is estimated by the Central Bureau of Statistics, whereas local governments identify potential beneficiaries for Jamkesmas. The signed list of these beneficiaries is sent to PT Askes and PT Askes issues membership cards. Those who are non-poor may be covered by their local government. Due to overstretched services in 2007, funds were not sufficient to compensate PT Askes. Various measures were taken, such as tight monitoring, medical investigation in some hospitals, reduced benefit packages etc. Financial feasibility and sustainability of scaling up beneficiaries is being conducted by sharing responsibility and finance with other parties, for example local governments and communities. Currently, strategies to integrate the schemes into a consolidated national pool are still in process of design. One alternative is “integrated decentralized management of the system”. Another is to request local governments to contribute to the central management of Jamkesmas.

Lessons learnt from the Jamkesmas scheme can be summarized as follows. The scheme has made a significant impact on reducing financial barriers of the poor. This increases the utilization of services, both in primary health care and hospitals. However, some homework need to be done especially on management, administrative issues, role of various stakeholders, management information system, financial sustainability and benefit packages.
3. Health, Income Generation and Poverty Alleviation

By: Ms Mittal Shah

The Self-Employed Women’s Association (SEWA) is a trade union of over 1.1 million women workers in the informal economy. SEWA aims to achieve full employment and self-reliance for poor women workers. Through organizing women workers, we strive to ensure income security, work security, food security and social security.

SEWA members work long, hard hours in difficult conditions. They fall sick frequently, and as a result often fall into debt from illness expenditure – and deeper into the cycle of poverty. Thus at SEWA, we have found that health security is a critical component of income security. To protect women from debt, we have developed a needs-based, integrated insurance product that provides illness, life and asset coverage. SEWA’s insurance programme, VimoSEWA, is integrated with microfinance, economic and health activities.

This paper will outline VimoSEWA’s scheme and design innovations. We have developed a cashless payment mechanism to promote quality of health care services and equity within our membership. VimoSEWA is fully implemented by grassroots women themselves, ensuring that services remain needs- and community-based. SEWA’s preventive and promotive health activities are fully integrated within the insurance program – a unique approach to promote primary health while improving efficiency in the insurance program. Lastly, the paper will share VimoSEWA’s experience in scaling up health insurance for the poor, including through a new government insurance scheme.
Panel discussions

Health System Strengthening using Primary Health Care approach

Panel D: “Social Partnership and Local Developments to Improve Health”

1. Community Empowerment through Micro-Credit Scheme to Improve Community Health
   Speaker: Mr Faruque Ahmed

2. Community-Based Health Worker and Community Health Volunteers in local Health Development
   Speaker: Dr San Shway Wynn

Moderator: Dr B.D. Chautat
1. **Community Empowerment through Micro-Credit Scheme to Improve Community Health**

**By: Mr Faruque Ahmed**

The Bangladesh Rural Advancement Committee (BRAC), one of the largest NGOs in Bangladesh, takes a holistic view of development and effectively uses a micro-credit scheme for poverty alleviation and empowerment of the poor.

Implementing a ‘credit-plus’ approach through its village organizations (VOs), BRAC provides inputs for development in many areas, including health, education, social development, human rights and legal support. The nucleus of BRAC’s development interventions, VOs carry out health interventions through community health volunteers (CHVs) culled from the VOs.

The CHVs are linked with a livelihood strategy through both micro-credit and a revolving fund for basic drugs. BRAC’s 70,000 CHVs reach 92 million people throughout Bangladesh. In 2007, BRAC’s TB case detection rate was 79% and the BRAC-VO member child immunization rate was 96%, compared to national rates of 71.5% and 82%, respectively.

BRAC’s micro-credit scheme vis-à-vis VOs have provided the critical foundation for the sustainable scaling-up of BRAC’s health programmes.
2. Community-Based Health Worker and Community Health Volunteers in local Health Development

By: Dr San Shway Wynn

Myanmar adopted Primary Health Care (PHC) approach and since 1978 four yearly plans have been drawn up and implemented. Since 1991 national health plans have been developed and implemented.

Community based health workers (basic health staff) led by township medical officer played the main role for health care coverage of the community, both urban and rural. In Urban areas health care delivery is undertaken by urban health centers, school health team and maternal and child health center take care of the health services. For rural health care each township has four to seven Rural Health Centers, and each RHC has four sub centers.

Basic health workers are health assistant, lady health visitor and midwife.

For 55.4 million population the country have 1452 rural health centers in 2005, 28,872 community health workers in 2003 and 6 bed/10,000 in 2005.

Community HW/10,000 population was 9.9 in 2004.

The proportion to rural population are 1/23100, 1/23970 and 1/4580 respectively, while the voluntary health workers are community health worker and auxiliary midwife with proportion of 1/900 and 1/1258 respectively. Community volunteer trained in 4 weeks to six months by township training team.

MDG progress: Targets for improved water and sanitation have been achieved, child mortality have been halved in the period of 1990 to 2003, this is on track for achieving MDG targets. Maternal health and nutrition may require scaling up.

The major health problems are Low Birth Weight (10% in 2004), stunted (32% in 2004) and underweight children (32% in 2004).
The main achievement: Steep increase in TB case detection (38% in 1990, 55% in 2000 and 95% in 2005) hence the increase in DOTS coverage.

Coverage of health services: Antenatal care/expected pregnant women coverage (four visit) 66% in 2004, deliveries by qualified attendant 68% in 2003, immunized children in 2005 76% for BCG and 72% for measles.

Issues and challenges in scaling up services: Improve community participation, managerial performance, improve CBHW and VHW teamwork, improve productivity efficiency and staff motivation, ensure universal coverage of health services and adjustment to the rapid change in political, economic, social environmental and technology.