Why this regional consultation—and why now?

Major new commitments and opportunities to advance UHC, and continuing needs

This consultation is being held at a time of unparalleled international commitment to universal health coverage (UHC), but with rising concerns about the pace of progress since the adoption of the 2030 Agenda for Sustainable Development in 2015. The UN Declaration on the Sustainable Development Goals (SDGs) encouraged an integrated approach to development, with a focus on the most vulnerable. SDG 3 aims to ‘Ensure healthy lives and promote well-being for all at all ages’ by 2030. The Declaration states that, to achieve this goal, ‘we must achieve UHC and access to quality health care. No-one must be left behind’.

In the South-East Asia Region (SEAR), there has been encouraging progress on UHC: essential service coverage has improved in all countries since 2010. However, despite these advances, around 800 million people still do not have full coverage of essential health services in the Region and at least 65 million people are pushed into poverty because of health spending. Projections suggest that, at the current rate, few countries in the South-East Asia Region will reach 80% essential service coverage by 2030 (Figure 1). The challenge today is therefore how to accelerate progress towards UHC.

Figure 1: UHC service coverage: projections to 2030, based on UHC index estimates, 2019

This is where the renewed attention to primary health care (PHC), especially frontline health services, comes in. Well-functioning frontline (primary care) services can safely meet the majority of a person’s health needs, whatever their age or health condition. Frontline services are also equitable and efficient: the Global Conference on Primary Health Care, held in Astana in October 2018, provided new international evidence as well as a renewed political commitment to PHC.

A long history of primary health care in SEAR, but uneven progress

Primary health care existed in the South-East Asia Region well before the 1978 Alma Ata Declaration on Primary Health Care, and indeed helped shape it. The commitment to PHC has been sustained, but progress has not been smooth. Discussions on ‘revitalizing primary health care’ started in 2008, around the 30th anniversary of Alma Ata. The 2008 World Health Report *Primary Health Care: Now More Than Ever,* together with a regional conference the same year, offer a preview of current discussions. The Report argued that the translation of the values of PHC into tangible reforms had been uneven, and that health gains had been unequal between and within countries. It pointed out that the nature of health problems was changing faster than anticipated, with the rise of noncommunicable diseases (NCDs), ageing populations and urbanization. It noted the growth in the unregulated ‘commercialization’ of health and argued that PHC needed to be more responsive to social change and rising expectations, and to tackle fragmentation. Within SEAR, misperceptions of PHC were highlighted in 2008: that it was often seen as only for the poor; only for rural areas; as being cheap and low-quality care; and for developing countries only. Recommendations were codified in a WHO SEARO resolution that year, and the 2012 regional strategy for UHC positioned primary health care-oriented systems as the ‘underpinning concept’ for UHC.

2019: time for a rethink of approaches to PHC

Many of the above challenges persist. So, the big question is: what needs to be done differently, to make greater progress in delivering good quality primary care services to all those that need them, regardless of their age or health condition?

As elsewhere in the world, the population in SEAR is ageing and noncommunicable diseases are rapidly rising. By 2020, people aged 60 years and over will outnumber children under 5 years in the Region. Given that — whether one is young or old — it is quite common to have more than one health condition at the same time, there are growing calls for people to receive more ‘integrated’ and person-centred care. The rise in chronic health conditions leads to a growing need for greater continuity of care over time and across levels of care.

*Primary health care at forty: reflections from South-East Asia,* a paper prepared for the 2018 Global Conference on PHC, concluded that - if PHC is indeed going to be the cornerstone for advancing UHC in SEAR - some significant transitions are needed. These are summarized in Box 1 and are well-reflected in the *Operational Framework for Primary Health Care,* that was produced as part of the Global Conference on PHC in 2018 and will be presented during this consultation.
Moving the PHC and public health agenda forward as part of UHC: transitions needed

- From institutional prescriptions, to a focus on health system outcomes: universal access to needed care without financial hardship.
- From primary level care in isolation, to addressing frontline and hospital services together, and harnessing new technologies.
- From episodic, low-quality frontline services, to continuity of high-quality care.
- From familiar to fresh approaches to community engagement, given more informed populations.
- From partial and ambivalent to more systematic and managed engagement of private providers.
- From routine primary care, to primary care also capable of outbreak surveillance and response.
- From political commitment to equity, to practical implementation of effective solutions for all.

How can this regional consultation help?

Today, many countries in SEAR recognize the need to strengthen frontline services (Box 2 provides definitions), and much is happening. However there is no blueprint on what to do. Common questions are: How can we introduce the new services needed for changing health problems into our existing primary care? What can we do to increase use of frontline services? How can we best manage the required changes? To what extent do new technologies help accelerate progress? Can we afford these changes? Can we afford not to make them? How will we know if the changes are working?

A note on terms and definitions

**Frontline services**

The term frontline services is used in this paper, and this consultation, to refer to services that are the first point of contact for people with the health care system. It refers to personal health services. Frontline services can be either community-based or facility-based. They can be public or private: in many SEAR countries almost half of first contact care is provided by private providers.

**Primary care**

Primary care is defined as the entry point to personal health services for the vast majority of health problems. An essential component of the health system, it also provides services with a family and community orientation, linking public health and personal health.

The terms frontline services and primary care are quite commonly used interchangeably.

**Primary health care**

Primary health care is defined in the Astana Declaration as “a whole-of-society approach to health that aims equitably to maximize the level and distribution of health and well-being by focusing on people’s needs and preferences (both as individuals and communities) as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people’s everyday environment. PHC has three inter-related and synergistic components:

- Primary care and essential public health functions as the core of integrated health services;
- Multisectoral policies and actions; and
- Empowered people and communities.”
This is a very large agenda. A three-day consultation cannot cover everything, and certainly not in depth. The focus of this consultation is on strengthening personal frontline services, prevention as well as treatment, not population-based services. It therefore does not cover the whole PHC agenda. It also will not cover clinical case management. Rather, it will focus on the ways frontline services as a whole are organized, managed and financed, to become more equitable and of good quality.

**This consultation: a regional perspective on strengthening frontline services for UHC**

A key objective of this meeting is to discuss the changes needed – or already happening – to strengthen frontline health services in ways that enable more people, especially the vulnerable, to actually receive the health care they need, without incurring financial hardship.

The programme is organized around three ‘pillars’: changing models of care for today’s health needs; improving service quality and safety; and monitoring and accelerating progress and performance. For all three pillars, a core question will be: do we know if the changes that are being introduced are leading to more equitable access to care, i.e., benefitting those currently most often excluded? Discussions will ‘road test’ ideas on the transitions needed, and experience with how to take them forward. The programme is designed to stimulate debate, share experience and identify priority actions that will make a difference in achieving well-functioning frontline services for UHC in the Region in the near- to medium-term.

**Access to essential health services: who is still being left behind and why**

On the whole, frontline services are located nearer hard-to-reach groups. Having facilities nearby is one aspect of access. But there are other barriers to access and use of services for the poor, vulnerable and marginalized. The meeting will therefore open with a discussion of who is still being left behind and why, to set the scene for the rest of the meeting.

Coverage of essential health services\(^a\) has improved in all SEAR countries, and the regional average has risen from 46% in 2010 to around 62% in 2019 (Figure 2). There are fewer examples of reduced inequalities in coverage by income, mother’s education level or geographical location (Figure 3). This means that, despite decades of effort, many are still being left behind: as mentioned earlier, around 800 million people in SEAR still lack access to a full range of essential services. There is also little information on coverage for vulnerable groups such as migrants, the urban poor or those from ethnic minority groups.

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\(^a\) The essential service coverage index has 16 indicators, in 4 groups.
Changing models of care to meet today’s health needs

Countries already have a wide range of approaches to organizing, staffing, managing and paying for frontline services. The rapidly changing epidemiological and demographic context means that existing models, i.e., publicly-financed frontline services with a focus on maternal and child health, are beginning to be critically re-examined and adjusted (Box 3). These changes are needed, but not necessarily easy to introduce.

**Box 3 New approaches to financing, organization and management of primary care in the South-East Asia Region**

- Health financing reforms in Indonesia since 2014 include contracting with primary health care providers.\(^17\)
- Contracting private and public providers: the primary care cluster approach in Thailand;\(^18\) contracting of public and private providers by BPJS in Indonesia;\(^19,20\) different forms of partnership with NGOs in Bangladesh.\(^21\)
- Gate-keeping and referral: different approaches to gate-keeping are being tried in Indonesia as part of the BPJS reforms;\(^22\) Bhutan has a nationwide triage and ambulance tracking system to facilitate timely referral in emergencies, using new information technology.\(^23\)
- Continuing, more integrated care: Thailand’s approach to elderly care emphasizes holistic care, and health worker training has been adapted to reflect this; there are plans to introduce family practitioners in primary care in Sri Lanka,\(^24,25\) Indonesia and the Maldives.\(^26\)
- Continuing more integrated care is a goal of the new Health and Wellness Centre reforms in India.\(^27,28\)
- Embedding outbreak detection and response in primary care, including communities: Nepal has created Rapid Response Teams that include staff from health posts; several countries use national NGOs such as Red Cross and Red Crescent for emergency preparedness and response at grassroots level.\(^29,30\)
Two important questions when thinking about new models of care concern the current use of frontline services, and where people are going for care – public or private? Figures 4 and 5 provide some information. Available data in SEAR countries suggest OPD consultations per person per year are quite low compared with, for example, OECD countries. These data reflect primarily public sector use: total consultations, public plus private, would be higher. They also reflect out-patient use at both primary care facilities and hospitals.

The private sector is a significant provider of frontline services in many SEAR countries. Available evidence from eight countries shows that the private sector provides over half the care for children under five years with common and sometimes life-threatening conditions such as diarrhoea and pneumonia in at least four of them (Figure 5). Other studies have shown that the poor as well as the rich use private providers.

The first 1.5 days of the consultation will be spent considering the transitions – or changes – that are needed to make service delivery models more fit-for-purpose for all people, whatever their age or health condition.

It will consider current international and regional evidence and experience with designing changes in frontline service organization, staffing and financing, and being introduced in the context of existing service delivery systems. It will consider what is known about introducing new health worker cadres and primary care teams and harnessing additional stakeholders, especially traditional medical practitioners and the private sector, to deliver essential health services. It will discuss how to make frontline services more effective in detecting and protecting against disease outbreaks. It will consider links with hospitals, and the role of hospitals in the future of primary care. It will discuss ways to make use of appropriate new technologies. It will explore how to manage implementation of agreed changes.
Key questions for discussion include:

- How can frontline services offer more ‘person-centred’ and ‘integrated’ care, putting people’s needs before programme needs?
- Are current strategies for human resources and medicines ‘fit for purpose’, given the aim of improving access to and use of frontline services?
- Do different payment methods support improved use of services, and better provider performance?
- How should frontline and hospital services be addressed together, and two-way referral encouraged, to increase the use of primary care and decrease over-crowding in hospitals?
- On the private sector, what are some new approaches to address the double challenge of protecting people from financial exploitation and poor-quality care, while also harnessing the private sector’s extensive assets?
- How can surveillance and response become essential elements of primary care?
- Where would we like to be in 2, 5 or 10 years’ time in terms of making frontline service delivery models more fit for purpose?

Improving quality and safety of frontline services: how to accelerate progress?

Improving access to poor quality health services is wasteful as well as unethical. Poor quality care remains common, especially in low and middle-income countries. Disadvantaged groups are particularly affected. The 2018 Lancet Global Health Commission on High-Quality Health Systems states that “Poor quality care is now a bigger barrier to reducing mortality than insufficient access. 60% of deaths from conditions amenable to health care are due to poor-quality care.” Assessments of quality of care involve many dimensions, all of which suffer from severe data limitations in low- and middle-income countries. SEAR countries are no exception: vaccination coverage data are quite commonly used as crude proxies for quality. Below is a summary of data that could be compiled for this consultation, focused on frontline service quality.

Quality (1) Availability of essential inputs

Quality health services cannot be delivered without some basics being present, such as clean water, adequate sanitation, essential equipment, health workers and medicines. Altogether, reliable data are limited.

Information on basic amenities is available from facility surveys in five SEAR countries. Figures 6 and 7 show significant variations and gaps in their availability in frontline health facilities.
The overall availability of health workers (doctors, nurses, midwives) had improved in almost all SEAR countries (Figure 8) in recent years. However, data cannot be disaggregated by level of care. In addition, some important cadres of frontline health workers are not captured in these figures, as they are not yet routinely counted. Most SEAR countries still face challenges in recruiting and retaining health workers in rural areas, where frontline services tend to be more accessible than hospitals. Data has begun to improve on retention but is still scarce. The availability of essential medicines in frontline facilities varies, according to existing limited data (Figure 9).

**Quality (2) Quality of clinical care**

Coverage data for conditions needing repeated contact with the health system such as antenatal care and hypertension detection and control are also used as rough proxies for **continuity of care**, which is one dimension of quality. Figures 10 and 11 show that these rates vary widely across countries.
Some limited data on appropriate clinical care exist from case studies of antibiotic use in SEAR. These show an inappropriately high percentage of upper respiratory tract infections being treated with an antibiotic (Figure 12).

The bottom line is that better data on quality are needed to track whether frontline services really are improving.

Most SEAR Member States have long had strategies to improve quality and safety, but challenges remain. Many quality improvement interventions are implemented by specific programmes. Many countries also have national quality and/or patient safety strategies, with interventions targeted at different levels of health facility. Box 4 offers a snapshot of selected policies and strategies being used in SEAR countries. To date, frontline services quality appears to have received less attention than hospital quality.
Box 4  Service quality and safety: selected policies and actions by Member States

- **Bangladesh** has introduced quality improvement committees at all levels of care in the public health sector, with a facility performance scoring system that is publicly accessible online in real-time.\(^3^2\)

- **India** has developed a national patient safety implementation framework (2018-2025) and introduced Health and Wellness Centre reforms to ensure better quality and more integrated care.\(^3^3,^3^4\)

- **Indonesia** has used accreditation of hospitals as a key policy instrument to improve quality for over two decades. In 2015 it established an Accreditation Commission for Primary Health Care Facilities.

- **Sri Lanka’s** National Policy on Healthcare Quality and Safety, 2015 sets 7 key result areas spanning clients, managerial and process systems, clinical effectiveness and staff development. A set of national quality guidelines and frameworks of standards are guiding progress.

- **Thailand** has developed outcome-based primary care quality monitoring indicators that capture progress on outcomes for high-burden conditions from existing data and are scored for use in pay-for-performance.\(^3^5\)

- **Timor-Leste** has entered into a Twinning Partnership for Improvement with Macau (SAR)China to obtain focused support on specific aspects of quality improvement in selected health facilities.

Figure 13 presents an overview of the types of intervention and levels currently targeted to improve quality of primary health care, based on an analysis of published literature 2008-2017, by the Lancet Commission on High-Quality Health Systems. Almost three-quarters of the interventions are at the point of care, or ‘micro level’. The Commission argues that such interventions on their own have modest effects on provider performance and are hard to ‘scale-up’ and sustain, if the surrounding system does not change.

Figure 13: Types of interventions and levels targeted to improve PHC quality according to published literature from 2008-17

Source: Lancet Global Health Commission on High-Quality Health Systems in the SDG Era: Time for a revolution, 2018
This consultation will review and build on suggestions from an informal expert consultation held in early 2019, to explore how SEARO could help consolidate and accelerate improvements in quality and safety of health services. Key conclusions from that consultation (Annex 1)\(^36\) were:

- There remains a need to get back to some real basics on quality and safety in the Region, especially for frontline facilities.
- Water, sanitation and hygiene as well as basic infection prevention and control (IPC) interventions are key entry points.
- There is a need to identify more synergies between programme-specific activities, to scale up and sustain their benefits.
- There is a need to raise awareness and create a sense of urgency for improved health care quality and safety, especially at the frontline.

The consultation will therefore spend much of the second day discussing three aspects of the quality and safety agenda.

- What should countries be doing differently, to generate a sense of urgency and support for improvements in health care quality and safety under the rubric of ‘cleaner, safer health facilities’?
- How to ensure that WHO actions collectively contribute to many more ‘cleaner, safer health facilities’?
- How to expand the ‘solution space’, as the Lancet Commission calls it, to accelerate progress on health care quality and safety in SEAR?

**Harnessing new technologies to improved coverage and quality**

New digital technologies have multiple applications in strengthening frontline services - in diagnosis and treatment, in service management, and in population-based monitoring. There are now literally thousands of projects demonstrating a wide range of uses. Relatively few are implemented at scale, though that is also changing rapidly.

There will be one session that specifically discusses what it takes to harness the power of such new technologies at scale in frontline facilities, and what has been learned about some of the ‘do’s and don’ts’.

**Monitoring progress and performance; linking to action**

Without good information, decision-makers cannot say where they are and set a course for where they want to get to. They cannot know whether their policies and strategies are making a difference. Current data on effective service coverage as well as quality and safety are scarce and can be unreliable.

However, recent years have seen real momentum in SEAR on monitoring UHC – both service coverage and financial protection. Monitoring service quality is beginning to get more attention. The SDGs also put more emphasis on monitoring equity – for example, for critical subpopulations, such as people living in rural areas and the poor. There is also more emphasis on accountability for progress.
One key message will be the importance of keeping a population perspective when thinking about how to track progress. This is crucial, because a key policy question is whether people previously not getting the care they need are now getting it. Just measuring service utilization does not give any information about those needing care but not getting it. A second question is whether the care being provided is effective and of reasonable quality. And a third question is around the performance of frontline facilities themselves.

All measurement metrics, but especially those for quality, can easily become detailed and complicated, as well as expensive, fragmented and burdensome. Fewer and better metrics are needed that can capture effective coverage, competent care processes, confidence in health systems and quality impacts. The private sector, where many seek care, needs to be included – a challenge for all monitoring exercises.

The final day of the consultation will discuss new developments in monitoring frontline services; approaches to addressing gaps in existing information, challenges with data quality and the use of data in policy and management decisions.

Participants will consider questions such as:

- Are we doing better in detecting trends in who is getting access to care, and in identifying whether the poor and other vulnerable groups are being reached?
- What additional steps can be taken to improve measurement of performance and accountability for progress on frontline services for UHC?
- What is the experience in SEAR with using data to raise awareness and stimulate policy debate about reaching those being left behind? How can better data be used in countries to drive improvements?

In conclusion: what next in SEARO?

The final sessions of the consultation will review ideas and suggestions on ‘what next’ raised in the preceding sessions, and then consider which are the biggest priorities – and how to take them forward in practical ways. Questions will come up during the meeting, but some that have already been identified in preparation for this meeting, and in other discussions, include:

- How to catalyze progress through more or different types of political, organizational and technical action?
- Which ideas from discussions during the meeting are priorities?

By the end of the consultation, we would like to have a manageable set of practical ideas on how to do things differently to accelerate the equitable delivery of high quality and safe frontline services as the foundation of UHC. The following are a few initial ideas for consideration, short, medium and longer-term:

- Accelerate improvements in regional evidence: scale-up real-time documentation of the design, implementation and results of new frontline service delivery models being implemented in the Region and the lessons they hold for others, including on reducing inequities.
Increase political attention to frontline service quality and safety: ignite demand for cleaner, safer health facilities among parliamentarians and the general public, as well as health workers and managers. Set a mid-decade target/s for the Region. Communicate status and progress on cleaner, safer health facilities with a dashboard, and share at Regional Committees as part of WHO’s annual report on progress on UHC and the SDGs.

Support facility and district/provincial management capacity development (in areas such as human resources for health, financial and support system management), including through regional courses, networks, cross-country learning and more cross-programme and inter-agency collaboration.
Annex 1: Summary of suggested actions from Promoting cleaner, safer health facilities in SEAR: informal experts’ consultation on improving quality and safety, 27-28 March 2019, New Delhi, India

Actions needed by level of care

Priorities for frontline level services

- Make primary care facilities more visible, with a focus on quality and safety.
- Use IPC as an entry point that brings many essentials together.
- Use outreach by community health workers to improve quality and public trust.
- Identify the indicators for a “fit-to-serve” health facility.
- Use appropriate timely referral between levels of care as a key indicator of quality.

Priorities for hospital level services

- Make hospitals part of service delivery redesign for better quality and safety.
- Identify key actions to scale up IPC in hospitals, including hand hygiene.
- Promote self-assessment of performance against benchmarks to guide tailored actions

Suggested follow-up actions from the experts’ consultation:

1. Ignite demand and create a sense of urgency for cleaner, safer health facilities, based on careful preparation, including through an awareness campaign targeting parliamentarians and the public.

2. At Regional Committee meetings, have Member States discuss strategic directions from 2020-2030 to accelerate progress towards cleaner-safer health facilities and set a mid-decade acceleration goal for annual monitoring.

3. As a basis for such discussions, develop a dashboard/index to measure cleaner, safer health facilities and share it with Member States at Regional Committee meetings as part of WHO’s annual UHC progress monitoring.

4. Support policymakers to use the dashboard/index to drive acceleration, with a “fit to serve” facility as the unit of interest, based on an underlying framework that includes the patient experience and reasons why given indicators are selected.

5. To build health workers’ capacity, prioritize CPD/in-service training in IPC for nurses and cleaners and strengthen the capacity of district level facility managers.

6. Implement actions to foster synergies between programmes.

7. Take the suggestions from this consultation to the Regional Consultation on Strengthening Frontline Services for UHC in July 2019.
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