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Maximizing the Return on Investments in Primary Health Care - Challenges and the Critical Role of Information

Purpose: Information
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MAXIMIZING THE RETURN
on
INVESTMENTS IN PRIMARY HEALTH CARE

Challenges and the critical role of information

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What are key investments in primary care?

- Key functions of primary care:
  - People-centered
  - First point of contact
  - Care coordination
  - Continuity of care

- Strengthening primary care also implies
  - Shifting care out of hospital
  - Developing information infrastructure to underpin quality monitoring and improvement

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What are the expected returns?

- Meets most health needs?
- Improves health outcomes?
- Reduces level of health spending?
- Slows down the rate of growth of health spending?

"Strong primary care in Europe has had a positive impact on population health, socioeconomic inequalities in health, and avoidable hospitalizations. However, health care spending is higher in countries with relatively stronger primary care provisions"

- D. S. Kringos, W. Boerma, P. Groenewegen et al., "Europe's Strong Primary Care Systems Are Linked to Better Population Health But Also to Higher Health Spending," Health Affairs, April 2013 32(4):686–94.

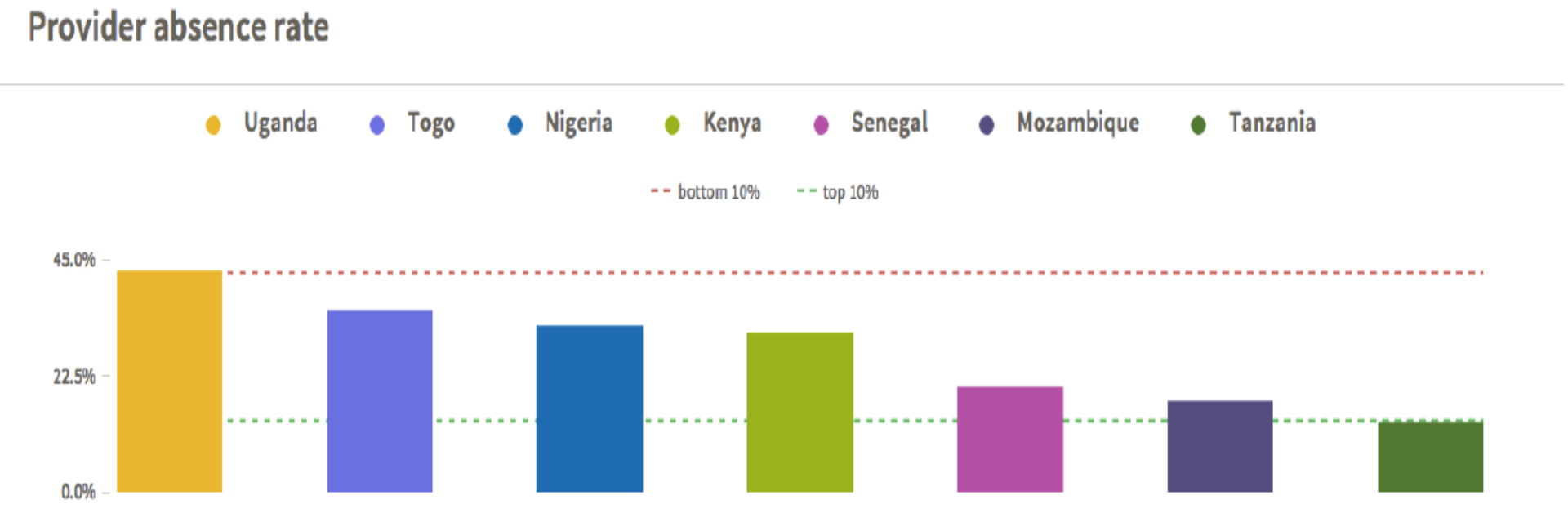
What are challenges to maximizing the returns on investing in primary care?

Underfunding and under-investment in primary care is often a major constraint:

- Underpaid health workers lacking in motivation
- Lack of complementary inputs
- Poor quality infrastructure

…..but not the only one

Too few providers?



Absences are largely approved.
Cause: not too few providers, but poor management

Source: Gayle Martin, Service Delivery Indicators , World Bank Group

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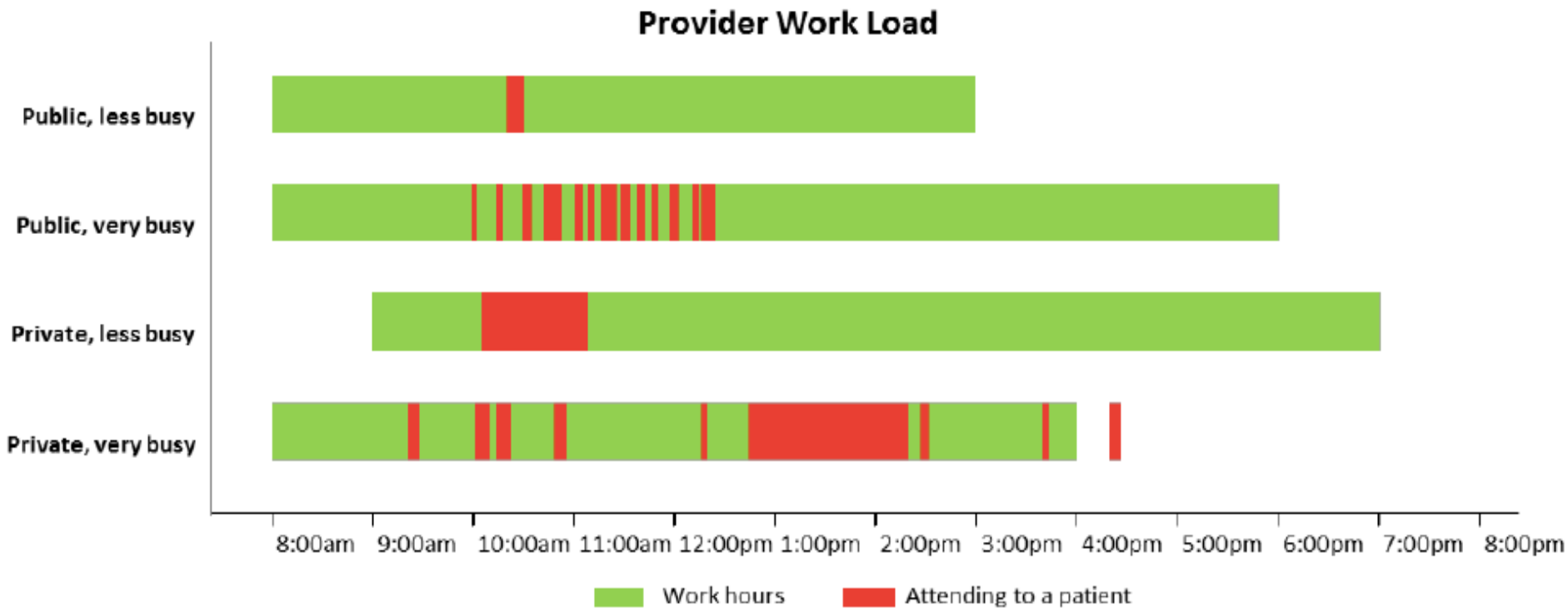
Provider workload too heavy?



Many providers do not see patients

Source: Jishnu Das, World Bank Group

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Dissatisfied patients?

An average patient-provider interaction:
diagnosis and treatment for chest pain (India)

3.89 minutes

2.89 questions

1.46 exams

2.34 medicines

Source: Jishnu Das, World Bank Group

Weak diagnostic accuracy?

Location	Condition Studied	% standardized patients who receive correct diagnosis
India: Delhi (Urban)	Angina, asthma, diarrhea	23%
India: Madhiya Pradesh (Rural)	Angina, asthma, diarrhea	12%
India: Bihar (rural)	Childhood diarrhea	3%
	Childhood pneumonia	8%
China: Shaanxi Province (Rural)	Dysentery and angina	37%
China: Sichuan, Shaanxi, and Anhui Province (Rural)	Tuberculosis	15%
Kenya: Nairobi (Urban)	Angina, asthma, diarrhea, and tuberculosis	32%

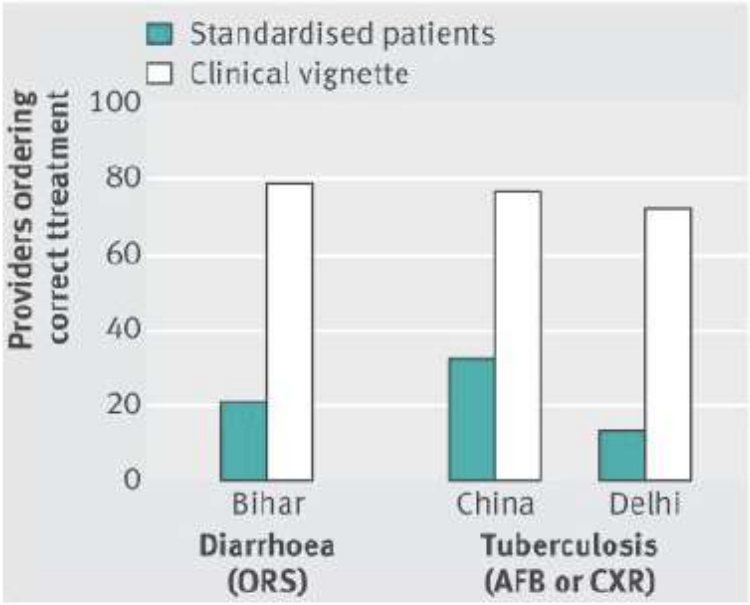

Fig 4 | Differences between how providers said they would manage diarrhoea and turberculosis in clinical vignettes and what they actually did with standardised patients presenting with the symptoms in the vignettes (ORS=oral replacement solution, AFB=acid fast bacilli test, CXR=chest radiography) [13 17 30]

Source: Das, Woskie, Rajbhandari, Abbasi, Jha, 2018.

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Information and measurement critical for maximizing returns from investment

Primary care is being asked to do more and demonstrate better value for money…

… but often 'flying blind'

Quality standards, indicators and monitoring frameworks much less developed in primary care than in hospital care.

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What is the information infrastructure?

Key feature: **Reliable measurement and data feedback loops**

Main elements

- Registration / empanelment at the frontline
- Record, collate and aggregate health related information on empaneled population
- Data feedback: compare each area's performance against benchmarks or targets
- Continuous measurement and quality improvement

➔ Requires investment in hard infrastructure as well as systems and capacity

PHCPI* early engagement in Chile: Cascading Performance Dashboards

- Established a monitoring framework that reflects a more comprehensive view of PHC and emphasizes the centrality of quality of care for stronger outcomes
- Created a system of cascading performance dashboard that allows for systematic monitoring and regular use of comparable data for all municipalities
- Increased capacity within the Ministry of Health to produce and regularly update performance dashboards
- Offered an opportunity for PHCPI to adapt its offering to the needs of middle-income countries and countries with an increased burden of non-communicable diseases

Source: World Bank

*Primary Health Care Performance Initiative

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THANK YOU!

EXTRA SLIDES

GLOBAL TRENDS AND IMPLICATIONS FOR SERVICE DELIVERY

Aging	**Coordinated care and continuity of care for multi-morbid, frail elderly**
NCDs	**Greater focus on primary and secondary prevention, disease and case management,**
Rising Incomes	**Rising expectations about access and quality and growth of technology needs to be managed effectively**

ABOUT PHCPI

The Primary Health Care Performance Initiative (PHCPI) brings together country policymakers, health system managers, practitioners, advocates and other development partners to support stronger, resilient, efficient, and equitable primary health care (PHC) systems that help countries achieve universal health coverage (UHC).

Launched in 2015, PHCPI is a partnership between the Bill & Melinda Gates Foundation, World Bank Group, and the World Health Organization with Ariadne Labs and Results for Development (R4D) as technical partners. We work to catalyze improvements to PHC systems in low- and middle-income countries through better measurement and knowledge- sharing.

Led by: BILL & MELINDA GATES foundation | THE WORLD BANK IBRD • IDA | WORLD BANK GROUP | World Health Organization

In partnership with: ARIADNE LABS | RESULTS FOR DEVELOPMENT

Promising Practices: A community-based approach to comprehensive Health Care

Pop: 206 M

Rural: 15 %

Context: Since mid-80s, Brazll has focused on strengthening primary health care as a mean of promoting and ensuring access to health services for its entire population

PHC reform objective: Reorienting the health care system with the creation of the Family Health Program (FHP)

Intervention proposed:

- The FHP redistributed the responsibility of ensuring effective care delivery to municipalities instead of states.
- Creation of Multidisciplinary teams (Physician, nurse, 4-6 community health agents. Responsible of up to 1,000 families.
- CHA live in the same communities where they work; strong relationship with families
- Trained during 3 months / assigned to approx. 150 families
- Monthly visits provide basic preventative care and collect vital data.
- High risk patients are refer to the clinical team.
- CHAs connects families to conditional cash transfer programs, welfare organization and other social services for issues such as housing or domestic violence.

- Results:
  - Model has been effective in addressing health disparities particularly in the poorest municipalities.
  - It is consider a successful and cost-effective intervention (31-51 USD) per person / per year).
- Challenges :
  - The impact is still limited in large urban centers.
  - The program has to increase the number of well-trained health care workers and improve the communication and referral system among primary, secondary and tertiary health services

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Promising Practices: Costa Rica

Context: Caja Costarricense de Seguro Social (CCSS) was established in 1941, as the social security insurance system for wage-earning workers. Overtime gradually incorporate workers dependents, people in rural areas, low income population and certain vulnerable population. In 1973, Ministry of Health adopt a steering role and the responsibility for the provision of care was transferred to the CCSS.

PHC reform objective: Expansion of universal health coverage and the strengthening of primary health care

Solution: Introduction of community-based PHC Teams (*Equipos Básicos de Atención Integral de Salud, EBAIS*) that initially consisted of a doctor, nurse, and public health worker and were assigned to specific geographic regions.

- Act as first point of contact for all services
- Provides services to 1,000 families
- Are multidisciplinary
- Now operate out of their own buildings
- Operate under performance agreements (management commitments, MCs) with the central level

Pop: 4.7 M

Rural: 24 %

- Outcomes:
  - By the end of 2001, 80% of the population was covered by an EBAIS team and nearly the entire country was covered by 2006.
  - Lower mortality among children and among adults compared to districts without EBAIS; decline in deaths by communicable diseases
- Challenges :
  - Addressing properly NCDs and ageing
  - Addressing health problems not mentioned in the MCs – obesity, depression, tobacco use and drug addiction
  - Reducing waiting time for in-person visits to PHC facilities
  - Improving vertical integration
  - Reducing high unnecessary demand for Emergency Services

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Promising Practices: Estonia

Pop: 1.3 M

Rural: 32 %

Context: Since the country gained independence from soviet Union in 1991, the country has made significant progress on improving health outcomes due to commitment to primary health care that lead to a transformation of the health system.

PHC reform objective: Establishing family medicine as a specialty to strengthen primary health care.

Intervention proposed: Family medicine specialty was established in 1993, to serve as first point of contact and gatekeepers of other health services

- Strong leadership provided by three chief actors in the Estonian Health Care System
- Nurses had the possibility to specialize in Primary Health Care.
- Standardized evidence-based guidelines are use for the management of acute and chronic conditions at high-quality care.
- Patients are assigned to a Primary Health Care team using fixed geographical areas.
- Financial incentives are included to assure productivity as well as quality.
- Telemedicine was introduce in 2005 free of charge for the first 5 minutes to any citizen regardless of insurance status
- eHealth system has been a valuable tool to ensure coordination and continuity of care.
- Use of single national record allow to document all the necessary medical information and link to all health providers and pharmacies.

- Results:
  - The country has 95% of the population covered for both curative and preventive services.
  - Hospital admission has been reduces as well as the number of hospitals.
  - Life expectancy increase up to 76.6 years in 2011.
  - Child mortality has been reduce to 3.1 death per 1000 live births.
- Challenges:
  - Shortage of family nurses and infrastructure gaps that limits the expansion of family doctors practices.
  - Recertification of family doctors is not happening at the required rate.
  - The aging of the population and the rise of Non Communicable Diseases (NCDs) will require to continue strengthening the Primary Health Care System
  - Follow evidence-based guidelines continues to be inconsistent because of resource constraints

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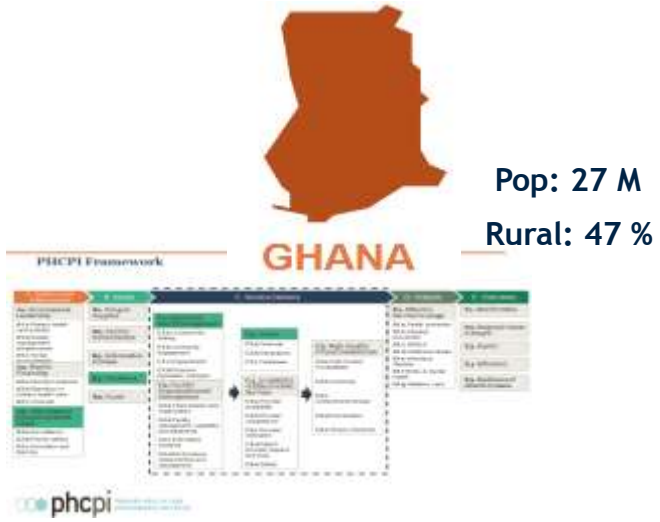
Promising Practices: Ghana

Context: Experimental trial in Navrongo in the Upper East Region during the early 1990 became preliminary success and lead to implementation of Community-based Health Planning and Services (CHPS).

PHC reform objective: The CHPS initiative in Ghana was created in 1994 with the aim of reducing barriers to geographic access to primary health care.

Intervention proposed: The Community-based Health Planning and Services (CHPS) following 15 Steps and Milestones promote community engagement and participation in order to reduce barriers to geographical access and strengthen PHC.

- Nurses are trained and deploy as Community Health Officers. They provide door to door services at community based CHPS compounds.
- The 15 steps are tied to a set of specific activities, including selection of sites for CHPS compounds, and selection and training of Community Health Management Committee.
- The 15 steps are organized into 6 Milestones to encourage a sense of accomplishment and progress within the district health management team, as well as the community.
- "**District of excellence**" serve as a model for peer-to-peer sharing in a week long observation and training course.



- Results:
  - Establishment of 3,000 CHPS zones
  - Ghana has long been seen as a leader in health systems performance in sub-Saharan Africa. Previous work on the CHPS strategy has informed primary health care reforms in Ethiopia, Burkina Faso, Tanzania, Nigeria and Sierra Leone
- Challenges :
  - Achieve national coverage of 6,000 CHPS zones.
  - Work with nursing and midwifery professional council to ensure CHPS and community engagement are integrated into pre-service training and included on licensing exams.

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